UC San Diego Health

MEDICAL STAFF BYLAWS

APPROVED:
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University of California, San Diego Medical Center
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UCSD MEDICAL STAFF BYLAWS

Preamble

These Bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the Medical Staff and the Governing Body of University of California, San Diego Medical Center to protect the quality of medical care provided in the Medical Center and to assure the competency of the Medical Center’s Medical Staff. The Bylaws provide a framework for self-government, assuring an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and to account to the Governing Body for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized medical staff relations with the Governing Body, and relations with applicants to and members of the Medical Staff. The Hospital’s Governing Body has the ultimate authority and responsibility for the oversight and delivery of health care rendered by licensed independent practitioners and other practitioners credentialed and privileged through the medical staff process or any other equivalent process.

The Regents delegated authority for the governance of the Medical Center to the Chancellor of the University of California, San Diego. The Chancellor has delegated this authority further to the Vice Chancellor for Health Sciences.

Consistent with the Standing Orders of the Regents and the policies of the Regents and the University of California, the Vice Chancellor further delegates governing body responsibilities to the Health System Executive Governing Body, which serves as the Governing Body of UCSD Medical Center for purposes of Medicare Conditions of Participation for Hospitals, Title 22 of the California Code of Regulations, and The Joint Commission governance standards (the “Governing Body”).

Accordingly, the Bylaws address the Medical Staff’s responsibility to establish criteria and standards for Medical Staff membership and privileges, and to enforce those criteria and standards; they establish clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities, including, but not limited to, periodic meetings of the Medical Staff, its committees, and departments; review and analysis of patient medical records; they describe the standards and procedures for selecting and removing Medical Staff Administrators; and they address the respective rights and responsibilities of the Medical Staff and the Governing Body.

Definitions

**Academic Department Chair** means the individual designated by the Dean of the School of Medicine as the head of an academic department in the School of Medicine.
**Academic Division Chief** means the individual designated by the Department Chair as the head of an academic division in the School of Medicine.

**Advanced Practice Professional or APP** means an individual, other than a licensed physician, dentist, or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable State Practice Act, who is qualified to render direct or indirect medical, dental, or podiatric care under the supervision or direction of a Medical Staff member possessing privileges to provide such care in the Medical Center in conformity with these Bylaws and the rules. AHPs are not eligible for Medical Staff membership.

**Chief Executive Officer (CEO)** means the Chief Executive Officer, UCSD Medical Center, who has been appointed by the Vice Chancellor on the recommendation of the Chancellor, and is responsible for the overall management of the Medical Center. The CEO will serve as Co-Chair of the Health System Executive Governing Body (the “Governing Body”) and reports to the Vice Chancellor Health Sciences.

**Chief Medical Officer (CMO)** means a Practitioner appointed by the CEO to serve as a liaison between the Medical Staff and the Medical Center administration.

**Chief of Staff (COS)** means the chief officer of the Medical Staff elected by the Medical Staff to act on their behalf.

**Clinical Division Chief** means the Member of the Attending Medical Staff who is the head of a clinical division at the Medical Center, appointed by the Chair of the Department to which that Division belongs.

**Clinical Psychologist** means a provider of clinical psychology services who completed an APA approved internship program, received a Ph.D. or Psy.D. in clinical psychology from an APA approved college or university program, and is currently licensed by the California Board of Psychology. Clinical psychologists are members of the Medical Staff and may admit patients if granted the specific privilege to admit.

**Clinical Services** of the Medical Staff shall correspond to the Clinical Departments of the School of Medicine University of California, San Diego.

**Complete Application** shall mean an application for either initial appointment or reappointment to the Medical Staff or Advanced Practice Professional Staff, or an application for clinical privileges that has been determined by the applicable Service Chief, the Credentials Committee, the Medical Staff Executive Committee (“MSEC”) and/or the Governing Body to meet the requirements of these Bylaws and related policies and procedures. Specifically, to be complete, the application must be submitted on a form approved by the MSEC and Governing Body, and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant.
Criminal conviction shall include the conviction of, or a plea of guilty or nolo contendere for any felony, or for any misdemeanor related to the practice of a health care profession, fraud or abuse relating to any government health program, third party reimbursement or controlled substance, whether or not an appeal of the conviction has been filed or is pending.

Date of receipt means the date any notice, special notice or other communication was delivered personally; or if such notice, special notice or communication was sent by mail, it shall mean 72 hours after the notice, special notice, or communication was deposited, postage prepaid, in the United States mail. [See also, the definitions of Notice.]

Day is defined as a calendar day unless otherwise specified herein.

Dean means the individual appointed by the Chancellor to supervise the professional affairs and administer the academic programs of the School of Medicine.

Dean of Clinical Affairs means a Physician who has been appointed by Vice Chancellor and is responsible for representing the UCSD Medical Group.

Dentist means a dentist or oral surgeon holding a D.D.S., or equivalent degree, and a valid unrestricted license to practice dentistry in the State of California.

Department means a clinical department at the Medical Center that corresponds to an academic department in the School of Medicine.

Department Chair means the Member of the Attending Medical Staff who is the head of a clinical department at the Medical Center.

Desigenee means an individual acting on behalf of another individual at that other individual’s request for a specific purpose in accordance with these Bylaws. Unless otherwise expressly provided in these Medical Staff Bylaws and accompanying Rules and Regulations, a reference to any of the following individuals or bodies shall include the designee of the individual or body: Chief of Staff, Department Chair or Chief of Service, MSEC, Credentials Committee, Dean of the Medical School, the Vice Chancellor for Health Sciences, and the Chancellor.

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

Governing Body means The Regents of the University of California or their designee(s). The Regents delegated authority for the governance of the Medical Center to the Chancellor of the University of California, San Diego. The Chancellor delegates this authority to the Vice Chancellor. Consistent with the Standing Orders of the Regents and the policies of the Regents and the University of California, the Vice Chancellor further delegates governing body responsibilities to the Health System Executive Governing Body, which serves as the
Governing Body of UCSD Medical Center for purposes of Medicare Conditions of Participation for Hospitals, Title 22 of the California Code of Regulations, and The Joint Commission governance standards.

**Government Health Program** includes, but is not limited to, Medicare, Medicaid, Medi-Cal, TriCare (formerly CHAMPUS), California Children’s Services, Maternal and Child Health Services Block Grant, Block Grants to State Children’s Health insurance programs, or any other federal or state program providing health care benefits that is funded directly or indirectly by the Government of the United States or the government of any state, territory or commonwealth within the United States.

**Housestaff** means any M.D. or D.O. in a training program that leads to eligibility for either general certification or subspecialty certification by an approved ABMS Specialty Board, or any M.D. or D.O. in a training program where ABMS Specialty Board certification has not been created. This would include all trainees in ACGME and/or non-ACGME accredited programs.

**In good standing** means that no adverse professional review action, as defined in the Health Care Quality Improvement Act, has been taken regarding the practitioner. Specifically neither the practitioner’s staff membership nor clinical privileges have been reduced, restricted, suspended, revoked, denied, or not renewed.

**Investigation** means a process specifically initiated to determine the validity, if any, of a concern or complaint raised against a Practitioner on the Medical Staff, and does not include activity of the Physician Well-being Committee.

**Joint Conference Committee** is a Medical Staff standing committee and functions primarily as a liaison between the Medical Staff, Hospital Administration, and the Governing Body.

**Medical Center (or hospital)** means the University of California, San Diego Medical Center and its ambulatory sites as defined by the Governing Body.

**Medical disciplinary cause or reason** means a basis for disciplinary action involving that aspect of a Practitioner’s competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

**Medical record** refers to the official written medical record and/or any patient specific information stored electronically for purposes of patient care.

**Medical Staff** means the organizational component of the Medical Center that includes all licensed physicians (M.D. or D.O.), dentists, clinical psychologists, and podiatrists who meet the eligibility requirements outlined in Article II and are privileged to attend patients in the Medical Center, and have been granted recognition as members pursuant to these Bylaws.
Medical Staff Administration means the department that provides support to the medical staff and processes all initial and reappointment applications for credentialing and privileging for the medical staff and advanced practice professionals.

Medical Staff Executive Committee (MSEC) means the Executive Committee of the Medical Staff.

Medical staff year means the period from July 1st through June 30th.

Medical Director means a Practitioner, employed or otherwise serving the Medical Center on a full or part-time basis, whose duties include administrative and clinical responsibilities and supervision of professional activities of Practitioners and other personnel under his/her direction. A medical administrative officer with clinical responsibilities must be a member of the Medical Staff.

Member means any Practitioner who has been appointed to the Medical Staff or Advanced Practice Professional Staff.

Notice means a written communication delivered personally to the addressee, sent by fax, e-mail, interoffice mail, or United States mail, first-class postage prepaid, return receipt requested, or by overnight delivery service addressed to the addressee at the last address as it appears in the official records of the Medical Staff Administration or the Medical Center.

Patient Safety Evaluation System (“PSES”) means the collection, management or analysis of information for reporting to or by a patient safety organization for patient safety activities including, but not limited to, efforts to improve patient safety and the quality of patient safety delivery, the collection and analysis of patient safety work product, the development and discrimination of information, maintenance of confidentiality and security measures and all other activities relating to improving patient safety.

Patient Safety Work Product means any data, reports, records, memoranda, analyses, including root cause analyses, or oral or written statements which are assembled or developed by or on behalf of the Medical Center for reporting to a patient safety organization or are developed by a patient safety organization for the conduct of patient safety activities and which could result in improved patient safety, healthcare quality or healthcare outcomes or which identify the fact of reporting to a patient safety organization.

Physician means an individual with an M.D. or D.O. degree who holds a valid unrestricted license or is registered or permitted to practice medicine by the Medical Board of California.

Podiatrist means a podiatrist holding a D.P.M., degree or its equivalent and a valid unrestricted license to practice podiatry in the State of California.
Practitioner means, unless otherwise expressly limited, any currently licensed or registered or permitted physician (M.D. or D.O.), dentist, clinical psychologist or podiatrist.

Preponderance of the Evidence means evidence that is more convincing and outweighs any evidence to the contrary and that leads one to believe that something is more likely to be true than not true.

Prerogative means a participatory right exercised by virtue of staff category or otherwise, to a Medical Staff member, that is exercisable subject to the conditions imposed in these Bylaws, Rules and Regulations and in other Medical Staff policies.

Privileges or Clinical Privileges means the permission granted by the Governing Body to a Practitioner to provide specific patient care services within defined limits, based on the individual Practitioner's license, education, training, experience, competence, health status and judgment.

Proctoring refers to the method by which Medical Staff members are evaluated for clinical competence in the areas in which they have privileges.

Regents means The Regents of the University of California established pursuant to Article IX, section 9 of the California Constitution.

Rules refers to the Medical Staff and/or department rules, if applicable, adopted in accordance with these Bylaws unless specified otherwise.

School of Medicine means the school of medicine at the University of California, San Diego.

Special notice means a notice sent by certified or registered mail, return receipt requested, addressed to the addressee at the last address as it appears in the official records of the Medical Staff Administration or the Medical Center.

Standardized procedures means the written policies and protocols formulated by the Interdisciplinary Practice Committee that is accountable to the MSEC of the UCSD Medical Center and approved by an authorized administrator. The standardized procedures delineate the conditions pursuant to which an AHP may render specific patient care functions that otherwise would be considered medical functions, including but not limited to, specifying any required training or supervision.

Substantial Evidence means such relevant evidence as a reasonable person might accept as adequate to support a conclusion.

System means the University of California, San Diego Medical Center.
Telemedicine is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

Vice Chancellor means the individual who has been appointed by and reports to the Chancellor as Vice Chancellor for Health Sciences.

Vice Chief of Staff means the person who shall become the Chief of Staff after the Chief of Staff’s term concludes and who has been elected by the Medical Staff.
ARTICLE 1
NAME AND PURPOSES

1.1 Name

The name of this organization shall be the Medical Staff ("Medical Staff") of the University of California, San Diego Medical Center.

1.2 Purposes

The Medical Staff’s purposes are:

To assure that all patients admitted or treated in any of the Medical Center services receive a uniform standard of quality patient care, treatment and efficiency consistent with generally accepted standards attainable within the Medical Center’s means and circumstances.

A. To provide for a level of professional performance that is consistent with generally accepted standards attainable within the Medical Center’s means and circumstances.

B. To organize and support professional education and community health education and support services.

C. To initiate and maintain Bylaws, rules and regulations, policies and procedures for the Medical Staff to carry out its responsibilities for the professional work performed in the Medical Center.

D. To provide a means for the Medical Staff, Governing Body and administration to discuss issues of mutual concern and to implement education and changes intended to continuously improve the quality of patient care.

E. To provide and foster education and research in an integrated manner with the clinical services of the medical center or health system.

1.3 Responsibilities

The Medical Staff’s responsibilities are:

A. To provide quality patient care;

B. To account to the Governing Body for the quality of patient care provided by all members authorized to practice in the Medical Center through the following measures:
1) Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;

2) An organizational structure and mechanisms that allows ongoing monitoring of patient care practices;

3) A credentials program, including mechanisms of appointment, reappointment and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated performance of the Medical Staff applicant or member;

4) A continuing education program based, at least in part, on needs demonstrated through the medical care evaluation program;

5) A utilization review program to provide for the appropriate use of all medical services;

C. To recommend to the Governing Body action with respect to appointments, reappointments, staff category and department assignments, clinical privileges and corrective action;

D. To establish and enforce, subject to the Governing Body approval, professional standards related to the delivery of health care within the Medical Center;

E. To account to the Governing Body for the quality of patient care through regular reports and recommendations concerning the implementation, operation, and results of the quality review and evaluation activities;

F. To initiate and pursue remedial action with respect to Members where warranted;

G. To provide a framework for cooperation with other community health facilities and/or educational institutions or efforts;

H. To establish and amend, from time to time as needed Medical Staff Bylaws, rules and policies for the effective performance of Medical Staff responsibilities, as further described in these Bylaws;

I. To select and remove Medical Staff Administrators;

J. As appropriate, to assess Medical Staff dues and utilize Medical Staff dues for the purposes of the Medical Staff.
K. To exercise its rights and responsibilities in a manner that does not jeopardize the Medical Center’s license, Medicare and Medi-Cal provider status, accreditation, or tax exemption status.

1.4 Health System Affiliation

The health system is comprised of the University of California, San Diego School of Medicine, the hospitals owned by University of California, San Diego and the University of California, San Diego Medical Group. One of the purposes of the system is to maintain comparable professional standards among its patient care facilities and to strive to provide efficient patient care and support services. In keeping with the foregoing, cooperative credentialing, peer review, corrective action, and procedural rights are hereby authorized, in accordance with these Bylaws.

1.5 Peer Review

The Medical Staff may enter into arrangements with University of California, San Diego Managed Care to assist it in peer review activities. This may include, without limitation, relying on information in other system members’ credentials and peer review files, and utilizing the other system members’ medical or professional staff support resources to conduct or assist in conducting peer review activities; provided, however, that all peer review information shall be maintained as confidential.

ARTICLE 2
MEDICAL STAFF MEMBERSHIP

2.1 Nature of Medical Staff Membership

Membership on the Medical Staff and/or privileges may be extended to and maintained by only those professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the rules. A Practitioner, including one who has a contract with the Medical Center to provide medical-administrative services, may admit or provide services to patients in the Medical Center only if the Practitioner is a member of the Medical Staff or has been granted temporary privileges in accordance with these Bylaws and the rules. Appointment to the Medical Staff shall confer only such privileges and prerogatives as have been established by the Medical Staff and granted by the Governing Body in accordance with these Bylaws.

Membership and privileges at another medical center do not automatically confer membership and/or similar privileges at this Medical Center.
Neither appointment to the Medical Staff nor the granting of Clinical Privileges shall confer entitlement to unrestricted use of the Medical Center or the resources thereof.

2.2 Qualifications for Membership

A. Membership on the Medical Staff and privileges shall be extended only to Practitioners who are professionally competent and continuously meet the qualifications, standards and requirements set forth in the Medical Staff Bylaws and Rules and Regulations.

B. A Practitioner must demonstrate and provide adequate information to validate compliance with all the basic standards set forth in this Section 2.2 B. in order to have an application for Medical Staff membership accepted for review. The Practitioner must:

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

   (i) Physicians must be licensed to practice medicine by the Medical Board of California or the Board of Osteopathic Examiners of the State of California or hold a valid registration to practice medicine issued by the Medical Board of California pursuant to Business and Professions Code 2113 or 2168.

   (ii) Dentists must be licensed to practice dentistry by the California Board of Dental Examiners.

   (iii) Podiatrists must be licensed to practice podiatry by the California Board of Podiatric Medicine.

   (iv) Clinical psychologists must be licensed to practice clinical psychology by the California Board of Psychology and Division of Allied Health Professions of the Medical Board of California.

2. Provide the following:

   information that validates applicant's current professional license to practice in any state or other professional registration/license;

   (i) DEA registration, if applicable, (DEA Certificate must include schedules 2, 2N, 3, 3N, 4 and 5); and issued with a State of California local address;
(ii) proof of professional liability insurance professional liability insurance with minimum limits of $1 million per occurrence and $3 million annual aggregate coverage, to include and explanation of endorsements and any limitations.

For each of the above requirements, indicate whether it is or has ever been or is currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, investigated or voluntarily or involuntarily terminated. Applicants shall also disclose whether the applicant has been charged with any felony or convicted of any crime and shall provide a full explanation if any of the above is answered affirmatively.

3. Except as otherwise provided in these Bylaws, be certified by or currently qualified:

(i) to take the board certification examination of a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Podiatric Medicine, the American Board of General Dentistry, the American Board of Pediatric Dentistry, or a board or association with equivalent requirements approved by the Medical Board of California or by the MSEC in the specialty that the Practitioner will practice at the Medical Center, or

(ii) have completed a residency approved by the Accreditation Council for Graduate Medical Education that provided complete training in the specialty or subspecialty that the Practitioner will practice at the Medical Center and be authorized to practice medicine by a valid unrestricted California medical license or certificate of registration or special faculty permit as defined by California Business and Professions Code sections 2113 or 2168. An appropriate time lapse will be permitted for recent graduates to obtain their board certification after completion of their residency programs. This section shall not apply to dentists or clinical psychologists.

4. Maintain liability insurance or equivalent coverage in amounts that meet the requirements of the University of California at a minimum of $1 million per occurrence / $3 million annual aggregate.
5. Conduct his or her office practice sufficiently close to the Medical Center to provide timely care to patients. This requirement does not apply to applicants desiring Consulting Staff or Telemedicine privileges only, if applicable.

6. Adhere to the ethics of their respective professions.

7. Work cooperatively and harmoniously with others so as to not adversely affect patient care or disrupt the operation of the Medical Center or to create a hostile work environment as outlined in MCP 216.6 Code of Conduct – Disruptive Physicians and Staff.

8. Keep confidential, as required by law, all medical information or medical records.

9. Participate in and properly discharge all responsibilities of the Medical Staff.

10. Have the background, experience and training sufficient to assure, in the judgment of the appointing authorities, that any patient admitted to or treated at the Medical Center shall be treated with professional care and skill.

11. Be a member, employee or subcontractor of the group or person that holds the contract, if requesting privileges only in departments operated under an exclusive contract.

12. Agree to provide, as a condition of appointment or reappointment to the Medical Staff, with or without request, information to the Credentials Committee regarding federal or state criminal convictions. Notification must occur within 15 days. Failure to provide such notification is cause for denial or termination of Medical Staff appointment or reappointment.

C. Additional Qualifications for Membership – In addition to meeting the basic standards, the Practitioner must:

1. document his or her adequate experience, education, and training in the requested privileges; current professional competence; good judgment; and adequate physical and mental health status (subject to any necessary reasonable accommodation); and
demonstrate to the satisfaction of the Medical Staff that he or she is professionally and ethically competent to provide patient care at the generally accepted professional medical standards of the Medical Center; adhere to the generally accepted ethical standards of his or her profession; work cooperatively with others in the Medical Center setting so as not to adversely affect patient care or Medical Center operations; and participate in and properly discharge Medical Staff responsibilities.

