BYLAWS OF THE MEDICAL STAFF
SANTA MONICA-UCLA MEDICAL CENTER & ORTHOPAEDIC HOSPITAL

PREAMBLE

These Bylaws and accompanying Rules and Regulations are adopted to provide a framework for self-governance for the organization of the Medical Staff of Santa Monica-UCLA Medical Center & Orthopaedic Hospital (SMH). They permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care and patient safety, to govern the orderly resolution of issues and the conduct of the Medical Staff functions supportive of those purposes, and to account to the Governing Body for the effective performance of Medical Staff responsibilities.

The Medical Staff is directly responsible for patient care under the ultimate responsibility of The Regents of the University of California as the Governing Body of SMH. The Regents has delegated to the Chancellor who has delegated to the Vice Chancellor for Health Sciences, the responsibility to act as the Governing Body on behalf of The Regents of the University of California.

These Bylaws and accompanying 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. The furtherance of medical education and research will also be more effectively addressed through an organized Medical Staff.

DEFINITIONS

Allied Health Professional or "AHP" means an individual who is neither a physician, dentist or podiatrist, and who is supervised by a member of the Medical Staff in the care of patients or who practices independently within the limits and scope of a lawful practice.

Attending Physician (the “Attending”) means the designated member of the Medical Staff who is responsible for the medical care of the patient while in the Medical Center.

Chief Medical Officer means an Active member of the Medical Staff appointed by the Governing Body to serve as liaison between the Medical Staff and Administration. The Chief Medical Officer is appointed by the Medical Staff to serve as a non-voting member of the Medical Staff Executive Committee as well as an ex-officio member of all Medical Staff Committees.

Chief of Staff means the Medical Staff member elected from and by the Medical Staff Executive Committee.

Clinical Privileges or Privileges means the permission granted to licensed independent practitioners to provide patient care and includes access to those Medical Center resources including, equipment, facilities, medical center personnel which are necessary to effectively exercise those privileges.

Day means a weekday, except legally recognized holidays.

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

Department means those members of the Medical Staff who, by virtue of their specialty training, are grouped into the Clinical Specialties of Emergency Medicine, Family Medicine, Medicine, Ob/Gyn, Pediatrics, and Surgery/Anesthesia.

Department Chair means a member of the Medical Staff Executive Committee who is appointed by the Chief of Staff to serve as chair of the department from which that member was elected.

Ex-Officio means service as a member of a body by virtue of an office or position held. An ex-officio appointment is without vote unless otherwise specified.

Executive Committee means the Medical Staff Executive Committee ("MSEC") of the Medical Staff with responsibilities set forth in these Bylaws.

Governing Body means the Vice Chancellor for Health Sciences acting on behalf of the Regents of the University of California.

Medical Center Director means the "Chief Administrative Officer" or "CAO". The Medical Center Director is the individual appointed by the Governing Body to act on its behalf in the overall adminstrative management of the Medical Center.

Medical Staff means the licensed physicians, dentists and podiatrists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.

Medical Staff Year means the first day of January and ends on the thirty-first (31st) day of December.

Notice means all notices, demands, requests, and other communications required or permitted to be served on or given to a party pursuant to these Bylaws. All notices, except where specific notice provisions are otherwise provided in these Bylaws, shall be either via electronic mail or in writing and shall be delivered personally or by United States Postal Service, first-class postage prepaid, certified, return receipt requested. In the case of a notice to a Medical Staff member, Allied Health Professional or other party, the notice shall be addressed to the address as it appears in the records of the Medical Center. If personally delivered, such notice shall be effective upon delivery, and if mailed as provided for above, such notice shall be effective two days after it is placed in the mail.

Physician means a person holding an M.D., D.O. degree and a license to practice medicine in the State of California.

Podiatrist means a podiatrist holding a D.P.M., degree and a license to practice podiatry in the State of California.

Rules and Regulations refers to the Medical Staff Rules and Regulations adopted in accordance with these Bylaws.

All references to the masculine gender mean the masculine or feminine gender.

ARTICLE I - NAME

The name of the organization shall be: "THE MEDICAL STAFF OF THE SANTA MONICA-UCLA MEDICAL CENTER & ORTHOPAEDIC HOSPITAL"

ARTICLE II - PURPOSE

The purposes of the organization shall be:

1. To ensure that all patients admitted to or treated in any of the facilities, departments or services of the Medical Center shall receive quality care, and such care shall be monitored through the ongoing quality improvement and evaluation program;

2. To propose and to enforce Medical Staff Bylaws, approved policies, Rules and Regulations for the self government of the Medical Staff;

3. To promote and secure optimal ethical, medical and educational standards within the Medical Center and to assist and encourage the professional advancement of all staff members, both within this Medical Center and within the community at large;

4. To provide a means for discussion and solution of medico-administrative problems of joint concern to the Medical Staff and to the Governing Body and the Medical Center Administration, to the end that the Medical Center shall remain a leader in its relations with patients, employees, the Medical Staff, and the community at large; and
5. To be accountable to the Governing Body for all professional work performed in the Medical Center by Medical Staff members.

ARTICLE III - MEMBERSHIP

Section 1. Membership a Privilege; Professional Conduct

Membership on the Medical Staff is a privilege which shall be extended only to those physicians, dentists and podiatrists who strictly and continuously meet the standards and qualifications required by these Bylaws and who, by accepting membership on the Medical Staff, have agreed to abide and be governed by these Bylaws, the Medical Staff and Departmental Rules and Regulations, policies, the Principles of Ethics of the American Medical Association, and the Guiding Principles of Physician-Medical Center Relationships of the California Medical Association.

Dentist members shall be guided by the principles of the American Dental Association and Podiatrist members shall be guided by the Code of Ethics of the California Podiatry Association and the principles of the American Podiatry Association. Any division of fees by members of the Medical Staff that is prohibited by law is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff. Appointment to the Medical Staff shall confer on the appointee only such rights and privileges as may be provided by these Bylaws and Medical Staff Rules and Regulations.

Section 2. Qualifications for Membership

All applicants for membership on the Medical Staff must hold a valid California license to practice their professions.

Unless the applicant only desires Consultant Staff membership, the applicant's office practice must be conducted sufficiently close to the Medical Center to provide continuous and timely care to patients.

Practitioners whose privileges at any other medical facility **have not** been voluntarily or involuntarily denied, reduced, revoked, or suspended for medical disciplinary cause or reason, or relinquished in anticipation or in lieu of an investigation or corrective action within five years of the date of application, or during the application processing period are qualified to request membership.

Board Certification

Board certification by a board recognized by the American Board of Medical Specialists, in their specialty, is a requirement of initial staff membership. Applicants who are not Board certified at the time of appointment must become Board certified within five (5) years from the date of graduation from their last training program.

Board certification equivalency shall include, but not be limited to, certification from another country, and shall be determined by the Department Chair to which the applicant seeks appointment. Exceptions to the requirement for Board certification equivalncy must be substantiated by appropriate medical education and training, and extraordinary experience and reputation, endorsed by the Department Chair and presented in writing, for decision by the MSEC through the Credentials Committee.

Maintenance of board certification is required for continued medical staff membership. Maintenance of dual certification is not required; however board certification in the specialty in which privileges have been granted is required. Exceptions may be granted to members who document:

(1) Plans to retire within 2 years of the request
(2) Having been “grandfathered” as a member prior to 6/30/2018

No applicant shall be denied Medical Staff membership on the basis of age, sex, race, creed, color, national origin, or physical or mental impairment that does not compromise the applicant's ability to exercise the specific clinical privileges that the applicant is requesting.

Practitioners whose practice falls outside the UCLA Policy on Professional Malpractice Coverage must maintain professional liability insurance coverage with limits of coverage not less $1 million occurrence/$3 million aggregate.

Members of the medical staff will obtain and maintain a valid electronic mail address, notifying the medical staff office of any changes.

Each medical staff member shall meet all educational requirements for membership, such as training on computer systems, training on compliance standards such as HIPAA, and other training as required by the MSEC.

Only those of the above qualified applicants whose total background, experience and training assures, in the judgment of the appointing authorities, that any patient admitted to or treated at the Medical Center shall be treated with professional care and skill, shall be qualified for Medical Staff membership. Membership and privileges at another Medical Center do not automatically confer membership and/or similar privileges at this Medical Center.

Physicians, dentists and podiatrists, as a condition of Staff membership, agree to adhere to the ethics of their respective professions, work cooperatively and harmoniously with others so as to not adversely affect patient care or disrupt the operation of the Medical Center or create a hostile work environment, keep confidential, as required by law, all information or records received in the patient-staff-member relationship, and participate in and properly discharge those responsibilities determined by the Medical Staff.

A practitioner who does not meet these basic qualifications is ineligible to apply for medical staff membership, and the application shall not be accepted for review. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic qualifications is not entitled to the procedural rights set forth in Article XIII.

Only those Medical Staff members whose qualifications and whose level of professional care, conduct, skill and judgment have been continually and affirmatively demonstrated to the satisfaction of officers or committees authorized to analyze and review such care, conduct, skill and judgment, shall remain qualified for Medical Staff membership.

Section 3. Agreements for Specialty Services

The Medical Center may execute exclusive agreements for specialty services with members of the Medical Staff, following review and recommendation of the contracting individual by the MSEC. Physicians rendering such services as laboratory, radiology, nuclear medicine and emergency room services, shall be subject to all criteria applicable to any Medical Staff member and shall be subject to the overall clinical supervision of the Medical Staff consistent with the Bylaws and Rules and Regulations of the Medical Staff.

Section 4. Term of Appointment/Reappointment

(a) By the Governing Body. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body according to the procedure contained in this Article III of these Bylaws. The Governing Body shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff through the MSEC unless the MSEC fails to act within the time set forth in Article III, Section 5(f) of these Bylaws.

(b) Term. Initial appointments shall be for twenty-four (24) months. Members shall apply for reappointment every two years or evaluated more frequently as determined by the MSEC.

These determinations shall be based on the demonstrated need for more frequent credentialing, as indicated by departmental, Credentials Committee, or MSEC reviews of staff members' practice patterns as they pertain to the quality of patient care, and to members' conformance with Medical Staff Bylaws, Rules and

Regulations. If a Medical Staff member is recommended for more frequent evaluation, such evaluation shall be limited to the determinate factor until the next reappointment cycle. Each applicant shall be subject to an evaluation of qualifications at the time of appointment and reappointment.

(c) Requirements. Appointments to the Medical Staff shall confer only such privileges as are outlined in these Bylaws, Rules and Regulations of the Medical Staff. Each applicant shall agree to provide continuous quality care and supervision of all patients, to cooperate in the proctoring process as set forth in Article III, Section 6 of these Bylaws and as required by the applicant's Department, to accept Medical Staff committee assignments, to complete the required training modules of the Medical Center, abide by Medical Staff Bylaws, Rules and Regulations, to accept consultation assignments and to participate in staffing the outpatient and special care units or services. All applicants shall confine their work in the Medical Center to the specialty/specialties approved on their applications and privilege sheets.

(d) Limitation on Privileges. It is specifically understood that the MSEC may place certain limits on privileges of members in order to assure that acceptable standards of medical care are maintained.

Section 5. Procedure for Appointment

(a) Application. The application shall certify that the applicant is currently licensed to practice in the State of California and set forth in detail the applicant's professional qualifications, past practice and Medical Center staff affiliations, and personal and professional references, preferably from the same specialty, with extensive knowledge of the applicant's personal and professional qualifications.

Letters may be obtained from a residency or fellowship director, program director, full time or clinical faculty member or the Chief of Staff or Chair of the applicant's department or section of all medical center staffs on which the applicant has served in the previous five years. Such application shall include information as to whether the applicant has suffered a revocation, suspension, voluntary relinquishment, denial, reduction, involuntary termination, voluntary or involuntary limitation, loss of staff privileges or membership, or a denial of application for privileges at any other Medical Center or institution, or is currently in the process of disciplinary review, or whether there has been a failure to renew such privileges, or whether there has been a previously successful or currently pending challenge to any licensure or registration. Information shall be requested as to whether membership in local, state or national professional societies has ever been suspended or terminated or is currently pending challenge. References shall be queried regarding the applicant's professional conduct.

Every application for staff appointment shall be signed by the applicant, and shall require the applicant's professional license number, Social Security number, DEA number (when indicated), and NPI number. Information shall be provided as to whether the applicant's license to practice in any health profession or such DEA registration have ever been voluntarily relinquished, suspended or revoked.

Information concerning the applicant's professional liability insurance coverage and professional liability experiences shall also be provided.

(b) Requirements on Application. Each applicant, in applying for membership, does thereby signify willingness to appear (if requested) before and be examined by the appropriate department committees, Credentials Committee and the MSEC, to allow authorized members of such committees to consult with any and all members of other medical center medical staffs with which the applicant has been associated and with other persons or entities concerning competence, and to allow such committees or authorized members thereof to inspect any and all records made at such medical centers or other entities which would be material to an evaluation of the applicant's conduct, moral, and ethical stature, current licensure, relevant training or experience, current competency, and ability to perform the privileges requested. The applicant releases from any liability all representatives of the Medical Center and its Medical Staff for their acts performed in connection with evaluating the applicant and credentials, and releases from any liability all individuals and organizations who provide information to the Medical Center in good faith and without malice concerning the applicant's competence, conduct ethics, character and other qualifications for Medical Staff appointment and clinical privileges, including otherwise privileged or confidential information. The applicant shall report all pending cases before the Medical Board of California and shall report all reportable professional liability incidents during the preceding five (5) years. (A reportable professional liability incident is one which must be reported to the Medical Board of California or the Board of Dental Examiners, pursuant to the Business & Professional Code 801-803.)

