

ZSFG Medical Staff ByLaws 2017-2018

Table of Substantive Changes

Sections	Page	Current Language	Change
Preamble	1		Updated name throughout: The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center
Definitions	2	Governing Body	Revised to align with Governing Body Bylaws Added: “Hospital” “Hospital Administration” and Joint Conference Committee” to align with Governing Body Bylaws
Article 1 – Name and Purposes	3	§1.2 Purposes and Responsibilities	Added: The purpose of the Medical Staff is to work with, and alongside, Hospital Leadership and Staff to achieve the Hospitals True North. Specifically,
Article 2 – Medical Staff Membership	5	§2.2.4. Professional Liability Insurance-minimum \$1 million each occurrence/\$3 million aggregate	Increased to \$2 million/\$6million; allows an “excess or umbrella” policy to meet minimums
	7	§2.8.E. Complete new hospital orientation within thirty (30) days of receipt of temporary privileges or appointment to the Medical Staff.	Complete new hospital orientation prior to exercising privileges.
Article 3 – Categories of the Medical Staff	8	Active, Courtesy and Provisional	Revised: §3.2 definition of “Courtesy” Added: §3.4 “Administrative” and §3.5 “Inactive”

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Article 4 – Appointment and Reappointments	11	§4.2.3 Incomplete Application	Added: The (Applicant) will be notified of the missing items within thirty (30) days of withdrawal”
	13	4.3.7 Failure to Return a Completed Reappointment Application	Added: The (Applicant) will be notified of the missing items Added: “Genetic Counselors .
	15	§ 4.7.1. Affiliated Professionals	Added: ”Genetic Counselors”
Article 5 – Clinical Privileges	17	5.1.1 Process	Added: The Rules and Regulations of each Clinical Service specify the Clinical Privileges for that Service.
	19	5.3.1 To Meet a Specific Need	Added: (Note: ZSFG administrative Policy 22.06 refers to this position as “Consulting Clinical Physician.”)
	21		Added §5.6. Physician Observers from Policy 22.06.
Article 6 – Corrective Action	24		Added: §6.2.1.C. The Director of Health, or her/his designee, may restrict a Member’s access to key aspects of the ZSFG infrastructure in instances involving serious, material violations of federal, state, or local laws, or ZSFG rules, regulations, or policies that are not primarily related to quality of patient care, including any violation of patient confidentiality laws or policies. Access to patient health records kept or maintained

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			by the City and/or to physical locations (ZSFG, clinics, or other buildings owned or operated by the City) may be restricted, suspended, or permanently revoked in this manner. The approval of the MEC is not required for such actions.
Article 6 Corrective Action	28	<p>§ 6.4.4 Employment Action</p> <p>Nothing in this article or elsewhere in these Bylaws is intended to limit the University's or City's ability to take appropriate action with respect to employment,</p>	<p>Added clarifying language:</p> <p>Nothing in this article or elsewhere in these Bylaws is intended to limit the University's or City's ability to take appropriate action with respect to employment. The University and the City have their own processes for employee discipline or other issues that are separate and distinct from processes under these Bylaws. To the extent that University or City take action against their own employees through their respective processes, such processes include appropriate due process protections.</p>
	30	§6.6.2. Licensure	<p>Added new subsection:</p> <p>D. A Member's Privileges automatically suspended under this subsection 6.6.2, may be reinstated only upon written notice from the Chief of Staff or his/her designee. Such reinstatement may include restrictions if imposed in</p>

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			accordance with section 6.3. If the Member provided patient care at ZSFG, or any City-affiliated institution while the Member's license or credential was revoked, suspended, expired, limited, restricted or while the Member was on probation, reinstatement may not be granted until all instances of the Member's patient care and billing during that time are reviewed to ensure that appropriate care was rendered, and to prevent improper billing.
Article 7 – Hearings and Appellate Reviews	32		Added: §7.2.2. Actions taken by the Director of Health, or her/his designee, pursuant to Section 6.2.1.C. are subject to hearing under these Bylaws only for the purpose of determining whether to revoke, suspend or restrict Privileges conferred by these Bylaws.
Article 8 – Structure of the Medical Staff	39		None
Article 9 – Clinical Services	42		None
Article 10 – Physician Leadership	47		Entire Article is new

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Article 11 – Committees of the Medical Staff	50	§11.2.10. Minutes and Reporting	Added: standard meeting minutes template, Appendix 2
	51	§11.3.1 Composition of MEC	Deleted: the Medical Director of Trauma Services,
	55	11.5.2 Ambulatory Care Committee Duties	H. Report to the MEC on activities, including policy recommendations, no less frequently than every annually.
	56	11.5.4 Reporting	Added: Submits a written report to the MEC on activities, including policy recommendations, annually.
	54	(former) §10.5. Joint Conference Committee	Deleted
	54	§11.8. Credentials	§11.8.4 Reports to MEC monthly
	57	§11.8.5. CIDP Subcommittee	§11.8.5.D. Reports Monthly
	58	§11.9.5(1) Donor Council Subcommittee	§11.9.5(1)D. Reports twice yearly
	59	§11.11. Infection Control	§11.11.1 Revised composition
	60		§11.11.2 Revised duties
	61	§11.11.3. Meets monthly	§11.11.3 Meets bimonthly
	62	§11.12. Medical Staff Well Being	§11.12.4. Reports to MEC quarterly
	63	§11.13. Operating Room	§11.13.1. Revised composition §11.13.2 Revised duties

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	65	§11.14. Pharmacy & Therapeutics	§11.14.4. Reports to MEC monthly
	65	§11.14.5.C. Medication Use Subcommittee	§11.14.5.C. Revised duties
	64	§11.14.5.E. Pain Management Subcommittee	§11.14.5.D. Revised duties Added: §11.14.5.D. Medication Error Reduction Plan Subcommittee Added: §11.14.6. Subcommittees report monthly
	66	§11.15. PIPS	§11.15.1. Revised composition §11.15.2. Revised duties §11.15.4. Reports to JCC monthly
	65-66	§11.15.5.B. Pediatric Emergency Medicine Subcommittee	§11.15.5.B. Deleted
	66	§11.15.5.C. Risk Management Subcommittee	§11.15.5.B. Renamed “Event Analysis & System Improvement Subcommittee (EASI) §11.15.5.B.(2) Revised duties

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	67	§11.15.5.D. Transfusion Subcommittee	§11.15.5.C.(1) Revised composition §11.15.5.C.(3) Reports to PIPS twice yearly
	67-68	§11.15.5.E. Trauma Program Operational Process Performance Subcommittee	§§11.15.5.D and F.(4) Trauma Program Operational Process Performance and Trauma Multidisciplinary Peer Review Subcommittees combined Trauma report to PIPS twice-yearly
	68	§11.15.5.F. Trauma Multidisciplinary Peer Review subcommittee	
	69	§11.15.5.G. Tissue Subcommittee	§11.15.5.F(2) Revised duties
		§11.15.5.H. Procedural Sedation Subcommittee	§11.15.5.G.(1) Revised Composition §11.15.5G.(4) Reports to PIPS twice yearly
	69	§11.16. Utilization Management	§11.16.5 Reports to MEC quarterly
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Article 16 – Adoption and Amendment	85		None

**THE PRISCILLA CHAN AND MARK ZUCKERBERG
SAN FRANCISCO GENERAL HOSPITAL
AND TRAUMA CENTER**

MEDICAL STAFF BYLAWS

2017-2018

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PREAMBLE

WHEREAS, The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG or Hospital) is a public hospital organized under the laws of the State of California and the Charter of the City and County of San Francisco; and

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

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

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

DEFINITIONS

Affiliated Professional: Individuals who are credentialed through the Medical Staff, are subject to general Medical Staff oversight, and belong to a professional category not eligible for Medical Staff Membership. They are not Members of the Medical Staff and are not afforded the due process rights set forth in these Bylaws.

Attending Faculty or Attending: Member of the Medical Staff.

Applicant: Physician, dentist, podiatrist or clinical psychologist who is applying for Medical Staff membership.

City and County: The City and County of San Francisco.

Clean Application: An application for membership to the Medical Staff for which there is no missing information, all primary source verifications have been completed, and there are no issues that give rise to the ethics, judgement, or quality of care of the application. The Chair of the Credentials Committee, in his/her sole discretion, shall make the final determination as to whether the application is clean. Such applications may be approved by an email vote of the Credentials Committee and the Medical Executive Committee. Approval by the Governing Body must occur at a meeting of the Governing Body or a Committee of the Governing Body.

Date of Receipt: The date on which any Notice, Special Notice or other communication that was delivered personally or electronically, or 3 days after it was postmarked.

Days: Calendar days.

Department Chair: The Chair of the Department at the University of California, San Francisco. For the Community Primary Care Service; (CPC), the Director of ~~Public~~ Health will act as the "Department Chair".

Director of Health: The Director of the San Francisco Health Department and the individual who serves as the Chief Executive Officer of the Governing Body and, as such, information required to be communicated to the Governing Body by these Bylaws may be communicated to the Director of Health without jeopardizing any peer review protections.

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Director of the San Francisco Health Network: The individual responsible for managing the delivery system of the Department of Health and who supervises the Hospital's Chief Executive Officer. Information required to be communicated to the Hospital's Chief Executive Officer may be communicated to the Director of the San Francisco Health Network without jeopardizing any peer review protections.

DPH: The San Francisco Department of Public Health.

Governing Body: The San Francisco Health Commission subject to the responsibilities designated to the ~~When the Governing Body has delegated authority to the~~ Director of Health by the San Francisco Charter and Municipal Code to make determinations regarding appointments, reappointments, termination of appointments, and the granting or revision of Clinical Privileges, the term "Governing Body" shall refer to the Director of Health.

Hospital: The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center.

Hospital Administration: Executive Staff Committee members, including the ZSFG Chief Executive Officer, Senior Associate Administrators, and Associate Administrators appointed by the Director of Health or ZSFG Chief Executive Officer, who implement the day-to-day operations of the Hospital.

House Staff: Trainees in ACGME or ABMS programs.

Joint Conference Committee for Quality Assurance (JCC): the committee where members of the Governing Body, Hospital Administration and Medical Staff review and discuss the Hospital's credentialing and quality assurance and performance improvement program.

Medical Staff Services Department (MSSD): The hospital department that administratively supports medical staff activities.

Medical Staff Year: The period from July 1 through June 30.

Member: Physicians, dentists, clinical psychologists, and podiatrists whose applications have been approved by the Medical Executive Committee and the Governing Body for membership on the Medical Staff.

Notice: A written communication delivered personally, by email, electronically, or sent by United States mail regarding an appointment, reappointment, privileges, or medical Staff status.

San Francisco Health Network (SFHN): The healthcare delivery system of the San Francisco Health Department. ~~Zuckerberg San Francisco General Hospital~~ and community primary care are ~~is~~ a components of this delivery system that also includes skilled nursing care, mental health, substance abuse, and jail health services.

Special Notice: Refers to a Notice regarding potential or pending corrective action regarding an appointment, reappointment, privileges, or Medical Staff status.

University or UCSF: The University of California, San Francisco.

Vice Chair of a Medical Staff Committee: An individual who is subordinate to the Committee Chair and need not be a Member of the Medical Staff. The Vice Chair may chair Committee meetings and may represent the Committee at Medical Executive Committee meetings in the absence of the Chair.

Vice Dean: The UCSF Vice Dean located at the Hospital.

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

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ARTICLE 1. NAME AND PURPOSES

1.1. Name

The name of this organization shall be the Medical Staff of The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center (SFGH/ZSFG or Hospital, as used herein).

1.2. Purposes and Responsibilities

The purpose of the Medical Staff is to work with, and alongside, Hospital Leadership and Staff to achieve the Hospital's True North (See, Appendix 1). Specifically, The Medical Staff's purposes and responsibilities are to:

1.2.1. Collaborate

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

1.2.2. Patient Care

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

1.2.3. Professional Performance

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

1.2.4. Educational Setting

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

1.2.5. Community Health Education

Organize and support community health education and support services;

1.2.6. Self-Governance

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

1.2.7. Communication

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

1.2.8. Performance Improvement and Patient Safety

Incorporate the principles of performance improvement and patient safety in the provision of clinical care.

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ARTICLE 2. MEDICAL STAFF MEMBERSHIP

1.1.2.1. General Qualifications

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

2.1.2.2. Basic Qualifications for Consideration of Application Active and Courtesy Medical Staff

An Applicant must demonstrate compliance with all the basic standards set forth in this Section 2 in order to have an application for ~~Member-Medical Staff Membership-membership~~ accepted for review. The Applicant must meet the following standards:

2.1.1.2.2.1. Licensure

Physicians must (1) be licensed to practice medicine by the Medical Board of California or ~~Board of Osteopathic Examiners of the State of California~~~~Osteopathic Medical Board of California~~ or (2) comply with all of the requirements of California Business and Professions Code Section 2113 or Section 2168 et seq., including possession of a valid and current Certificate of Registration under those code sections and approval by the UCSF Dean, School of Medicine and the Vice Dean at ~~SFGHZSFG~~.

Dentists must be licensed to practice dentistry by the Dental Board of California.

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

Clinical psychologists must be licensed to practice clinical psychology by the California Board of Psychology of the Medical Board of California.

2.1.2.2.2.2. Drug Enforcement Agency (DEA)

Applicants must possess a valid federal DEA number unless the Applicant will never prescribe, or supervise the prescribing of, medications.

2.1.3.2.2.3. Board Certification

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

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training in that specialty or subspecialty. Applicants/re-applicants must become board certified before their first reappointment. Where this is not possible due to board requirements, the Applicant must become board certified within two years of meeting board requirements and no later than six years after the initial granting of Medical Staff membership. Re-applicants who have let their board certification lapse must become board certified no later than the second reappointment after their certification lapsed.

- B. A Clinical Service Chief may submit a written request for waiver of the certification requirement or an extension of the six year period to become board certified to the Medical Executive Committee (**MEC**) for persons who demonstrate that his/her education, training, experience, ability, judgment and medical skills make them sufficiently qualified to serve as Medical Staff Members. The ~~Medical Executive Committee~~ and the Governing Body will consider each request and determine whether approval is in the best interest of the patients and of the Hospital.
- C. The board certification requirement does not apply to the following:
 - 1) Dentists, podiatrists, and clinical psychologists;
 - 2) UCSF physicians practicing medicine with the approval of the Medical Board of California under California Business and Professions Code 2113 or 2168 (foreign trained physicians).

2.1.4.2.2.4. Professional Liability Insurance

Individuals who are not Members of the faculty of the University and are not employed by the City and County of San Francisco, shall maintain professional liability insurance in an amount not less than ~~\$1.2~~ million each occurrence, ~~\$3-6~~ million ~~aggravate-aggregate and if applicable,~~ with an insurance carrier acceptable to the ~~Chief Executive Officer~~**City's Risk Manager**. Each such Member shall upon acceptance of the Medical Staff and thereafter at any time requested by the Credentials Committee, provide the Credentials Committee with written evidence of conforming coverage. An excess or umbrella policy for liability coverage that "follows form" can be used to meet this requirement. Each such Member shall promptly report to the Credentials Committee any reduction, restriction, cancellation for termination of the required insurance coverage or, if applicable, change of insurance carrier. Insurance requirements set forth in these Bylaws are subject to review and approval by the City's Risk Manager, and may be updated by the City's Risk Manager from time to time as conditions warrant.

2.1.5.2.2.5. Participation in Medicare, Medicaid and Other Federal Health Care Programs

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

2.2.2.3. Qualifications for Membership

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

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2.2.1.2.3.1. Experience, Education and Training

Document his/her (1) adequate experience, education, and training in the requested privileges; (2) current professional competence; (3) ability to perform the privileges requested; (4) good judgment; and (5) adequate physical and mental health to perform patient care activities, and demonstrate to the satisfaction of the Medical Staff that he/she is professionally and ethically competent to reliably provide the quality of care acceptable by the Medical Staff.

2.2.2.2.3.2. Ethics

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

2.3.2.4. Condition and Duration of Appointment

2.3.1.2.4.1. Governing Body Action

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

2.3.2.2.4.2. Duration

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

2.3.3.2.4.3. Clinical Privileges

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

2.3.4.2.4.4. Provide Care

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

2.3.5.2.4.5. Shall Not Discriminate

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

2.3.6.2.4.6. Division of Fees

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

2.4.2.5. Harassment Prohibited

Harassment by ~~Medical Staff~~ Member against any individual (e.g., against another Medical Staff Member, House Staff, Hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, age, disability, marital status, sex, gender or sexual orientation

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shall not be tolerated. All allegations of harassment will be investigated according to policies adopted by the City/~~County of San Francisco~~ and/or University ~~of California~~.

2.5.2.6. Nondiscrimination

No aspect of Medical Staff ~~Membership-membership~~ or Clinical Privileges shall be denied on the basis of race, religion, color, national origin, ancestry, age, disability, marital status, sex, gender or sexual orientation. The credentialing and recredentialing processes will be conducted in a non-discriminatory manner and Members responsible for credentialing decisions will be required to sign an affirmative statement that they will make decisions in a non-discriminatory manner. Additionally, the Medical Staff shall not discriminate with respect to staff privileges or the provision of professional services against a licensed physician and surgeon or podiatrist on the basis of whether the physician and surgeon or podiatrist holds an M.D., D.O., or D.P.M.

2.6.2.7. Effect of Other Affiliations

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

2.7.2.8. Basic Responsibilities of the Medical Staff

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

- A. Provide his or her patients with care that is of a generally recognized professional level of quality and efficiency~~;~~
- B. Abide by the Medical Staff Bylaws and Rules and Regulations and all other lawful standards and policies of the Medical Staff and the Hospital~~;~~
- C. Abide by applicable laws and regulations of government agencies, standards of The Joint Commission on the Accreditation of Health Care Organizations, and the Center for Medicare and Medicaid Services (CMS) Conditions of Participation~~;~~ ~~and~~
- D. Discharge such Medical Staff, Clinical Service, committee and service functions for which he or she is responsible by appointment, election or otherwise~~;~~ ~~and~~
- E. Complete new hospital orientation ~~within thirty (30) days of receipt of temporary privileges or appointment to the Medical Staff prior to exercising privileges.~~

2.8.2.9. Non-Compliance With Basic Qualifications

An Applicant who does not meet these basic qualifications is ineligible to apply for Medical Staff membership and the application shall not be accepted for review. If it is determined during the review process that an Applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An Applicant who does not meet the basic qualifications is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific qualifications which adversely affected such Applicant, to the Credentials Committee.

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Those comments and requests shall be reviewed by the Credentials Committee and MEC which shall have the sole discretion to determine whether the Applicant complies with the basic qualifications for Medical Staff membership.

ARTICLE 3. CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall be divided into Active, Courtesy, ~~and~~ Provisional, ~~Administrative, and Inactive~~ Staff categories.

2.9.3.1. Active Medical Staff

The Active Medical Staff shall consist of physicians, dentists, clinical psychologists and podiatrists qualified for Medical Staff membership who spend the majority of their clinical effort regularly treating patients under the direction of a Clinical Service of the Medical Staff at SFGHZSFG or DPH healthcare facilities. Members of the Active Medical Staff shall be appointed to a specific Clinical Service, shall be eligible to vote, to hold Medical Staff offices and to serve on Medical Staff committees. Active Medical Staff Members are required to participate in Clinical Service conferences, meetings and continuous quality improvement.

2.10.3.2. Courtesy Medical Staff

The Courtesy Medical Staff shall consist of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who do not ~~regularly spend the majority of their clinical effort, or who~~ spend an average of less than 4 hours per week, treating patients under the direction of a Clinical Service of the Medical Staff. Courtesy Medical Staff Members shall be appointed to a specific Clinical Service and may serve on Medical Staff ~~C~~committees. Courtesy Medical Staff Members shall not be eligible to hold Medical Staff Offices or to vote on amendments to these Bylaws and Rules and Regulations. ~~Courtesy Medical Staff Members are encouraged, but not required, to participate in Clinical Service conferences and meetings; eligibility to vote at such conferences and meetings is at the discretion of the Chief of the Clinical Service.~~

2.11.3.3. Provisional Medical Staff

The Provisional Medical Staff shall consist of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who have yet to complete initial proctoring requirements. Provisional Medical Staff Members shall be appointed to a specific Clinical Service and may serve on Medical Staff Committees. Provisional Medical Staff Members shall not be eligible to hold Medical Staff Offices or to vote on amendments to these Bylaws and Rules and Regulations. Provisional Medical Staff Members are required to participate in Clinical Service conferences and meetings; eligibility to vote at such conferences and meetings is at the discretion of the Chief of the Clinical Service.

3.4. Administrative Medical Staff

The Administrative Medical Staff shall consist of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who have a significant administrative medical role, ~~have been granted access to Medical Records, consult with other Members of the Medical Staff, but who do not have Clinical Privileges or provide direct care to patients. Administrative Medical Staff Members need not be appointed to a specific Clinical Service, shall be eligible to vote, to hold Medical Staff offices and to serve on Medical Staff committees.~~

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3.5. Inactive Medical Staff

The Inactive Medical Staff shall consist of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who are missing one or more requirements to begin or continue practicing privileges. These requirements may include, but are not limited to, initial and annual hospital orientation and Environmental Health & Safety (E-H & S)- requirements such as TB testing and N95 fit testing.

ARTICLE 3.ARTICLE 4. APPOINTMENT AND REAPPOINTMENTS

3.1.4.1. General

3.1.1.4.1.1. Application Process

All applications for appointment and reappointment to the Medical Staff must be in writing, signed by the Applicant, and submitted to the Medical Staff Services Department ("MSSD") on a form approved by the Governing Body, upon recommendation of the Credentials Committee.

3.1.2.4.1.2. Application Content

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

- A. Any previous denial, revocation, suspension, reduction, limitation, probation, loss or relinquishment, whether voluntary or involuntary, to a professional license or ~~Drug Enforcement Administration (DEA)~~ license;
- B. Voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital or other health care organization;
- C. A factual synopsis of all pending and resolved professional liability actions, made within the previous five (5) years;
- D. For any resolved professional liability actions, a description of the judgment, arbitration award, settlement or other disposition;
- E. Attestation questions regarding the following issues:
 - 1) Reason for an inability to perform essential functions of the position;
 - 2) History of chemical dependence or substance abuse;
 - 3) Violations of any criminal law or statutes;
 - 4) Denial, revocation, suspension, reduction, limitation, probation, loss or relinquishment of licensure;
 - 5) Disciplinary activity or limitation of privileges and/or Medical Staff status;

3.1.3.4.1.3. Completion of Application

An application is "completed" when the Applicant has supplied all of the requested information and all necessary verifications have been obtained — including, but not limited to,

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current license, licensing board disciplinary records, specialty Board Certification status, National Practitioner Data Bank (NPDB) information, DEA certificate, if appropriate, training and practice from professional school through the present, current malpractice liability insurance and history, and reference letters, as specified in Section 4.2.2, below.

3.1.4.1.4. Application Misrepresentation or Omission

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

3.1.5.4.1.5. Effect of Application

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

- A. Signifies his/her willingness to appear for interviews with the ~~medical-Medical staff~~Staff;
- B. Authorizes the Medical Staff to consult with Medical Staff Members of other health care facilities with which the Applicant has been associated and who may have information bearing on the Applicant's competence, character, ethical qualifications, relevant mental and physical health, and any claims history;
- C. Consents to the Medical Staff's inspection of all records and documents pertinent to the Applicant's current licensure, specific training, experience, current clinical competence and ability to perform the privileges requested and other matters that may be material to an evaluation of professional qualifications for Medical Staff membership;
- D. Releases from any liability the Hospital, the Medical Staff, the Governing Body, the City ~~and County~~, and the University, for any acts performed in good faith and without malice in connection with evaluating the Applicant's credentials; and
- E. Certifies that he/she shall promptly report to the ~~Medical Staff Services Department (MSSD)~~ any changes in the information submitted on the application which may subsequently occur.