D. A Practitioner who does not meet the basic standards described in Sections 2.2 B. and C. above and 2.2 E. below shall be ineligible to apply for medical staff membership, and, except for applicants to the Emeritus medical staff, the application shall not be accepted for review. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific standards that adversely affected such Practitioner. Those comments and requests shall be reviewed by the MSEC and the Governing Body, which shall have sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed by Section 2.2 E., Waiver of Qualifications.

E. Waiver of Qualifications

To the extent consistent with applicable law, the Governing Body has the discretion to deem a Practitioner to have satisfied a qualification as described in Section 2.2 B. and C., if after consulting with the MSEC, it determines that if the Practitioner has demonstrated he or she has substantially comparable qualifications and that this waiver is necessary to serve the best interests of the patients and of the Medical Center. There is no obligation to grant any such waiver, and Practitioners have no right to have a waiver considered and/or granted. A Practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws.

2.3 Other Affiliations

No Practitioner shall be entitled to Medical Staff membership merely because he or she holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or
because he or she had, or presently has, staff membership or privileges at another health care facility.

Appointment to the faculty of the School of Medicine, University of California, San Diego, shall not automatically result in conferral of Medical Staff membership, nor shall appointment to the Medical Staff automatically result in a faculty appointment. Absence of a faculty appointment shall not disqualify a person from Medical Staff membership.

2.4 Nondiscrimination

Membership shall be determined by uniformly applied professional criteria. Medical Staff membership or particular privileges shall not be denied on the basis of age, sex, religion, race, creed, color, national origin, or any physical or mental impairment if, after any necessary reasonable accommodation, the applicant complies with the Bylaws or rules of the Medical Staff or the Medical Center.

2.5 Administrative and Contract Practitioners

A. Contractors with No Clinical Duties

A Practitioner employed by or contracting with the Medical Center in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the Medical Center and to the terms of his or her contract or other conditions of employment.

B. Contractors Who Have Clinical Duties

A Practitioner with whom the Medical Center contracts to provide services that involve clinical duties or privileges must be a member of the Medical Staff, achieving his or her status by the procedures described in these Bylaws. Unless a contract or agreement executed after this provision is adopted provides otherwise, or unless otherwise required by law, those privileges made exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty policy will automatically terminate, without the right of access to the review, hearing, and appeal procedures of Article 12, Hearings and Appellate Reviews, of these Bylaws, upon termination or expiration of such Practitioner’s contract or agreement with the Medical Center. In the event there is a conflict between the Medical Staff Bylaws and a System contract with a practitioner, the contract shall prevail.

C. Subcontractors

Practitioners who subcontract with Practitioners or entities who contract with the Medical Center may lose any privileges granted pursuant to an
exclusive or semi-exclusive arrangement if their relationship with the contracting Practitioner or entity is terminated, or the Medical Center and the contracting Practitioner’s or entity’s agreement or exclusive relationship is terminated. The Medical Center may enforce such an automatic termination even if the subcontractor’s agreement fails to recognize this right.

2.6 Basic Responsibilities of Medical Staff Membership

Except for Emeritus members (see Article 3, Categories of the Medical Staff), each Medical Staff member and each Practitioner exercising temporary privileges shall continuously meet all of the following responsibilities:

A. Provide his or her patients with care of the generally recognized professional level of quality and efficiency.

B. Treat patients in accordance with the practitioner's delineated clinical privileges as further described in Article V.

C. Supervise the provision of care by the Medical Center staff.

D. Abide by the Medical Staff Bylaws and Rules and all other lawful standards, policies and rules of the Medical Staff and the Medical Center and with the policies of the University of California.

E. Comply with all applicable laws and regulations of governmental agencies and comply with applicable standards of The Joint Commission (TJC).

F. Discharge such Medical Staff, department, section, committee and service functions for which he or she is responsible by appointment, election or otherwise.

G. Prepare and complete in a timely manner the medical and other required records for all patients to whom the Practitioner in any way provides services.

H. Abide by the ethical principles of his or her profession and as outlined in MCP 216.6 Code of Conduct – Disruptive Physicians and Staff.

I. Refrain from unlawful fee splitting or unlawful inducements relating to patient referral.

J. Refrain from any unlawful discrimination or discrimination against any person (including any patient, Medical Center employee, Medical Center independent contractor, Medical Staff member, housestaff, volunteer or
visitor) based upon the person's age, sex, religion, race, creed, color, national origin, health status, ability to pay or source of payment.

K. Refrain from any harassment, including sexual harassment, against any patient, University employee, Medical Center independent contractor, Medical Staff member, housestaff member, University volunteer or Medical Center visitor. "Harassment" is any unwelcome conduct that has the purpose or effect of creating a hostile or intimidating environment that is sufficiently severe or pervasive to alter the working conditions of a reasonable person. "Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

L. Refrain from delegating the responsibility for diagnosis or care of Medical Center patients to a Practitioner or AHP who is not qualified to undertake this responsibility or who is not adequately supervised.

M. Seek consultation whenever warranted by the patient’s condition or when required by the Bylaws, rules and regulations or by Medical Center policies and procedures.

N. Actively participate in and cooperate as requested with the Medical Staff in assisting the Medical Center to fulfill its obligations related to patient care, including, but not limited to, continuous quality improvement, peer review, utilization management, quality evaluation, and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time.

O. Upon request, provide information from his or her office records or from outside sources as necessary to facilitate the care of or review of the care of specific patients.

P. Communicate with appropriate department officers and/or Medical Staff Administrators when he or she obtains credible information indicating that a fellow Medical Staff member may have engaged in unprofessional or unethical conduct or may have a health condition that poses a significant risk to the well-being or care of patients and then cooperate as reasonably necessary toward the appropriate resolution of any such matter.
Q. Accept responsibility for participating in Medical Staff proctoring in accordance with the Bylaws, rules and regulations or Medical Center policies and procedures.

R. Complete continuing medical education (CME) that meets all licensing requirements and is appropriate to the Practitioner’s specialty.

S. Work cooperatively with members, nurses, Medical Center administrative staff and others so as not to adversely affect patient care or Medical Center operations.

T. Participate in emergency service coverage and consultation panels as allowed and as required by the rules.

U. Cooperate with the Medical Staff in assisting the Medical Center to meet its uncompensated or partially compensated patient care obligations.

V. Continuously meet the qualifications for and perform the responsibilities of membership as set forth in these Bylaws. A member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws upon the reasonable request of the MSEC.

W. Cooperate with the Medical Staff in its efforts to comply with accreditation, reimbursement, and legal requirements.

X. Supply requested information and appear for interviews with regard to his/her membership or Privileges.

Y. Provide complete and accurate information on applications for Medical Staff appointment and reappointment and Clinical Privileges and immediately notify the Medical Staff Administration of all changes in such information.

Z. Discharge Staff, Departmental, committee and Medical Staff functions for which he/she is responsible.

AA. Authorize the Medical Staff to consult with members of the Medical Staff of other medical centers with which the applicant or Medical Staff Member trained, has been associated with, or with others who may have information bearing on his/her health status, training, experience, competence, skill, character, ethical and other qualifications.

BB. Consent to the Medical Staff’s inspection of all records and documents that may be material to an evaluation of his/her professional qualifications for the Clinical Privileges he/she requests and/or is
granted as well as of his/her moral and ethical qualifications for Staff membership.

CC. Release from liability, to the full extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant or Medical Staff Member and his/her credentials. Release from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant or Medical Staff Member, including otherwise confidential information;

DD. Inform the Chief of Staff of the Medical Staff and Medical Staff Administration in writing promptly but no later than 14 calendar days following any malpractice claims, any criminal investigations, pleas of nolo contendere, or convictions, and any limitations or sanctions imposed or proposed by any other healthcare entity, licensing or drug control authorities, or the Medicare or Medicaid programs and of any voluntary or involuntary relinquishment of any license, registration, privileges or Medical Staff membership, or any report filed with the National Practitioner Data Bank, or any other action that could affect his/her Medical Staff standing and/or clinical privileges at the Medical Center.

EE. Conduct clinical research in accordance with all applicable laws and University policies regarding human subjects' research. Prior to conducting any clinical studies involving any patient at the Medical Center, the member must have: (a) received approval from the UCSD IRB to conduct and/or participate in the study; and (b) been granted those privileges necessary to conduct the procedures involved in the study.

FF. Provide continuous care to his or her patients, which shall include but not be limited to identifying acceptable and appropriate coverage for his/her patients when he/she is unavailable.

GG. Coordinate an individual patient's care, treatment and services with other Practitioners and Medical Center personnel, including, but not limited to, seeking consultation whenever warranted by the patient's condition or when required by the rules or policies and procedures of the Medical Staff or applicable department.

HH. Adhere to the Medical Staff Standards of Conduct (as further described at Section 2.2), so as not to adversely affect patient care or Medical Center operations.
II. Participate in patient and family education activities, as determined by the department or Medical Staff Rules, or the MSEC.

JJ. Discharge such other Medical Staff responsibilities as may be lawfully established from time to time by the Medical Staff or MSEC.

2.7 Standards of Conduct

Members of the Medical Staff are expected to adhere to the Medical Staff Standards of conduct, including but not limited to the following:

A. General:

1. It is the policy of the Medical Staff to require that its members fulfill their Medical Staff obligations in a manner that is within generally accepted bounds of professional interaction and behavior. The Medical Staff is committed to supporting a culture and environment that values integrity, honesty and fair dealing with each other, and to promoting a caring environment for patients, Practitioners, employees and visitors.

2. Rude, combative, obstreperous behavior, as well as willful refusal to communicate or to comply with reasonable rules of the Medical Staff and the Medical Center may be found to be disruptive behavior. It is specifically recognized that patient care and Medical Center operations can be adversely affected whenever any of the foregoing occurs with respect to interactions at any level of the Medical Center, in that all personnel play an important part in the ultimate mission of delivering quality patient care.

3. In assessing whether particular circumstances in fact are affecting quality patient care or Medical Center operations, the assessment need not be limited to care of specific patients, or to direct impact on patient health. Rather, it is understood that quality patient care embraces—in addition to medical outcome—matters such as timeliness of services, appropriateness of services, timely and thorough communications with patients, their families, and their insurers (or third party payors) as necessary to effect payment for care, and general patient satisfaction with the services rendered and the individuals involved in rendering those services.
B. Conduct Guidelines

1. Upon receiving Medical Staff membership and/or privileges at the Medical Center, the member shall comply with the common goals of all members of the organization to endeavor to maintain the quality of patient care and appropriate professional conduct.

2. Members of the Medical Staff are expected to behave in a professional manner at all times and with all people—patients, professional peers, Medical Center staff, visitors, and others in and affiliated with the Medical Center.

3. Interactions with all persons shall be conducted with courtesy, respect, civility and dignity. Members of the Medical Staff shall be cooperative and respectful in their dealings with other persons in and affiliated with the Medical Center.

4. Complaints and disagreements shall be aired constructively, in a nondemeaning manner, and through official channels.

5. Cooperation and adherence to the reasonable rules of the Medical Center and the Medical Staff is required.

6. Members of the Medical Staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral or behavioral.

C. Adoption of Rules – The MSEC may promulgate rules or policies further illustrating and implementing the purposes of this Section, including but not limited to, procedures for investigating and addressing incidents of perceived misconduct, and progressive remedial measures, including, when necessary, disciplinary action.

2.8 Residents and Fellows

For physicians who are in training programs and are either licensed by or registered with the appropriate State of California licensing or examining board or agency, practice in the Medical Center shall at all times be under the direction of appropriately credentialed members of the Medical Staff (e.g., clinical non-teaching Medical Staff members cannot supervise or teach residents), provided such practice is in accordance with the regulations of the appropriate State of California licensing or examining board and in accordance with these Bylaws and the policies established by the University of California, San Diego Medical Center.
ARTICLE 3
CATEGORIES OF THE MEDICAL STAFF

3.1 Categories

Each Medical Staff member shall be assigned to a Medical Staff category based upon the qualifications defined in the Rules and Regulations. The members of each Medical Staff category shall have the prerogatives and shall carry out the duties defined in the Bylaws and rules. Action may be initiated to change the Medical Staff category or to terminate the membership of any member who fails to meet the qualifications or fulfill the duties described in the rules. Changes in Medical Staff category shall not be grounds for a hearing unless they adversely affect the member's clinical privileges.

Categories are:

Affiliate
Attending
Consulting
Consulting
Emeritus
Provisional Attending
Telemedicine
Time Limited Medical Staff

3.2 Affiliate Staff

The Affiliate Staff shall consist of practitioners who do not require clinical admitting or inpatient consulting privileges, but otherwise choose to affiliate with UCSD Medical Center and meet the general provisions for medical staff membership in accordance with the Bylaws or qualifications for advanced practice professionals as delineated in the Rules and Regulations.

Other rights and responsibilities:

A. Affiliate staff, who have faculty appointments in the UCSD School of Medicine, may:

1. Serve as teachers in the educational programs of the Medical Center as applicable;

2. Provide appropriate supervision of House Staff when assigned by the Graduate Medical Education Program Director at facilities other than UCSD Medical Center.
B. Affiliate staff are not eligible to admit or exercise clinical privileges;

C. Affiliate staff are not eligible to vote on matters of the Medical Staff or the department of which the individual is a member;

D. Affiliate staff may serve on Medical Staff committees when requested; however, may not serve as Committee Chair;

E. Affiliate staff are not eligible to serve as officers of the Medical Staff;

F. Affiliate staff status does not authorize the affiliate staff member to provide clinical care at any UC San Diego facility.

Affiliate staff that requires admitting or clinical privileges shall apply for a change in staff status and complete a delineation of privilege form. This application will then be evaluated by the Credentials Committee for modification of status and privileges.

3.3 **Attending Medical Staff**

Shall consist of practitioners:

A. Who meet the general eligibility requirements for Medical Staff membership;

B. Who satisfy the minimum clinical activity criteria established by their department(s).

Other Rights and Responsibilities

Members of the Attending Medical Staff:

A. Are eligible to vote on matters affecting the Medical Staff;

B. Shall serve on Medical Staff committees when requested;

C. Shall attend Medical Staff meetings in accordance with the provisions of Article X;

D. Who have faculty appointments in the UCSD School of Medicine shall:
   
   1. Serve as teachers in the educational programs of the Medical Center as applicable;
   
   2. Provide appropriate supervision of House Staff when assigned by the Graduate Medical Education Program Director;
E. Are eligible to serve as officers of the Medical Staff, in accordance with Article VII.

Rights and responsibilities in paragraphs A), B) and C) are not applicable to members of the Attending Medical Staff who hold only telemedicine privileges.

Members of the Attending Medical Staff may be transferred to the Courtesy Attending Staff category upon failure to meet departmental criteria for continuance on the Attending Staff.

3.4 Consulting Medical Staff

Shall consist of practitioners:

Members of the Consulting Medical Staff:

A. Who possess ability and knowledge that enable them to provide valuable assistance in difficult cases.

B. Are members in good standing of another Joint Commission accredited facility, although exceptions to this requirement may be made by the Credentials Committee for good cause.

Other Rights and Responsibilities

A. Are able to consult and refer patients;

B. May not admit;

C. May exercise those clinical privileges that have been approved;

D. Are not eligible to vote on matters of the Medical Staff or the department of which the individual is a member;

E. May serve on Medical Staff committees; however may not serve as Committee Chair;

F. Are not eligible to serve as officers of the Medical Staff;

G. Shall complete medical records in a timely manner as indicated by the Rules and Regulations.

3.5 Courtesy Attending Medical Staff

Shall consist of practitioners:
A. Who meet the general qualifications for Attending Staff (Article III) and who reasonably anticipate that they will admit or care for at least one (1) patient per year at UCSD Medical Center, but who do not anticipate that they will admit or regularly care for the minimum number of patients specified by their department/division in order to maintain Attending Medical Staff status or are not regularly involved in the medical staff functions as determined by the Medical Staff;

B. Are members in good standing of the active or advanced practice professional staff of another Joint Commission accredited facility, although exceptions to this requirement may be made by the Credentials Committee for good cause.

Other rights and responsibilities

Members of the Courtesy Attending Medical Staff:

A. Are not eligible to vote on matters of the Medical Staff or the department of which the individual is a member except within committees when the right to vote is specified at the time of appointment;

B. May serve on Medical Staff committees;

C. Are encouraged, but not required to attend Medical Staff meetings;

D. Who have faculty appointments in the UCSD School of Medicine shall:
   1. Serve as teachers in the educational programs of the Medical Center as applicable;
   2. Provide appropriate supervision of House Staff when assigned by the Graduate Medical Education Director;

E. Are not eligible to serve as officers of the Medical Staff.

Rights and responsibilities in paragraphs B) C), and E) are not applicable to members of the Courtesy Medical Staff that hold only telemedicine privileges.

Members of the Courtesy Medical Staff who regularly admit or care for patients at the Medical Center shall be obligated to seek appointment to the Attending Medical Staff category.

3.6 Emeritus Medical Staff
Shall consist of practitioners:

A. Who are clinically inactive, (retired with no regular office or office hours for seeing patients);

B. Who are recommended for appointment to the Emeritus Staff by their department chair on the basis of a record of distinguished service to UCSD Medical Center and are processed through the Credentials Committee in accordance with Article IV of the Bylaws of the Medical Staff;

C. Who are physicians, dentists, podiatrists, and clinical psychologists who may or may not be duly licensed or registered;

D. Who hold faculty appointments in the UCSD School of Medicine;

E. Who have signed a statement that they have received, read, and agree to abide by these Bylaws, Rules and Regulations.

Other Rights and Responsibilities

A. Are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital/clinics;

B. Are not eligible to vote on matters affecting the Medical Staff;

C. Are not eligible to be officers of the Medical Staff;

D. May serve on medical staff committees on the basis of current expertise of unique value to the particular committee(s) without vote, except that s/he may vote on the Medical Ethics Committee and the Physician Well Being Committee;

E. Who may participate in didactic teaching activities of medical students and House Staff;

F. May attend staff and departmental meetings, including open committee meetings and educational programs;

G. Who, if holding an Emeritus faculty appointment, are not assessed a process (Medical Staff Dues) fee.

3.7 Provisional Medical Staff

Shall consist of practitioners:
A. Who are newly appointed to the Medical Staff and plan to qualify for, and seek transfer to, the Attending, Courtesy Attending or Consulting Staff in twelve (12) months, but not more than 24 months;

B. Who are assigned to specific departments and shall be under such monitoring procedures as determined by each department.

Other Rights and Responsibilities

Members of the Provisional Medical Staff:

A. Are not eligible to vote on matters affecting the Medical Staff;

B. May serve on Medical Staff committees when requested;

C. Shall attend Medical Staff meetings in accordance with the provisions of Article XIV;

D. Who have faculty appointments in the UCSD School of Medicine shall:

   1. Serve as teachers in the educational programs of the Medical Center as applicable;

   2. Provide appropriate supervision of House Staff when assigned by the Graduate Medical Education Program Director;

E. Are not eligible to serve as officers of the Medical Staff, in accordance with Article XI.

Rights and responsibilities in paragraphs 1), 2) and 3) are not applicable to members of the Provisional Medical Staff who hold only telemedicine privileges.

3.8 Telemedicine Staff

Shall consist of practitioners who:

A. Provide patient care, treatment, or services to UCSD patients solely via electronic communication link;

B. Meet all the requirements for Medical Staff membership as specified under Eligibility;

C. Are expected to maintain the same Ethical and Professional Responsibilities as other members of the Medical Staff;
D. Diagnose or treat patients via telemedicine link are subject to the same credentialing and privileging processes defined in Articles IV and V;

E. Provide interpretive or consulting services via telemedicine link,

F. May substitute credentialing and privileging information from the distant site provided the distant site is a Joint Commission accredited organization and the telemedicine practitioner holds the appropriate privileges at the distant site;

G. Are subject to credentialing and privileging processes defined in Articles IV and V if the distant site is non-Joint Commission accredited;

H. Are exempt from meeting appointment and reappointment requirements to comply with the Tuberculosis Screening Program;

I. Comply with agreed upon contractual arrangement;

J. Provide telemedicine services as recommended by the medical staff.

Other rights and responsibilities

A. Are not eligible to vote on matters of the Medical Staff or the department of which the individual is a member;

B. Who shall have faculty appointments in the UCSD School of Medicine shall:

1. Serve as teachers in the educational programs of the Medical Center as applicable;

2. Provide appropriate supervision of House Staff when assigned by the Graduate Medical Education Director;

C. Are not eligible to serve as officers of the Medical Staff;

Limitation of Rights

The rights set forth above are general in nature and may be subject to limitation by special conditions attached to the practitioner’s staff membership, by other provisions of these Bylaws, Rules and Regulations or by other policies of the Medical Center.