Upon receipt of an application, the National Practitioner Data Bank shall be queried. Current provisions of the Data Bank system shall be completed before the application is considered complete. No application for Medical Staff membership shall be processed until the applicant has provided all required information. All credentials will be verified from either the primary source or other Joint Commission recognized agencies after the applicant's signed agreement to be governed by the Bylaws and Rules and Regulations of the Medical Staff during the pendency of the application, as well as after acceptance to staff membership. It is the responsibility of the applicant to provide all documentation necessary to complete the application form.

(c) Burden of Producing Information
In connection with all applications for initial membership, membership renewal, advancement, or transfer, the applicant shall have the burden of producing accurate and complete information for an evaluation of the applicant’s qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant’s failure to sustain this burden shall be grounds for denial of the application. To the extent consistent with law, this burden may include submission to a medical or psychological examination, at the applicant’s expense, if deemed appropriate by the MSEC which may select the examining physician. Until the Credentials Committee has declared the application complete, the application will be filed as incomplete.

(d) Department Review. The Department shall forward the application, all supportinq material and request for privileges to the Credentials Committee for its evaluation

and recommendation. Representatives from the applicant's department or section shall be invited to provide input.

(e) Credentials Committee. The Credentials Committee shall be organized in such a manner to assure a credentials review consistent with the standards and requirements of these Bylaws. At all times the applicant shall have the burden of producing adequate information for a proper evaluation of competence, character, conduct, ethics and other qualifications, and for resolving any doubts about such qualifications.

The Credentials Committee, with input from the applicant's department or division/section, shall evaluate the conduct, moral and ethical stature, current licensure, relevant training or experience, current competence, health status as it pertains to professional competence, and ability to perform the privileges requested, and shall verify, through references given by the applicant and other sources available to it, including approval of the privileges applied for by the appropriate department, that the applicant meets and has established all the necessary qualifications set forth in Article III, Section 2 of these Bylaws. Within 180 days after receipt of the completed application for membership, the Credentials Committee shall make a written report of its evaluation and recommendation to the MSEC, recommending that the applicant be appointed or rejected.

(f) MSEC Review. Upon receipt of the report of the Credentials Committee, the MSEC, at its next regular meeting, shall consider the report and recommend to the Governing Body, through the Vice Chancellor for Health Sciences or designee, that the applicant be appointed or rejected. Any recommendations for initial appointments may include provisional conditions relating to privileges. When a recommendation is made to defer for further consideration, it must be followed up within 180 days by a recommendation to accept or reject the applicant. The Vice Chancellor for Health Sciences or designee shall notify the applicant by mail of any recommendation to reject the applicant, within fifteen (15) days after such decision is made. A practitioner shall be entitled to the procedural rights afforded by Bylaws Article XIII, Hearing and Appeal Procedures only if the application is denied for a medical disciplinary cause or reason. In all other cases, the practitioner shall not be entitled to any procedural rights.

(g) Governing Body Action. The Governing Body, at its next regular meeting after receipt of the final report and recommendations of the Medical Staff on any initial application for membership, shall consider same and accept the recommendations of the Medical Staff or refer it back for further consideration, stating the reasons for such action, and set a time limit within which to report back.

After its receipt, the Governing Body shall make a final decision and, acting through the Vice Chancellor for Health Sciences or designee, shall notify the Secretary of the Medical Staff, and the applicant, of the action taken.

Section 6. Focused Professional Practice Evaluation/Proctoring Requirements

(a) All Provisional members shall undergo a period of focused professional practice evaluation (proctoring) to evaluate their proficiency in exercising the clinical privileges provisionally granted (Ref. MS Policy and Procedure 107 Professional

Practice Evaluation and MS 128 Focused Professional Practice Evaluation). Requirements shall be established by each department. Eligible members of the Medical Staff who have themselves completed proctoring and hold unrestricted privileges to perform the procedures and/or manage the clinical cases to be proctored, regardless of Medical Staff membership category, are required to accept proctoring assignements with reasonable notice. Provisional Staff members who are not reappointed due to failure to successfully complete proctoring must wait for a minimum of twelve (12) months before submitting another application for Medical Staff membership.

(b) The Provisional member shall be responsible for ensuring that all proctoring requirements are met. The Provisional member shall immediately report to the department chair any perceived undue proctoring delays. If intervention by the department chair does not resolve the issue, the Provisional member shall present the problem in writing to the Chief of Staff for review by the Credentials Committee. Prior to advancement to Active status, a Provisional member must furnish to the Credentials Committee a statement signed by the department chair to which the appointee: (1) meets all the qualifications, has discharged all the responsibilities, and has not exceeded or abused the prerogatives to which provisional appointment was made; (2) has satisfactorily demonstrated ability to exercise the clinical privileges granted. All proctoring reports shall be completed, signed by the proctor and Department Chair and submitted to the Credentials Committee prior to advancement to Active status.

(c) A Focused Professional Practice Evaluation Program established by the department shall be required for current members requesting additional privileges, regardless of specialty or membership category. The focused professional practice evaluation for a practitioner who has been granted temporary privileges pending appointment to the Medical Staff shall begin during this period.

(d) Reciprocal proctoring (as outlined in MS Policy #120) may be performed at another healthcare facility provided that: 1) it is accredited by the Joint Commission; 2) the proctoring is carried out by a member in good standing of the other institution, who holds unrestricted clinical privileges; and 3) the practitioner being proctored is responsible for ensuring that proctoring forms from other healthcare facilities are forwarded to the Medical Staff.

Section 7. Procedure for Reappointment

The Credentials Committee shall act on reappointment applications for those applicants before the end of their current appointment date. All Medical Staff members due for renewal shall return a completed application for reappointment. The application for renewal shall be in writing and on a form designated by the MSEC and approved by the Governing Body and shall contain but not be limited to the following:

(a) Certification by the applicant as to details, if any, of any suspension, revocation, voluntary relinquishment, non-renewal, probation or other limiting of a license to practice, narcotics license, privileges or other staff membership at any other health care institution.

(b) Certification by the applicant as to the details of any reportable professional liability incidents during the preceeding two (2) years. (A reportable professional liability incident is one which must be reported to the Medical Board of California or the Board of Dental Examiners, pursuant to California Business & Professional Code 801-803.)

(c) Certification by the applicant as to the details of any continuing medical education received or undertaken to support the request for privileges and any specialty board memberships obtained.

(d) Certification by the applicant releasing from any liability all representatives of the Medical Center and its Medical Staff for their acts performed in connection with evaluating the applicant for reappointment.

(e) The applicant's request, if any, for additional privileges, or for reduction in or deletion of specified privileges previously granted. Privilege requests shall be reviewed by the departmental committee and forwarded with a recommendation to the Credentials Committee.

Each department shall establish guidelines for Medical Staff reappointment. Such guidelines shall include current competence, relevant training or experience, and ability to perform the privileges requested. They shall also include cooperation with Medical Center authorities and personnel; frequency of use of the Medical Center facilities for patients, relations with other Medical Center staff members; adherence to the Medical Staff Bylaws, Rules and Regulations; quality of care standards as established by the respective department committees; timely and proper maintenance of medical records, health status as it pertains to professional competence; and payment of dues.

Minimum standards for the number of admissions and consultations by each applicant may vary, commensurate with the type of practice and category of staff appointment, as established by each department. The MSEC shall review these standards from time to time to verify equal treatment of Medical Staff members in all staff categories who are from different departments, but are in similar fields of practice.

The MSEC, after reviewing all information available on the members of the Medical Staff under consideration for reappointment for the renewal period, shall recommend approval or denial of reappointment to the appropriate staff category. Specific consideration shall be given to each member with respect to the Credentials Committee recommendations and the guidelines and privileges established pursuant to this section.

The MSEC shall forward its report to the Governing Body through the Vice Chancellor for Health Sciences or designee, recommending for or against reappointment to a designated Medical Staff category and privileges of each member of the Medical Staff for the ensuing renewal period. Where non-reappointment or curtailment of privileges is recommended, the reasons therefore shall be stated in writing. Thereafter, the procedure of the Governing Body for reappointment or non-reappointment shall be the same as set forth in Article III, Section 5 of these Bylaws and shall not be effective until such action is taken.

The applicant releases from any liability all representatives of the Medical Center and its Medical Staff for their acts performed in connection with evaluating the applicant's credentials, and releases from any liability all individuals and organizations who provide

information to the Medical Center in good faith and without malice concerning the applicant's competence, conduct, ethics, character and other qualifications for Medical Staff appointment and clinical privileges, including otherwise privileged or confidential information.

Section 8. Failure to Complete Reappointment

The non-submission of a complete reappointment application by the reappointment expiration date shall be considered a voluntary resignation from the Medical Staff. The practitioner must reapply to the Medical Staff should membership be requested after that date, subject to terms and conditions set forth below.

(a) Members separated from the Medical Staff due to failure to return a complete reappointment application or supporting documentation by the reappointment due date may apply for reappointment if the application or required documents are submitted to the Medical Staff within 30 days of separation.

(b) If more than 30 days have elapsed since the member was separated from the Medical Staff, the practitioner must submit an application for initial appointment, along with required processing fees. Such practitioners may be placed on Provisional status and subject to a focused professional practice evaluation (proctoring).

Section 9. Failure to Meet Minimum Activity or Proctoring Requirements

Practitioners who do not meet minimum clinical activity levels or proctoring requirements at the time of reappointment will be separated from the Medical Staff. Practitioners who then supply documentation that they have met the applicable requirement(s), may apply for reappointment if the information is submitted to the Medical Staff within 30 days of separation.

Section 10. Medical Leave of Absence

At the discretion of the Medical Staff Executive Committee (MSEC), a medical staff member may obtain a voluntary medical leave of absence from the staff upon submitting a written request to the MSEC stating the approximate period of leave desired, which may not exceed one year without a formal request for an extension. Should the extended time of leave exceed the reappointment period, the staff member will be responsible for the reapplication process. Failure to request reappointment will result in termination. During the period of the medical leave, the member shall not exercise clinical privileges at the hospital and membership rights and responsibilities shall be inactive. The practitioner must continue to maintain malpractice insurance coverage. At least 30 days prior to the termination of the medical leave of absence, or at any earlier time, the medical staff member may request reinstatement of privileges by submitting a written notice to that effect to the MSEC. A written statement that the staff member is able to perform his/her clinical duties will also be required. The MSEC shall make a recommendation concerning the reinstatement.

Section 11. Release of Information

All applicants, as well as members of the Medical Staff, consent to the release of information for any purpose set forth in these Bylaws and release from liability and agree to hold

harmless any person or entity furnishing or releasing such information concerning the application or Medical Staff status.

ARTICLE IV - CLINICAL PRIVILEGES

Section 1. Clinical Privileges

(a) Granting. Medical Staff members shall be entitled to exercise only those clinical privileges specifically granted by the Governing Body in this Article IV.

(b) Request. Every application for Staff appointment and reappointment must contain a request for the specific privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references and other relevant information, including an appraisal by the representative for the clinical department in which such privileges are sought. The applicant shall have the burden of establishing all qualifications and competence in the clinical privileges requested.

c) Review. Review of clinical privileges shall be based upon the care provided, review of records of patients treated in this or other medical centers and review of the records of the Medical Staff which document the evaluation of the Medical Staff member's participation in the delivery of medical care.

(d) New Privileges. New or additional clinical privileges shall be considered only upon the written application of the Medical Staff member in a manner approved by the MSEC and the Governing Body. Such application for additional privileges shall be processed in the same manner as an initial application for Medical Staff appointment.

(e) Dentist and Podiatrist Medical Staff Members
Privileges granted to dentist and podiatrist Medical Staff members shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of clinical procedures that each such member may perform shall be specifically delineated and granted in the same manner as all other clinical privileges are granted. All patients admitted by dentist and podiatrist Medical Staff members shall receive the same basic medical appraisal as patients admitted to other surgical or medical services. A physician member of the Medical Staff shall be responsible for completing the admission history and physical examination of podiatric patients and for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization not covered by the license or competence of the dentist or podiatrist member. The dentist or podiatrist member shall be responsible for patient care in such member's specialty area, which shall include definitive and complete description of procedures in the medical record. Any such Medical Staff member performing surgical procedures, such as oral surgeons and podiatrists, shall be under the overall supervision of the Chair of the Department of Surgery/Anesthesia.

Section 2. Temporary Privileges

(a) Application Pending. Temporary privileges pending appointment may be granted when a completed application for medical staff membership/privileges from an

appropriately licensed physician, dentist or podiatrist, is awaiting review and recommendation by the MSEC and approval by the Governing Body. The completed application includes verification of current licensure, relevant training or experience, current competence, ability to perform the privileges requested and any other criteria required by the Medical Staff Bylaws. The National Practitioner Data Bank query results must have been obtained and evaluated. The application should have no current or previous successful challenge to licensure or registration, has not been subject to involuntary termination of medical staff membership at another institution, and has not been subject to involuntary limitation, reduction, denial or loss of clinical privileges.

