UCSF Health
St. Mary's Hospital

UCSF Health
Saint Francis Hospital

MEDICAL STAFF

BYLAWS OF THE JOINT MEDICAL STAFF OF UCSF HEALTH ST. MARY'S

AND UCSF HEALTH SAINT FRANCIS

(2024)

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MEDICAL STAFF BYLAWS OF THE JOINT MEDICAL STAFF OF UCSF HEALTH ST. MARY'S AND UCSF HEALTH SAINT FRANCIS

PREAMBLE

The joint Medical Staff of UCSF Health St. Mary's and UCSF Health Saint Francis ("the Medical Staff") recognizes and acknowledges that the ability to provide quality medical care and education, as well as to conduct research, depends on the mutual accountability, interdependence, and responsibility of the Medical Staff and the Governing Body for the proper performance of their respective obligations.

These Medical Staff Bylaws provide for the organization of the Medical Staff and provide a framework for its self-governance, in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of patient care and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors, and relations with applicants to and members of the Medical Staff.

DEFINITIONS

1. The terms "ADMINISTRATOR" and "HOSPITAL PRESIDENT" mean the person appointed by the Board of Directors to serve in an administrative capacity.

2. The term "ALLIED HEALTH PROFESSIONAL" means an individual (who is not a licensed physician, dentist, or podiatrist) who is qualified to render direct or indirect medical or psychological care if that individual is supervised or directed by a Medical Staff member who possesses privileges to provide such care in the Hospital, who exercises independent judgment within the limits established by the Governing Body, the Medical Staff, and the State of California and within the areas of their professional competence, and who may be eligible to exercise privileges and prerogatives in conformity with these Bylaws and the Allied Health Professional Rules and Regulations as adopted by the Governing Body. Allied health professionals are not eligible for membership in the Medical Staff.

3. The terms "AUTHORIZED REPRESENTATIVE" and "HOSPITAL'S AUTHORIZED REPRESENTATIVE" mean the individual designated by the Hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.

4. The terms "BOARD OF DIRECTORS," "BOARD," and "GOVERNING BODY" mean the Board of Directors of UCSF Health Community Hospitals d/b/a UCSF Health St. Mary's and UCSF Health Saint Francis.

5. The term "CHIEF OF STAFF" means the chief officer of the Medical Staff elected by members of the Medical Staff.

6. The terms "CLINICAL PRIVILEGES" and "PRIVILEGES" mean the permission granted to Medical Staff members to provide patient care and includes unrestricted access to those Hospital resources (including equipment, facilities, and Hospital personnel), which are necessary to effectively exercise those privileges.

7. The term "DEPARTMENT" means the group of practitioners who have privileges to practice one of the general areas of medicine, surgery, and special services ("special services" includes diagnostic radiology, pathology and nuclear medicine, and radiation therapy) at the Hospital.

8. The term "DEPARTMENT CHAIR" means the Medical Staff member who is duly elected in accordance with these Bylaws to serve as the head of a Department.

9. The term "DISTANT SITE," when used in the context of a discussion regarding Telehealth, means the location from which the Telehealth practitioner delivers their patient care services.

10. The term "DIVISION CHIEF" means an individual appointed by the Service Chief in the corresponding UCSF Medical Center department to: (i) serve as a liaison between the Department Chair and the UCSF Medical Center Service Chief; (ii) facilitate cooperation

between the Department and the corresponding UCSF Medical Center department; and (iii) coordinate between the MEC and UCSF's Executive Medical Board on matters involving quality, safety, performance improvement, and professional competence and conduct.

11. All references in these Bylaws to the term "HOSPITAL" shall mean UCSF Health St. Mary's and UCSF Health Saint Francis, including all inpatient and outpatient locations and services operated under the auspices of these hospitals' licenses.

12. The term "IN GOOD STANDING" means a member currently meets all membership requirements (including, but not limited to, meeting attendance requirements and payment of dues or assessments) and is not currently subject to suspension of any kind, an adverse action or recommendation by the Medical Executive Committee for a medical disciplinary cause or reason, or any limitation of any Medical Staff rights or privileges. "LIMITATION" may include, but is not limited to, suspension, concurrent proctoring unrelated to initial privileges, or consultation requirement.

13. The term "INVESTIGATION" means a process specifically instigated by the Medical Executive Committee, or by a committee or individual acting on behalf of the Medical Executive Committee, to determine the validity, if any, to a concern or complaint raised with respect to a member of the Medical Staff, and does not include activity of the Medical Staff Well-Being Committee.

14. The term "LIMITED LICENSE PRACTITIONERS" specifically means any oral surgeon, dentist, clinical psychologist, or podiatrist holding a current license to practice within the scope of their license who is a member of the Medical Staff.

15. The term "MEDICAL EXECUTIVE COMMITTEE" means the executive committee of the Medical Staff, which shall constitute the governing body of the Medical Staff as described in these Bylaws.

16. The terms "MEDICAL STAFF" and "STAFF" mean those physicians (MD or DO or their equivalent, as defined in Definition No. 21 and Section 2.2-2(A)), dentists, podiatrists, oral surgeons, clinical psychologists, and all other practitioners in all categories of the Medical Staff who hold a current license to practice within the scope of that license and who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.

17. The terms "MEDICAL STAFF MEMBERS," "STAFF," "MEMBERS," and/or "PRACTITIONERS" mean, unless otherwise expressly limited, any physician (MD or DO or their equivalent, as defined in Definition No. 21 and Section 2.22(A)), dentist, podiatrist, clinical psychologist, oral surgeon, and any other practitioner in any other category of the Medical Staff.

18. The term "MEDICAL STAFF YEAR" means the period from January 1 to December 31.

19. The term "NOTICE" means a written notification sent to the addressee via the United States Postal Service, first-class postage prepaid, or an alternative delivery mechanism if

that alternative mechanism is reliable and expeditious (e.g., e-mail, facsimile, or in-house Medical Staff Member mailbox).

20. The term "ORIGINATING SITE," when used in the context of a discussion regarding Telehealth, means the location at which the patient is located.

21. The term "PEER" means a practitioner within the same professional discipline.

22. The term "PHYSICIAN" means an individual with an MD or DO degree or the equivalent to either of those degrees. "The equivalent" shall mean any degree (i.e., a foreign degree) recognized by the licensing boards in the State of California, including the Medical Board of California or the Osteopathic Medical Board of California, to practice medicine.

23. The terms "PLURALITY VOTE," "MAJORITY VOTE," and "TWO-THIRDS VOTE," unless otherwise specified, shall mean the designated proposition (i.e., plurality, majority, and two-thirds, respectively) received from those votes cast by persons entitled to vote, excluding blanks or abstentions.

24. The term "SPECIAL NOTICE" means written notification that is effected upon delivery (*see also* definition of "NOTICE," above) and that may be transmitted in any of the following ways, within the discretion of the Chief of Staff:

    (a) By hand delivery (a receipt that is dated and signed by the addressee of the Special Notice should be obtained at the time of delivery, but is not required);

    (b) By U.S. Certified Mail, return receipt requested, sent to the official address of record in the Medical Staff Office (each Member must ensure that the Medical Staff Office is in possession of a current official address at all times);

    (c) By any reliable commercial delivery service, where delivery may be verified (e.g., Federal Express; UPS); and/or

    (d) By facsimile machine designated in writing by the Member as the preferred means of delivery, where proof of successful transmission is readily available.

25. The term "TELEHEALTH PRACTITIONER" means the individual practitioner who provides health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, data communications, or other virtual care delivery mechanisms to patients at the Hospital.

26. The term "TELEHEALTH" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, data communications, or other virtual care delivery mechanisms. The Medical Staff recommends to the Governing Body which clinical services are appropriately delivered through this medium, according to commonly accepted quality standards.

27. "UCSF Health" refers to the academic medical center, faculty practice organization, and related health facilities and clinics operated by The Regents of the University of California

in the San Francisco Bay Area; and which oversees affiliate facilities and assists them in operating consistent with the mission and values of the University of California, UCSF, and UCSF Health.

ARTICLE I

NAME, PURPOSES, AND AUTHORITY

1.1 NAME

The name of this organization is "the Joint Medical Staff of UCSF Health St. Mary's and UCSF Health Saint Francis."

1.2 PURPOSES

The purposes of the Medical Staff are:

(A) To promote and maintain high-quality patient care that is commensurate with available resources for all patients who receive any of the services of the Hospital or who are treated in any facilities or Departments of the Hospital;

(B) To assume a leadership role in Hospital performance improvement activities, in order to improve the quality of care rendered by all practitioners authorized to practice in the Hospital through an appropriate delineation of clinical privileges and through an ongoing review and evaluation of each practitioner's performance in the Hospital;

(C) To provide an educational setting to maintain scientific standards, further medical education and clinical investigation, and lead to continuous advancement in professional knowledge and skill;

(D) To initiate and maintain the Rules and Regulations of the Medical Staff;

(E) To strive for cooperation between all clinical services;

(F) To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Board of Directors and the Hospital President;

(G) To provide care and access to services in a manner that does not discriminate on the basis of sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, immigration status, or political affiliation;

(H) To be the formal organizational structure through which (1) the benefits of membership on the staff may be obtained by individual practitioners and (2) the obligations of staff membership may be fulfilled;

(I) To serve as the primary means of accountability to the Board of Directors for the appropriateness of the professional performance and ethical conduct

of its members and to strive towards the continual improvement of the quality and efficiency of patient care delivered in the Hospital consistent with the state of the healing arts and the resources locally available; and

(J) To maintain self-governance in accordance with the policies of the Board of Directors, the Standards of Hospital Accreditation of The Joint Commission, and the Guiding Principles for Physician-Hospital Relationships of the California Medical Association.

1.3 AUTHORITY

The Medical Staff has a right of self-governance. This right includes, but is not limited to, all of the following:

(A) Establishing, in these Bylaws and in the Rules and Regulations, the criteria for Medical Staff membership and privileges, and enforcing those criteria and standards;

(B) Establishing, in these Bylaws and in the Rules and Regulations, clinical criteria and standards to oversee and manage quality improvement, utilization review, and other Medical Staff activities, including, but not limited to, periodic meetings of the Medical Staff, its committees, and its Departments, and review and analysis of patient medical records;

(C) Selecting and removing Medical Staff Officers;

(D) Assessing Medical staff dues and utilizing the Medical Staff dues as appropriate for the purposes of the Medical Staff;

(E) The ability to retain and be represented by independent legal counsel at the expense of the Medical Staff; and

(F) Initiating, developing, and adopting Medical Staff Bylaws, Rules and Regulations, and amendments thereto, subject to the approval of the Governing Body, which approval must not be unreasonably withheld.

ARTICLE II

MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

Membership on the Medical Staff of the Hospital is a privilege which shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. No physician or limited license practitioner, including individuals in a medical administrative position by virtue of a contract with the Hospital, shall admit patients or provide medical or health-related services to patients in the Hospital unless the physician or limited license practitioner is a member of the Medical Staff or has been granted privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

All members of the Medical Staff and allied health professionals will be deemed to be members of the Medical Staff Organized Health Care Arrangement ("MSOHCA") with the Hospital under the Health Insurance Portability and Accountability Act ("HIPAA").

The Hospital will issue a joint Notice of Privacy Practices ("JNPP") to its patients. This JNPP will fulfill HIPAA requirements for both the Hospital and MSOHCA members who see patients at the Hospital. When members of the MSOCHA see patients at the Hospital, they must not issue another Notice of Privacy Practices to that patient while the patient is in the Hospital.

MSOHCA members' usage of the Hospital's protected health information is restricted to those members listed in the JNPP. The Hospital will solicit an acknowledgment of the JNPP from its patients; MSOHCA members must not solicit a separate acknowledgment of the JNPP from patients at the Hospital.

The JNPP does not fulfill practitioners' obligations when those practitioners see patients outside of the Hospital or in their own private offices. MSOHCA members remain responsible for issuing their own Notices of Privacy Practices outside of the Hospital, and practitioners remain responsible for obtaining their own acknowledgments of the Notices of Privacy Practices outside the Hospital.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 BASIC QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP

Except for the Honorary Staff category, in which case these criteria shall only apply as deemed individually applicable by the Medical Staff, physicians and limited license practitioners must meet the following requirements, and maintain ongoing compliance with such requirements, to demonstrate they possess the minimum basic qualifications for membership in the Medical Staff. Physicians and limited license practitioners must:

(A) Provide evidence of the following:

1. Current license to practice in the State of California, which license is not restricted by any suspensions, probations, or other limitations;

2. Current eligibility to participate in federal and state healthcare programs, including, but not limited to, Medicare and Medicaid;

3. Adequate experience, education, and training;

   a. Except for applicants who are seeking Outpatient Services – No Privileges or Surgical Assist privileges only, all applicants licensed as allopaths, osteopaths, or podiatrists seeking initial or new appointment to the Medical Staff or a privilege or privileges not directly and clinically related to privileges currently enjoyed must have successfully completed an approved residency program in their specialty;

   b. All applicants that are licensed as psychologists or dentists must document completion of an approved residency program in the pertinent specialty or demonstrate that combination of specialty training, experience, current expertise and prospective contribution to the mission of the Hospital and the Medical Staff that warrant the recognition of an exemption to this requirement;

4. Current professional competence and expertise;

5. Good judgment; and

6. Current adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that the physician/limited license practitioner is professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care.

(B) Show an ability and commitment to:

1. Adhere to the ethics of their respective professions;

2. Work cooperatively with others so as not to adversely affect patient care or jeopardize the ability of a patient's treatment team to provide quality patient care, as determined by the Medical Executive Committee;

3. Keep confidential all information or records received in the physician-patient relationship, as required by law; and

4. Participate in and properly discharge those responsibilities determined by the Medical Staff, including peer review;

(C) Ensure coverage under a current policy of professional liability insurance which covers all requested clinical privileges and has policy limits which are at least equal to the minimum amount established by the Medical Executive Committee ("minimum limits"), which policy shall be kept in effect for as long as the applicant remains a staff member. Medical Staff Members are responsible for ensuring that their current professional liability carrier supplies the Medical Staff Office with a certificate of insurance or declaration of continuous coverage. Any cancellation, reduction of coverage below the minimum limits, or change of this policy related to current clinical privileges shall be reported to the Department of Medical Staff Services within fifteen (15) days; and

(D) Have offices or residences which are located within the counties of San Francisco, San Mateo, Marin, Contra Costa, or Alameda, and/or which are, in the opinion of the Medical Executive Committee, located close enough to the Hospital to provide appropriate continuity of quality care. Telehealth practitioners are excluded from this requirement.

2.2-2 PARTICULAR QUALIFICATIONS

(A) Physicians.

1. An applicant for physician membership in the Medical Staff must hold an MD or DO degree or their equivalent and a valid license to practice medicine that is issued by the Medical Board of California or the Board of Osteopathic Examiners of the State of California and that is not revoked, suspended, or otherwise restricted.

2. An applicant for physician membership must also either be:

a. Board Certified by a member Board of the American Board of Medical Specialties (ABMS), a member Board of the American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada, or another board which is otherwise approved by the Medical Executive Committee or must become Board Certified by a member Board of the American Board of Medical Specialties (ABMS), a member Board of the American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada, or another board which is otherwise approved by the Medical Executive Committee in the area of requested Privileges. Certification must be obtained within the board eligible period designated by the applicable Board following completion of residency/fellowship, with

the exception of Boards with no time limits in which case Board Certification must be obtained within five years of completing residency/fellowship. The timeframe may be extended by the Governing Body upon recommendation of the Medical Executive Committee for those applicants and appointees whose practice in medical subspecialties require specific practice prerequisites for admissibility to Board examination or within three cycles of administration of the examination (maximum six years); or

b. Members who were Members in good standing on the Medical Staff of St. Francis Hospital or St. Mary's Medical Center at the time these Bylaws were adopted and who were exempted from the Board-Certification requirement existing at that time, are also exempted from the Board-Certification requirement under these Bylaws for so long as they maintain continuous membership and privileges on the Medical Staff.

3. Once a Member obtains Board Certification, the Member must continuously maintain Board Certification in order to be qualified for continued Medical Staff membership and Privileges. If a Member maintains Board Certification in a subspecialty which is the focus of the Member's practice, the Member need not renew Board Certification in the primary area of practice; however, if Hospital requires Board Certification in order to exercise Privileges in a particular subspecialty, the Member must be Board Certified in that subspecialty.

4. Any physician who had earlier secured appointment to the Medical Staff and/or privileges based on satisfaction of board certification and/or board examination qualification criteria and who then loses certification and/or examination qualification will be deemed to have relinquished that appointment and those privileges, and will not be entitled to an information meeting, a hearing, or appellate review, as those proceedings are described in Article VII of these Bylaws.

(B) Limited License Practitioners.

1. Dentists.

a. An applicant for dental membership on the Medical Staff must hold a DDS, DMD, or equivalent degree and a valid certificate to practice dentistry that is issued by the Board of Dental Examiners of California and that is not revoked, suspended, or otherwise restricted.

b. Oral surgery applicants must be Board-certified in the applicant's intended field of practice by the American Board of Oral and Maxillofacial Surgery or a specialty board that is recognized by the Committee on Accreditation of the American Dental Association; alternatively, the applicant must become Board certified in the area of requested privileges. Certification must be obtained within the board-eligible period designated by the applicable Board following completion of residency/fellowship, with the exception of Boards with no time limits (in which case Board certification must be obtained within five years of completing residency/fellowship). The timeframe may be extended by the Governing Body upon recommendation of the Medical Executive Committee for those applicants and appointees whose practices in medical subspecialties require specific practice prerequisites for admissibility to Board examination, but the maximum extension of this timeframe is limited to three cycles of administration or six years, whichever period is longer.

c. Any oral surgeon who had earlier secured appointment to the Medical Staff and/or privileges based on satisfaction of board certification and/or board examination qualification criteria and who then loses certification and/or examination qualification will be deemed to have relinquished that appointment and those privileges, and will not be entitled to an information meeting, a hearing, or appellate review, as those proceedings are described in Article VII of these Bylaws.

2. Podiatrists.

a. An applicant for podiatric membership on the Medical Staff must hold a DPM degree and a valid license to practice podiatry that is issued by the Podiatric Medical Board of California and that is not revoked, suspended, or otherwise restricted.

b. Podiatric applicants must be Board-certified in the applicant's intended field of practice by the American Board of Foot and Ankle Surgery (previously known as the American Board of Podiatric Surgery), American Board of Multiple Specialties in Podiatry, or the American Board of Podiatric Medicine; alternatively, the applicant must become Board-certified in the area of requested privileges. Certification must be obtained within the board-eligible period designated by the applicable Board following

completion of residency/fellowship, with the exception of Boards with no time limits (in which case Board certification must be obtained within five years of completing residency/fellowship). The timeframe may be extended by the Governing Body upon recommendation of the Medical Executive Committee for those applicants and appointees whose practices in medical subspecialties require specific practice prerequisites for admissibility to Board examination, but the maximum extension of this timeframe is limited to three cycles of administration or six years, whichever period is longer.

c. Any podiatrist who had earlier secured appointment to the Medical Staff and/or privileges based on satisfaction of board certification and/or board examination qualification criteria and who then loses certification and/or examination qualification will be deemed to have relinquished that appointment and those privileges, and will not be entitled to an information meeting, a hearing, or appellate review, as those proceedings are described in Article VII of these Bylaws.

3. Clinical Psychologists. An applicant for clinical psychologist membership on the Medical Staff must hold a clinical psychologist degree, have not fewer than two years of clinical experience in a multi-disciplinary facility that is licensed or operated by the state of California, another state, or the United States to provide health care or be listed in the latest edition of the National Register of Health Service Providers in Psychology, and hold a valid certificate to practice clinical psychology that is issued by the California Board of Psychology and that is not revoked, suspended, or otherwise restricted.

2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the Medical Staff merely because that person holds a certain degree, is licensed to practice in the state of California or in 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 healthcare facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in contracts with a third party that contracts with this Hospital; nor on employment or appointment at UCSF Health or the UCSF School of Medicine.

2.4 NONDISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, color, religion, ancestry, national origin, genetic information, marital status, sexual orientation, citizenship, primary language, immigration status, or political affiliation; nor on the basis of disability or medical condition that, with reasonable accommodation, does not pose a threat to the quality of patient care.

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

The ongoing responsibilities of each member of the Medical Staff, regardless of staff category or privilege condition, include:

(A) Providing patients with the quality of care meeting the professional standards of the Medical Staff of this Hospital;

(B) Abiding by the Medical Staff Bylaws and Medical Staff Rules and Regulations and Hospital policies consistent with these Bylaws applying to the activities of a Staff member;

(C) Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;

(D) Preparing and completing medical records for all the patients to whom the member provides care in the Hospital in a timely fashion;

(E) Abiding by the lawful ethical principles of the California Medical Association or other applicable professional associations (for example, the American Medical Association, the American Osteopathic Association, the American Podiatric Medical Association, and the American Dental Association);

(F) Maintaining the standards and meeting the requirements to warrant at all times full accreditation of the Hospital by The Joint Commission;

(G) Maintaining Board Certification status as required in Article II, Section 2.22 of these Bylaws;

(H) Aiding in any Medical Staff-approved educational programs for medical interns, resident physicians, staff physicians, podiatrists, dentists, nurses, and other personnel;

(I) Working cooperatively with members, nurses, Hospital administration, and others so as not to adversely affect patient care;

(J) Making appropriate arrangements for the continuous coverage of their patients as determined by the Medical Staff;

(K) Refusing to engage in improper inducements for patient referrals (including fee splitting);

(L) Continuously maintaining eligibility to participate in federal and state healthcare programs, including, but not limited to, Medicare and Medicaid, during any term of membership;

(M) Participating in continuing education programs as determined by the Medical Staff;

(N) Participating in such emergency service coverage or consultation panels as may be determined by the Medical Executive Committee;

(O) Providing a valid e-mail address, which shall be used as an official communication method for Hospital and Medical Staff dissemination of information;

(P) Discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee;

(Q) Cooperating, as appropriate, in the Medical Staff's performance of its quality and peer review functions;

(R) Providing care at the Hospital consistent with the Guiding Principles of Physician-Hospital Relationships of the California Medical Association;

(S) Maintaining a professional liability insurance policy with limits at least equal to the minimum amount established by the Medical Executive Committee and approved by the Governing Body;

(T) Conducting all research/experiments involving human subjects in accordance with procedures established by the Hospital's Institutional Review Board ("IRB") or another IRB designated by the Hospital under the appropriate agreements, and consistent with applicable regulatory requirements and Hospital policies;

(U) Agreeing to respect and maintain the confidentiality of all discussions, deliberations, proceedings, and activities of the Medical Staff Committees and Departments which have the responsibility for evaluating and improving the quality of care in the Hospital. Such information shall not be disclosed voluntarily to anyone, except to persons authorized to receive it in the conduct of such Medical Staff affairs or as directed by the Medical Executive Committee. Any questions regarding whether information is confidential shall be resolved by the Chief of Staff prior to disclosure;

(V) Except in an emergency, Physicians must not directly administer medical care to their family members, which includes serving as the admitting or consulting physician and writing orders. In accordance with federal and

state privacy laws, physicians shall not be permitted to read the medical records of their family members without the written authorization of the patient or as allowed by applicable law. Provision of care and treatment to a family member in violation of this policy will result in an automatic review by the Medical Executive Committee; and

(W) Agreeing to adhere to a code of conduct that promotes a safe, cooperative and professional healthcare environment in which all individuals are treated courteously, respectfully and with dignity. The Medical Staff recognizes that disruptive and/or disrespectful conduct affects the ability of others to do their jobs competently and creates a hostile work environment for Hospital employees, practitioners, patients, and other individuals.