3.1.6.4.1.6. Applicant's right to be informed

Each Applicant has the right to be informed of the status of ~~their~~ his/her credentialing or recredentialing application upon request.

3.2.4.2. Initial Appointment Process

3.2.1.4.2.1. Applicant's Receipt of Medical Staff Information

The Applicant shall be provided with a copy of, or access to, the Medical Staff Bylaws and Rules and Regulations, and Clinical Service Rules and Regulations governing the Applicant's specialty.

3.2.2.4.2.2. Completed Application

The completed application for initial appointment shall include detailed information concerning the Applicant's professional qualifications, including, but not limited to, education, professional training, experience, licensure, relevant physical and mental health, disciplinary history, claims history, information regarding possible involvement in professional liability actions, biographical data, requests for Clinical Privileges, peer references, health care facility affiliations, current professional insurance coverage, documentation of additional appropriate

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licenses, certificates, or registrations required by law and/or the Medical Staff Bylaws and the appropriate Clinical Service Rules and Regulations, specialty board status, University faculty appointment status and employee status; a signed agreement that the Applicant has read and shall abide by the Medical Staff Bylaws and the appropriate Clinical Service Rules and Regulations; a release from liability for all parties engaging in good faith peer review, commencing with the credentialing process; a signed statement of commitment to the confidentiality of all Medical Staff proceedings.

3.2.4.2.3. Incomplete Application

An incomplete application will not be processed, ~~and if~~ an Applicant fails to complete the application within sixty (60) days after the date of initial submission, it will be considered voluntarily withdrawn, ~~and~~ the Applicant will be notified of the missing items within thirty (30) days of withdrawal. Such withdrawal shall not entitle the Applicant to the rights set forth in these Bylaws. The Credentials Committee may, for a good cause, extend the time for completion of the application.

3.2.4.2.4. Recommendation for Medical Staff Membership and Clinical Privileges

When the ~~Medical Staff Services Department (MSSD)~~ has received all necessary verifications, the completed application, ~~and~~ all supporting documentation and other relevant information (~~the "file"~~) shall be submitted to the Service Chief for review and recommendations regarding membership and Privileges. The Service Chief's written recommendations shall then be forwarded to the Credentials Committee. If the Applicant is seeking privileges in more than one ~~eClinical sService~~, then the ~~file~~ shall be submitted to ~~both the applicable~~ Service Chiefs for written recommendations.

3.2.5.4.2.5. Credentials Committee Review and Action

The Credentials Committee shall review the completed application and ~~file~~ and the Service Chief's recommendations at the next regularly scheduled Credentials Committee meeting. The Credentials Committee, or a subcommittee thereof, may interview the Applicant if there are contents of the application that require clarification in person. The Credentials Committee shall then submit to the ~~Medical Executive Committee (MEC)~~ its written report and recommendations as to membership and Privileges.

3.2.6.4.2.6. Medical Executive Committee Review and Action

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

- A. When the recommendation of the MEC is favorable to the Applicant, it shall be forwarded to the Governing Body, through the Director of Health.

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- B. When the recommendation of the MEC is to defer the application for further consideration, the MEC must reconsider the application at its next regularly scheduled meeting.
- C. When the recommendation of the MEC is adverse to the Applicant in respect to appointment or Clinical Privileges, the Chief of Staff shall promptly notify the Division/Service Chief. The Chief of Staff shall also notify the Applicant by Special Notice, in accordance with Section 7.3 of these Bylaws. The Governing Body shall be generally informed of the recommendation for informational purposes, but it shall not act on it until after the Applicant has exercised, or has been deemed to have waived, his/her procedural rights set forth in Articles 6 and 7 of these Bylaws.

3.2.7.4.2.7. Governing Body Review and Action

The Governing Body shall act upon favorable recommendation at its next regularly scheduled meeting and notify the Applicant of its decision. If the Governor Body's decision is adverse to the Applicant in respect to appointment or Clinical Privileges, the Chief of Staff, upon receiving notice of the Governing Body's decision, through the Director of Health, shall promptly notify the Applicant and Chief of the Clinical Service of such adverse decision by Special Notice, in accordance with Section 7.3 of these Bylaws. Such adverse decision shall be held in abeyance until the Applicant has exercised, or has been deemed to have waived, his/her procedural rights under Articles 6 and 7 of these Bylaws. The fact that the adverse recommendation or decision is held in abeyance during the hearing and appellate review shall not confer Privileges where none existed before.

- A. In the event the Governing Body wishes to defer action, it may do so by referring the matter back to the MEC with a statement of its reasons for doing so. Any such referral to the MEC shall set a time limit (not to exceed sixty (60) days) for the MEC is to provide additional information or recommendations or take further action.
- B. The final decision of the Governing Body shall be made within forty-five (45) days of its initial consideration of a decision contrary to the recommendation of the MEC. This final decision shall be promptly forwarded to the MEC and the Applicant.
- C. The time periods set forth in this section are guidelines only, and are not directives which create any right for an Applicant to have an application processed within these precise periods. When no time periods are specified, all parties shall act as soon as reasonably practicable.

3.3.4.3. Reappointment Process

3.3.1.4.3.1. Frequency

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

3.3.2.4.3.2. Reappointment Application Process

At least one hundred and twenty (120) days before the expiration of a **Medical Staff** Member's appointment, the MSSD shall mail the Member a reappointment application. Within

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thirty (30) days of the date the application was mailed, the Member must return the completed application to the MSSD, along with all required information and materials.

3.3.3.4.3.3. Recommendation for Reappointment

Each Service Chief in which the ~~Medical Staff~~ Member requests, or has exercised Privileges, shall review the Member's completed application and file and forward his/her written recommendations to the Credentials Committee. The recommendations shall include a statement that the recommendations are based on the Clinical Service's performance improvement information for the Medical Staff Member, any professional liability claims, the Member's clinical activity, education, and training, and any other pertinent information.

In addition to the items listed in subsection 4.3.3 above, each recommendation concerning reappointment of a ~~Medical Staff~~ Member, and the Clinical Privileges to be granted upon reappointment, shall be based upon such Member's current professional performance, evidence of progression towards Board Certification or re-certification (if applicable), current competence, clinical or technical skills and judgment in the treatment of patients, ongoing provider specific continuous quality improvement evaluations, ethical conduct, attendance at Medical Staff meetings and participation in Medical Staff affairs, compliance with these Bylaws and Rules and Regulations, voluntary or involuntary loss and/or relinquishment of Privileges or licensure, results from the National Practitioner Data Bank inquiry, and mental or physical health that permits the Member to carry out the essential functions of his/her Medical Staff category or Privileges, with or without reasonable accommodation.

3.3.4.4.3.4. Credentials Committee Action

The Credentials Committee shall review the completed reappointment application and file and the Clinical Service Chief's final recommendations at the next regularly scheduled Credentials Committee Meeting. The Credentials Committee, or a subcommittee thereof, may interview the Applicant if there are contents of the application that require clarification in person. The Credentials Committee shall then submit to the MEC its written report and recommendations as to reappointment and Privileges.

3.3.5.4.3.5. Medical Executive Committee Action

At its next regularly scheduled meeting after receipt of the written report and recommendations of the Credentials Committee, the MEC shall review the Credentials Committee's report and recommendations, and make recommendations to the Governing Body that the application be approved, denied, or deferred for further consideration.

When the recommendations include a denial of reappointment or a reduction in Clinical Privileges, the MEC shall document the reasons for such recommendations in the minutes. Thereafter, the procedures set forth in Section 4.2.6 above shall apply.

3.3.6.4.3.6. Term of Reappointment

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

3.3.7.4.3.7. Failure to Return a Completed Reappointment Application

If the ~~Medical Staff~~ Member has not returned a completed reappointment application to the MSSD within 30 days, then the MSSD will send a final reminder allowing a 15 day

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extension. Failure of a Medical Staff Member to return a completed application for reappointment at least ~~seventy-five (75) days~~ ~~one hundred and twenty (120) days~~ prior to the expiration of his/her current term can result in automatic termination of the Member's ~~P~~privileges effective on the date the Member's current term expires. The respective Clinical Service Chief shall be notified in writing of the delinquent reappointment and pending termination. Members who automatically resign under this section will be processed as a reappointment if he/she submits a completed reappointment application within thirty (30) days from the date of termination.

4.3.8. Reapplication After Adverse Decision

An Applicant or Member who has received a final adverse decision regarding appointment, reappointment, membership, or Privileges, or who has resigned after notice of an adverse recommendation or a final adverse decision, shall not be eligible to reapply to the Medical Staff for a period of two (2) years from the date of the final adverse decision or resignation. Thereafter, the Applicant may apply as a new Applicant and must submit information to demonstrate that the basis for the earlier adverse decision or recommendation no longer exists.

3.4.4.4. Access to Own Credentials File

~~Medical Staff~~ Members shall be provided with access to information in their own credentials file subject to the following provisions:

- A. The Member may receive a copy of only those documents provided by or addressed to the Member as well as Ongoing Professional Practice Evaluation (OPPE) reports;
- B. A summary of peer review information, committee findings, letters of reference, proctoring reports, and complaints shall be provided to the Member by the Chief of Staff within 30 days of receipt of such a request. Summaries of peer review materials shall disclose the substance, but not the source, of the information.

3.5.4.5. Right to Request Corrections/Additions

~~Medical Staff~~ Members may exercise the right to request corrections or additions to their credentials file following the protocol set forth below:

- A. Members shall have the right to add to his/her own credentials file a statement responding to any information contained in the file;
- B. A Member may submit a written request to the Chief of Staff for the correction or deletion of information in the credentials file. Such requests shall include a statement of the basis for the action requested;
- C. The Chief of Staff shall recommend to the MEC whether or not to make the requested correction or deletion;
- D. The MEC shall approve or deny the Chief of Staff's recommendation by a majority vote; ~~and~~
- E. The Member shall be notified by the Chief of Staff of the decision of the MEC.

3.6.4.6. House Staff

House Staff are not eligible for Medical Staff membership.

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3.7.4.7. Affiliated Professionals

3.7.1.4.7.1. General

- A. Affiliated Professionals are individuals who:
- 1) Are employees of the City ~~and County~~, or faculty or employees of the University, or functioning under an MOU approved by the MEC and Governing Body, and provide health services requiring them to exercise independent judgment within the area of his/her professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable State laws.
 - 2) Do not qualify for Medical Staff membership because they are not licensed as physicians, dentists, clinical psychologists, or podiatrists and may not vote on amendments to the Bylaws and Rules and Regulations; and
 - 3) Belong to one of the following professional categories:
 - Licensed Acupuncturists
 - Certified Nurse Midwives
 - Certified Registered Nurse Anesthetists
 - Nurse Practitioners
 - Physician Assistants
 - Clinical Pharmacists (PharmD)
 - Optometrists
 - Genetic Counselors
- B. Although not eligible for Medical Staff membership, Affiliated Professionals shall be credentialed through the Medical Staff and shall be subject to general Medical Staff oversight and to ~~the~~ the direction ~~of~~ by Medical Staff Members.
- C. The clinical responsibilities of each Affiliated Professional shall be set forth in standardized procedures developed by the Committee on Interdisciplinary Practice and approved by the Credentials Committee, ~~Medical Executive Committee~~, and the Governing Body, Joint Conference Committee.

3.7.2.4.7.2. Role of Medical Staff

- A. The work of each Affiliated Professional shall be conducted with oversight of a physician Member who shall be available either physically or electronically at any time the Affiliated Professional is acting pursuant to a standardized procedure. A Medical Staff Member can supervise the clinical activities of no more than four Affiliated Professionals at one time.
- B. Affiliated Professionals may practice within the scope of his/her licensure, as limited by any relevant Hospital and Medical Staff policies and procedures.
- C. As employees of either the City ~~and County~~ or the University, Affiliated Professionals shall be recruited and hired through the usual personnel processes of each entity. Any

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~~offer of employment~~-clinical activity shall be contingent upon Medical Staff approval following the procedures set forth below.

3.7.3.4.7.3. Appointment

- A. Each Affiliated Professional who has been provisionally hired shall submit an application to the MSSD for appointment to Affiliated Professional status. The Applicant shall furnish all information required on the application form or reasonably requested by the Interdisciplinary Practice Committee, Credentials Committee, or the MEC. The Applicant shall have the burden of producing adequate information for a proper evaluation of competency, character, and ethics. An Applicant who fails to provide all requested information within thirty (30) days of the date of being notified of any deficiencies shall be deemed to have withdrawn the application.
- B. An Applicant who is on the Office of Inspector General (OIG) Exclusion List is not eligible for appointment as an Affiliated Professional.
- C. An Applicant must possess a National Provider Identifier (NPI) or must have submitted an application for a NPI in order to be considered for appointment or reappointment as an Affiliated Professional.
- D. An Applicant must possess a DEA certificate or have submitted the application for a DEA certificate unless the Applicant will be working in an area where no medications are prescribed (such as Radiology or Pathology) or whose licensure does not allow prescribing medications.
- E. An Applicant must have enrolled in Medicare and received an enrollment confirmation letter, excluding PharmDs whose professional services are not reimbursed by Medicare and Nurse Practitioners hired prior to April, 2004 without a master's degree.
- F. Nurse Practitioners hired by the City ~~and County~~ or University after April, 2004 must have a master's degree in nursing and ~~are~~be board eligible.
- G. The MSSD shall forward the completed application to the Chair of the Interdisciplinary Practice Subcommittee of the Credentials Committee. The Interdisciplinary Practice Subcommittee shall review the application and shall forward the application together with its recommendation to the Credentials Committee.
- H. The Credentials Committee shall review the application and make a recommendation to the MEC.
- I. The MEC shall review the recommendation of the Credentials Committee and make a recommendation to the Governing Body.
- J. The Governing Body shall review the recommendation of the MEC and shall make a decision whether to approve the Affiliated Professional. .
- K. If the Governing Body denies the Applicant's admission to Affiliated Professional status, the Applicant shall be limited to the remedies set forth in the Grievance Procedures in the applicable Memorandum of Understanding. The Applicant shall not be entitled to any of the procedural rights set forth in these Bylaws.

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- L. Services that require a standardized procedure may not be performed until the Applicant's credentials and a standardized procedure have been approved by the Medical Staff.
- M. An Affiliated Professional who is admitted to Affiliated Professional status shall be subject to a period of proctoring/evaluation under rules and procedures established by the relevant clinical service.
- N. By applying for Affiliated Professional status, the Applicant agrees to the same provisions that apply to Applicants for Medical Staff membership set forth in Sections 4.1.3, 4.1.4 and 4.1.5 of these Bylaws.
- O. Any material misrepresentation by an Applicant may be grounds for ~~disapproval~~ denial of the application or for termination of Affiliated Professional status.

3.7.4.4.7.4. Reappointment

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

3.7.5.4.7.5. Corrective Action

- A. Any corrective action against an Affiliated Professional shall be in accordance with the procedures set forth in the applicable City or University employment Memorandum of Understanding (MOU). The Applicant shall not be entitled to any of the procedural rights set forth in these Bylaws.
- B. In the event that immediate action is necessary to prevent imminent danger to the health or safety of any individual, the Affiliated Professional's right to perform some or all duties set forth in the Job Description may be suspended immediately, in accordance with the procedures set forth in the applicable Memorandum of Understanding MOU. The Applicant shall not be entitled to any of the procedural rights set forth in these Bylaws.

ARTICLE 4. ARTICLE 5. CLINICAL PRIVILEGES

4.1.5.1. Clinical Privileges

4.1.1.5.1.1. Process

Members ~~of the Medical Staff~~ shall be entitled to exercise only those Clinical Privileges specifically granted to him/her by the Governing Body except as provided in Sections 5.2 herein regarding temporary privileges. The granting of Privileges depends upon an individual's documented experience in categories of diagnostic and treatment areas and current competence as judged by ongoing continuous quality improvement reviews. The Rules and Regulations of each Clinical Service specify the Clinical Privileges for that Service.

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4.1.2.5.1.2. Education, Training and Experience

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

4.1.3.5.1.3. Evaluation

Ongoing monitoring of Clinical Privileges shall be based on direct observation of the care provided, review of medical records, and other peer review activities.

4.2.5.2. Temporary Privileges

4.2.1.5.2.1. Pending Application for Permanent Medical Staff Membership

- A. In the event that there is a compelling patient care need ~~for~~ which the Chief of the Clinical Service could not have anticipated, the Chief of Staff may grant temporary privileges to an Applicant who has a Clean Application that has been approved by the Credentials Committee and the Medical Executive Committee and is pending the next meeting of the Governing Body for final approval.
- B. No person with Temporary Privileges may vote or hold office.
- C. Temporary Privileges may be granted for a period not to exceed sixty (60) days.

4.2.2.5.2.2. Application and Review

The Chief of Staff, with the concurrence of the Chief Executive Officer, may grant Temporary Privileges after the following has been completed:

- A. The Chair of the Credentials Committee has determined that the Applicant has a "Clean Application" as defined in the Definition section of these Bylaws.
- B. The Applicant has been approved by a quorum of both the Credentials Committee and the ~~Medical Executive Committee~~. Such approval may be obtained through a vote via email.
- C. The Chief of the Clinical Service provides the Chief of Staff with a compelling patient care need that could not have been anticipated and that requires that the services of the Applicant begin before the application can be approved at the next meeting of the Governing Body.

4.2.3.5.2.3. General Conditions

- A. There is no right to Temporary Privileges, ~~and~~ they may be granted at the sole discretion of the Chief of Staff only after a Clean Application has been approved by the Credentials Committee and ~~Medical Executive Committee~~.
- B. 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.

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- C. In exercising Temporary Privileges, the Applicant shall act under the supervision of the Chief of Service, or designee, to whom he/she is assigned and shall be proctored and monitored in accordance with the Clinical Service Rules and Regulations and the proctoring provisions set forth in these Bylaws.
- D. Temporary Privileges shall not be granted unless the Applicant has an academic appointment with the University, is an employee of the City ~~and County of San Francisco~~, or provides documentation of professional liability coverage in accordance to Section 2.2-4 of these Bylaws.
- E. Temporary Privileges shall not be granted unless the Applicant signs an acknowledgment that he/she has received, or been given access to, a copy of the Medical Staff Bylaws and agrees to be bound by the terms thereof.
- F. The Chief of Staff may use his/her discretion to restrict, suspend, or terminate any or all of the Temporary Privileges granted. In such an event, the Applicant shall not be entitled to the procedural rights set forth in Article 6 of these Bylaws, or to any other procedural rights, unless such action requires the filing of a report to either the Medical Board of California or the National Practitioner Data Bank.

4.3.5.3. Visiting Privileges

4.3.1.5.3.1. To Meet a Specific Need

- A. Visiting Privileges may be granted for a specified period of time, not exceed ninety (90) days, on a case-by-case basis when a patient(s) of a Clinical Service require the services of a physician, dentist, podiatrist, or clinical psychologist who is not a Member of the Medical Staff. If the individual with Visiting Privileges desires to join the Medical Staff, he/she shall submit an application as a new appointment. No person with Visiting Privileges shall vote or hold office. (Note: ZSFG Administrative Policy 22.06 refers to this position as “Consulting Clinical Physician”.)
 - 1) ~~(1)~~—The Chief of Staff, with the concurrence of the Chief Executive Officer, may authorize Visiting Privileges if ~~the~~ person has submitted a completed application for Visiting Privileges;
 - 2) ~~(2)~~—The Chief of Staff reasonably believes that the person has the qualifications, ability, and judgment required for Medical Staff membership;
 - 3) ~~(3)~~—The Chief of the Clinical Service requiring a person's services recommends the person; and
 - 4) ~~(4)~~—The Chief of the Clinical Service has provided, in writing, the clinical need for granting such privileges.

4.3.2.5.3.2. General Conditions

- A. In exercising Visiting Privileges, the Applicant shall act under the supervision of the Chief of Service, to which he/she is assigned.
- B. Visiting Privileges shall not be granted unless the Applicant has an academic appointment with the University, is an employee of the City ~~and County of San~~

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~~Francisco~~, or provides documentation of professional liability coverage in accordance with Section 2.2-4 of these Bylaws.

- C. Visiting Privileges shall not be granted unless the Applicant signs an acknowledgment that he/she has received, or been given access to, a copy of the Medical Staff Bylaws and agrees to be bound by them.
- D. The Chief of Staff may use his/her discretion to restrict, suspend, or terminate the Visiting Privileges. In such an event, the Practitioner shall not be entitled to the procedural rights set forth in Articles 6 and 7 of these Bylaws, or to any other procedural rights, unless such action requires the filing of a report to either the Medical Board of California or the National Practitioner Data Bank.

E. The Chief of Staff shall inform the Governing Body that Visiting Privileges were granted for a patient care need that could not be met by a Member ~~of the Medical Staff~~.

E.F. All requirements of ZSFG Administrative Policy 22.06 must be met.

4.4.5.4. **Emergency Situations**

4.4.1.5.4.1. **Medical Staff Members and Affiliated Professionals**

In the event of an emergency, any Member ~~of the Medical Staff~~ and Affiliated Professionals shall be permitted to do everything reasonable to save the life of a patient or to save a patient from serious harm. The Member or Affiliated Professional shall promptly yield such care to a more qualified Member ~~of the Medical Staff~~ when one becomes available.

4.5.5.5. **Disaster Privileges**

5.5.1. **Emergency Management Plan Activated**

In the event that the Emergency Management Plan has been activated and the Hospital is unable to handle the immediate patient needs, Disaster Privileges may be granted by the Chief Executive Officer, the Chief of Staff, or his/her designee(s) upon presentation of the following:

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

4.5.1.5.5.2. **Physician Oversight**

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

4.5.2.5.5.3. Primary Source Verification

Primary source verification of licensure shall occur as soon as the disaster is under control or within seventy-two (72) hours from the time the physician presented him/herself to the Hospital, whichever comes first. If primary source verification cannot be completed within seventy-two (72) hours due to extraordinary circumstances, the following shall be documented:

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

4.5.3.5.5.4. No Provider Care

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

5.6. 6 Visiting Physicians Observers

ZSFG Administrative Policy 22.06 "Visiting Physicians" (see, Appendix 2) defines "Consulting Clinical Physician", "Consulting Academic Physician", "Physician Observer", and "Visiting Research Physician". Physicians in these roles do not have Privileges unless specifically granted under Section 5.3, above, may not direct patient care, do not have access to medical records, and must follow all requirements of ZSFG Administrative Policy 22.06 for their specific category regarding:

- A. Their Role in interacting with the patient and Members.
- B. Maintenance of Professional Liability coverage must be maintained either through their primary institution or own insurance company.
- C. Sponsorship by the Chief of the sponsoring Clinical Service, or for Visiting Research Physicians, the Principal Investigator with the consent of the Clinical Service Chief.
- D. Immunizations—if in patient care settings, must meet same requirements as clinical staff.
- E. Orientation as applicable for the specific category.
- F. Identification badges if in patient care areas.
- G. Required Patient consent is required if interacting with, or observing patients.

4.6.5.7. Proctoring

4.6.1.5.7.1. General

All new appointees to the Medical Staff and existing Members requesting additional privileges, regardless of specialty or category of membership, shall be assigned a Proctor by the

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Clinical Service Chief and complete a period of proctoring, as defined in ~~5.5~~4.5.7.4 “Proctoring Duration” below.

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

4.6.2.5.7.2. Function and Responsibility of the Proctor

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

4.6.3.5.7.3. Responsibility of the Proctoree

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

5.7.4. Proctoring Duration

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

For privileges that are infrequently performed by the ~~Medical Staff~~ Member, the Clinical Service Chief may submit a written request to the Credentials Committee to expand the proctoring period. Alternatively, the Clinical Service Chief may request that proctoring occur at another accredited hospital. These privileges shall be voluntarily relinquished or withdrawn if proctoring is not completed within twenty-four (24) months of the initial granting of the infrequently performed privileges unless an extension is approved by the ~~Medical Executive Committee~~ and the Governing Body.