3.9 Time Limited Medical Staff

Shall consist of practitioners:
A. Whose qualifications have been determined by the residency director and the appropriate department chair, the Credentials Committee, the MSEC and the Governing Body, to meet the requisite standards of experience, training, competence, health and ethics;

B. Who are duly licensed;

C. Who may or may not have completed the training requirements of their current ACGME accredited program, or a program that is non-accredited for which there is an American Board of Medical Specialties (ABMS), Certificate of Added Qualifications (CAQ) or a Certificate of Special Qualifications (CSA) available;

D. Who may be board-certified or eligible in a specialty related to their privilege request;

E. Who are contract employees of the UCSD Medical Center;

F. Who have signed a statement that they have received, read, and agree to abide by these Bylaws, Rules and Regulations;

G. Who have received attestations of qualifications by the program training director and department chairman by signing on the MSP contract.

Other Rights and Responsibilities

Members of the Time Limited Medical Staff:

A. Are not eligible to serve on Medical Staff Committees;

B. Are not eligible to serve as officers of the Medical Staff;

C. Are not eligible to vote on matters of the Medical Staff or the department of which the individual is a member;

D. Are not authorized to admit patients;

E. Are authorized to treat patients in accordance with the practitioner’s delineated clinical privileges and Article V;

F. Shall actively participate in performance improvement activities of the medical staff;

G. Shall complete medical records in a timely manner as indicated by the Medical Staff Bylaws, Rules and Regulations;
H. Shall only be entitled to any of the rights of access to review, hearing and appeal procedures of these Bylaws if the practitioner’s medical staff membership or privileges are terminated or revoked for a medical disciplinary reason. The Time Limited Medical Staff practitioner’s medical staff membership and privileges will automatically terminate upon the termination or expiration of practitioner’s contract or agreement with the Medical Center and the practitioner shall not be entitled to any of the rights of the review, hearing and appeal procedures of these Bylaws.

I. Appointment procedures for Time Limited Medical Staff will be the same as the procedures for the Medical Staff in accordance with Article IV of the Bylaws.

**Practitioners Other Than Members of the Medical Staff**

3.10 Advanced Practice Professional Staff
The Advanced Practice Professional Staff is designated as dependent practitioners and are under direct supervision of a licensed physician. Shall consist of duly licensed, certified or registered nurse anesthetists, nurse midwives, nurse practitioners, physician assistants, clinical psychologists, and other health professionals as determined by the Medical Staff Executive Committee on the recommendation of the Interdisciplinary Practices Committee:

A. With or without appointment to the faculty of the School of Medicine, according to policy established by the Medical Staff Executive Committee, on the recommendation of the Interdisciplinary Practices Committee;

B. Whose applications and qualifications for appointment and reappointment to the Advanced Practice Professional Staff have been determined by the appropriate department chair or chief of service and the Interdisciplinary Practices Committee to meet specific standards for experience, training, competence, ethics, and teaching ability (as appropriate);

C. Who have signed a statement that they have received, read, and agrees to abide by these Bylaws, Rules and Regulations.

D. Who will be subject to the Appointment and Reappointment processes as outlined for Medical Staff members

**Rights and Responsibilities**

Members of the Advanced Practice Professional Staff:

A. May serve on medical staff committees;
B. Shall serve as teachers in the educational programs of the Medical Center and the School of Medicine, as appropriate;

C. Shall provide the proper quality of professional care in the Medical Center;

D. May conduct history and physicals for those procedures they are trained and privileged to perform. Advanced Practice Professional Staff history and physicals must be authenticated by a supervising physician;

E. May obtain informed consent for those procedures they are trained and privileged to perform; and

F. Shall abide by the UCSD Medical Center Policies and Procedures.

Standardized Protocols/Delineation of Clinical Privileges:

- Shall be determined for each individual by the appropriate department chair or chief of service and the Interdisciplinary Practices Committee following consideration of the individual’s training, experience, and competency;
- Shall be approved by the Governing Body or designee, on the recommendation of the department chair or service chief, following review and approval by the Interdisciplinary Practices Committee and the Medical Staff Executive Committee.

Designation of privileges and/or standardized protocols shall include, as applicable:

- Supervision under direction of a licensed physician who is a member of the attending medical staff
- Clinical duties and responsibilities
- Guidelines for mandatory referral/consultation
- Standing orders
- Furnishing/transmittal of medication orders

Advanced Practice Professional privileges are described in Appendix 6.

3.11 House Staff

A. The responsibilities of the Medical Staff to the house staff are identified in the UCSD House Officer Policy and Procedure Document and in the UCSD Graduate Medical Education Supervision Policy Appendix II of these Bylaws, Rules and Regulations. The Medical Staff shall supervise and document the care of all patients. The components of supervision by attending faculty specify that:

1. Educational objectives are defined
2. The supervisor assesses the skill level of the house staff by direct observation

3. The supervisor authorizes independent action by the house staff

4. The supervisor defines the course of progressive independence from performing functions together with decreasing frequency of review. This process starts with close supervision, progressing towards independence as skills are observed.

5. Written evaluation and feedback are considered in the progression levels. At all times, and at any level, the house staff has access to advice and direction from the supervisor.

B. House staff physicians are authorized to interact with the nursing service and all other Medical Center departments in the capacity of medical staff practitioners under the supervision of the medical staff.

C. House staff physicians are not members of the Medical Staff. The responsibilities of the house staff are identified in the UCSD Resident/Fellow Position Description document, Appendix III of these Bylaws, Rules and Regulations.

D. When a member of the house staff is delinquent in completing medical records in a timely manner, the CEO, UCSD Medical Center, may automatically suspend the house officer as per policy approved by the Medical Staff Executive Committee. The house officer may appeal the suspension within five business days of receiving notice to the Medical Staff Executive Committee through the Director, Health Information Services or designee.

The Director, Health Information Services or designee, may rescind the suspension if warranted. If not, the appeal will be directed to the Chair, Medical Staff Executive Committee, who will appoint a panel to include: the Medical Director or a designee, the appellant's department chairperson (or designee), the President of the House Staff Association and the Director, Health Information Services or designee.

The panel will review the facts of the suspension and conduct interviews as necessary. Within five business days of receipt of the appeal, the panel will notify the appellant in writing of the final decision, which cannot be further appealed.

3.12 Medical Students
The responsibilities of the Medical Staff and of the house staff to the medical students and the responsibilities of the medical students while engaged in clinical clerkship programs at UCSD Medical Center, are defined in the Medical Staff approved Policies of the Clinical Clerkship Programs at UCSD Medical Center.

ARTICLE 4
PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

4.1 General

The Medical Staff shall consider each application for appointment, reappointment and privileges, and each request for modification of Medical Staff category using the procedure and the criteria and standards for membership and clinical privileges set forth in the Bylaws and the rules. The Medical Staff shall perform this function also for practitioners who seek temporary privileges. The Medical Staff shall investigate each applicant before recommending action to the Governing Body. For matters of medical staff privileges, the Regents of the University of California have delegated authority to the Vice Chancellor of Health Sciences, who has further delegated this responsibility to the Health System Executive Governing Body (the “Governing Body”). The Governing Body shall ultimately be responsible for granting membership and privileges; provided, however, that these functions may be delegated to the Chief of Staff, CEO or Chief Medical Officer with respect for temporary privileges. By applying to the Medical Staff for appointment or reappointment (or by accepting Emeritus Medical Staff appointment), the applicant agrees that regardless of whether he or she is appointed or granted the requested privileges, he or she will comply with the responsibilities of Medical Staff membership and with the Medical Staff Bylaws, rules and policies as they exist and as they may be modified from time to time.

4.2 Applicant’s Burden

A. An applicant for appointment, reappointment, advancement, transfer, and/or privileges shall have the burden of producing accurate and adequate information for a thorough evaluation of the applicant’s qualifications and suitability for the requested status or privileges, resolving any reasonable doubts about these matters and satisfying requests for information. The provision of information containing significant misrepresentations or omissions and/or a failure to sustain the burden of producing information shall be grounds for denying an application or request. This burden may include submission to a physical or mental health examination as determined by the Credentials Committee or MSEC. The MSEC will designate the examining physician who will either be a member of the Medical Staff or, if the applicant so
desires, a physician chosen by the applicant from a panel of three outside physicians designated by the Credentials Committee or MSEC.

B. Any committee or individual charged under these Bylaws with the responsibility for reviewing the appointment or reappointment application and/or request for clinical privileges may request further documentation or clarification. If the practitioner or member fails to respond within one month, the application or request shall be deemed to be incomplete and shall be withdrawn. The processing of the application or request will then be discontinued. Unless the circumstances are such that a report to the Medical Board of California is required, such a withdrawal shall not give rise to hearing and appeal rights pursuant to Article 12, Hearings and Appellate Reviews.

4.3 Application for Initial Appointment and Reappointment

A. Application Form

A practitioner applying for appointment or reappointment shall complete an application form that requests information regarding the applicant and documents the applicant’s agreement to abide by the Medical Staff Bylaws and Rules (including the standards and procedures for evaluating applicants contained therein) and releases all persons and entities from any liability that might arise from their review and/or acting on the application. The information shall be verified and evaluated by the Medical Staff using the procedure and standards set forth in the Bylaws, rules and credentialing policies and procedures. Following its review, the Credentials Committee shall recommend to the MSEC and the Governing Body whether to appoint, reappoint or grant specific privileges. Privileges are granted for a period not to exceed two years.

B. Basis for Appointment

1. Recommendations for appointment to the Medical Staff and for granting privileges shall be based upon the practitioner’s training, experience, and professional performance at this Medical Center, if applicable, and in other settings, whether the practitioner meets the qualifications and can carry out all of the responsibilities specified in these Bylaws and the rules, and upon the Medical Center’s patient care needs and ability to provide adequate support services and facilities for the practitioner. Recommendations from peers in the same professional discipline as the practitioner, and who have personal knowledge of the applicant’s professional skills, are to
be included in the evaluation of the practitioner's qualifications.

The Medical Center shall verify that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing either a current picture hospital ID card or a valid picture ID issued by a state or federal agency (i.e. driver’s license or passport). The Medical Center shall verify in writing from the primary source whenever feasible the following information:

- The applicant’s current licensure at the time of initial granting, renewal and revision of privileges and at the time of license expiration.
- The applicant’s relevant training; and
- The applicant’s current competence.

2. An applicant who does not meet the basic qualifications as outlined in these Bylaws and related policies and procedures is ineligible to apply for membership, and the application shall not be accepted for review. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in the Fair Hearing Plan.

C. Basis for Reappointment

Recommendation for reappointment to the Medical Staff and for renewal of privileges shall be based upon a reappraisal of the member’s performance at this Medical Center and in other settings. The reappraisal shall include confirmation of adherence to Medical Staff membership requirements as stated in these Bylaws, the Medical Staff rules, the Medical Staff and Medical Center policies, and the applicable department rules. Such reappraisal should also include relevant member-specific information from performance improvement activities and, where appropriate, comparisons to aggregate information about performance, judgment and clinical or technical skills. The results of peer review activities shall also be considered. In the case of reappointment of a member of the Telemedicine Staff, reappointment may be based upon information provided by the medical center(s) where the practitioner routinely practices.
D. Failure to File Reappointment Application

Failure without good cause to file a completed application for reappointment within the time specified pursuant to Medical Staff Policy and Procedures, the practitioner shall be deemed to have resigned membership on the Medical Staff. In the event membership terminates for the reasons set forth herein, the practitioner shall not be entitled to any hearing or review.

4.4 Approval Process for Initial Appointments

A. Recommendations and Approvals

The Department Chair or the written designee in the absence of the Department Chair shall review applications, engage in further consideration if appropriate, as further described in the Bylaws, Rules, policies and procedures and make a recommendation to the Credentials Committee regarding staff appointments and clinical privileges. The Credentials Committee shall then review the application and make a recommendation to the MSEC. The MSEC shall make a recommendation to the Governing Body that is either favorable, adverse or defers the recommendation.

B. The Governing Body’s Action

The Governing Body shall review the recommendation from the MSEC and take action by adopting, rejecting, modifying or sending the recommendation back for further consideration. After notice, the Governing Body may also take action on its own initiative if the MSEC does not give the Governing Body a recommendation in the required time. The Governing Body may also receive and take action on a recommendation following procedural rights allowed at Article 12, Hearings and Appellate Reviews.

C. Final Action

If the parties are unable to resolve a dispute between the MSEC and the Credentials Committee, the Governing Body shall make a final determination giving great weight to the actions and recommendations of the MSEC. Further, the Governing Body determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the Medical Center.
D. Notice of Final Decision

The CEO shall give notice to the applicant, and, if the decision differs from the recommendation of the MSEC, notice shall also be given to the MSEC.

4.5 Approval Process for Reappointments

The Department Chair or the written designee in the absence of the Department Chair shall review applications for reappointment, engage in further consideration if appropriate, as further described in the Rules, and make a recommendation to the Credentials Committee regarding medical staff reappointment applications. The Credentials Committee shall then review the application and make a recommendation to the MSEC. The MSEC shall review the Credentials Committee’s recommendations and all other relevant information available to it and shall forward their recommendation to the Governing Body. The Governing Body acting on behalf of the Regents of University of California has the authority to grant or deny reappointments.

4.6 Leave of Absence (General)

Members must request a leave of absence for any anticipated leave that exceeds six (6) months. Any such request for a leave must be approved by the MSEC and cannot exceed the Member’s current time for reappointment. The member must provide relevant information regarding his or her activities during the leave of absence. During the period of the leave, the member shall not exercise privileges at the Medical Center, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue unless waived by the MSEC.

At least 30 days prior to the end of the leave, or at any earlier time, the member may request reinstatement of his or her privileges and prerogatives by submitting a request along with the necessary documentation to the Service Chief who shall promptly forward the request to the Credentials Committee and to the MSEC. The documentation by the member shall include a written summary of his or her relevant clinical activities during the leave. The MSEC, upon receipt of the request from the Credentials Committee, shall recommend to the Governing Body whether to approve the member’s request for reinstatement of privileges and prerogatives. Reinstatement at the end of the leave must be approved in accordance with the standards and procedures set forth in the requirements for reappointment review. Privileges will not be considered officially reinstated until the member receives written notification from the Governing Body.

Members who are on leave at the time they are due to be reappointed to the Medical Staff must submit a reappointment application to the Medical Staff Administration.
4.7 Leave of Absence (Military)

Requests for leave of absence to fulfill military service obligations shall be granted upon notice to the MSEC. Reactivation of membership and clinical privileges previously held shall be granted by MSEC notwithstanding the provisions of Section 4.3 above, but may be granted subject to monitoring and/or proctoring as determined by the MSEC.

4.8 Leave of Absence (Medical)

Members must request a medical leave of absence from their Service Chief, which must then be approved by the MSEC. The request for a medical leave of absence must state the reason for the leave and the specific period of time, which may not exceed two (2) years. During the period of leave, the member shall not exercise privileges at the Medical Center, and membership rights and responsibilities shall be inactive.

Requests for medical leave shall not be granted if the MSEC concludes leave is being sought to avoid reportable restrictions of privileges or any medical cause or disciplinary reason.

At least 30 days prior to the end of the leave, or at any earlier time, the member may request reinstatement of his or her privileges and prerogatives by submitting a request along with the necessary documentation to the Service Chief. The Service Chief shall promptly forward the request to the Credentials Committee and to the MSEC, along with written verification that the member’s health status and ability to carry out delineated clinical privileges have been reviewed and were not adversely affected as a result of the time away from clinical practice at the Medical Center.

4.9 Waiting Period after Adverse Action

A. Who Is Affected

1. A waiting period of 24 months shall apply to the following practitioners:

   a) An applicant who:

      (i) Has received a final adverse decision regarding appointment; or

      (ii) Withdrew his or her application or request for membership or privileges following an adverse recommendation by the MSEC or the Governing Body.

   b) A former member who has:
(i) Received a final adverse decision resulting in termination of Medical Staff membership and/or privileges; or

(ii) Resigned from the Medical Staff or relinquished privileges while an investigation was pending or following the issuance of an adverse recommendation by MSEC or Governing Body.

c) A member who has received a final adverse decision resulting in:

(i) Termination or restriction of his or her privileges; or

(ii) Denial of his or her request for additional privileges.

2. For purposes of this section, an action is considered adverse only if it is based on the type of occurrences that might give rise to corrective action. An action is not considered adverse if it is based upon reasons that do not pertain to medical or ethical conduct, such as a failure to maintain a practice in the area (which can be cured by a move), to pay dues (which can be cured by paying dues), or to maintain professional liability insurance (which can be cured by obtaining the insurance).

B. Date When the Action Becomes Final

The action is considered final on the latest date on which the application or request was withdrawn, a member’s resignation became effective, or upon completion of: (i) all Medical Staff and Medical Center hearings and appellate reviews; and (ii) all judicial proceedings pertinent to the action served within two years after the completion of the Medical Center proceedings.

C. Effect of the Waiting Period

Practitioners subject to waiting periods cannot reapply for Medical Staff membership or the privileges affected by the adverse action for at least 24 months after the action became final. After the waiting period, the practitioner may reapply; however, the practitioner’s past performance shall be taken into consideration. The application will be processed as a new application. The practitioner shall document that the basis for the adverse action no longer exists, that he or she has corrected any problems that prompted the adverse action, and/or that he or she has complied with any specific training or other conditions that were imposed.

4.10 Confidentiality; Impartiality

To maintain confidentiality and to assure the unbiased performance of appointment and reappointment functions, participants in the credentialing process shall limit
their discussion of the matters involved to the formal avenues provided in the Bylaws and rules for processing applications for appointment and reappointment.

4.11 Termination of Appointment and Other Discipline

Medical Staff membership for persons in a medical administrative capacity shall be neither extended nor withdrawn based solely on the administrative appointment, but shall be subject to the same appointment and termination provisions outlined in these Bylaws.

ARTICLE 5
PRIVILEGES

5.1 Exercise of Privileges

Except as otherwise provided in these Bylaws or the rules, every practitioner providing direct clinical services at this Medical Center shall be entitled to exercise only those setting-specific procedures approved for him or her.

5.2 Criteria for Privileges

Subject to the approval of the MSEC and Governing Body, each department will be responsible for developing criteria for granting setting-specific privileges including, but not limited to, identifying and developing criteria for any privileges that may be appropriately performed via telemedicine. These criteria shall assure uniform quality of patient care, treatment, and services.

5.3 Delineation of Privileges in General

A. Requests

A request for privileges or a modification of privileges must be supported by documentation of training and/or experience supportive of the request.

B. Basis for Privilege Determinations

Requests for privileges shall be evaluated on the basis of the applicant’s license, education, training, experience, demonstrated professional competence, judgment and clinical performance, health status, the documented results of patient care and other quality improvement review and monitoring, performance of a sufficient number of procedures each year to develop and maintain the applicant’s skills and knowledge, and compliance with any specific criteria applicable to the privileges. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other
institutions and health care settings where an applicant exercises privileges. When renewing privileges, a review of the practitioner’s performance within the organization shall be completed. Peer recommendations shall be obtained and include written information regarding the practitioner’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism. The hospital shall query the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges and when a new privilege is requested.

Before recommending privileges, the organized medical staff shall also evaluate any challenges to any license or registration; voluntary or involuntary relinquishment of any license or registration, termination of medical staff membership, limitation, reduction or loss of clinical privileges; any evidence of an unusual pattern or excessive number of professional liability actions resulting in a final judgment against the applicant; documentation as to the applicant’s health status; relevant practitioner data as compared to aggregate data when available and morbidity and mortality data when available.

C. Telemedicine Privileges

Practitioners who wish to participate in the delivery of telemedicine services (whether to patients of this Medical Center or to patients of another facility that this Medical Center is assisting via telemedicine technology) must apply for and be granted setting and procedure-specific telemedicine privileges. Additionally, practitioners who are not otherwise members of this Medical Center’s Medical Staff must apply for and be granted privileges as part of the telemedicine staff in order to provide services to patients of this Medical Center.