Examples of unacceptable behavior include, but are not limited to:

- ♦ Rude, vulgar, or abusive conduct toward or in the presence of patients, residents, nurses, Hospital employees, visitors, or other practitioners;
- ♦ Inappropriate comments attacking or impugning the quality of care in the Hospital, Hospital staff, or other practitioners;
- ♦ Disrupting the administrative functions of the Hospital or Medical Staff;
- ♦ Non-constructive criticism presented in a way so as to intimidate, belittle, or impute stupidity or incompetence;
- ♦ Engaging in discrimination or unwelcome harassment of any Hospital employee, patient, medical resident, visitor, or other practitioner; and
- ♦ Unwelcome sexual advances, sexual jokes or comments, or sexual contacts.

The failure by any Medical Staff member to abide by any of the duties specified above shall be grounds for corrective action, including the suspension or termination of privileges and staff membership or for automatic action under Article VI, as applicable.

2.6 SIX CORE COMPETENCIES

1. Patient Care

Practitioners must provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

2. Medical/Clinical Knowledge

Practitioners must demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.

3. Practice-Based Learning Environment

Practitioners must be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

4. Interpersonal and Communication Skills

Practitioners must demonstrate interpersonal communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of the healthcare team.

5. Professionalism

Practitioners must demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society.

6. Systems-Based Practice

Practitioners must demonstrate both an understanding of the contexts and systems in which health care is provided and the ability to apply this knowledge to improve and optimize health care.

2.7 HISTORY & PHYSICAL EXAMINATION

A complete history and physical examination ("H&P") must be written or dictated within 24 hours of admission, and dated and timed. If an H&P has been performed within 30 days of the patient's admission, a durable, legible copy of this report may be used in the patient's medical record providing that any changes that may have occurred are recorded in an interval note in the medical record at the time of admission. An H&P performed prior to the patient's admission to the Hospital must be supplemented with an update/interval note prior to surgery or a procedure requiring anesthesia services. The update to the H&P must document any changes to the patient's condition. The H&P must be completed by a practitioner who is credentialed and privileged by the Medical Staff to perform the exam.

A suitable short H&P and discharge summary form may be substituted for admissions that meet the criteria specified in Medical Staff Policy & Procedure MS-30 (History & Physical Exam) (or its successor policy).

The H&P must include:

(A) Appropriate identification data;

(B) Medical history, including:

1. Chief complaint;

2. History of present illness;

3. Current medications and medication history;

4. Relevant past, social, and family histories (appropriate to the patient's age);

5. A notation of allergies; and

6. An inventory of all major body systems;

(C) Pertinent laboratory results;

(D) A statement of the conclusions and/or impressions drawn as an assessment or problem list from the H&P;

(E) The treatment plan; and

(F) A complete physical examination that may be focused depending on the nature of the presenting illness, complexity of intervention, and the clinical judgment of the physician.

ARTICLE III

CATEGORIES OF MEMBERSHIP IN THE MEDICAL STAFF

3.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active Staff; Courtesy Staff; Telehealth Staff; Consulting Staff; Provisional Staff; Honorary Staff; Administrative Staff; Outpatient Services Staff, and Outpatient Services – No Privileges Staff. At each time of the member's reappointment to the Medical Staff, the member's staff category shall be determined.

3.2 ACTIVE STAFF

3.2-1 QUALIFICATIONS

The Active Staff consists of members who:

(A) Meet the general qualifications for membership set forth in Section 2.2 and 2.2-2, and whose primary interest is in the Hospital;

(B) Have offices or residences that, in the opinion of the Medical Executive Committee, are located close enough to the Hospital to provide appropriate continuity of quality care;

(C) Regularly care for or provide consulting services for patients in the Hospital or, to the extent permitted in individual cases by the Medical Executive Committee (see Sections 3.2-3(B) and (D)), are otherwise regularly involved in the care of patients in the Hospital;

(D) Have satisfactorily completed their proctoring requirements and have been a member in good standing of the Provisional Staff for at least 6 months, and have satisfied the requirement for transfer to Active Staff as specified in Section 3.66(A); and

(E) Maintain quality of care in the Hospital.

3.2-2 PREROGATIVES

(A) Except as otherwise provided, the prerogatives of the Active Staff are to:

(B) Admit patients and exercise such clinical privileges as are granted pursuant to Article V. During any period in which the surgical-medical admissions are limited to "urgent," preference for elective admissions and surgery scheduling shall be given to members of the Active Staff;

(C) Have the right to be listed in any professional referral panel operated by the Hospital;

(D) Attend and vote on matters presented at general and special meetings of the Medical Staff and of the department and committees of which they are a member; and

(E) Hold staff or department office and serve as a voting member of committees to which the member is duly appointed or elected by the Medical Staff or a duly authorized representative thereof.

3.2-3 DUTIES OF ACTIVE STAFF MEMBERS

Active Staff members must:

(A) Fulfill the basic responsibilities of Medical Staff Membership as provided in Section 2.5;

(B) Be required to have a requisite number of admissions, outpatient procedures, or consultations per year as defined by the Rules and Regulations of the Medical Staff. If a staff member does not have the requisite number of admissions, outpatient procedures, or consultations, the staff member may be moved to another staff category;

1. This provision can be waived by the Medical Executive Committee for good cause. Exceptions may be made for those who make a meaningful professional contribution appropriate to the nature of their specialty. In such cases, additional peer references will be required at reappointment.

(C) Participate, as requested, in one or more Hospital-connected activities, such as research, teaching, outpatient department, proctoring, committee work, attendance at meetings of the Medical Staff and of the Department, service on committees of which they are a member, or such other activities that contribute to the Hospital's welfare deemed to be equivalent by the Chair of the member's Department or Chief of their Section;

(D) Assume, when requested by the Department Chair, proctoring and consultation responsibilities; and

(E) Participate in continuing education programs as required to maintain medical licensure, and thereby remain informed about pertinent new developments in diagnostic and therapeutic aspects of patient care related to their profession;

If a Medical Staff member does not meet these requirements, the Medical Staff member will be moved to another category or removed entirely from the Medical Staff, as appropriate.

3.2-4 TRANSFER OF ACTIVE STAFF MEMBERS

After one appointment cycle in which a member of the Active Staff fails to meet one or more of the criteria or duties for Active Staff membership, such member may be transferred to the appropriate category for which the member remains qualified, or if there is not such category, the member may not be reappointed to the Medical Staff. Members shall not be entitled to request a hearing pursuant to Article VII to contest such changes; however, members shall be entitled to an informal meeting before the Medical Executive Committee, upon timely request, in accordance with Section 7.2-1. The sole issue for review at such informal meeting will be whether the member has complied with the requirement/s that has/have triggered their demotion.

3.3 COURTESY STAFF

3.3-1 QUALIFICATIONS

The Courtesy Staff consists of members who:

(A) Meet the general qualifications set forth in subsections (A) and (B) of Section 3.2-1;

(B) Do not regularly care for patients at the Hospital or are not regularly involved in Medical Staff functions, as determined by the Medical Staff, or are clinically active at the Hospital, but do not wish to fulfill the duties as specified in subsection (B) through (E) of Section 3.2-3;

(C) Are members in good standing of the Active Staff of another California licensed Hospital and maintain such standing as long as they are not Active members of the Medical Staff; however, exceptions to this requirement may be made by the Medical Executive Committee in special circumstances, such as when staff members are new to the community or just out of their training program;

(D) Have satisfactorily completed their proctorship requirements and have been a member in good standing of the Provisional Staff for at least 6 months;

(E) Are located close enough to the Hospital to provide continuous care to their patients or otherwise arrange for another Medical Staff Member to provide continuous care to their patients.

3.3-2 PREROGATIVES

Except as otherwise provided, Courtesy Staff members are entitled to:

(A) Admit patients to the Hospital within the limitations of Section 3.3-3 and exercise clinical privileges pursuant to Article V;

(B) Provide on-call coverage for any member of the Active Staff; and

(C) Attend meetings of the Medical Staff and the Department of which they are a member, including open committee meetings and educational programs. However, Courtesy Staff do not have the right to vote at such meetings, except within committees in which the right to vote is specified at the time of appointment.

3.3-3 LIMITATIONS

(A) Courtesy Staff who admit patients or regularly care for patients at the Hospital must be reviewed by the Chair, who may recommend appointment to a more appropriate staff category. If a member of the Courtesy Staff does not have the requisite number of admissions, outpatient procedures, or consultations in a given reappointment cycle, or does not participate in Medical Staff activities, they may be moved to another category.

(B) Courtesy Staff are not eligible to hold office in the Medical Staff.

3.4 TELEHEALTH STAFF

3.4-1 QUALIFICATIONS

The Telehealth Staff consists of physicians who meet all general and particular qualifications for membership set forth in Sections 2.2-1 and 2.2-2 of these Bylaws and who provide diagnostic or treatment services to Hospital patients through virtual care delivery mechanisms, including via Telehealth devices (i.e., interactive – involving real-time (synchronous) or near real-time (asynchronous) two-way transfer of medical data and information, audio, video, or data communications) between physician and patient.

3.4-2 LIMITATIONS

(A) Telehealth Staff members may not admit patients to the Hospital or exercise clinical privileges whatsoever in person in the Hospital. Members of this staff category may only provide patient care services from a Distant Site.

(B) Telehealth Staff members may attend meetings of the Medical Staff and of the Department(s) and/or Section(s) to which they are assigned (including open committee meetings and educational programs), but have no right to vote at such meetings. A Telehealth Staff member may attend meetings of committees to which the member is assigned but has no right to serve as Chair of the committee or to vote at committee meetings, unless the right to vote is specified at the time of appointment.

(C) Telehealth Staff members are not eligible to hold office in the Medical Staff.

(D) Telehealth Staff members are not required to pay dues.

3.5 CONSULTING STAFF

3.5-1 QUALIFICATIONS

Any member of the Medical Staff in good standing may consult in their area of expertise; however, the Consulting Staff consists of such practitioners who:

(A) Are not otherwise members of the Medical Staff and meet the general and particular qualifications set forth in Sections 2.2-1 and 2.2-2 of these Bylaws, except that this requirement shall not preclude an out-of-state practitioner from appointment as may be permitted by law if that practitioner is otherwise deemed qualified by the Medical Executive Committee;

(B) Possess special expertise in their field of medicine and are able to make unique contributions to the care of difficult patients;

(C) Do not routinely provide patient care or act as an attending physician, but are able to promptly respond when called to render clinical services within their area of expertise;

(D) Are members of the Active Staff of another Hospital licensed by California or another state, although exceptions to this requirement may be made by the Medical Executive Committee for good cause; and

(E) Have satisfactorily completed appointment in the Provisional Staff category.

Proctoring of these individuals will be determined by their respective Department Chair as appropriate.

3.5-2 PREROGATIVES

The Consulting Staff are entitled to:

(A) Exercise clinical privileges pursuant to Article V;

(B) Serve on committees; and

(C) Attend meetings of the Medical Staff and the Department of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees in which the right to vote is specified at the time of appointment.

3.5-3 LIMITATIONS

(A) Consulting Staff do not have admitting privileges at the Hospital.

(B) Consulting Staff are not eligible to hold offices in the Medical Staff.

3.6 PROVISIONAL STAFF

3.6-1 PURPOSE OF PROVISIONAL STAFF AND DURATION OF APPOINTMENT

All new members of the Medical Staff, except for Outpatient Services and Outpatient Services – No Privileges Staff Members, must first be appointed to the Provisional Staff for a period of observation, during which the members' clinical competence and ethical and moral conduct will be closely evaluated. Throughout their status as a Provisional Staff member, a member will be assigned to a Department where their performance will be proctored by the Department Chair in order to determine their eligibility for courtesy or active staff membership.

New appointees will remain on the Provisional Staff for a minimum of 6 months after appointment to the Medical Staff. Upon satisfactory completion of the proctoring requirements and upon meeting any qualifications for another staff category, Provisional Staff members may advance to another appropriate staff category. Provisional Staff members are expected to promptly complete all proctoring requirements within 12 months from the date of appointment but, if necessary, may remain in the Provisional Staff category for up to 2 years.

3.6-2 PREROGATIVES

Provisional Staff members are able to:

(A) Admit patients, attend patients, enter orders for patients, and exercise such clinical privileges as are granted;

(B) Attend meetings of the Medical Staff and the Department of which that person is a member, including open committee meetings and educational programs; and

(C) Serve on Medical Staff Committees.

3.6-3 LIMITATIONS

(A) Provisional Staff members are not eligible to hold office in the Medical Staff or chair a committee in the Medical Staff.

(B) Provisional Staff members must not vote on any Medical Staff matter unless they are specifically permitted to do so by these Bylaws or unless they vote within committees when the right to vote is specified at the time of appointment.

3.6-4 PROCTORING OF PROVISIONAL STAFF MEMBERS

All Provisional Staff members must undergo a period of proctoring by designated proctors as described in Section 5.3. The purpose of proctoring is to evaluate the member's: (1)

proficiency in the exercise of clinical privileges initially granted, and (2) overall eligibility for continued staff membership and advancement within Medical Staff categories.

Proctoring of Provisional Staff will follow whatever frequency and format the appropriate Department deems necessary in order to adequately evaluate the Provisional Staff, including, but not limited to, concurrent and/or retrospective chart review, report reviews, mandatory consultation, and/or direct observation. Appropriate records concerning the proctorship, including observations, must be maintained. The results of the proctorship must be communicated by the appropriate Department Chair to the Medical Executive Committee.

Evidence of proctoring from other facilities can be, but is not required to be, accepted to supplement the proctoring evaluation, provided that the proctor is a member in good standing of the Medical Staff at the facility/facilities and the range and level of the proctor's privileges are commensurate at each facility.

3.6-5 TERM OF PROVISIONAL STAFF STATUS

Provisional Staff status may not extend beyond 2 years.

3.6-6 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

(A) If the Provisional Staff member has satisfactorily demonstrated their ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, as determined by the appropriate Department, the member will become eligible for placement in the Active, Courtesy, or Consulting Staff category as appropriate upon recommendation of Medical Executive Committee.

(B) Failure to Complete Necessary Volume Within Proctoring Time Frame: When a satisfactory demonstration has not been made because the member failed to complete the required number of proctored cases within the time frame established, the member will be deemed to have voluntarily resigned their membership in the Medical Staff and relevant clinical privileges if the incomplete proctoring pertains only to non-core privileges or new privileges, and they will not be afforded the rights of hearing or appeal set out in Article VII of these Bylaws. However, the Department has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Medical Executive Committee. The inability to obtain such an extension will not give rise to the procedural rights described in Article VII. Any member deemed to have resigned pursuant to this Section may not reapply to the Medical Staff or request the resigned privileges for a minimum of 1 year unless the Medical Executive Committee makes an exception for good cause.

(C) Failure to Satisfactorily Complete Proctoring: When a satisfactory demonstration has not been made because the member failed to perform satisfactorily during proctoring, even if the necessary volume of proctored

cases was completed, the Medical Executive Committee may recommend a modification or termination of that member's clinical privileges and/or of Medical Staff membership. If this occurs, the member will be afforded the procedural rights described in Article VII of these Bylaws.

3.7 HONORARY STAFF

3.7-1 QUALIFICATIONS

The Honorary Staff consists of physicians, dentists, clinical psychologists, podiatrists, and other practitioners eligible for Medical Staff membership who do not actively practice at the Hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct. Honorary Staff members will be selected upon recommendation of the Medical Executive Committee and approved by the Board.

3.7-2 PREROGATIVES

Honorary Staff are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital, or to vote or hold office in this Medical Staff organization, but they may serve upon committees at the discretion of the Medical Executive Committee. They may attend staff and department meetings, including open committee meetings and educational programs. Members of the Honorary Staff are not subject to reappointment, dues assessment, or meeting requirements of any kind.

3.8 ADMINISTRATIVE STAFF

3.8-1 QUALIFICATIONS

Administrative Staff category membership is for any Physician, Dentist, Oral Surgeon, or Podiatrist who is retained by the Hospital or Medical Staff solely to perform ongoing medical administrative activities.

Administrative Staff consists of Members who:

(A) Are charged with assisting the Medical Staff in carrying out medical administrative functions, including, but not limited to, quality improvement and utilization management;

(B) Document their (1) current California licensure that is not revoked, suspended, or restricted; (2) adequate experience, education, and training; (3) current professional competence; (4) good judgment; and (5) current physical and mental health status (subject to any necessary reasonable accommodation), so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent to exercise their duties;

(C) Are exempt from the general and particular qualifications for membership set forth in Sections 2.2-1 and 2.2-2, except to the extent noted in this Section;

(D) Meet the requirements of Section 6.6-8 or comparable health screening requirements that may be imposed by virtue of the member's applicable contract and/or employment requirements; and

(E) Are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the quality assessment and improvement functions, and (3) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff.

3.8-2 LIMITATIONS

(A) Administrative Staff members may attend meetings of the Medical Staff and of the Department(s) and/or Section(s) to which they are assigned (including open committee meetings and educational programs), but they have no right to vote at such meetings. An Administrative Staff member may attend meetings of committees to which the member is assigned but has no right to serve as Chair of the committee or to vote at committee meetings, unless the right to vote is specified at the time of appointment.

(B) Administrative Staff members may not admit patients or exercise clinical privileges.

(C) Administrative Staff members are not eligible to hold office in the Medical Staff.

3.9 OUTPATIENT SERVICES STAFF

3.9-1 QUALIFICATIONS

(A) The Outpatient Services Staff consists of members who have met all of the general and particular qualifications for membership set forth in Sections 2.2-1 and 2.2-2 of these Bylaws to qualify for clinical privileges.

(B) An applicant may be appointed directly to the Outpatient Services category.

3.9-2 LIMITATIONS

(A) An Outpatient Services Staff member may attend meetings of the Medical Staff and of the Department(s) to which they are assigned (including open committee meetings and educational programs), but has no right to vote at such meetings. An Outpatient Services Staff member may attend meetings of committees to which the member is assigned and vote at such committee meetings, unless the member has been appointed as a committee member

without the right to vote. An Outpatient Services Staff member has no right to serve as Chair of the committee.

(B) Outpatient Services Staff members are not eligible to hold office in the Medical Staff.

(C) Outpatient Services Staff members may be granted outpatient clinical privileges but may not admit patients or write inpatient orders.

(D) Outpatient Services Staff members who wish to apply for inpatient clinical privileges must demonstrate current competence in the care of acute inpatients and to exercise the specific privileges requested as recommended by the appropriate clinical Department(s) and the Medical Executive Committee. This required demonstration will likely require the member to obtain recent education and training from a program which is approved by the appropriate clinical Department(s) and the Medical Executive Committee and which is specifically designed to enable the member to demonstrate current competence in the care of acute inpatients. Outpatient Services Staff members applying for clinical privileges may be required to have an interview with the Credentials Committee or Medical Executive Committee. Successful applicants will be approved for the Provisional Staff and must satisfactorily complete all proctoring requirements before advancing to any other staff category.

3.10 OUTPATIENT SERVICES – NO PRIVILEGES STAFF

3.10-1 QUALIFICATIONS

(A) Outpatient Services – No Privileges Staff consists of practitioners who do not have clinical privileges but who regularly provide professional services for patients in the community served by the Hospital. Outpatient Services – No Privileges members must meet the basic requirements of Section 2.5 to the extent that they are applicable to the category.

3.10-2 PREROGATIVES

(A) Outpatient Services – No Privileges Staff members are not eligible to admit patients to the Hospital or hold clinical privileges.

(B) Outpatient Services – No Privileges Staff members may attend meetings of the Medical Staff and of the Department to which they are a member in a nonvoting capacity. Outpatient Services – No Privileges staff members may attend meetings of committees to which the member is assigned and vote at such committee meetings, unless the member has been appointed as a committee member without the right to vote. Outpatient Services – No Privileges staff members may not chair a committee.

(C) Outpatient Services – No Privileges Staff members may not hold office in the Medical Staff.

(D) Outpatient Services – No Privileges Staff members may not vote on any Medical Staff matter except as specifically permitted by these Bylaws or as part of a committee appointment.

3.11 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these Bylaws, or by the Medical Staff Rules and Regulations.

Active Staff who are in good standing at the time that these Bylaws are adopted will not be held to the residency requirements.

3.12 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the Medical Staff, limited license practitioners:

(A) May only vote on matters within the scope of their licensure. In the event of a dispute over voting rights, the matter must be resolved by the Chair of the meeting, subject to final decision by the Medical Executive Committee; and

(B) Must exercise only those clinical privileges that are within the scope of their licensure and as set forth in Section 5.4.

3.13 MODIFICATION OF MEMBERSHIP CATEGORY

(A) On its own, upon recommendation of the Department Chair, upon request by a member under Section 4.6-1(B), or upon direction of the Board of Directors as set forth in Section 6.4-6, the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

(B) Any practitioner may request a change on Staff category at the time of reappointment or, with the recommendation of the chair of the practitioner's department, at any other time. To be eligible for transfer, the member must: (1) meet all qualifications for the category to which they seek appointment, and (2) demonstrate compliance, during the 6 months immediately preceding the request for transfer, with all Staff, Department, and committee requirements applicable to the Staff category to which they seek appointment. All requests for transfer must be reviewed by the practitioner's Department and by the Medical Executive Committee, and action must be taken by each according to the procedure set forth in Section 4.6. If the Medical Executive Committee recommends to deny the request,

the practitioner is entitled to the procedural rights as provided in Article VII only if the exercise of the member's clinical privileges is affected by the denial.

A change of Medical Staff category is effective upon approval by the Board. Such an application must be processed in substantially the same manner as provided for in Article IV of these Bylaws relating to applications for reappointment to Medical Staff membership. Additionally, such an application must include documentation of clinical activity, training, and/or experience that supports the request.

(C) Any member who fails to discharge the responsibilities attendant to the staff category of which they are a member may, after 1 year of such failure, be subject to demotion to a different category. The Medical Executive Committee may, in its discretion, recommend demotion, subject to approval by the Board. Any recommendation of demotion by the Medical Executive Committee entitles the member to the procedural rights set out in Article VII of these Bylaws only if the demotion adversely affects the exercise of the member's clinical privileges.