4.6.4.5.7.5. Reciprocal Proctoring

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

- A. The reciprocal Proctor is an active Member of the Medical Staff at an accredited hospital;

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- B. The reciprocal Proctor possesses unrestricted privileges to perform the procedure for which the proctoring is being performed; and
- C. The reciprocal proctoring arrangement and the reciprocal Proctor have been approved by the Chief of the Clinical Service.

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

ARTICLE 5, ARTICLE 6. CORRECTIVE ACTION

5.1.6.1. Routine Monitoring

5.1.6.1.1. Routine Monitoring and Education, Including Verbal and Written Counseling

Responsibilities of the Chiefs of the Clinical Services

- A. The Chiefs of the Clinical Services are responsible for ensuring the quality of patient care rendered by their service and maintaining professional standards of behavior among Members of their service. Academic performance or employment are University matters and not addressed in these Bylaws.
- B. Quality of Patient Care - Education, Monitoring and Investigation and Response to Concerns Identified
- C. The Chiefs of Clinical Services are responsible for carrying out peer review and quality improvement functions for their service. The Chief of the Clinical Service may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the Member 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 to discuss the matter with the Chief of the Clinical Service. Documentation of any informal actions, monitoring, or counseling shall be maintained by the Chief of the Clinical Service.

5.2.6.2. Professional Standards of Behavior

5.2.6.2.1. Professional Conduct

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

Expected Behaviors of Members of the Medical Staff:

- A. All Members ~~of the Medical Staff~~ are expected to treat patients and their families, as well as other providers, nurses, and ancillary staff, in a courteous, dignified, and respectful manner.
- B. Examples of Inappropriate Behaviors include, but are not limited to, the following:
 - 1) Shouting or using vituperative language;
 - 2) Use of profanity directed at an individual;

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- 3) Slamming or throwing objects;
- 4) Physical or verbal intimidation, harassment and/or violence;
- 5) Hostile, condemning, or demeaning communications;
- 6) Derisive, insulting, or demeaning criticism of performance;
- 7) Deliberate failure to abide by Hospital, Medical Staff, departmental or committee bylaws, policies and procedures, or directives, including but not limited to, refusal to comply with required duties;
- 8) Behavior inappropriate to the delivery of quality patient care; and
- 9) Retaliation against any person who addresses or reports incidents of unacceptable behavior.

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

C. The Director of Health, or her/his designee, may restrict a Member's access to key aspects of the ZSFG infrastructure in instances involving serious, material violations of federal, state, or local laws, or ZSFG rules, regulations, or policies that are not primarily related to quality of patient care, including- any violation of patient confidentiality laws or policies. Access to patient health records kept or maintained by the City and/or to physical locations (ZSFG, clinics, or other buildings owned or operated by the City) may be restricted, suspended, or permanently revoked in this manner. The approval of the MEC is not required for such actions.

~~5.2.2.~~

5.2.3.6.2.2. **Investigation in Response to Alleged Inappropriate Behavior**

- A. Alleged violations of the Code of Professional Conduct may be reported by any Hospital personnel using the confidential and Evidence Code §1157-protected Unusual Occurrence (UO) reporting form designed for this purpose, or reported in writing to a direct supervisor, the Chief of the Clinical Service or the Chief of Staff. Confidentiality will be maintained throughout the investigation of the alleged behavior and for any counseling, warning, or disciplinary action resulting from the investigation. The person allegedly demonstrating Inappropriate Behavior will be informed of the report by the Chief of the Clinical Service Staff or designee and have the opportunity to respond to or refute the allegations. If the investigation finds that the allegation does not meet the level of Inappropriate Behavior as defined by this Code, the report will be closed and dismissed. Dismissed reports will not be considered in determinations of recurrent Inappropriate Behaviors.
- B. The Chief of the Clinical Service shall conduct an initial investigation within one (1) week of becoming aware of the issue. When the Chief of the Clinical Service is the subject of the alleged behavior, the Chief of Staff will conduct the investigation. The

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Chief of the Clinical Service may discuss the event with the affected Member. The Chief of Service or Chief of Staff shall take appropriate action based on the following guidelines:

- 1) **Dismissed/No Action:** The alleged behavior does not meet the level of Inappropriate Behavior as defined in these Bylaws. The Chief of Service will report this outcome to Risk Management, including a brief explanation of why the alleged behavior did not meet the level of behavior as defined by these Bylaws. The UO report will be recorded as “dismissed.” No further action shall be taken.
- 2) **Meeting for Resolution:** The behavior is relatively minor, had low potential to adversely affect patient care, and likely can be resolved by a meeting of the involved parties. The Chief of Service will convene and facilitate a face-to-face Meeting for Resolution between the Member and the affected party. The Chief of Staff may help identify an alternative facilitator/mediator upon request. The Chief of Service will notify Risk Management of the outcome of the Meeting for Resolution.
- 3) **Verbal Counseling:** The behavior had the potential to adversely affect patient care and is a first confirmed Inappropriate Behavior event for the Member. The Chief of Service shall verbally counsel the Member when an instance of Inappropriate Behavior warrants such counseling. The Verbal Counseling shall emphasize the particular conduct that is inappropriate and stress that future similar conduct may result in more formal action under the Corrective Action procedures. A record of the Verbal Counseling will be kept by the Chief of Service and will include expectations, the action plan, and the consequences of repeat behavior of a similar nature (which will include Written Counseling). A Member also may be directed by the Chief of Service to issue an apology to the involved party or parties. The Chief of the Clinical Service shall maintain documentation of the counseling and notify Risk Management of this outcome.
- 4) **Written Counseling:** The behavior had the potential to adversely affect patient care and is sufficiently serious to make Verbal Counseling insufficient, inappropriate, or it represents recurrent Inappropriate Behavior that previously was addressed with Verbal Counseling. The Chief of Service will meet with the Member and write a formal letter that sets forth the serious nature of the Inappropriate Behavior, reiterates any previous Verbal Counseling in relation to similar Inappropriate Behavior exhibited by the Member, emphasizes the responsibility of ~~Medical Staff~~ Members to treat all persons at the Hospital courteously, respectfully, and with dignity, and informs the Member that future similar conduct may result in referral of the matter to the ~~Medical-Executive Committee~~ for possible Corrective Action. The letter will include expectations, the action plan, and the consequences of repeat behavior of a similar nature. The Member also may be directed by the Chief of Service to issue an apology to the involved party or parties. A copy of the Written Counseling shall be sent to the Chief of Staff, the Vice Dean, and the ~~Medical Staff Services Office- MSSD~~ for inclusion in the Members peer review (credentials) file. The ~~Medical Staff~~ Member may submit a letter of rebuttal that will be placed in the Member’s peer

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review file. The Chief of Service will report this outcome to Hospital and -UCSF ZSFG Risk Management.

- 5) Action Plans may include remedial education, referral for psychological evaluation and treatment, referral for anger management counseling, or other professional assistance programs. The Chief of ~~Staff~~ Service is encouraged to consult with the Chief of Staff, Vice Dean, Chief Medical Officer and/or Chief Executive Officer in determining the appropriate plan of action. The level of action may be revised by the Chief of Service, in consultation with the Chief of Staff, Vice Dean, Chief Medical Officer and/or Chief Executive Officer as appropriate, after further information is obtained in the course of investigation and counseling.
- 6) Reporting: The Chief of Staff will report aggregate data on Code of Professional Conduct issues to the ~~Medical Executive Committee~~ no less than annually. The identity of individual Members will not be disclosed in these reports.

5.2.4.6.2.3. Medical Executive Committee Approval is not Required and Procedural Rights are not Triggered

The approval of the ~~Medical Executive Committee~~ (MEC) is not required for actions taken by the Chief of the Clinical Services as set forth in Section 6.1 herein nor do such ~~actions~~ give rise to procedural rights for the ~~Medical Staff~~ Member as set forth in Article 7 herein.

5.3.6.3. Corrective Action Investigations

5.3.1.6.3.1. Criteria for Initiation of Corrective Action

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

- A. Detrimental to patient safety or to the delivery of quality patient care within the Hospital;
- B. Unethical;
- C. Contrary to the Medical Staff Bylaws and Rules and Regulations;
- D. Below applicable professional standards;
- E. Disruptive of Medical Staff or Hospital operations or the delivery of quality patient care; and/or
- F. A documented pattern of Inappropriate Behavior as defined as more than two (2) incidents warranting Verbal or Written Counseling within a two (2) year period.

5.3.2.6.3.2. Initiation of Corrective Action

- A. Any person who believes that corrective action may be warranted may provide information to the Chief of Staff, any other Medical Staff officer, any Clinical Service Chief, the Governing Body, or the Chief Executive Officer.
- B. If the Chief of Staff, any other Medical Staff officer, any Clinical Service Chief, the Governing Body, or the Chief Executive Officer determines that Corrective Action may be warranted under this Section 6.2 of these Bylaws, that person or entity may request the

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initiation of a formal Corrective Action Investigation or may recommend particular Corrective Action. Such requests must be conveyed to the MEC in writing. The MEC may conduct an informal review of the matter to determine whether an investigation is warranted.

- C. The Chief of Staff shall notify the Chief Executive Officer, and the MEC and shall continue to keep them fully informed of all action taken. In addition, the Chief of Staff shall immediately forward all necessary information to the committee or person that will conduct any Investigation.

5.3.3.6.3.3. Formal Investigation

- A. If the MEC concludes that a Formal Investigation (Investigation) is warranted, it shall direct an Investigation to be undertaken. The MEC may conduct the Investigation itself, may assign the Investigation to an officer of the medical staff or a standing committee of the medical staff, or may appoint an ad hoc committee to conduct the Investigation.
- B. The affected ~~Medical Staff~~ Member shall be given an opportunity for an interview to discuss or refute the charges. Such an interview shall not constitute a “hearing” as the term is used in Article 7 of these Bylaws, and none of the procedural rights under Article 7 of these Bylaws shall apply
- C. The Investigation shall proceed in a prompt manner and the investigatory body shall maintain a written record of its proceedings.
- D. The investigatory body shall determine whether the Member has provided a quality of care or professionalism that, in its unbiased and good faith determination, is consistent with the expectations for Members ~~of the Medical Staff~~.
- E. A written report of the Investigation shall be forwarded to the MEC within thirty (30) days of completion of the Investigation. The report shall include findings of fact and recommendations for appropriate corrective action, if any.

F. If the MEC concludes action is indicated, but no further Investigation is necessary, it shall proceed to take action.

5.4.6.4. Corrective Action

5.4.1.6.4.1. Medical Executive Committee Action

Within thirty (30) days of receipt of the written report of the Investigation, the MEC shall take action that may include, without limitation:

- A. Determining no corrective action be taken or that additional information is needed. If the MEC determines there was no credible evidence for the complaint, any adverse information shall be removed from the Member’s credentials file.
- B. Deferring action for a reasonable time when circumstances warrant.
- C. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department or committee chairs from issuing informal written or oral warnings outside of the mechanism for Corrective Action. In the event such letters are issued, the affected Member may make a written response that shall be placed in the Member’s file.

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

* Actions reported to the Medical Board of California and entered into the National Provider Databank.

5.4.2.6.4.2. Procedural Rights

- A. When No Corrective Action is Required
 - 1) If the MEC determines that no corrective action is required or that only a letter of warning, admonition, reprimand, or censure should be issued, the decision shall be transmitted to the Governing Body. The Governing Body may affirm, reject, or modify the action. The Governing Body shall give great weight to the MEC's decision and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the MEC, and the MEC still has not acted. The decision shall become final if the Governing Body affirms it or takes no action on it within seventy (70) days after receiving the Notice of Decision.
- B. When Corrective Action is Recommended
 - 1) If the MEC recommends an action that is a ground for a hearing under Section 7.2 of these Bylaws, the Chief of Staff shall give the Member Special Notice of the adverse recommendations and of the right to request a hearing in accordance with Section 7.3 of these Bylaws. The Governing Body may be informed of the recommendation, but shall take no action until the Member has either waived his/her right to a hearing or completed the hearing.

5.4.3.6.4.3. Initiation of Governing Body Action

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

5.4.4.6.4.4. University ~~Employment~~ Other Action

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Nothing in this article or elsewhere in these Bylaws is intended to limit the University's or City's ability to take appropriate action with respect to employment. The University and the City have their own processes for employee discipline or other issues that are separate and distinct from processes under these Bylaws. To the extent that the University or City take action against their own employees through their respective processes, such processes include appropriate due process protections.

6.5. Summary Action

5.4.5.6.5.1. Criteria for Initiation

- A. Whenever the Member's conduct is such that a failure to take action may result in imminent danger to the health or safety of any individual, the Chief of Staff, the MEC, or the Chief of the Clinical Service in which the Member holds Privileges may summarily restrict or suspend the Medical Staff membership or Clinical Privileges of such Member.
- B. Unless otherwise stated, such summary restriction or suspension (Summary Action) shall become effective immediately upon imposition, and the person or body responsible shall promptly give written Special Notice generally describing the reasons for the action to the Member, and Notice to the MEC, the Chief Executive Officer and the Governing Body.
- C. The Summary Action may be limited in duration and shall remain in effect for the stated period or until resolved as set forth herein. Unless otherwise indicated by the terms of the summary action, the Chief of the involved Clinical Service shall make the necessary arrangements to provide alternate coverage for proper and necessary patient care during the period of restriction or suspension.
- D. The notice of the Summary Action given to the MEC shall constitute a request to initiate corrective action and the procedures set forth in Article 6 of these Bylaws shall be followed.

5.4.6.6.5.2. Medical Executive Committee Action

The affected Member may request an interview with the MEC. The interview shall be convened as soon as reasonably practicable under the circumstances but in no event less than seven (7) days after the Summary Action was taken. The interview shall not constitute a hearing, as that term is used in these Bylaws, and none of the procedural rights under Article 7 of these Bylaws shall apply. The MEC may thereafter continue, modify, or terminate the terms of the Summary Action. It shall give the Member written Special Notice of its decision, which shall include the information specified in Section 7.3 of these Bylaws, if the action constitutes grounds for a hearing.

5.4.7.6.5.3. Procedural Rights

Unless the MEC terminates the summary action, it shall remain in effect during the completion of the corrective action and hearing and appellate review process. When a Summary Action is continued, the affected Member shall be entitled to the procedural rights set forth in Article 7 these Bylaws, but the hearing may be consolidated with the hearing on any corrective action that is recommended so long as the hearing commences within sixty (60) days after the

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hearing on the Summary Action was requested.

5.4.8.6.5.4. Initiation of Corrective Action by the Governing Body

- A. If no one authorized under Section 6.5 of these Bylaws is available to take a Summary Action to summarily restrict or suspend a Member's membership or Privileges, the Governing Body (or its designee) may immediately suspend or restrict a Member's Privileges if failure to do so may result in imminent danger to the health or safety of any individual, provided that the Governing Body (or its designee) has made reasonable attempts to contact the Chief of Staff and the MEC, and the Chief of the Service to which the Member is assigned before acting.
- B. Such Summary Action is subject to ratification by the MEC. If the MEC does not ratify such Summary Action within two (2) working days of its imposition, excluding weekends and holidays, the Summary Action shall terminate automatically.

5.5.6.6. Administrative Suspension of Privileges

5.5.1.6.6.1. Basis for Administrative Suspensions

The Chief of Staff may administratively suspend a Member's privileges for failing to complete training mandated by the hospital for regulatory purposes, failing to complete medical record documentation on a timely basis, failing to complete administrative responsibilities as required by the Chief of the Clinical Service or Chief Executive Officer, and failure to obtain required health screening. Such administrative suspensions shall not give rise to the due process rights of these Bylaws unless the suspension is in place for more than fourteen (14) days and therefore becomes reportable to the Medical Board.

5.5.2.6.6.2. Licensure

Automatic suspension or termination of Privileges or memberships may occur:

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

D. A Member's Privileges automatically suspended under this subsection 6.6.2, may be reinstated only upon written notice from the Chief of Staff or his/her designee. Such reinstatement may include restrictions if imposed in accordance with section 6.3. If the Member provided patient care at ZSFG, or any City-affiliated institution while the

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Member's license or credential was revoked, suspended, expired, limited, restricted or while the Member was on probation, reinstatement may not be granted until all instances of the Member's patient care and billing during that time are reviewed to ensure that appropriate care was rendered, and to prevent improper billing.

~~5.5.3.~~

5.5.4.6.6.3. DEA Certificate

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

5.5.5.6.6.4. Medical Records

~~Medical Staff~~ Members are required to complete medical records within the time prescribed by the MEC. Failure to timely complete medical records shall result in an automatic suspension after notice is given. Such suspension shall apply to the ~~Medical Staff m~~ Member's right to admit, treat, or provide services to patients in the inpatient or outpatient settings. The suspension shall continue until the issue is ~~satisfactorily~~ resolved.

5.5.6.6.6.5. Procedural Rights

~~Medical Staff~~ Members whose Privileges are automatically suspended and/or who have been deemed to have automatically resigned his/her Medical Staff membership shall be entitled to the procedural rights set forth in Article 7 of these Bylaws only if the suspension is reported pursuant to California Business and Professions Code Section 805.

5.5.7.6.6.6. Notice of Administrative Suspension and Transfer of Patients

Notice of an automatic suspension shall be given to the Member, and to the appropriate Chief of Service, Patients affected by an automatic suspension shall be assigned to another Member of the Clinical Service.

5.5.8.6.6.7. Automatic Termination

If a Member is administratively suspended for more than three (3) months, his/her ~~M~~ membership shall be automatically terminated. Thereafter, reinstatement to the Medical Staff shall require application and compliance with the appointment procedures applicable to new Applicants.

ARTICLE 6. ARTICLE 7. HEARINGS AND APPELLATE REVIEWS

6.1.7.1. General Provisions

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

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- A. “Body Whose Decision Prompted the Hearing” refers to the MEC in all cases when the MEC or authorized Medical Staff officers, Members or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Governing Body in all cases where the Governing Body or its authorized officers, directors or committees took the action or rendered the decision, which resulted in a hearing being requested.
- B. “Petitioner” ~~as used in this Article,~~ refers to the Member who has requested a hearing pursuant to Section 7.3.2 of these Bylaws.
- C. Technical, insignificant or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.
- D. If an adverse action described in Section 7.2.1 of these Bylaws is taken or recommended, the Petitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

~~6.2.7.2.~~ **Grounds for Hearings**

~~6.2.1,7.2.1.~~ **Grounds for Hearings**

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

- A. Denial of Medical Staff appointment, reappointment, or ~~p~~Privilege(s);
- ~~B.~~ Revocation, suspension, restriction, involuntary reduction of Medical Staff membership and/or Privileges;
- ~~C.~~ Involuntary imposition of significant consultation or proctoring; or ~~Any-any~~ other corrective action or recommendation that must be reported to the Medical Board pursuant to California Business and Professions Code Section 805;

7.2.2. Actions Taken by Director of Health

Actions taken by the Director of Health, or her/his designee, pursuant to Section 6.2.1.C, are subject to hearing under these Bylaws only for the purpose of determining whether to revoke, suspend, or restrict Privileges conferred by these Bylaws.

~~6.2.2,7.2.3.~~ **Termination from Medical Staff**

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

~~6.3.7.3.~~ **Requests for Hearing**

~~6.3.1,7.3.1.~~ **Notice of Action for Proposed Action**

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

- A. What action has been proposed against the Petitioner;

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- B. Whether the action, if finally adopted, will be reported to the Medical Board under California Business and Professions Code Section 805 and to the National Practitioner Data Bank;
- C. The reasons for the action or proposed action;
- D. That the Petitioner may request a hearing;
- E. That hearing must be requested within thirty (30) days; and
- F. That the Petitioner has the hearing rights described in the Medical Staff Bylaws.

6.3.2.7.3.2. Request for Hearing

The Petitioner shall have thirty (30) days following receipt of Notice of such action or proposed action to request a hearing. The request shall be in writing, addressed to the Chief of Staff with a copy to the Chief Executive Officer. The Petitioner shall state, in writing, his/her intentions with respect to attorney representation at the time he/she files the request for a hearing. If the Petitioner does not request a hearing within the time and manner described, the Petitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Such final recommendation shall be considered by the Governing Body, within seventy (70) days and shall be given great weight by the Governing Body, although it is not binding on the Governing Body.

6.3.3.7.3.3. Hearings Prompted by Governing Body Action

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

6.3.4.7.3.4. Time and Place for Hearing

Upon receipt of a timely request for a hearing made by the Petitioner, the Chief of Staff shall notify the Chief Executive Officer and the MEC, appoint a Judicial Review Committee, and shall schedule ~~and arrange for~~ a hearing before the Judicial Review Committee. The Chief of Staff shall give Special Notice of the hearing within thirty (30) days after receipt of the request. The notice shall state the time, place, and date of the hearing. The date of the commencement of the hearing shall be within thirty (30) to sixty (60) days from the date the Chief of Staff received the hearing request.

6.3.5.7.3.5. Notice of Charges

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

6.3.6.7.3.6. Judicial Review Committee

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

6.4.7.4. The Hearing Procedure

6.4.1.7.4.1. The Hearing Officer

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

6.4.2.7.4.2. Representation

- A. The Petitioner shall be entitled, at his/her own expense, to be represented at the hearing by an attorney at law or by a ~~Physician-physician~~ licensed to practice in the State of California. If the Petitioner is represented by legal counsel, the MEC may also be represented by legal counsel. The MEC shall not be represented by legal counsel if the Petitioner is not so represented. If the Petitioner elects not to be represented by an attorney at the hearing, the MEC shall appoint a representative from the active Medical Staff to present the recommendation and evidence in support thereof and to examine witnesses. Notwithstanding the foregoing and regardless of whether the Petitioner elects

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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.

- B. The Judicial Review Committee shall determine the role of legal counsel when attorneys are allowed to attend the hearing. The Judicial Review Committee may eject any legal counsel whose activities at the hearing are, in the judgment of the Judicial Review Committee, disruptive to the proper conduct of the hearing proceedings
- C. Any time attorneys ~~will be~~ allowed to represent the parties at a hearing, the Hearing Officer shall have the discretion to limit the attorneys' role to advising his/her clients, rather than presenting the case.

6.4.3.7.4.3. Postponements and Extensions

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

6.4.4.7.4.4. Failure to Appear or Proceed

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

6.4.5.7.4.5. Discovery

A. Rights of Inspection and Copying

The Petitioner may inspect and copy (at his/her own expense) any documentary information relevant to the charges that the Body Whose Decision Prompted the Hearing has in its possession or under its control. The Body Whose Decision Prompted the Hearing may inspect and copy (at its expense) any documentary information relevant to the charges that the Petitioner has in his/her possession or under his/her control. The request for discovery shall be fulfilled as soon as practicable. Failure to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall be good cause for a continuance of the hearing.

B. Limits on Discovery

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

C. Ruling on Discovery Disputes

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

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

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

The Body Whose Decision Prompted the Hearing may object to the introduction of evidence that was not provided during the appointment or reappointment process. The information will be barred from the hearing by the Hearing Officer unless the Petitioner can prove he/she previously acted diligently and could not have submitted the information.

6.4.7.7.4.7. Pre-Hearing Document Exchange

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

6.4.8.7.4.8. Witness Lists

At the request of either party, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing.

Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as he/she becomes aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

6.4.9.7.4.9. Procedural Disputes

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

6.4.10.7.4.10. Record of Hearing

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

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6.4.11-7.4.11. Rights of the Parties

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

6.4.12-7.4.12. Rules of Evidence

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

6.4.13-7.4.13. Burdens of Presenting Evidence and Proof

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

6.4.14-7.4.14. Adjournment and Conclusion

The hearing officer may adjourn the hearing and reconvene the same at the convenience of the participants without Special Notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Judicial Review Committee shall thereupon, outside of the presence of any person, conduct its deliberations and render a decision and accompanying report.

7.4.15. Basis for Decision

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The decision of the Judicial Review Committee shall be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence and testimony. The Judicial Review Committee shall determine whether the Member has provided a quality of care or professionalism that, in its unbiased and good faith determination, is consistent with the expectations for Members ~~of the Medical Staff~~.