Temporary privileges may be granted for a limited period of time, not to exceed 120 days by the Chief Medical Officer (or designee) or Chief of Staff upon recommendation of the applicable clinical department chair, Credentials Committee Chair and the Chief of Staff.

(b) Care of Specific Patient. Temporary clinical privileges may be granted by the Governing Body or designee, at the request and recommendation of the appropriate Department Chair or Chief of Staff for the care of a specific patient to a physician, dentist or podiatrist who is not an applicant for membership in the same manner and upon the same conditions as set forth in Article IV, Section 2(a) of these Bylaws. Such temporary privileges shall be restricted to the treatment of not more than four (4) patients in any one (1) year by any such physician, dentist or podiatrist after which the individual shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients.

(c) Requirements. Temporary privileges are granted for a period up to 120 days. Primary source verifications required are: medical license, malpractice insurance, DEA certificate and a National Practitioner Data Bank query.

Physicians, dentists and podiatrists granted temporary privileges shall abide by the Bylaws, Rules and Regulations of the Medical Staff and special requirements of supervision and reporting may be imposed by the department chair concerned on any such persons.

(d) Termination. The Vice Chancellor for Health Sciences or designee or Chief Medical Officer may, upon the recommendation of the Chief of Staff and chair of the department concerned, terminate the temporary privileges of a physician, dentist or podiatrist effective as of the discharge from the Medical Center of the physician's, dentist's or podiatrist's patient(s) then under care in the Medical Center. Temporary privileges shall be immediately terminated by the Vice Chancellor for Health Sciences or designee upon notice of any failure by the physician, dentist or podiatrist to comply with such special conditions, or with any applicable Bylaws, Rules and Regulations, or policies. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the physician, dentist or podiatrist, the Chief of Staff and the department chair shall request a Medical Staff member to consult and assume all responsibility for the care of such patient(s) until discharge from the Medical Center. The wishes of the patient(s) shall be considered where feasible in the selection of said consultant.

(e) Procedural Rights. No physician, dentist or podiatrist applying for or holding temporary privileges shall be entitled to the procedural rights afforded by Article XIII because the request for temporary privileges is refused or because all or any portion of the temporary privileges are terminated or suspended.

Section 3. Emergency Privileges

An “emergency" is defined as a condition in which serious, permanent harm or aggravation of injury or disease would result to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

In the case of an emergency, any Medical Staff member, to the degree permitted by the member's license and regardless of service or Staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of the patient, using every facility of the Medical Center necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such Staff member must call in a Staff member who holds the privileges necessary to treat the patient or request the privileges necessary to continue to treat the patient if patient safety is not compromised by the delay necessary to request and obtain such privileges. If the Staff member giving emergency treatment is not the patient’s primary physician, the primary physician shall be notified.

Section 4. Granting Disaster Privileges

Any volunteer Licensed Independent Practitioner not currently privileged by the Medical Staff wishing to provide patient care services in a disaster must be granted temporary privileges, or be granted temporary disaster privileges, pursuant to Medical Staff Policy: Credentialing Volunteer Licensed Independent Practitioners in the Event of a Disaster.

The individuals authorized to grant temporary disaster privileges are not required to grant temporary disaster privileges to any volunteer practitioner and are expected to make such decisions on a case-by-case basis in accordance with the needs of the organization and its patients, and on the qualifications of its volunteer practitioners. Temporary disaster privileges shall be granted to an appropriately qualified practitioner based upon the needs of the Hospital to augment staffing due to the disaster situation.

The Chief Administrative Officer of the Hospital or the Chief of Staff or their designees may grant temporary disaster privileges upon presentation of identification as outlined in Medical Staff Policy: Credentialing Volunteer Licensed Independent Practitioners in the Event of a Disaster. Members of the medical staff shall oversee those granted disaster privileges by direct observation.

Primary source verification of licensure by Medical Staff Services begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presented to the organization. The following additional information shall be obtained and verified as soon as is reasonably possible:

- Drug Enforcement Agency registration;
- Certificate of malpractice insurance, except for practitioners deployed by the Federal government who are covered by the Federal Tort Claims Act;

- List of hospital affiliations where the practitioner holds active staff privileges, or evidence of government agency employment (e.g., CDC identification badge); and
- National Practitioner Data Bank query.

The organization will make a decision (based on the information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the temporary disaster privileges initially granted. Termination of temporary disaster privileges shall occur:

- In the event that verification of information results in negative or adverse information about the qualifications of the practitioner;
- When the emergency situation no longer exists, or when Medical Staff members can adequately provide care; or
- When temporary disaster privileges are otherwise removed by the individual(s) authorized to grant temporary disaster privileges.

Section 5. Requirements for Histories and Physicals

1. Admitting History and Physical:

   a. Within 24 hours after admission or immediately before, an H&P examination shall be performed providing the patient condition permits;

      If the dictated H&P is not available in the chart at the time of the Attending physician's first hospital visit, he or she shall document the essential elements of the patient's H&P in the progress notes. This note shall contain a summary of the present illness, allergies, medications, any pertinent findings from the past, social, and family histories and review of systems, any pertinent findings on physical examination, and the physician's assessment and plans.

      When an H&P has been performed less than 30 days prior to admission, a new H&P must be performed. A copy of the prior H&P may be used as documentation. The examiner must document that he or she has reviewed the prior H&P, and must record any interval changes on the patient record;

   b. the use of a progress or consult note as an H&P for inpatients where Length Of Stay is greater the 30 days is acceptable as long as all the elements required for an H&P are noted therein.

2. Podiatric H&P:
   In podiatric cases, the medical history and physical examination must be completed by a physician member of the Attending Staff. Podiatrists shall complete a history and examination pertinent to their care.

3. Dental H&P
   In dental cases, the medical history and physical examination may be completed by the patient's oral surgeon who is a member of the Medical Staff only if qualified and credentialed to do so.

4. Interval History & Physical Examination:
Readmissions within 30 days for the same or related problem require an interval H&P that reflects significant changes in the H&P exam since the previous admission. The interval H&P may be separately documented in the progress notes.

5. H&Ps by Non-Staff Members:
Physicians who are not Medical Staff members, may perform an admission history and physical examination. The Attending physician assumes the responsibility of the clinical accuracy of the H&P performed by the non-staff member.

The content of complete and focused history and physcial examination is delineated in the Medical Staff Rules and Regulations.

Section 6. Protection from Liability

In matters relating to clinical privileges, all Medical Staff members, and all appropriate Medical Center personnel, including members of the Governing Body and Medical Center management, shall be acting pursuant to the same rights, privileges, immunities and authority as are provided for in Article III and Article XV of these Bylaws.

ARTICLE V - CATEGORIES OF THE MEDICAL STAFF

Section 1. The Medical Staff

Each member of the Medical Staff shall be categorized as an Active, Courtesy, Consultant, Provisional, Administrative, or Emeritus member of the Medical Staff.

Section 2. The Active Staff

(a) Composition. The Active Staff shall consist exclusively of Medical Staff members who regularly care for patients in the Medical Center, as determined by the Medical Staff through department specific criteria.

(b) Duties and Privileges. Members of the Active Staff shall have the exclusive right to hold office, to vote, and otherwise to transact the business of the Medical Staff, except as hereinafter expressly provided. Active Staff members shall chair all Standing Committees except as otherwise determined by the MSEC. Active Staff members shall have a continuing obligation to faithfully discharge such duties as may be assigned by the Chief of Staff. They shall pay dues and assessments as determined by the MSEC.

(c) Transfer of Active Staff Member. If a member of the Active Staff fails to regularly care for patients in the Medical Center, that member shall be automatically transferred to the appropriate category, if any, for which the member is qualified at the time of reappointment.

Section 3. The Courtesy Staff

(a) Composition. The Courtesy Staff shall consist of Medical Staff members who have satisfactorily completed Provisional Staff requirements and who do not regularly care for patients in the Medical Center or are not regularly involved in Medical Staff

functions as determined by the Medical Staff through department-specific rules and regulations. The Courtesy Staff member may be granted clinical privileges based upon documentation of training and experience. Appointment shall be based upon standards to evaluate current clinical competence as determined by the member's department, and may include a review of office records. Courtesy Staff members shall be members in good standing of the Active medical staff of another California-licensed hospital.

(b) Duties and Privileges. Courtesy Staff members shall accept duties which may be assigned by the Chief of Staff, shall be eligible to serve and vote on committees other than Bylaws and the MSEC, but shall not be eligible to hold office or to vote on or transact the business of the Medical Staff. They shall pay dues and assessments as determined by the MSEC.

Section 4. The Consultant Staff

(a) Composition. The Consultant Staff shall be limited to practitioners who serve only as consultants in their department, and for whom there is a programmatic need within their Clinical Department determined by the Chair of the Department. Members of the Consultant Staff must be Active members in good standing at another California-licensed hospital that will provide credentialing and quality assurance data necessary for documentation of current clinical competence. Consultant Staff may perform procedures appropriate to their approved clinical privileges, consult on patients, and write progress notes and write orders. Members of the Consultant Staff may not admit patients, shall have no voting rights, and may not hold office in standing or special committees or subcommittees of the MSEC.

(b) Duties and Privileges. Nothing contained in these Bylaws shall be construed to restrict consultation by any member of the Medical Staff except where otherwise specified by the Rules and Regulations of the Medical Staff. Consultant members shall accept duties which may be assigned by the Chief of Staff, shall be eligible to serve and vote on committees other than Bylaws and the MSEC, but shall not be eligible to hold office or to vote on or transact the business of the Medical Staff. They shall pay dues and assessments as determined by the MSEC.

Section 5. The Provisional Staff

(a) Composition. Membership on the Provisional Staff shall be recommended for those applicants who request privileges and intend to meet Provisional Staff requirements at the time of appointment.

(b) Duties and Privileges. Each Medical Staff member appointed to the Provisional Staff shall serve thereon for a minimum of twelve (12) months and a maximum of twenty-four (24) months. After twelve (12) months and the successful completion of proctoring, a Provisional Staff member may be advanced from the Provisional category. Membership upon the Provisional Staff shall expire at the end of twelve (12) months, unless the MSEC grants an extension of up to twelve (12) months. Upon failure of the MSEC to award advancement, the Provisional Staff member shall be removed from the Medical Staff and shall be so notified. Such a Provisional Staff member may thereafter request a hearing according to the procedure set forth in Article XIII. The remedy set forth herein shall be the sole and exclusive remedy

available to the Provisional Staff member whose membership shall have been terminated. An initial appointment shall remain provisional until the appointee has demonstrated to the Credentials Committee that all of the qualifications have been met, all of the responsibilities have been discharged, the prerogatives of the Staff category to which appointment was provisionally made have not been exceeded or abused, and the ability to exercise the clinical privileges provisionally granted has been satisfactorily demonstrated by means of completed proctoring or the equivalent thereof.

Provisional Staff members shall be obligated to accept duties which may be assigned by the Chief of Staff. Provisional Staff members shall be eligible to serve and vote on Staff committees other than Bylaws and the MSEC, but shall not be eligible to hold office or to vote or transact the business of the Medical Staff. They shall pay dues and assessments as determined by the MSEC.

Section 6. Administrative Staff

Administrative Staff membership shall be open to any physician, dentist or podiatrist who is clinically inactive within the Medical Center, but is retained by the department to perform ongoing administrative activities related to performance improvement and patient safety. Administrative Staff shall be considered for appointment upon recommendation of the Department Chair.

The Administrative Staff shall consist of members who:

(a) Are charged with assisting the medical center in carrying out administrative functions utilizing their medical expertise.

(b) Document their current licensure; adequate experience, education and training; good judgment; and physical and mental health status, so as to demonstrate that they are professionally and ethically competent to exercise their duties;

(c) Are determined to adhere to the ethics of their respective professions; to be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the performance improvement and patient safety functions; and to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff.

The Administrative Staff shall be entitled to attend meetings of the Medical Staff, including open committee meetings and educational programs. They shall not be eligible to vote or hold office, shall have no assigned duties, shall not admit or consult on patients and shall not be required to pay dues.

Section 7. The Emeritus Staff

(a) Composition. The Emeritus Staff shall consist of former Medical Staff members who are retired from medical practice and who are honored for their past service by this appointment. These are members who have had ten (10) years or more of service on the Active Staff and have outstanding academic or professional reputations with a record of exemplary service to the Medical Center.

To be considered for the Emeritus Staff, a retired member must be nominated, in writing, by a current member of the Active Staff. Additional support by other members of the Active Staff is encouraged. As this staff category is honorific with no patient care privileges, the nomination will be forwarded directly to the MSEC for consideration for appointment.

(b) Duties and Privileges. Members of the Emeritus Staff shall be accorded the privilege of Medical Staff membership as provided in these Bylaws, except they shall not be eligible to vote or hold office, shall have no assigned duties, shall not admit or consult on patients and shall not be required to pay dues.

Section 8. Limitation of Duties and Privileges

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

ARTICLE VI - ALLIED HEALTH PROFESSIONALS

Section 1. Definition

(a) Allied Health Professionals ("AHPs") are defined as health care professionals who hold a license or other legal credential, as required by California law, to provide certain patient care services, but are not eligible for Medical Staff membership.