ARTICLE IV

APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

Except as otherwise specified herein, no person may exercise clinical privileges in the Hospital unless and until that person applies for and receives appointment to the Medical

Staff or is granted temporary privileges as set forth in these Bylaws. By applying to the Medical Staff for appointment or reappointment (or, in the case of members of the Honorary Staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these Bylaws and agrees that throughout any period of membership that person will comply with the responsibilities of Medical Staff membership, the Bylaws, and Rules and Regulations of the Medical Staff, all as they exist and as they may be modified from time to time. Appointment to the Medical Staff confers on the appointee only such clinical privileges as have been granted in accordance with these Bylaws.

4.2 BURDEN OF PRODUCING INFORMATION

(A) In connection with all applications for appointment, reappointment, or new clinical privileges, the applicant has the burden of producing adequate and complete information in a timely fashion for a proper evaluation of their competence, character, ethics, and other basic qualifications for membership. Applicants whose license to practice in the State of California is restricted or encumbered by the Medical Board of California, the Osteopathic Medical Board of California, or any other licensing agency may not be considered for initial appointment to the Medical Staff.

(B) At any time during the processing of an application, any committee or individual responsible for review of an application may request in writing (via mail, fax, or e-mail) further documentation or clarification from the applicant. The application is incomplete when any such request is pending. If the applicant fails to respond to such written request within 30 days, the application will be deemed automatically withdrawn.

(C) Only complete applications will be processed. The failure to consider applications deemed incomplete will not entitle the applicant to procedural rights pursuant to Article VII of these Bylaws.

4.3 APPOINTMENT AUTHORITY

Appointments to the Medical Staff, and denials and revocations thereof, shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Executive Committee or as set forth in Section 6.4-6.

4.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these Bylaws, initial appointments to the Medical Staff may be made by the Board after recommendation by the Medical Executive Committee and the appropriate Department.

Appointments and reappointments shall be made for no more than 2 years or such longer period as may be permitted by applicable law, The Joint Commission, and the Board; and will be staggered in accordance with policies established by the Medical Executive Committee and the Board.

4.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

4.5-1 PROCEDURE

Any practitioner applying for initial membership or reappointment must first file with the Medical Staff Services Department a written application developed by the Medical Executive Committee. An initial application fee is required as a condition of appointment in the amount fixed by the Medical Executive Committee, with the exception of applicants for Telehealth Staff status.

Each applicant's completed initial application form must provide the following information, without limitation and, in the case of reappointment, the form shall provide updated information regarding the same matters, without limitation:

(A) The applicant must sign a statement to the effect that the member has read and agrees to be bound by the Bylaws, Rules and Regulations, and other Hospital policies as they exist and as they may be modified from time to time consistent with these Bylaws applying to their activities as a member; that they agree to be bound by the terms thereof if they are granted membership and/or privileges; and that they agree to be so bound in all matters relating to consideration of their application, whether or not the member is granted membership and/or privileges. The Medical Staff Services Department must provide the applicant with a copy of the Bylaws, the Rules and Regulations of the Medical Staff, Departmental Rules and Regulations, and other relevant policies pertaining to members;

(B) The applicant must provide information relative to initial (which includes pre-medical school, medical school, internship, residency and fellowship training) and continuing professional education and training of the applicant and regarding their professional experience, including, as necessary, documentation of specific specialty training/certification and experience requirements for any requested clinical privileges. They must state that their physical and mental health status is sufficient, with reasonable accommodations if and as requested and granted consistent with applicable law and Hospital policy, to permit them to perform all the duties of their practice and exercise the privileges requested with or without reasonable accommodation;

(C) The applicant must include proof that the applicant's California license to practice and/or DEA license, if any, are current (the applicant's records from the National Practitioner Data Bank and the Medical Board of California will be reviewed);

(D) The applicant must submit a signed Medicare Physician Attestation Statement. Primary source verification is required whenever feasible;

(E) The initial applicant must provide names of at least three (3) practitioners (i.e., peer references) from the applicant's specialty who have worked with the applicant and observed their professional performance and who can provide information as to the applicant's professional ability, judgment, ethical character, and ability to work with others. With the exception of applicants for Telehealth Staff membership, at least 2 of these practitioners must be members of the Active Staff, whenever possible;

(F) The applicant must submit a specific request setting forth the category of membership to which the applicant wishes to be appointed, the Department to which the applicant seeks membership, and the privileges for which the applicant wishes to be considered;

(G) The applicant must provide a chronological history of all of the applicant's past Medical Staff privileges at the Hospital and privileges at any other healthcare institution;

(H) The applicant must provide information as to whether any of their prior applications for Medical Staff membership and/or privileges, membership status, and/or Medical Staff privileges have ever been voluntarily or involuntarily relinquished, denied, revoked, suspended, reduced, not renewed, or otherwise restricted at the Hospital or any other hospital or healthcare institution, and as to whether any of the following has ever been voluntarily or involuntarily relinquished, denied, revoked, suspended, reduced, not renewed, or otherwise restricted:

1. membership/fellowship in a local, state or national professional organization;

2. specialty board certification;

3. license to practice any profession in any jurisdiction; or

4. Drug Enforcement Administration ("DEA") certificate.

If any such actions are now pending, details about those actions must be included.

(I) The applicant must provide information concerning the applicant's malpractice experience, including any professional liability litigation

brought against the applicant, the disposition of such litigation (including final judgments or settlements), and their consent to the release of information by their present and past malpractice insurance carrier(s);

(J) The applicant must provide proof of current professional liability coverage for at least the minimum limits established by the Medical Executive Committee;

(K) The applicant must supply other information relating to evaluation of the applicant's professional qualifications, ethical character, and prior professional experience that is deemed relevant by the Department Chair;

(L) The applicant must sign a statement releasing from liability the Hospital, its Staff members, and its authorized representatives for their acts performed in connection with the evaluation of the application, credentials, and qualifications of the applicant, and also releasing all individuals and organizations that provide information to the Hospital or its Staff members concerning the professional competence, ethics, and other qualifications of the applicant for Staff appointment and privileges; and

(M) The applicant must sign a pledge to provide professional services in an ethical manner and on a continuous basis to all of the applicant's patients, and must consent to provide care at the Hospital consistent with the Guiding Principles of Physician-Hospital Relationships of the California Medical Association.

4.5-2 EFFECT OF APPLICATION

In addition to the matters set forth in Sections 4.1 and 4.2, by applying for appointment to the Medical Staff, each applicant:

(A) Agrees to provide in a timely fashion any additional information and to resolve any questions relating to their application which are requested or posed by the Medical Executive Committee or its representatives. The provision of information containing misstatements or omissions, or a failure to produce adequate information, will result in the application being deemed incomplete. If the applicant fails to complete a pending but incomplete application after 6 months, the applicant will be notified by special notice that their application has been deemed withdrawn. Such termination of the credentialing process shall not entitle the applicant to review or appeal pursuant to the Bylaws;

(B) Agrees to be interviewed by the Department Chair and Division Chief of the Department where privileges are requested, and agrees to be interviewed by other individuals, as appropriate, as part of the application process;

(C) Agrees to appear before the Medical Executive Committee or any authorized members of the Hospital and Medical Staff who are responsible for evaluation of the applicant and their credentials;

(D) Authorizes consultation with others who have been associated with the applicant and who may have information that is relevant to the applicant's competence, qualifications, and performance, and authorizes such individuals and organizations to candidly provide this information;

(E) Consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

(F) Releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;

(G) Releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

(H) Consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations, as permitted by law, any information regarding the applicant's professional or ethical standing that the Hospital or Medical Staff may have, and releases the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law;

(I) Acknowledges responsibility for timely payment of Medical Staff dues;

(J) Pledges to provide for continuous quality care of their patients;

(K) Pledges to maintain an ethical practice, including refraining from illegal inducements for patient referrals (such as fee-splitting), providing continuous care of their patients, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners;

(L) Agrees that, in the event of any adverse recommendations or decisions with respect to Medical Staff membership or privileges, the applicant will exhaust all of the administrative remedies afforded by these Bylaws before resorting to arbitration or filing a lawsuit; and

(M) Agrees to respect and maintain the confidentiality of all discussions, deliberations, proceedings, and activities of Medical Staff Committees and Departments that have the responsibility for evaluating and improving the

quality of care in the Hospital. The applicant must not voluntarily disclose this information to anyone except persons authorized to receive it in the conduct of such Medical Staff affairs (including, without limitation, the applicant's legal representatives) or unless they are directed to do so by the Medical Executive Committee or the Board. Any questions regarding whether information is confidential will be resolved by the Chief of Staff. Any violation of this provision may subject the member to corrective action, including summary suspension, as provided in Article VI of these Bylaws.

4.5-3 VERIFICATION OF INFORMATION

The applicant must deliver a completed application, together with the application fee (if applicable), to the Medical Staff Services Department, and must also deliver advance payment of Medical Staff dues or fees to the Medical Staff Services Department.

Once this has been done, the application and all supporting materials then available will be transmitted to the Chair of each Department in which the applicant seeks privileges. Medical Staff Services will expeditiously seek to collect or verify the references, licensure status**,** evidence of current competence, and other evidence submitted in support of the application by the applicant with information from the primary source(s) whenever feasible.

The Hospital's authorized representative must query the applicable licensing board(s) and the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the Department Chair for inclusion in the applicant's or member's credentials file.

The applicant must be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information. When collection and verification are accomplished, all such information shall be transmitted to the appropriate Department(s).

4.5-4 DEPARTMENT ACTION

When the application is deemed verified and complete, the appropriate Chair or appropriate committee of each Department to which the application is submitted will review the application and supporting documentation and may conduct a personal interview with the applicant at the Chair's or committee's discretion. The Chair will investigate the character, professional and clinical competence, qualifications, and ethical standing of the applicant to exercise the privileges they request and will verify, through references given by the applicant and other sources available to it, that the applicant meets all necessary requirements. If there is any doubt as to the clinical competence or other qualifications of the applicant to perform the medical and surgical privileges they seek to perform in the Hospital, the burden will be upon the applicant to resolve such doubt. The Chair or appropriate committee will evaluate all matters deemed relevant to a

recommendation, including information concerning the applicant's provision of services within the scope of privileges granted.

Within 60 days of the Department's receipt of the application, the appropriate Chair or committee will then transmit to the Credentials Committee a written report and recommendation specifying appointment of the applicant. If appointment is recommended, the report will provide details as to staff category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment.

4.5-5 CREDENTIALS COMMITTEE ACTION

The Credentials Committee must evaluate all matters that are deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted. After the Credentials Committee completes its evaluation, it must transmit a written report and recommendation regarding appointment to the Medical Executive Committee within 60 days of the Committee's receipt of that recommendation. If the Credentials Committee recommends appointment, it must include a recommendation as to membership category, Department affiliation(s), clinical privileges to be granted, and any special conditions to be attached.

The Credentials Committee may also request that the Medical Executive Committee defer action on the application.

4.5-6 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the Department Chair report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee must consider the report and any other relevant information. The Medical Executive Committee may request additional information, delegate the matter to an ad hoc Committee for further investigation, and/or elect to interview the applicant.

After its review has concluded, and within 60 days of the Medical Executive Committee's receipt of the Department's report, the Medical Executive Committee must forward to the Hospital President, for prompt transmittal to the Board (or, in cases eligible for expedited processing, the committee duly appointed by the Board to handle expedited cases), a written report and recommendation as to Medical Staff appointment and, if appointment is recommended, as to membership category, Department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also defer action on the application. The reasons for each recommendation must be stated in the written report.

4.5-7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(A) Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it must be promptly forwarded, together with supporting documentation, to the Board or, in cases eligible for expedited processing, the committee duly appointed by the Board to handle expedited cases.

(B) Adverse Recommendation: When a final recommendation of the Medical Executive Committee is adverse to the applicant, the Chief of Staff, Hospital President, or the Hospital President's designee must promptly inform the applicant by Special Notice of the adverse decisions and the reasons for the adverse decision. The applicant will then be entitled to the procedural rights as provided in Article VII. No adverse recommendation is to be forwarded to the Board until the applicant's rights under Article VII of these Bylaws have been exercised or waived.

(C) Deferral: When the recommendation is to defer the application for further consideration, unless the application has been deemed incomplete, the Medical Executive Committee's deferral must be followed within 60 days with a subsequent recommendation by the Medical Executive Committee for appointment with specified clinical privileges or for rejection of Medical Staff membership.

4.5-8 ACTION ON THE APPLICATION

The Board or, in cases eligible for expedited processing, the duly appointed committee of the Board, may accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures will apply with respect to action on the application:

(A) If the Medical Executive Committee issues a favorable recommendation, the Board or, in cases eligible for expedited processing, its duly appointed committee, must give great weight to the Medical Executive Committee's recommendation and must not, in any case, act in an arbitrary or capricious manner concerning the application.

1. If the Board concurs in the Medical Executive Committee's recommendation, the decision of the Board will be deemed final action.

2. If the tentative final action of the Board is unfavorable, the Chief of Staff, Hospital President, or Hospital President's designee must:

    a. Submit the matter to a Joint Conference Committee; and

b. If the action of Board of Directors continues to be adverse following review by the Joint Conference Committee, the Chief of Staff, Hospital President, or Hospital President's designee shall promptly inform the applicant by Special Notice of the tentative adverse recommendation, and the applicant will be entitled to the procedural rights set forth in Article VII. If the applicant waives their procedural rights, the decision of the Board of Directors will be deemed final action.

3. If the Board does not receive a Medical Executive Committee recommendation within 60 days of the Medical Executive Committee's receipt of the report and recommendations from the Department Chair, the Board may, after notifying the Medical Executive Committee, take action on the Board's own initiative with respect to the application. If the Board's action is favorable, it shall become effective as the final action of the Hospital. If the Board's action is an adverse action, as defined in Articles VI and VII of these Bylaws, the Chief of Staff, Hospital President, or Hospital President's designee must promptly so inform the applicant by Special Notice, and the applicant will be entitled to a hearing in accordance with Article VII.

In cases that are eligible for expedited processing, if the duly appointed committee and the Board concur in their recommendations to grant membership on the Medical Staff, the positive decision must be ratified by the Board at its next regularly scheduled meeting. The ratification by the Board will be deemed final action. If the committee's decision is adverse to the applicant, or if the Board fails to ratify the committee's decision, the matter must be referred back to the Medical Executive Committee for further evaluation.

(B) If the recommendation of the Medical Executive Committee, or any significant part of it, is unfavorable to the applicant, the procedural rights set forth in Article VII of these Bylaws will apply.

1. If the applicant waives their procedural rights, the recommendations of the Medical Executive Committee must be forwarded to the Board for final action. The Board must give great weight to the Medical Executive Committee's recommendation, and must not, in any case, act in an arbitrary or capricious manner concerning the application.

2. If the applicant requests a hearing following the adverse Medical Executive Committee recommendation pursuant to Section 4.5-7(B) or an adverse tentative final action from the Board pursuant to

Section 4.58(A)(2), the Board must take final action only after the applicant has exhausted all of their procedural rights as established by Article VII of these Bylaws. After all of the procedures set forth in Article VII have been exhausted, the final decision must be reported at the next regular meeting of the Board. If the hearing process results in a decision of a Judicial Review Committee as described in Section 7.4-10 that has not been appealed pursuant to Section 7.5, the decision and report of the Judicial Review Committee must be reported at the next regular meeting of the Board. At this meeting, the Board must vote to accept the decision, defer action, or tentatively reject the decision. If it votes to accept the decision, its acceptance will constitute the final action of the Hospital. If it votes to defer the action, it must follow up on this action by deciding to either accept or tentatively reject the action within 60 days. If it votes to tentatively reject the decision, the Board must conduct a review, the nature and scope of which is provided for appeals pursuant to Section 7.5. The action of the Board following such an appeal will be considered the final action of the Hospital.

3. In the event of an adverse decision by the Board where the applicant has not previously been afforded the right to a hearing, the Board's decision must be held in abeyance until the applicant has requested and exhausted all of its procedural rights under Article VII of these Bylaws or waived any right to a hearing. If the applicant requests a hearing, the hearing will be before the Board or a committee of the Board. The procedures governing such hearing will be adopted by action of the Board. The decision following the hearing will be the final action of the Hospital.

(C) Applicants are ineligible for expedited processing if, at the time the applicant's membership is considered, any of the following has occurred:

1. The application submitted by the applicant is incomplete;

2. The Medical Executive Committee makes a qualified recommendation, such as not approving all privileges requested by the practitioner.

3. There is a current challenge or previously successful challenge to the applicant's licensure or DEA registration;

4. The applicant has received an involuntary termination of Medical Staff membership at another Hospital;

5. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges; or

6. When one or more of the following specific conditions exist:

   a. Letter/s from education and/or training institutions that include a qualified endorsement of the applicant's ability (i.e. recommend with some reservation or do not recommend);

   b. Letter/s of reference that include a qualified endorsement of the applicant's ability (i.e., recommend with some reservation or do not recommend);

   c. Unfavorable findings in the National Practitioner Data Bank report (at reappointment, new issues that were not previously identified in prior reappointment periods);

   d. An unexplained gap in the applicant's training or professional practice exceeding 60 days;

   e. The applicant dropped or otherwise failed to complete the applicant's residency/fellowship training programs;

   f. The applicant opted out of Medicare/Medicaid Patient Acceptance;

   g. A pending challenge or previous successful challenge to the applicant's licensure or DEA registration;

   h. Evidence of the applicant's behavioral, practice, or competency issues; for instance, the applicant has/had a behavioral issue that could put staff, patients or the organization at risk (including a conviction of driving while impaired) within the past 7 years for initial applicants, or since the last appointment for reapplicants;

   i. Evidence of judgments or settlements, individually or in the aggregate, in excess of $250,000, that were finalized within the past 7 years for initial appointments and within the past 2 years for reapplicants; or

   j. Multiple settlements or judgments in liability actions that demonstrate a problematic trend or pattern will be flagged for Department Chair review and Department Chair final determination

4.5-9 NOTICE OF FINAL DECISION

(A) Notice of the Board's final decision must be given, through the Hospital President or the Hospital President's designee, to the Chief of Staff, the

Chair of each Department concerned, and, by Special Notice, to the applicant.

(B) A decision and notice to appoint or reappoint must include, if applicable:

1. The staff category to which the applicant is appointed;

2. The Department to which that person is assigned;

3. The clinical privileges granted; and

4. Any special conditions attached to the appointment.

4.5-10 REAPPLICATION AFTER ADVERSE APPOINTMENT DECISION

An applicant who has received a final adverse decision regarding appointment, reappointment, or clinical privileges is not eligible to reapply to the Medical Staff for a period of 36 months. Any such reapplication by that applicant will 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 action no longer exists.

4.5-11 TIMELY PROCESSING OF APPLICATIONS

Applications for appointments to the Medical Staff will be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following provides a guideline for routine processing of applications:

(A) Evaluation, review, and verification of application and all supporting documents by the Medical Staff office;

(B) Review and recommendation by Department Chair;

(C) Review and recommendation by the Credentials Committee;

(D) Review and recommendation by the Medical Executive Committee; and

(E) Final action: will occur within 180 days of receipt of all necessary documentation and verifications by the Medical Staff Services Department, 60 days after receipt of all necessary documentation and verification by the Medical Staff Services Department in expedited cases, or 14 days after conclusion of hearings.

4.6 REAPPOINTMENTS AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

4.6-1 APPLICATION

(A) Terms of appointment to the Medical Staff may not exceed 2 years or such longer period as may be permitted by applicable law, The Joint Commission, and the Board. At least 5 months prior to the expiration date of the current staff appointment, Medical Staff Services must mail or deliver a reapplication form to the member whose application is expiring. The Medical Staff member must then submit, within 30 days of receiving the form, the completed application form for renewal of appointment to the Medical Staff and renewal or modification of clinical privileges. If the completed application is not received within 30 days of the date the application was sent, a late fee may be assessed as per Section 4.6-5. Payment of the late fee does not guarantee that the application will be considered complete or that the application will be fully processed and decided upon before expiration of the member's membership and clinical privileges. The reapplication form must include all information that is necessary to update and evaluate the qualifications of the applicant, including, but not limited to, the matters set forth in Section 4.5-1, as well as other relevant matters. Upon receipt of the completed application, the information must be processed as set forth commencing at Section 4.5-3.

(B) A Medical Staff member who seeks a change in their Medical Staff status or a modification of their clinical privileges may submit such a request at any time upon a form developed by the Medical Executive Committee, except that such application may not be filed within 12 months after a similar request has been denied.

4.6-2 EFFECT OF APPLICATION

The effect of an application for reappointment or modification of staff status or privileges is the same as that set forth in Section 4.5-2.

4.6-3 STANDARDS AND PROCEDURE FOR REVIEW

When a Medical Staff member submits their first application for reappointment, and at each reappointment thereafter, or when the member submits an application for modification of their Medical Staff status or clinical privileges, the member will be subject to an in-depth review generally following the procedures set forth in Sections 4.5-3 through 4.5-11.

4.6-4 TIME-LIMITED AND MEMBER-SPECIFIC PRIVILEGES

If an application for reappointment will not be fully processed by the expiration date of the member's appointment to the Medical Staff, for reasons that are not the responsibility of the member, the Medical Executive Committee and Board may

approve a time-limited and member-specific granting of privileges to cover the processing period of the member's application. Any subsequent reappointment will then be retroactive to the end of the member's prior appointment term and will last no longer than 2 years. These time-limited and member-specific privileges do not create a vested right in the member for continued appointment. They are intended only to cover such time as is necessary to conclude reappointment application processing.

4.6-5 FAILURE TO FILE REAPPOINTMENT APPLICATION

A member's failure without good cause to timely file a completed application for reappointment will result in the expiration of the member's admitting privileges, practice privileges, and prerogatives at the end of the current staff appointment, unless otherwise extended by the Medical Executive Committee with the approval of the Board. If the reappointment application is not received by the Medical Staff Services Department following the member's initial request for reappointment, a fee for delinquent reappointment applications may be levied, as determined and approved by the Medical Executive Committee. If the member fails to submit a completed application for reappointment within 30 days past the date it was due, the member will be deemed to have resigned membership in the Medical Staff as of the expiration of the current appointment term. In the event that membership terminates for the reasons set forth herein, the procedures set forth in Article VII of these Bylaws will not apply.

Such former Medical Staff members are permitted to reapply for appointment to the Medical Staff at any time upon expiration of their present staff appointments.

If submitted within six months of expiration of membership, such former member may apply using the reappointment application. Otherwise, the former member must submit an initial application that will be processed as if the former member were a new applicant.

4.6-6 REQUEST FOR REINSTATEMENT AFTER VOLUNTARY RESIGNATION

A former Medical Staff member who requests reinstatement after voluntary resignation may not be required to complete an initial application form, but instead may submit a reappointment application, if the reappointment application is received within six months of the effective date of the resignation. However, the former Medical Staff member will be expected to respond to requests for additional information, if any, from the Medical Staff relative to the request for reinstatement.

4.7 LEAVE OF ABSENCE

4.7-1 LEAVE STATUS

(A) At the discretion of the Medical Executive Committee, a Medical Staff member may obtain a voluntary leave of absence from the staff upon

submitting a written request to the Medical Executive Committee stating the approximate period of leave desired, not to exceed one (1) year. Requests for extension of leave may be granted at the discretion of the Medical Executive Committee. During the period of the leave, the member may not exercise clinical privileges at the Hospital, and membership rights and responsibilities will be inactive, but the obligation to pay dues will continue, unless waived by the Medical Executive Committee.