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6.4.15;7.4.16. Decision of the Judicial Review Committee

Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a written decision. If the Petitioner is currently under suspension, however, the time for the decision and report shall be fifteen (15) days after final adjournment. Final adjournment shall be when the Judicial Review Committee has concluded its deliberations. A copy of the decision shall be forwarded to the Chief Executive Officer, the MEC, the Governing Body, and to the Petitioner. The report shall contain the Judicial Review Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the Petitioner and the Body Whose Decision Prompted the Hearing shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Review Committee shall be considered final, subject only to such rights of appeal or Governing Body review as described in these Bylaws.

6.5.7.5. Appeal

6.5.1;7.5.1. Time for Appeal

Within thirty (30) days after receipt of the decision of the Judicial Review Committee, either the Petitioner or the Body Whose Decision Prompted the Hearing may request an appellate review by the Governing Body. Said request shall be delivered to the Chief of Staff in writing, in person or by certified mail and shall include a brief statement as to the reasons for appeal. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become, pending ratification by the Governing Body, final and shall be effective immediately.

6.5.2;7.5.2. Grounds for Appeal

On appeal, the Governing Body may exercise its independent judgment in determining:

(1) whether there was substantial failure of the Judicial Review Committee to comply with the procedures required by these Bylaws so as to deny fair hearing, (2) whether the decision is reasonable and warranted, (3) and whether any bylaw, rule, or policy relied on by the Judicial Review Committee is unreasonably applied or interpreted.

6.5.3;7.5.3. Time, Place, and Notice

In the event of an appeal to the Governing Body, the Governing Body shall within thirty (30) days after receipt of such notice of appeal, schedule and arrange for an appellate review. The Governing Body shall provide notice of the time, place and date of the appellate review. The date of the appellate review shall be within thirty (30) to sixty (60) days from the Date of Receipt of the request for the appellate review; however, when a request for appellate review comes from a Member who is under suspension, the review shall be held as soon as practical, but not to exceed ten (10) days from the Date of Receipt of the request. The time for appellate review may be extended by the President of the Governing Body for good cause.

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6.5.4.7.5.4. Nature of Appellate Review

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

6.5.5.7.5.5. Final Decision

Within thirty (30) days after the conclusion of the proceedings before the Governing Body, the Governing Body shall render a final decision in writing and shall deliver copies thereof to the Applicant or Member of the Medical Staff and to the Chief of Staff, in person or by certified mail.

6.5.6.7.5.6. Delegation to Governing Body Members on the Joint Conference Committee

Nothing herein shall prevent the Governing Body from delegating the appellate process to those Governing Body Members appointed to the Joint Conference Committee. In such an event, the Governing Body Members of the Joint Conference Committee shall submit a written report and recommendations to the full Governing Body for approval.

6.5.7.7.5.7. Further Review

Unless the Governing Body refers the matter back to the Judicial Review Committee for further review and recommendations, the final decision of the Governing Body following the appeal procedures set forth in these Bylaws shall be effective immediately and shall not be subject to further review. If the matter is referred back to the Judicial Review Committee for further review and recommendations, said Committee shall promptly conduct its review and make its recommendations to the Governing Body. This further review process and the report back to the Governing Body shall in no event exceed thirty (30) days except as the parties may otherwise stipulate.

6.5.8.7.5.8. Right to One Hearing Only

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

6.5.9.7.5.9. Affiliated Professionals, House Staff, Medical Students and Trainees

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

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6.5.10-7.5.10. Denial of Applications for Failure to Meet the Minimum Qualifications

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

6.5.11-7.5.11. Automatic Suspension or Limitation of Privileges

A Member shall not be entitled to any procedural rights when the Member's license or legal credential to practice has been revoked or suspended as set forth in Article 6 of these Bylaws. In other cases described in Article 6 of these Bylaws, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or the DEA was unwarranted, but only whether the Member may continue to practice in the Hospital with those limitations imposed. Members whose Privileges are automatically suspended and/or who have resigned his/her Medical Staff membership for failing to complete medical records or for failing to maintain malpractice insurance are not entitled under these Bylaws to any procedural rights, except when a suspension for failure to complete medical records will exceed fourteen (14) days and it must be reported to the California Medical Board pursuant to California Business and Professions Code Section 805.

ARTICLE 7, ARTICLE 8. STRUCTURE OF THE MEDICAL STAFF

7.1-8.1. Medical Staff Year

The Medical Staff Year is July 1 through June 30.

7.2-8.2. Officers of the Medical Staff

The officers of the Medical Staff shall be the Chief of Staff, Chief of Staff-Elect, or, in alternate years, the Chief of Staff-Past.

7.2.1-8.2.1. Qualifications of Officers

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

7.2.2-8.2.2. Election of Chief of Staff-Elect

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

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

If floor nominations are made, a hand vote will be taken to elect the Chief of Staff-Elect. A simple majority of the Active Medical Staff Members attending the meeting shall determine

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the election. If no floor nominations are made, a vote of acclamation will be requested by the presiding Chief of Staff.

7.2.3.8.2.3. Term of Office

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

7.2.4.8.2.4. Vacancies in Office

In the event of the temporary absence of the Chief of Staff, the Chief of Staff shall designate a Member of the ~~Medical Executive Committee~~ or a previous Chief of Staff to serve as the acting Chief of Staff, including chairing the ~~Medical Executive Committee Meetings~~meetings.

If the position of the Chief of Staff becomes permanently vacant during the first year of the two (2) year term, the Chief of Staff-Past shall assume all designated responsibilities through the end of the Medical Staff Year. If the Chief of Staff-Past is unable to serve, the MEC will appoint an Acting Chief of Staff who will serve through the end of the Medical Staff Year. If the vacancy occurs in the second year of the Chief of Staff's elected term, the Chief of Staff-Elect will assume the duties of the office through the end of the Medical Staff Year and then continue as the Chief of Staff for a two (2) year term.

7.2.5.8.2.5. Duties of Officers

A. Chief of Staff

The Chief of Staff Shall:

- 1) ~~(1)~~—Serve as Chief of the Medical Staff;
- 2) ~~(2)~~—Represent the views, policies (including strategic planning and budget considerations), needs and grievances of the Medical Staff and MEC to the Governing Body, to the Chief Executive Officer, and to the Vice Dean;
- 3) ~~(3)~~—Receive and ~~interpret~~present to the MEC the activities of the Governing Body;
- 4) ~~(4)~~—Report medical staff activities to the Governing Body;
- 5) ~~(5)~~—Be the spokesperson for the Medical Staff and the MEC in external professional and public relations;
- 6) ~~(6)~~—Appoint committee Chairs and approve Members to all Medical Staff committees except the MEC and Joint Conference Committee;
- 7) ~~(7)~~—Call, preside at, and be responsible for the agenda of all regular and special meetings of the MEC and of the Medical Staff;

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- 8) ~~(8)~~ — Be responsible for the enforcement of Medical Staff Bylaws and for corrective action as provided for in these Bylaws;
- 9) ~~(9)~~ — Serve as a Member of the Joint Conference Committee;
- 10) ~~(10)~~ — Serve as a Member of the Credentials Committee;
- 11) ~~(11)~~ — Preside at the Annual Meeting of the Medical Staff;
- 12) ~~(12)~~ — Serve as an interface between the Medical Staff and the leadership of the hospital; and
- 13) ~~(13)~~ — Attend any Medical Staff committee meetings as necessary and appropriate in his/her discretion.

B. Chief of Staff-Elect

The Chief of Staff-Elect shall:

- 1) ~~(1)~~ — Perform duties as assigned by the Chief of Staff and, in the absence of the Chief of Staff, shall assume the duties and have the authority of the Chief of Staff.
- 2) ~~(2)~~ — Serve as Chair of the Bylaws Committee, or co-chair the committee with the Chief of Staff;
- 3) ~~(3)~~ — Serve as a Member of the Credentials Committee;
- 4) ~~(4)~~ — Serve on the MEC;
- 5) ~~(5)~~ — Beginning six ~~(6)~~ months prior to assuming the role of Chief of Staff, serve as a Member of the Joint Conference Committee; and
- 6) ~~(6)~~ — Assume the office of Chief of Staff at the end of the current Chief of Staff's term.

C. Chief of Staff-Past

The Chief of Staff-Past shall:

- 1) ~~(1)~~ — Perform duties as assigned by the Chief of Staff and shall assume the duties and have the authority of the Chief of Staff in the absence of the Chief of Staff;
- 2) ~~(2)~~ — Chair the Nominating Committee of the Medical Staff;
- 3) ~~(3)~~ — Serve on the MEC, Joint Conference Committee and the Credentials Committee.

7.2.6.8.2.6. Removal of Officers

A Medical Staff Officer may be removed from office for any valid cause including, but not limited to, failure to carry out the duties of the office, gross neglect or malfeasance in office, or serious acts of moral turpitude. Except as otherwise provided in these Bylaws, removal of Medical Staff officers may be initiated by the MEC or upon the written request of twenty percent (20%) of the Active Medical Staff. Such removal may be effected by majority vote of the MEC Members or by a two-thirds vote of the Active Medical Staff. Voting on the removal of an elected officer shall be by secret written ballot.

ARTICLE 8. ARTICLE 9. CLINICAL SERVICES

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8.1.9.1. Organization of Clinical Services

8.1.9.1.1. Overall Supervision

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

8.1.9.1.2. ~~9.1.2~~ Clinical Services

The Clinical Services are as follows: Anatomic Pathology, Anesthesiology and Peri-Operative Care, Community Primary Care, ~~Dentistry~~ Oral & Maxillofacial Surgery, Dermatology, Emergency ~~Services~~ Medicine, Family and Community Medicine, Laboratory Medicine, Internal Medicine, Neurology, Neurosurgery, Obstetrics-Gynecology-, Ophthalmology, Orthopedic Surgery, Otolaryngology and Head & Neck Surgery, Pediatrics, Psychiatry, Radiology, Surgery and Urology.

8.2.9.2. Qualifications, Selection and Tenure of Chiefs of Clinical Services

8.2.9.2.1. Qualifications

- A. All Chiefs shall be board certified or re-certified in their respective specialty.
- B. Chiefs shall have a University faculty appointment, excepting the Chief of the Community Primary Care Service (CPC).
- C. Chiefs may be the Chair or Vice Chair of his/her respective University department.
- D. Chiefs shall be Members of the Active Medical Staff and Clinical Privileges shall be determined as set forth in Article 6 of these Bylaws.

8.2.9.2.2. Selection of a Chief of Service

- A. Upon notification that a Service Chief will vacate his/her position prior to the appointment of a new Service Chief, the Chief of Staff, in consultation with the Chief Executive Officer, the UCSF Department Chair, and Vice Dean, shall appoint an Interim Chief of Service.
- B. Within six months of a vacancy, the Chief of Staff, in consultation with the Vice Dean, UCSF Department Chair and Chief Executive Officer, shall appoint a search committee. The search committee shall be chaired by a Member of the Active Medical Staff and shall be composed of Members of the Active Medical Staff, University faculty, the Vice Dean or their designee, and the Hospital Chief Executive Officer or their designee.
- C. The Chief of Staff shall consult with the Director of Health or designee, and the Chief Executive Officer in appointing the ad hoc search committee for the selection of the Chief of the CPC. The search committee for the CPC Chief shall be chaired by a Member of the Active Medical Staff and shall include Members of the Active Medical Staff, Members of the CPC, the Director of Health, and the Chief Executive Officer.
- D. The ad hoc search committee shall provide a progress report on his/her deliberations to the Chief of Staff.

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- E. The recommendations of the search committee shall be made to the Chief of Staff who shall, with the approval of the UCSF Department Chair in consultation with the Vice Dean, nominate the Chief of Clinical Service. The recommendations of the search committee for the Chief of the CPC shall be made to the Chief of Staff who shall, with the approval of the Director of Health, nominate the Chief of the CPC.
- F. The nomination shall be acted upon by the MEC. Ratification of the nomination shall be accomplished by a two-thirds vote, and shall be forwarded to the Governing Body for approval.
- G. Upon approval of the Governing Body, the nominee shall assume the office of Chief of the Clinical Service.
- H. If the MEC or Governing Body disapprove the nomination, the Chief of Staff shall reconstitute an ad hoc search committee.

8.2.3.9.2.3. Review and Reappointment

- A. Chiefs of Clinical Services shall be reviewed every five (5) years or at any time as requested by the Chief of Staff, the Vice Dean, or the Chief Executive Officer. Continuation as the Chief of the Clinical Service is contingent upon a favorable result of this review.
- B. The review shall be conducted by the Chief of Staff, the Vice Dean, and the Chief Executive Officer
- C. A summary of the review shall be placed in the Service Chief's credentials file that includes strengths/accomplishments and areas for improvement.
- D. The Chief of Staff shall make a recommendation regarding the reappointment of a Chief of a Clinical Service based on the review committee's findings. The reappointment shall require approval by a majority vote of the MEC and the Governing Body.

8.2.4.9.2.4. Removal of a ~~Service~~ Chief of Service

- A. Request for removal of a Chief may be initiated by:
 - 1) A two-thirds vote of all Active Medical Staff Members of the Clinical Service;
 - 2) The Vice Dean Chief Executive Officer, or Chief of Staff; or
 - 3) By two-thirds vote of the MEC.
- B. When a request for removal has been initiated, a Review Committee shall be appointed by the Chief of Staff in consultation with the Vice Dean and the Executive Administrator. The findings of the Review Committee shall be acted upon by the MEC.
- C. The recommendation of the MEC shall be forwarded to the Governing Body for approval.

8.2.5.9.2.5. Temporary Absence of a Chief of Service

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- A. When a Chief of a Clinical Service is temporarily absent from the position for more than thirty (30) days, prompt notification shall be made to the Chief of Staff. Upon receipt of such notice, the Chief of Staff shall appoint an Acting Chief for the Clinical Service in consultation with the permanent Chief of the Clinical Service.
- B. Appointment of an Acting Chief of a Clinical Service for more than ninety (90) days shall require the approval of the MEC, the Vice Dean and the Governing Body

8.3.9.3. ~~Functions of~~ Selection of a Chief of Service ~~f~~ Chiefs of Clinical Services

Each Chief shall:

8.3.1.9.3.1. Credentialing/Privileging

- A. Recommend criteria for clinical privileges in the Clinical Service;
- B. Recommend a sufficient number of qualified and competent individuals to provide care/clinical services;
- C. Make reports to the Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for each Applicant seeking privileges in the Clinical Service;
- D. Make recommendations to the Credentials Committee regarding the qualifications and competence of Affiliated Professionals in the Clinical Service;
- E. Make recommendations for granting temporary privileges;
- F. Be responsible for the evaluation of all new appointees and report thereon to the Credentials Committee.

8.3.2.9.3.2. Performance Improvement

- A. Continuously monitor and evaluate the quality and appropriateness of patient care provided within the clinical service;
 - 1) ~~(1)~~—Recommended for approval by the Credentials Committee and MEC the criteria to be used in conduct of Ongoing Professional Practice Evaluation (OPPE) and conduct OPPE for each Member of the Clinical Service at least every six (6) months. Data used to complete OPPE forms will be maintained and stored in each Clinical Service for the duration of each medical staff Member’s tenure, but in no event less than ten (10) years.
 - 2) ~~(2)~~—Monitor and evaluate the quality and appropriateness of patient care provided by the attending staff;
 - 3) ~~(3)~~—Monitor and evaluate the quality and appropriateness of House Staff supervision by attending staff;
 - 4) ~~(4)~~—Monitor and evaluate the quality and appropriateness of patient care provided by House Staff.
- B. Continuously monitor the professional performance of all individuals who have delineated clinical privileges and affiliated professionals in the Clinical Service, and

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report thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;

- C. Hold regular Performance Improvement Conferences no less than quarterly to present and discuss specific patient cases and best practices;
- D. Appoint ad hoc committees and working groups as necessary to carry out quality improvement activities;
- E. Conduct a ~~focus review~~ **Focused Professional Practice Evaluation (FPPE)** of any individual with privileges in the Clinical Service if there is a reasonable basis to be concerned that the individual's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics or other matters might directly or indirectly affect patient care.
 - 5) ~~(1)~~—The ~~focus review~~**FPPE** shall consider the individual's overall performance as well as specific cases. Comparison with historical, departmental and external benchmarks may be considered.
 - 6) ~~(2)~~—A peer review panel may be appointed to conduct a ~~focus review~~**FPPE**.
 - 7) ~~(3)~~—Recommendations from a ~~focus review~~**FPPE** may be used as the basis for continued routine monitoring and education or for pursuing formal corrective action.

8.3.3.9.3.3. Education and Research

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

8.3.4.9.3.4. Administration

- A. Designate an Acting Chief when absent for more than twenty (24) hours but less than thirty (30) days. After thirty (30) days, the process described in Section 9.2.5 will be followed;
- B. Be responsible and accountable to the Governing Body, through the Chief of Staff, for all clinically and administratively related activities within the Clinical Service;
- C. Be a Member of MEC and regularly disseminate decisions made and issues discussed at MEC meetings to the Members of the Clinic Service. It is the expectation that the Chiefs of the Clinical ~~s~~Services shall attend at least fifty percent (50%) of the MEC meetings each year and that they shall send a designee when unable to attend.
- D. Be responsible for the integration of the Clinical Services into the primary functions of the organization;
- E. Be responsible for the coordination and integration of interdepartmental and intradepartmental services;

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- F. Review and update the Clinical Service Rules and Regulations at least every two years;
- G. Be responsible for the orientation of new Members and for the enforcement of the Medical Staff Bylaws and Rules and Regulations and the Hospital's policies and procedures within the respective Clinical Service;
- ~~H.~~ Ensure adequate input from his/her Clinical Service at Medical Staff committee meetings through attendance by service Members;
- ~~I.~~ Be responsible for the orientation of new members and enforcement of the Medical Staff Bylaws and Rules and Regulations in the hospital's policies and procedures within the respective Clinical Service;
- ~~J.~~ H. Be responsible for implementation within the Clinical Service of actions taken by the Governing Body and the MEC;
- ~~K.~~ I. Participate in the administration of his/her Clinical Service through cooperation with the Nursing Service, Hospital Administration and all personnel involved in matters affecting patient care; Report and make recommendations to hospital management when necessary with respect to matters affecting patient care in the Clinical Service, including personnel, space, resources, supplies, special regulations, standing orders and techniques;
- ~~L.~~ J. Be responsible for the process of assessing and recommending off-site sources that provide patient care services not available at the Hospital.
- ~~M.~~ K. Assist in the preparation of annual records, including budgetary planning, pertaining to the Clinical Service as may be required by the Chief of Staff, the MEC, the Vice Dean, Chief Executive Officer, or the Governing Body;
- ~~N.~~ L. Delegate to a vice chief or other Active Staff Member of the Clinical Service such duties as appropriate;
- ~~O.~~ M. Establish divisions, sections or services within the Clinical Service and appoint Chiefs thereof, subject to the approval of the MEC and the Governing Body;
- ~~P.~~ N. Develop and implement policies and procedures that guide and support the provisions of services;
- ~~Q.~~ O. Maintain quality improvement programs; and
- ~~R.~~ P. Make a presentation to the MEC at least every two (2) years on the activities of the Clinical Service.

8.4.9.4. Functions of Clinical Services

- A. Each Clinical Service shall establish written criteria consistent with the policies of the MEC for the granting of Clinical Privileges.
- B. Each Clinical Service shall be responsible for maintaining and supervising a high quality education and training program for graduate and undergraduate education in the health sciences.

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- C. Each Clinical Service shall be responsible for the supervision of House Staff and the House Staff training programs.
- D. The Chief of the CPC shall collaborate with the appropriate Chief of Clinical Service and the Vice Dean to maintain and supervise high quality training experiences within the CPC clinical sites for graduate and undergraduate students in the health sciences.
- E. Each Clinical Service shall develop criteria under which consultation will be required; these shall not preclude a requirement for consultation when the Chief of the Clinical Service determines that a patient would benefit from such consultation.
- F. Each Clinical Service shall meet as frequently as necessary, but at least quarterly, to consider findings from the ongoing monitoring and evaluation of quality and appropriateness of the care and treatment provided to patients. Written summaries and recommendations of any and all new policies or changes in policies shall be submitted to the Medical Executive Committee for its approval.

8.5.9.5. Assignment to Clinical Service

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

ARTICLE 10. PHYSICIAN LEADERSHIP

10.1. Definitions of Physician Leaders (in addition to Service Chiefs of Service as set forth in Article 9)

- A. Central Leadership Positions: are (1) Medical Directors of multi-specialty service lines or (2) Medical Directors of hospital departments that cut across all services. (See, Appendix 123.)**

Examples: 1. Medical Directors of Critical Care, Perioperative Services, Trauma; 2. Medical Directors of Risk Management, Quality Improvement, Care Experience, Informatics, Infection Control.

- B. Service Leadership Positions: are Medical Directors of units or services within a single Clinical Service.**

Examples: Medical Directors of Family Health Center, Medicine Inpatient Services, EMS Base Station, Sleep Center, Diabetes Program, Asthma Clinic.

10.2. Qualifications of Physician Leaders

Physician Leaders shall be Members of the Active Medical Staff at the time of appointment and must remain Members in good standing during his/her tenure.

10.3. Appointment of Physician Leaders

- A. Central leadership positions are appointed by an open search process organized by the Chief Medical Officer or designee. The search committee is composed of clinical**

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stakeholder leaders. The candidate selected must be approved by the Chief Medical Officer, Chief Executive Officer, and Vice Dean.

A.

B. Service Leadership positions are appointed by the Chief of Service.

Service Leadership positions are appointed by the Chief of Service.

10.4. Term of Appointment

A. Central leadership positions are one (1) year appointments subject to annual review based on satisfactory performance and the needs of ZSFG. Review is performed by the Chief Medical Officer in consultation with Executive Leadership.

B. Service Leadership positions are one (1) year appointments subject to annual review based on satisfactory performance and the needs of ZSFG. Review is performed by the Chief of Service in consultation with the Chief Medical Officer.

10.5. Reporting Relationships

A. Central leadership positions report to the Chief Medical Officer

B. Service Leadership positions report jointly to their Service Chief and hospital leadership via the Chief Medical Officer for this administrative role.

10.6. Duties of Physician Leaders

A. In partnership with the Nurse dyad, the Physician Leader is responsible for the quality of patient care, patient experience, and operational management of care provided by the clinical unit in alignment with True North goals and hospital leadership vision.

B. The central function of this position is to serve as the physician leader for the clinical area, engaging front line providers to optimize operational, clinical quality, patient experience, and financial metrics. This includes meeting clinical enterprise performance and outcome benchmarks set by hospital leadership.

C. Specific duties are detailed in the job descriptions.

10.7. Salary Support for Physician Leader Effort

A. Central leadership positions are funded via the Affiliation Agreement Central Physician Leadership account.

B. Service Leadership positions are funded by the Service.

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ARTICLE 9.ARTICLE 11. COMMITTEES OF THE MEDICAL STAFF

9.1.11.1. Committee Designation

Standing committees, subcommittees and ad hoc committees of the Medical Staff described in these Bylaws and in the Committee Manual, are created for, and meet the purpose of evaluation and improvement of the quality of care rendered in the Hospital. Medical Staff functions covered by appropriate committees included, but are not limited to, executive review, credentialing, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting the ~~Medical Staff~~ Members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services.

9.2.11.2. General Provisions

9.2.1.11.2.1. Ad Hoc Committees

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

9.2.2.11.2.2. Parliamentary Procedure

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

9.2.3.11.2.3. Scheduling

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

9.2.4.11.2.4. Appointment of Chairs of Committees

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

9.2.5.11.2.5. Committee Membership Appointment

Members of all committees shall be appointed by committee chairs, after consultation with the Chief of Staff or Chief Executive Officer, as appropriate. The ~~Medical Staff Services Department-MSSD~~ shall maintain an accurate Membership and attendance roster of all committees of the Medical Staff.