(b) AHPs who meet the eligibility requirements established by these Bylaws and the Interdisciplinary Practice Committee ("IPC") may be given specified privileges in the Medical Center if they hold a license, certificate, or other credentials in a category of AHPs that the Governing Body has identified as eligible to apply for practice privileges; and (b) they are professionally competent and continuously meet the qualifications, standards and requirements set forth.

Such privileges shall be granted in accordance with the department specific policies of the department to which the person is assigned and shall be subject to the supervision requirements developed in each department and approved by the IPC, the Credentials Committee, the MSEC and the Governing Body.

(c) The categories of AHPs eligible to apply for practice privileges at the Medical Center as approved by the Governing Body and who must be credentialed hereunder include: (a) Nurse Practitioners, (b) Physician Assistants, (c) Clinical Licensed Psychologists, (d) Acupuncturists, (e) Certified Registered Nurse Anesthetists, (f) Certified Nurse Midwives, and (g) Licensed Clinical Social Workers.

(d) General Requirements. The applicant must belong to an AHP category approved for practice in the Medical Center by the Governing Body. If required by law, the applicant must hold a current, unrestricted state license or certificate. In addition, those AHPs providing services under a contractual arrangement, shall meet all the conditions of their contract with the Medical Center.

Section 2. Processing the Application

(a) Applications shall be submitted and processed in a manner similar to that specified for Medical Staff applicants in the Medical Staff Bylaws. Once the application is determined to be complete, it will be forwarded to the IPC for review and recommendation to the Credentials Committee. Thereafter, the application shall be referred to the MSEC and Governing Body.

(b) Duration of Appointment and Re-appointment. AHPs shall be granted privileges for no more than two (2) years. Reappointment to the AHP staff shall be processed in a manner parallel to that specified in the Medical Staff Bylaws. Applications for renewal of the AHPs privileges must be completed by the AHP and supervising physician and submitted for processing in a parallel manner to the reappointment procedures set forth in the Medical Staff Bylaws.

Section 3. General Duties

Upon appointment, each AHP shall be expected to:

(a) Exercise independent judgment within the area of competence consistent with the privileges granted, and, if applicable, within the limits of an approved standardized procedure, provided that a Medical Staff member who has appropriate privileges shall retain the ultimate responsibility for each patient's care.

(b) Participate directly in the management of patients to the extent authorized by their license, certificate, and other legal credentials, any applicable standardized procedures, and by the privileges granted by the Governing Body.

(c) Write orders to the extent established by any applicable Medical Staff or department policies, rules or standardized procedures and consistent with the privileges granted.

(d) Record reports and progress notes on patient charts to the extent determined by the appropriate department, and in accordance with any applicable standardized procedures.

(e) When required, the supervising physician shall assure that records are countersigned. Unless otherwise specified in the Rules and Regulations or specific supervision protocols, all chart entries that require countersignatures must be countersigned within 14 days after the entry is made.

(f) Consistent with the privileges granted, perform consultations as requested by a Medical Staff member.

(g) Comply with all Medical Staff Bylaws, Rules and Regulations, and Medical Center policies.

Section 4. Prerogatives and Status

AHPs are not members of the Medical Staff and thus shall not be entitled to vote on any Medical Staff or Clinical Department matters.

Section 5. Standardized Procedures

(a). Definition. "Standardized Procedures" means the written polices and protocols for the performance of Standardized Procedure functions, and which have been developed in accordance with the requirements of California Law.

(b) Standardized procedures are required whenever any registered nurse (including NPs) practices beyond the scope of practice taught in the basic curriculum for registered nurses as contemplated by the California Nurse Practice Act (i.e., whenever special training and/or experience are necessary in order for the nurse to perform the procedure or practice in question).

(c) Development of Standardized Procedures: Standardized procedures may be initiated by the appropriate department or the affected AHPs. Representatives of the category of AHPs that will be practicing pursuant to the Standardized Procedure shall be involved in developing the standardized procedures. Standardized procedures shall be reviewed by the IPC, the MSEC and the Governing body. In accordance with Title 22, the Interdisciplinary Practice Committee shall be responsible for assuring that standardized procedures are a collaborative effort among administration and health professions, including physicians and nurses. Standardized procedures will be reviewed every two years.

Section 6. Temporary Privileges

From time to time it may be necessary to grant temporary privileges to individual AHPs to provide specialized care to a patient with a unique condition. Based on the recommendation of Chief of Staff and the Chair of the IPC, temporary privileges may be granted by the Governing Body or designee provided the application has been approved by the IPC Committee, its Chair or designee.

Section 7. Termination and Suspension of Privileges and Grievance Procedure

An AHP's privileges shall automatically terminate in the event: (a) the medical staff membership of the supervising physician is terminated, whether such termination is voluntary or involuntary, (b) the supervising physician, if any, no longer agrees to act as the supervising physician for any reason or the relationship between the AHP and the supervising physician, if any, is otherwise terminated, regardless of the reason, (c) the AHPs certification of license expires, is revoked, or is suspended, and (d) an AHP's privileges may also be terminated or suspended for cause by the chair of the department to which the AHP is assigned for the Chief of Staff. An AHP's privileges shall be automatically suspended during the period that the Medical Staff membership or clinical privileges of the supervising physician if any, are suspended.

Nothing contained in these Bylaws shall be interpreted to entitle an AHP to the hearing rights set forth in Article XIII. However, the AHP shall have the right to challenge any action that would constitute grounds for a hearing under Section1(b) of Article XIII of the Medical Staff Bylaws by filing a written grievance with their department chair in which the AHP has privileges or the right to render the services in question, within fifteen (15) days of such action. Upon receipt of such grievance, the department chair shall initiate a careful investigation and afford the affected AHP an opportunity for an interview before the

department committee. The department committee shall include, for the purpose of this interview, an AHP with privileges at the Medical Center and holding the same or similar license or certificate as the affected AHP. Such AHPs shall be appointed to the committee for this purpose by the department chair. The interview shall not constitute the same type of "hearing" as is established by Article XIII of the Medical Staff Bylaws and shall not be conducted according to the procedural rules applicable with respect to hearings. Before the interview, the AHP shall be informed of the general nature of the circumstances giving rise to the proposed action, and at the interview, the AHP may present information relevant thereto. Neither the department chair, the department committee nor the AHP shall be represented at the interview by an attorney at law. A record of the findings of such interview shall be made. A report of the findings and recommendation shall be made by the department chair to the MSEC that shall act thereon. The action of the MSEC shall be final, subject to approval by the Governing Body.

ARTICLE VII – DEPARTMENTS, DIVISIONS AND SECTIONS

Section 1. Clinical Departments

The clinical departments of the Medical Staff shall be Emergency Medicine, Family Medicine, Medicine, Obstetrics and Gynecology, Pediatrics, and Surgery/Anesthesia.

Section 2. Assignment to Departments

(a) Each Medical Staff member shall indicate on the application the department desired for appointment. No member shall be appointed to more than one (1) department.

(b) The MSEC shall, based upon the recommendation of the Credentials Committee, recommend to the Governing Body department assignments for all Medical Staff members.

Section 3. Organization of Departments, Divisions, and Sections

(a) Each department shall be organized as a separate part of the Medical Staff, and each may contain subunits designated as divisions or sections. The Department of Medicine shall contain the Allergy/Immunology, Cardiology, Dermatology, Endocrinology, Gastroenterology, Geriatrics, Hematology/Oncology, Infectious Disease, Nephrology, Neurology, Nuclear Medicine, Pathology, Psychiatry, Pulmonary Medicine, Radiology, Radiation Oncology, and Rheumatology sections; and the Department of Surgery and Anesthesia shall contain the Division of Anesthesia and the Division of Surgery. The Division of Surgery shall contain the sections of Dentistry; Otolaryngology, General Surgery, Neurosurgery, Ophthalmology, Oral and Maxillofacial Surgery, Orthopedic Surgery, Plastic Surgery, Podiatry, Thoracic/Cardiovascular Surgery, Urology, and Vascular Surgery.

(b) Each department shall have a chair with responsibilities for the department as detailed below.

Section 4. Qualifications and Selection of Department Chair

(a) Each department chair is appointed by the Chief of Staff from representatives of the appropriate departments on the MSEC, with approval of the MSEC. In the case of

the Department of Surgery/Anesthesia, the department chair so appointed shall also become the chair of the division.

(b) Each chair shall be a member of the department, certified by an appropriate specialty Board, or qualified by experience, training, and demonstrated ability to assume the position.

(c) Each department chair may appoint a vice chair subject to the approval of the Chief of Staff and the department committee. In the absence of the chair, the vice chair shall assume the duties of the chair.

Section 5. Functions of Department/Division/Section Chair

(a) Each Department Chair shall:

(1) Be a member of the MSEC;

(2) Be the chair of the department committee;

(3) Appoint a chair of each of the sections of that department with the approval of the Chief of Staff and the MSEC. The chair of the department may delegate to these section chairs responsibilities for various duties as related to the function of the sections.

(4) Be responsible within the department for all clinically related activities;

(5) Be responsible within the department for oversight of administratively related activities as otherwise provided for by the Medical Center;

(6) Be responsible for enforcement of the Medical Staff Bylaws and Rules and Regulations;

(7) Be responsible for implementation of Medical Center and Medical Staff policies and procedures within the department;

(8) Be responsible for oversight of the professional performance of all individuals in the department who have delineated clinical privileges;

(9) Be responsible for the maintenance of quality control programs, as appropriate; and the continuous assessment and improvement of the quality of care and services provided;

(10) Be responsible for recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;

(11) Be responsible for recommending clinical privileges for each member of the department;

(12) Be responsible for assessing and recommending to the relevant hospital administration off-site sources for needed patient care services not provided by the Medical Center;

(13) Be responsible for the integration of the department into the primary functions of the Medical Center and the coordination and integration of interdepartmental and intradepartmental services;

(14) Be responsible for the development and implementation of policies and procedures that guide and support the provision of services;

(15) Be responsible for the recommendations for a sufficient number of qualified and competent Medical Center personnel to provide care or service;

(16) Be responsible for the determination of the qualifications and competence of department members.

(b) Each division/section chair shall:

(1) Have general supervision of the professional activities within the division and shall be responsible to the MSEC;

(2) Be a member of the department committee;

(3) Keep the department chair fully informed of the division's activities.

Section 6. Functions of Departments

(a) Each department shall establish its own criteria, consistent with the policies of the Medical Staff and with the approval of the MSEC, for appointment and reappointment to the Medical or AHP Staff, and for recommending the granting of clinical privileges.

(b) Each department shall conduct its own business and professional affairs and shall report its activities directly to the MSEC.

(c) Each department shall have a committee that shall hold regular meetings to review and evaluate the clinical work of Medical Staff members with privileges in the department and to evaluate the quality and appropriateness of retrospective reviews of medical records and other pertinent Medical Center sources of information.

The committee shall supervise the necessary business and administration of the department and recommend policies to the MSEC.

(d) In matters relating to medical care evaluation and medical records review, all Medical Staff members and AHPs and all appropriate Medical Center personnel shall be acting pursuant to the same rights, privileges, immunities and authorities as are provided for in Articles III, IV, XV of these Bylaws.

ARTICLE VIII – MEDICAL STAFF EXECUTIVE COMMITTEE AND OFFICERS

Section 1. Medical Staff Executive Committee (“MSEC”)

(a) Composition and Election of Members

(1) The MSEC shall consist of fourteen (14) members of the Active Staff. There shall be one (1) representative from the Department of Emergency Medicine, two (2) representatives from the Department of Family Medicine, two (2) from the Department of Surgery/Anesthesia, three (3) from the Department of Medicine, one (1) from the Department of Pediatrics and one (1) from the Department of Obstetrics and Gynecology, one (1) from the Section of Orthopedic Surgery, one (1) from Orthopaedic Hospital, designated by the CEO, ex-officio with vote, two (2) seats from members-at-large, elected from any department of the Active Medical Staff. Election of above representatives shall be by vote of their respective departments with the exception of Orthopedics who will elect a member via vote by the Section of Orthopedics and the members-at-large, which shall be elected by vote of the Active Medical Staff.

(2) Each representative shall be elected for a term of three (3) years. In October, members of the Active Staff of each department shall nominate (via email or fax) one (1) or more members for each MSEC vacancy in their department. Following the closing of the nominations, ballots shall be e-mailed to each member of the department's Active Staff. The ballot shall set forth the names of the nominees proposed and the member shall vote for one (1) nominee for each position. Ballots shall be counted immediately prior to the meeting of the MSEC on the fourth Tuesday in November. The nominee for each position, elected by a majority, shall serve on the MSEC for a term of three (3) years.

(3) If the vote for nominated members to the MSEC results in a tie, the MSEC shall cast votes to break the tie. If the incumbent member of the department in question is already on the MSEC, the member shall not take part in the voting. In addition, the Chief of Staff shall only vote in the event that the MSEC voting ends in a tie.

(4) In the event that any member of the MSEC shall have resigned the position thereon or shall have ceased to be a member of the Medical Staff or, for any other reason, shall have become unable to complete the term of the Board appointment, the Chief of Staff shall immediately declare a vacancy. All such unexpired terms shall be filled by a member of the Active Staff who shall be nominated and elected by the Active members from the department to which the vacating member belonged following the procedure noted in (2). The winning candidate shall succeed to the unexpired term. Such nominations and election may, at the discretion of the MSEC, be held simultaneously with the nominations and elections required in the preceding paragraph provided, however, that the unexpired term created by any such vacancy shall be filled within two (2) months of the creation of such vacancy.