(B) When a member is away from Medical Staff and/or patient care responsibilities for longer than thirty (30) days and such absence is related to the member's physical or mental health or their ability to care for patients safely and competently, the member must report the absence to the Medical Staff Office. Upon receipt of an absence report from a Member or receipt of credible information that a member should have made such report under this provision, the Chief of Staff may place the member on leave of absence status without a request from the Medical Staff member.

(C) Absence for longer than one year will result in automatic relinquishment of Medical Staff membership and clinical privileges unless an extension is granted by the Medical Executive Committee.

(D) If a Medical Staff member's current appointment is due to expire during the leave, the member must apply for reappointment consistent with Section 4.6-1. Otherwise, membership and clinical privileges will expire at the end of the appointment period. Expiration of membership and clinical privileges will not be considered an adverse decision, and the procedures set forth in Article VII will not apply.

(E) Leaves of absence are matters of courtesy, not of right. Denial of a request for a leave of absence or refusal to grant an extension of a leave of absence will not be considered an adverse decision, and the procedures set forth in Article VII will not apply.

4.7-2 TERMINATION OF LEAVE

At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. If the Medical Executive Committee so requests, the Medical Staff shall submit a summary of relevant activities during the leave or other information regarding the leave or the Medical Staff's ability to resume membership and privileges at the Hospital. If deemed necessary, the Medical Executive Committee may require the member to provide information to the Medical Executive Committee and/or Physicians' Health Committee. Examples of information the Medical Executive Committee may request include, but are not limited to, measures taken to maintain qualifications. The Medical Executive Committee may also require the Medical Staff member to submit to a medical and/or psychological examination at the

member's expense. After the Medical Executive Committee has received and fully considered all required information, the Medical Executive Committee will make a decision concerning return from the leave of absence. No individual may return from a leave of absence unless they have a valid and current appointment to the Medical Staff under Article IV of these Bylaws.

4.7-3 MILITARY LEAVE OF ABSENCE

Requests for leave of absence to fulfill military service obligations will be granted upon notice and review by the Medical Executive Committee. Reactivation of membership and clinical privileges previously held will be granted, notwithstanding the provisions of Sections 4.7-1 and 4.7-2, but may be granted subject to focused professional practice evaluation, as determined by the Medical Executive Committee.

4.7-4 FAILURE TO REQUEST REINSTATEMENT AFTER LEAVE OF ABSENCE

Failure to request reinstatement will be deemed a voluntary resignation from the Medical Staff and will result in automatic termination of membership, privileges, and prerogatives. A request for Medical Staff membership subsequently received from a member so terminated must be submitted and processed in the manner specified for applications for initial appointments. A Medical Staff whose membership is automatically terminated is not entitled to the procedural rights provided in Article VII.

ARTICLE V

CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, a member providing clinical services at this Hospital is entitled to exercise only those clinical privileges that are specifically granted to the member. Said privileges and services must be Hospital-specific; within the scope of any license, certificate, or other legal credential authorizing practice in the state of California and consistent with any restrictions thereon; and subject to the Rules and Regulations of the clinical department and the authority of the Department Chair and Medical Staff. Medical Staff privileges may be granted, continued, modified, or terminated by the Governing Body of the Hospital only upon recommendation of the Medical Staff, only for reasons directly related to quality of patient care and the provisions of the Medical Staff Bylaws, and only following the procedures outlined in these Bylaws.

5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2-1 REQUESTS

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. A written request by a member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. To obtain additional privileges, a member of the Medical Staff must make a written request to the appropriate Department Chair that states the type of privileges desired, related training and/or experience, and a resume of cases. The Department Chair will recommend to the Medical Executive Committee that the application for additional privileges be granted or denied following the procedures contained in Article IV of these Bylaws.

5.2-2 BASIS FOR PRIVILEGES DETERMINATION

Requests for clinical privileges must be considered and, if warranted, then evaluated on the basis of the applicant's education; training; experience; satisfaction of the credentialing prerequisites set forth in Article II of these Bylaws; demonstrated professional competence and judgment; clinical performance; performance of a sufficient number of procedures each year to develop and maintain the member's skills and knowledge; the Hospital's ability to provide adequate facilities and supportive services for the applicant and the applicant's patients; and the documented results of patient care and other quality assessment and improvement activities which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and healthcare settings in which an applicant exercises clinical privileges. If an applicant (including a Medical Staff member) requesting a modification of

privileges fails to timely furnish the information that is necessary to evaluate the applicant's request, the application will automatically lapse, and the applicant will not be entitled to a hearing under Article VII of these Bylaws.

5.3 PROCTORING

5.3-1 GENERAL PROVISIONS

Except as otherwise determined by the Medical Executive Committee, all initial appointees to the Medical Staff and all members granted new clinical privileges will be subject to a period of proctoring. The proctoring process will include those requirements customarily applied to monitor a practitioner's performance, including, but not limited to, concurrent and/or retrospective review, mandatory consultation, and direct observation. Each appointee or recipient of new clinical privileges will be assigned to a Department where performance on an appropriate number of cases is established by the appropriate Department Chair and will be proctored by the Chair of the Department or the Chair's designee during the period of proctoring specified in the Department's Rules and Regulations to determine the member's suitability to continue to exercise the clinical privileges granted in that Department. The exercise of clinical privileges in any other Department will also be subject to proctoring by that Department's Chair or designee. The member will remain subject to such proctoring until the Medical Executive Committee has been furnished with:

(A) A report signed by the Chair of the Department(s) to which the member is assigned, describing the types and numbers of cases proctored and the evaluation of the member's performance, and containing a statement that the member appears to meet all of the qualifications for unsupervised practice in that Department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and

(B) A report signed by the Chair of the other Department(s) in which the member may exercise clinical privileges, describing the types and number of cases proctored and the evaluation of the member's performance, and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those Departments.

(C) A summary of proctoring documentation from another institution may be furnished to the Medical Executive Committee at the discretion of the Department Chair and only if the proctors are eligible to be a proctor in both the Hospital and the other institution, the same privileges are requested at both institutions, and the proctor's reports are filed at both institutions.

5.3-2 PROCTORING REQUIREMENTS

(A) Proctoring must analyze the six core competencies as defined in Section 2.6;

(B) A plan must be in place for monitoring the specific privileges granted;

(C) Specific criteria must be used to monitor performance;

(D) The circumstances requiring external proctoring must be defined;

(E) The evaluation results must be communicated by the proctor to the member and to the appropriate Department Chair and Division Chief;

(F) Changes must be implemented to improve practitioner performance, as appropriate;

(G) A sufficient variety and number of cases must be proctored depending upon the scope of clinical privileges sought;

(H) Each proctoring episode must be recorded in a written document, as appropriate;

(I) Proctoring summary reports must include the number and types of cases reviewed as well as the applicant's performance; and

(J) Proctoring reports must be maintained in the member's credential file.

5.3-3 FAILURE TO OBTAIN CERTIFICATION

If an initial appointee to the Medical Staff fails, within the time of provisional membership, to furnish the proctorship certification required, or if a member exercising new clinical privileges fails to furnish such certification within the time allowed by the Department, those specific clinical privileges will automatically terminate unless an extension for good cause is granted, and the member will not be entitled to a hearing, upon request, pursuant to Article VII unless such failure is due to an action concerning clinical competency or conduct.

5.3-4 MEDICAL STAFF ADVANCEMENT

The failure to obtain certification for any specific clinical privileges will not, by itself, preclude advancement in Medical Staff category of any member. If such advancement is granted absent such certification, continued proctorship on the uncertified procedure will continue for the specified time period.

5.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

5.4-1 ADMISSIONS

(A) Except as otherwise provided in these Bylaws, when podiatrists, dentists, and oral surgeons who are members of the Medical Staff admit patients, they are responsible for arranging for a physician member of the Medical Staff who will conduct or directly supervise the admitting H&P (except the

portion related to dentistry or podiatry) and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice. [*See* exception below relating to admission of certain patients by podiatric surgeons.]

(B) With respect to the Hospital records concerning a podiatrist or oral surgeon admitting a patient, the podiatrist or oral surgeon shall make a record of the following:

1. A detailed podiatric or dental history justifying the Hospital admission;

2. A detailed description of podiatric or dental examination and a preoperative diagnosis;

3. A complete operative report describing findings and techniques. All tissues (including teeth) shall be sent to the Hospital's pathologist for examination; and

4. Progress notes as are pertinent to the patient's podiatric or dental condition.

5.4.1.1 PODIATRIC ADMISSIONS OF ASA I AND ASA II PATIENTS

(A) When a podiatric surgeon admits a patient with ASA I or ASA II classifications (American Society of Anesthesiologists' physical status categorization system), the podiatric surgeon is permitted to conduct and document the H&P and assume responsibility for the care of the patient's medical problems present at the time of admission. If the patient's ASA status is elevated above ASA II, an immediate consultation with an appropriate medical specialist must be sought.

(B) Podiatrists admitting patients with ASA classifications higher than II must adhere to the Bylaws provisions stipulated in Section 5.4-1.

5.4-2 SURGERY

Surgical procedures performed by limited license practitioners must be under the overall supervision of the Chair of the Department of Surgery or the Chair's designee.

5.4-3 MEDICAL APPRAISAL

All patients admitted for care in the Hospital by a dentist or podiatrist must receive the same basic medical appraisal as patients admitted to other services, and the dentists or podiatrists, except as provided under Section 5.4-1, must seek consultation with a physician member to determine the patient's medical status and

need for medical evaluation whenever the patient's clinical status indicates the development of a new medical problem. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Department(s).

5.5 TEMPORARY PRIVILEGES

5.5-1 CIRCUMSTANCES

(A) Practitioners who are not members of the Medical Staff may be granted temporary privileges to fulfill an important patient care, treatment, or service need, including, but not limited to, consulting on a patient who is under the care of an attending Medical Staff member, assisting a Medical Staff member in surgery, or providing professional education. The duration of temporary privileges granted for an important patient care, treatment, or service need must be reasonable as determined by the Chief of Staff in light of the important patient care, treatment, or service need.

(B) Temporary privileges may be granted to practitioners who are licensed in a state other than California for the sole purpose of conducting professional education to the extent permitted by law as outlined in Section 2060 of the California Business and Professions Code.

(C) In circumstances where the important patient care, treatment, or service need is to serve as a locum tenens for a current Member of the Medical Staff in order to meet the needs of that Member's patients in their absence, the Practitioner granted temporary Privileges may attend only patients for whom the Member would otherwise be responsible.

1. A practitioner who has been granted locum tenens privileges may attend only patients of the Medical Staff member(s) for whom the practitioner is providing coverage for a period not to exceed 4 months or 4 separate periods of time within a calendar year, after which the practitioner must apply for Medical Staff membership and privileges.

2. The locum tenens practitioner must complete a full locum tenens application, submit their application to the Medical Staff Services Department, and pay an application fee.

3. Before locum tenens privileges may be granted, the practitioner must provide evidence of current malpractice insurance. The practitioner's record from the National Practitioner Data Bank and the Medical Board of California will also be requested and reviewed.

(D) Temporary privileges may be granted when there is a clean, completed Medical Staff application for Staff privileges and the Department Chair determines that they have received reliable and substantive information regarding the applicant's current professional competence, ethical character, and ability to work well with others so as not to adversely affect patient care. In such instances, when Board approval is anticipated, temporary privileges may take effect upon a favorable determination by the Department Chair and extend until the date of the acceptance or rejection of the application, but in no event shall these temporary privileges last for more than 120 days.

5.5-2 APPLICATION AND REVIEW

(A) Upon the written concurrence of the Department Chair who will supervise the temporary privileges holder directly or through the Division Chief, the Hospital President or designee will have the authority to grant temporary privileges to an appropriately licensed practitioner who desires to attend a specific patient in the Hospital or perform specific services in a Hospital-based Department, but is not a Staff member. Such temporary privileges are granted on a case-by-case basis for a stated period or for a period spanning the care of a specific patient, upon such practitioner's submission to the Medical Staff Services Department of a completed temporary privileges request/application, in the form and accompanied by the supporting documentation prescribed by the Medical Executive Committee. The practitioner must provide evidence of current malpractice insurance, the verification of their licensure, and current competence. The practitioner's record from the National Practitioner Data Bank and the Medical Board of California will also be requested and reviewed. In the exercise of such privileges, a practitioner shall be under the supervision of the Department Chair.

(B) If the applicant requests temporary privileges in more than one Department, written concurrence must be obtained from the appropriate Department Chairs following the application procedure set forth in this Section.

5.5-3 GENERAL CONDITIONS

(A) If granted temporary privileges, the practitioner must act under the supervision of the Department Chair to which the applicant has been assigned and must ensure that the Chair or the Chair's designee is kept closely informed as to the practitioner's activities within the Hospital.

(B) Temporary privileges will automatically terminate at the end of the designated period, unless earlier terminated as set forth in Section 5.5-3(F) or unless affirmatively renewed following the procedure as set forth in Sections 5.5-1 and 5.5-2.

(C) The Chief of Staff, after consultation with the Department Chair or designee, must impose upon any practitioner granted temporary privileges requirements for proctoring and monitoring, including, but not limited to, those in Section 5.3, on such terms as may be appropriate under the circumstances. In connection with the granting of temporary privileges, special requirements of supervision and reporting may be imposed upon the practitioner to whom such temporary privileges are granted. Failure to comply with such special conditions will result in the immediate termination of the temporary privileges.

(D) At the discretion of the appropriate Department Chair, those surgeons who have temporary privileges may be required to obtain a consultation prior to surgery from a member of the Active Surgical Staff who has operative privileges for the proposed procedure. This consultant must be present at surgery unless the requirement is waived by the Chair of the Department of Surgery or their appointed representative.

(E) There is no right to temporary Privileges. If the available information is inconsistent or casts any reasonable concerns on the practitioner's qualifications, action on the request for temporary Privileges must be deferred until the concerns have been satisfactorily resolved.

(F) A practitioner's temporary privileges may, at any time, be terminated by the Hospital President and/or the Chief of Staff with the concurrence of the Department Chair or their designees. In such cases, the appropriate Department Chair or, in the Chair's absence, the Chair of the Medical Executive Committee, must assign a member of the Medical Staff to assume responsibility for the care of the practitioner's patient(s). The wishes of the patient must be considered when assigning a replacement Medical Staff member. A practitioner is entitled to the procedural rights afforded by Articles VI and VII whenever their temporary privileges are terminated for any cause for corrective action identified in Section 6.4-1.

(G) Temporary privileges may be granted by the Hospital President (or their designee when the Hospital President is unavailable) on the recommendation of the Chief of Staff or the Department Chair where the Privileges will be exercised as the Chief of Staff's designee. If the Chief of Staff or Department Chair is unavailable, they may designate someone to act in their absence. If circumstances require that temporary privileges must be granted during hours when the Medical Staff Services Department is closed, the Medical Staff Services Department must be notified as soon as possible of the name and contact information of the practitioner for whom temporary privileges are granted.

(H) All persons requesting or receiving temporary privileges are bound by the Bylaws and the Rules and Regulations of the Medical Staff.

5.6 EMERGENCY PRIVILEGES

(A) For the purpose of this Section, an "emergency" is defined as either of the following:

1. An unexpected or sudden event that significantly disrupts the Hospital's ability to provide care or the environment of care itself; or

2. Any occasion in which serious or permanent harm could result to a patient or in which the life of a patient is in immediate danger, and any delay in administering treatment could add to that danger.

(B) In the case of an emergency, any practitioner, to the degree permitted by their license and regardless of Department affiliation, Staff status, or scope of clinical privileges, will be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm, including calling for a consultation and appropriate treatment by a specialist physician, even if that specialist is not a member of the Medical Staff, and using every facility of the Hospital that is necessary. The practitioner must make every reasonable effort to communicate promptly with the Department Chair concerning the need for emergency care and assistance by members of the Medical Staff with appropriate clinical privileges and, once the emergency has passed or assistance has been made available, must defer to the Department Chair with respect to further care of the patient at the Hospital.

(C) In the event of an emergency, any person will be permitted to do whatever is reasonably necessary to save the life of a patient or to save a patient from serious harm. Such persons must promptly yield such care to qualified members of the Medical Staff when those members become reasonably available.

(D) In the event of an emergency, the patient's attending physician will be allowed to admit and render care without regard to temporary suspension due to incomplete medical records. Any such admission should be reported to the Chair of the Department involved to confirm the authenticity of the emergency of such admission. In turn, the Department Chair must report any abuses of such emergency privileges to the Medical Executive Committee.

5.7 DISASTER PRIVILEGES

(A) For the purpose of this Section, a "disaster" is defined as an emergency that, due to its complexity, scope, or duration, threatens the Hospital's capabilities and requires outside assistance in order to sustain patient care, safety, or security functions.

(B) Disaster privileges may be granted by the Hospital president (or designee), by the Chief of Staff (or designee), or by a Department Chair (or designee) when the Hospital's emergency management plan has been activated and the Hospital is unable to handle immediate patient needs. The option to grant disaster privileges is made on a case-by-case basis in accordance with the needs of the Hospital and the patients and based on the qualifications of the volunteer practitioners.

(C) In the event of a disaster, physicians or allied health professionals ("AHPs") who are not already credentialed members and who arrive to assist must be directed to the Medical Staff Office or other appropriate station. The Medical Staff Services Department is responsible for ensuring that physicians and AHPs who are not members of the Medical Staff or AHP staff are credentialed to assist the facility in the event of a disaster.

(D) In the event of a disaster, volunteer practitioners may be granted disaster privileges after the Hospital obtains valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:

1. A current picture identification card from a known health care organization that clearly identifies professional designation;

2. A current license to practice;

3. Primary source verification of licensure;

4. 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;

5. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or

6. Confirmation by a licensed independent practitioner who is 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.

If possible, copies of the information should be made.

(E) The Medical Staff Office must immediately contact the appropriate source to verify licensure and information completed on the application. If these verifications cannot be completed immediately, privileges may still be

issued pending subsequent verification of the member's status as soon as the immediate situation is under control.

(F) Primary source verification of licensure must occur, if possible, as soon as the immediate disaster is under control, or within 72 hours of the time that the volunteer licensed independent practitioner is granted disaster privileges. If primary source verification cannot be completed within 72 hours, there must be documentation regarding why primary source verification could not be performed.

(G) When a disaster continues beyond 72 hours, the Chief of Staff, Hospital president, or their respective designees must decide whether the practitioner should continue disaster responsibilities based on personal observations or medical record review. Within 72 hours of the time that primary source verification of licensure occurs, a decision will be made whether to continue the disaster privileges granted to the practitioner.

(H) Clinical Staff Volunteers are assigned to a proctor who will give the Clinical Volunteer a brief orientation to the Hospital, including a safety orientation, and will assess the Clinical Volunteer for competency for skills for the area(s) assigned, by direct observation and clinical record review.

(I) Members of the Medical Staff must comply with any proctoring, participation in departmental quality improvement activities, or other requirements upon which the exercise of the member's disaster privileges is conditioned by the Medical Executive Committee, Chief of Staff, or Department Chair.

(J) Disaster privileges will be immediately terminated by the Chief of Staff or designee:

1. When the disaster no longer requires the services of non-members; or

2. If adverse information is received that suggests the member is incapable of rendering quality care.

(K) Termination of disaster privileges will not give rise to a hearing, review, or other procedural rights under Article VII of these Bylaws, regardless of the reason for termination.

5.8 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, upon recommendation of the Department Chair, or pursuant to a request under Section 4.6-1(B), the Medical Executive Committee may recommend a change in the clinical privileges or Department assignment(s) of a member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current

Medical Staff member be made subject to proctoring in accordance with procedures similar to those outlined in Section 5.3.

5.9 LAPSE OF APPLICATION

If a Medical Staff member requesting a modification of clinical privileges or Department assignments fails to timely furnish the information necessary to evaluate the request, the application will automatically lapse, and the applicant will not be entitled to a hearing as set forth in Article VII.

5.10 NEW TECHNOLOGIES/ NEW PROCEDURES OR SERVICES

5.11 -1 PROCEDURE:

(A) A request to perform a new procedure or provide a new service at the Hospital will be evaluated by the appropriate clinical Department, the Medical Executive Committee, and the Board, taking into consideration the following elements:

1. Community need;

2. Efficacy;

3. Effectiveness;

4. Hospital-specific capabilities;

5. Risks; and

6. Equipment and staffing needs.

(B) An initial request to perform a new procedure or service will be submitted to the appropriate clinical Department for determination of whether to perform the requested procedure or to provide the proposed services at the Hospital. A "New Procedures/Service Request Form" must be completed.

1. If the respective appropriate clinical Department determines that a new procedure or service is a community need and could improve patient care, it must individually or collectively with other specialties evaluate the privilege or service, develop and submit respective criteria sufficient for credentialing individuals in the procedure or service and include this information in the appropriate clinical department Rules and Regulations.

5.12 PRIVILEGES DOCUMENTATION

To ensure that practitioners are appropriately privileged to perform all services rendered at the Hospital, documentation of current privileges must be available to the Hospital

admissions/registration office and such other scheduling and health information services personnel as necessary to maintain an up-to-date listing of privileges for purposes of scheduling and monitoring.

ARTICLE VI

CORRECTIVE ACTION

6.1 ROUTINE MONITORING AND EDUCATION

6.1-1 RESPONSIBILITY

It is the responsibility of the Department Chair to design and implement an effective program:

(A) To monitor and assess the quality of professional practice in each Department; and

(B) To promote high quality of practice in each Department by:

1. providing education and counseling;

2. issuing letters of admonition, warning or censure, as necessary; and

3. requiring routine monitoring.

6.1-2 PROCEDURE

(A) Review and Studies: Each Department will conduct regular patient care reviews and studies of practice within the Department in conformity with the Hospital's general quality assessment and improvement plan and shall investigate complaints and practice-related incidents.

(B) Informal Counseling: In order to assist Department members to conform their conduct or professional practice to the standards of the Medical Staff and Hospital, Department Chairs or Division Chiefs may issue informal comments or suggestions, either orally or in writing. Such comments or suggestions will be subject to the confidentiality requirements of all Medical Staff information and may be issued by Department Chairs or Division Chiefs with prior discussion with the recipient. Such comments or suggestions shall not be considered a restriction of privileges, shall not be considered to be corrective action as provided in Section 6.4, and shall not give rise to hearing, review, or appeal rights under Article VII of these Bylaws.

(C) Routine Monitoring: Following discussion or identified concerns with any Department member, any Department may authorize the Department Chair to issue a letter of suggestions for improvement, guidance, admonition, or warning, or to require such member to be subject to routine monitoring for such time as may appear reasonable. The term "routine monitoring," as used in this Section, means review of a member's practice for which the member's only obligation is to provide reasonable notice of admissions,

procedures, or other patient care activity. All members of the Medical Staff, regardless of status, are subject to potential routine monitoring. The discussions of such action with individual members will be informal. Such action shall not constitute a restriction of privileges, shall not be considered to be corrective action as provided in Section 6.4 of these Bylaws, and shall not give rise to hearing review or appeal rights under Article VII of these Bylaws.