1. The initial appointment of practitioners to the Telemedicine Staff may be based upon:

   (i) The practitioner’s full compliance with this Medical Center’s credentialing and privileging standards;

   (ii) The Medical Center’s standards but relying on information provided by the Medical Center(s) at which the practitioner routinely practices; or

   (iii) If the setting where the practitioner routinely practices is TJC-accredited and agrees to provide a comprehensive report of the
practitioner’s qualifications, by relying on the credentialing and privileging provided of that other facility.

2. Reappointment of a Telemedicine Staff member's privileges may be based upon performance at this Medical Center, and, if insufficient information is available, upon information from the Medical Center(s) where the practitioner routinely practices.

3. All telemedicine practitioners must be licensed to practice medicine in the State of California or must be registered as a telemedicine provider with the Medical Board of California.

5.4 Special Conditions and Privileges for Dentists, Oral Surgeons, Clinical Psychologists and Podiatrists

A. ADMISSIONS BY CLINICAL PSYCHOLOGISTS

Clinical psychologist members may admit patients only if a physician member assumes responsibility for the care of the patient's medical problems present at the time of admission or for medical problems that may arise during hospitalization that are outside of the limited license practitioner’s lawful scope of practice. Clinical psychologists shall be under the overall supervision of the Chair of Department of Psychiatry or the Department of Family Medicine and Public Health.

B. Special Conditions for Dentists

Dentists who are members of the Medical Staff shall be appointed to the Department of Surgery as outlined in Article 4.4 of these Bylaws. They may also be considered for appointment in any other appropriate service of the Medical Center by the usual appointive mechanism. Their activities in the Medical Center will be under the overall supervision of the Chief, Division of Plastic Surgery.

Dentists who are members of the Medical Staff may admit patients to the Medical Center. A physician shall be responsible for the medical care of the patient throughout his/her hospital stay, including performance of a complete history and physical examination. The dentist will be responsible for that portion of the history and physical examination that is applicable to the dentist's scope of practice.

Oral and maxillofacial surgeon members of the Medical Staff, with appropriate privileges, may perform the history and physical examination and assess the medical risks of the proposed surgical procedures unless the
patient is known to have serious medical problems in which event the patient shall be referred to an appropriate physician.

C. Special Conditions for Podiatrists

Podiatrists who are members of the Medical Staff shall be appointed to the Department of Orthopaedic Surgery or Emergency Medicine as outlined in Article 4.4 of these Bylaws. Their activities will be under the overall supervision of the Orthopaedic Service or Emergency Medicine. A physician shall be responsible for the medical care of the patient, and for the admission and history and physical examination of any inpatient. The podiatrist will be responsible for that portion of the history and physical examination applicable to their scope of practice.

Surgical care to be provided by podiatrists will also be subject to the overall supervision of the Chief Orthopaedic Surgery or Emergency Medicine. A request for surgical clinical privileges by a podiatrist shall be directed to the Chief of the Orthopaedic Surgery or Emergency Medicine who will make recommendations concerning such requests after appropriate consultation.

D. Surgery and High Risk Interventions by Dentists and Podiatrists

Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the chair of the designated department or the chair’s designee. Additionally, the findings, conclusions, and assessment of risk must be confirmed or endorsed by a physician member with appropriate privileges, prior to major high-risk (as defined by the responsible department) diagnostic or therapeutic interventions.

E. Medical Appraisal

All patients admitted for care in the Medical Center by a dentist, oral surgeon, clinical psychologist, or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member with appropriate privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient.

5.5 Temporary Privileges

A. Temporary privileges may be granted after appropriate application to fulfill an important patient care, treatment, and service need or for an applicant for new privileges with a complete application that raises no concerns that is awaiting review and approval by the MSEC and Governing Body:
B. Temporary privileges may be granted after the applicant completes the appropriate application procedure and the Medical Staff Administration completes the application review process. Temporary privileges for applicants for new privileges cannot exceed 120 days. The following conditions apply:

1. There must first be verification of:

   (i) Current licensure
   (ii) Full unrestricted privileges at a TJC accredited hospital
   (iii) Current malpractice insurance;
   (iv) Relevant training or experience;
   (v) Current competence;
   (vi) Ability to perform the privileges requested.

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

3. The applicant has:

   (i) Filed a complete application with the Medical Staff Administration;
   (ii) Demonstrated no current or previously successful challenge to licensure or registration exists;
   (iii) Not been subject to involuntary termination of medical staff membership at another organization; and
   (iv) Not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

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

D. If the available information is inconsistent or casts any reasonable doubts on the applicant’s qualifications, action on the request for
E. Temporary privileges may be granted by the CEO (or his or her designee, including Chief Medical Officer (CMO), or Chief of Staff (COS), or Credentials Committee Chair (CCC) on the recommendation of: (1) the Chief of Staff (COS); or (2) the department chair where the privileges will be exercised, or (3) Chief Medical Officer (CMO), or (4) Credentials Committee Chair (CCC), or their designee).

F. A determination to grant temporary privileges shall not be binding or conclusive with respect to an applicant’s pending request for appointment to the Medical Staff.

G. General Conditions and Termination

1. Practitioners granted temporary privileges shall be subject to the proctoring and supervision specified in the rules.

2. Temporary privileges shall automatically terminate at the end of the designated period, unless affirmatively renewed as provided at Section 5.5, or earlier terminated as provided at Section 4.3.

3. Temporary privileges may be terminated with or without cause at any time by the Chief of Staff, the responsible department chair, the Chief Medical Officer, or the CEO after conferring with the Chief of Staff or the responsible department chair. A person shall be entitled to the procedural rights afforded by Bylaws Article 12, Hearings and Appellate Reviews, only if a request for temporary privileges is refused based upon, or if all or any portion of temporary privileges are terminated or suspended for, a medical disciplinary cause or reason. In all other cases (including a deferral in acting on a request for temporary privileges), the affected practitioner shall not be entitled to any procedural rights based upon any adverse action involving temporary privileges.

4. Whenever temporary privileges are terminated, the appropriate department chair or, in the chair’s absence, the Chief of Staff shall assign a member to assume responsibility for the care of the affected practitioner’s patient(s). The wishes of the patient and affected practitioner shall be considered in the choice of a replacement member.
5. All persons requesting or receiving temporary privileges shall be bound by the Bylaws and rules.

5.6 Disaster and Emergency Privileges

A. Disaster Privileges may be granted when the Medical Center’s emergency management plan has been activated and the organization is unable to handle the immediate patient needs. The following provisions apply:

1. Disaster Privileges may be granted when the Medical Center’s Emergency Management Plan has been activated and the organization is unable to handle the immediate patient needs. A medical disaster occurs when the destructive effects of natural or man-made forces overwhelm the ability of the Medical Center to meet the demand for health care services. Disaster privileges are granted pursuant to the Medical Staff Disaster Privileges for Volunteer Licensed Independent Practitioners & Advanced Practice Professionals Policy (MSP 004) and are upon the recommendation of the Chief Executive Officer, Chief Medical Officer, or his/her designee(s) upon presentation of a valid government–issued photo identification issued by a state or federal agency (i.e. driver’s license or passport) and any of the following:

(i) A current picture hospital identification card;

(ii) A current license to practice and a valid picture ID issued by a state, federal or regulatory agency;

(iii) Identification indicating that the practitioner is a member of a Disaster Medical Assistance Team (DMAT);

(iv) Identification indicating that the practitioner has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity;

(v) Presentation by current Medical Center or Medical Staff Member(s) with personal knowledge regarding the practitioner’s identity.

2. Persons granted Disaster Privileges shall wear identification badges denoting their status as a DMAT member and be
assigned to a licensed independent practitioner for oversight of patient care rendered.

3. The Medical Staff Administration shall begin the process of verification of credentials and Privileges as soon as the immediate situation is under control, using a process identical to that described as Section 4.4 (except that the individual is permitted to begin rendering services immediately, as needed).

4. The primary source credentialing verifications and queries shall begin immediately upon stabilization of the emergency conditions and/or is completed within 72 hours from the time the volunteer practitioner presents to the organization. If extraordinary circumstances do not permit primary source verification in 72 hours, it shall be done as soon as possible with documentation supporting the inability to complete.

5. The responsible department chair shall arrange for appropriate concurrent or retrospective monitoring of the activities of practitioners granted Disaster Privileges.

B. In the event of an emergency, any member of the Medical Staff or any credentialed AHP shall be permitted to do everything reasonably possible, within the scope of their licensure, to save the life of a patient or to save a patient from serious harm. The member or AHP shall promptly yield such care to a qualified member when one becomes available.

5.7 Transport and Organ Harvest Teams

Properly licensed practitioners who individually, or as members of a group or entity, have contracted with the Medical Center to participate in transplant and/or organ harvesting activities may perform services within the scope of their agreement with the Medical Center.

5.8 Proctoring

A. General Proctoring Requirements

1. Except as otherwise determined by the MSEC and Governing Body, all initial appointees to the Medical Staff and all members granted new privileges shall be subject to a period of proctoring in accordance with standards and procedures set forth in the Bylaws and the criteria established by the department in which the member will be exercising privileges.
In addition, members may be required to be proctored as a condition of renewal of privileges (for example, when a member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the member's current competence in that area). Proctoring may also be implemented whenever the MSEC determines that additional information is needed to assess a practitioner's performance. Proctoring is not normally viewed as a disciplinary measure; but rather it is an information gathering measure; therefore, it should be imposed only for such period (or number of cases) as is reasonably necessary to enable such assessment. Proctoring does not give rise to the procedural rights described in Article 12, Hearings and Appellate Reviews, unless the proctoring becomes a restriction of privileges because procedures cannot be done unless a proctor is present and proctors are not available after reasonable attempts to secure a proctor.

2. During the proctoring, the practitioners must demonstrate they are qualified to exercise the privileges that they were granted. During the proctoring, the practitioners must demonstrate they are qualified to exercise the privileges that they were granted. Newly appointed practitioners must complete a minimum of ten (10) proctored procedures. The specific cases to be proctored will be determined by the Department Chair. Practitioners who completed an ACGME post-graduate training program at UCSD in the previous 12 months and are board certified/board eligible in their specialty may be eligible for reduction in required proctoring to five (5) procedures if recommended by the appropriate department Chair. Current Medical Staff and Advanced Practice Professional Staff members granted new privileges will be required to complete proctoring for the number of procedures identified by the Department Chair and procedure-specific credentialing criteria. Proctoring may be accomplished utilizing a combination of prospective proctoring, direct observation evaluation and/or retrospective chart review.

3. All initial appointees to the Medical Staff and all members granted new privileges shall be subject to a period of proctoring not to exceed 180 days, except as otherwise determined by the Credentials Committee and the MSEC. When new privileges are requested that are not new to the member’s current practice, the department chair may request
a waiver of the proctoring requirement through the Credentials Committee.

4. Each appointee or recipient of new clinical privileges shall be assigned to a department where performance of an appropriate number of cases, as established by the department chair and approved by the Credentials Committee and the MSEC, shall be proctored by one or more Attending members of the Medical Staff who is approved for the privilege being proctored. In the event that there is no Medical Staff physician eligible to proctor the appointee, the chair of the department may select a proctor with similar training and sufficient experience to evaluate performance of the privilege, as established by the department chair and approved by the Credentials Committee and the MSEC. Proctoring may be performed at another local institution provided: (1) the institution is TJC accredited; (2) the proctoring is carried out by a member in good standing who holds unrestricted clinical privileges at both Medical Center and the other institution; and (3) the individual being proctored is responsible for ensuring that departmental proctoring forms from the Medical Center are sent directly from the proctor to Medical Staff Administration.

5. Each new appointee will be assigned a proctor by the department and/or given a listing of names of individuals who are eligible proctors. It is the responsibility of the new appointee to arrange for a proctor and to schedule his/her cases at a time when an eligible proctor has agreed to be available. Proctoring requirements are referenced in each department’s Clinical Privileges forms. Such proctoring shall be conducted to determine the suitability of the practitioner to continue to exercise the clinical privileges granted in that department.

B. Completion of Proctoring

Completed proctoring reports must be submitted to the appropriate Department Chair and/or Section Chief who will be responsible for reviewing all proctoring forms to assure standard of care has been met. The Department Chair and/or Section Chief will forward the completed proctoring forms to Medical Staff Administration accompanied by their recommendation to discontinue proctoring or recommend further action. The recommendation of the Department Chair and/or Section Chief will be
forwarded for review to the Credentials Committee and MSEC for final recommendation.

Proctoring shall be deemed successfully completed when the practitioner satisfactorily completes the required number of proctored cases within the time frame established in the Bylaws and the rules, and the practitioner’s professional performance in the cases meet the standard of care of the Medical Center.

C. Effect of Failure to Complete Proctoring

1. **FAILURE TO COMPLETE NECESSARY VOLUME.** A physician who has not had adequate volume or opportunity to perform procedures required for proctoring within the 180-day time frame may request a one-time, 90-day extension through the appropriate Department Chair. The Department Chair will be required to appeal for approval of the extension to the MSEC. Any practitioner or member who fails to complete the required number of proctored cases within the time frame above shall be deemed to have withdrawn voluntarily his or her request for membership (or the relevant privileges), and he or she shall not be afforded the procedural rights provided in Article 12, Hearings and Appellate Reviews.

2. **FAILURE TO COMPLETE PROCTORING SATISFACTORILY.** If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, he or she may be terminated for medical disciplinary cause or reason (or the relevant privileges may be revoked), and he or she shall be afforded the procedural rights as provided in Article 12, Hearings and Appellate Reviews. In the event procedural rights are invoked, the practitioner who has not successfully completed proctoring shall be deemed an “applicant” for purposes of Section 4.2.

3. **EFFECT ON ADVANCEMENT.** The failure to complete proctoring for any specific privilege shall not, by itself, preclude advancement from Provisional Staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the specified privileges. The specific privileges may be voluntarily relinquished or terminated if proctoring is not completed thereafter within a reasonable time.

D. Proctor: Scope of Responsibility
1. All members who act as proctors of new appointees and/or members of the Medical Staff do so at the direction of and as an agent for the department, the MSEC and the Governing Body.

2. The intervention of a proctor shall be governed by the following guidelines:

   (i) A member who is serving as a proctor does not act as a supervisor of the member or practitioner he or she is observing. His or her role is to observe and record the performance of the member or practitioner being proctored, and to report his or her evaluation to the department and/or the Credentials Committee.

   (ii) A proctor is not mandated to intervene when he or she observes what could be construed as deficient performance on the part of the practitioner or member being proctored.

   (iii) In an emergency situation, a proctor may intervene, even though he or she has no legal obligation to do so, and by intervening in such a circumstance, the proctor is acting in good faith should be qualified as a good samaritan within the “Good Samaritan” laws of the State of California.

3. The activities of a proctor constitute an integral part of the peer review system of the Medical Staff, and as such, all records, reports, documents, and any other information regarding the proctorship shall be subject to all confidentiality requirements within these Bylaws, and the proctors are subject to all immunities accorded Medical Staff peer review activities by these Bylaws, and any applicable regulations, statutes or legal decisions.

5.9 History and Physical Exam Privileges

A. Admission

All patients admitted for inpatient care will have a complete medical history and physical examination performed by a qualified physician, licensed independent practitioner, or Advanced Practice Professional, who has been granted such privileges, by the earlier of (i) 24 hours of admission or (ii) the initiation of a surgical or other procedure requiring anesthesia. This requirement also applies to outpatient procedures that are high-risk and/or require anesthesia. Abbreviated H&P’s are permitted for outpatient procedures requiring moderate sedation. All or part of the H&P may be delegated to another licensed independent practitioner or Advanced Practice Professional in accordance with
State law and hospital policy, including house staff, nurse practitioners and physician assistants. The supervising medical staff member is responsible to authenticate and sign the H&P and as applicable, the update note, and assumes full responsibility for the H&P. H&Ps performed by medical students shall not be used as the sole admission history and physical.

B. Interval Assessments for H&P

An H&P performed within 30 days prior to admission is acceptable provided an interval assessment performed by a qualified practitioner, which includes a physical assessment of the patient to update components of the patient’s current medical status that may have changed since the prior H&P and addresses any areas where more current data is available. The interval assessment shall be completed by the earlier of performed by the earlier of (i) 24 hours of admission or (ii) the initiation of a surgical or other procedure requiring anesthesia. This assessment should also address the care plan and confirm the necessity for admission, procedures or surgery. The depth of the assessment should reflect the patient’s condition and any co-morbidities and indication for admission. The interval assessment must be authenticated by the supervising medical staff member within 24 hours of admission and should be attached to the original H&P. If a patient is readmitted within 30 days of a previous discharge for the same or a related condition, an interval assessment, as defined above, may be performed provided a copy of the prior admission’s complete H&P is attached to the interval assessment.

ARTICLE 6
MEDICAL STAFF ADMINISTRATORS;
CHIEF MEDICAL OFFICER

6.1 General Provisions

A. Identification

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

   (i) Chief of Staff;

   (ii) Vice Chief of Staff

2. In addition, the Medical Staff’s department chairs, division chiefs, and committee chairs shall be deemed to be Medical Staff Administrators within the meaning of California law.

B. Qualifications – All Medical Staff Officers shall:
1. Understand the purposes and functions of the Medical Staff and demonstrate willingness to assure that patient welfare always takes precedence over other concerns;

2. Understand and be willing to work toward attaining the Medical Center’s policies and procedures;

3. Have administrative ability as applicable to the respective office;

4. Be able to work with and motivate others to achieve the objectives of the Medical Staff and Medical Center;

5. Demonstrate clinical competence in his or her field of practice;

6. Be an Attending Medical Staff member (and remain in good standing as an Attending Medical Staff member while in office); and

7. Not have any significant conflict of interest.

C. Conflict of Interest

All nominees for election or appointment to Medical Staff Offices shall, at least 20 days prior to the date of election or appointment, disclose in writing to the MSEC those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. The MSEC shall evaluate the significance of such disclosures and shall discuss any significant conflicts with the nominee. If a nominee with a significant conflict remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

6.2 Method of Selection—General Officers

A. Succession of Vice Chief of Staff to Chief of Staff

The Vice Chief of Staff shall accede to the position of Chief of Staff upon the Chief of Staff’s completion of his or her term.

B. Nominating Committee

Candidates for Vice Chief shall be nominated by an ad hoc nominating committee of the MSEC appointed by the Chief of Staff, or by a petition signed by at least five (5) members of the Attending Medical Staff. The Chief of Staff shall prepare a slate of candidate(s) meeting the qualifications of office as
described in Section 6.1.B from those nominated at least 45 days prior to the scheduled election.

C. Election

The election shall be by ballot, and the outcome shall be determined by a majority of the votes cast by ballots that are returned to the Medical Staff Administration within 15 days after the ballots were sent to the voting Medical Staff members.

D. Term of Office

1. The Vice Chief shall be elected in spring of odd-numbered years and shall take office the following July.

2. The term of office shall be two years. No officer shall serve consecutive terms in the same position.

3. In the event that the Vice Chief must replace the Chief of Staff at any time during the first year of the two-year term, the Vice Chief shall serve a full term after completing the term of the absent Chief of Staff.

6.3. Duties of Officers

A. Chief of Staff - The Chief of Staff shall serve as the Chief Officer of the Medical Staff. The duties of the Chief of Staff shall include, but not be limited to:

1. Enforcing the Medical Staff Bylaws and Rules, promoting quality of care, implementing sanctions when indicated, and promoting compliance with procedural safeguards when corrective action has been requested or initiated;

2. Calling, presiding at, and being responsible for the agenda of all annual or special meetings of the Medical Staff;

3. Serving as chair of the MSEC and Patient Care and Peer Review Committee (PCRC);

4. Serving as an ex-officio member of all other Medical Staff committees, unless his or her membership in a particular committee is required by these Bylaws;

5. Appointing, in consultation with the Chief Medical Officer and MSEC, committee members for all standing, ad hoc, and special
Medical Staff liaison, or multi-disciplinary committees except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the chairs of these committees;

6. Being a spokesperson for the Medical Staff in external professional and public relations;

7. Serving on liaison committees with the Governing Body and administration, and with outside licensing or accreditation agencies;

8. Regularly reporting to the Governing Body on the performance of Medical Staff functions and communicating to the Medical Staff any concerns expressed by the Governing Body;

9. In the interim between MSEC meetings, performing those responsibilities of the committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the committee;

10. Interacting with the CEO and Governing Body in all matters of mutual concern within the Medical Center;

11. Representing the views and policies of the Medical Staff to the Governing Body and to the CEO;

12. Being accountable to the Governing Body, in partnership with the CMO and in conjunction with the MSEC, for the effective performance, by the Medical Staff, of its responsibilities with respect to quality and efficiency of clinical services within the Medical Center and for the effectiveness of the quality assurance and utilization and review programs; and

13. Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff or the MSEC.