(5) If an MSEC member has requested or is on a leave of absence for six (6) months or more, there may be a call for a special election to replace that member on the Committee.

(6) A member of the Medical Staff whom an ad hoc committee has been appointed to investigate, pursuant to Article XII of these Bylaws, or against

whom disciplinary action as defined in Article XII is current, shall not be eligible for nomination or election to the MSEC. An MSEC member can be removed from the Committee if the Medical Staff acts to remove that member from the position held in the same manner as provided in Section 7. Removal of Elected Officers.

(b) Delegation of Authority
By adopting these Bylaws, the Medical Staff has delegated to the MSEC the authority to perform on behalf of the medical staff all functions described in this section and Article XIV.

(c) Duties. Its duties shall be:

(1) To represent and to act on behalf of the Medical Staff during and between meetings, as authorized by and subject to such limitations as may be imposed by these Bylaws;

(2) To coordinate the activities and general policies of the various departments;

(3) To receive and act upon department and committee reports and recommendations;

(4) To implement policies of the Medical Staff;

(5) To provide liaison between the Medical Staff and the Governing Body, in all matters relating to the welfare of the Medical Center, its patients, and the community at large;

(6) To recommend action to the Governing Body on matters of a medico administrative nature;

(7) To make recommendations on Medical Center management matters to the Governing Body through the Vice Chancellor for Health Sciences or designee;

(8) To fulfill the Medical Staff's responsibility to the Governing Body for the medical care rendered to patients in the Medical Center;

(9) To participate in the accreditation process and to ensure that the Medical Staff is kept abreast of the accreditation programs and informed of the accreditation status of the Medical Center;

(10) To receive recommendations from the Credentials Committee regarding the conduct, current licensure, relevant training or experience, current competence and ability to perform the privileges requested by the Medical Staff members and Allied Health Professionals, and, after review, to recommend appropriate action to the Governing Body;

(11) To review periodically information available regarding the conduct, current licensure, relevant training or experience, current competence and ability to perform the privileges requested by Medical Staff members and Allied Health

Professionals. As a result of such reviews, the MSEC shall make recommendations for reappointments and renewal or changes in clinical privileges;

(12) To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, and AHPs including the initiation and/or participation in Medical Staff corrective or review measures when warranted;

(13) To propose Bylaws amendments and refer them to the Bylaws Committee prior to submission to the Active Staff for approval;

(14) To make and approve rules and regulations governing the Medical Staff and to approve rules and regulations proposed by each department committee;

(15) To insure the participation of the Medical Staff in organizational performance improvement activities and to assure that corrective actions are implemented in response to the performance measures when indicated;

(16) To levy dues and assessments;

(17) In January of each year, the MSEC will determine the amount of any honorarium to be paid to the Chief of Staff. The honorarium shall be paid from the annual dues.

(18) To make recommendations to the Governing Body pursuant to the Bylaws in areas such as the Medical Staff's structure; the mechanisms used to review credentials and to delineate individual clinical privileges; the mechanism by which Medical Staff membership may be terminated; the mechanism for fair hearing procedures;

(19) To take reasonable steps to develop continuing education activities and programs for the Medical Staff;

(20) To designate such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approve or reject appointments to those committees by the Chief of Staff;

(21) To develop and maintain methods for the protection and care of patients and others in the event of internal or external disaster;

(22) To appoint such Special meetings or Ad Hoc committees as may seem necessary or appropriate to assist the MSEC in carrying out its functions and those of the Medical Staff;

(23) To establish a mechanism for dispute resolution between Medical Staff members involving the care of a patient;

(24) To initiate a conflict management process to address disagreements between members of the Medical Staff and the MSEC on issues including but not limited to proposals to remove some authority delegated to the MSEC

by the Medical Staff under these Bylaws (by amending the Bylaws); or to adopt or revise Rules and Regulations, or Policies; and

(25) To fulfill such other duties as the Medical Staff has delegated to the MSEC in these Bylaws.

(d) Meetings. The MSEC shall meet as often as necessary but at least ten (10) times a year; maintain a permanent record of its proceedings and actions, and report regularly to the Governing Body. The Vice Chancellor for Health Sciences or designee, and other members of hospital administration, at the request of the MSEC, may attend the meetings in an ex-officio capacity without vote. The presence of two-thirds (2/3) of the voting members of the MSEC shall constitute a quorum.

(e) Reports are submitted to the Governing Body four times a year by the Chief of Staff including: recommendations for membership, recommendations for clinical privileges, medical staff Performance Improvement opportunities, high profile departmental matters and policy, recommendations for services, space, and resources.

(f) Executive Session
Executive Session is a meeting which only medical staff members may attend, unless others are expressly requested by the member presiding at the meeting to attend. Executive Session may be called to discuss peer review issues, or any other sensitive issues requiring confidentiality.

Section 2. Officers of the Medical Staff

The Medical Staff shall have the following officers: Chief of Staff, Vice Chief of Staff and Secretary/Treasurer. These officers shall be elected annually from and by the newly elected MSEC at a meeting that shall be held in January of each year.

Section 3. Qualification of Officers

Officers must be members of the Active Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain Active Staff status shall be cause for removal from office.

Section 4. Chief of Staff

(a) Duties

(1) Act in coordination and cooperation with the Vice Chancellor for Health Sciences or designee in all matters of mutual concern within the Medical Center;

(2) Represent the Medical Staff in any matter that requires judgment and action conjointly with the Vice Chancellor for Health Sciences or designee. In any controversy which may arise between any member of the Medical Staff and the Medical Center Administration, the Chief of Staff shall represent the general interest of the Medical Staff.

(3) Call, preside at, and be responsible for the agenda of all meetings of the Active Staff and all special meetings of the Medical Staff;

(4) Serve as chair of the MSEC;

(5) Serve as an ex-officio member of all other Medical Staff committees with the right to vote;

(6) Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations; for implementation of sanctions, including summary suspensions where these are indicated; and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

(7) Appoint, with the approval of the MSEC, chair and committee members to all standing and special Medical Staff committees, except the MSEC;

(8) Receive and present the policies of the Governing Body to the Medical Staff;

(9) Report to the Governing Body on the performance and maintenance of the quality of medical care;

(10) Be responsible for the educational activities of the Medical Staff;

(11) Be the spokesperson for the Medical Staff in its external professional and public relations;

(12) Be empowered to request consultation in those cases where such consultation is judged to be in the best interest of the patient;

(13) Make such recommendations as are deemed advisable relative to the performance and duties of non-physician personnel in the Medical Center;

(14) At the beginning of each year, with the approval of the MSEC, appoint the members of all department and standing committees, except for Judicial Review and special committees, which shall be appointed by the Chief of Staff as necessary. Vacancies shall be filled in the same fashion, as they occur. The Chief of Staff shall also designate the committee chairs. Chairs of standing committees may be requested to attend the MSEC at the request of the Chief of Staff.

Section 5. Vice-Chief of Staff

The Vice-Chief of Staff shall serve as Vice-Chair of the Medical Staff, shall assist the Chief of Staff whenever called upon to do so, and shall perform the duties of the Chief of Staff during the Chief of Staff's absence. The Vice-Chief of Staff shall succeed to the office of Chief of Staff whenever that office shall have become vacant due to death, resignation, or ineligibility for Medical Staff membership.

Section 6. Secretary-Treasurer

The Secretary-Treasurer shall serve as the Secretary-Treasurer of the Medical Staff; shall issue call for the regular monthly and any special meeting of the MSEC, and for any Medical Staff meeting, by e-mailing announcements; shall make and preserve accurate minutes of all MSEC and Medical Staff meetings; shall preserve all reports from other committees of the Medical Staff; and shall also maintain a proper record of all financial transactions, bank accounts, and monies received and disbursed. In the absence of the Chief of Staff and Vice-Chief of Staff, the Secretary-Treasurer shall perform the duties of the Chief of Staff.

Section 7. Removal of Elected Officers

Recommendation for removal of a Medical Staff officer, or department officer, may occur if the officer's demonstrated conduct fails to meet the standards of the Medical Staff, including, but not limited to, unprofessional or unethical behavior, or physical or mental impairment that prevents the officer from discharging the assigned duties in an appropriate manner. The recommendation may be initiated as follows: (a) by a majority vote of the MSEC in the case of a Medical Staff officer; (b) by a majority vote of the department committee in the case of a department officer; or, in both cases, (c) by a petition signed by twenty-five percent (25%) of the Active Staff.

No such removal shall be effective unless and until the action has been approved by two-thirds (2/3) vote at a duly constituted meeting of the Active Staff for a Medical Staff officer, or by a two-thirds (2/3) vote of the Active Staff of the department for a department officer, and ratified by the Governing Body.

ARTICLE IX - COMMITTEES

Department Committees

Each department/division shall have a committee. Each of these committees shall consist of a minimum of five (5) members from its respective department. Each department committee shall meet on a date established by the chair, shall maintain a permanent record of its proceedings and activities, and shall make a monthly report thereof to the MSEC. The chair of the committee shall be the department chair.

All departments shall hold regular meetings that will contribute to the continuing education of every practitioner and to the process of developing criteria to assure optimal patient care. Such meetings may be accomplished in section meetings. Such meetings may include consideration of selected deaths, unimproved patients, patients with infections, complications, diagnostic and therapeutic problems, tissue review reports, unresolved problem cases, and such other reports as are believed to be important by the department committee, as well as other educational programs of professional interest.

Standing Committees

The standing committees shall be the Bioethics, Bylaws, Cancer, Clinical Excellence, Credentials, Graduate Medical Education, Infection Prevention, Pharmacy Therapeutics & Clinical Nutrition, Medical Staff Health, Risk Management, and Utilization Review.

Section 1. Bioethics Committee

(a) Composition. The Bioethics Committee shall be chaired by a member of the Medical Staff and shall consist of Medical Staff members as the MSEC may deem appropriate. It may also include (with vote) nurses, lay representatives, social workers, clergy, ethicists, attorneys, and administrators.

(b) Duties. The duties of the Committee shall be to:

(1) Participate in development of guidelines for consideration of cases having bioethical implications;

(2) Develop and implement procedures for the review of such cases;

(3) Develop and/or review institutional policies regarding care and treatment of such cases;

(4) Retrospectively review cases for the evaluation of bioethical policies;

(5) Consult with concerned parties to facilitate communication and aid conflict resolution; and

(6) Educate the Medical Staff and Medical Center on bioethical matters.

(c) Meetings. The Committee shall meet as often as necessary but at least ten (10) times a year. It shall maintain a record of its activities and report to the MSEC.

Section 2. Bylaws Committee

(a) Composition. The Bylaws Committee shall consist of members of the Active Staff, one of whom shall be the Chair. The Vice-Chief of Staff shall be an ex-officio member of the committee, with vote.

(b) Duties. The duties of the committee shall be to:

(1) Survey the Medical Staff Bylaws to assure their compliance with Federal and State law regulations, accreditation standards of The Joint Commission, and the changing needs of the Medical Staff;

(2) Review all referrals regarding Medical Staff Bylaws pursuant to Article XIV, of these Bylaws;

(3) Initiate proposed amendments to these Bylaws;

(4) Submit proposed amendments to the MSEC.

(c) Meetings. The Committee shall meet as often as necessary, maintain a record of its proceedings, and report its recommendations to the MSEC.

Section 3. Cancer Committee

(a) Composition. The Cancer Committee may include but not be limited to members of the Medical Staff from Pathology, Pediatrics, Surgery (oncology related specialty), Radiation Oncology, Diagnostic Radiology, Medical Oncology, OB/Gyn, and representatives from Administration, Cancer Center, Nursing, Quality Management, Social Services, Tumor Registry, and Pain/Palliative Care liaisons

(b) Duties. The Cancer Committee shall oversee the general management of cancer patients and

1. Facilitate the growth and improvement of all aspects of cancer patient care
2. Advise as to the effective function of the tumor registry
3. Promote clinical cancer research
4. Advise Medical Center Administration in the development of patient care for cancer.

(c) Meetings. This Committee shall meet as often as necessary, but at least quarterly, shall maintain a record of its proceedings and actions, and shall report thereon to the MSEC.

Section 4. Clinical Excellence Committee

(a) Composition. The Clinical Excellence Committee is comprised of the Chief Medical Officer, the Chief Administrative Officer, the Chief of Staff, the Hospital Directors of Quality, Nursing, Pharmacy, Infection Prevention, and Operative Services. Active Medical Staff from the Departments are represented.