Active Medical Staff Members shall have voting prerogatives. Individuals who are not Members of the active Medical Staff shall be appointed as non-voting Members unless the Chair specifies voting prerogatives at the beginning of the Medical Staff year. This shall be

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documented in committee minutes at the beginning of the Medical Staff year and shall remain in effect for the membership appointment period of one (1) year.

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

9.2.6;11.2.6. Quorum

Unless otherwise stipulated in these Bylaws, a quorum is constructed by at least three (3) Members of the Active Medical Staff. For the MEC, a quorum shall consist of at least ten (10) or more Members of the Active Medical Staff.

9.2.7;11.2.7. Manner of Action

Having established a voting quorum, the action of a simple majority of the voting Members present shall represent the action of the committee. Action may be taken without a meeting when, in the discretion of the Committee Chair, the action is sufficiently straightforward that discussion and deliberation is not necessary. In such an event, and if there are no objections from the committee Members who are Active Members ~~of the Medical Staff~~, action may be taken by vote through email and upon the approval of the number of committee Members that constitute a quorum.

9.2.8;11.2.8. Attendance Requirements

Excused absences can be issued by Chairs or Chiefs if requests for absences are submitted before the scheduled meeting. Any committee may invite the attendance of any individuals who may be useful to its work. All committee Members are expected to attend or have a designee present for fifty percent (50%) of the committee's meetings.

9.2.9;11.2.9. Notice of Meetings

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

9.2.10;11.2.10. Minutes and Reporting

- A. Minutes of all meetings, unless otherwise stated, shall be forwarded to the Medical Staff Services Department, which shall serve as the official repository for official business of the Medical Staff. Chairs of Committees will utilize a standardized meeting minutes template maintained by the Medical Staff Office. (See, Appendix 234.)
- B. Minutes of meetings shall include, at a minimum, summaries and recommendations of any and all new policies or changes in policy. Such recommendations shall be submitted to the Medical Executive Committee for its approval.
- C. Each committee shall submit reports to MEC on its activities, including policy recommendations, per the guidelines set forth below. Such reports shall be made by the committee chair, or designee if not available:

Ambulatory Care.....	Annually
Bylaws.....	As needed to present proposed
amendments	No less than every two years
Utilization Management Committee.....	Every six <u>three months</u>
Cancer.....	Every six months <u>Twice yearly</u>
Credentials.....	Every month

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Critical Care.....	Every six months Twice yearly
Ethics.....	Every six months Twice yearly
Infection Control.....	Every three months
<u>Medical Staff Well Being.....</u>	<u>Every three months</u>
Operating Room.....	Every six months Twice yearly
Pharmacy and Therapeutics.....	Every month
Performance Improvement and Patient Safety.....	Every month
Medical Staff Well Being.....	Every six three months
Utilization Management Committee.....	Every three months
Medical Records Committee.....	Every three months

~~D.~~

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

9.2.11.11.2.11. **Special Meetings**

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

9.2.12.11.2.12. **Terms of Committee Members**

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

9.2.13.11.2.13. **Removal**

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

9.2.14.11.2.14. **Vacancies**

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

9.3.11.3. **Medical Executive Committee (MEC)**

9.3.1.11.3.1. **Composition of MEC**

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The MEC consists of the Officers of the Medical Staff, the Chiefs of the twenty (20) Clinical Services identified in Section 9.1-2 herein, the Director of Health, the Chief Medical Officer of the San Francisco Health Network, the Chief Executive Officer, the Vice Dean, the Chief Nursing Officer, the Chair of the Credentials Committee, the Chief Medical Officer, ~~the Medical Director of Trauma Services,~~ four (4) At-Large Members elected in accordance with Section 10.4-2 herein, and up to three (3) representatives of the House Staff appointed by the Chief of Staff. The Chief of Staff may invite other persons to attend meetings.

9.3.2-11.3.2. Attendance and Voting

- A. It is the expectation that all Medical Staff Members of the MEC shall attend MEC meetings and shall send an alternate when unable to attend. If a ~~Medical Staff~~ Member fails to attend fifty percent (50%) of the MEC meetings during a Medical Staff Year, the Chief of Staff may appoint an alternate to serve in that Member's place for the following Medical Staff Year.
- B. Each At-Large Member has one (1) vote.
- C. When a Chief of a Clinical Service cannot attend a meeting, he/she may designate an alternate to attend and exercise a proxy vote in the Chief's absence.
- D. When a Chief of the Clinical Service also holds the position of an officer of the Medical Staff or serves as the Vice Dean, no additional Members of the MEC will be named, and that single individual will represent both membership categories and have only one (1) vote.
- E. The three (3) Members of the House Staff shall collectively have a single vote.

9.3.3-11.3.3. Officers and At-Large Members

- A. The current or acting Chief of Staff shall serve as the Chair of the MEC.
- B. The Chief of Staff-Elect shall serve a one (1) year term when elected at the annual meeting of the Medical Staff or shall serve for the remainder of the unexpired term of the vacancy he/she fills when elected by the MEC.
- C. The Chief of Staff-Past shall serve a one (1) year term after completion of his/her year as Chief of Staff.
- D. The four (4) At-Large MEC Members who are elected shall not serve more than three (3) consecutive one (1) year terms. However, an ~~At-Large~~ Member shall not be appointed to a successive term if he/she has not attended at least fifty percent (50%) of the MEC meetings during the current appointment term.
- E. Vacancies in any of the four (4) At-Large Members arising during the Medical Staff Year shall be filled by the nomination of a Member of the Active Medical Staff by the Chief of Staff and approval by a vote of the MEC.

9.3.4-11.3.4. Duties of MEC

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

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- A. Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;
- B. Coordinate the activities of the Medical Staff committees and of the Clinical Services;
- C. Receive and act upon reports and recommendations from Medical Staff Committees and Clinical Services;
- D. Provide a forum in which the Medical Staff leadership can discuss issues and recommendations with the Chief Executive Officer, Chief Nursing Officer, Chief Financial Officer, Chief Medical Officer, and Vice Dean;
- E. Fulfill the Medical Staff's accountability to the Governing Body for the quality of care rendered to patients;
- F. Ensure that the Medical Staff is kept abreast of new laws, regulations, licensing and accreditation standards, and CMS Conditions of Participation;
- G. Review the credentials of all Applicants and make recommendations to the Governing Body for Medical Staff appointments, assignments to departments and delineation of Clinical Privileges;
- H. Review the recommendations from the Credentials Committee and make recommendations to the Governing Body for reappointment and renewal or changes in Clinical Privileges;
- I. Ensure the professional and ethical conduct and competent clinical performance of Medical Staff Members, including the initiation of investigations and corrective action when warranted;
- J. Review and approve all hospital-wide administrative and environment of care policies and clinical policies proposed by Medical Staff committees, and
- K. Make recommendations directly to the Governing Body for its approval regarding the following:
 - 1) ~~(1)~~—The Medical Staff's structure;
 - 2) ~~(2)~~—The mechanism used to review credentials and to delineate individual clinical privileges;
 - 3) ~~(3)~~—Individuals for Medical Staff Membership and Affiliated Professionals;
 - 4) ~~(4)~~—Delineated Clinical Staff Privileges for each eligible individual;
 - 5) ~~(5)~~—The mechanism for hearing procedures and the mechanism by which membership on the Medical Staff may be terminated;
 - 6) ~~(6)~~—The organization of the quality assessment and improvement activities of the Medical Staff.
- L. To amend these Bylaws and Rules and Regulations, in accordance with **Article XVI, Article 156**, Section ~~156.54~~, in the case of a documented need for an urgent amendment necessary to comply with law, regulation, or deficiency issued by The Joint Commission or state or federal regulating body.

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- M. To take such other actions as may reasonably be deemed necessary in the best interest of the Medical Staff and Hospital. The authority delegated pursuant to this section ~~10.3-4~~, may be removed by amendment of these Bylaws and Rules and Regulations.

9.4.11.4. Nominating Committee

9.4.11.4.1. Composition

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

9.4.2.11.4.2. Duties

The committee shall act upon the following requirements:

- A. Nominate a Member of the Active Medical Staff to serve as Chief of Staff-Elect prior to the end of the first year of the Chief of Staff's term of office.
- B. Should the incumbent Chief of Staff be re-nominated to serve an additional year, a previous Chief of Staff will also be nominated as Chief of Staff-Past until a new Chief of Staff-Elect is nominated. In no event shall an individual serve more than six consecutive years as Chief of Staff.
- C. Nominate four (4) Members of the Active Medical Staff to serve a one-year term as Members-At-Large on the MEC. Members-At-Large may not serve more than three (3) consecutive years. An at-large Member shall not be appointed to a successive term if he/she has not attended at least fifty percent (50%) of the MEC meetings during the current appointment term.
- D. Election of the Medical Staff Officers will occur at the Annual Meeting in accordance with Section 8.2-2 herein.

9.4.3.11.4.3. Meetings

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

~~9.5. — Joint Conference Committee~~

~~9.6. — Composition~~

~~9.7. — The Committee shall consist of at least two (2) representatives of the Governing Body appointed by the President of the Governing Body, the Director of Health, the Chief of Staff, the Vice Dean, the Chief Medical Officer, the Chief Executive Officer, the Chief Nursing Officer, the Chief Quality Officer, and the Chief Financial Officer. The Chief of Staff-Past shall be a member of the committee and shall remain a member of the Committee for six (6) months following the expiration of the term of office. The Chief of Staff-Elect shall become a member of the Committee six (6) months prior to assuming the responsibilities of Chief of Staff. The President of the Governing Body shall appoint one of the Governing Body representatives to~~

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~~serve as Chair of the Committee and the Chief Executive Officer shall serve as Secretary.~~

9.8. — Duties

~~9.9. — The duties of the Joint Conference Committee shall be as follows:~~

~~9.10. — The Joint Conference Committee shall provide a forum for effective communication among the Medical Staff, Hospital Administration, and Governing Body to ensure Medical Staff Representation and participation in deliberations affecting the discharge of Medical Staff responsibilities and an effective means for the Medical Staff to participate in the development of all Hospital Policies.~~

9.11. — Meetings

~~9.12. — The Joint Conference Committee shall meet monthly at least ten (10) times annually, and shall transmit reports of its activities to the MEC through the Chief of Staff. The agenda of each meeting shall be set by the Chair of the Committee, in consultation with the Chief Executive Officer and the Chief of Staff.~~

9.13.11.5. Ambulatory Care Committee

9.13.1.11.5.1. Composition

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

~~A. A~~ A minimum of one (1) Active physician Member of the Medical Staff from ~~the following services:~~ Medicine, Medical Subspecialty, Family and Community Medicine, Community Primary Care (CPC), Pediatrics, Obstetrics-Gynecology, ~~a~~ Surgical Service, and Emergency Medicine. Members of the Medical Staff from other Clinical Services may be on the committee as deemed appropriate by the Co-chairs and Chief of Staff.

~~B.A.~~ Representatives This may include, but is not limited to representatives from Hospital Administration, Nursing, Information Services, Laboratory Medicine, Pharmacy, Radiology and Quality Management.

~~C.B.~~ B. The committee shall be co-chaired by an Active Member of the Medical Staff from Community Primary Care and the SFGH Associate Chief ~~Integration~~ Medical Officer for Specialty Care and Diagnostics or his/her designee.

9.13.2.11.5.2. Duties

The committee shall:

- A. Address cross-department operational issues, with a focus on communication, coordination of services, and inter-disciplinary problem solving. The committee will engage on-and off-campus primary care, medical and surgical specialty services, diagnostic and ancillary services in identifying and addressing areas of need.
- B. Serve as a forum to discuss issues related to the planning, development, quality, and delivery of integrated ambulatory care services.

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- C. Lead the development of Hospital policies, procedures, and practices, and measurement tools that are common to department, services, and programs providing ambulatory care services.
- D. Review clinic specific practices as needed to ensure that they are aligned with the Hospital's mission and operational and organizational systems.
- E. Identify opportunities to improve care in the ambulatory setting that relate to clinical, diagnostic, or ancillary services; patient experience; or at the request of committee Members or the Chief of Staff.
- F. Develop and maintain a communication network for SFGHZSFG and CPC leaders in ambulatory care.
- G. Facilitate linkages and collaboration between primary care in the sub-specialty care providers; between hospital based and community based providers; and between medical providers and other clinical disciplines.

~~9.13.3. Report to the MEC on activities, including policy recommendations, no less frequently than every annually.~~
~~9.13.4.11.5.3. Meetings~~

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

11.5.4. Reporting

Submits a written report to the MEC on activities, including policy recommendations, annually.

9.14.11.6. Bylaws Committee

9.14.1.11.6.1. Composition

This Committee shall consist of at least seven (7) Members of the Active Medical Staff including the Chief of Staff, Chief of Staff-Elect, Chiefs of Staff-Past, the Chief Medical Officer, one representative from Hospital Administration, one representative from the Dean's Office and one representative from the CPC service. The Chair shall be the Chief of Staff-Elect or co-chaired with the Chief of Staff.

1.1.1.11.6.2. Duties

The Committee shall conduct a periodic review of the Medical Staff Bylaws and Rules and Regulations no less than every two years, and shall submit recommendations for changes to the MEC prior to any required notification of the Active Medical Staff.

9.14.2.11.6.3. Meetings

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

9.15.11.7. Cancer Committee

9.15.1.11.7.1. Composition

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The Cancer Committee shall consist of five (5) Active Medical Staff Members representing Diagnostic Radiology, Pathology, Medical Oncology, ~~Radiation Oncology~~Palliative Care and General Surgery. Other Members shall include: the Cancer Program Administrator, Oncology Nurse, ~~Pain Control Nurse~~Radiation Oncologist, Social Worker, Certified Tumor Registrar, Performance Improvement representative, ~~Palliative Care team member~~, Clinical Research, Genetics professional/counselor, Rehabilitation Services, Registered Dietician, and a Pharmacist ~~and a representative from the American Cancer Society.~~

9.15.2.11.7.2. Duties

The Cancer Committee shall:

- A. Actively supervise the Tumor Registry doing quality review of abstracting, staging, and completeness of extent of disease information. This shall include ensuring that the Tumor Registry meets the standards of the American College of Surgeons and Commission on Cancer.
- B. Appoint and oversee the functions of the Tumor Board, a separate, multidisciplinary, weekly consultative and education committee.
- C. Perform continuous quality improvement functions for the Medical Staff with respect to cancer patients. These shall include working with individual Clinical Services and Hospital Administration as well as performing patient care evaluations as mandated by the Commission on Cancer.
- D. Ensure that consultative services from all major disciplines are available for all ~~Zuckerberg San Francisco General Hospital~~ cancer patients.
- ~~E. Ensure that educational programs for the Medical Staff include all major cancer treatment sites.~~
- ~~F.E. Report to the MEC on its activities, including policy recommendations, no less than every six months.~~

9.15.3.11.7.3. Meetings

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

11.7.4. Reporting

~~Submits a written r~~Report to the MEC on its activities, including policy recommendations, no less than every six months on a twice-yearly basis.

9.16.11.8. Credentials Committee

9.16.1.11.8.1. Composition

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

9.16.2.11.8.2. Duties

The Credentials Committee shall:

- A. Review the credentials of Applicants and make recommendations for membership and delineation of Clinical Privileges in compliance with these Bylaws;
- B. Make a report to the MEC on each Applicant for Medical Staff membership and privileges, which shall include recommendations from the appropriate Clinical Service Chief;
- C. Review all information available regarding the competence of Medical Staff Members and as a result of such review makes recommendations for the granting of Privileges, reappointments, and the assignment of Applicants to the various Clinical Services as provided in these Bylaws. ~~Make a report to the MEC regarding approval of Affiliated Professionals, which shall include recommendations from the appropriate Clinical Service Chief.~~

9.16.3.11.8.3. Meetings

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

11.8.4. Reporting

~~Make a r~~Report to the MEC regarding approval of Affiliated Professionals, which shall include recommendations from the appropriate Clinical Service Chief monthly.

9.16.4.11.8.5. Subcommittees

(1) Clinical Interdisciplinary Practice Subcommittee (CIDP)

A. Composition

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

B. Duties

This Subcommittee shall:

Review and approve standardized procedures and protocols for patient care activities of the Affiliated Professionals in accordance with the requirements of Title 22 of the California Code of Regulations governing committees on interdisciplinary practice.

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

C. Meetings

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

D. Reporting

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

9.17.11.9. Critical Care Committee

9.17.1.11.9.1. Composition

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

9.17.2.11.9.2. Duties

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

9.17.3.11.9.3. Meetings

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

11.9.4. Reporting

~~Submits a report to the MEC on its activities, including policy recommendations, on a twice-yearly basis.~~

9.17.4.11.9.5. Subcommittee

1) ~~Donor Council Subcommittee~~

A. Composition

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

B. ~~b.~~ Duties

The subcommittee shall:

- Review data collected by ~~CTDN~~DNW;

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- Prepare reports on donor statistics for Quality Management and the Critical Care Committee;
- Review and revise ~~SFGHZSFG~~ policies, as needed;
- Review and discuss concerns related to the donor process; and
- Coordinate education activities hospital-wide, as needed.

C. Meetings

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

D. Reporting

Reports to the Critical Care Committee on a twice-yearly basis.

9.18.11.10. Ethics Committee

9.18.1-11.10.1. Composition

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

9.18.2-11.10.2. Duties

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

9.18.3-11.10.3. Meetings

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

11.10.4. Reporting

~~The Committee shall submit~~ Submits a written reports to the MEC on his/her activities, including policy recommendations, no less frequently than every six months on a twice-yearly basis.

9.19-11.11. Infection Control Committee

9.19.1-11.11.1. Composition

This Committee shall consist of:

~~A. Members~~ Members from the Active Medical Staff ~~from each of the following Clinical Services (with vote);~~ diverse services involved in clinical care and operations. Current Members include:

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A. Medical Staff:

- 1) ~~(1)~~ (1)—Laboratory Medicine
- 2) ~~(2)~~ (2)—Medicine, with expertise in Infectious Disease
- ~~3) (3)~~—Medicine, with expertise in ~~Infectious Disease~~
- ~~4) (4)~~ (4)—Medicine, with expertise in Occupational Health (when position is filled)
- ~~5) (5)~~ (4)—Pediatrics
- ~~6) (6)~~—Surgery
- ~~7) (7)~~—Obstetrics and Gynecology
- ~~8) (8)~~ (5)—Anesthesiology

B. Director of Quality Management (with vote)

C. Director of Health and Safety (with vote)

D. Other representatives (with vote) from:

~~(1) Infection Prevention and Control Nurse Practitioner~~ Program Manager

~~(2) C. Chief Quality Officer~~

D. Inpatient Nursing Administration Administrative Representative

~~(3) House Staff~~

~~(4) Central Processing and Distribution~~

~~(5) Operating Room~~

~~(6) Nursery~~

E. Consultative Representatives (without vote) from:

E. 4A SNF Nurse Manager

F. Outpatient Nursing Director

G. Patient safety Officer

H. Senior Industrial Hygienist

I. Infection Control Department members, including Infection Control Practitioners, Analyst, and Data Manager

J. Infectious Diseases Pharmacist

K. Environmental Services

L. Facilities Management

M. Occupational Health

N. Additional Ad Hoc or Consultant Members (non-voting):

1) ~~(1)~~ (1)—Dietary ~~Sterile Processing Department Manager~~

2) ~~(2)~~ (2)—Housekeeping ~~Operating Room Manager~~

~~3) (3)~~—Laundry

~~4) (4)~~—Pharmacy

~~5) (5)~~—Engineering

~~6) (6)~~—Other departments, as requested

~~3) (3)~~ (3)—Food & Nutritional Services Director

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9.19.2.11.11.2. Duties

This Committee shall be responsible for directing ~~all phases of~~ the infection control program for ~~Zuckerberg San Francisco General Hospital and Trauma Center and other entities covered under the Hospital and its clients license, such as on-site clinics and the 4A Skilled Nursing Facility.~~ The Committee shall ~~directly supervise the guide and help prioritize the activities of the~~ Infection Control staff; ~~establish;~~ ~~assist with~~ definitions and guidelines for surveillance of infections ~~and determine whether he/she is nosocomial; determine and report pertinent;~~ ~~receive reports of~~ infection rates; ~~carry out epidemiologic studies of nosocomial infection, when appropriate, determine infection control measures, clusters of infections, and outbreaks;~~ promote a ~~preventive corrective prevention~~ program designed to minimize infection hazards; ~~establish and monitor precautions;~~ ~~review~~ procedures and programs ~~in association with the Employee Health Service~~ for surveillance and prevention of infections in ~~healthcare workers and other~~ employees; and review and approve infection control policies and procedures, ~~including those for cleaning, waste disposal, disinfection and sterilization.~~ The Infection Control Committee, ~~through its Chair,~~ may institute ~~any~~ appropriate control measures or ~~studies~~ ~~investigations~~ when there is ~~a~~ reasonable concern of danger to ~~any patient~~ ~~patients~~ or personnel. ~~Under supervision of the Committee through the Chair, the Infection Control Practitioner or the Registered Nurse responsible for a patient care unit may initiate cultures and appropriate isolation procedures with notification of the Medical Staff member responsible for the patient. The Committee shall submit reports to the MEC on its activities, including policy recommendations, no less frequently than every three (3) months.~~

9.19.3.11.11.3. Meetings

This Committee shall meet at least ~~monthly~~ ~~bimonthly~~, maintain a record of proceedings, and activities. ~~and report to the MEC and Governing Body at least quarterly.~~ ~~Infection Control staff, the Chair, the Infection Control Practitioner and Chief Executive Officer shall meet as frequently as necessary to carry on the business of the Infection Control function of the Hospital.~~

11.11.4. Reporting

Submits a written report to the MEC on its activities, including policy recommendations, quarterly.

9.20.11.12. Medical Staff Well Being Committee

9.20.1.11.12.1. Composition

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

9.20.2.11.12.2. Duties

The duties of the committee shall be as follows:

- A. To foster and actively support the well-being of Medical Staff Members and other staff Members in leadership positions;
- B. To support Chiefs of Service in addressing Well-Being issues among Members of their team, including faculty, staff and trainees.

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- C. To provide education to Members of the Medical Staff about illness and impairment issues specific to Medical Staff Members;
- D. To facilitate self-referral by Medical Staff Members and referral by other organization staff;
- E. To facilitate referral of the affected Medical Staff Members to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern;
- F. To provide for the maintenance of the confidentiality of the Medical Staff Members seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened;
- G. To assure evaluation of the credibility of a complaint, allegation, or concern;
- H. To monitor the affected Medical Staff Member and the safety of patients until the rehabilitation or any disciplinary process is completed;
- I. To assure a reporting to the Medical Staff leadership in instances in which a Medical Staff Member is providing unsafe treatment; ~~and~~
- J. To provide assistance, counseling, and referrals for disruptive Medical Staff Members; ~~and~~.
- K. To organize and oversee “Schwartz Rounds”, which are ad hoc multidisciplinary rounds for Members and hospital staff Members around difficult and/or challenging cases.

9.20.3.11.12.3. Meetings

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

11.12.4. Reporting

Submits a written report to MEC on its activities, including policy recommendations quarterly.

~~9.21.—~~

9.22.11.13. Operating Room Committee:

9.22.1.11.13.1. Composition

This Committee shall consist of:

- Medical Staff Members representing all services performing procedures within the Clinical Services perioperative areas;
- The ~~d~~Department of Surgery, Orthopedic Surgery, Anesthesiology, Obstetrics and Gynecology; and one (1) representative drawn from each of the following Clinical Services: Neurosurgery, Urology, Ophthalmology, Otolaryngology and Dentistry/Oral and Maxillofacial Surgery. ~~a~~Anesthesia;
- The Perioperative Nursing Director;

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- The Chief of the Infection Control Committee, ~~the~~;
- The Director of the Blood Bank;
- A representative from Hospital Administration, ~~and the Assistant Director of Nursing for the Operating Room shall serve with vote.;~~ and
- One (1) non-voting Member of the House Staff shall be invited to serve.