(D) Actions taken pursuant to subsections (B) and (C) of this Section must be reported to the Medical Executive Committee promptly after such actions are taken.

6.2 ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

All members are subject to evaluation based on Medical Staff peer review criteria adopted consistent with these Bylaws.

6.3 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

(A) The focused professional practice evaluation allows the Medical Staff to focus evaluation on a specific aspect of a practitioner's performance. This process is used in the following 2 circumstances:

1. When a practitioner has the credentials to suggest competence and is granted new privileges, but additional information or a period of evaluation is needed to confirm competence in the organization's setting; and

2. If questions arise regarding a currently privileged practitioner's ability to provide safe, high quality patient care.

6.4 CORRECTIVE ACTION

6.4-1 CRITERIA FOR INITIATION

Corrective action may be initiated when reliable information indicates a member of the Medical Staff may have exhibited acts, demeanor, or conduct reasonably likely to:

(A) Be below the professional standards of the Medical Staff;

(B) Be disruptive to the operation of the Hospital;

(C) Reflect that the member may have failed to exercise ordinary care and diligence in applying requisite standards of ethics, learning, and skills in the treatment of patients;

(D) Reflect that the member may be in violation of these Bylaws, Rules and Regulations, and policies of the Medical Staff, Departmental Rules and Regulations;

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

(F) Constitute fraud or abuse; or

(G) Result in the imposition of sanctions by any governmental authority.

6.4-2 INITIATION

An investigation may be requested by any committee of the Medical Staff, any Department Chair, the Hospital president or designee, the Board, or any officer of the Medical Staff.

A request for an investigation must be in writing, submitted to the Chief of Staff, and supported by reference to specific activities or conduct alleged. The request must include a description of the conduct or statement that constitutes the grounds for the request.

6.4-3 INVESTIGATION

Upon receipt of such request, the Chief of Staff must inform the Medical Executive Committee.

If the facts or allegations warrant it, the Medical Executive Committee may appoint an Ad Hoc Committee consisting of persons who are not also on the Medical Executive Committee and make an appropriate recordation of the reasons. The Medical Executive Committee in its discretion may appoint practitioners who are not members of the Medical Staff as temporary members of the Medical Staff for the sole purpose of serving on an Ad Hoc Committee and not for the purpose of granting these practitioners temporary clinical privileges under Section 5.5.

The Ad Hoc committee must proceed with the investigation in a prompt manner. In conducting any investigation pursuant to this Article, the Ad Hoc Committee may interview and consult with any individuals and review any records and documents necessary to ascertain all the facts surrounding the request. As part of its investigation, the Ad Hoc Committee may, but is not obligated to, conduct interviews with persons involved; however, such interviews will not constitute a "hearing" as that term is used in Article VII of these Bylaws, nor will the procedural rules with respect to hearings or appeals apply.

After conducting a preliminary investigation, the Ad Hoc Committee must invite the Medical Staff member whose act or conduct is in question to appear before the Committee. At such interview, the member must be informed of the general nature of the charges against them and must be invited to discuss, explain, or refute them.

This interview will not constitute a hearing and will be preliminary in nature, and none of the procedural rights provided in Article VII of these Bylaws with respect to hearings or appeals will apply. The Ad Hoc Committee must make a record of all such interviews.

Despite the status of any investigation, at all times, the Medical Executive Committee will retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action. An investigation is a process specifically instigated by the Medical Executive Committee to determine the validity, if any, of a concern or complaint raised against a member of the Medical Staff and does not include activity of the Physician Well-Being Committee.

6.4.3.1 FINDINGS AND RECOMMENDATIONS OF THE AD HOC COMMITTEE

At the conclusion of its investigation the Ad Hoc Committee shall deliver a report to the Medical Executive Committee and the relevant Division Chief. This report must include findings, consisting of a listing of the results of the investigation and recommendations that may include any of the following:

(A) No formal corrective action. This is appropriate when it is found either that the allegations are without merit or that the alleged act or conduct lacks sufficient seriousness to warrant further corrective action;

(B) Deferral of action. This is appropriate when immediate corrective action does not appear warranted, but the matter will be held open for additional consideration and/or review within a reasonable time period;

(C) Letter of admonition, letter of censure, or letter of reprimand. In the event such letters are issued, the affected member may make a written response. All such letters and responses must be placed in the member's file;

(D) Imposition of terms of probation or special limitation upon continued staff members or exercise of continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, and/or monitoring;

(E) Reduction, modification, suspension, or revocation of all or any portion of the Staff member's clinical privileges;

(F) Suspension of clinical privileges until the member completes specific conditions or requirements;

(G) Suspension or revocation of Medical Staff membership; or

(H) Any other corrective action or combination of corrective actions that appears to be warranted by the findings.

Nothing herein shall be deemed to preclude Department Chairs from issuing informal written or oral warnings outside of the Medical Executive Committee mechanism for corrective action.

6.4-4 MEDICAL EXECUTIVE COMMITTEE ACTION

The Medical Executive Committee will then review the findings and recommendations of the Ad Hoc Committee. The Medical Executive Committee may invite the Staff member whose conduct is in question to appear before it prior to taking action. The member's appearance will not constitute a hearing and will be preliminary in nature and none of the procedural rules provided in these Bylaws with respect to hearings and appeals apply. The Medical Executive Committee must make a record of all such appearances before it. As soon as practicable after the conclusion of the investigation, the Medical Executive Committee will recommend action.

6.4-5 RECOMMENDATION OF THE MEDICAL EXECUTIVE COMMITTEE

The Medical Executive Committee will consider the findings and recommendations of the Ad Hoc Committee and accept, reject, or modify them. The Medical Executive Committee may request further investigation by the Ad Hoc Committee.

(A) Favorable Recommendation. If the Medical Executive Committee's recommendation is favorable to the Medical Staff member, the Medical Executive Committee may determine no corrective action should be taken, and if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, it will enter a statement to that effect in the member's file.

(B) Adverse Recommendation. If the Medical Executive Committee's recommendation is an adverse action as described in Section 6.4.3.1(D)-(H), the Medical Executive Committee must promptly notify the affected Medical Staff member by special notice of the right to proceed under the provisions set forth in Article VII of these Bylaws. However, the hearing rights of Article VII will only apply if the Medical Executive Committee's action or recommended action would require a report to the National Practitioner Data Bank or to the California Medical Board (or the physician, dentist, or podiatrist's applicable licensing board) under Section 805 of the California Business and Professions Code.

6.4-6 INITIATION BY GOVERNING BODY

If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. The Board's request for Medical Staff action must be in writing and must set forth the basis for the request. If the Medical Executive Committee fails to take action in response to the Board's

direction, the Board may initiate corrective action after written notice to the Medical Executive Committee, but this corrective action must comply with Articles VI and VII of these Bylaws.

6.5 SUMMARY RESTRICTION OR SUSPENSION

6.5-1 CRITERIA FOR INITIATION

Whenever a member's conduct appears to require that immediate action be taken because failure to do so may result in an imminent danger to the health of any patient, prospective patient, or other person, the Chief of Staff, the Medical Executive Committee, the Department Chair or designee in the department in which the member holds privileges, or the Hospital President or designee may summarily restrict or suspend the Medical Staff membership or clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension will become effective immediately upon imposition, and the person or body responsible must promptly give written notice of the restriction or suspension to the Board, the Medical Executive Committee, and the Hospital President. In addition, the affected Medical Staff member must be provided with a Special Notice of the action which fully complies with the requirements of Section 6.5-2 below.

The summary restriction or suspension may be limited in duration and will remain in effect for the period stated or, if no period is stated, it will remain in effect until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients must be promptly assigned to another member by the Department Chair or by the Chief of Staff. Where feasible, the wishes of the patient in the choice of a substitute member will be considered.

6.5-2 WRITTEN NOTICE OF SUMMARY SUSPENSION OR RESTRICTION

Within 3 working days of the imposition of a summary suspension or restriction, the affected Medical Staff member must be provided with written notice of such suspension or restriction. For purposes of these Bylaws, "working days" means Monday through Friday and excludes weekends and UCSF-designated holidays. This initial written notice must include a statement of facts demonstrating that the suspension was necessary because failure to summarily suspend or restrict the member's privileges could reasonably result in an imminent danger to the health of any individual. The statement of facts provided in this initial notice must also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3-3 (which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension). The notice under Section 7.3-3 may supplement the initial notice provided under this Section by including any additional relevant facts supporting the need for summary suspension or other corrective action.

6.5-3 MEDICAL EXECUTIVE COMMITTEE ACTION

Within 10 working days after such summary restriction or suspension has been imposed, the Medical Executive Committee must convene in a meeting to review and consider the action. The Staff member whose clinical privileges have been summarily suspended or restricted must be invited to attend a meeting with the Medical Executive Committee. The attendance of the Staff member at such a meeting is mandatory and is a prerequisite to their ultimate exercise of hearing rights pursuant to Article VII of these Bylaws. The member may make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event will any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article VII of these Bylaws, nor will any procedural rules apply. The Medical Executive Committee may vote to modify, continue, or terminate the summary restriction or suspension. The Medical Executive Committee must furnish the member with notice of its decision within 2 working days of the meeting.

6.5-4 PROCEDURAL RIGHTS

Unless the Medical Executive Committee promptly terminates the summary restriction or suspension in accordance with Section 6.5-3, the member will be entitled to the procedural rights afforded by Article VII of these Bylaws.

6.5-5 INITIATION BY GOVERNING BODY

If the Chief of Staff, members of the Medical Executive Committee, and the head of the Department (or the Chair's designee) in which the member holds privileges are not available to summarily restrict or suspend the member's Medical Staff membership or clinical privileges, the Board (or designee) may immediately suspend a member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any patient, prospective patient, or other person, provided that the Board (or designee) made reasonable attempts to contact the Chief of Staff, members of the Medical Executive Committee, and the head of the Department (or designee) before the suspension.

Such a suspension is subject to ratification by the Chief of Staff. If the Chief of Staff does not ratify such a summary suspension within 2 working days, excluding weekends and holidays, the summary suspension must terminate automatically. If the Chief of Staff does ratify the summary suspension, all other provisions under Section 6.5 of these Bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Chief of Staff for purposes of compliance with the notice and hearing requirements.

6.6 AUTOMATIC SUSPENSION, LIMITATION, OR TERMINATION

In the following instances, the member's privileges or membership will be automatically suspended, limited, or terminated as described.

6.6-1 LICENSURE

The following changes in status of licensure constitute grounds for action:

(A) Revocation and Suspension. Whenever a member's license or other legal credential authorizing practice in this state is revoked or suspended, Medical Staff membership and clinical privileges will be automatically revoked as of the date such action becomes effective. The member may apply as a new applicant pursuant to Article IV of these Bylaws upon reinstatement of the license or other credential authorizing practice in this state.

(B) Expiration. Whenever a member's license or other legal credential authorizing practice in this state expires, Medical Staff membership and clinical privileges will be automatically suspended as of the date of expiration. The automatic suspension will remain in effect until the license or other credential authorizing practice in this state is renewed or reinstated. Should the suspension remain in effect for more than 3 months, the membership and privileges will automatically terminate.

(C) Restriction. Whenever a licensing or certifying authority limits or restricts a member's license or other legal credential authorizing practice in this state, any clinical privileges that the member has been granted at the Hospital and that are within the scope of the limitation or restriction will be automatically limited or restricted in a similar manner as of the date such action becomes effective and throughout its term.

(D) Probation. Whenever a licensing or certifying authority places a member on probation, the member's Medical Staff membership status and clinical privileges will automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

6.6-2 CONTROLLED SUBSTANCES

(A) Revocation, Limitation, Suspension, and Expiration: Whenever a member's DEA certificate is revoked, limited, suspended, or expired, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

(B) Probation: 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.

6.6-3 FAILURE TO SATISFY SPECIAL APPEARANCE OR RESPONSE REQUIREMENT

If a member fails, without good cause, to appear at a peer review meeting and/or respond to a peer review inquiry under Sections 6.4-3 and 11.6-1 of these Bylaws, that failure will result in the automatic suspension of the member's privileges as specified by those Sections.

6.6-4 MEDICAL RECORDS

Members of the Medical Staff are required to complete medical records within the timeframes required by the relevant regulatory bodies. A limited suspension, in the form of withdrawal of admitting and other related privileges, until medical records are completed, shall be imposed by the Chief of Staff or designee after notice of delinquency for failure to complete medical records within such period. Such suspension shall not affect the right to continue to care for a patient that the Medical Staff member has already admitted or is treating or who has been scheduled for surgery.

For the purpose of this Section, "related privileges" means voluntary on-call service for the emergency room, scheduling surgery/ procedures, assisting in surgery/ procedures, consulting on Hospital cases, and providing professional services within the Hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations.

The suspension will continue until lifted by the Chief of Staff or designee. Detailed rules regarding the procedures to be followed when medical records are delinquent are set forth the Rules and Regulations of the Medical Staff.

6.6-5 FAILURE TO PAY DUES/ASSESSMENTS

Failure without good cause as determined by the Medical Executive Committee to pay dues or assessments, as required under Section 13.2, will result in automatic suspension of a member's clinical privileges. If within 90 days after written request for payment the member does not pay the required dues or assessments, the member's membership will be automatically terminated.

6.6-6 PROFESSIONAL LIABILITY INSURANCE

Whenever a Staff member's professional liability insurance limits of coverage fall below the minimum required by these Bylaws or their professional liability insurance coverage is terminated for any reason, the member will be automatically suspended until the member verifies reinstatement of appropriate coverage. "Appropriate coverage" includes coverage of any acts or potential liabilities that may have occurred during the period of any lapse in coverage.

Failure to provide documentation of professional liability insurance within thirty (30) consecutive days of termination of insurance coverage will be deemed voluntary resignation of the Staff member's Medical Staff membership and clinical privileges.

6.6-7 MEDICARE PHYSICIAN ATTESTATION STATEMENT

Any member of the Medical Staff who fails to submit a Medicare Physician Attestation Statement will be automatically suspended, and will remain suspended until the Statement is submitted.

6.6-8 INFECTION PREVENTION TESTING AND VACCINATIONS

Members are required to comply with all applicable infection control policies and communicable disease screening and immunization requirements as set forth in these Bylaws, Rules and Regulations, Medical Staff and Hospital Policies, and local, state, and federal public health orders, laws, or regulations.

Except for members of the Telehealth Staff, each member of the Medical/Allied Health Staff must document that they have received annual PPD testing and, if their PPD testing is positive, must provide documentation of annual tuberculosis screening. In addition, each member must obtain, or provide documentation of, annual influenza vaccination or documentation of declination.

Failure to comply with infection prevention testing and immunization requirements within 30 days following receipt of written notice from the Chief of Staff will result in an automatic suspension of the member's clinical privileges and prerogatives. If a member's privileges and prerogatives remain suspended under this Section for 90 days, the member will be deemed to have voluntarily resigned from the Medical Staff.

6.6-9 ACCUMULATION OF SUSPENSION DAYS

If a Staff member accumulates more than 60 cumulative suspension days, their membership (or the affected privileges, if the suspension is a partial restriction or limitation) will be automatically terminated. Reinstatement to the Medical Staff will require submission of an application and compliance with the appointment procedures as set forth under these Bylaws.

6.6-10 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after action is taken or warranted as described in subsection (B), (C), or (D) of Section 6.6-1 or Sections 6.6-2, 6.6-3, 6.6-4, 6.6-5, or 6.6-6,, the Medical Executive Committee will convene to review and consider the facts based on information disclosed or otherwise made available to it. The Medical Executive Committee may recommend corrective action as it may deem appropriate following the procedure generally set forth commencing at Section 6.4. The Medical Executive Committee review of suspensions under Sections 6.6-1 and 6.6-2 of these

Bylaws will not address the propriety of the actions taken by governmental agencies, but instead will address what action should be taken by the Medical Staff. There is no need for the Medical Executive Committee to act on automatic suspensions under any other provision of Section 6.6.

6.6-11 INFORMAL HEARING RIGHTS REGARDING AUTOMATIC SUSPENSION OR LIMITATION OF PRIVILEGES OR MEMBERSHIP

Except when the grounds for automatic suspension or limitation result from circumstances set forth in Section 6.6-1(A), the member may request a hearing, but such hearing will be limited to the question of whether the grounds for automatic suspension have occurred. In cases described in Sections 6.6-1(B), (C), and (D) and 6.6-2, the issues which may be considered at a hearing, if requested, will not include evidence designed to show that the determination by the licensing or credentialing authority or the DEA was unwarranted, but only whether the practitioner may continue practice in the Hospital with those limitations imposed.

The nature of the hearing permitted under this Section is abbreviated and informal and does not include all the rights and procedures set forth in Article VII of these Bylaws. Rather, if a hearing is requested, the Medical Staff member will be permitted to meet with the Medical Executive Committee to present relevant information regarding whether the grounds for automatic suspension have occurred. The Medical Executive Committee or a subcommittee thereof may request additional information as it deems appropriate. After considering the facts, the Medical Executive Committee may then continue such suspension in effect or remove or modify the same as appropriate.

ARTICLE VII

HEARINGS AND APPELLATE REVIEWS

7.1 GENERAL PROVISIONS

Informal Meeting, Hearing and Appeal Processes

The following hearing and appellate review procedures govern the conduct of a challenge to Medical Staff and Board decisions concerning applications for admission to the staff, renewals, privileges or curtailments thereof, limitations, probations, expulsions, or other corrective action measures involving Staff members or applicants, except where otherwise provided in these Bylaws. Any Staff member or applicant who is a licentiate under Business and Professions Code Section 809(b) and who is the subject of a final proposed action which must be reported to the applicable licensing board pursuant to Business and Professions Code Section 805 is entitled to notice and hearing rights under this Article VII.

7.1-1 EXHAUSTION OF REMEDIES

If adverse action described in Article VI is taken or recommended, the applicant or member agrees to and must exhaust all the remedies afforded by these Bylaws before resorting to other legal action.

7.1-2 APPLICATION OF ARTICLE

For purposes of this Article, the term "practitioner" or "member" may include an "applicant," as it may be applicable under the circumstances, unless otherwise stated.

7.1-3 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within a reasonable time.

7.1-4 FINAL ACTION

Recommended adverse actions described in Article VI shall become final only after the hearing and appellate rights set forth in these Bylaws have either been exhausted or waived.

7.2 GROUNDS FOR AN INFORMAL MEETING

Grounds for an informal meeting shall include those circumstances in which the action or recommendation of the Medical Executive Committee will require a report to the Medical Board of California or applicable licensing board (i.e., a Section 805 report).

7.2-1 INFORMAL MEETING NOTICE

Prior to invoking any other rights which such practitioner may have under these Bylaws, the member must, within 14 days of receipt of the Special Notice, submit a written request (the "informal meeting request") to the Medical Executive Committee to schedule an informal meeting regarding the recommended action.

Such informal meeting, if requested, will be held within 30 days following the Medical Executive Committee's receipt of the informal meeting request. In order to adequately inform itself of all such relevant factors, the Medical Executive Committee, in cooperation with the appropriate Department Chair and its Investigating Committee, may conduct such additional investigation of the recommended action and/or the facts underlying it as the Medical Executive Committee deems appropriate. The Medical Executive Committee and practitioner may agree to waive the informal meeting requirement in situations involving a summary suspension or restriction.

7.2-2 INFORMAL MEETINGS: GENERAL PRINCIPLES

The informal meeting with the Medical Executive Committee or its designee, as prescribed herein, may not involve the participation of any attorney at law. Furthermore, the informal meeting will not constitute a "hearing," and none of the procedural rights set out in Section 7.3 of these Bylaws apply.

The informal meeting is intended to provide the affected applicant or staff member with an opportunity to meet with the Medical Executive Committee or its designee on an informal basis to discuss and attempt to informally resolve the matters that prompted the recommended action. At the applicant's or staff member's request, or at the request of the Medical Executive Committee, the Division Chief may attend the informal meeting.

7.2-3 MEDICAL EXECUTIVE COMMITTEE RECOMMENDATIONS

Notice of the recommendations of the Medical Executive Committee following the informal meeting will be sent to the practitioner within 14 days following the informal meeting, with a copy of the Medical Executive Committee's recommendations following the informal meeting by Special Notice. In those instances where the recommendation continues to be adverse and where the practitioner, if dissatisfied, is entitled to a hearing under Article VII, the notice must also comply with Section 7.3-3. The Board must also be sent a copy of the Medical Executive Committee's recommendation, but the Board may not take action until after the practitioner has exercised or waived their rights to a hearing under Article VII if those rights are triggered by the Medical Executive Committee's action or recommendation.

7.3 GROUNDS FOR FORMAL JUDICIAL REVIEW HEARING

In all cases where the member has a right to an informal meeting under Section 7.2, s/he is entitled to request a formal hearing only after s/he has requested an informal meeting and is dissatisfied with the resulting recommendation or, in the case of a hearing right triggered by a summary suspension or restriction, after the member or the Medical Executive Committee waives the right to an informal meeting. The hearing request shall be made to the Chief of Staff in writing and within 30 days following the affected applicant's or Staff member's receipt of a copy of the informal meeting recommendation in accordance with Section 7.2-3 of these Bylaws. A Judicial Review Committee hearing must be held prior to the affected applicant's or practitioner's exercise, if at all, of their rights of appeal to the Board under Section 7.5.

7.3-1 REQUEST FOR HEARING

The practitioner shall have 30 days following the practitioner's receipt of notice of an action constituting grounds for hearing under these Bylaws to request a hearing. The request must be in writing addressed to the Medical Executive Committee with a copy to the Board. In the event the practitioner does not request a hearing within the time and in the manner described, the practitioner will be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

7.3-2 TIME AND PLACE FOR HEARING

Upon receipt of a timely request for hearing, the Medical Executive Committee must schedule a hearing and, within 15 days, must give notice to the practitioner of the time, place, and date of the hearing. Unless extended by the hearing officer or agreement of the parties, the date of the commencement of the hearing must be not less than 30 days nor more than 60 days from the date of receipt of the request by the Medical Executive Committee for a hearing. However, when the request is received from a practitioner who is under summary suspension, the hearing must be held as soon as the arrangements may reasonably be made, so long as the member has at least 30 days from the date of notice to prepare for the hearing or waives this right.

7.3-3 NOTICE OF HEARING

Together with the notice stating the place, time, and date of the hearing, the Medical Executive Committee may supplement the reasons for the action provided in the notice of decision by including, as part of the notice of hearing, a statement of the acts or omissions with which the Medical Staff practitioner is charged or the reasons for the action or recommendation upon which it intends to rely at the hearing and providing, when appropriate, a list of the charts under question.