B. Vice Chief of Staff

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a member of the MSEC and of the Joint Conference Committee, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the MSEC.
6.4 Chain of Command

In the absence of all the elected officers, the chain of command of the Medical Staff shall be transferred to the Chief Medical Officer followed by the Dean of Clinical Affairs. Each shall assume all duties of the Chief of Staff and shall have the authority of the Chief of Staff.

6.5 Chief Medical Officer

A. Appointment

The Chief Medical Officer shall be appointed by the CEO and approved by the MSEC.

B. Responsibilities

1. The Chief Medical Officer’s duties shall be delineated by the Governing Body in keeping with the general provisions set forth in subparagraph 2, below. Approval by the MSEC shall be required for any Chief Medical Officer duties that relate to authority to perform functions on behalf of the Medical Staff or that directly affect the performance or activities of the Medical Staff. The Chief Medical Officer shall consult with the CEO regarding the appointment of any Medical Center and/or Clinical Department medical director.

2. In keeping with the foregoing, the Chief Medical Officer shall:
   a) Serve as administrative liaison among Medical Center administration, the Governing Body, outside agencies and the Medical Staff;
   b) Be a spokesperson for the Medical Staff in external professional and public relations;
   c) Assist the Medical Staff in performing its assigned functions and coordinating such functions with the responsibilities and programs of the Medical Center;
   d) In cooperation and close consultation with the Chief of Staff and the MSEC, supervise the day-to-day performance of the Medical Staff Administration and the Medical Center’s quality improvement personnel; and
e) Being accountable to the Governing Body, in partnership with the COS and in conjunction with the MSEC, for the effective performance, by the Medical Staff, of its responsibilities with respect to quality and efficiency of clinical services within the Medical Center and for the effectiveness of the quality assurance and utilization and review programs.

C. Participation in Medical Staff Committees

The Chief Medical Officer:

1. Shall be an ex officio member without vote on all Medical Staff Committees and any hearing committee except that the Chief Medical Officer shall be a voting member of the following committees: Medical Risk Management, Medical Staff Executive, Patient Care and Peer Review, Patient Safety Committee, and Quality Council; and

2. Shall serve as Secretary of the MSEC; and

3. May attend any meeting of any department or section.

6.6 Filling Vacancies

A. Vacancies created by resignation, removal, death, or disability shall be filled as follows:

1. A vacancy in the office of Chief of Staff shall be filled by the Vice Chief of Staff.

2. A vacancy in the office of Vice Chief of Staff shall be filled by special election held in general accordance with Section 6.2.C.

6.7 Recall of Officers

A general Medical Staff officer may be recalled from office for any valid cause, including, but not limited to, failure to carry out the duties of his or her office. Except as otherwise provided, recall of a general Medical Staff officer may be initiated by the MSEC or by a petition signed by at least one-third percent of the Medical Staff members eligible to vote for officers; but recall itself shall require a two-thirds percent vote of the MSEC or two-thirds percent vote of the Medical Staff members eligible to vote for general Medical Staff officers.
ARTICLE 7
COMMITTEES

7.1 General

A. Designation

The MSEC and the other committees described in these Bylaws and the rules shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the MSEC or a department to perform specified tasks. Any committee—whether Medical Staff-wide or department or other clinical unit, or standing or ad hoc—that is carrying out all or any portion of a function or activity required by these Bylaws is deemed a duly appointed and authorized committee of the Medical Staff.

B. Appointment of Members

1. Unless otherwise specified, the chair and members of all committees shall be appointed by, and may be removed by, the Chief of Staff, subject to consultation with and approval by the MSEC. Medical Staff committees shall be responsible to the MSEC.

2. A Medical Staff committee created in these Bylaws is composed as stated in the description of the committee in these Bylaws or the rules. Except as otherwise provided in the Bylaws, committees established to perform Medical Staff functions required by these Bylaws may include any category of Medical Staff members; housestaff, allied health professionals; representatives from Medical Center departments such as administration, nursing services, or health information services; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff member who serves on a committee participates with a vote unless the statement of committee composition designates the position as nonvoting.

3. The Chief of Staff, or his or her designee, in consultation with the CEO and CMO, shall appoint any non-Medical Staff members who serve in non-ex officio capacities.

4. The committee chair, after consulting with the Chief of Staff, may call on outside consultants or special advisors.
5. Each committee chair shall appoint a vice chair to fulfill the duties of the chair in his or her absence and to assist as requested by the chair. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

C. Representation on Medical Center Committees and Participation in Medical Center Deliberations

The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management and physical plant safety by providing Medical Staff representation on Medical Center committees established to perform such functions.

D. Ex Officio Members

The Chief of Staff, CEO, and the Chief Medical Officer or their respective designees are ex officio members of all standing and special committees of the Medical Staff and shall serve with vote unless provided otherwise in the provision or resolution creating the committee.

E. Action Through Subcommittees

Any standing committee may use subcommittees to help carry out its duties. The MSEC shall be informed when a subcommittee is appointed. The committee chair may appoint individuals in addition to, or other than, members of the standing committee to the subcommittee after consulting with the Chief of Staff regarding Medical Staff members, and the CEO, CMO (or their designee) regarding Medical Center staff.

F. Terms and Removal of Committee Members

Unless otherwise specified, a committee member shall be appointed for a term of three years with and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall resign sooner or be removed from the committee. Any committee member who is appointed by the Chief of Staff may be removed by a majority vote of the MSEC. Any committee member who is appointed by the department chair may be removed by a majority vote of his or her department committee or the MSEC. The removal of any committee member who is automatically assigned to a committee because he or she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

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

H. Conduct and Records of Meetings

Committee meetings shall be conducted and documented in the manner specified for such meeting in Article 9, Meetings.

I. Attendance of Nonmembers

Any Medical Staff member who is in good standing may ask the chair of any committee for permission to attend a portion of that committee’s meeting dealing with a matter of importance to that practitioner. The committee chair shall have the discretion to grant or deny the request and shall grant the request only if the member’s attendance will reasonably aid the committee to perform its function. If the request is granted, the invited member shall abide by all Bylaws and rules applicable to that committee.

J. Accountability

All committees shall be accountable to the MSEC.

7.2 Joint Conference Committee

A. Composition

The membership of the Joint Conference Committee shall be composed of at least nine (9) members as follows: Vice Chancellor; CEO, UCSD Medical Center; Chief of Staff, UCSD Health Sciences; Chief Medical Officer, UCSD Medical Center; Chief Clinical Officer, UCSD Medical Center; Chief of Staff, UCSD Medical Center, Vice Chief of Staff, UCSD Medical Center; Dean of Clinical Affairs, UCSD Health Sciences; and CFO, UCSD Medical Center. All members are voting members. The Vice Chancellor shall serve as the Joint Conference Committee chair.

B. Duties and Meeting Frequency

1. The Joint Conference Committee shall serve as a focal point for furthering an understanding of the roles, relationships, and responsibilities of the Governing Body, Medical Center administration, and the Medical Staff. It may also serve as a forum for discussing any hospital matters regarding the provision of patient care. It shall meet as often as necessary to
fulfill its responsibilities. Any member of the committee shall have the authority to place matters on the agenda for consideration by the committee.

2. The Joint Conference Committee may serve as a forum to exercise the meet and confer provisions contemplated by Article 13 of these Bylaws; provided, however, that upon request of at least four committee Members (which four must be comprised of at least three Medical Staff representatives and one Governing Body representative, or of at least three Governing Body representatives and one Medical Staff representative), a neutral mediator, acceptable to both contingents, shall be engaged to assist in dispute resolution. It is the intent that the Joint Conference Committee will assist in the resolution of controversy between the Medical Staff, the Governing Body and Hospital Administration, as may be needed from time to time.

7.3 Medical Staff Executive Committee

A. Composition

The MSEC shall be composed of the Medical Staff officers listed in Article 7, Past Chief of Staff; Chief Medical Officer, and the department chairs for each hospital department, the Dean of the School of Medicine, the Associate Dean, Graduate Medical Education; Chair, Quality Council; Chair, Credentials Committee; and Dean of Clinical Affairs. The Chief Executive Officer, Pharmacist-in-Chief; and Chief Clinical Officer shall serve as ex officio members without vote. The Chief of Staff shall chair the MSEC. A majority of the committee shall be physicians.

1. Representation

Except for the Chief of Staff and Vice Chief of Staff, a designee who will have voting privileges by proxy may represent the above members. Only one member per department may vote.

B. Duties

With the assistance of the Chief of Staff and the CMO, the MSEC shall perform the duties listed below.

1. Supervise the performance of all Medical Staff functions, which shall include:
(i) Requiring reports and recommendations from the departments, committees and officers of the Medical Staff concerning discharge of assigned functions upon request;

(ii) Issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and

(iii) Following up to assure implementation of all directives.

2. Coordinate the activities of the committees and departments.

3. The MSEC makes recommendations to the Governing Body on at least the following: adoption of Bylaws and rules establishing the structure of the Medical Staff; the mechanism used to review credentials and to delineate individual privileges; the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities; the mechanism by which membership on the Medical Staff may be terminated; and the mechanism for hearing procedures.

4. Based on input and reports from the departments and the Credentials Committee, assure that the Medical Staff adopts Bylaws, rules or regulations establishing criteria and standards, consistent with California law, for Medical Staff membership and privileges (including but not limited to any privileges that may be appropriately performed via telemedicine), and for enforcing those criteria and standards in reviewing the qualifications, credentials, performance, and professional competence and character of applicants and Staff members.

5. Assure that the Medical Staff adopts, as needed, Bylaws, rules, regulations, policies and procedures establishing clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records.

6. Evaluate the performance of practitioners exercising clinical privileges whenever there is doubt about an applicant's and/or member's ability to perform requested privileges.
7. Based upon input from the departments and the Credentials Committee, make recommendations regarding all applications for Medical Staff appointment, reappointment and privileges.

8. When Allied Health Professionals provide or are recommended to provide services in the Medical Center, the committee shall make recommendations to the Governing Body on their qualifications to provide those services and on the degree of supervision required.

9. When indicated, initiate and/or pursue disciplinary or corrective actions affecting Medical Staff members.

10. With the assistance of the Chief of Staff and CMO, supervise the Medical Staff’s compliance with:

   (i) The Medical Staff Bylaws, rules, and policies;
   
   (ii) The hospital’s bylaws, rules, and policies;
   
   (iii) State and federal laws and regulations; and
   
   (iv) TJC accreditation requirements.

11. Oversee the development of Medical Staff policies, approve (or disapprove) all such policies, and oversee the implementation of all such policies.

12. Implement, as it relates to the Medical Staff, the approved policies of the hospital.

13. With the department chairs, set departmental objectives for establishing, maintaining and enforcing professional standards within the hospital and for the continuing improvement of the quality of care rendered in the hospital; and assist in developing programs to achieve these objectives.

14. Regularly report to the Governing Body through the Chief of Staff and the CEO on at least the following:

   (i) the outcomes of Medical Staff quality improvement programs with sufficient background and detail to assure the Governing Body that quality of care is consistent with professional standards; and
(ii) the general status of any Medical Staff disciplinary or corrective actions in progress.

15. Review and make recommendations to the CEO regarding quality of care issues related to exclusive contract arrangements for professional medical services.

16. Assist the hospital in: reviewing and advising on clinical services to be provided by consultation, contractual arrangements or other agreements; and in evaluating the levels of safety and quality of services provided via consultation, contractual arrangements, or other agreements and providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by hospital administration in making exclusive contracting decisions.

17. To review, recommend and approve off-site contractors for patient care services.

18. Coordinate the activities and general policies of the various services.

19. Receive and act upon minutes of all Medical Staff Committees.

20. Accept presentation from Chairs of the Medical Staff Committees of written minutes.

21. Reports shall be transmitted to the Governing Body at least monthly.

22. All committees of the Medical Staff shall report to the MSEC. Additionally, the following committees shall make specific reports summarizing their activities to the Governing Body through the MSEC: Physicians’ Well-Being; and Medical Ethics shall make quarterly reports; Risk Management shall make an annual report.

23. Assure that educational programs incorporate the recommendations and results of Medical Staff quality assessment and improvement activities.

24. Establish, as necessary, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the MSEC.
25. Establish, as necessary, the date, place, time and program of the regular meetings of the Medical Staff.

26. Represent and act on behalf of the Medical Staff between meetings of the Medical Staff.

C. Meetings

The MSEC should meet on a monthly basis and shall meet at least ten (10) times during the calendar year and shall maintain a permanent record of its proceedings and actions. In all instances, the quorum shall consist of a majority of voting members.

7.4 Standing Committees

The Standing Committees are as follows:

- Cardiovascular Quality Committee
- Cancer Committee
- Clinical Resource Management Committee
- Credentials Committee
- Critical Care Committee
- Joint Conference Committee
- Infection Control Committee
- Interdisciplinary Practice Committee
- Medical Ethics Committee
- Medical Risk Management Committee
- Patient Care and Peer Review Committee
- Patient Safety Committee
- Perinatal Practices
- Perioperative Services Executive Committee
- Pharmacy & Therapeutics Committee
- Physicians’ Well-Being Committee
- Quality Council
- Resident Physician Council

Committee charges are detailed in the Rules and Regulations of the Medical Staff.

ARTICLE 8
DEPARTMENTS AND DIVISIONS

8.1 Organization of Clinical Departments

Each department shall be organized as an integral unit of the Medical Staff and shall have a chair and a vice chair who are selected and shall have the authority, duties, and responsibilities specified in the rules. Additionally, each department may appoint a department committee and such other standing or ad hoc committees as it deems appropriate to perform its required functions. The composition and responsibilities of each standing department committee shall be specified in the rules. Departments may also form divisions as described below.

8.2 Designation

A. Current Designation

The current departments and divisions are:
- Anesthesiology
- Dermatology
- Emergency Medicine
- Family Medicine and Public Health
  - Division of Family Medicine
- Hospice & Palliative Medicine
- Medicine
  - Divisions: Allergy; Cardiology; Endocrinology and Metabolism; Gastroenterology; General Medicine; Geriatrics; Genetics; Hematology/Oncology and Blood & Marrow Transplantation; Hospital Medicine, Infectious Disease; Nephrology and Hypertension; Rheumatology; and Pulmonary Medicine and Critical Care Medicine
- Neurosciences
  - Divisions: Adult Neurology and Clinical Neurophysiology
- Ophthalmology
• Orthopaedic Surgery
• Pathology
  o Divisions: Anatomic Pathology; Neuropathology; and Laboratory Medicine
• Pediatrics
  o Divisions: Adolescent Medicine; Allergy/Immunology; Biochemical Genetics; Cardiology; Dermatology; Dysmorphology; Endocrinology; Gastroenterology; General Pediatrics; Hematology/Oncology; Infectious Disease; Medical Genetics; Metabolic Diseases; Molecular Genetics; Neonatology/Perinatal Medicine; Nephrology; Pulmonary Medicine
• Psychiatry
• Radiation Medicine
• Radiology
  o Divisions: Diagnostic Radiology; Magnetic Resonance Imaging; Nuclear Medicine; Vascular and Interventional Radiology
• Reproductive Medicine
  o Divisions: Gynecologic Oncology; Obstetrics/Gynecology; Perinatal Medicine; Reproductive Endocrinology; and Urogynecology
• Surgery
  o Divisions: Cardiothoracic Surgery; General Surgery; Neurosurgery; Otolaryngology/Head and Neck Surgery; Pediatric Surgery; Plastic Surgery; and Trauma/Burns
• Urology

B. Future Departments

The MSEC will periodically assess the designation of the departments and recommend to the Governing Body what action(s), if any, are desirable in creating, eliminating, or combining departments for better organizational efficiency and improved patient care. Action shall be effective upon approval by the MSEC and the Governing Body.

8.3 Assignment to Departments

Each member shall be assigned membership in one department, but may also be granted membership and/or clinical privileges in other departments consistent with the practice privileges granted.

8.4 Functions of Departments
The departments shall fulfill the clinical, administrative, quality improvement/risk management/utilization management, and collegial and educational functions described in the rules, if applicable. When the department or any of its committees meets to carry out the duties described below, the meeting body shall constitute a peer review committee, which is subject to the standards and entitled to the protections and immunities afforded by federal and state law for peer review committee(s). Each department or its committees, if any, must meet regularly to carry out its duties.

8.5 Department Chair and Vice Chair

A. Qualifications

Each department chair and department vice chair shall be Attending Medical Staff members, shall have demonstrated ability and be Board certified in at least one of the clinical areas covered by the department, or shall satisfy the Credentials Committee of equivalent competence, and shall be willing and able to faithfully discharge the functions of his or her office.

B. Selection

Unless otherwise provided, each Medical Center Department Chairperson shall be chairperson of the equivalent department in the School of Medicine.

C. Roles and Responsibilities of Department Chairpersons

Department Chairpersons shall have the following duties and responsibilities, subject to the authority of the Vice Chancellor, the Chancellor, the President and The Regents of the University of California:

1. Maintain membership on the Medical Staff of UCSD Medical Center.

2. The Chair, in consultation with members of the department, shall elect a Vice-Chair. The Vice-Chair shall be responsible to and shall assist the Department Chair in the performance of his or her duties, and shall assume the duties of the Department Chair in his or her absence or during periods when he or she is unable to serve.

3. Provide for the ongoing clinical practice of medicine by members of the department in accordance with the Medical Staff Bylaws and Rules and Regulations as well as applicable sections of Title 22 of the California Code of Regulations, Conditions of Participation of the Health Care Financing
Administration, and guidelines set forth by The Joint Commission.

4. Be accountable to the MSEC for all professional and Medical Staff administrative activities within the department.

5. Establish an ongoing review process to evaluate the quality of patient care rendered within the Department and maintain Department quality improvement programs, to include criteria for FPPE and OPPE. Results of these activities will be reported at least quarterly.

6. Convene, at a minimum, a quarterly Department meeting to review Departmental professional activities of its members, to discuss administrative matters and to conduct departmental educational programs. Minutes of these meetings, using a format approved by the MSEC, will be maintained and made available to the Chief of Staff for review and action by the MSEC.

7. Develop departmental privileging criteria for approval by the Credentials Committee, the MSEC and the Governing Body.

8. Using the privileging criteria, supervise and evaluate the clinical work performed by members of the department and assure that department members practice within the privileging limits granted them by the Governing Body.

9. Approve all appointments and reappointments and recommend clinical privileges of Department Medical Staff members. Provide applicant evaluation in accordance with provisions of these Bylaws for all appointments and reappointments.

10. Assure adequate orientation and continuing professional education for members of the department.

11. Recommend changes, as needed, to the Director, Hospital and Clinics, divisions of the respective Departments to assist them in carrying out their duties and responsibilities.

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

13. Assess and recommend to the relevant hospital authority off-site sources for needed patient care services not provided by UCSD Medical Center.

14. Assure there is adequate coverage of the services provided by the department. Coverage includes assessment and assignment of appropriate number of competent, privileged practitioners needed to provide safe, quality patient care services. Appropriate on-call and back up services shall also be provided. The chairperson shall inform the Chief of Staff or Chief Medical Officer of coverage deficiencies or inability to provide services.

15. Coordinate and integrate services of the Department with services of other clinical departments the Medical Center.

16. Participate in the development and implementation of policies and procedures that guide and support the provision of care, treatment and services.

17. Determine the qualifications and competence of Department personnel who are not licensed independent practitioners and who provide patient care, treatment and services.