9.22.2-11.13.2. **Duties**

The Operating Room Committee shall be responsible for the evolution of the safe, proper, and efficient utilization of Operating & Procedural Rooms within the Hospital, including the Surgical and Procedural unit on the ground floor, and the operating rooms in Labor & Delivery. This Committee shall be responsible for the development of policies and procedures regarding the safe, proper, and efficient conduct of surgical procedures. ~~The Committee shall submit reports to the MEC on its activities, including policy recommendations, no less frequently than every six (6) months.~~

9.22.3-11.13.3. **Meetings**

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

11.13.4. **Reporting**

Submits a written report to MEC on its activities, including policy recommendations on a twice-yearly basis.

9.23-11.14. **Pharmacy and Therapeutics Committee**

9.23.1-11.14.1. **Composition**

This Committee shall consist of it least five (5) Members of the Active Medical Staff including one (1) representative from the CPC service. One (1) House Staff representative shall be invited to serve. In addition, representatives from the Pharmaceutical Service, the Nursing Service, Food Services, Hospital Administration, and other services as appropriate shall serve with vote. The Director of Pharmaceutical Services, or designee, shall serve as Secretary to the Committee. A Member of the Medical Staff with expertise in pharmacology shall serve as Chair. The Chief Pharmacy Officer shall serve as Vice Chair.

9.23.2-11.14.2. **Duties**

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

- A. Serve as an advisory group to the Medical Staff and the Department of Pharmaceutical Services on matters pertaining to the choice of available drugs;
- B. Publish~~ed~~ and maintain the Hospital formulary;

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- C. Establish and maintain standards concerning the use and control of investigational drugs and of research in the use of approved drugs;
- D. Make recommendations concerning drugs to be stocked on nursing units and other special services;
- E. Prevent unnecessary duplication in stocking pharmaceuticals;
- F. Evaluate clinical data concerning new pharmaceuticals requested for use in this Hospital and make recommendations to the Medical Executive Committee regarding what pharmaceuticals should be made available and placed on the formulary;
- Oversee sample use in clinics;

G.

~~H. Shall submit reports on its activities, including policy recommendations to the Medical Executive Committee, no less frequently than quarterly and as needed~~ Promote medication use safety;

G.I. Report issues to the Performance Improvement and Patient Safety Committee.

9.23.3.11.14.3. Meetings

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

11.14.4. Reports

Submits a written report to MEC on its activities, including policy recommendations to the MEC monthly.

9.23.4.11.14.5. Subcommittees

The Committee shall conduct the ~~bulk~~majority of its business through five (5) subcommittees. The Chair of each subcommittee shall be a Member of the Pharmacy and Therapeutics Committee and shall be appointed by the Chair of the Committee with the approval of the Chief of Staff.

A. Antibiotic Advisory Subcommittee

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

B. Formulary Review Subcommittee

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

C. Medication Use and Safety Subcommittee

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

D. Nutrition Subcommittee

The Subcommittee shall recommend therapeutic enteral and parenteral nutritional formulations for the Formulary and ~~to~~ monitor and assess nutritional therapies.

Additionally, the Subcommittee shall serve to review and approve policies and procedures relating to nutritional therapy of the Food and Nutritional Service, Outpatient Nutrition Service and the Nutritional Support Services, including the Diet Manual.

E. Pain Management Subcommittee

This Subcommittee shall recommend a program ~~for identifying and ameliorating barriers~~ ~~to~~ promote effective pain management. It will collaborate with the ~~Adverse Drug Reaction and Drug Medication Error Reduction Plan and Medication Use Evaluation Subcommittee and the Formulary Subcommittee and Safety Subcommittees~~ around ~~pharmaco-therapypolicies related to pharmacotherapy~~ of pain. It will review and recommend policies and procedures pertinent to pain management.

F. Medication Error Reduction Plan Subcommittee

This Subcommittee shall set system-wide and department-specific policies to reduce medication errors and adverse drug events. The subcommittee shall review and revise the California Department of Public Health mandated Medication Error Reduction Plan annually to assess effectiveness and identify weaknesses or deficiencies that could contribute to errors. The subcommittee shall also review and report all unusual occurrences related to medications and make recommendations to the Pharmacy and Therapeutics Committee on ways to ~~p~~prevent such occurrences in the future.

11.14.6. Reporting

The subcommittees report to the Pharmacy and Therapeutics Committee monthly.

9.24.11.15. Performance Improvement and Patient Safety Committee (PIPS)

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This ~~is a Joint Hospital Leadership and~~ Medical Staff committee ~~is~~ responsible for implementing the objectives of the organization-wide performance improvement and patient safety program. The committee takes an interdisciplinary and proactive approach to the prevention of adverse events, medical errors and near misses, and promotes patient outcomes/safety and reduction of health disparities as the core values in providing quality patient care.

9.24.1.11.15.1. **Composition**

This Committee shall consist of at least seven (7) physician representatives from the Active Medical Staff. It shall also include one (1) representative from Radiology, Clinical Lab, Pharmacy, Infection ~~Prevention and Control and Nursing and the Behavioral Health Center.~~ In addition, The Executive Leadership Team including the Chief Executive Officer, Chief Operations Officer, Chief Nursing Officer, Administrative Director of Quality Improvement, Chief Pharmacy Officer and the UCSF Vice Dean shall serve with one vote. The Administrative Director of Utilization Management ~~Management~~, and the Patient Safety Officer shall also be Members. ~~The~~ Chief Medical Officer or Vice Chief Medical Officer shall serve as ~~the~~ Chair and the Chief Quality Officer shall serve as Vice-Chair.

9.24.2.11.15.2. **Duties**

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

~~Reviews performance improvement reports from clinical laboratory services, diagnostic radiology services, and dietetic services as part of the annual report.~~

- C. Formulates and recommends ~~action~~ actions for improving patient care and safety to clinical services, ancillary/diagnostic departments, and performance improvement committees as appropriate.
- D. Makes recommendations based on an evaluation of the care provided (e.g. efficacy, appropriateness) and how well it is done (e.g. availability, timelines, effectiveness, continuity with other services, safety, efficiency, respect, and caring).

~~Reviews and approves the Hospital Utilization Management plan on an annual basis. Conducts utilization review studies designed to evaluate the appropriateness of admission to the hospital, lengths of stay, discharge practices, and use of medical and hospital services that may contribute to the effective utilization of services.~~

~~Reports and forwards recommendations at least quarterly/monthly to the Joint Conference Committee through the Chief Medical Officer and Chief Quality Officer, based on the review and recommendations made by the MEC.~~

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- E. ~~Reviews quality, utilization, and patient safety issues relevant to the Tertiary Care Contract and to the care of managed care patients.~~ Submits an annual report to the MEC.
- F. Facilitates a multidisciplinary, interdepartmental collaborative approach to improving the quality of patient care and safety, and appropriate utilization of resources through the designation of Performance Improvement ~~and Utilization Management subcommittees.~~

9.24.3.11.15.3. Meetings

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

11.15.4. Reporting

Reports and forwards recommendations monthly to the Joint Conference Committee through the Chief Medical Officer and Chief Quality Officer, based on the review and recommendations made by the MEC.

9.24.4.11.15.5. Subcommittees

- A. Code Blue Subcommittee
 - (1) Composition

Physician representatives from Cardiology, Emergency Department, Pulmonary Service, ~~nursing representation and Anesthesia. Additional representatives from the Quality Improvement Coordinating Committee and Respiratory, Nursing Education, staff representation from Pharmacy Service, Respiratory Therapy Service, the Product Evaluation Committee and the Hospital Quality Management Department management will also serve.~~

- (2) Duties

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

- (3) Meetings

The Code Blue Subcommittee shall meet monthly and shall maintain permanent records of its proceedings and activities. ~~The Chair and Co Chair will report to PIPS on a twice-yearly basis.~~

- (4) Reporting

Submits to a written report to PIPS on a twice-yearly basis.

- B. ~~Pediatric Emergency Medicine Subcommittee~~

- (1) ~~Composition~~

~~This Subcommittee shall consist of the Director of Pediatric Emergency Medicine; at least one (1) physician and one (1) nurse from Children's Health Center; at least one of the Pediatric Chief Residents; the Nurse Manager from critical care and trauma services; the Director of Pediatric Trauma; and the nurse managers from pediatrics and emergency medicine or his/her designates.~~

- (2) ~~Duties~~

~~The Subcommittee shall:~~

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

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

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

(3) — Meetings

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

~~CB. Risk Management Subcommittee Event Analysis & System Improvement Subcommittee (EASI)~~

(1) Composition.

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

(2) Duties

The Subcommittee shall:

- a. ~~Provide oversight of the quality and safety event review process~~Identify general areas of potential risk in the clinical aspects of patient care and safety;
- b. ~~Provide oversight to ensure identification of clinical risk, system vulnerabilities, and opportunities for quality improvement~~Identify and evaluate the specific cases with potential risk in the clinical aspects of patient care and safety;
- c. ~~Ensure implementation of recommend corrective action to mitigate or eliminate future recurrence of similar~~Recommend corrections for problems in the clinical aspects of patient care and safety identified by risk management activities; and
- d. ~~Establish framework that improves clinical and operational systems, improves patient safety and quality outcomes using a shared accountability model~~Design programs to reduce risk in the clinical aspects of patient care and safety.
- e. ~~Establish a framework that improves performance and patient safety, addressing both systems issues and individual behaviors.~~

(3) Meetings

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

(4) Reporting

Submits a written report to PIPS on a twice-yearly basis.

CD. Transfusion Subcommittee.

(1) Composition

The Transfusion Subcommittee shall consist of the ~~Head-Nurse~~ from ~~Manager~~ for the Operating Room, the Nurse Manager for the Surgical ~~Clinical Head Nurse~~ Clinics, the ~~Chief~~ Blood Bank ~~Technologists~~ Senior Supervising Technologist, the Director of the Transfusion Service/Division Chief of the Blood ~~Bank~~ Bank and one (1) Member each from the Departments of Anesthesia/~~Critical Care~~, Surgery, ~~OB/GYN~~ Obstetrics, Pediatrics/Neonatology, Hematology/Oncology and Emergency Services.

(2) Duties

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

(3) Reporting

Submits a written Report-report to PIPS quarterly on a twice-yearly basis.

ED. Trauma Program Operational Process Performance Subcommittee

(1) Composition

The Subcommittee shall be ~~Chaired~~ chaired by the Trauma Medical Director and the Trauma Program ~~manager~~ Manager shall serve as Vice Chair. The Subcommittee shall consist of the representatives from the Departments of Emergency Medicine, Anesthesia, Neurosurgery, Orthopedics, Radiology, Physical Medicine, Rehabilitation, Respiratory Therapy, Perioperative Services, Laboratory Medicine, and Pediatrics; the Nursing Directors or Managers of the Surgical ICU, Emergency Department, Surgical Nursing, PACU and Operating Room; Neurosurgical, Emergency Department and Surgical CNS representatives, Risk Management and Quality Management Nursing representatives, Trauma PI Coordinators, Trauma, Orthopedic and Neurosurgical NP representatives, Medical Director of SFFD Emergency Medical Services Division, ~~SFGHZSFG~~ Base Hospital Coordinator, EMSA Medical Director and Trauma Coordinator, San Mateo EMS Clinical Coordinator, and other professionals are invited to participate as needed.

(2) Duties

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

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

(3) Meetings

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

(4) Reporting

The Chair and Co-Chair of the Trauma Program Operational Process Performance and Trauma Multidisciplinary Peer Review Subcommittees will submit a written combined Trauma report to PIPS on a twice-yearly basis.

~~FE.~~ Trauma Multidisciplinary Peer Review SubcCommittee

(1) Composition

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

(2) Duties

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

- a. Evaluate provider performance through objective and systematic monitoring.
- b. Analyze problems related to provider performance and develop plans for improvement, resolution, and modification of current practices.
- c. Communicate the results of review and plans of correction to all Members of the Committee and the Trauma Panel.
- d. Facilitate and direct a development of clinical management guidelines or protocols for the management trauma.

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- e. Measure the effectiveness of any corrective action taken or protocols generated.

(3) Meetings

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

(4) Reporting

The Chair and Co-Chair of the Trauma Program Operational Process Performance and Trauma Multidisciplinary Peer Review Subcommittees will submit a written combined Trauma report to PIPS on a twice-yearly basis.

~~*** Note The Chair and Co Chair of the Trauma Program Operational Process Performance and Trauma Multidisciplinary Peer Review Subcommittees will present a combined Trauma report to PIPS on a twice yearly basis~~

GE. Tissue Subcommittee

(1) Composition

The Tissue Subcommittee shall consist of attending physicians from Pathology (including the Chief of Pathology) selected by the Tissue Subcommittee Chair, and other Members that the Chief of Staff appoints from surgical subspecialties and other areas.

(2) Duties

- a. The Tissue Subcommittee shall be responsible for the review of all selected surgical case reports; those with pathology reports will correlate pre and post-operative diagnosis and pathology findings. Discrepancies shall be ~~reviewed with the Chief of the Clinical Service with concurrent notification of the Medical Executive Committee. All non-tissue surgical cases shall be reviewed by the presented to the~~ Performance Improvement and Patient Safety Committee. ~~The Performance Improvement and Patient Safety reviewer shall be an ex-officio member of the~~ The Tissue Subcommittee and shall report to the Tissue Subcommittee will review tissue specimens submitted to Pathology to ensure proper tissue handling and adequate completion of requisition forms.

- b. Make recommendations based on results;

- ~~e. Report to Performance Improvement and Patient Safety Committee quarterly.~~

(3) Meetings

The Tissue Subcommittee shall meet as needed, but no less than twice per year, and shall maintain permanent records of its proceedings and activities.

(4) Reporting

Submits a written report to PIPS quarterly.

GH. Procedural Sedation Subcommittee

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

(1) Composition:

The subcommittee shall be ~~Co~~-Chaired by the Chief of Anesthesia or designee and a nursing administrator and consist of physician and ~~or~~ nursing representatives from all clinical services providing procedural sedation, including: Gastroenterology, Radiology, Oral and Maxillofacial Surgery, Pulmonology, Emergency Medicine, Critical Care, Women's Option Clinic, Neonatal Intensive Care Unit, Post Anesthesia Care Unit, Cardiac catheterization lab, and the Clinical and Translational Science Institute.

(2) Duties:

This subcommittee is tasked with ~~recommending hospital~~ setting system wide and department specific procedural sedation policy to ensure the safe delivery of procedural sedation and to meet regulatory compliance requirements for procedural sedation throughout the institution. Policies shall be reviewed and revised no less frequently than every three years. The subcommittee will track audit data on a quarterly basis. All procedural sedation related unusual occurrences will be discussed and any recommendations forwarded to the involved department.

(3) Meetings:

The subcommittee shall meet monthly at least ten (10) times annually and shall maintain permanent records of its meetings and activities.

(4) Reporting

Submits a written report to PIPS on a twice-yearly basis.

9.25.11.16. Utilization Management Committee

9.25.1-11.16.1. Composition:

This committee shall consist of at least seven (7) Members of the Active Medical Staff, including 1) the Chief Medical Officer or the Medical Director of Utilization Management, 2) the Chief of Staff or his/her designee, 3) one Member from CPC, 4) a representative from Surgical Clinical Services, 5) a representative from the Medicine service and 6) two (2) or more representatives from other Clinical Services. Additional administrative Members include the Director of Utilization Management, Chief Operating Officer, Chief Pharmacy Officer or designee, and representative of the UCSF Dean's office. Other individuals from the clinical, administrative, and support services whose participation is deemed necessary to increase the effectiveness of the work of the committee will be invited to meetings as needed. The Chief Medical Officer or Medical Director of Utilization Management shall serve as Chair and the Chief Operating Officer or designee shall serve as Vice Chair.

9.25.2-11.16.2. Duties

This committee shall have two primary functions:

- A. Provide oversight for all Utilization Management functions, and

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- B. Make rational and system-coordinated recommendations on the priority of clinical services and resource allocation related to clinical care based on best available evidence.

9.25.3.11.16.3. Utilization Data Review

The Committee will review data related to Utilization Management at least quarterly, including, but not limited to:

- Medical necessity/appropriateness of hospital admissions
- Medical necessity/appropriateness of continued stay and treatment authorizations
- Lengths of stay variations and timeliness of discharge
- Professional services furnished, including drugs and ~~biological~~biologicals
- Appropriate availability and use of ancillary services
- Overuse, underuse, and timeliness in provision of services
- Therapeutic procedures
- Adequacy of medical record documentation
- Third party payer denials
- Utilization of the Tertiary Care Contract
- Contracted Health Plan utilization and cost data
- Out-of-network referral costs
- Utilization Review Plan (review and approve annually)

Review of the above data elements may be concurrent or retrospective, and may be conducted on a sample basis for cases reasonably assumed to be outliers based on lengths of stay or extraordinary high costs. The UMC will work closely with financial services, social services, case management, patient placement services, and the Medical Staff to maximize appropriate utilization of resources. The UMC will report relevant findings to the Medical Executive Committee including problems, areas of opportunity, and actions addressed with departments, Clinical Services, Medical Staff, and other hospital entities.

9.25.4.11.16.4. Meetings

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

9.25.5.11.16.5. ~~Reports~~Reporting

~~and shall s~~Submit ~~a written reports~~ on its activities to the ~~Medical Executive Committee~~, including policy recommendations, ~~no less frequently than every six (6) months~~quarterly.

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ARTICLE 12. MEETINGS OF THE ~~WHOLE ENTIRE~~ MEDICAL STAFF

~~1.1.12.1.~~ Annual Meeting

An annual Medical Staff meeting shall be held within sixty (60) days of the end of the Medical Staff year.

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

The agenda at the annual Medical Staff meeting shall be:

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

~~1.1.12.2.~~ Voting

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

~~1.2.12.3.~~ Special Meetings

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

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- D. Agenda will include Reading of the notice of the meeting, Transaction of business for which the meeting was called and Adjournment.

**ARTICLE 2. ARTICLE 13. CONFIDENTIALITY OF INFORMATION;
IMMUNITY AND RELEASES**

2.1. 13.1. Authorization and Conditions

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

- A. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon information bearing upon, or reasonably believed to bear upon, the Applicant's professional ability and qualifications;
- B. Authorizes persons and organizations to provide information concerning such Applicant to the Medical Staff;
- C. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under Section ~~12~~13.2.4 below; and
- D. Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff Membership, the continuation of such membership, and to the exercise of clinical privileges at this Hospital.

2.2. 13.2. Confidentiality of Information

2.2.1. 13.2.1. General

Discussions, deliberations, records and proceedings of all Medical Staff committees having responsibility of evaluation and improvement of quality of care rendered in this Hospital shall, to the fullest extent permitted by law, be confidential. This confidentiality protection includes, but is not limited to, information regarding any Member or Applicant to this Medical Staff, meetings of the Medical Staff, meetings of Clinical Services, meetings of committees of the Medical Staff, and meetings of ad hoc committees created by the ~~Medical Executive~~ ~~Committee~~.

2.2.2. 13.2.2. When Disclosure is Permitted

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

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- E. Initiation of a corrective action investigation, submission of an 805 report to the California Medical Board, and adverse actions related to medical staff membership and/or privileges shall be reported to the peer review bodies of any other component of the San Francisco Health Network in which the Member provides patient care services.

2.2.3.13.2.3. Breach of Confidentiality

Effective quality of care activities, peer review, and consideration of the qualifications of Medical Staff Members and Applicants to perform specific procedures must be based on free and candid discussions within a quality improvement process. Any breach of confidentiality of the discussions, deliberations, records or proceedings of Medical Staff Clinical Services or committees is outside appropriate standards of conduct for Medical Staff Members, violates these Medical Staff Bylaws, and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee MEC may undertake such corrective action as it deems appropriate. In particular, and without limitation, a breach of confidentiality includes any unauthorized voluntary testimony or unauthorized offer to testify before a court of law or in any other proceeding as to matters protected by this confidentiality provision.

2.2.4.13.2.4. Immunity from Liability

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

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

- B. For Providing Information.

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

2.2.5.13.2.5. Activities and Information Covered

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

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

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ARTICLE 3. ~~ARTICLE 14.~~ CONFLICTS AND DISPUTE RESOLUTION

~~3.1.14.1.~~ Conflicts and Disputes between the Medical Staff and the MEC

- A. The Chief of Staff shall convene a meeting to resolve a conflict or dispute between the MEC and the Medical Staff upon receipt of a written petition, signed by at least twenty percent (20%) of the Active Medical Staff Members that sets forth the rule, policy, or other significant matter at issue.
- B. The meeting shall include up to five representatives of the Active Medical Staff selected by the petitioners and an equal number of MEC Members selected by the Chief of Staff. The meeting shall be chaired by the Chief of Staff who will not be considered as one of the MEC representatives and who will not have voting privileges at this meeting.
- C. The representatives of the Medical Staff and of the MEC shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the position of the Medical Staff, the leadership responsibilities of the MEC, and the safety and quality of patient care at the Hospital.
- D. Resolution at this level requires a majority vote of the representatives of the Medical Staff and a majority vote of the representatives of the MEC.
- E. Unresolved matters shall be submitted to the Joint Conference Committee for final resolution.

~~3.2.14.2.~~ Conflicts and Disputes between the Medical Staff and the Governing Body

- A. The Chief of Staff shall convene a meeting to resolve a conflict or dispute between the Medical Staff and the Governing Body upon a majority vote of the MEC or petition of at least twenty percent (20%) of the Active ~~Medical Staff~~ Members. The Chief of Staff shall work with the Secretary of the Governing Body to ensure compliance with public notice requirements.
- B. The Medical Staff shall be represented by the two officers of the Medical Staff and three Active Medical Staff Members selected by the Chief of Staff. The Governing Body shall be represented by the Governing Body members on the Joint Conference Committee. The Hospital Chief Executive Officer shall also be invited to attend this meeting.
- C. The meeting shall be chaired by the Chair of the Joint Conference Committee.
- D. The meeting participants shall gather and share relevant information and shall work in good faith to resolve differences in a manner that respects the position of the Medical Staff, the governing responsibilities of the Governing Body, and the safety and quality of patient care at the Hospital.
- E. Resolution at this level requires a majority vote of the representatives of the physicians and a majority vote of the representatives of the Governing Body.
- F. Unresolved matters shall be submitted to the Governing Body for final resolution. The Governing Body shall make its final determination giving great weight to the actions and recommendations of the Medical Staff, shall not be arbitrary and capricious, and

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shall be in keeping with its legal responsibilities to act to protect the safety and quality of patient care and to ensure the responsible governance of the Hospital.

ARTICLE 4.ARTICLE 15. RULES AND REGULATIONS

4.1.15.1. Rules and Regulations of the Medical Staff

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

4.2.15.2. Rules and Regulations of the Clinical Services

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

ARTICLE 5.ARTICLE 16. ADOPTION AND AMENDMENT

5.1.16.1. Medical Staff Responsibility

5.1.1.16.1.1. Initial Responsibility

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

5.1.2.16.1.2. ~~Hospital-ZSFG~~ Chief Executive

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

5.1.3.16.1.3. Proposed Amendments

Proposed amendments shall be reviewed and considered at a meeting of the Joint Conference Committee prior to distribution to the Medical Staff for a vote. The Governing Body Members of the Joint Conference Committee have the right to have their comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

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5.2.16.2. Amendments

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

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

5.3.16.3. Method

5.3.1.16.3.1. Combined

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

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

5.3.2.16.3.2. Governing Body Vote

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

5.3.3.16.3.3. Approval of Amendments

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

5.4.16.4. ~~15.4~~ Corrections

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

5.5.16.5. Urgent Amendments

In the case of a documented need for an urgent amendment to these Bylaws and Rules and Regulations necessary to comply with law, regulation, or deficiency issued by the Joint Commission or state of federal regulating body, these Bylaws may be amended for that sole purpose by a two-thirds (2/3) affirmative vote of the MEC and by an affirmative vote of each

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Governing Body representatives on the Joint Conference Committee. In such an event, the amendment shall be submitted to the Medical Staff for retrospective review. If there is a dispute regarding such an amendment, the Medical Staff may pursue the conflict management process set forth in Article 14 of these Bylaws.