7.3-4 JUDICIAL REVIEW COMMITTEE

When a hearing is requested, the Medical Executive Committee will appoint a Judicial Review Committee. The Judicial Review Committee must be composed of

at least 3 members of the Active Staff. The Judicial Review Committee may gain no direct financial benefit from the outcome of the hearing and may not have acted as accuser, investigator, fact finder, or initial decision maker, or otherwise actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Judicial Review Committee. If is not feasible to appoint a Judicial Review Committee from the Active Staff, the Medical Executive Committee may appoint members from other staff categories or practitioners who are not members of the Medical Staff. When appointing the Judicial Review Committee, the Medical Executive Committee may designate one member as the Chair. Membership on a Judicial Review Committee must consist of one member who has the same healing arts licensure as the accused and, where feasible, include an individual practicing the same specialty as the practitioner. All other members must have MD or DO degrees or their equivalent as defined in Section 2.2-2(A). The Medical Executive Committee may, where feasible, appoint one or more alternates who meet the standards described above and who can serve if a Judicial Review Committee member becomes unavailable.

7.3-5 FAILURE TO APPEAR OR PROCEED

The practitioner's failure, without good cause, to personally attend and proceed at such a hearing in an efficient and orderly manner will be deemed to constitute voluntary acceptance of the recommendations or actions involved

7.3-6 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the Hearing Officer on a showing of good cause or upon agreement of the parties.

7.4 HEARING PROCEDURE

7.4-1 PREHEARING PROCEDURE

(A) If either side to the hearing requests in writing a list of witnesses, within 15 days of such request, each party must furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. This list must be updated as necessary and appropriate at least 10 days prior to commencement of the hearing.

(B) At least 30 days prior to the hearing, the practitioner has the right to inspect and copy, at their expense, any documentary information relevant to the charges which the Medical Executive Committee has in its possession or under its control. This information includes documents or other evidence upon which the charges are based and evidence which is reasonably necessary to enable the practitioner to prepare a defense, including all evidence which was considered by the Medical Executive Committee in

determining whether to proceed with the adverse action, and any exculpatory evidence in the possession of the Hospital or Medical Staff. The practitioner and the Medical Executive Committee have the right to receive all evidence which will be made available to the Judicial Review Committee.

(C) The Medical Executive Committee has the right to inspect and copy at its expense any documents or other evidence relevant to the charges and that the practitioner has in their possession or control. . The practitioner must make such documents and evidence available to the Medical Executive Committee as soon as practicable and at least 30 days prior to the hearing.

(D) The failure by either party to provide access to this information at least 30 days before the hearing will constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the practitioner under review.

(E) The Hearing Officer will consider and rule upon any dispute or controversy concerning a request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the Hearing Officer must consider, among other facts:

1. whether the information sought may be introduced to support or defend the charges;

2. the exculpatory or inculpatory nature, if any, of the information sought, (i.e., whether there is a reasonable probability that the result of the hearing would be influenced significantly by the information if received into evidence);

3. the burden imposed on the party in possession of the information sought if access is granted;

4. any previous requests for access to information submitted or resisted by the parties to the same proceeding; and

5. whether the information sought is advisory or deliberative, rather than factual, and whether its disclosure would intrude on privacy rights or otherwise threaten the frank and open exchange of ideas in the process by which peer review decisions or policies are formulated.

(F) The practitioner is entitled to a reasonable opportunity to question and challenge the impartiality of Judicial Review Committee members and the Hearing Officer. Challenges to the impartiality of any Judicial Review Committee member or the Hearing Officer must be ruled on by the Hearing Officer in accordance with applicable legal principles defining standards of

impartiality for hearing panels and hearing officers in proceedings of this type. The Hearing Officer will establish the procedure by which this right may be exercised, which may include requirements that voir dire questions be proposed in writing in advance of the hearing and that the questions be presented by the Hearing Officer.

(G) It is the duty of the practitioner and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the Chair of the Judicial Review Committee 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 prehearing decisions may be succinctly made at the hearing.

7.4-2 REPRESENTATION

The hearings provided for in these Bylaws are for the purpose of intraprofessional resolution of matters bearing on professional conduct, professional competency, or character. The practitioner may be represented by legal counsel in any phase of the hearing, should they so choose, and will receive notice of the right to obtain representation by an attorney at law.

If the practitioner elects to forego legal counsel, the practitioner may be accompanied by and represented at the hearing by a practitioner licensed to practice in the state of California who is not also an attorney at law or a witness in the proceeding, and the Medical Executive Committee will appoint a representative from the Medical Staff who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The Medical Executive Committee may not be represented at the hearing by an attorney at law if the practitioner is not so represented.

7.4-3 THE HEARING OFFICER

A Hearing Officer must be appointed by the Medical Executive Committee. The Hearing Officer will preside at the hearing, and will ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence. S/he shall be entitled to determine the order or procedure during the hearing. S/he shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on questions that pertain to matters of law and to the admissibility of evidence. The Hearing Officer may gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate for the Hospital, Board, Medical Executive Committee, or body whose recommendations prompted the hearing. The Hearing Officer must 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

may determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions that pertain to matters of law, procedure or the admissibility of evidence. 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 may be an attorney at law who is qualified to preside over a quasi-judicial hearing, but attorneys from a firm that is regularly utilized by the Hospital, the Medical Staff, or the affected practitioner for legal advice regarding their affairs and activities are not eligible to serve as the Hearing Officer.

7.4-4 RECORD OF THE HEARING

The Judicial Review Committee must maintain a record of the hearing proceedings. A court reporter must be present to make a record of the hearing proceedings and, if deemed appropriate by the Hearing Officer, the pre-hearing proceedings. The Hospital will bear the cost of attendance of the court reporter. The party requesting a transcript will bear the cost of the transcript. The Judicial Review Committee may, but is not required to, order that oral evidence be taken only on oath administered by any person lawfully authorized to administer such oath.

7.4-5 RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing are entitled to be provided with all of the information available to the Judicial Review Committee to make a record of the proceedings, call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who have testified orally or in writing on any matter relevant to the issues, and otherwise rebut evidence. Further, the practitioner may be called by the Medical Executive Committee and examined as if under cross-examination.

These rights must be exercised in an efficient and expeditious manner.

7.4-6 MISCELLANEOUS RULES

Civil or judicial rules of evidence and procedure relating to the conduct of litigation or other hearings, examination of witnesses, and presentation of evidence will not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, may 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.

Each party will have the right to submit written arguments in support of their case. The Judicial Review Committee may request that written arguments be filed following the close of the hearing.

The Judicial Review Committee may interrogate witnesses or call additional witnesses if it deems such action appropriate.

7.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

(A) At the hearing, the Medical Executive Committee will have the initial duty to present evidence for each case or issue in support of its action or recommendation. The applicant will be obligated to present evidence in response.

(B) The applicant bears the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, of their qualifications by producing information that allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications for membership and privileges. An applicant will not be permitted to introduce information that was requested by the Medical Staff but not produced upon request of the Medical Executive Committee during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(C) Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

7.4-8 ADJOURNMENT AND CONCLUSION

After consultation with the Chair of the Judicial Review Committee, the Hearing Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing will be closed. Thereupon, the Judicial Review Committee, outside of the presence of any other person, except for the Hearing Officer, must, within the time specified in Section 7.4-10, conduct its deliberations and render a decision and accompanying reports as provided in Section 7.4-10.

7.4-9 BASIS FOR DECISION

The decision of the Judicial Review Committee must be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the Judicial Review Committee will be subject to such rights of appeal as are described in these Bylaws, but must otherwise be affirmed by the Board as the final action if it is supported by substantial evidence following a fair procedure.

7.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within 30 days after final adjournment of the hearing, the Judicial Review Committee must render a decision that is accompanied by a report in writing. This decision and report must be delivered to the Medical Executive Committee and the body whose recommendation prompted the hearing.

If the practitioner is currently under suspension, however, the time for the decision and report is 15 days after final adjournment of the hearing. A copy of said decision must also be forwarded to the Hospital President and the Board and to the practitioner by Special Notice.

The written report must contain a concise statement of the reasons in support of the decision, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. An explanation of the procedure that is available for requesting and pursuing an appeal must also be provided.

7.5 APPEAL

7.5-1 TIME FOR APPEAL

Within 15 days after receipt of the decision of the Judicial Review Committee, the practitioner requesting the hearing, the Medical Executive Committee, or the body prompting the hearing may request an appellate review by the Board. A written request for such review must be delivered by Special Notice to the Hospital President and the other party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation must be affirmed by the Board as the final action if it is supported by substantial evidence following a fair procedure.

7.5-2 GROUNDS FOR APPEAL

A written request for an appeal must include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The only grounds for appeal from the hearing are:

(A) Substantial non-compliance of the Judicial Review Committee, Hearing Officer, or Medical Executive Committee with the procedures required by these Bylaws or applicable law, and such noncompliance has created demonstrable prejudice; or

(B) The decision was arbitrary, unreasonable, or not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5-5.

7.5-3 TIME, PLACE AND NOTICE OF APPELLATE REVIEW

If an appellate review is to be conducted, the Board must, within 30 days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place, and date of the appellate review. The date of appellate review must not be less than 15 or more than 60 days from the date of such notice, provided, however, that when a request for appellate review concerns a practitioner who is under suspension which is then in effect, the appellate review must be held as soon as the arrangements may reasonably be made and not to exceed 30 days from the date of the notice. The time for appellate review may be extended by the Board for good cause.

7.5-4 APPEAL BOARD

The Board will serve as the Appeal Board. Knowledge of the matter involved will not preclude any person from serving as a member of the Appeal Board as long as that person did not take part in a prior hearing on the same matter. The Board may select an attorney to assist it in the proceeding, but that attorney will not be entitled to vote with respect to the appeal. The attorney selected by the Board must not be the attorney who represented either party at the hearing before the Judicial Review Committee.

7.5-5 APPEAL PROCEDURE

The proceeding by the Appeal Board will be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence, and subject to the same rights of cross-examination or confrontation provided before the Judicial Review Committee; or the Appeal Board may remand the matter to the Judicial Review Committee for the taking of further evidence and for decision.

Each party will have the right to be represented by legal counsel or any other representative designated by that party in connection with the appeal, to present a written statement in support of his/ her position on appeal, and to personally appear and make oral argument. The Appeal Board may place reasonable limits on such oral argument as to time and issues.

At the conclusion of the oral argument, the Appeal Board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The Appeal Board shall present its written recommendations as to whether it affirms, modifies, or reverses the Judicial Review Committee decision or remands the matter to the Judicial Review Committee for further review and decision.

7.5-6 DECISION

(A) Within 30 days after the conclusion of the proceedings before the Board, the Board must render a final decision in writing and must deliver by Special Notice copies to the person who requested the hearing, the Hospital President, and the Medical Executive Committee. Except when the matter is referred for further review and recommendations in accordance with Section 7.5-5, the final decision of the Board following appeal procedures set forth in this Article will be effective immediately and is not subject to further review.

(B) Should the Board determine that the Judicial Review Committee decision is not supported by substantial evidence, the Board may modify or reverse the decision of the Judicial Review Committee and may instead, or must, if it determines that fair procedure has not been afforded, remand the matter to the Judicial Review Committee for reconsideration, stating the purpose for the remand. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the Committee must promptly conduct its review and make its recommendations to the Board. This further review and the time required to report back must not exceed 30 days in duration except as the parties may otherwise agree or for good cause as jointly determined by the Chair of the Board and the Judicial Review Committee.

(C) The Board's decision will be in writing, will specify the reasons for the action taken, and will be forwarded to the Chief of Staff, the Medical Executive Committee, the affected practitioner, and the Hospital President at least 10 days prior to submission to the Medical Board of California and National Practitioner Data Bank.

7.5-7 RIGHT TO ONE HEARING

No practitioner will be entitled to more than one evidentiary hearing and one appellate review on any single matter that was the subject of adverse action or recommendation, regardless of whether such action is the result of action by the Medical Executive Committee, the Board, or a combination of acts of both bodies.

7.6 EXCEPTION TO HEARING RIGHTS

7.6-1 EXCLUSIVE CONTRACTS

(A) Prior to any final Board decision to execute an exclusive contract in a previously open department or service, the Board must notify the Medical Executive Committee and provide the Medical Executive Committee sufficient time to review the proposal and make recommendations to the Board in accordance with Section 13.10 of these Bylaws regarding quality of care issues related to exclusive arrangements for physician services. In such cases, the Medical Executive Committee's recommendation must be made within a reasonable time in light of the Hospital's need to execute

such an exclusive contract, as determined by the Board in its sole discretion. Regarding Board decisions (i) to renew or modify an exclusive contract in a particular Department or service, or (ii) to terminate an exclusive contract in a particular Department or service, the Board must consult with the Medical Executive Committee regarding quality of care issues related to such decisions prior to taking final action on the contracts, unless the Board decides that such prior consultation would subject the Hospital's business interests or its patients to a risk of imminent harm. In cases in which the Board decides that it must proceed without such prior consultation, the Board shall, within 30 days of taking action, inform the Medical Executive Committee of the reason for its decision, excluding confidential financial information.

(B) When a practitioner may no longer exercise any clinical privileges at the Hospital because the member is not (or is no longer) affiliated with a party to an exclusive contract, the practitioner's membership on the Medical Staff will be automatically terminated or restricted as to those privileges covered by the exclusive contract if their membership in, subcontract with or affiliation with the exclusive contractor is terminated or if their privileges with the group are restricted by the group.

(C) The hearing and appellate review rights of Article VII do not apply to a practitioner whose application for privileges was denied, in whole or in part, on the basis that the privileges sought are covered by an exclusive contract in a closed Department or service.

(D) The hearing and appellate review rights of Article VII do not apply to a practitioner whose privileges are terminated, suspended, or restricted following the decision to enter into an exclusive contract for the provision of the subject services in a closed Department or service.

(E) The hearing and appellate review rights of Article VII do not apply to a practitioner whose privileges are terminated, suspended, or restricted because they are terminated, suspended, or restricted by, or they are no longer affiliated with, the physician or group holding the exclusive contract in a closed Department or service.

ARTICLE VIII

OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1-1 IDENTIFICATION

The officers of the Medical Staff are the Chief of Staff, Vice-Chief of Staff, Immediate Past Chief of Staff, and the Secretary-Treasurer.

8.1-2 QUALIFICATIONS

Officers must be members of the Active Staff at the time of their nomination and election and must remain members in good standing during their term of office. The Chief and Vice-Chief must have been members of the Active Staff for at least 5 years prior to election. Failure to maintain such status shall create a vacancy in the office involved. All officers of the Medical Staff shall be voting members of the Medical Executive Committee.

The Chief of Staff and Vice-Chief of Staff must either be a doctor of medicine or osteopathy.

8.1-3 NOMINATIONS

(A) The Medical Staff election year is each even numbered Medical Staff year.

(B) The procedure and timeline for nominations are as follows:

1. No later than April 1st of the election year, the Medical Executive Committee appoints a Nominating Committee.

2. The Nominating Committee consists of each of the current Department Chairs, the previous two (2) Chiefs of Staff, one (1) Division Chief who is appointed by the Medical Executive Committee, and two (2) members of the Active Staff who are appointed by the Medical Executive Committee.

3. Prior to the May meeting of the Medical Executive Committee, the Nominating Committee presents in writing to the Medical Executive Committee one or more nominees for the offices of Chief of Staff, Vice-Chief, Secretary-Treasurer and for the Medical Executive Committee members-at-large, the hospitalist/intensivist member of the Medical Executive Committee, and the primary care physician member of the Medical Executive Committee.

4. After review and approval by the Medical Executive Committee, the Medical Executive Committee reports the nominations to all voting members of the Medical Staff.

5. Within 10 days following notification of the nominees, any voting member of the Medical Staff may make further nominations for any office by submitting the name of the candidate in writing, including by e-mail or other electronic means, to the Chair of the Nominating Committee, along with the candidate's written consent and documentation, in a verifiable form acceptable to the Medical Executive Committee, that at 10% of other members who are eligible to vote endorse the candidate. The Nominating Committee must determine whether the candidate meets the requirements of Section 8.1-2. If the candidate meets the requirements of Section 8.1-2 and was submitted consistent with the requirements of this Section 8.1-3, then the candidate must be included on the ballot. Further nominations for any office may also be made by any voting member of the Medical Staff from the floor at the June General Staff meeting and will be recognized only if the nominee is present and consents to the nomination.

6. Ballots must also allow for write-in nominations at the time of voting. Write-in candidates will not be considered, however, unless they meet the requirements of Section 8.1-2.

7. This nomination process applies to special elections, but the timelines may be shortened.

8.1-4 ELECTIONS

(A) Voting will be by ballot, which may be written ballot, email, or other electronic means, so long as adequate precautions are taken to ensure reliability and security.

(B) Ballots must contain the names of the candidates who were nominated by the Nominating Committee and the candidates who were nominated pursuant to Section 8.1-3(B)(5) of these Bylaws.

(C) Ballots must be sent to voting members at least 14 days prior to the deadline for submission of votes. Ballots not returned by the deadline will not be counted.

(D) Tally of the votes will be by 4 tellers appointed by the Chief of Staff. The Secretary-Treasurer and tellers will supervise the opening of the ballots (paper or electronic) and record the count. Ballots will be kept on file for a period of at least 1 month. A recount may be ordered on written request to the President.

(E) If no candidate for a particular office receives more than 50% of the votes cast on the first ballot, a run-off election between the 2 candidates receiving the highest number of votes must be held within 14 days of the first count. Voting will be conducted in the same manner as the first election, in accordance with the procedures specified in this Section 8.1-4. In the case of a tie on the second ballot, the Medical Executive Committee must decide the election by majority vote at its next meeting or a special meeting called for that purpose.

(F) The results of the election will be communicated to the Medical Staff.

8.1-5 TERM OF ELECTED OFFICE

Each officer is elected for a 2-year term, commencing on the first day of the Medical Staff Year following the election. Officers may be re-elected, but may not serve for more than two (2) consecutive terms. Each officer will serve in their office until the end of that officer's term or until a successor is elected, unless that officer resigns or is removed from office earlier. At the end of their term, the Chief of Staff automatically assumes the office of Immediate Past Chief of Staff.

8.1-6 REMOVAL OF ELECTED OFFICERS

Any officer whose election is subject to these Bylaws may be removed from office for valid cause, including, but not limited to, failure to perform the duties of office, including, failure to regularly attend meetings, gross neglect, misfeasance in office, or serious acts of moral turpitude. Removal of a Medical Staff officer may be initiated by the Medical Executive Committee, by a petition signed by at least 25% of the Active Staff members or by vote of the Medical Executive Committee. Removal requires a two-thirds vote of the Medical Executive Committee. Removal must be considered at a Special Meeting called for that purpose. Such removal will not trigger the procedures under Articles VI or VII of these Bylaws.

8.1-7 VACANCIES IN ELECTED OFFICE

(A) Vacancies in office occur upon the death, disability, resignation or removal of the officer, or such officer's loss of Active membership in the Medical Staff.

(B) If there is a vacancy in the office of Chief of Staff, the Vice-Chief will serve out the remaining term.

(C) Vacancies in the offices of Vice-Chief or Secretary-Treasurer must be filled by action of the Medical Executive Committee. In the event there are concurrent vacancies in the offices of Chief of Staff and Vice-Chief, the Medical Executive Committee must appoint an Acting Chief. The Acting Chief must immediately instruct the Nominating Committee to prepare a slate of candidates for a special election of the Staff to be held 2 weeks after

the slate of candidates has been approved. The special election will otherwise be held in accordance with Section 8.1-4 of these Bylaws.

8.2 DUTIES OF OFFICERS

8.2-1 CHIEF OF STAFF

The Chief of Staff serves as the chief officer of the Medical Staff. The duties of the Chief of Staff include, but are not limited to:

(A) Enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

(B) Calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;

(C) Serving as Chair of the Medical Executive Committee;

(D) Serving as an ex-officio member of all other Staff committees without vote, unless their membership in a particular committee is required by these Bylaws;

(E) Serving as an ex-officio member of the Governing Body;

(F) Interacting with the Administrator and Board in all matters of mutual concern within the Hospital;

(G) Appointing, in consultation with the Medical Executive Committee, committee members for all standing and special Medical Staff, liaison, or multidisciplinary committees, except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the Chairs of these committees;

(H) Representing the views, policies and grievances of the Medical Staff to the Board and to the Hospital President;

(I) Being a spokesperson for the Medical Staff in external professional and public relations;

(J) Performing such other functions as may be assigned to the Medical Staff President by these Bylaws, the Medical Staff, or by the Medical Executive Committee;

(K) Serving on liaison committees with the Board and administration, as well as outside licensing or accreditation agencies;

(L) Being responsible for the functioning of the Medical Staff organization of the Hospital and keeping, or causing to be kept, a careful supervision over the clinical work in all departments;

(M) Evaluating, counseling, and recommending action, via appropriate committees, regarding the quality of medical care; and

(N) Acting in coordination and cooperation with the Hospital President and the Board of Directors in all matters of mutual concern within the Hospital.

The Chief of Staff will be compensated from the Medical Staff funds according to the specifications of the Medical Executive Committee. The Chief of Staff must be compensated by the Hospital in an amount not to exceed the compensation from the Medical Staff fund.

8.2-2 VICE-CHIEF OF STAFF

The Vice-Chief of Staff is a voting member of the Medical Executive Committee. The duties of the Vice-Chief include, but are not limited to:

(A) Assuming all duties and authority of the Chief of Staff in the absence of the Chief of Staff;

(B) Performing such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the Medical Executive Committee.

8.2-3 SECRETARY-TREASURER

The Secretary-Treasurer is a voting member of the Medical Executive Committee. The duties of the Secretary-Treasurer include, but are limited to:

(A) Keeping accurate and complete minutes of all Medical Executive Committee and general Medical Staff meetings;

(B) Keeping a quarterly report of all Medical Staff funds, and reporting quarterly to the Medical Executive Committee the amount of money received, deposited, and expended;

(C) Collecting and disbursing Medical Staff funds;

(D) Annually reviewing Medical Staff dues and making recommendations to the Medical Executive Committee regarding dues; and

(E) Performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

8.2-4 IMMEDIATE PAST CHIEF OF STAFF

Although not a voting member of the Medical Executive Committee, the Immediate Past Chief of Staff is an ex-officio member of the Medical Executive Committee for at least 1 year following the expiration of their completed term of office of Chief of Staff. The Immediate Past Chief must perform such other duties as may be assigned by the Chief of Staff or delegated by these Bylaws or by the Medical Executive Committee.

ARTICLE IX

CLINICAL DEPARTMENTS

9.1 ORGANIZATION OF CLINICAL DEPARTMENTS

The Medical Staff is divided into clinical Departments. Each Department is organized as a separate component of the Medical Staff and has a Chair selected and entrusted with the authority, duties, and responsibilities specified in Section 9.5-5 of these Bylaws. Decisions regarding the creation, elimination, modification or combination of Departments may be made by the Medical Executive Committee.