18. Make recommendations for space and other resources needed by the Department.

19. Coordinate the management of the clinical activities of the department.

### 8.6 Divisions

Each clinical division within a department shall have a chief, appointed by the department chair, who is responsible to the chair for the functioning of the division. The Division Chief shall be certified by an appropriate specialty Board or shall satisfy the Credentials Committee of equivalent competence.

### 8.7 Advanced Practice Professionals
Advanced Practice Professionals ("APPs") are defined as health care professionals who hold a license or other legal credential, as required by California law, to provide a certain scope of services. APPs are not eligible for Medical Staff membership. APPs may render services within the scope of their licensure and within the limitations and conditions set by the Interdisciplinary Practices Committee of the Hospital. APPs may participate in the direct management of a patient's care only under the supervision and direction of a physician member of the Medical Staff. Individuals classified as APPs shall be assigned to a Department/Division for supervision and performance evaluation purposes and shall be subject to all applicable Division, Department, Medical Staff, and Medical Center policies, rules and regulations. Attendance at and participation in Department and Division meetings shall be as determined by the appropriate Department or Division Chief. (Refer to Medical Staff General Rules and Regulations).

ARTICLE 9
MEETINGS

9.1 Medical Staff Meetings

A. Special Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, MSEC, the CEO or the Vice Chancellor, or upon the written request of ten percent of the voting members. The meeting must be called within 30 days after receipt of such request. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

B. Combined or Joint Medical Staff Meetings

The Medical Staff may participate in combined or joint Medical Staff meetings with staff members from other hospitals or healthcare entities owned and operated by the University of California; however, precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed, and to assure that this Medical Staff (through its authorized representative(s)) maintains access to and approval authority of all minutes prepared in conjunction with any such meetings.

9.2 Department and Committee Meetings

A. Regular Medical Staff Meetings

Departments and committees, by resolution, may provide the time for holding regular meetings and no notice other than such resolution shall then be required. Each department shall meet as often as necessary, to review and
discuss patient care activities and to fulfill other departmental responsibilities.

B. Special Meetings

A special meeting of any department or committee may be called by, or at the request of, the chair thereof, the MSEC, Chief of Staff, or by one-third of the group’s current members, but not fewer than three members. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

C. Combined or Joint Department or Committee Meetings

The departments or committees may participate in combined or joint department or committee meetings with staff members from other hospitals or health care entities owned and operated by the University of California; however, precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed, and to assure that this Medical Staff (through its authorized representative(s)) maintains access to and approval authority of all minutes prepared in conjunction with any such meetings.

9.3 Notice of Meetings

Notice stating the place, day and hour of any regular Medical Staff meeting shall be delivered, either personally, electronically or by mail, to the voting membership no later than 30 days before the meeting. Written notice of a special Medical Staff meeting or of any regular or special department or committee meeting not held pursuant to resolution shall be delivered either personally, electronically, or by mail to each person entitled to be present not fewer than two working days nor more than 45 days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

9.4 Quorum

A. Medical Staff Meetings

The presence of 25 percent of the voting Medical Staff members at any regular or special meeting shall constitute a quorum. Individuals participating by telephone or video link shall be counted for purposes of establishing a quorum.

B. Committee Meetings

The presence of 50 percent of the voting members shall be required for MSEC meetings. For other committees, a quorum shall consist of no fewer than three
of the voting members of a committee. Individuals participating by telephone or video link shall be counted for purposes of establishing a quorum.

C. Department Meetings

The presence of no fewer than three voting Medical Staff members at any regular or special department meeting shall constitute a quorum. Individuals participating by telephone or video link shall be counted for purposes of establishing a quorum.

9.5 Manner of Action

An action will only be deemed approved by the membership of the medical Staff (or a Committee or Department of the Medical Staff) if taken pursuant to Section 9.5(A) or 9.5(B).

A. Action Taken By Qualified Meeting. Valid action may be taken by Qualified Meeting. A Qualified Meeting is one in which (i) a quorum is present and (ii) a majority of the members present and voting take a specific position with respect to a given matter. 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 required by these Bylaws. Individuals participating by telephone or video link shall be counted for purposes of establishing a quorum and voting on a matter. The meeting chair shall refrain from voting except when necessary to break a tie.

B. Action Taken Other Than Via a Qualified Meeting. Valid action may be taken without a meeting if (and only if) all of the following requirements are satisfied: (i) written notice of the specific proposed action is given – at least seventy-two hours prior to implementation – to all members entitled to vote on such action, (ii) the action is explicitly approved in writing (in advance of implementation) by a majority of the members entitled to vote on the matter. Written notice and written approval may be provided via electronic communications.

9.6 Minutes

Minutes of all meetings shall be prepared and shall include a record of the attendance of members, the vote taken on each matter, forwarded to the MSEC or other designated committee and made available to the Governing Body. Each committee shall maintain a permanent file of the minutes of each meeting. When meetings are held with outside entities, access to minutes shall be limited as

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necessary to preserve the protections from discovery, as provided by California law.

9.7 Attendance Requirements

A. Regular Attendance Requirements

There are no specific attendance requirements for Medical Staff and departmental meetings. Attending Medical Staff members are encouraged to attend Medical Staff and departmental meetings and when unable to attend, are expected to be knowledgeable regarding Medical Staff and departmental activities.

B. Special Appearance

A committee, at its discretion, may require the appearance of a practitioner at a committee meeting during a review of the clinical course of treatment regarding a patient. If possible, the chair of the meeting should give the practitioner at least ten days’ advance written notice of the time and place of the meeting. In addition, whenever an appearance is requested because of an apparent or suspected deviation from standard clinical practice, the notice to be given shall include a statement of the issue involved and that the practitioner’s appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he or she was given such notice shall (unless excused by the MSEC upon a showing of good cause) result in an automatic suspension of the practitioner’s privileges for at least two weeks, or such longer period as the MSEC deems appropriate. The practitioner shall be entitled to the procedural rights described at Article 14, Hearings and Appellate Reviews.

9.8 Conduct of Meetings

Unless otherwise specified, meetings shall be conducted according to Robert’s Rules of Order; however, technical failures to follow such rules shall not invalidate action taken at such a meeting.

ARTICLE 10
CONFIDENTIALITY, IMMUNITY, RELEASES, AND DEFENSE

10.1 General

Medical Staff, department, section or committee minutes, files and records—including information regarding any member or applicant to this Medical Staff—shall, to the fullest extent permitted by law, be confidential. Such confidentiality
shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff committee files and shall not become part of any particular patient’s file or of the general hospital records. Dissemination of such information and records shall be made only where expressly required by law or as otherwise provided in these Bylaws.

10.2 Breach of Confidentiality

Inasmuch as effective credentialing, quality improvement, 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, and inasmuch as practitioners and others participate in credentialing, quality improvement, and peer review activities with the reasonable expectation that this confidentiality will be preserved and maintained, any breach of confidentiality of the discussions or deliberations of the Medical Staff, its departments, sections, or committees, except in conjunction with another University of California medical center or medical group, or a professional society or licensing authority of peer review activities, is outside the appropriate standard of conduct for this Medical Staff and will be deemed to be disruptive to the operations of the hospital. If it is determined that such a breach has occurred, the MSEC may undertake such corrective action as it deems appropriate.

10.3 Access to and Release of Confidential Information

A. Access for Official Purposes

Medical Staff records, including confidential committee records and credentials files, shall be accessible by:

1. Committee members, and their authorized representatives, for the purpose of conducting authorized committee functions.

2. Medical Staff and department officials, and their authorized representatives, for the purpose of fulfilling any authorized function of such official.

3. The CEO, the Governing Body, and their authorized representatives, for the purpose of enabling them to discharge their lawful obligations and responsibilities.

4. Upon approval of the CEO and Chief of Staff, the peer review bodies of another University of California medical center or medical group, as reasonably necessary to facilitate review of an applicant or member from that University of California medical center or medical group.
5. Information contained in the credentials file of any member may be disclosed as authorized by the member in his or her Medical Staff application to other medical staffs, hospitals, professional licensing board(s), health care entities, managed care plans and to other entities that qualify as "peer review bodies." Prior to disclosing credentials file information, each such entity should provide in writing that:

(i) is a peer review body as described in California Business & Professions Code section 805;

(ii) it comes within the scope of Evidence Code section 1157 and/or California Health & Safety Code section 1370;

(iii) it will maintain the information as confidential; and

(iv) it will not further disclose the credentials file information unless required by law.

B. Member’s Access

1. A Medical Staff member shall be granted access to his or her own credentials file, subject to the following provisions:

(i) Notice of a request to review the file shall be given by the member to the Chief of Staff (or his or her designee) at least three days before the requested date for review.

(ii) 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 peer review committee findings, letter of reference, proctoring reports, complaints, etc., shall be provided to the member, in writing, by the designated officer of the Medical Staff within a reasonable period of time (not to exceed two weeks). Such summary shall disclose the substance, but not the source, of the information summarized.

(iii) The review by the member shall take place in the Medical Staff Administration, during normal work hours, with an officer or designee of the Chief of Staff present.

(iv) In the event a Notice of Charges is filed against a member, access to that member’s credentials file shall be governed by Article 10.
2. A member may be permitted to request correction of information as follows:

   (i) After review of his or her file, a member may address to the Chief of Staff a written request for correction of information in the credentials file. Such request shall include a statement of the basis for the action requested.

   (ii) The Chief of Staff shall review such a request within a reasonable time and shall recommend to the MSEC whether to make the correction as requested, and the MSEC shall make the final determination.

   (iii) The member shall be notified promptly, in writing, of the decision of the MSEC.

   (iv) In any case, a member shall have the right to add to his or her credentials file a statement responding to any information contained in the file. Any such written statement shall be addressed to the MSEC, and shall be placed in the credentials file immediately following review by the MSEC.

10.4 Immunity and Releases

   A. Immunity from Liability for Providing Information or Taking Action

      Each representative of the Medical Staff and hospital and all third parties shall be exempt from liability to an applicant, member or practitioner for damages or other relief by reason of providing information in good faith to a representative of the Medical Staff, hospital or any other health-related organization concerning such person who is, or has been, an applicant to or member of the Medical Staff or who did, or does, exercise privileges or provide services at this hospital or by reason of otherwise participating in a Medical Staff or hospital credentialing, quality improvement, or peer review activities.

   B. Activities and Information Covered

      1. Activities

      The immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health-related institution’s or organization’s activities concerning, but not limited to:
(i) Applications for appointment, privileges, or specified services;

(ii) Periodic reappraisals for reappointment, privileges, or specified services;

(iii) Corrective action;

(iv) Hearings and appellate reviews;

(v) Quality improvement review, including patient care audit;

(vi) Peer review;

(vii) Utilization reviews;

(viii) Morbidity and mortality conferences; and

(ix) Other hospital, department, section, or committee activities related to proctoring, monitoring and improving the quality of patient care and appropriate professional conduct.

2. Information

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner’s professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or other matter that might directly or indirectly affect patient care.

3. Breach of confidentiality

Inasmuch as effective quality assurance activities, peer review, and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, all such discussions and deliberations shall be confidential and restricted in accordance with Article 11 and Medical Staff policies for peer review and clinical competence. Any breach of confidentiality of the discussions or deliberations of Medical Staff departments, divisions, or committees is outside appropriate standards of conduct for Medical Staff members and will be deemed disruptive to the operations of the Medical Center. If it is determined that such a breach has occurred, the MSEC may undertake such corrective action as it deems appropriate. In particular, and without limitation, a breach includes any unauthorized testimony or
unauthorized offer to testify before a court of law or in any proceeding, as to matters protected by this confidentiality provision.

10.5 Releases

Each practitioner shall, upon request of the hospital, execute general and specific releases in accordance with the tenor and import of this Article; however, execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

10.6 Cumulative Effect

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

10.7 Defense

The Medical Center shall provide defense to the Medical Staff and its individual members in accordance with University policy from and against losses and expenses (including reasonable attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the course and scope of peer review or quality assessment activities including, but not limited to:

A. As a member of or witness for a Medical Staff department, service, committee, or hearing panel;

B. As a member of or witness for the Governing Body or any hospital task force, group or committee; and

C. As a member providing information to any Medical Staff or hospital group, officer, Governing Body 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 Center shall retain responsibility for the sole management and defense of any such claims, suits, investigations or other disputes against indemnitees, including but not limited to selection of legal counsel to defend against any such actions. The indemnity set forth herein is expressly conditioned on indemnitees’ good faith belief that their actions and/or communications are reasonable and warranted and in furtherance of the Medical Staff's peer review, quality assessment or quality improvement responsibilities, in accordance with the purposes of the Medical Staff as set forth in these Bylaws and in accordance with University policies.
and procedures. In no event will the hospital indemnify an indemnitee for acts or omissions taken in bad faith or in pursuit of the indemnitee’s private economic interests.

ARTICLE 11
PEER REVIEW AND CORRECTIVE ACTION

11.1 Role of Medical Staff in Organization-wide Quality Improvement Activities

The Medical Staff is responsible to oversee the quality of medical care, treatment and services delivered at all Medical Center sites. An important component of that responsibility is the oversight of care rendered by members and AHPs practicing at the Medical Center sites. The following provisions are designed to achieve quality improvements through collegial peer review and educative measures whenever possible, but with recognition that, when circumstances warrant, the Medical Staff is responsible to embark on informal corrective measures and/or corrective action as necessary to achieve and assure quality of care, treatment and services. Toward these ends:

A. Members are expected to participate actively and cooperatively in a variety of peer review activities to measure, assess, and improve the performance of their peers in the Medical Center.

B. The primary goals of the peer review processes are to prevent, detect and resolve actual and potential problems through routine collegial monitoring, education and counseling; however, when necessary, remedial measures, including formal investigation and discipline, may be implemented and monitored for effectiveness.

C. The departments and Medical Staff committees are responsible for determining the type of data to be collected for on-going professional practice evaluation with approval by the organized medical staff, for carrying out delegated peer review and quality improvement functions in a manner that is consistent, timely, fair and ongoing. All such activities shall be incorporated within the Medical Staff’s peer review process.

11.2 Informal Corrective Activities

The Medical Staff officers, department chairs, division chiefs, and Medical Staff committees may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the Practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions and warnings may be issued orally or in writing. The member shall be
given an opportunity to respond in writing and may be given an opportunity to meet with the officer, department chair, division chief, or committee. Any informal actions, monitoring or counseling shall be documented in writing in the member’s peer review file. MSEC approval is not required for such actions, although the actions shall be reported to the MSEC. The actions, including the filing of a Business and Professions Code Section 801 Report (malpractice) with the Medical Board of California, shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights under Article 13, Hearings and Appellate Reviews.

11.3 Criteria for Initiation of Formal Corrective Action

A formal corrective action investigation may be initiated whenever reliable information indicates a member may have exhibited acts, demeanor or conduct, either within or outside of the Medical Center, which is reasonably likely to be:

A. detrimental to patient safety or to the delivery of quality patient care within the Medical Center;

B. unethical;

C. contrary to the Medical Staff Bylaws, Rules and Regulations. This shall include, but is not limited to, failure to disclose information pertinent to and necessary for the evaluation of the member’s qualifications for appointment or re-appointment to the Medical Staff;

D. care below applicable professional standards. This shall include, but is not limited to, incompetence, negligence, gross negligence, clinical care that is below the standard of practice established by the department or clinical service, or substantial or consistent misdiagnosis;

E. disruptive of Medical Staff or Medical Center operations. This shall include, but is not limited to, harassment, discrimination, personality conflict (the inability to work in harmony with others), patient abandonment, disruptive behavior or falsification of records;

F. improper use of Medical Center resources;

G. criminal conviction, including a conviction or plea of guilty or nolo contendere for any felony or for any misdemeanor related to the practice of a health care profession, fraud or abuse relating to any governmental health program, third party reimbursement, or controlled substance, whether or not an appeal has been filed or is pending;
H. failure to comply with the University’s Compliance or Research Programs if after a final decision by the University body with appropriate jurisdiction (i.e., the Committee on Privilege and Tenure or other applicable University committee), the Medical Staff determines that the failure to comply with the compliance or research program has an impact on the member’s ability to provide clinical care appropriately; or

I. unprofessional conduct.

Generally, formal corrective action measures should not be initiated unless reasonable attempts at informal resolution have failed; however, this is not a mandatory condition, and formal corrective action may be initiated whenever circumstances reasonably appear to warrant formal action. Any recommendation of formal corrective action must be based on evaluation of member-specific information.

11.4 Initiation

A. Any person who believes that formal corrective action may be warranted may provide information to the Chief of Staff, the Chief Medical Officer, any other Medical Staff officer, the applicable department chair or applicable chief of service, the Vice Chancellor or the CEO and such requests may, but need not be, referred to the department chair or Chief(s) of Service for review and investigation. When such information about a member of his/her service comes to the attention of the department chair or Chief(s) of Service, he/she may review and investigate the matter, either directly or by delegation. If the department chair or Chief(s) of Service thereafter concludes that there appear to be grounds for corrective action, he/she must submit a request for such corrective action in accordance with Section 11.6; however, such prior investigation by the service is not a precondition for making a request for corrective action.

B. If the Chief of Staff, any other Medical Staff officer, the applicable department chair, the Vice Chancellor, or the CEO determines that corrective action may be warranted under Section 11.6, that person, entity, or committee may request the initiation of a formal corrective action investigation or may recommend particular corrective action. Such requests shall be conveyed to the Chief of Staff in writing.

C. The Chief of Staff shall notify the CEO, or his or her designee and the MSEC and shall continue to keep them fully informed of all actions taken. In addition, the Chief of Staff shall appoint and immediately
forward all necessary information to a committee or person that will conduct any preliminary investigation; provided, however, that the Chief of Staff or the MSEC may limit further investigation of matters deemed to have been already adequately investigated.

11.5 Expedited Initial Review

A. Whenever information suggests that expedited corrective action may be warranted, the Chief of Staff or his or her designee may, on behalf of the MSEC, immediately investigate and conduct whatever interviews may be indicated or may delegate such activities as appropriate. The information developed during this initial review shall be presented at its next regularly scheduled meeting to the MSEC, which shall decide whether to initiate a corrective action investigation.

B. In cases of complaints of harassment or discrimination involving a patient, member, or an employee, an expedited initial review shall be conducted on behalf of the MSEC by the Chief of Staff, the Chief of Staff’s designee, or the Chief Medical Officer or a designee, together with representative(s) of administration. In cases of complaints of harassment or discrimination where the alleged harasser is a Medical Staff member and the complainant is not a patient, an expedited initial review shall be conducted by the Chief Medical Officer and the Medical Center’s human resources director or their designee. The Chief of Staff shall be kept apprised of the status of the initial review. The information gathered from an expedited initial review shall be referred to the MSEC if it is determined that corrective action may be indicated against a Medical Staff member.

11.6 Formal Investigation

A. If the MSEC concludes that corrective action is indicated but that no further investigation is necessary, it may proceed to take action without further investigation in accordance with Article 12.

B. If the MSEC concludes a formal investigation is warranted, it shall direct an investigation to be undertaken and the member shall be informed in writing of the investigation and of the allegations that give rise to the investigation. The MSEC may conduct the investigation itself or may assign the task to an appropriate officer or standing or ad hoc committee to be appointed by the Chief of Staff. The investigating body should not include individuals with a conflict of interest, which may include partners, associates or relatives of the individual being investigated. Additionally, the investigating person or body may, but is
not required to, engage the services of one or more outside reviewers as deemed appropriate or helpful in light of the circumstances. If the investigation is delegated to an officer or committee other than the MSEC, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the MSEC as soon as practicable. The report may include recommendations for appropriate corrective action.

C. Prior to any adverse action being approved, the MSEC shall assure that the member was given an opportunity to provide information in a manner and upon such terms as the MSEC, investigating body, or reviewing committee deems appropriate. The investigating body or reviewing body may, but is not obligated to, interview persons involved; however, such an interview shall not constitute a hearing as that term is used in Article 12, Hearings and Appellate Reviews, nor shall the hearings or appeals rules apply.

D. Despite the status of any investigation, at all times the MSEC shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary action.