(b) Duties. The Clinical Excellence Committee provides Performance Improvement and Patient Safety leadership. The duties of the Committee shall be to:

1. Assure compliance with national recommendations for patient safety, including the National Patient Safety Goals.

2. Oversee and set/reset priorities for the Medical Center's comprehensive, interdisciplinary Performance Improvement (PI) program;

3. Develop an environment that encourages and empowers staff to identify and address issues through the performance improvement process in a collegial, just manner;

4. Empoweri its subcommittees to identify opportunities, design performance improvement activities and resolve issues;

5. Monitor patient safety and quality-related functions;

6. Review reports from its subcommittees and make recommendations regarding operational, safety, and quality of care issues;

7. Oversee performance measures that are required by accrediting and licensing agencies related to patient safety and quality;

8. Review medical record documentation compliance trends and recommend operational improvements and actions when appropriate

9. Obtain input for improvement opportunities from committee representatives, hospital department heads or representatives, administrative reports including incident reports, survey findings from professional organizations such as The Joint Commission, departmental quality assessment reports, and continuous hospital-wide trend reports on mortality and readmission;

10. Identify opportunities for interdisciplinary approaches as needed to efficiently and efficaciously resolve problems;

11. Charter performance improvement teams addressing organizational priorities and review their activities;

12. Refer issues to appropriate performance improvement teams, clinical services, departments or committees;

13. Facilitate dissemination, discussion and understanding of clinical and management Performance Improvement and Patient Safety data;

14. Educate Medical Staff and Medical Center employees in Performance Improvement and Patient Safety principles and processes;

15. Report to the MSEC and Hospital Administration on significant issues;

16. Assure compliance with accreditation standards and regulatory agency requirements.

17. Monitor Sentinel Events, Root Cause Analyses, and Adverse Event Investigation findings and action plans.

18. Select, approve, and review Failure Mode and Effects Analyses performed by the organization.

(c) Meetings. The Committee shall meet as often as necessary, but at least quarterly and shall maintain a permanent record of its proceedings and actions and shall report to the MSEC.

Section 5. Credentials Committee

(a) Composition. The Credentials Committee shall include representation from each Medical Staff department.

(b) Duties. The Credentials Committee shall:

(1) Review and evaluate the qualifications of each practitioner applying for initial appointment, reappointment or modification of clinical privileges, and, in

connection therewith, obtain and consider the recommendations of the appropriate departments;

(2) Submit required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, department affiliation, clinical privileges and special conditions;

(3) Evaluate, review and report on matters referred by the Chief of Staff or the MSEC regarding the professional criteria that at least pertain to evidence of current licensure, relevant training or experience, current competence and ability to perform the privileges requested. In the case of reappointment, the Committee shall also evaluate the criteria selected by departments to measure results of treatment, performance improvement findings, judgment and clinical technical skills; and

(4) Review, evaluate, act upon and recommendations for further action related to the content contained with referrals from the Interdisciplinary Practice Committee.

(c) Meetings. The Credentials Committee shall meet as often as necessary, but at least ten (10) times a year. The Committee shall maintain a record of its proceedings and actions and shall report to the MSEC.

Section 6. Graduate Medical Education Committee

(a) Composition. The Graduate Medical Education Committee (GMEC) shall consist of the following members of the Medical Staff: 1) The Program Directors of any Santa Monica-UCLA Medical Center based sponsored residency programs; 2) A Chief Resident from each of the Santa Monica based residency programs. The Chair shall be selected by the Chief of Staff from the above list of Active Staff members.

Ex-officio members shall include: The Chief Medical Officer and the Associate Dean for Graduate Medical Education from the David Geffen School of Medicine at UCLA. Ad hoc members may be appointed from each of the remaining departments whose expertise may be called upon by the Committee as needed. Such members may become full-time voting committee members as residency programs are established in their departments.

The GMEC shall have the responsibility for monitoring all aspects of residency education, maintain records as required by accreditation bodies or applicable laws, and report to and advise the MSEC on all issues covering graduate medical education at the hospital. It will oversee and support compliance with Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME).

(b) Duties

(1) Establish and implement policies that affect all residency programs regarding the work environment for medical students and post-graduate trainees.

(2) Establish and maintain appropriate oversight of and liaison with program directors.

(3) Review all Santa Monica based post-graduate training programs to assess their compliance with both the Institutional Requirements and Program Requirements of the ACGME. The review shall include, but not be limited to:

- The educational objectives of each program;
- The adequacy of available educational and financial resources to meet these objectives;
- The effectiveness of each program in meeting its objectives;
- The effectiveness in addressing citations from ACGME, letters of accreditation, and previous internal reviews.

(4) Review all applications by external programs to rotate medical students and post-graduate trainees through SMH and make recommendations for approval to the MSEC.

(5) Review quality of care issues reported by the hospital departments to the MSEC.

(c) Meetings. The Committee shall meet as needed and shall report its proceedings and recommendations to the MSEC.

Section 7. Infection Prevention Committee

(a) Composition. The Infection Prevention Committee shall consist of physician members of the Medical Staff and the following, with vote: An Infection Control nurse, a Hospital representative of Pharmacy, Nursing, Bacteriology–Microbiology and those Medical Center services recommended by the Medical Director of Infection Control. It shall be chaired by a physician member of the Medical Staff.

The Infection Prevention Committee shall be responsible for the surveillance of inadvertent Medical Center infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Medical Center's activities.

(b) Duties.

(1) Establish periodic review and update of Infection Prevention procedures;

(2) Publish an Infection Prevention manual;

(3) Review infections and propose corrective action when indicated;

(4) Review problems or procedures brought to the Committee's attention by other sources in the Medical Center relative to Infection control;

(5) Assist in the establishment of duties of the infection control nurse;

(6) Establish and review the environmental surveillance program;

(7) Collaborate with the Microbiology Laboratory concerning utilization and services;

(8) Monitor antibiotic usage and distribute data on antibiotic sensitivities;

(9) Bring to the attention of the Medical Staff and the Medical Center proper techniques and other infection prevention matters through in-service education and informal discussions.

(c) Meetings. The Committee shall meet as often as necessary, but at least quarterly, shall maintain a permanent record of its proceedings and actions, and shall report to the MSEC.

Section 8. Interdisciplinary Practice Committee

(a) Composition. The Interdisciplinary Practice Committee shall consist of an equal number of Medical Staff and Nursing Staff members (including a designee of the Director of Nursing), as well as representatives from other categories of Allied Health Professionals. The Chair of the committee shall be a member of the voting Medical Staff appointed by the Medical Staff Executive Committee.

(b) Duties. The Interdisciplinary Practice Committee shall:

1. Provide Medical Staff oversight as well as fulfill State of California requirements related to performance of standardized procedures by advance practice nurses and privileging of licensed independent practitioners who are not members of the Medical Staff;

2. Develop and review standardized policies that apply to advanced practice nurses;

3. Develop and review requests for standardized procedures that apply to policy and approve same periodically. Such policies and procedures shall, at the minimum, be related to standardized procedures for:
   - Assessing patients
   - Planning treatments

4. Serves the "Committee on Interdisciplinary Practice" function required by the California Code of Regulations, Title 22. As such, the Committee establishes and implements policies and procedures for application, review and approval of registered nurses functioning in expanded roles and/or performing standardized procedures outside of their scope of practice. Assures that the Standardized Procedures are a collaborative effort among administration and health professionals, including nurses and physicians. Report findings, conclusions, recommendations and actions taken to address matters related to policies and procedures to the Credentials Committee.

5. Review all Allied Health Professional applications and requests for standardized procedures and privileges and forward recommendations to the Credentials Committee

6. Participate in performance improvement and patient safety activities as related to ongoing professional practice evaluations provided on all allied health practitioners.

7. Initiate corrective action, when indicated, in accordance with the Medical Staff Bylaws

(c) Meetings. The Interdisciplinary Practice Committee shall meet as necessary and submit reports to the Credentials Committee.

Section 9. Medical Staff Health Committee

(a) Composition. The Medical Staff Health Committee shall be comprised of Active, Courtesy, or Consultant members of the Medical Staff. Insofar as possible, members of this Committee shall not serve simultaneously on the Medical Staff Executive Committee, the Credentials Committee, or a Peer Review Committee. It shall be chaired by a physician member of the Medical Staff.

(b) Duties. The Medical Staff Health Committee supports the wellbeing and health of the members with the aim of protecting patient welfare, advancing patient care, fostering a culture of safety, and improving member function. The Committee offers confidential assistance to any Medical Staff member by creating an environment and consultation mechanisms that is conducive to referral, self-referral and rehabilitation of members who may be suffering from a medical, cognitive, psychiatric, behavioral or substance-use related problem that poses a threat to patient care, self and/or others.

The Committee, having educated the Medical Staff in recognizing physician impairment and compromise, shall receive, investigate, and evaluate the referrals to determine creditivbility, and advise the Chief of Staff if the physical, mental health, or behavior of the medical staff member impairs their ability to function, or poses unreasonable risk or hearm to patients, themselves, or other staff members. If an impairment may exist, the committee will adivse the Chief of Staff or their delegate as soon as possible. The committee shall offer assistance in referral to appropriate evaluation and treatment resources. The Committee shall monitor the affected member through the entire rehabiliation period. Confidentiality of the member seeking referral or refered for assistance shall be kept, except as limited by law, ethical obligation, or when the safety of a patient is threatened. In instances in which a member poses unreasonable risk of harm to patients or health care team members, the Committree shall report all instances to the Medical Staff Executive Committee. The Committee is not disciplinary in nature and does not preclude other review mechanisms set forth in this Bylaws.

The Committee shall also consider general matrters related to the health and well being of the Medical Staff. With the approval of the Medical Staff Executive Committee, the Committee shall develop educational progrmas or related activities

to improve physician health and wellness, prevention and interventions of condidtions and behaviors that undermine a culture of safety.

(c) Meetings. This Committee shall meet as often as necessary, but at least quarterly and reports a summary of its activities to the MSEC. Additionally committee members shall meet for ad hoc meetings with new referrals throughout the year, or for phone consultations regarding those individuals being monitored by the committee. This Committee shall be empowered to meet in executive session, during which records need not be kept. Medical Staff members under discussion by this Committee shall not be identified in Committee records.

Section 10. Perioperative Surgical Services Committee

(a) Composition. The Perioperative Surgical Services Committee shall include but not be limited to voting members of the Medical Staff and voting members of Medical Center Administration:

- UCLA SOM Department Chair, Anesthesiology and Perioperative Medicine (Co-Chair)
- UCLA SOM Division/Department Chair, surgical department (Co-Chair)
- UCLA SOM Department Chair, Surgery
- UCLA SOM Department Chair, Head & Neck Surgery
- UCLA SOM Department Chair, Neurosurgery
- UCLA SOM Department Chair, Obstetrics & Gynecology
- UCLA SOM Department Chair, Ophthalmology
- UCLA SOM Department Chair, Orthopedic Surgery
- UCLA SOM Department Chair, Urology
- UCLA SOM Department Vice Chair, Anesthesia
- Chief Medical Officer, Santa Monica-UCLA Medical Center
- Chief Medical Officer, Ronald Reagan UCLA Medical Center
- Chief Medical and Quality Officer, UCLA Health
- Chief Operating Officer, UCLA Health
- Chief of Operations for Ambulatory and Community Practices, UCLA Health
- Chief Nursing Executive, UCLA Health
- Chief Financial Officer, UCLA Hospital System
- Medical Director, Operating Room Services
- Executive Director of Perioperative Services, UCLA Health

(b) Duties. The Perioperative Surgical Services Committee shall:

- Coordinate medical and hospital activity within Perioperative Services
- Track, monitor, and report Perioperative Services performance indicators such as block time utilization, block release timing, service volumes, and other related metrics.
- Provide recommendations to address and improve performance
- Review and act upon work team findings and recommendations
- Establish policies and guidelines for standard operational procedures to assure quality, efficiency and compliance with regulatory guidelines.
- Develop enforcement mechanisms for all established policies
- Ensure collaboration between nursing, surgeons, anesthesiologists and the UCLA Health system as it relates to Surgical Services operations

- Serve as a forum to facilitate multidisciplinary communications and a means to resolve interdisciplinary issues.
- Support, develop and facilitate innovative surgical care and identify capital needs and make recommendations to the UCLA Health President's Council, the Chief Financial Officer, or the Chief Operating Officer.
- Provide oversight for the ongoing Quality Assurance of Surgical Services Quality Committees

(c) Meetings. The Perioperative Surgical Services Committee shall meet at least quarterly or more often as necessary and submit reports to the SMH Medical Staff Surgery Department.

Section 11. Pharmacy and Therapeutics Committee

(a) Composition. The Pharmacy, Therapeutics and Clinical Nutrition Committee shall consist of members of the medical staff, representing Medicine, Surgery, Pediatrics, OB/Gyn, Family Medicine, and Emergency Medicine, and representation, with vote, from Nursing, the Pharmacy Director, Nutrition, and Administration, as applicable. The Chief of Staff shall appoint the Chair from the Medical Staff and members to the Pharmacy and Therapeutics Committee will be appointed by the Chair.

(b) Responsibilities of the Pharmacy and Therapeutics Committee

1. Establish, develop and maintain a unified UCLA Health-wide Drug Formulary, including the establishment of criteria-for-use for formulary and non-formulary agents.
2. Assess the effectiveness, cost, benefit, and safety of the Drug Formulary to the UCLA Health population and to the institution. Implement, support, and monitor compliance with formulary guidelines and cost avoidances initiatives.
3. Provide oversight of the development and evaluation of UCLA Health medication use policies.
4. Establish pharmacological management guidelines for specific disease states as required.
5. Provide oversight of pharmacy operations and medication safety.
6. Provide oversight of the Pharmacy and Therapeutics Subcommittees:
    a) Antibiotic subcommittee
    b) Medication Event Committee(s)
7. Recommend, review and approve medication order sets within the electronic medical record system, including modifications and enhancements.
8. Provide oversight for the performance of evidence-based, therapeutic drug class reviews that may lead to further Drug Formulary standardization.
9. Provide oversite for the management of drug shortages and drug recalls.
10. Perform all functions required in the most current Joint Commission Accreditation Manual for Hospitals and conform to current laws and regulations as set forth in California Code of Regulations Title 22 and other applicable rules and regulations as outlined by the California Department of Public Health.
11. Monitor non-formulary drug use and provide the information and/or mechanisms for improvement to the Medical Staff Executive Committee.