ZSFG

MEDICAL STAFF BYLAWS

APPENDIX 1

**PATIENT
COMMUNITY**

VISION

To be the best hospital by exceeding patient expectations and advancing community wellness in a patient centered, healing environment.

MISSION

To provide quality healthcare and trauma services with compassion and respect.

VALUES

Learn Improve Engage Care

True North Metrics

Safety

- Zero Patient Harm
- Zero Staff Injuries

Quality

- Preventable Mortality
- Reduce Readmissions

Care Experience

- Patient Satisfaction
- Access & Flow

Developing People

- Staff Satisfaction
- Develop Problem Solvers

Financial Stewardship

- Meet budget goals
- Decrease length of stay

ZSFG Leadership System

**PATIENT
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Respect Responsibility/Ownership Teamwork Courage

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SAFETY

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QUALITY

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CARE EXPERIENCE

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DEVELOPING PEOPLE

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COMMUNITY**

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Financial Stewardship

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- Decrease length of stay

FINANCIAL STERWARDSHIP

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COMMUNITY**

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- Access & Flow

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Financial Stewardship

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- Decrease length of stay

SFGH Management System

ZSFG

MEDICAL STAFF BYLAWS

APPENDIX 2

Administrative Policy Number: 22.06

TITLE: Visiting Physicians

PURPOSE:

To set forth the requirements for the various types of visiting physicians and to identify those activities that require credentialing and privileging by the Medical Staff Services office.

DEFINITIONS:

Visiting physicians fall within one of the following categories:

- A. **Consulting Clinical Physician:** A visiting physician who is consulting on the care of a particular patient or group of patients.
- B. **Consulting Academic Physician:** A visiting physician who is participating in a medical education program in
 - 1. a patient care setting, e.g. nursing unit, clinic, operating room, etc., and/ or
 - 2. a non-patient care setting, e.g. grand round, morbidity and mortality conference, lecture
- C. **Physician Observer:** A visiting physician who wishes to observe patient care for her or his own edification
- D. **Visiting Research Physician :** A Visiting physician who is consulting or observing in research settings in
 - 1. a patient care setting, e.g. nursing unit, clinic, operating room, etc., and/ or
 - 2. a non-patient care setting, e.g. laboratory

Note: This policy would similarly apply to visiting dentists, podiatrists and clinical psychologists. This policy does not apply to physician trainees.

STATEMENT OF POLICY:

SFGH welcomes visiting physicians who can contribute to the clinical, educational and clinical research activities of the hospital or who wish to learn from observing those activities.

Visiting physicians who administer treatments, perform procedures or interventions on SFGH patients, document in patients' medical records, or supervise house staff must be credentialed and privileged by the Medical Staff Services office.

PROCEDURE:

A. **Consulting Clinical Physician:**

- 1. Privileges: With the recommendation of the Chief of the sponsoring Clinical Service, a Consulting Clinical Physician must apply to SFGH Medical Staff Services for visiting privileges as defined in section 5.3 of the SFGH Medical Staff Bylaws. ("Bylaws").

Visiting Privileges are distinct from temporary privileges which are defined in section 5.2 of the Bylaws.

2. No Institutional Reciprocity: It is important to note that while closely affiliated, SFGH, the University of California, San Francisco Medical Center (“UCSF”), and Laguna Honda Hospital are separate institutions and medical staff privileges are **not** reciprocal. Similarly a UCSF faculty appointment does not by itself confer the faculty member with medical staff privileges at SFGH.
3. Immunizations: Consulting Clinical Physicians must meet the same immunization requirements as clinical staff employed at SFGH.
4. Orientation: It is the responsibility of the Chief of the sponsoring Clinical Service or her or his designee to orient the Consulting Clinical Physician to all SFGH policies and procedures that are relevant to the Consulting Clinical Physician’s visit such as patient privacy, infection control, and environmental health and safety procedures. Consulting Clinical Physicians must sign the DPH Confidentiality form.

B. Consulting Academic Physician:

1. Role: The role of the Consulting Academic Physician (**Consultant**) is didactic or instructional and must not involve any direct patient care. While the Consultant may offer treatment recommendations for a patient or group of patients usually in the context of a specific disease process or condition, the patient’s attending physician retains responsibility for all treatment decisions. Consultants shall not administer treatments, perform procedures or interventions on SFGH patients, document in patients’ medical records, or supervise house staff. These patient care activities require SFGH Medical Staff privileges.
2. Professional Liability Coverage. Although a Consultant shall not engage in direct patient care, any Consultant, who may be interacting with patients, has the responsibility to maintain coverage for professional liability from an insurance company or a program of self-insurance from her or his primary institution in the event the Consultant’s activities at SFGH becomes an issue in a claim or lawsuit.
3. Sponsorship: Consultants are on the SFGH campus at the invitation of the Chief of the sponsoring Clinical Service.
4. Immunizations: Consultants who will be in patient care settings (e.g. participating in clinical rounds) must meet the same immunization requirements as clinical staff employed at SFGH.
5. Orientation: It is the responsibility of the Chief of the sponsoring Clinical Service or her or his designee to orient the Consultant to all SFGH policies and procedures that are relevant to the Consultant’s visit such as patient privacy, infection control, and environmental health and safety procedures. Consultants who may have any access to patient information in any form must sign the DPH Confidentiality form.
6. Identification Badges: If the Consultant will be in patient care areas, the sponsoring Clinical Service will provide her or him with an identification badge with the Consultant’s

name, designation as a visiting consultant, and the sponsoring Clinical Service. The identifying information will be typed (18 to 24 font size) or clearly printed on a white card or paper and placed in a standard conference style, clear vinyl, 3" x4" identification badge holder with a clip or pin.

7. **Patient Consent:** If a Consultant is to interact directly with a patient, a member of the sponsoring Clinical Service or the patient's primary medical team ("responsible SFGH Provider") must remain with the Consultant. The responsible SFGH Provider will introduce and explain the Consultant's role to the patient, and obtain the patient's oral consent before proceeding. If the patient lacks the capacity to consent, the Consultant's limited interaction with the patient shall be deemed within the scope of the patient's implied consent (or substitute consent through a surrogate) to routine medical care.

C. **Physician Observer:**

1. **Role:** The role of the Physician Observer ("**Observer**") is solely to observe patient care or hospital operations. Observers shall not perform physical or mental health examinations, administer treatments, perform procedures or interventions on SFGH patients, document in patients' medical records, or supervise house staff. These patient care activities require SFGH Medical Staff privileges.
2. **Sponsorship:** Observers are on the SFGH campus at the invitation of the Chief of the sponsoring Clinical Service. A member of the sponsoring Clinical Service should accompany the Observer at all times while in patient care areas.
3. **Immunizations:** Observers who will be in patient care settings must meet the same immunization requirements as clinical staff employed at SFGH
4. **Orientation:** It is the responsibility of the Chief of the sponsoring Clinical Service or her or his designee to orient the Observer to all SFGH policies and procedures that are relevant to the Observer's visit such as patient privacy, infection control, and environmental health and safety procedures. Observers who may have access to patient information in any form must sign the DPH Confidentiality form.
5. **Identification Badges:** If the Observer will be in patient care areas, the sponsoring Clinical Service should provide her or him with an identification badge with the Observer's name, designation as a visiting physician, and the sponsoring Clinical Service. The identifying information will be typed (18 to 24 font size) or clearly printed on a white card or paper and placed in a standard conference style, clear vinyl, 3" x4" identification badge holder with a clip or pin.
6. **Patient Consent:** If an Observer is to directly observe a patient's care, the responsible SFGH Provider will introduce and explain the Observer's role to the patient and obtain the patient's oral consent before proceeding. If the patient lacks the capacity to consent, the Observer's limited interaction with the patient shall be deemed within the scope of the patient's implied consent (or substitute consent through a surrogate) to routine medical care.

D. **Visiting Research Physician:**

1. Role: The role of the Visiting Research Physician (**Visiting Researcher**) may involve interactions with patients as an observer or in a limited participatory manner. Researchers shall not be involved in any direct patient/ research subject interventions.
2. Professional Liability Coverage. Although a Visiting Researcher must not engage in direct patient care, any Visiting Researcher, who may be interacting with patients, has the responsibility to maintain coverage for professional liability from an insurance company or a program of self-insurance from her or his primary institution in the event the Visiting Researcher's activities at SFGH becomes an issue in a claim or lawsuit.
3. Sponsorship: Visiting Researchers are on the SFGH campus at the invitation of the Chief of the sponsoring Clinical Service or Principal Investigator of the research project with the knowledge and consent of the Chief of the sponsoring Clinical Service.
4. Immunizations: Visiting Researchers who will be in patient care settings must meet the same immunization requirements as clinical staff employed at SFGH.
5. Orientation: It is the responsibility of the Chief of the sponsoring Clinical Service or Principal Investigator of the research project to orient the Visiting Researcher to all SFGH policies and procedures that are relevant to the Researcher's visit such as privacy, infection control, and environmental health and safety procedures, including any safety gear and precautions that are specific to the research project. Visiting Researchers who may have access to patient information in any form must sign the DPH Confidentiality form.
6. Identification Badges: If the Visiting Researcher will be in patient care areas or otherwise interacting with patients, the sponsoring Clinical Service should provide her or him with an identification badge with the Visiting Researcher's name, designation as a visiting physician, and the sponsoring Clinical Service. The identifying information will be typed (18 to 24 font size) or clearly printed on a white card or paper and placed in a standard conference style, clear vinyl , 3" x4" identification badge holder with a clip or pin.
7. Patient Consent: If the Visiting Researcher is to interact directly with a patient or observe a patient intervention, the responsible SFGH Provider or Principal Investigator of the research project will introduce and explain the Visiting Researcher's role to the patient and obtain the patient's oral consent before proceeding. If the patient lacks the capacity to consent, the Visiting Researcher's limited interaction with the patient shall be deemed within the scope of the patient's implied consent (or substitute consent through a surrogate) to participate in the research project.

E. INSURANCE

1. Professional Liability:

- a. Neither the City and County of San Francisco ("CCSF") nor the University of California ("UC") will provide professional liability coverage to visiting physicians unless the visiting physician is a Visiting Clinical Consultant who has existing coverage from CCSF as an employee of the SF Department of Public Health or from UC as an employee of UCSF or another UC-owned facility.

- b. A Visiting Clinical Physician is required to produce evidence of professional liability coverage as part of the credentialing and privileging process. Any other visiting physician, who may be interacting with patients, has the responsibility to maintain coverage for professional liability from an insurance company or a program of self-insurance from her or his primary institution in the event the visiting physician's activities at SFGH becomes an issue in a claim or lawsuit

- b. Consultants who provide treatment recommendations that may be construed as patient specific and not generalized or hypothetical or who intervene in an emergency or other clinical situation should discuss potential liability exposure with their insurance carrier or self-insurance program manager to ensure that have coverage while at SFGH. In the event a patient makes a claim or files a lawsuit and the investigation or pretrial discovery implicates a Consultant in the patient's care, UCSF or SFGH may pursue a subrogation claim against the Consultant and his/ her insurer. Similarly other visiting physicians who may intervene in a clinical situation should seek assurances of a defense and, if applicable, indemnity from their insurance carrier.

2. Workers Compensation:

Neither the City and County of San Francisco nor the University of California, San Francisco will provide workers compensation insurance coverage to visiting physicians unless the visiting physician is a Visiting Clinical Consultant who has existing coverage from CCSF as an employee of the SF Department of Public Health or from UC as an employee of UCSF or another UC-owned facility

F. ADMINISTRATION AND RECORD KEEPING

Each Clinical Service that sponsors a visiting physician should maintain its own records concerning the physician's visit. The scope and detail of the records will vary with the situation, but may include the date(s) and purpose of the visit, the signed DPH Confidentiality form, an attestation of current vaccinations, and contact information in case it is necessary to reach the physician for any reason after her or his visit.

	Privileges Required	Immunizations	Orientation	ID Badges	Patient Consent	Professional Liability Coverage
Consulting Clinical Physician	Yes	Same as all clinical staff	Yes	Yes	Yes	Yes, must provide evidence of coverage to Medical Staff Office per Bylaws
Academic Consultant Physician	No	If in patient care settings, same as all clinical staff	Yes	Yes, if in patient care settings	Yes, if interacting with patients or observing patient interventions	Yes, visiting physician has the responsibility to maintain coverage if interacting with patients
Physician Observer	No	If in patient care settings, same as all clinical staff	Yes	Yes, if in patient care settings	Yes, if observing patient interventions	No
Visiting Research Physician	No	If in patient care settings or otherwise interacting with patients, same as all clinical staff	Yes	Yes, if in patient care settings or otherwise interacting with patients	Yes, if interacting/observing patient interventions	Yes, visiting physician has the responsibility to maintain coverage if interacting with patients

APPROVAL

Nursing Administrative Forum	4/01/14
Medical Executive Committee	4/17/14
Quality Council	4/15/14
JCC	5/13/14
Exec Committees B-25 Readiness	12/17/15

Date Adopted: 5/10**Date Reviewed:** 5/13

ZSFG

MEDICAL STAFF BYLAWS

APPENDIX 3

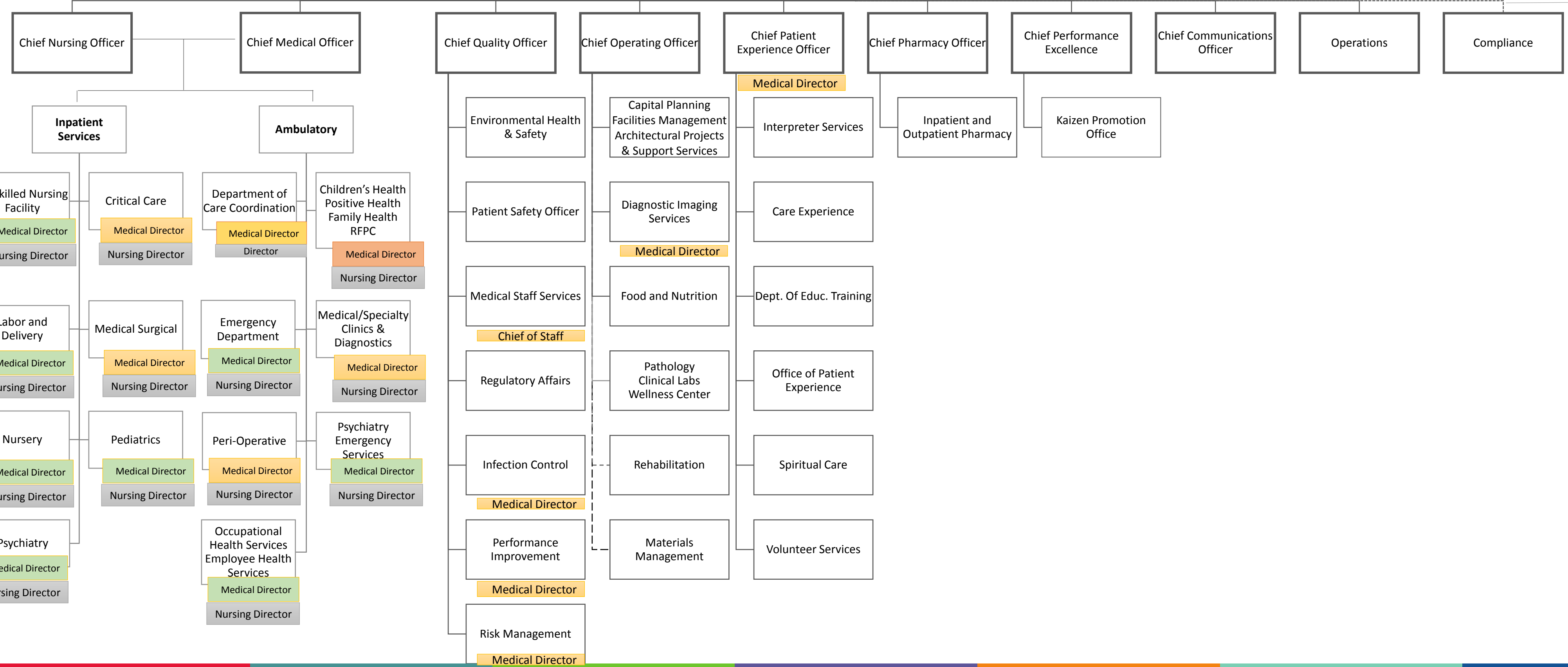
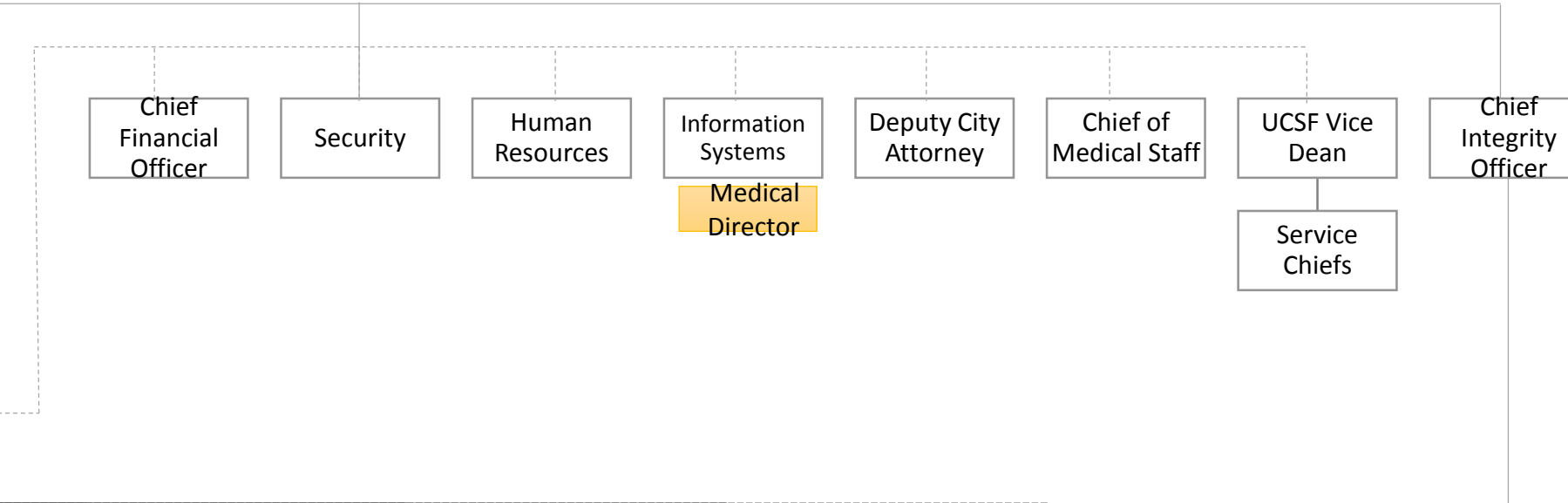
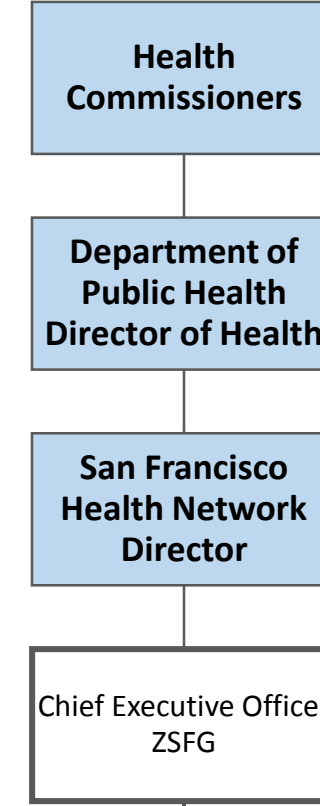


ZUCKERBERG SAN FRANCISCO GENERAL

Hospital and Trauma Center

Functional Organizational Chart with Clinical Dyads

Last updated | 9/6/17



Central Leadership

Service Leadership

San Francisco Health Network Leader

ZSFG

MEDICAL STAFF BYLAWS

APPENDIX 4

CONFIDENTIAL
PROTECTED BY THE ATTORNEY-CLIENT PRIVILEGE AND CALIFORNIA EVIDENCE CODE 1157

{Medical Staff Committee Title}
 {Date}

CHAIR:
CO-CHAIRS:

ATTENDANCE

Medical Staff Bylaws Mandatory Medical Staff Members (List Here):
Medical Staff Bylaws Other Members Present (List Here):
Other Members Present (List Here):
Guests (List Here):

Excused:
Absent:

AGENDA ITEM	DISCUSSION	DECISION/ACTION
I. Call To Order		
II. Minutes		
III. Follow-up Items from Previous Meeting		
IV. Agenda Item		
V. Agenda Item		
VI. Agenda Item		
VII. Agenda Item		
VIII. Agenda Item		
Next Meeting	The next meeting will be held {Date} in {Room} {Time}	

**ZSFG Medical Staff ByLaws
Rules & Regulations
2017-2018**

Table of Substantive Changes

Section 5 Surgeries	5	§5.A. Records to be completed within 14 days	§5.A. Records to be completed within 5 calendar days
Section 6 Medical Records	7	§6.B.iii.c. operative reports to be completed within 14 days	§6.B.iii.c. operative reports to be completed within 5 calendar days
		§6.B.vi. Records to be completed with within 14 days	§6.B.vi. Records to be completed within 5 calendar days
	8	§6.C.iv. Records to be completed with within 14 days	§6.C.iv. Records to be completed within 5 calendar days
	8	§6.D.ii. Records to be completed with within 14 days	§6.D.ii. Records to be completed within 5 calendar days
Section 10 Discharge and Transfer of Patients	15	§10.A. Records to be completed with within 14 days	§10.A. Records to be completed within 5 calendar days

THE PRISCILLA CHAN AND MARK ZUCKERBERG
SAN FRANCISCO GENERAL HOSPITAL
AND TRAUMA CENTER

MEDICAL STAFF
Rules and Regulations

20174-20185

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1. Admission and Attendance Policies

- A. Patients shall be admitted only upon the order and under the care of a ~~an~~ Active member Member of the Medical Staff (Member) (~~Member~~) of the Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG or Hospital) who is lawfully authorized to diagnose, prescribe and treat patients. The patient's condition and provisional diagnosis shall be established at time of admission by the ~~member~~ Member of the Medical Staff who admits the patient. ~~A Physician (M.D. / D.O); The Member~~ must be responsible for the care of any medical problems that may arise during the course of a patient's Hospital stay. Other members of the Medical Staff may evaluate and record portions of the history and physical, which pertain to his/her scope of licensure and privileging.
- B. Patients in Skilled Nursing Facility (SNF) beds must have an evaluation of his/her mental and physical condition within seventy-two (72) hours of admission. If the patient's condition has not significantly changed or if significant changes have occurred and are recorded at the time of admission, a durable legible original or reproduction of a history and physical, obtained by ~~a~~ a Member physician, completed five (5) days before readmission or admission and recorded in the Medical Record is acceptable.
- C. Except in an emergency, patients shall be admitted to the Hospital only after a provisional diagnosis has been provided. In the case of emergency, the provisional diagnosis shall be ~~started~~ provided as soon as possible after admission.
- D. The responsible ~~attending~~ Member Attending Physician (Attending), or his/her designee, who believes that a patient may pose an imminent risk to staff or other patients due to a history of violent behavior, shall be responsible for providing that information to the charge nurse and other staff as necessary.
- E. Each inpatient shall be seen daily by a Member ~~n~~ Attending or his/her designee, and a note shall be placed in the medical record. This note shall reflect the involvement of ~~the~~ Member in the patient's care ~~n~~ attending. Either ~~this~~ Member Attending Physician, or ~~the~~ a designated Attending who is a ~~Member~~ Member of the Medical Staff, shall be available on a call twenty-four

(24) hours per day to meet the needs of the patient. This provision shall not apply to patients in the GCRC admitted for the purpose of a research study.