11.7 Medical Staff Executive Committee Action

As soon as practicable after the conclusion of the investigation, the MSEC shall take action including, without limitation:

A. Determining no corrective action should be taken and, documenting the basis for those findings in the member’s peer review file;

B. Deferring action for a reasonable time;

C. Issuing letters of admonition, censure, reprimand or warning, although nothing herein shall be deemed to preclude department or committee chairs from issuing informal written or oral warnings outside of the mechanism for formal corrective action. In the event such letters are issued, the affected member may make a written response and both letters which shall be placed in the member’s peer review file;

D. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of privileges including, without limitation, requirements for co-admissions, mandatory consultation or monitoring;

E. Recommending reduction, modification, suspension or revocation of privileges. If suspension is recommended, the terms and duration of the
suspension and the conditions that must be met before the suspension is ended shall be stated;

F. Recommending reductions of membership status or limitation of any prerogatives directly related to the member’s delivery of patient care;

G. Recommending suspension, revocation or probation of Medical Staff membership. If suspension or probation is recommended, the terms and duration of the suspension or probation and the conditions that must be met before the suspension or probation is ended shall be stated; and

H. Taking other actions deemed appropriate under the circumstances.

11.8 Time Frames

Insofar as is feasible under the circumstances, formal and informal investigations should be conducted expeditiously, as follows:

A. To the extent possible, informal investigations should be completed and the results should be reported within 60 days.

B. To the extent possible, preliminary reviews should be completed and the results should be reported within 30 days.

C. To the extent possible, other formal investigations should be completed and the results should be reported within 90 days.

Timeframes are guidelines only.

11.9 Procedural Rights

A. If the MSEC determines that no corrective action is required or that only a letter of warning, admonition, reprimand or censure should be issued, the decision shall be transmitted to the Governing Body. The Governing Body may affirm, reject or modify the action. The Governing Body shall give great weight to the MSEC’s decision and may initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the MSEC and the MSEC still has not acted. The decision shall become final if the Governing Body affirms it or takes no action on it within 60 days after receiving the notice of decision. If the corrective action does not constitute “grounds for hearing” as that term is defined in the Medical Staff Bylaws, that action shall not entitle the member to a hearing.
B. If the MSEC recommends an action that is a ground for a hearing under Section 12.2, the Chief of Staff shall give the member special notice of the proposed action and of the right to request a hearing. The Governing Body may be informed of the recommendation, but shall take no action until the member has either waived his or her right to a hearing or exhausted all procedural rights set forth in Article 12.

11.10 Initiation by Governing Body

A. The Medical Staff acknowledges that the Governing Body must act to protect the quality of medical care provided and the competency of its Medical Staff, and to ensure the responsible governance of the Medical Center in the event that the Medical Staff fails in any of its substantive duties or responsibilities.

B. Accordingly, if the MSEC fails to investigate or to take disciplinary action contrary to the weight of the evidence, the Governing Body may direct the MSEC to initiate an investigation or disciplinary action, but only after consulting with the MSEC. If the MSEC fails to act in response to that Governing Body direction, the Governing Body may, in furtherance of the Governing Body’s ultimate responsibilities and fiduciary duties, initiate corrective action, but must comply with applicable provisions of Article 11, Peer Review and Corrective Action, and Article 12, Hearings and Appellate Reviews, of these Bylaws. The Governing Body shall inform the MSEC in writing of what it has done.

11.11 Summary Restriction or Suspension

A. Criteria for Initiation

1. Whenever a member’s conduct appears to require that immediate action be taken to protect the life or well-being of any patient, prospective patient, or other individual, the Chief of Staff, the MSEC, the Chief Medical Officer, the chair of the department in which the member holds privileges, the CEO, the Governing Body or his/her designee may summarily restrict or suspend the Medical Staff membership or privileges of such member.

2. Unless otherwise stated, such summary restriction or suspension (summary action) shall become effective immediately upon imposition and the person or body responsible shall promptly give written special notice to the Member, the Governing Body, the MSEC, or the chair of the
department, and the CEO. The special notice shall generally describe the reasons for the action.

3. The summary action may be limited in duration and shall remain in effect for the period stated or, if none, until ratified by the MSEC. Unless otherwise indicated by the terms of the summary action, the member’s patients shall be promptly assigned to another member by the department chair, or by the Chief of Staff considering, where feasible, the wishes of the patient and the affected member in the choice of a substitute member.

4. The notice of the summary action given to the MSEC shall constitute a request to initiate corrective action and the procedures set forth in Article 13 shall be followed.

5. Within two (2) working days of imposition of a summary suspension or summary restriction, the member shall be provided with written notice of such suspension. This initial notice shall include a statement of facts explaining why the suspension was necessary. The written notice shall inform the member: (1) of the right to an informal interview upon request; (2) that if a summary suspension or restriction remains in effect for more than fourteen (14) days, the action will be reported to the Medical Board of California pursuant to Business and Professions Code Section 805; and (3) that the suspension could be reportable to the National Practitioner Data Bank if it becomes final.

B. MSEC Action

Within seven (7) days after such summary restriction or suspension has been imposed, a meeting of the MSEC shall be convened to review and consider the action. The affected member may request an interview with the MSEC at such meeting. The interview shall be informal, and shall not constitute a hearing, as that term is used in the Bylaws. The MSEC may thereafter continue, modify or terminate the terms of the summary action. It shall give the Practitioner written special notice of its decision within two (2) working days of its meeting. Said notice shall include the information specified in Section 12.3 if the action is adverse.
C. PROCEDURAL RIGHTS

Unless the MSEC terminates the summary action, it shall remain in effect during the pendency and completion of the corrective action process and of the hearing and appellate review process. When a summary action is continued, the affected member shall be entitled to the procedural rights afforded by Article 12, Hearings and Appellate Reviews, but the hearing may be consolidated with the hearing on any corrective action that is recommended so long as the hearing commences within sixty (60) days after the hearing on the summary action was requested.

11.12 Automatic Suspension or Limitation

In the following instances, the member’s privileges or membership may be suspended or limited automatically as follows and such suspensions or limitations shall be recorded by the Medical Center:

A. Licensure

1. Revocation, Suspension or Expiration: Whenever a member’s license or other legal credential, certificate or permit authorizing practice in this state is revoked, suspended or expired, Medical Staff membership and privileges shall be automatically revoked as of the date such action becomes effective.

2. Restriction: Whenever a member's license, other legal credential authorizing practice in this state, certificate or permit issued to permit specific privileges following routine testing is limited or restricted by the applicable licensing or certifying authority or by the Medical Center, any privileges which are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

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

B. Drug Enforcement Administration (DEA) Certificate
1. 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.

2. 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.

C. Failure to Satisfy Special Appearance Requirement

A member who fails without good cause to appear and satisfy the requirements of Section 12.4 G. shall automatically be suspended from exercising all or such portion of privileges as the MSEC specifies.

D. Medical Records

Medical Staff members are required to complete medical records within the time prescribed in the Bylaws, Rules and Regulations. Failure to complete medical records in a timely manner shall result in an automatic suspension after notice is given as provided in the rules. Such suspension shall apply to the Medical Staff member’s right to admit, treat or provide services to new patients in the Medical Center, but shall not affect the right to continue to care for a patient the Medical Staff member has already admitted or is treating. The suspension shall continue until the medical records are completed. If, after 90 consecutive days of suspension the member remains suspended, the member shall be considered to have resigned voluntarily from the Medical Staff.

E. Cancellation of Professional Liability Insurance

Failure to maintain professional liability insurance as required by the University of California and by these Bylaws shall be grounds for automatic suspension of a member’s privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage. A failure to provide evidence of appropriate
coverage within six months after the date of automatic suspension shall be deemed a voluntary resignation of the member from the Medical Staff.

F. Exclusion from Government and Other Third Party Payor Programs

1. The MSEC shall be empowered to determine that compliance with certain specific third party payor, governmental agency and professional review organization rules or policies is essential to Medical Center and/or Medical Staff operations and that compliance with such requirements can be objectively determined. The rules may authorize the automatic suspension of a member who fails to comply with such requirements. The suspension shall be effective until the member complies with such requirements.

2. Whenever a member is excluded from a Federal or State health care program, the member’s Medical Staff membership and clinical privileges shall be terminated automatically as of the date the exclusion becomes effective. Federal and State health care programs shall include, but are not limited to, Medicare, Medi-Cal, TriCare (formerly CHAMPUS), California Children’s Services, Maternal and Child Health Services, and Block Grants to the State Children’s Health Insurance Program.

G. Felony Conviction

A member who has been convicted of a felony or who pleads nolo contendere to a felony may be suspended automatically by the MSEC if that committee concludes that the felony conviction has a relationship to the qualifications, functions or duties of Medical Staff membership. Such suspension shall become effective immediately upon such conviction regardless of whether or not an appeal is taken or pending from said judgment. Such suspension shall remain in effect until the matter is resolved by the Courts.

H. Automatic Termination

If a member is suspended for more than six months for any reason set forth above in Sections 12.3, his or her membership (or the affected privileges, if the suspension is a partial suspension) shall be automatically terminated. Thereafter, reinstatement to the Medical Staff shall require a new application and compliance with the appointment procedures applicable to applicants.

I. Medical Staff Executive Committee Deliberation and Procedural Rights
1. As soon as practicable after action is taken or warranted as described in Section 11.11 A, Licensure, Section 11.11 B, Drug Enforcement Administration (DEA) Certificate, or 11.11 C, Failure to Satisfy Special Appearance Requirement, the MSEC shall convene to review and consider the facts and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Section 11.6, Formal Investigation. The MSEC’s review and any subsequent hearings and reviews shall not address the propriety of the licensure or DEA action, but instead shall address what, if any, additional action should be taken by the Medical Center. There is no need for the MSEC to act on automatic suspensions for failures to complete medical records (Section 11.11 D), maintain professional liability insurance (Section 11.11 E), or comply with government and other third party payor rules and policies (Section 11.11 F).

2. Members whose privileges are automatically suspended and/or who have been deemed to have resigned their Medical Staff membership automatically shall be entitled to a hearing only if the suspension is reportable to the Medical Board of California or the federal National Practitioner Data Bank.

J. Notice of Automatic Suspension or Action

Special notice of an automatic suspension or action [for reasons other than delinquent medical records] shall be given to the affected individual, and regular notice of the suspension shall be given to the Department, CEO and Governing Body, but such notice shall not be required for the suspension to become effective. Patients affected by such automatic suspension shall be assigned to another member by the department chair, Division Chief or Chief of Staff. The wishes of the patient and affected member shall be considered, where feasible, in choosing a substitute member.

K. Automatic Action Based upon Actions Taken by Another University of California Peer Review Body

1. In instances in which a member has Medical Staff privileges at more than one hospital owned and operated by the University of California, the MSEC shall be empowered automatically to impose any adverse action that has been taken by another University of California peer review body (as that term is used in the Medical Staff Hearing Law, Business and Professions Code Section 809 et seq.) after a hearing by that other peer review body that meets the requirement of the
Medical Staff Hearing Law or when the recommended action becomes final, whichever occurs first. Such an adverse action may be any action taken by the original peer review body, including, but not limited to, denying membership and/or privileges restricting privileges or terminating membership and/or privileges. The action may be taken automatically only if the original Medical Center took action based upon standards that were essentially the same as those in effect at this Medical Center at the time the automatic action will be taken. Also, the action that will be the basis of the automatic action shall have become final within the past 36 months. The action may be taken once the member has completed the hearing and any appeal at the other Medical Center or when the recommended action becomes final, whichever occurs first. It is not necessary to await a final disposition in any judicial proceeding that may be brought challenging the action.

2. The member shall not be entitled to any hearing or appeal unless the MSEC takes an action that is more restrictive than the final action taken by the original peer review body. Any hearing and appeal that is requested by the member shall not address the merits of the action taken by the original peer review body, which were already reviewed at the original peer review body's hearing, and shall be limited to only the question of whether the automatic action is more restrictive than the original peer review body's action. The member shall not be entitled to challenge the automatic peer review action unless he or she successfully overturns the original peer review action in court.

3. Nothing in this section shall preclude the Medical Staff or Governing Body from taking a more restrictive action than another peer review body based upon the same facts or circumstances.

11.13 Interview

Interviews shall neither constitute nor be deemed a hearing as described in Article 12, Hearings and Appellate Reviews, shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable with respect to hearings. The MSEC shall be required, at the member's request, to grant an interview only when so specified in this Article 11, Peer Review and Corrective Action. In the event an interview is granted, the member shall be informed of the general nature of the reasons for the recommendation and may present information relevant thereto. A record of the matters discussed and the findings resulting from an interview shall be made.

11.14 Confidentiality
To maintain confidentiality, peer review participants shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for peer review, corrective action and discipline.

ARTICLE 12
HEARINGS and APPELLATE REVIEWS

12.1 General Provisions

A. Review Philosophy

The purpose of these hearing and appellate review procedures is to provide a process for fair review of decisions that adversely affect members (as defined below), and at the same time, to protect peer reviewers from liability. It is further the intent to establish flexible procedures that do not create burdens that will discourage the Medical Staff and Governing Body from carrying out peer review.

Accordingly, discretion is granted to the Medical Staff and Governing Body to create a hearing process that provides for the least burdensome level of formality in the process while still providing a fair review and to interpret these Bylaws in that light. The Medical Staff, the Governing Body, and their officers, committees and agents hereby constitute themselves as peer review bodies under the federal Health Care Quality Improvement Act of 1986 and the California peer review hearing laws and claim all privileges and immunities afforded by the federal and state laws.

B. Exhaustion of Remedies

If an adverse action as described in Article 11 is taken or recommended, the member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

C. Intra-Organizational Remedies

The hearing and appeal rights established in the Bylaws are quasi-judicial rather than legislative in structure and function. The hearing committees have no authority to adopt or modify rules and standards or to decide questions about the merits or the substantive validity of Bylaws, rules or policies; however, the Governing Body may, in its sole discretion, entertain challenges to the merits or substantive validity of Bylaws, rules or policies and may decide those questions. If the only issue in a case is whether a Bylaw, rule or policy is lawful or meritorious, the member is not entitled to a hearing or appellate review. In such cases, the member must submit his or
her challenge first to the Governing Body and only thereafter may he or she seek judicial intervention by a Petition for Writ of Administrative Mandamus.

D. Definitions

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

1. “Body whose decision prompted the hearing” refers to the MSEC in all cases where the MSEC or authorized Medical Staff Administrators, members or committees took the action or rendered the decision that resulted in a hearing being requested. It refers to the Governing Body in all cases where the Governing Body or its authorized officers, directors or committees took the action or rendered the decision that resulted in a hearing being requested.

2. Member, as used in this Article, refers to the member or applicant who has requested a hearing pursuant to Article 12.

E. Substantial Compliance

Technical, insignificant or nonprejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

F. Final Action

Recommended final actions described in Article 11 shall become final only after the hearing rights set forth in these Bylaws have either been exhausted or waived.

12.2 Grounds for Hearing

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

A. Denial of Medical Staff membership;

B. Denial of requested advancement in membership category;

C. Denial of Medical Staff reappointment;

D. Suspension of staff membership;

E. Expulsion from membership;
F. Denial of requested clinical privileges;
G. Involuntary reduction of current clinical privileges;
H. Suspension of clinical privileges;
I. Termination of some or all clinical privileges;
J. Involuntary imposition of significant consultation or monitoring requirements (excluding consultation/monitoring incidental to provisional status and other regular proctoring) that restricts a practitioner’s exercise of privileges; or
K. Any other action that requires a report to be made to the Medical Board of California under the provisions of Section 805 of the Business & Professions Code.

12.3 Requests for Hearing

A. Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in Section 12.2, the member shall be given special notice of the recommendation or action and of the right to request a hearing pursuant to Section 12.3, Request for Hearing. The notice must be delivered or sent by certified or registered mail, return receipt requested, and must state:

1. What recommendation or action has been proposed against the member;
2. Whether the action, if adopted, must be reported under Business and Professions Code Section 805;
3. A brief indication of the reasons for the action or proposed action including the acts or omissions with which the member is charged;
4. That the member may request a hearing pursuant to Article 12;
5. That a hearing must be requested within 30 days; and
6. That the member has the hearing rights described in the Medical Staff Bylaws, including those specified in Section 12.4, Hearing Procedure.

B. Request for Hearing
1. The member shall have 30 days following receipt of special notice of such action to request a hearing. The request shall be in writing addressed to the Chief of Staff with a copy to the CEO. Said request shall be delivered or sent by certified or registered mail, return receipt requested. If the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and to have accepted the recommendation or action involved and it shall thereupon become the final action or recommendation of the Medical Staff. Such final recommendation shall be considered by the Governing Body within 45 days and shall be given great weight by the Governing Body, although it is not binding on the Governing Body.

2. The member shall state, in writing, his or her intentions with respect to attorney representation at the time he or she files the request for a hearing. Notwithstanding the foregoing and regardless of whether the member elects to have attorney representation at the hearing, the parties shall have the right to consult with legal counsel to prepare for a hearing or an appellate review.

12.4 Hearing Procedure

A. Hearings Prompted by Governing Body Action

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

B. Time and Place for Hearing

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within 30 days from the date he or she received the request for a hearing, give special notice to the member of the time, place and date of the hearing. The date of the commencement of the hearing shall be not less than 30 days nor more than 60 days from the date the Chief of Staff received the request for a hearing; provided, however, that when the request is received from a member who is under summary suspension, the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed 45 days from the date of receipt of the request.

C. Notice of Charges
Together with the special notice stating the place, time and date of the hearing, the Chief of Staff shall state clearly and concisely in writing the reasons for the adverse proposed action taken or recommended, including the acts or omissions with which the member is charged and a list of the medical record numbers in question, where applicable. The Notice of Charges shall contain a list of witnesses expected to testify at the hearing on behalf of the Medical Staff. A supplemental notice may be issued at any time, provided the member is given sufficient time to prepare to respond.

D. Hearing Committee

1. When a hearing is requested, the Chief of Staff shall appoint a Hearing Committee composed of not less than five voting members who shall gain no direct financial benefit from the outcome and who shall not have acted as accuser, investigator, fact finder, initial decision-maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the medical staff from serving as a member of the Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from the Attending medical staff, the Chief of Staff may appoint members from other medical staff categories or members who are not Attending medical staff members. Such appointment shall include designation of the chair. The Hearing Committee shall include when feasible, at least one member who has the same healing arts licensure as the member and who practices the same specialty as the member. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Hearing Committee member becomes unavailable.

2. The Hearing Committee shall have such powers as are necessary to discharge its or his or her responsibilities.

E. The Hearing Officer

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

F. Representation

The member shall have the right, at his or her expense, to attorney representation at the hearing. If the member elects to have attorney representation, the body whose decision prompted the hearing may also have attorney representation. Conversely, if the member elects not to be represented by an attorney at the hearing, then the body whose decision prompted the hearing shall not be represented by an attorney at the hearing but may be represented by a Physician licensed to practice medicine in the State of California. When attorneys are not allowed, the member and the body whose decision prompted the hearing may be represented at the hearing only by a medical member licensed to practice in the State of California who is not also an attorney at law.

G. Failure to Appear or Proceed

Failure without good cause of the member to attend personally and to proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved. Such recommendations or action shall become the final recommendation or action of the Medical Staff. Such final recommendation or action shall be considered by the Governing Body within forty-five (45) days, but shall not be binding on the Governing Body until so adopted.

H. 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 upon a showing of good cause, as follows:

1. Until such time as a Hearing Officer has been appointed, by the Judicial Review Committee or its chair acting upon its behalf;

2. By the Hearing Officer, once he/she has been appointed; or

3. Upon the agreement of both parties.

I. Discovery

1. Rights of Inspection and Copying:

The member may inspect and copy (at his or her expense) any documentary information upon which the charges are based that the Medical Staff has in its possession or under its control. The body whose decision prompted the hearing may inspect and copy (at its expense) any documentary information upon which the charges are based that the member has in his or her possession or under his or her control. The requests for discovery shall be fulfilled as soon as practicable. Failure to comply with reasonable discovery requests at least 30 days prior to the hearing shall be good cause for a continuance of the hearing or for the Hearing Officer to bar or otherwise limit the introduction of any documents not provided to the other party.