12. Monitor and trend Adverse Drug Events (ADEs) to identify opportunities for future improvement and avoidance. Provide trended information to the Medical Staff Executive Committee.
13. Monitor Medication Events and develop policies and procedures to minimize or eliminate them via the Medication Event Committee(s).

(c) Meetings. The Committee shall meet as often as necessary, but at least ten (10) times a year. The minutes of Committee meetings shall be approved by the Committee and submitted to the MSEC for concurrence of actions taken. The quorum shall consist of a majority of voting medical staff members present.

Section 12. Risk Management Committee

(a) Composition. The Risk Management Committee shall consist of physician members of the medical staff, and representation with vote (except in peer review cases) from Nursing Service and the Director of Risk Management. It shall be chaired by a physician member of the Medical Staff.

(b) Duties.

(1) Identify potential sources of professional liability claims for correction and prevention;

(2) Review all professional liability complaints in which the Medical Center is named;

(3) Review complaints by patients against the Medical Center or Medical Staff members concerning quality of care;

(4) Review documents regarding informed consent and liability between patient and Medical Center;

(5) Report to the MSEC conduct that adversely affects patient care.

(c) Meetings. The Committee shall meet as often as necessary, but at least quarterly, shall maintain a permanent record of its proceedings and actions, and shall report to the MSEC.

Section 13. Utilization Review Committee

(a) Composition. The Utilization Review Committee shall consist of physician members of the Medical Staff, including one representative without vote from Quality Improvement. It shall be chaired by a physician member of the Medical Staff.

(b) Duties

(1) Conduct utilization review studies designed to evaluate the appropriateness of admissions to the Medical Center, lengths of stay, discharge practices, use of medical and Medical Center services, and all related factors which may contribute to the effective utilization of Medical Center and physician services:

(2) Analyze the effect of utilization of each of the Medical Center's services on quality and appropriateness of patient care, study patterns of care, obtain criteria relating to average or normal lengths of stay by specific disease categories, and evaluate systems of utilization review employing these criteria;

(3) Monitor continuity of care upon discharge through evaluation of discharge planning activities;

(4) Formulate and review annually a written utilization plan for the Medical Center;

(5) Assist, as needed, in the review activities of non-physician reviewers;

(6) Evaluate the medical necessity for continued Medical Center services when indicated.

(c) Meetings. The Utilization Review Committee shall meet as often as necessary, but at least quarterly, shall maintain a permanent record of its proceedings and actions and shall report to the MSEC.

ARTICLE X – DEPARTMENT AND COMMITTEE MEETINGS

Section 1. Regular Meetings

(a) Committees may, by resolution, provide the time for holding regular meetings in accordance with these Bylaws without notice other than such resolution.

(b) Where geographic and other conditions make it feasible, and upon concurrence of the MSEC, arrangements may be made to provide joint meetings with medical staffs of UCLA Health medical centers. Minutes of these meetings shall be taken in such form that the record of each Medical Center's activities is kept separately.

Section 2. Special Meetings

A special meeting of any committee may be called by the chair of the committee, by the Chief of Staff, or by twenty-five percent (25%) of the group's members.

Section 3. Notice of Meetings

(a) Notice of a meeting is given at the time of committee appointments and monthly through the Medical Staff Calendar. Special or emergency meetings shall be made known by separate notice.

(b) Special or Regular Meetings. Written or oral notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee not less than five (5) days before the time for such meeting, by the person or persons calling the meeting. The notice of the meeting shall be deemed delivered when sent via e-mail addressed to the member's address as it appears on the records of Medical Staff Administration. The

attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

(c) Emergency Meetings. Emergency meetings of the MSEC may be called by the Chief of Staff, upon the determination that an emergency exists sufficient to warrant a call of the MSEC without notice as provided in this Section 3. Oral notice stating the place, day and hour of any emergency meeting must be provided to each MSEC member, or an attempt at such made at the telephone number provided by each member for such purpose.

Section 4. Quorum

Ten percent (10%) or not fewer than two Medical Staff members of the voting members of a committee shall constitute a quorum at any meeting.

Section 5. Manner of Action

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee.

Section 6. Minutes

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the result of vote taken on each matter. The minutes shall be signed by the presiding officer and forwarded to the MSEC. Each committee shall maintain a permanent file of the minutes of each meeting.

Section 7. Attendance

(a) Attendance at meetings of Medical Staff Committees is a responsibility of Medical Staff members appointed to those committees.

(b) A member of the committee may be dropped from committee membership after three (3) absences.

ARTICLE XI - MEDICAL STAFF MEETINGS

Section 1. Special Meetings

The Chief of Staff or a majority of the MSEC may call a meeting of the Medical Staff or the Active Staff at any time. The Chief of Staff shall call a meeting of the Medical Staff or the Active Staff within fifteen (15) days after receipt of a written request for same by not less than twenty-five percent (25%) of the Active Staff.

Section 2. Voting

Only members of the Active Staff shall be eligible to vote at meetings of the Medical Staff and the Active Staff.

Section 3. Notice

Written notice stating the place, day, and, hour of any meeting of the Medical Staff or Active Staff shall be delivered, by or at the direction of the Chief of Staff by e-mail, to each member fifteen (15) days before the date of the meeting. The notice of the meeting shall be deemed delivered when addressed to each Staff member's address as it appears on the records of the Medical Center. 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.

Section 4. Quorum

The presence of twenty-five percent (25%) of the total membership of the Active Staff at a Medical Staff or Active Staff meeting shall be deemed a quorum for all actions, including amendment of the Bylaws.

ARTICLE XII EVALUATION AND CORRECTIVE ACTION

Section 1. Informal Corrective Activities

The Chief of Staff, Chief Medical Officer, Department Chairs, Section Chiefs and Medical Staff committees may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions and warnings may be issued orally or in writing. The member shall be given an opportunity to respond in writing and may be given an opportunity to meet with the Chief of Staff, Chief Medical Officer, Department Chair, Section Chief, or Committee. Any informal actions, monitoring or counseling shall be documented in writing in the member's peer review file. MSEC approval is not required for such actions. The actions shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights under Article XIII.

Section 2. Criteria for Initiation of Formal Corrective Action

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

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

(b) Unethical or unprofessional;

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

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

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

(h) Criminal conviction, including a conviction or plea of guilty or nolo contendere for any felony or for any misdemeanor related to the practice of a health care professional, fraud or abuse relating to any governmental health program, third party reimbursement, or controlled substance, whether or not an appeal has been filed or is pending; or

(i) A breach of privacy and confidentiality.

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

Section 3. Initiation

(a) Any person who believes that formal corrective action may be warranted may provide information to the Chief of Staff, Chief Medical Officer, or the applicable Department Chair. Such requests may but need not be, referred to the Department Chair for review and investigation. When such information about a member comes to the attention of the Department Chair, he/she may review and investigate the matter, either directly or by delegation. If the Department Chair thereafter concludes that there appears to be grounds for corrective action, he/she must submit a request for such corrective action in accordance with this section; however, such prior investigation by the department is not a precondition for making a request for corrective action.

(b) If the Chief of Staff, Chief Medical Officer, or the applicable Department Chair determines that corrective action may be warranted under this section, that person may request the initiation of a formal corrective action investigation or may recommend particular corrective action by conveying such request to the Chief of Staff, as Chair of the MSEC, in writing and supported by reference to and documentation of the specific activity or conduct that constitutes the grounds for the request. For clarity, an investigation of a matter that could warrant formal corrective action will be deemed to begin when the Chief of Staff receives a request such as that described in this section.

(c) The Chief of Staff shall notify the MSEC, the Chief Medical Officer, and the Department Chair where the member has such privileges, and the member of the action to be taken, and shall continue to keep them fully informed of all actions taken. In addition, if there is to be a preliminary investigation as described in Section 4, the Chief of Staff shall appoint and immediately forward all necessary information to a committee or person that will conduct any preliminary investigation.

Section 4. Preliminary Investigation

Whenever information suggests that corrective action may be warranted (including but not limited to, cases of complaints of harassment or discrimination involving a patient, member or an employee), the Chief of Staff or designee, on behalf of the MSEC, may immediately investigate and conduct whatever interviews may be indicated or may delegate such activities as appropriate. The information developed during this initial review shall be presented at its next regularly scheduled meeting to the MSEC, which shall decide whether to initiate a formal investigation as described in Section 6.

Section 5. Interview

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

Section 6. Formal Investigation

(a) If the Chief of Staff, acting on behalf of the MSEC, concludes that corrective action is indicated but that no further investigation is necessary, he or she may proceed to take action without further investigation or summarily suspend the member in accordance with the procedures set forth in Section 9.

(b) If the Chief of Staff, acting on behalf of the MSEC, concludes a formal investigation is warranted, he or she shall direct an investigation to be undertaken and the member shall be informed in writing of the investigation and of the allegations that give rise to the investigation. The Chief of Staff may personally conduct the investigation or may assign the task to an appropriate standing or ad hoc committee to be appointed by the Chief of Staff. The investigating body should not include individuals with a conflict of interest, which may include partners, associates or relatives of the individual being investigated. Additionally, the investigating person or body may, but is not required to engage the services of one or more outside reviewers as deemed appropriate or helpful in light of the circumstances. If the investigation is delegated to a committee other than the MSEC, such committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the MSEC within sixty (60) days of the assignment. The MSEC may authorize an extension of this time period for good cause. The report may include recommendations for appropriate corrective action.

(c) Within five days of receipt of the report of findings and recommendations, the MSEC shall notify the affected staff member, furnish copies of the request for corrective action and the report of findings and recommendations and offer the member an opportunity to make an appearance before the MSEC prior to action being taken. Neither this appearance nor the investigation referred to in Section 5 shall constitute a hearing. This appearance shall be at the next regularly scheduled meeting of the MSEC, shall be preliminary in nature, and none of the procedural rules of the Bylaws with respect to hearings shall apply.

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

Section 7. MSEC Action

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

(a) Determining no corrective action be taken and, if the MSEC determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;

(b) Deferring action for a reasonable time;

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

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

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

(f) Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;

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

(h) Taking other actions deemed appropriate under the circumstances; and

(i) Determining whether the action is taken for any of the reasons required to be reported pursuant to Business & Professions Code §805.01. Section 805.01 reports are intended to expedite the investigation process; according to the Medical Board of California, section 805.01 reports are not disseminated and not posted on a licensee's profile. Section 805.01 reports must be filed under the following circumstances:

- Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent

or in such a manner as to be dangerous or injurious to any person or to the public;

- The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug, as defined in Business & Professions Code §4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely;

- Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions; and

- Sexual misconduct with one or more patients during a course of treatment or an examination.

Section 8. Time Frames

Following full investigation, a report of findings and recommendations shall be returned to the MSEC within sixty (60) days of receipt of the assignment. The report may include recommendations for appropriate corrective action. The MSEC may authorize extension of this time period for good cause.

Section 9. Procedural Rights

(a) If the MSEC determines that no corrective action is required or only a letter of warning, admonition, reprimand or censure should be issued, the decision shall be transmitted to the Governing Body. The Governing Body may affirm, reject or modify the action. The Governing Body shall give great weight to the MSEC's decision and may initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the MSEC and the MSEC still has not acted. The decision shall become final if the Governing Body affirms it or takes no action on it within 60 days after receiving the notice of decision. If the corrective action does not constitute "ground for hearing" as that term is defined in Article XIII, Section 2, that action shall not entitle the member to a hearing.

(b) If the MSEC recommends an action that is a ground for a hearing, the Chief of Staff shall give the member prompt written notice of the proposed action and of the right to request a hearing. The Governing Body will be informed of the recommendation, but shall take no action until the member has either waived his or her right to a hearing or exhausted all procedural right set forth in Article III.

Section 10. Summary Restriction or Suspension

Criteria for Initiation

(a) Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of any patient, prospective patient, or other individual or to prevent the disruption of the Medical Center, any two (2) of the following shall have the authority to summarily suspend and concurrently notify the Chief of Staff: the Department Chair, Chief Medical Officer, Chief of Staff and a Medical Staff Executive Committee member.

(b) If the Chief of Staff, the MSEC's, or Department Chair's (or designee) in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the Governing Body (or designee) may summarily restrict or suspend the member's membership or clinical privileges for the reasons stated above, provided that the Governing Body made reasonable attempts to contact the Chief of Staff, the MSEC and the Department Chair (or designee) before the suspension. The MSEC must ratify any summary suspension imposed by Governing Body within two (2) days. If the MSEC does not ratify a summary suspension imposed within two (2) working days, the summary suspension shall terminate automatically. If the MSEC does ratify the summary suspension, all other provisions under Section XIV of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the MSEC for purposes of compliance with notice and hearing requirements.

(c) The summary action may be limited in duration and shall remain in effect for the period stated or, if none, until ratified by the MSEC as set forth in this Section.