9.2 DEPARTMENTS

Current Departments include:

Department of Anesthesiology

Department of Emergency Medicine

Department of Medicine

Department of Cardiovascular Medicine

Department of Orthopaedics

Department of Radiology

Department of Surgery

9.3 ASSIGNMENT TO DEPARTMENTS

Each member of the Medical Staff is assigned membership in at least one Department within such Department. Each member may also be granted membership and/or clinical privileges in other Departments consistent with practice privileges granted. An applicant to the Medical Staff or Staff member who requests admitting and/or clinical privileges in more than one Department must meet the qualifying standards for each Department. The applicant or member will be required to declare a Department of primary association and will be responsible for meeting all membership obligations of that Department in accordance with these Bylaws and applicable Rules and Regulations.

Except as otherwise expressly provided, each member of this Staff may have voting privileges in only one Department. Assignment to a Department will be made by the Board upon recommendation by the Medical Staff Medical Executive Committee.

An additional delineation of privileges form for the area of secondary activity must be reviewed by the appropriate Department Chair and processed through the normal credentialing procedures.

9.4 FUNCTIONS OF DEPARTMENTS

A Department of the Medical Staff will consist of a group of members of the Staff who devote their activities to a special function within the Hospital and who have attained sufficient importance and medical activity to warrant recognition as a distinct unit. To retain its status as a Department, its members must meet regularly and must fulfill the responsibilities of a Department described in these Bylaws.

The general functions of each Department include:

(A) Evaluating the quality and appropriateness of care and treatment provided to patients within the Department. Peer review will be conducted regarding all clinical work performed under the jurisdiction of the Department, regardless of whether the member whose work is subject to such review is a member of that Department;

(B) Recommending to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the Department;

(C) Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that Department;

(D) Conducting, participating in and making recommendations regarding continuing education programs pertinent to departmental clinical practice;

(E) Reviewing and evaluating departmental adherence to: (1) Medical Staff policies and procedures and (2) sound principles of clinical practice;

(F) Coordinating patient care provided by the Department's members with nursing and ancillary patient care services;

(G) Submitting written reports to the Medical Executive Committee concerning: (1) the Department's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the Department and the Hospital;

(H) Meeting at least quarterly for the purpose of considering patient care review findings and the results of the Department's other review and evaluation activities, as well as reports on other department and staff functions;

(I) Establishing such committees or other Medical Executive Committee mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols;

(J) Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;

(K) Accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the Department;

(L) Appointing such committees as may be necessary or appropriate to conduct Department functions; and

(M) Formulating recommendations for departmental Rules and Regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee and the Medical Staff.

9.5 DEPARTMENT HEADS

9.5-1 QUALIFICATIONS

Each Department shall have a Chair who is a member of the Active Staff. Department Chairs must be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the Department. They must have high standing and recognition within the medical profession, concentrate their medical activities at the Hospital, and be certified by the appropriate specialty boards or demonstrate comparable competence.

9.5-2 SELECTION

The Active Staff members of the Department who are eligible to vote for general officers of the Medical Staff elect Department Chairs every 3 years. For the purpose of this election, each Department must select a Nominating Committee of 3 members at least 60 days prior to the date set for return of the completed ballots by the voting members. Before the names are circulated to the voting members of each Department, the Medical Executive Committee must have an opportunity to consider the nominee(s) for Chair. Only nominee(s) approved by the Medical Executive Committee may be circulated to the voting members for vote. The names of nominees must be circulated to the voting members at least 20 days prior to the date set for return of the completed ballots by the voting members. Voting may occur by written ballot, e-mail, or other electronic means, so long as adequate precautions are taken to ensure reliability and security. Election of Department Chairs is subject to ratification by a majority vote of the Medical Executive Committee. If, for any reason, the Chair does not complete their term, this vacancy must be filled for the unexpired term through special election by the respective Department with such mechanisms as that Department may adopt.

9.5-3 TERM OF OFFICE

Department Chairs serve a 3-year term that coincides with the Medical Staff year or until their successors are chosen unless they sooner resign, are removed from office, or lose their Medical Staff membership or clinical privileges in that Department. Department Chairs are limited to two consecutive three-year terms unless (a) an exception is approved by the MEC or (b) no other candidate is willing to run for the position.

9.5-4 REMOVAL

Any Department Chair whose election is subject to these Bylaws may be removed from office for good cause, including, but not limited to, gross neglect or misfeasance in office or serious acts of moral turpitude. After election and ratification, the Chair of a Department may be removed and a special election called when two-thirds of the Medical Executive Committee requests such action. Removal of the Chair during their term of office may also be initiated by a two-thirds vote of all Active Staff members of the Department, but no such removal will be effective unless it has been ratified by two-thirds of the Medical Executive Committee and by the Board. Such removal does not trigger the procedures under Articles VI or VII of these Bylaws.

9.5-5 DUTIES

Each Chair has the following authority, duties, and responsibilities:

(A) Act as presiding officer at departmental meetings;

(B) Report to the Medical Executive Committee and directly to the Medical Staff President regarding all professional and administrative activities and quality of care within the Department;

(C) Generally monitor the quality of patient care and professional performance rendered by members with clinical privileges in the Department through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the Department by the Medical Executive Committee;

(D) Determine the qualifications and competence of Department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(E) Develop and implement processes for performance improvement, credentials review, and privilege delineation;

(F) Give guidance on the overall medical policies of the Medical Staff and Hospital and make specific recommendations and suggestions regarding the Department;

(G) Transmit to the Medical Executive Committee the Department's recommendations concerning practitioner appointment and classification, reappointment, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in the Department, and make specific recommendations and suggestions regarding the Department to the Medical Executive Committee; staff Bylaws, rules, policies and regulations within the Department;

(H) Endeavor to enforce the Medical Staff Bylaws, rules, policies and regulations within the Department;

(I) Implement within the Department appropriate actions taken by the Medical Executive Committee;

(J) Participate in every phase of administration of the Department, including cooperation with the nursing service and the Hospital administration in matters such as personnel, supplies, special regulations, standing orders and techniques;

(K) Assist in the preparation of such annual reports, including budgetary planning, pertaining to the Department as may be required by the Medical Executive Committee;

(L) Recommend delineated clinical privileges for each member of the Department;

(M) As appropriate, evaluate the professional performance of Medical Staff members who exercise privileges in their Department and recommend, when appropriate, that a practitioner be required to submit to the Medical Executive Committee a certification of health and fitness to practice;

(N) Endeavor to ensure that practices or procedures carried out by Department members are in accordance with high quality, rational, and humane care;

(O) Appoint committees as needed to conduct department functions;

(P) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee; and

(Q) Assess and recommend to the relevant Hospital authority offsite sources for needed patient care services not provided by the Department or the organization.

(R) Engage with the Division Chief to support and facilitate the above activities.

9.5-6 VICE-CHAIRS OF DEPARTMENTS

On assuming office, the Chair of the Department must appoint a Vice-Chair. In the event of the Chair's death, resignation, or removal from office, the Vice-Chair may serve for a maximum of 2 months, during which time the Chief of Staff is responsible for assuring that a replacement is selected in the manner described in Section 9.5-2 of these Bylaws. In the absence of the Chair of the Department, the Vice-Chair acts in their capacity with full authority and assumes all responsibilities of the office.

9.5-7 ASSOCIATE VICE CHAIRS OF DEPARTMENTS

On assuming office, the Chair of the Department may appoint Associate Vice-Chairs to carry out the duties of the Chair at the respective Hospital campuses.

9.5-8 DIVISION CHIEFS OF DEPARTMENTS

The Division Chiefs shall facilitate open communications, collaboration, and mutual support between the Department and the corresponding department at UCSF to advance quality, safety, and performance assessment and improvement; and to conduct peer review pursuant to these Bylaws and, as applicable, the UCSF Medical Staff Bylaws. All such activities shall be subject to the confidentiality requirements of these Bylaws, the UCSF Medical Staff Bylaws and any applicable peer review sharing agreements.

9.6 ADMINISTRATIVE DEPARTMENTS

9.6-1 DEPARTMENT OF GRADUATE MEDICAL EDUCATION

The Department of Graduate Medical Education (GME) is comprised of the Director of Graduate Medical Education and all other designated members of the Staff who have primary responsibility for medical student, resident, and fellow education. These members may be full-time, part-time, or volunteers, and also may be administrative staff while also functionally members of a clinical Department. All clinical Departments with ACGME or CPME accredited residency or fellowship programs will have representation in this Department. Hospital administration will be represented by the administrator responsible for medical education oversight. The Department will function through the Graduate Medical Education Committee.

9.6-2 FUNCTIONS

The responsibilities of the Department of Medical Education are as follows:

(A) Oversight of GME accreditation, quality, and compliance with accrediting body, state medical boards, and hospital policies regarding resident physicians and fellows-in-training;

(B) Recruitment, credentialing, and appointment of qualified candidates for graduate medical education training programs

(C) Establishment and maintenance of GME affiliation agreements as required by regulatory and accrediting agencies;

(D) Development and assessment of the content and scope of educational activities and functions of the GME training programs;

(E) Coordination and support of GME residency and fellowship programs in conjunction with departmental program directors;

(F) The GME Director will serve as Hospital committee liaison for educational affairs;

(G) Provision of resource support and counseling in the development and maintenance of accreditation for GME programs sponsored by the Hospital; and

(H) Collaboration with the Continuing Medical Education Committee on matters pertaining to the continuing medical education programs for the Medical Staff.

9.7 DESIGNATION OF DEPARTMENTS

9.7-1 FUTURE DEPARTMENTS

When deemed appropriate and consistent with the provisions of Section 9.7-2, the Medical Executive Committee, with the approval of the Board, may create, eliminate, subdivide, further subdivide, or combine Departments.

9.7-2 MODIFICATIONS IN DEPARTMENTS

In creating, eliminating, subdividing, or combining Departments or any other clinical organization units that may exist or be contemplated, the following guidelines must be followed:

(A) Creation or Subdivision

When a sufficient number of practitioners are available for appointment to and will be appointed to and/or actively participate in the new organizational component to enable accomplishment of the functions generally assigned to such components in these Bylaws and the Rules and Regulations, and when the patient or service activity to be associated with the new component is substantial enough to warrant imposition of the responsibility to accomplish those functions, a new and separate component should be created.

(B) Elimination

When the number of practitioners is no longer adequate and will not be so in the foreseeable future to accomplish assigned functions, or the patient or service activity associated with the component to be dissolved is no longer substantial enough to warrant imposition of the responsibility to accomplish those assigned functions, the component should be eliminated.

(C) Combination

When the union of two or more organizational components will result in more effective and efficient accomplishment of assigned functions, and when the patient or service activity to be associated with the combination is substantial enough, without being unwieldy, to warrant imposition of the responsibility to accomplish those assigned functions, components should be combined.

In all instances of modification, the Hospital's written plan of development as it is currently being implemented and any constraints or mandates imposed by external planning authorities must also be considered.

ARTICLE X

COMMITTEES

10.1 DESIGNATION

Medical Staff Committees include, but are not limited to, (A) the Medical Staff meeting as a committee of the whole, (B) meetings of Departments and Standing Committees, and (C) meetings of Special or Ad Hoc committees created by the Medical Executive Committee (pursuant to this Section) or by Departments (pursuant to Sections 9.4(I) and (L)). Standing Committees of the Medical Staff are the Medical Executive Committee, Bylaws Committee, Cancer Committee, Credentials Committee, Infection Control Committee, Interdisciplinary Practice Committee, Medical Ethics Committee, Quality Improvement Council, Pharmacy and Therapeutics Committee, Resource Allocation Committee, WellBeing/Physician Health Committee, Multi-Specialty Peer Review Committee, Graduate Medical Education Committee, and those other committees set forth in the Medical Staff Rules and Regulations.

The composition, duties, and meeting frequency and reporting responsibilities of all Standing Committees are described in the Medical Staff Rules and Regulations.

Special or Ad Hoc Committees may be created by the Medical Executive Committee to perform specified tasks. Unless otherwise specified, the Chair and members of all Committees shall be appointed by and may be removed by the Chief of Staff. Except when otherwise expressly provided, Committees act in an advisory capacity and shall be responsible to the Medical Executive Committee.

10.2 GENERAL PROVISIONS

10.2-1 COMMITTEE MEMBERSHIP

Unless otherwise specified, the Chief of Staff shall appoint all Standing and Special Committees. Standing Committees shall be appointed at the beginning of the Medical Staff year. Unless otherwise provided in these Bylaws, the Chief of Staff shall also designate an Active Staff member as the Committee Chair. Chairs of Committees may be requested to attend the Medical Executive Committee meeting at the request of the Chief of Staff. In such cases, the Committee Chair will be ex-officio without vote.

Committee members shall be appointed by the Chief of Staff and shall serve until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

A Medical Staff Committee established to perform one or more of the Medical Staff functions required by these Bylaws is composed of appointees of the Active category and may include, where appropriate, representation from Hospital administration, nursing services, medical records services, pharmaceutical services,

social services, and such other individuals as are appropriate to the function(s) to be discharged.

10.2-2 REMOVAL

If a member of a Committee ceases to be a member in good standing of the Medical Staff, loses employment or a 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 from the Committee by the Medical Executive Committee.

10.2-3 VACANCIES

Unless otherwise specifically provided, vacancies on any Committee will be filled in the same manner in which an original appointment to such Committee is made; however, if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Medical Executive Committee. Such removal will not trigger the procedures under Articles VI or VII of these Bylaws.

10.2-4 STAFF SUPPORT

The Chief of Staff may assign individuals to attend and provide staff support to all Medical Staff Committee meetings.

10.2-5 EX-OFFICIO MEMBERS

Unless otherwise indicated, persons designated as ex-officio members of a Committee shall have all rights and privileges of regular members. The Chief of Staff and Vice-Chief of Staff are ex-officio members of all Medical Staff Committees except the Nominating Committee.

10.2-6 ATTENDANCE BY OTHERS

Non-members of the Medical Staff may be appointed to a Committee only upon approval of the Chief of Staff. Such personnel may only vote and be counted for purposes of deciding a quorum if permitted by the Chair of that Committee or by the rules of that Committee.

10.2-7 ADOPTION OF POLICIES, RULES AND PROCEDURES

When written policies, rules and procedures are developed by a Committee to assist it in fulfilling its functions, such policies, rules and procedures must be adopted as provided in Article XIV of these Bylaws.

10.2-8 PARTICIPATION

Committees must meet as often as necessary to conduct business. (See the Medical Staff Rules & Regulations for meeting frequency.) Committee members must attend 50% of all Committee meetings. Failure to do so may result in removal from the Committee.

10.2-9 GENERAL PROVISIONS

(A) A majority of Medical Executive Committee members eligible to vote constitutes a quorum of the Medical Executive Committee. For all other committees, 50% of the Active Staff of a Committee, but no fewer than three (3) members, constitutes a quorum. At the discretion of the Chair, meetings may be conducted, in whole or in part, by telephone, video conference, or virtual platform that allows synchronous participation.

(B) Except as otherwise provided in this Section, the manner of voting is at the discretion of the Chair. However, a secret ballot must be taken upon the request of any Active Staff Committee member.

(C) The Chair or any member may call for an executive session consistent with Section 11.8 of the Bylaws.

(D) Valid action may be taken without a meeting by a Committee if the action is approved by a unanimous vote of the members entitled to vote.

10.3 MEDICAL EXECUTIVE COMMITTEE

10.3-1 COMPOSITION

The Medical Executive Committee is composed of the following members:

(A) Chief of Staff, who shall serve as Chair of the Committee;

(B) Vice-Chief of Staff;

(C) Secretary-Treasurer;

(D) One elected hospitalist or intensivist;

(E) One (1) elected primary care physician;

(F) Two (2) elected members-at-large;

(G) The Chairs of all clinical Departments;

(H) Hospital President, as ex-officio without vote;

(I) Immediate Past Chief of Staff, as ex-officio without vote, for at least one (1) year;

(J) The Director of Medical Education, as ex-officio without vote; and

(K) The Chief Medical Officer, as ex-officio without vote.

Officers, the hospitalist/intensivist member, the primary care physician member, and members at-large will be elected every 2 years by duly authorized voting members of the Active Staff.

10.3-2 DUTIES

The Medical Staff delegates to the Medical Executive Committee broad authority to oversee the operations of the Medical Staff. Without limiting this broad delegation of authority, the duties of the Medical Executive Committee include, but are not limited to:

(A) Adopting Rules and Regulations as may be necessary pursuant to Article XIV of these Bylaws;

(B) Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;

(C) Coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

(D) Receiving and acting upon reports and recommendations from Medical Staff Departments, Committees, and assigned activity groups;

(E) Recommending actions to the Board on matters of a medical- administrative nature, including, but not limited to, the following:

1. Reviewing the job description of medical directorships in the Hospital to assure their adequacy for Medical Staff purposes and to avoid a conflict of medical director duties and any Medical Staff leader;

2. Participating in the interview and review of candidates for medical directors in the Hospital and making recommendations to the Board regarding selection of such candidates; and

3. Periodically reviewing the performance of the Hospital's medical directors and transmitting the results of those reviews with any recommendations to the Board for its consideration.

(F) Making recommendations to the Board concerning additions to, reductions of, or changes in the scope of clinical services offered by the Hospital;

(G) Establishing the structure of the Medical Staff; the Medical Executive Committee mechanism to review credentials and delineate individual clinical privileges; the organization of performance improvement/quality assessment activities and Medical Executive Committee mechanisms of the Medical Staff; procedures for termination of Medical Staff membership and fair hearing procedures; and other matters relevant to the operation of an organized Medical Staff;

(H) Evaluating the medical care rendered to patients in the Hospital;

(I) Participating in the development of all Medical Staff and Hospital policies, practices, and planning;

(J) Reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members, and making recommendations to the Board regarding Staff appointments and reappointments, assignments to Departments, clinical privileges, and corrective action;

(K) Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members, including the initiation of and participation in Medical Staff corrective or review measures when warranted;

(L) Taking reasonable steps to develop and provide for continuing education activities and programs for the Medical Staff;

(M) Designating such Committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Medical Staff President;

(N) Reporting to the Medical Staff at each regular Staff meeting;

(O) Assisting in the obtaining and maintenance of accreditation;

(P) Developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster;

(Q) Appointing such Special or Ad Hoc Committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff;

(R) Reviewing the quality and appropriateness of services provided by contract physicians;

(S) Reviewing and approving the designation of the Hospital's authorized representative for National Practitioner Data Bank purposes;

(T) Appointing members to serve on an Ad Hoc Investigative Committee when an investigation is requested pursuant to Section 6.4-3 of these Bylaws; and

(U) Taking such other action that may reasonably be deemed necessary in the best interests of the Medical Staff and the Hospital.

The authority delegated to the Medical Executive Committee pursuant to Section 10.3-2 of these Bylaws may be removed by amendment of these Bylaws, or by resolution of the Medical Staff approved by a two-thirds vote of the voting Medical Staff, as conducted at a general meeting or special meeting preceded by notice that a purpose of the meeting will be to consider removal of authority of the Medical Executive Committee as specifically described in these Bylaws.

10.3-3 MEETINGS

The Medical Executive Committee must meet at least 10 times per year on call of the Chief of Staff or designee, and must maintain a record of its proceedings and actions.

ARTICLE XI

MEETINGS

11.1 MEDICAL STAFF MEETINGS

11.1-1 GENERAL STAFF MEETINGS

General meetings of the Medical Staff are held twice a year in the months of June and December.

11.1-2 AGENDA

The Chief of Staff and Medical Executive Committee will determine the order of business at a meeting of the Medical Staff. The agenda may include, insofar as feasible:

(A) Administrative reports from the Chief of Staff, Departments, Committees, and the Hospital President;

(B) Election of officers when required by these Bylaws;

(C) Reports by responsible officers, Committees, and Departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the Staff and on the fulfillment of other required staff functions;

(D) Old business; and

(E) New business.

11.1-3 SPECIAL MEETINGS

The Chief of Staff or the Medical Executive Committee may call special meetings of the Medical Staff at any time. The Medical Executive Committee must call a special meeting upon the written request of 20% of the members of the Active Staff. The person calling or requesting the special meeting must state the purpose of such meeting in writing. The Medical Executive Committee must schedule the meeting within 30 days after receipt of such request. No later than 14 days prior to the meeting, notice must be mailed or delivered to the members of the Staff. The meeting notice must include the stated purpose of the meeting. No business may be transacted at any special meeting except that stated in the notice calling the meeting.

11.1-4 MINUTES

Minutes of each general and special meeting of the Medical Staff must be prepared and include a record of the attendance of members and vote taken on each matter.

The minutes must be signed by the Chief of Staff.

11.2 COMMITTEE AND DEPARTMENT MEETINGS

11.2-1 REGULAR MEETINGS

Except as otherwise specified in these Bylaws, the Department Chairs, and Committee Chairs may establish the times for the holding of regular meetings. The Chairs must make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

11.2-2 SPECIAL MEETINGS

A special meeting of any Medical Staff Committee or Department may be called by the Chair thereof, the Medical Executive Committee, or the Chief of Staff. A special meeting of any Medical Staff Committee or Department must be called if the Chair, Medical Executive Committee, or Chief of Staff receive a written request of one-third of the current members of such Committee or Department eligible to vote.

11.3 QUORUM

11.3-1 STAFF MEETINGS

The presence of twenty-five percent of the total members of the Active Staff at any regular or special meeting in person or through written ballot shall constitute a quorum. The concurrence of a majority of such quorum is necessary for the transaction of business unless otherwise provided in these Bylaws.

11.3-2 DEPARTMENT AND COMMITTEE MEETINGS

The presence or participation of twenty-five percent of the voting members of a Committee or Department, or at least 3 physician members, whichever is more, constitutes a quorum for Committee and Department meetings.

11.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present will be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws. At the discretion of the Chair, meetings may be conducted, in whole or in part, by telephone, video conference, or virtual platform that allows synchronous participation. A Committee may take valid action without a meeting if the action is acknowledged by a writing setting forth the action and signed by at least two-thirds of the members entitled to vote.

11.5 MINUTES

Except as otherwise specified herein, minutes of meetings must be prepared and retained. They must include, at a minimum, a record of the attendance of members and the vote taken on significant matters with regular reports to the Medical Executive Committee.

11.6 ATTENDANCE REQUIREMENTS

Members of the Active Staff are strongly encouraged to attend at least 50% of the Medical Staff meetings and the meetings of the Department, Service, and Committees of which they are members as set forth in these Bylaws. However, there are no specific meeting attendance requirements.

11.6-1 SPECIAL ATTENDANCE

(A) At the discretion of the Chair or presiding officer, when a member's conduct or clinical practice is scheduled for discussion at a regular Department or Committee meeting, the member may be requested to attend. If the issue is conduct, the provisions of Policy & Procedure MS-25 (Disruptive Physicians Behaviors that Undermine a Culture of Safety) (or its successor policy) will be followed. If the issue is suspected deviation from standard clinical practice, Special Notice must be given at least 14 days prior to the meeting and must include the time and place of the meeting and a general indication of the issue involved. The member's appearance at that meeting will be mandatory.

(B) Failure of a member to appear at any such meeting after the member was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, will result in an automatic suspension of the member's privileges until such time as the member attends the next scheduled meeting for that purpose.