2. Limits on Discovery:

The Hearing Officer shall rule on discovery disputes that the parties cannot resolve themselves. Discovery may be denied when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either party does not extend to confidential information referring to an individually identifiable member other than the member under review nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

3. Ruling on Discovery Disputes:

In ruling on discovery disputes, the factors that may be considered include:
(i) Whether the information sought may be introduced to support or defend the charges;

(ii) Whether the information is exculpatory in that it would dispute or cast doubt upon the charges or inculpatory in that it would prove or help support the charges and/or recommendation;

(iii) The burden on the party requested to produce the requested information; and

(iv) Any other discovery requests the party has previously made.

4. Objections to Introduction of Evidence Previously Not Produced for the Medical Staff:

The body whose decision prompted the hearing may object to the introduction of the evidence that was not provided during an appointment, reappointment or privilege application review or during corrective action despite the requests of the peer review body for such information. The information will be barred from the hearing by the hearing officer unless the member can prove he or she previously acted diligently and could not have submitted the information.

J. Pre-Hearing Document Exchange

At the request of either party, the parties must exchange all documents that will be introduced at the hearing. The documents must be exchanged at least fifteen days prior to the hearing. A failure to comply with this rule is good cause for the Hearing Officer to grant a continuance. Repeated failures to comply shall be good cause for the Hearing Officer to limit the introduction of any documents not provided to the other side in a timely manner.

K. Witness Lists

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

L. Procedural Disputes

1. The parties must exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

2. The parties shall be entitled to file motions as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the full Hearing Committee. Such motions shall be in writing and shall specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving party shall deliver a copy of the motion to the opposing party, who shall have five working days to submit a written response to the Hearing Officer, with a copy to the moving party. The Hearing Officer shall determine whether to allow oral argument on any such motions. The Hearing Officer’s ruling shall be in writing and shall be provided to the parties promptly upon its rendering. All motions, responses and rulings thereon shall be entered into the hearing record by the Hearing Officer.

M. Record of the Hearing

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings if deemed appropriate by the Hearing Officer. The cost of attendance of the court reporter shall be borne by the Medical Center, but the cost of the transcript, if any, shall be borne by the party requesting it. The member is entitled to receive a copy of the transcript upon paying the reasonable cost for preparing the record. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken only under oath administered by any person lawfully authorized to administer such oath.

N. Rights of the Parties
Within reasonable limitations, both sides at the hearing may ask the Hearing Committee members and Hearing Officer questions that are directly related to evaluating their qualifications to serve and for challenging such members or the Hearing Officer, call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, receive copies of all information made available to the Hearing Committee. Any challenge directed at one or more members/alternates or the Hearing Officer shall be ruled on by the Hearing Officer or the Chair of the Judicial Review Committee if a Hearing Officer has not been appointed. The member requesting the hearing may be called by the body whose decision prompted the hearing or the Hearing Committee and examined as if under cross-examination. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. The hearing will be confidential and closed to the public.

O. Rules of Evidence

Formal judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

P. Miscellaneous Rules

Each party shall have the right to submit a statement at the commencement of the hearing in support of the party’s position. At its discretion, the Judicial Review Committee may request the parties to submit proposed findings of fact and conclusions of law to be filed following the conclusion of the presentation of oral testimony. At its discretion, the Judicial Review Committee may permit oral argument.

Q. Burden of Presenting Evidence and Proof

1. At the hearing, the body whose decision prompted the hearing shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.

2. An applicant for membership and/or privileges shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that he or she is qualified for membership and/or
the denied privileges. The applicant must produce information that allows for adequate evaluation and resolution of reasonable doubts concerning his or her current qualifications for membership and privileges.

3. Except as provided above for applicants for membership and/or privileges, throughout the hearing, the body whose decision prompted the hearing shall bear the burden of persuading the Hearing Committee by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

R. 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. Both the MSEC and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

S. Basis for Decision

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

T. Presence of Hearing Committee Members and Vote

A majority of the Hearing Committee must be present throughout the hearing and deliberations. In unusual circumstances when a Hearing Committee member must be absent from any part of the proceedings, the hearing will not proceed unless; (a) he or she is replaced by an alternate or (b) both parties stipulate, in writing, that it is acceptable for the absent member to review the transcript. If the parties so stipulate, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent. If the Hearing Committee member is replaced by an alternate, the alternate will appear for all parts of the hearing but will not vote at the end, unless he or she is accepted by the parties and made a voting member of the hearing committee. The final decision of the Hearing Committee must be sustained by a majority vote of the number of members appointed.
U. Decision of the Hearing Committee

Within 30 days after final adjournment of the hearing, the Hearing Committee shall render a written decision. If the member is currently under suspension, however, the time for the decision and report shall be 15 days after final adjournment. Final adjournment shall be when the Hearing Committee has concluded its deliberations. A copy of the decision shall be forwarded to the CEO, the MSEC, and the Governing Body and by special notice to the member. The report shall contain the Hearing Committee’s findings of fact and its conclusions of law articulating the connection between the evidence produced at the hearing and the decision reached. Both the member and the body whose decision prompted the hearing shall be provided a written explanation of the procedure for appealing the decision. The decision of the Hearing Committee shall be considered final, subject only to such rights of appeal or Governing Body review as described in these Bylaws. If the final proposed action adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days and is based on medical disciplinary cause of reason (as defined in Business and Professions Code Section 805(a) (6)), the decision shall state that the action, if adopted, will be reported as applicable to the Medical Board of California and the National Practitioner Data Bank.

12.5 Appeal

A. Time for Appeal

Within 10 days after receiving the decision of the Hearing Committee, either the member or the MSEC may request an appellate review. A written request for such review shall be delivered in person or by certified or registered mail, return receipt requested, to the Chief of Staff, the CEO, and the other party in the hearing. If appellate review is not requested within such period, that action or recommendation shall thereupon become the final action of the Medical Staff. The Governing Body shall consider the decision within 45 days, and shall give it great weight; however, it is not binding upon the Governing Body until adopted.

B. Grounds for Appeal

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; (b) the decision was not supported by the evidence based upon the hearing record or such additional
information as may be permitted pursuant to this Article or (c) the action taken was arbitrary, unreasonable or capricious.

C. Time, Place and Notice

If an appellate review is to be conducted, the Appeal Board shall, within 30 days after receiving a notice of appeal, schedule a review date and cause each side to be given notice, with special notice to the practitioner, of the time, place, and date of the appellate review. The appellate review shall commence within 60 days from the date of such notice provided; however, when a request for appellate review concerns a member who is under suspension that is then in effect, the appellate review should commence within 45 days from the date the request for appellate review was received. The time for appellate review may be extended by the Appeal Board for good cause.

D. Appeal Board

The Governing Body may sit as the Appeal Board, or it may appoint an Appeal Board which shall be composed of not less than three members designated by Governing Body. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding. If an attorney is selected, he or she may act as an Appellate Hearing Officer and shall have all of the authority of and carry out all of the duties assigned to a hearing officer as described in this Article 12. That attorney shall not be entitled to vote with respect to the appeal. The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

E. Appeal Procedure

The proceeding by the Appeal Board shall be an appellate hearing based upon the record of the hearing before the Hearing 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 Hearing Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing; or the Appeal Board may remand the matter to the Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel or any other representative designated by that party in connection with the appeal. The appealing party shall submit a written statement concisely stating the specific grounds for appeal. In addition, each party shall have the right to
present a written statement in support of his, her or its position on appeal. The Appellate Hearing Officer may establish reasonable time frames for the appealing party to submit a written statement and for the responding party to respond. Each party has the right to appear personally and to make oral argument. The Appeal Board may then, at a time convenient to itself, deliberate outside the presence of the parties.

F. Decision

1. Except where the matter is remanded to the Hearing Committee, within 30 days after the adjournment of the Appellate Review proceeding, the Appeal Board shall render a final decision in writing. Final adjournment shall not occur until the Appeal Board has completed its deliberations.

2. The Appeal Board may affirm, modify, reverse the decision or remand the matter for further review by the Hearing Committee or any other body designated by the Appeal Board.

3. The Appeal Board shall give great weight to the Hearing Committee’s recommendation, and shall not act arbitrarily or capriciously. The Appeal Board may, however, exercise its independent judgment in determining whether a member was afforded a fair hearing, whether the decision is reasonable and warranted, and whether any Bylaw, rule or policy relied upon by the Hearing Committee is unreasonable or unwarranted. The decision shall specify the reasons for the action taken and shall provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such findings and conclusions differ from those of the Hearing Committee.

4. The Appeal Board shall forward copies of its decision to each side involved in the hearing. The decision shall be in writing, shall specify the reasons for the action taken, and shall be forwarded to the Chief of Staff, and the Medical Staff Executive Committee, the subject of the hearing, and the CEO.

5. The Appeal Board may remand the matter to the Hearing Committee or any other body the Appeal Board designates for reconsideration or may refer the matter to the full Governing Body for review. If the matter is remanded for further review and recommendation, the further review shall be completed
within 30 days unless the parties agree otherwise or for good cause as determined by the Appeal Board.

G. Right to One Hearing

No member shall be entitled to more than one evidentiary hearing and one appellate review on any matter that shall have been the subject of adverse action or recommendation.

12.6 Confidentiality

A. To maintain confidentiality in the performance of peer review, disciplinary and credentialing functions, participants in any stage of the hearing or appellate review process shall limit their discussion of the matters involved to the formal avenues provided in the Medical Staff Bylaws.

B. By requesting a hearing or appellate review under these Bylaws, a member agrees to be bound by the provisions in the Medical Staff Bylaws relating to immunity from liability for the participants in the hearing process.

12.7 Governing Body Committees

A. In the event the Governing Body should delegate some or all of its responsibilities described in this Article 12 to its committees, the Governing Body shall nonetheless retain ultimate authority to accept, reject, modify or return for further action or hearing the recommendations of its committee.

12.8 Exceptions to Hearing Rights

A. Allied Health Professionals

Allied health professionals (AHPs) are not entitled to the hearing rights set forth in this Article unless the action involves a clinical psychologist and must be reported under Business and Professions Code Section 805. (See Medical Staff Rules and Regulations for a description of AHP hearing rights.)

B. Failure to Meet the Minimum Qualifications

Members shall not be entitled to any hearing or appellate review rights if their membership, privileges, applications or requests are denied because of their failure to have a current California license to practice medicine, dentistry, clinical psychology, or podiatry; to maintain an unrestricted Drug
Enforcement Administration certificate (when it is required under these Bylaws or the rules); to maintain professional liability insurance as required by the rules; or to meet any of the other basic standards specified in Article 2 or to file a complete application.

C. Automatic Suspension or Limitation of Privileges

No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Article 12. In other cases described in Article 13, the issues that may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or the Drug Enforcement Administration was unwarranted, but only whether the member may continue to practice in the Medical Center despite the limitations imposed.

Members whose privileges are automatically suspended and/or who have resigned their medical staff membership for failing to satisfy a special appearance, failing to complete medical records, failing to maintain malpractice insurance, failing to pay dues, or failing to comply with particular government or other third party payor rules or policies are not entitled under Article 12 to any hearing or appellate review rights except when a suspension for failure to complete medical records will exceed 30 days in any 12-month period, and must be reported to the Medical Board of California.

D. Failure to Meet Minimum Activity Requirements

Members shall not be entitled to the hearing and appellate review rights if their membership or privileges are denied, restricted or terminated or their medical staff categories are changed or not changed because of a failure to meet the minimum activity requirements set forth in the Medical Staff Bylaws or rules. In such cases, the only review shall be provided by the MSEC through a subcommittee consisting of at least three MSEC members. The subcommittee shall give the member notice of the reasons for the intended denial or change in membership, privileges, and/or category and shall schedule an interview with the subcommittee to occur no less than 30 days and no more than 100 days after the date the notice was given. At this interview, the member may present evidence concerning the reasons for the action, and thereafter the subcommittee shall render a written decision within 45 days after the interview. A copy of the decision shall be sent to the member, MSEC and Governing Body. The subcommittee decision shall be final unless it is reversed or modified by the MSEC within 45 days after the decision was rendered, or the Governing Body within 90 days after the decision was rendered.
E. Denial or Termination of Temporary Privileges

No practitioner shall be entitled to a hearing or appeal if temporary privileges are denied or terminated or otherwise restricted, unless such action or recommendation would require the filing of a report pursuant to Business & Professions Code, Section 805.

ARTICLE 13
GENERAL PROVISIONS

13.1 Forms

Application forms and any other prescribed forms required by these Bylaws for use in connection with Medical Staff appointments, reappointments, delineation of privileges, corrective action, notices, recommendations, reports and other matters shall be approved by the MSEC and the Governing Body. Upon adoption, they shall be deemed part of the Medical Staff rules. They may be amended by approval of the MSEC and the Governing Body.

13.2 Dues

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

13.3 Legal Counsel

Legal Counsel shall be provided or retained by the Office of the General Counsel. The Medical Staff may, at its expense, retain and be represented by independent legal counsel only upon approval by The Regents of the University of California and in accordance with the Bylaws and Standing Orders of The Regents of the University of California.

13.4 Authority to Act

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

13.5 Disputes with the Governing Body
In the event of a dispute between the Medical Staff and the Governing Body relating to the rights of the Medical Staff, as further described in California Business and Professions Code section 2282.5, the following procedures shall apply.

A. Invoking the Dispute Resolution Process

1. The MSEC may invoke formal dispute resolution, upon its own initiative, or upon written request of 25 percent of the members of the Attending Staff.

2. In the event the MSEC declines to invoke formal dispute resolution, such process shall be invoked upon written petition of 50 percent of the members of the Attending Staff.

B. Dispute Resolution Forum

1. Ordinarily, the forum for dispute resolution shall be the Joint Conference Committee, which shall meet and confer as further described in Section 8.2 of the Bylaws.

2. However, upon request of at least 2/3 of the members of the MSEC, the requirement to meet will be conducted by a meeting of the full MSEC and the full Governing Body. A neutral mediator acceptable to both the Governing Body and the MSEC may be engaged to further assist in dispute resolution upon request of: (a) at least a majority of the MSEC plus two members of the Governing Body; or (b) at least a majority of the Governing Body plus two members of the MSEC.

C. If the parties are unable to resolve the dispute, the Governing Body shall make its final determination giving great weight to the actions and recommendations of the MSEC. Further, the Governing Body’s determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the hospital.

13.6 Disputes between Medical Staff and Medical Staff Executive Committee

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

ARTICLE 14
ADOPTION AND AMENDMENT OF BYLAWS AND RULES AND REGULATIONS OF THE MEDICAL STAFF

14.1 Bylaws

A. MEDICAL STAFF RESPONSIBILITY. The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend Medical Staff bylaws and amendments, which shall be effective when approved by the Governing Body, whose approval shall not be unreasonably withheld. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, taking into account the provision of patient care quality, and efficiency, consistent with the mission of the University of California.

B. PERIODIC REVIEW. The Bylaws shall be reviewed periodically and amended, as necessary, to reflect the Medical Center’s current practices with respect to the Medical Staff organization and functions.

C. INITIATION OF AMENDMENTS. Proposals for amendments may be initiated by: (a) the MSEC; or (b) a Medical Staff member by petition signed by at least ten percent [10] percent of the Medical Staff’s voting members. All proposed amendments shall be submitted to the Chief of Staff. With the exception of technical and/or editorial changes as described in Section 14.4 below, the Chief of Staff shall refer all such suggested changes to the MSEC for review.

D. REFERRAL TO MSEC. The MSEC shall submit all proposed amendments for approval at a meeting of the Medical Staff or by electronic or mail ballot. The MSEC shall provide notice to the Medical Staff as to the time and place of the meeting if vote not conducted by electronic or mail ballot and shall include the subject of the proposed amendment(s) in the notice.

E. NO UNILATERAL AMENDMENT. The Bylaws may not be unilaterally amended by the Medical Staff, Medical Staff officers, MSEC or the Governing Body, or in a manner that is inconsistent with the Bylaws and/or Standing Orders of The Regents of the University of California.

14.2 Rules and Regulations and Policies
A. **OVERVIEW AND RELATION TO BYLAWS.** These Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Governing Body. Accordingly, the key standards for Medical Staff membership, appointment, reappointment and privileging are set out in these Bylaws. Additional provisions, including but not limited to, administrative procedures for implementing the Medical Staff standards may be set out in Medical Staff or department rules, or in policies adopted or approved as described below. Upon proper adoption, as described below, all such rules and policies shall be deemed an integral part of the Medical Staff Bylaws.

B. **GENERAL MEDICAL STAFF RULES.** The Medical Staff shall initiate and adopt such rules as it may deem necessary and shall periodically review and revise its rules to comply with current Medical Staff practice. Recommended changes to the rules shall be submitted to the MSEC for review and approval as described below. Following approval by the MSEC, a rule shall become effective following approval of the Governing Body, which approval shall not be withheld unreasonably or automatically within 60 days if no action is taken by the Governing Body. If there is a conflict between the Bylaws and the rules, the Bylaws shall prevail.

C. **DEPARTMENTAL RULES.** Subject to the approval of the MSEC and Governing Body, each department may formulate its own rules for conducting its affairs and discharging its responsibilities. Such rules shall not be inconsistent with the Medical Staff or hospital Bylaws, rules or other policies.

D. **DIVISION RULES.** Subject to the approval of the committee of the department that oversees the section, the MSEC and the Governing Body, each section may formulate its own rules for conducting its affairs and discharging its responsibilities. Such rules shall not be inconsistent with the Medical Staff or hospital Bylaws, rules, or policies.

E. **MEDICAL STAFF POLICIES.** Policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff rules. The policies may be adopted, amended or repealed by majority vote of the MSEC and approval by the Governing Body. Such policies shall not be inconsistent with the Medical Staff or hospital Bylaws, rules or other policies.

F. **VOTE OF MEDICAL STAFF.** Medical Staff Bylaws may be adopted, amended or repealed by the following combined actions:
1. The affirmative vote of a majority of the Medical Staff members, who cast a ballot, provided that, at least fourteen days' advance written notice, accompanied by the proposed Bylaws and/or alterations, has been given, and a minimum of 10% of voting members cast ballots; and

2. The approval of the Governing Body that shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the Governing Body in writing, and shall be forwarded to the Chief of Staff, the MSEC and the Bylaws committee.

G. REQUIRED CONDITIONS. In recognition of the ultimate legal and fiduciary responsibility of the Governing Body, the organized Medical Staff acknowledges that, in the event the Medical Staff has unreasonably failed to exercise its responsibility and, after notice from the Governing Body to such effect, including a reasonable period of time for response, the Governing Body may impose conditions on the Medical Staff that are required for continued state licensure, approval by accrediting bodies, or to comply with law or a court order. In such event, Medical Staff recommendations and views shall be carefully considered by the Governing Body in its actions.

14.3 Rules and Regulations

The MSEC shall, in consultation with the Chief Medical Officer, adopt such rules and regulations ("Rules") and Medical Staff Administration Policies and Procedures as may be necessary to assure the proper conduct of Medical Staff activity. Such rules and regulations and Medical Staff Administration Policies and Procedures shall be consistent with these Bylaws and may be amended without advance notice at any meeting of the MSEC.

14.4 Technical and Editorial Amendments

The MSEC shall have the power to adopt such amendments to the Bylaws and Rules that are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression or inaccurate cross-references. The action to amend may be made by motion and acted upon in the same manner as any other motion before the MSEC subject to final approval by the MSEC and Governing Body. Such changes shall be communicated in writing to the Medical Staff by the MSEC or Governing Body.

14.5 Urgent Amendments to Comply with Law or Regulation
In cases where the MSEC recognizes a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the MSEC shall have the power to provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification to the medical staff. In such cases, the medical staff will be immediately notified by the MSEC. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the medical staff and MSEC, then the provisional amendment stands. If there is a conflict, then the process for resolving conflict between the organized medical staff and the MSEC is implemented. If necessary, a revised amendment is submitted to the governing body for action.
ADOPTION

These bylaws may be amended as specified above, shall replace any previous Bylaws, and shall become effective when approved by the Governing Body.

ADOPTED by the Medical Staff on
June 19, 2015

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Peter Fedullo, MD
Chair, Medical Staff Executive Committee
UCSD Medical Center

APPROVED by the CEO, UCSD Medical Center on
October 1, 2014

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Paul Viviano

APPROVED by the Vice Chancellor, Health Sciences,
University of California, San Diego on
October 1, 2014

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David A. Brenner, M.D.