- F. Each patient in a SNF bed shall be seen by ~~at the attending Member Attending physician~~ at least once during a thirty (30) day period and in accordance with the patient's needs. ~~Each This attending Member Attending physician~~ shall designate an alternative ~~physician Member~~ to contact for regular or emergency care when the ~~attending admitting Member Attending physician~~ is not available.
- G. When a patient is transferred from one Clinical Service (Service) to another Clinical Service, all of the following must occur:
 - i. ~~Physicians Medical Staff Members~~ on both the transferring and the receiving ~~services Services~~ approved the transfer and agree upon the ongoing role, if applicable, of the transferring ~~service Service~~.
 - ii. A transfer note describing the patient's condition completed by the transferring service shall accompany the patient to the ~~new-receiving~~ Service.
 - iii. A ~~Member n-Attending~~ of record for the receiving Service shall be identified.
 - iv. All orders shall be rewritten upon transfer to the receiving Service.
- H. The Patient Rights and Responsibilities, as detailed in the ~~San Francisco General~~ Hospital Administrative Policy and Procedure ~~No. -,16.04~~, shall be observed by all ~~Mm~~ members of the Medical Staff.
- I. All research involving human subjects shall be subject to the policies and regulations of the University's Committee on Human Research.

2. Medical Histories and Physical Examinations ("H&P"s)

- A. H&P's shall be performed and documented by a Member of the Medical Staff or by an Affiliated Professional pursuant to a Standardized Procedure. ~~H&P's are monitored quarterly by Medical Record review.~~ Components include:
 - i. Chief complaint/reason for admission
 - ii. History of present illness

- iii. Past medical history/surgical history
- iv. Current medications
- v. Allergies/adverse drug reactions
- vi. Review of systems (as pertinent)
- vii. Physical examination (as pertinent)
- viii. Diagnostics (if relevant)
- ix. Assessment
- x. Plan

For non-inpatient services, a directed history and physical examination shall include those components listed above as relevant and indicated by the clinical setting and nature of the visit.

B. For surgical patients, the assessment shall be as follows:

- i. Acute Hospital Admission: The patient's H&P, nursing assessment, and other screening assessments are completed within the first twenty-four (24) hours after admission, and prior to surgery or a procedure requiring anesthesia services. H&P's performed within thirty (30) days prior to admission as an inpatient must be in the medical record and updated within the first twenty-four (24) hours after admission.
- ii. Surgical or other invasive diagnostic or therapeutic procedures, including both "come and go" and "come and stay" surgeries: The H&P shall be performed within thirty (30) days prior to the procedure and be present in the medical record. An interval updated H&P must be done and recorded in the chart after registration or admission and within 24 hours prior to surgery for a procedure requiring anesthesia services. An interval update records any changes since the last H&P was performed.
- iii. Procedures performed under moderate sedation: The H&P shall be performed within the preceding thirty (30) days, with an interval update if the H&P was performed more than twenty-four (24) hours prior to the procedure.

- iv. Oral and maxillofacial surgery: Oral and maxillofacial surgeons who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U. S. Office of Education and have been determined by the Medical Staff to be competent to do so, may perform a history and physical examination and determine the ability of patients, who have been admitted for oral/maxillofacial surgery and who have no other relevant medical problems, to undergo the surgical procedures the oral and maxillofacial surgeon proposes to perform. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the Medical Staff must conduct or directly supervise the admitting history and physical examination, except the portion related to oral and maxillofacial surgery, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the oral and maxillofacial surgeon's lawful scope of practice.

3. Consent

Each ~~clinical-Clinical service-Service~~ will monitor compliance with the ~~hospital~~ Hospital informed consent policy. Procedures requiring consent shall be performed only upon signed informed consent, which contains evidence that the risks, benefits and alternative treatments have been explained and understood by the patient. It is the responsibility of the ~~Member~~Attending to ensure that the signed consent form and documentation of the informed consent discussion is contained in the medical record. For Oral and Maxillofacial Surgery, Medical Staff members of the Oral and Maxillofacial Surgery are responsible to ensure that the signed consent form and documentation of the informed consent discussion is contained in the medical record. Emergency procedures may be performed when signed consent has not been obtained if, in the opinion of the ~~Attending~~Member, serious harm would befall the patient if the procedure were not performed. The need for the emergency procedure shall be documented in the medical record.

4. Consultations/Communications

- A. In order to insure informed and timely management of patients and to utilize the variety of special expertise at ~~San Francisco General~~the Hospital,

consultations are encouraged. Consultations shall be obtained whenever the consultation might reasonably be expected to assist in the patient's continuing care as provided by the applicable Clinical Services Rules and Regulations.

- B. When in-patient consultation is requested, the patient should be seen within twenty-four (24) hours by the consulting Member. A satisfactory consultation includes examination of the patient and the medical record. An urgent request for consultation should be honored within six (6) hours. Request for emergency consultation should be honored promptly. A brief note consisting of the consulting Member's consultant's assessment and plan should be entered into the medical record at the completion of the consultation. A complete consulting Member's consultant's report should be in the medical record within forty-eight (48) hours. All consultations must be in writing and signed by the consulting Member/consultant.

5. Surgeries

- A. All operations shall be fully described by the operating physician or oral surgeon and operative reports shall be dictated, ~~or electronically written~~ entered into the electronic health record or written on a standardized, approved form immediately following completion of surgery. The reports shall contain a description of the findings, operative procedures performed, ~~the specimen(s)~~ removed, if any, any complications/adverse events, the preoperative and postoperative diagnosis, and the name of the primary surgeon ~~only~~ and assistant(s). All ~~summaries-reports~~ shall be signed by the responsible licensed physician within five (5) calendar days fourteen (14) days. If the operative report is dictated, a brief operative summary must be written in the patient's chart immediately after surgery. When standard forms that have been approved by the Medical Records Committee exist, his/her completion can be substituted for a dictation of the operative procedure.
- B. When an inpatient undergoes surgery, cancellation of all standing orders, is automatic and new orders shall be written after surgery is completed. A DNR order may be held in abeyance during and immediately following an invasive procedure (generally, those requiring informed consent) at the discretion of the physician performing the procedure and/or the anesthesiologist. The possibility of resuscitating a patient under these circumstances shall be

discussed with the patient or his/her surrogate discussion-maker as part of the informed consent process.

- C. Tissues removed at operation shall be sent to the Hospital pathologist, who shall make such examination as he/she may consider necessary to arrive at a pathological diagnosis and he/she shall sign the report for inclusion in the patient's chart.

6. Medical Records

A. Overview

- i. All patients admitted for care in the inpatient and outpatient settings must have a complete medical record. All encounters where care is provided must be documented.

B. Inpatient Medical Records

i. Admissions

- a. For all admissions to the inpatient units, a complete history and physical examination shall be performed and documented within the first twenty-four (24) hours after admission.

ii. The inpatient medical record will ~~also~~ include the following:

- a. ~~Initial diagnostic/clinical impression and plan;~~
- b. Reports (such as consultation, clinical laboratory, ~~electrocardiogram, x-ray diagnostic studies, radiology reports etc and other~~);
- ~~e.~~ Medical and/or surgical treatment;
- ~~d.~~ Pathologist's findings;
- ~~e.~~ Daily progress notes; and
- ~~f.~~ Discharge summary which briefly recapitulates the reason for hospitalization, significant findings, procedures performed, treatment rendered, final diagnosis, patient's condition on discharge, medications

to be taken at discharge, plans for outpatient follow-up and discharge instructions as pertinent.

iii. Anesthesia/Operative Procedures

- a. If a patient undergoes anesthesia or operative procedures, the anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation.
- b. A post-anesthetic follow-up note shall be written in the patient's chart by an anesthesiologist within 24-48 hours of the patient's procedure.
- c. Operative reports must be completed within five (5) calendar days ~~fourteen (14) days~~ of the patient's discharge and are considered part of the medical record.
- d. A record will be considered incomplete if it is missing the anesthesia ~~report and~~/or operative report.

iv. Antibiotic Orders

- a. All inpatient orders for antibiotics (oral, intra-muscular or intravenous), without specific limitations as to dosage, must be written on the antibiotic order sheet which specifies renewal frequency.

v. Verbal Orders

- a. Verbal orders are only appropriate in an emergency situation or for pain ~~management or management or in situations~~ situations in which a delay may adversely affect the patient. ~~Verbal orders for SNF patients must be signed within five (5) days.~~
- b. All verbal orders, including telephone and face-to-face orders, will be signed within forty-eight (48) hours by the licensed independent practitioner who gave the order. Verbal orders for SNF patients must be signed within five (5) days. The signature of the Attending physician who was responsible for the care of the patient at the time that the order was given is acceptable if the practitioner is not available.

- vi. Inpatient mMedical records shall be completed promptly and authenticated or signed by the relevant physician, nurse practitioner, physician assistant, clinical psychologist, dentist or podiatrist within five (5) calendar days ~~fourteen (14) days~~ following the patient's discharge.
- C. Skilled Nursing Facility Medical Records
- i. Admissions: For all Skilled Nursing Facility (SNF) admissions, an evaluation of his/her mental and physical condition shall be documented within seventy-two (72) hours of admission.
 - ii. The medical record will also include the following:
 - a. -Initial diagnostic impression and plan, reports (such as consultation, clinical laboratory, ~~electrocardiogram, x-ray~~diagnostic studies, radiology reports, and other), medical and/or surgical treatment and Pathologist's findings;
 - b. Progress notes at least every thirty days; and
 - c. Discharge summary which briefly recapitulates the reason for hospitalization, significant findings, procedures performed, treatment rendered, final diagnosis, patient's condition on discharge, medications to be taken at discharge and discharge instructions as pertinent.
 - iii. Antibiotic Orders
 - a. All ~~inpatient~~ skilled nursing orders for antibiotics (oral, intra-muscular or intravenous), without specific limitations as to dosage, must be written on the antibiotic order sheet which specifies renewal frequency.
 - iv. Medical records shall be completed promptly and authenticated or signed by the relevant physician, nurse practitioner, physician assistant, clinical psychologist, dentist or podiatrist within five (5) calendar days ~~fourteen (14) days~~ following the patient's discharge.
- D. Outpatient Medical Records

- i. In addition to the appropriate history and physical examination, the outpatient medical record will include the following:
 - a. Problem List: a summary list of significant past and present diagnoses and health problems;
 - b. A list of current- medications;
 - c. A recording of significant allergies and drug sensitivities;
 - e.d. Complete assessment that outlines the diagnosis(es) and clinical impression (and possible differential diagnoses) as well as the plan which should include the treatment and diagnostic plan as appropriate.
 - ii. Medical records shall be completed promptly and authenticated or signed by a physician, clinical psychologist, dentist, or podiatrist or nurse practitioner within five (5) calendar fourteen (14) days following the patient's visit.
- E. Oversight of Medical Records
- i. The Chief of the Clinical Service shall be responsible for all aspects of medical records pertaining to his/her service, including the following:
 - a. Adherence to guidelines for inpatient, SNF, and outpatient medical records;
 - b. Completeness of the medical record; and
 - c. Timely record completion.
 - ii. The Chief of the Clinical Service will be held responsible for the completion of clinical service patients' medical records according to his/her established procedures and those outlined in the Bylaws that have not been completed in a timely manner, as defined above, by their medical staff.
 - iii. The Chief of Staff or the relevant Chief of Service may suspend the Privileges of Medical Staff members or the Standardized Procedures of Affiliate Staff members for failure to complete records within the timelines outlined for each clinical area.

F. Practitioner Responsibilities

- i. All medical record entries shall be legible.
- ii. The physician, nurse practitioner, physician assistant, clinical psychologist, dentist or podiatrist dictation notes for the medical record shall be personally signed or electronically authenticated.
- iii. In addition to the practitioner's signature, the entry shall include the practitioner's unique identifier~~CHN~~ number, and the entry shall be timed and dated.
- iv. All records shall be completed in a timely manner in accordance with the timelines outlined for each clinical area.
- v. Medical Record Authentication
- vi. All medical records must be authenticated by members of the Medical Staff or Affiliated Medical staff. This includes review and attestation to the medical records completed by trainees.
 - a. All students and House Staff writing in the medical record will indicate his/her year in training and unique identifier~~CHN ID~~ number, date and time. An order may be written by a medical student after conferring with a supervising physician who will counter-sign the order.
 - b. Notes written by medical students should be countersigned by a physician within twenty-four (24) hours.
- vii. The method of authentication must be one of the following.
 - a. Handwritten signature with legible unique identifier~~CHN~~ number# denotation, date, and time;
 - b. Electronic signature authorization;
 - ~~viii. Electronically generated digital signature.~~

~~ix-viii.~~ ix-viii. Electronic Authentication

a. When authentication is by electronic signature authorization or digital signature, the following characteristics must be included: identification of the author by first and last name, professional degree, unique identifier~~CHN number, and date and time of authentication;~~

~~b.a. Each method of authentication must contain the identification of the author by first and last name, professional degree, CHN#, and date and time of authentication.~~

~~e.b.~~ An authentication statement must include current CMS-approved language, e.g., “Electronically signed by _____”.

~~d.c.~~ A member of the Medical Staff shall not allow anyone else to use his/her electronic signature.

~~e.d.~~ The ~~Director of Health Information~~Associate Chief of Medical Health Informatics Officer Services will certify that Medical Staff members using the Hospital’s electronic health record will have a unique and confidential code to generate the electronic signature.

G. The Chief of a Clinical Service that maintains an independent electronic medical information system is responsible for ensuring that each individual Medical Staff member has his/her own code to generate the electronic signature and that the codes and passwords are confidential.

H. Medical Records, Definition, Ownership and Control

i. Medical records ~~or are~~ legal documents ~~and~~ and are the property of the Zuckerberg San Francisco General Hospital and are under the custody of the Health Information Services Department.

ii. Medical records contain valuable and confidential information and are to be safeguarded against loss, defacement, tampering, or use by unauthorized persons. Nothing shall be removed or deleted from a medical record, and no irrelevant or facetious notations may be made in them.

iii. Medical records are to be in the Health Information Services Department or at the site of patient care service. Medical records may be used outside the Health Information Services Department for specific occasions, such as

conferences and meetings. Persons with records checked out to them must always have them immediately available for patient care. Records are not to leave the Zuckerberg San Francisco General Hospital campuses except pursuant to a court order, subpoena, or statute.

- iv. Medical records may be borrowed only by authorized borrowers, who must adhere strictly to established Zuckerberg San Francisco General Hospital administrative policies for request and return of records to Health Information Services at the end of the day.
- v. Medical records of inpatients must be available for pick-up by Health Information Services Department immediately following discharge.

vi. Medical records requested by clinics must be returned on the day of the visit.

~~vi.vii. visit. Use of medical records for research shall be governed by procedures adopted by the Medical Records Committee and approved by the MEC.~~

~~vii.viii.~~ The following are criteria for research review:

- a. Approval must be obtained from the UCSF Committee on Human Research ~~of UCSF and completion and approval of the Zuckerberg San Francisco General Protocol Application~~ -if the researcher plans to contact the patient directly.
- b. Record must be reviewed in the Health Information Services Department.
- c. No more than twenty-five (25) records at a time may be requested.~~requested.~~
- d. Distribution and access of medical records for patient care and utilization review shall have priority over use for study and research.

I. Special Circumstances for Organ Donation

- i. The requirements for the medical record of the donors of organs or tissue shall be the same as for any ~~surgical~~ inpatient.

- ii. When the donor organ or tissue is obtained from a brain dead patient, the medical record shall include the date and time of brain death, documentation by and identification of the physician who determined the death, the method of transfer and machine maintenance of the patient for organ or tissue donation, and documentation of the renewal of the organ or tissue.
- iii. When a cadaveric organ or cadaveric tissue is removed for purposes of donation, the removal is documented in the donor's medical record.

7. Clinical Service Rules and Regulations

 Each Clinical Service shall formulate its own rules and regulations and proctoring protocol for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall be consistent with these Bylaws, the general rules and procedures of the Medical Staff and other policies of the Hospital, shall be reviewed annually by the Chief of the Clinical Service and revised as appropriate and shall include at a minimum:

- A. Scope of Service;
- B. Development and annual review of Criteria of Delineation of Privileges;
- C. Annual review of privilege forms;
- D. Method for reviewing applications for appointment, reappointment, increase in privileges, modifications of clinical service and/or staff status, and granting of privileges;
- E. Proctoring requirements including exceptions;
- F. Clinical indicators and elements of individual practitioner's performance profiles;
- G. Methods for monitoring and evaluation of the appropriateness of patient care provided within the clinical service;
- H. Methods for monitoring and evaluating the professional performance of all individuals who have delineated clinical privileges in the clinical service (regardless of clinical service assignment);
- I. Reporting individual practitioner's monitoring and evaluation results to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;
- J. Frequency and format of clinical service meetings; and

- K. Rules and regulations pertaining to House Staff supervision and oversight.

8. House Staff

- A. ~~Attending faculty~~Medical Staff Members shall supervise House Staff in such a way that House Staff assumes progressively increasing responsibility for patient care according to his/her level of training, ability and experience.
- B. Guidelines pertaining to House Staff supervision and oversight are set forth in the Rules and Regulations of each Clinical Service. Such departmental Rules and Regulations shall include:
- C. Written descriptions of the role, responsibilities, and patient care activities of the House Staff;
- D. Identification of the mechanisms by which the House Staff members' supervisors and the graduate education program director make decisions about each House Staff members' progressive involvement and independence in specific patient care activities; and
- E. The delineation of House Staff members who may write patient care orders, the circumstances under which he/she may do so, and what entries, if any, must be countersigned by a member of the Medical Staff.
- F. Pursuant to California Business and Professions Code 2065 and 22 California Code of Regulations Section 70705, unlicensed resident trainees may write orders without obtaining a countersignature if they are graduates of an approved medical school, are registered with the Division of Licensing of the California Medical Board, and are engaged in the University's postgraduate training program.
- G. If patient care is provided by residents, interns and medical students, such care shall be in accordance with the provisions of an approved program and under the supervision of a Medical Staff member with appropriate clinical privileges.

9. Outpatient Medical Screening/Emergency Medical Treatment and Labor Act (EMTALA)

- A. An appropriate screening exam shall be provided to all persons who present themselves to the Hospital Emergency Department, Psychiatric Emergency Service, and designated urgent care centers in the hospital and who request, or have a request made on his/her behalf, for examination or treatment of a medical condition. Where there is no verbal request, the request will nevertheless be considered to exist if a prudent layperson observer would conclude, based on the person's appearance or behavior, that the person needs emergency examination or treatment. In such an event, the Hospital shall not seek authorization from an individual's insurance company until a medical screening examination has been provided and any necessary stabilizing treatment has been initiated. The patient will not be transferred to another facility unless the patient's condition is stabilized or it is in the patient's best interest to be transferred due to the hospital's inability to provide the needed services or level of care.
- B. The medical screening exam must be performed by a Physician Member of the Medical Staff or by a Nurse Practitioner, Physician Assistant, or Certified Nurse Midwife pursuant to a standardized procedure.
- C. In the event that a request is made for emergency care in the Hospital department off the Hospital's main campus, such as Community Primary Care Services Clinic, EMTALA does not apply. The clinic shall provide whatever assistance is within its capability and shall call the local emergency medical service to take the individual to an emergency department.

10. Discharge and Transfer of Patients

- A. The records of all acute care patients who have been hospitalized for longer than forty-eight (48) hours require a discharge summary, which must be dictated or otherwise recorded within ~~fourteen-five~~ (514) days of discharge. The discharge summary should recapitulate concisely the reason for admission, pertinent features of the course in the Hospital, relevant laboratory, electrocardiographic and x-ray findings, treatment rendered and procedures performed, the condition of patient on discharge, and the instructions provided to the patient and/or family or institution in relation to diet, exercise, activity, rehabilitation, follow-up care and medications. Transfer summaries are required for patients who are to be placed in skilled nursing facilities and

should be dictated at the earliest time prior to patient transfer. All summaries shall be signed and dated by the responsible ~~physician, clinical psychologist, dentist or podiatrist or designee~~ Medical Staff Member.

- B. The Clinical Service transferring a patient from an acute care unit to an extended care or acute care unit shall be responsible for assuring continuing care of the patient with adequate documentation in the medical record.
- C. A patient shall not be discharged or transferred from an acute care unit to an acute or extended care facility without a written order from the treating Medical Staff Member ~~physician, clinical psychologist, dentist, podiatrist or designee~~. A patient discharge plan (PDP form) shall be completed at the time of Hospital discharge, or transfer to an acute care facility. A discharge note shall be written in the medical record which includes the discharge diagnosis, recommendations for further care, including scheduled outpatient clinic appointments, limitations of activity, if any, dietary restrictions if any, and discharge medications. Whenever possible, patient discharges shall be arranged before nine (9) A.M., in keeping with Hospital policy.
- D. No patient shall be discharged to another health care facility unless arrangements have been made in advance for admission to that facility and the person legally responsible for the patient has been notified, or attempts have been made to notify such person over a twenty-four (24) hour period. Discharge shall not be carried out if, in the opinion of the patient's treating Medical Staff Member ~~physician, clinical psychologist, dentist or podiatrist~~, such discharge would endanger the patient.

11. Deaths and Autopsies

- A. The ~~Attending Physician~~ Physician Member or designee shall certify the time of death and notify the next of kin.
- B. Every member of the Medical Staff is expected to be actively interested in securing autopsies, particularly when a quality assurance, legal, or educational issue ~~or goal~~ exists. No autopsy shall be performed without legal consent. All autopsies shall be performed by the Hospital pathologist as prescribed by the State of California. The Medical Examiner shall be notified in appropriate cases as defined by statute and hospital policy.

- C. The Medical Staff, ~~and specifically the Member Attending Physicians~~, shall be notified when and where an autopsy on his/her patient is being performed.
- D. Responsible efforts shall be made to identify potential organ and tissue donors and to cooperate in the procurement of anatomical gifts. All organ and tissue donations shall be coordinated through the ~~California Transplant~~ Donor Network West (CTDNW). Only those recovery teams which have been approved by and referred from the CTDNW will be permitted to recover organs and tissues.

12. General

- A. All research involving human subjects shall comply with the policies and regulations of the University's Committee of Human Research.
- B. Medical Staff members and the Affiliated Professionals shall abide by the Hospital-wide administrative policy regarding Restraint and Seclusion.
- C. Medical Staff members and the Affiliated Professionals shall abide by the Hospital-wide administrative policy regarding the administration of moderate or deep sedation.
- D. Positions requiring x-ray supervisor and operator certification in accordance with Division 20, Chapter 7.4, Sections 25668(e) and 25699 of the California Health and Safety Code, shall maintain a current license.
- E. Both UCSF and San Francisco General Hospital have adopted policies prohibiting sexual harassment. The Medical Staff acknowledges and affirms these policies.
- F. Members of the Medical Staff shall comply with the DPH Notice of Privacy Practices, the Hospital policies and procedures regarding patient privacy and the Healthcare Insurance Portability and Accountability Act of 1996 (~~HIPPA~~HIPAA) and shall abide by the following:
 - i. Protected health information shall only be accessed, discussed or divulged as required for the performance of job duties;

- ii. User IDs and/or passwords shall only be disclosed to Hospital Information System staff;
- iii. Members shall not log into Hospital information system or authenticate entries with the user ID or password of another; and.
- iv. Members shall only install software on Hospital computers that have been appropriately licensed and authorized by Hospital Information System staff.
- v. Members agree that violation of this section regarding the privacy and security of Protected Health Information may result in corrective action as set forth in Articles VI and VII of these Bylaws.

13. Adoption and Amendment

These Rules and Regulations may be amended or repealed, in whole or in part, as prescribed in Article XIII of the Medical Staff Bylaws.