(C) A Committee Chair or Medical Staff officer may also request in writing that a member respond to a formal communication or participate in a discussion. Failure to cooperate with such a request within 15 days of the member's receipt of written notice will result in an automatic suspension of the member's privileges until such time as the member provides the requested information or engages in the requested discussion.

(D) If the member does not comply with the request for information or attend the requested meeting within 30 days of automatic suspension, the member will be deemed to have voluntarily resigned from the Medical Staff.

11.7 CONDUCT OF MEETINGS

Unless otherwise specified, meetings will be conducted according to Robert's Rules of Order. However, technical or non-substantive departures from such rules will not invalidate action taken at such a meeting.

11.8 EXECUTIVE SESSION

Executive session is a meeting of a Medical Staff Committee at which only voting Medical Staff Committee members and others whom the Committee expressly invites may attend. Executive session may be called by the presiding officer at the request of any Medical Staff Committee member. Executive session must be called by the presiding officer pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

ARTICLE XII

CONFIDENTIALITY, IMMUNITY AND RELEASES

12.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within this Hospital, a practitioner:

(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 practitioner'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 acts in accordance with the provisions of this Article; 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 the exercise of clinical privileges at this Hospital.

12.2 CONFIDENTIALITY OF INFORMATION

12.2-1 GENERAL

Records and proceedings of all Medical Staff committees which have the responsibility of evaluation and improvement of quality of care rendered in this Hospital, including, but not limited to, meetings of the Medical Staff meeting as a committee of the whole, meetings of Departments, meetings of Committees established under Article X of these Bylaws, and meetings of Special or Ad Hoc committees created by the Medical Executive Committee (pursuant to Section 10.1) or by Departments (pursuant to Sections 9.4(I) and (L)) and including information regarding any member or applicant to this Medical Staff are, to the fullest extent permitted by law, confidential under California Evidence Code, Section 1157, California Civil Code, Sections 43.7, 43.8, and 45, and other laws pertaining to confidential or privileged information. Such information must be treated with the strictest confidentiality within the Hospital and Medical Staff, and dissemination of such information and records must only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff, or when specifically authorized by the Medical Executive Committee. Medical Staff members pledge to invoke the protection of all applicable laws, including California Evidence Code Section 1157, as applicable, in legal proceedings in order to preserve the confidentiality of this information.

12.2-2 BREACH OF CONFIDENTIALITY

Inasmuch as effective 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, any breach of confidentiality of the discussions or deliberations of Medical Staff Departments or Committees, except in conjunction with other hospitals, professional societies, or licensing authorities, is outside appropriate standards of conduct for this Medical Staff 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, which may include suspension or termination of eligibility to hold office or to serve as a member of Medical Staff Committees and/or restriction, suspension, limitation, or revocation of clinical privileges and/or Medical Staff membership. The confidentiality and other legal protections that attach to the proceedings and actions of Medical Staff Committees also pertains to Department meetings and to any Committees thereof.

12.2-3 CONSULTANTS AND CONFIDENTIALITY

The membership of any Medical Staff Committee may be augmented by the addition of consultants who are not members of the Medical Staff. Such consultants must be appointed by the Chief of Staff. All communications and records of such consultants, written and oral, are deemed part of the records and proceedings of the applicable Committee and must be viewed in strictest confidence, and disclosed only as authorized in written policies governing the confidentiality of Medical Staff Committee records and files.

12.3 IMMUNITY FROM LIABILITY

12.3-1 FOR ACTION TAKEN

Each representative of the Medical Staff and Hospital is immune, to the fullest extent permitted 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. Each member of the Medical Staff or applicant to the Medical Staff waives any right of personal redress against the Medical Staff, the Board, the Hospital, the Judicial Review Committee under Article VII of these Bylaws, and any representative(s) thereof for any action taken or statements or recommendations made within the scope of duties exercised.

12.3-2 FOR PROVIDING INFORMATION

Each representative of the Medical Staff and Hospital and all third parties are immune, to the fullest extent permitted 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, or otherwise consistent with any peer review sharing agreement 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. Each member of the Medical Staff or applicant to the Medical Staff waives any right of personal redress against the Medical Staff, the Board, the Hospital, the Judicial Review Committee under Article VII of these Bylaws, and any representative(s) thereof for any such provisions of information.

12.4 ACTIVITIES AND INFORMATION COVERED

12.4-1 ACTIVITIES

The confidentiality and immunity provided by this Article apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this Hospital or any other healthcare facility's or organization's activities concerning, but not limited to:

(A) Applications for appointment, reappointment, or clinical privileges;

(B) Corrective action;

(C) Hearings and appellate reviews;

(D) Utilization reviews;

(E) Other Department, Committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

(F) National Practitioner Data Bank queries and reports, peer review organizations, and Medical Board of California and similar reports.

12.5 RELEASES

Each applicant or member must, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases is not a prerequisite to the effectiveness of this Article.

12.6 INDEMNIFICATION

The Hospital must indemnify, defend, and hold harmless the Medical Staff and its individual members from and against losses and expenses (including attorney's fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending, or completed action, lawsuit, investigation, proceeding, or other dispute that relates to or pertains to any alleged act or failure to act within the scope of peer review or quality assessment activities, including, but not limited to, (1) as a member of or witness for a Medical Staff Department, Service, Committee, or Hearing Panel; (2) as a member of or witness for the Board or any task force, group, or committee of the Hospital; and (3) as a person providing information to any Medical Staff

or Hospital group, officer, Board member, or employee for the purpose of aiding in the evaluation of the qualifications, fitness, or character of a Medical Staff member or applicant.

The Medical Staff or a Medical Staff member may seek indemnification for such losses and expenses under this Bylaws provision, statutory and case law, any available liability insurance, or otherwise as the Medical Staff or member sees fit, and concurrently or in such sequence as the Medical Staff or member may choose. Payment of any losses or expenses by the Medical Staff or member is not a condition precedent to the Hospital's indemnification obligations hereunder.

12.7 MEDICAL STAFF CREDENTIALS FILES

12.8 -1 CONTENTS OF CREDENTIALS FILE

Only information generated through Medical Staff functions, including, but not limited to, credentialing activities, peer review, and formal investigations, will be included in the Medical Staff member's credentials file, subject to the ratification of the Medical Executive Committee. A member is entitled to submit a rebuttal to any adverse information or letter of counseling, warning, or reprimand placed in their credentials file.

12.9 -2 CONFIDENTIALITY

The following applies to records of the Medical Staff and its Departments and Committees responsible for the evaluation and improvement of patient care:

(A) The records of the Medical Staff and its Departments and Committees responsible for the evaluation and improvement of the quality of patient care rendered at the Hospital must be maintained as confidential.

(B) Access to such records must be limited to duly appointed officers and Committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

(C) Information disclosed to the Governing Body of the Hospital or its appointed representatives in order that the Governing Body may discharge its lawful obligations and responsibilities must be maintained by the Governing Body as confidential.

(D) Confidential information, including information contained in the credentials file of any member, may be shared with other peer review bodies pursuant to a valid peer review sharing agreement, California Business and Professions Code Section 809.08, or any other applicable law that allows the sharing of peer review information for peer review purposes. Such released confidential information will maintain its privileges and immunities under state and federal law, including, but not limited to, the

protection from discovery pursuant to California Evidence Code Section 1157.

(E) Information contained in the credentials file of any member may be disclosed with the member's consent, or to any Medical Staff, peer review body, or professional licensing board consistent with appropriate safeguards regarding confidentiality, or as required by law.

(F) A Medical Staff member will be granted access to the individual's credentials file, subject to the following provisions:

1. Timely notice of such must be made by the member to the Chief of Staff or the Chief of Staff's designee;

2. The member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information, including, but not limited to, peer review committee findings, letters of reference, proctoring reports, and complaints, will be provided to the member, in writing, by the designated officer of the Medical Staff, within a reasonable period of time, as determined by the Medical Staff. Such summary must disclose the substance, but not the source, of the information summarized and may not be removed from the review site; and

3. The review by the member must take place in the Medical Staff office, during normal work hours, with an officer or designee of the Medical Staff present.

(G) In the event a notice of action or proposed action is filed against a member, access to that member's credentials file will be governed by Sections 7.4 of these Bylaws.

ARTICLE XIII

GENERAL PROVISIONS

13.1 DEPARTMENT RULES AND REGULATIONS

Each Department may adopt Department Rules and Regulations as may be necessary for the proper conduct of its work and to implement more specifically the general principles found within these Bylaws. Such Departmental Rules and Regulations must be in concert with these Bylaws and may be amended or repealed at any regular meeting of the Medical Executive Committee or at a special meeting of the Medical Executive Committee called for that purpose. If there is a conflict between the Bylaws and Departmental Rules and Regulations, the Bylaws prevail. The Medical Executive Committee mechanism described herein will be the sole method for the initiation, adoption, amendment, or repeal of Departmental Rules and Regulations.

13.2 DUES OR ASSESSMENTS

Payment of annual dues is mandatory for all categories of membership on the Medical Staff except Honorary and Telehealth Staff. The Medical Executive Committee has the power to recommend the amount of annual dues or assessments for each category of Medical Staff membership and to determine the manner of expenditure of such funds.

13.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. These Bylaws apply with equal force to all sexes and all genders regardless of the gender of the term used.

13.4 AUTHORITY TO ACT

Any member or members who act in the name of this Medical Staff without proper authority will be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

13.5 DIVISION OF FEES

Any division of fees by members of the Medical Staff is forbidden, and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

13.6 NOTICES TO THE MEDICAL STAFF

Except where specific notice provisions are otherwise provided in these Bylaws or required by law, any notice, request, or demand to the Medical Staff or officers or committees thereof must be addressed to the Medical Staff Office.

13.7 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, Department Chairs, or the Medical Executive Committee must, at least 20 days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

13.8 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

Candidates for positions as Medical Staff representatives to UCSF administrative or professional committees should be filled by such selection process as the Medical Staff may determine. Nominations for such positions shall be made by a nominating committee appointed by the Medical Executive Committee.

13.9 MEDICAL STAFF COMMITTEE FILES

Rules and Regulations pertaining to the confidentiality of Medical Staff Committee files and records are contained in the Medical Staff Rules and Regulations.

13.10 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

The Medical Executive Committee must review and make recommendations to the Board regarding service and quality of care issues related to exclusive arrangements for physician and/or professional services, prior to any decision being made, in the following situations:

(A) The decision to execute an exclusive contract in a previously open Department or service;

(B) The decision to renew or modify an exclusive contract in a particular Department or service;

(C) Schedule of contract renewals; or

(D) The decision to terminate an exclusive contract in a particular Department or service.

ARTICLE XIV

ADOPTION AND AMENDMENT OF BYLAWS

14.1 PROCEDURE

(A) These Bylaws and any part thereof may be amended or repealed. The procedure for amendment may be initiated by any of the following procedures:

1. Recommendation by either the Medical Executive Committee or Bylaws Committee and, if by the Bylaws Committee, subsequent review and approval by a majority of the Medical Executive Committee.

2. By direct proposal from the Medical Staff through a written resolution signed by at least 10% of the members of the Staff entitled to vote. Such amendment shall be submitted to the Bylaws Committee and to the Medical Executive Committee, and the proposed amendment shall then be submitted to the Medical Staff for a vote pursuant to Section 14.1(B) of these Bylaws.

(B) After being initiated according to Section 14.1(A), proposed amendments to these Bylaws must be submitted to the Medical Staff for adoption by one of the following two methods:

1. Submitted with a ballot by mail, e-mail, or other electronic means, so long as adequate precautions are taken to ensure reliability and security, to the voting membership along with the written comments of the Bylaws Committee and the Medical Executive Committee. Each ballot must be returned to the Secretary-Treasurer of the Medical Staff or designee. Approval by the Medical Staff requires an affirmative vote of two-thirds of those who return ballots and subsequent adoption by the Board; or

2. Submitted by mail, e-mail, or other electronic means to the voting members of the Medical Staff and voted upon at any regular or special meeting of the Staff occurring at least 10 days after transmitting copies of the proposed amendments to the Medical Staff. A two-thirds vote of the eligible members present at the meeting will be necessary for approval. An amendment thus approved will become effective only if adopted by the Board.

The Chief of Staff may choose, at their discretion, either procedure for amending the Bylaws.

(C) The existing Medical Staff of Saint Francis Memorial Hospital and the existing Medical Staff of St. Mary's Medical Center, have by a majority

vote of each Medical Staff under the process identified under Section 17.3 of the Saint Francis Medical Staff Bylaws and Section 14.1-1 of the St. Mary's Medical Staff Bylaws, approved the merger of the two Medical Staffs, effective upon approval by their respective Board of Directors and the conditions set forth in Section 15.1 below.

(D) Subsequent to the merger of the Medical Staffs as stated in Section 14.1(C), the members of this Medical Staff who are eligible to vote and whose primary practice is at one of the facilities may petition for dissolution of the merged medical staff. Such petition will, if made by 35% of the physicians eligible to vote whose practice is at one of the facilities, lead to a dissolution vote by all physicians who are eligible to vote at that facility. Dissolution will be made if over 50% of the petitioning facility's eligible voters vote to accept the dissolution.

14.2 TECHNICAL AND EDITORIAL CORRECTIONS

The Medical Executive Committee has the power to adopt such amendments to the Bylaws, Rules and Regulations, and Policies and Procedures as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of sections, or correction of grammatical or punctuation errors. Substantive amendments are not permitted pursuant to this Section. Corrections may be effected by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, the Medical Executive Committee must advise the Medical Staff and the Board of such amendments.

Such amendments are effective immediately and are permanent if not disapproved by the Medical Staff or Board within 90 days of adoption by the Medical Executive Committee. For purposes of this Section, disapproval by the Medical Staff must be shown by a majority vote of the Medical Staff in which at least 25% of the voting members of the Medical Staff cast ballots.

14.3 FINAL APPROVAL

Adoption of any amendment to the Bylaws will only become effective after approval by the Board, which approval may not be unreasonably withheld. Amendments will be automatically approved within 60 days if the Board does not take action. If approval is withheld, the Board must specify in writing the reasons for doing so and must forward the reasons to the Chief of Staff, the Medical Executive Committee, and the Bylaws Committee.

Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws. The Medical Staff Bylaws, Rules and Regulations and policies and procedures, and the Governing Body's Bylaws will not conflict.

14.4 EXCLUSIVITY

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

14.5 SUCCESSOR IN INTEREST

These Bylaws, and privileges of individual members of the Medical Staff accorded under these Bylaws, will be binding upon the Medical Staff and the Board of any successor in interest in this Hospital, except where the Medical Staff is being combined with other hospital medical staffs.

14.6 AMENDMENTS TO THE RULES AND REGULATIONS OF THE MEDICAL STAFF

14.6-1 PROCEDURE

The Medical Staff has delegated to the Medical Executive Committee authority over Rules and Regulations. A vote for an amendment to the Rules and Regulations of the Medical Staff (whether adding a new provision or repealing or amending an existing provision) may be initiated by the Medical Executive Committee, or by recommendation of the Bylaws Committee, or by written resolution signed by at least 10% of the members of the Staff entitled to vote. A proposal to add, repeal, or amend the Rules and Regulations (hereafter referred to as a "proposed Rule") must be submitted to the Medical Executive Committee for review and action, as follows:

(A) Except as provided at Section 14.6-1(D) with respect to circumstances requiring urgent action, the Medical Executive Committee may not act on the proposed Rule until the Medical Staff has had a reasonable opportunity to review and comment on the proposed Rule. This review and comment opportunity may be accomplished by posting proposed Rules on the Medical Staff website (if one exists) at least 30 days prior to the scheduled Medical Executive Committee meeting, together with instructions regarding how interested members may communicate comments. A comment period of at least 15 days must be afforded, and the comments must be summarized and that summary then provided to the Medical Executive Committee prior to Medical Executive Committee action on the proposed Rule.

(B) To take effect, the proposed Rule must be approved by the Medical Executive Committee, unless the proposed Rule is one generated by petition of at least 10% of the voting members of the Medical Staff. In this circumstance, if the Medical Executive Committee fails to approve the proposed Rule, the Medical Executive Committee must notify the Medical Staff. The Medical Executive Committee and the Medical Staff may decide to invoke or waive the conflict management provisions of Section 14.9.

1. If the conflict management process is not invoked within 30 days, it will be deemed waived. In this circumstance, the Medical Staff's proposed Rule must be forwarded to the Board for action. The Medical Executive Committee may forward its comments regarding

the proposed Rule and the reasons it declined to approve the proposed Rule to the Board.

2. If the conflict management process is invoked by either the Medical Executive Committee or the Medical Staff, the proposed Rule may not be forwarded to the Board until the conflict management process has been completed. The results of the conflict management process must be communicated to the Board.

(C) Following approval by the Medical Executive Committee or waiver or completion of the conflict management process described above, a proposed Rule must be forwarded to the Board for approval, which approval may not be withheld unreasonably. The Rule will become effective immediately following approval of the Board or automatically within 60 days if no action is taken by the Board.

(D) Where urgent action is required to comply with law or regulation, the Medical Executive Committee is authorized to conditionally adopt a Rule and forward it to the Board for approval and immediate implementation, subject to the following. If the Medical Staff did not receive prior notice of the proposed Rule (as described in Section 14.6-1(A) of these Bylaws), the Medical Staff must be notified of the conditionally adopted and approved Rule and may, by petition signed by at least 10% of the voting members of the Medical Staff, require the Rule to be submitted for possible recall. The approved Rule will remain effective until such time as a superseding Rule meeting the requirements of the law or regulation that warranted the initial urgent response has been approved pursuant to any applicable provision of this Section 14.6-1, including, if necessary, invocation of the conflict management process under Section 14.9.

14.7 AMENDMENTS TO BYLAWS, RULES AND REGULATIONS

Medical Staff members will be provided copies of all revisions to the Medical Staff Bylaws and Rules and Regulations within 60 days of approval by the Board.

14.8 AMENDMENTS TO THE POLICIES AND PROCEDURES OF THE MEDICAL STAFF

Policies and Procedures of the Medical Staff and of particular Departments must be consistent with these Bylaws and the Medical Staff Rules and Regulations and circulated and continuously available to all members.

The Medical Staff has delegated to the Medical Executive Committee authority over Policies and Procedures. A vote for an amendment to the Policies and Procedures (whether adding a new provision or repealing or amending an existing provision) may be initiated by the Medical Executive Committee, by recommendation of the Bylaws Committee, by an interested clinical Department, or by written resolution signed by at least 10% of the members of the Staff entitled to vote. A proposal to add, repeal, or amend a Policy and

Procedure (hereafter referred to as a "proposed Policy") must be submitted to the Medical Executive Committee for review and action, as follows:

(A) To take effect, the proposed Policy must be approved by the Medical Executive Committee unless the proposed Policy is one generated by petition of at least 10% of the voting members of the Medical Staff. In this circumstance, if the Medical Executive Committee fails to approve the proposed Policy, it must notify the Medical Staff. The Medical Executive Committee and the Medical Staff may decide to invoke or waive the conflict management provisions of Section 14.9.

1. If the conflict management process is not invoked within 30 days, it will be deemed waived. In this circumstance, the Medical Staff's proposed Policy must be forwarded to the Board for action. The Medical Executive Committee may forward its comments regarding the proposed Policy and the reasons it declined to approve the proposed Policy to the Board.

2. If the conflict management process is invoked by either the Medical Executive Committee or the Medical Staff, the proposed Policy may not be forwarded to the Board until the conflict management process has been completed. The results of the conflict management process must be communicated to the Board.

(B) Following approval by the Medical Executive Committee or waiver or completion of the conflict management process described above, a proposed Policy must be forwarded to the Board for approval, which approval may not be withheld unreasonably. The Policy will become effective immediately following approval of the Board or automatically within 60 days if no action is taken by the Board.

(C) The Medical Staff must be notified of the approved Policy and may, by petition signed by at least 10% of the voting members of the Medical Staff, require the Policy to be submitted for possible recall. The approved Policy will remain effective until such time as it is repealed or amended pursuant to any applicable provision of this Section.

14.9 CONFLICT MANAGEMENT

In the event of a conflict between the Medical Executive Committee and the Medical Staff, as represented, for these purposes, by a written petition signed by at least 10% of the voting members of the Medical Staff, regarding a proposed or adopted Rule or Policy, the Chief of Staff must convene a meeting with the petitioners' representative(s). The foregoing petition must include a designation of up to 5 members of the voting Medical Staff who will serve as the petitioners' representative(s). The Medical Executive Committee will be represented by an equal number of Medical Executive Committee members.

The Medical Executive Committee's and the petitioners' representative(s) must exchange information relevant to the conflict and must work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the Hospital. Resolution at this level requires a majority vote of the Medical Executive Committee's representatives at the meeting and a majority vote of the petitioner's representatives.

Unresolved differences must be submitted to the Board for final resolution.

ARTICLE XV

TRANSITIONAL PROVISIONS

15.1 BACKGROUND

The consolidation of the UCSF Health Saint Francis and the UCSF Health St. Mary's Medical Staffs, approved under Section 14.1(C) of these Bylaws, will become effective upon the closing of the transaction through which UCSF Health will become the sole corporate member of the Hospitals and approval of the Board that will serve as the Governing Body post-closing. A transition period is required to allow for continued, effective medical staff practices as the Medical Staff fully integrates. This Article XV provides for such a transition period.

15.2 TRANSITION PERIOD STRUCTURE

During the transition period, the following will be the structure of the combined medical staffs:

(A) The existing officers of each individual medical staff will, collectively, be the officers of the merged medical staff. The officers elected by each campus prior to the merger will retain primary authority for the affairs of their individual campuses until elections are held under Article VIII.

(B) The membership of the combined Medical Executive Committee will be comprised of the members of each, separate MEC prior to the merger. The Chief of Staff of the former Saint Francis Medical Staff and the Chief of Staff of the former St. Mary's Medical Staff will co-chair meetings of the MEC on a monthly basis. All medical staff committees will also utilize this combined structure. At any time during the transition period, the MEC has the discretion to modify this combined structure as it fully implements the structure set forth in Articles VIII, IX, and X so as to assist the transition process in advance of the deadline set by Section 15.3.

(C) The Department officers provided for under Section 9.5 will also retain the officers of the Saint Francis Departments and those of the St. Mary's departments for the transition period under the merged medical staff structure. As in Section 15.2(A), the Department officers will retain primary authority over their individual campuses. At any time during the transition period, the MEC has the discretion to modify this combined structure as it fully implements the structure set forth in Articles VIII, IX, and X so as to assist the transition process in advance of the deadline set by Section 15.3.

(D) During the transition period, the existing Chiefs of Staff will appoint new members to and/or replace existing members on Committees to achieve equal representation, as feasible, on each committee of Medical Staff members whose primary practice is at each hospital. With respect to

committees that may address issues only relevant at one hospital, such equal distribution is not necessary.

15.3 TRANSITION PERIOD

The transition period will last from the time consolidation is implemented until the structure set forth in Articles VIII, IX, and X is implemented, but no later than December 31st of the year following consolidation.