1) Unless otherwise stated, such summary restriction or suspension (summary action) shall become effective immediately upon imposition, and the person or body responsible shall immediately give written special notice to, the Governing Body, the MSEC, the Department Chair, and the Chief Administrative Officer of the Hospital. The special notice shall generally describe the reasons for the action.

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

2) The notice of the summary action given to the MSEC shall constitute a request to initiate corrective action and the procedures set forth in this Section shall be followed.

3) Unless otherwise indicated by the terms of the summary action, the member's

patients shall be promptly assigned to another member of the department, by the Chief of Staff or Department Chair considering, where feasible, the wishes of the patient and the affected member in the choice of a substitute member.

Section 11. MSEC Action

Within seven (7) days after any summary restriction or suspension has been imposed, a meeting of the MSEC shall be convened to review and consider the action. Upon request, the affected member may attend and request an interview with the MSEC. The interview shall be convened as soon as reasonably possible, shall be informal, and shall not constitute a hearing, as that term is used in these Bylaws. The MSEC may thereafter continue, modify or terminate the terms of the summary action. It shall give the member written special notice of its decision within two (2) working days of its meeting. Said notice shall include the information specified in section 10 if the action is adverse**.**

Section 12. **Procedural Rights**

Unless the MSEC terminates the summary action, it shall remain in effect during the pendency and completion of the corrective action process and of the hearing and appellate review process. When a summary action is continued, the affected member shall be entitled to the procedural rights afforded by Article XIII. In addition, the affected member shall have the following rights:

Any affected member shall have the right to challenge imposition of the summary suspension, particularly on the issue of whether or not the facts stated in the notice present a reasonable possibility of "imminent danger" to an individual. Initially, the member may present this challenge to the MSEC at the meeting held within one week of imposition of the suspension. If the MSEC's decision is to continue the summary suspension, then any member who has properly requested a hearing under the Medical Staff Bylaws may request that the hearing be bifurcated, with the first part of the hearing being devoted exclusively to procedural matters, including the propriety of summary suspension. Along with any other appropriate requests for rulings, the affected member may request that the hearing officer [or hearing panel] stay the summary suspension, pending the final outcome of the hearing and any appeal.

At the conclusion of the procedural portion of the hearing, the hearing officer shall issue a written opinion on the issues raised, including whether or not the facts stated in the written notice to the affected member adequately support a determination that failure to summarily restrict or suspend could reasonably result in "imminent danger" to an individual. Such written opinion shall be transmitted to both the affected practitioner and the Medical Staff Executive Committee within one week of the date of the procedural hearing.

If the hearing officer's determination is that the facts stated in the notice required by Section 11 do not support a reasonable determination that failure to summarily restrict or suspend the practitioner's privileges could result in imminent danger, the summary suspension shall be immediately stayed pending the outcome of the hearing and any appeal.

If the hearing officer determines that the facts stated in the notice required by Section 11 support a reasonable determination that summary suspension was necessary to avoid imminent danger to an individual, the summary suspension shall remain in effect pending conclusion of the hearing and any appellate review.

Section 13. Automatic Suspension or Limitation

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

13.1 Licensure

(a) Revocation, Suspension or Expiration: Whenever a member's license or other legal credential, certificate or permit authorizing practice in this state is revoked, suspended or expired, Medical Staff membership and privileges shall be automatically revoked as of the date such action becomes effective. If, after 180 consecutive days of suspension the member remains suspended, the member shall be considered to have resigned voluntarily from the Medical Staff.

(b) Restriction: Whenever a member's license, other legal credential authorizing practice in this state, certificate or permit issued to permit specific privileges following routine testing is limited or restricted by the applicable licensing or certifying authority or by the Hospital, 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) Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority his or her membership status and privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

13.2 Drug Enforcement Administration (DEA) Certificate

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

(b) Probation: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

13.3 Medical Records

Medical Staff members are required to complete medical records within the time prescribed in the Bylaws, Rules and Regulations. Failure to complete medical records in a timely manner shall result in an automatic suspension after notice is given as provided in the Rules. Such suspension shall apply to the member's right to admit, treat or provide services to new patients in the Hospital, but shall not affect the right to continue to care for a patient the member has already admitted or is treating. The suspension shall continue until the medical records are completed. If, after 180 consecutive days of suspension the member remains suspended, the member shall be considered to have resigned voluntarily from the Medical Staff.

13.4. Cancellation of Professional Liability Insurance

Failure to maintain professional liability insurance as required by the University of California and by these Bylaws shall be grounds for automatic suspension of a member's privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage. A failure to provide evidence of appropriate coverage after 180 days of suspension shall be deemed a voluntary resignation of the member from the Medical Staff.

13.5 Failure to Pay Fees/Fines

Failure, without good cause as determined by the MSEC, to pay fees/fines shall be grounds for automatic suspension of a member's clinical privileges, and if within six months after written warnings of the delinquency the member does not pay the required fees/fines, the member's membership shall be automatically terminated.

13.6 Call Coverage (Back-Up Panel)

As noted in the Medical Staff Rules and Regulations (III.D.4), and as specified in Department Rules and Regulations, an attending physician is required to have another physician with the same privileges and in the same specialty/sub-specialty, who is on the Medical Staff at SMH, available for appropriate coverage. Failure to submit a list of possible covering physicians and/or failure of the candidates to accept that responsibility shall be grounds for automatic suspension of a member's clinical privileges, and if within six months after written warnings, the member does not have a designated back-up physician, the member's membership shall be automatically terminated.

13.7 Other Regulatory Requirements

(a) Failure to provide evidence of the current status of Tuberculin Testing (Ref IC 004 Tuberculosis Exposure Control Plan) at the time of initial appointment and reappointment shall be grounds for automatic suspension of a member's privileges. The suspension shall be effective until notification of clearance from the Hospital's Occupational Health Facility. A failure to provide evidence of clearance after 180 days of suspension shall be deemed a voluntary resignation of the member from the Medical Staff.

(b) Failure to provide evidence of the UCLA Health Insurance Portability and Accountability Act (HIPAA) Privacy & Security Workforce Training at the time of initial appointment and reappointment shall be grounds for automatic suspension of a member's privileges. The suspension shall be effective until notification of completion from the UCLA Office of Privacy and Compliance. A failure to provide evidence of completion after 180 days of suspension shall be deemed a voluntary resignation of the member from the Medical Staff.

13.8 Exclusion from Government Programs

Whenever a member is excluded from a Federal or State health care program in accordance with applicable federal or state laws and regulations, the member's Medical

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

13.9 Failure to Satisfy Special Attendance Requirement

Failure of a member without good cause to provide information or appear when requested by a Medical Staff committee as described in these Bylaws shall result in the referral to the MSEC for action, which may include automatic suspension of all privileges. The automatic suspension shall remain in effect until the practitioner has provided requested information and/or satisfied the special attendance requirement which has been made by the MSEC.

13.10 Felony Conviction

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

13.11 Automatic Termination

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

13.12 MSEC Deliberation and Procedural Rights

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

13.13 Notice of Automatic Suspension or Action

Special notice of an automatic suspension or action for reasons other than delinquent medical records, professional liability insurance, and other regulatory requirements, shall be given to the affected individual, and regular notice of the suspension shall be given to the Department and the Governing Body, but such notice shall not be required for the suspension to become effective. Patients affected by such automatic suspension shall be assigned to another member by the Department Chair. The wishes of the patient and affected member shall be considered, where feasible, in choosing a substitute member.

13.14 Automatic Action Based Upon Actions Taken by Another University of California Peer Review Body After a Hearing

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

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

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

13.15 Confidentiality

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

ARTICLE XIII HEARINGS AND APPEAL PROCEDURES

Section 1. General Provisions

1.1 Exhaustion of Remedies

If an adverse action as described in Section 2 is taken or recommended, the member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

1.2 Definitions

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

(a) "*Body whose decision prompted the hearing*" refers to the MSEC in all cases where it took the action or rendered the decision that resulted in a hearing being requested. It refers to the Governing Body in all cases where the Governing Body or its authorized officers, directors or committees took the action or rendered the decision that resulted in a hearing being requested.

(b) ***"****Member,*" as used in this Article, refers to the member or applicant who has requested a hearing pursuant to Section 3 of this Article.

1.3 Substantial Compliance

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

Section 2. Grounds for Hearing

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

(a) Denial of Medical Staff membership for a medical disciplinary cause or reason;

(b) Denial of requested advancement in membership;

(c) Denial of Medical Staff reappointment;

(d) Suspension of staff membership;

(e) Termination of membership;

(f) Denial of requested clinical privileges;

(g) Involuntary reduction of current clinical privileges;

(h) Suspension of clinical privileges;

(i) Termination of some or all clinical privileges;

(j) Involuntary imposition of significant consultation or monitoring requirements (excluding consultation/monitoring incidental to provisional status and other regular proctoring) that restricts a practitioner's exercise of privileges; or

(k) Any other action or recommendation that requires a report to be made to the relevant licensing agencies in accordance with Section 805 or 805.01of the Business and Professions Code or requires a report to be made to the National Practitioner Data Bank.

Section 3. Requests for Hearing

3.1 Notice of Action or Proposed Action

In all cases in which the MSEC has taken any actions constituting grounds for hearing as set forth in Section 2, the member, or applicant as the case may be, shall be given notice within ten (10) days. In all cases in which action has been taken or a recommendation made as set forth in Section 2, the MSEC shall give the member prompt written notice of the recommendation or final proposed action and that such action, if adopted shall be taken and reported to the Medical Board of California pursuant to Section 805 or the National Practitioner Data Bank.

3.2 Request for Hearing

The member or applicant shall have 30 days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the MSEC with a copy to the Governing Body. In the event the member or applicant does not request a hearing within the time and in the manner described, the member or applicant shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

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

Section 4 Hearing Procedure

4.1 Time and Place for Hearing

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

4.2 Notice of Charges

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

4.3 Hearing Committee

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

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

4.4 The Hearing Officer

The Chief of Staff shall appoint a Hearing Officer to preside at the hearing.

The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but not an attorney regularly utilized by the Hospital for legal advice regarding its affairs and activities.

The Hearing Officer shall not be biased for or against any party, shall gain no direct financial benefit from the outcome (i.e., the hearing officer's remuneration shall not be dependent upon or vary depending upon the outcome of the hearing), and must not act as a prosecuting officer or as an advocate.

The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained.

The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing.

He/she shall have the authority and discretion to make all rulings on questions that pertain to matters of law, procedures, or the admissibility of evidence that are raised prior to, during or after the hearing. This shall include deciding when evidence may or may not be introduced, granting continuances, ruling on disputed discovery requests, and ruling on challenges to Hearing Committee members or to himself or herself in their capacity as the Hearing Officer.

If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems

warranted by the circumstances, including, but not limited to, limiting the scope of examination and cross-examination and setting fair and reasonable time limits on either side's presentation of its case.

The hearing officer shall preside over the voir dire process and may question panel members directly, and shall make all rulings regarding service by the proposed hearing panel members or the hearing officer.

When no attorney is accompanying any party to the proceedings, the hearing officer shall have the authority to interpose any objections and to initiate rulings necessary to ensure a fair and efficient process.

If requested by the Hearing Committee, the Hearing Officer may participate in the deliberations of such Committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote.

4.5 Representation

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

4.6 Failure to Appear or Proceed

Failure without good cause of the person requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved which shall become final and effective immediately.

4.7 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted upon a showing of good cause, as follows:

(a) Until such time as a Hearing Officer has been appointed, by the Hearing Committee or its chair acting upon its behalf;

(b) By the Hearing Officer, once he/she has been appointed; or

(c) Upon the agreement of both parties.

4.8 Discovery

(a) Rights of Inspection and Copying

The member may inspect and copy (at his or her expense) any documentary information upon which the charges are based that the Medical Staff has in its possession or under its control. The body who decision prompted the hearing may inspect and copy (at its expense) any documentary information upon which the charges are based that the member has in his or her possession or under his or her control. The member shall also have the right to receive at least 30 days prior to the hearing a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the member to prepare a defense. Failure to comply with reasonable discovery requests shall be good cause for a continuance of the hearing or for the Hearing Officer to bar or otherwise limit the introduction of any documents not provided to the other party.

Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least 10 days before the commencement of the hearing shall constitute good cause for a continuance.

(b) Limits on Discovery

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

(c) Ruling on Discovery Disputes

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

1) Whether the information sought may be introduced to support or defend the charges;

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

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

4) Any other discovery requests the party has previously made.

(d) Objections to Introduction of Evidence Previously Not Produced for the Medical Staff

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

4.9 Pre-Hearing Document Exchange

At the request of either party, the parties must exchange all documents that will be introduced at the hearing. The documents must be exchanged at least 15 days prior to the

hearing. A failure to comply with this rule is good cause for the Hearing Officer to grant a continuance. Repeated failures to comply shall be good cause for the Hearing Officer to limit the introduction of any documents not provided to the other side in a timely manner.

4.10 Witness Lists

Not less than 15 days prior to the hearing, each party shall furnish to the other party a written list of names and addresses of the individuals, so far as they are then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least fifteen days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

4.11 Procedural Disputes

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

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

4.12 Record of the Hearing

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

4.13 Rights of the Parties

Within reasonable limitations, both sides at the hearing may ask the Hearing Committee members and Hearing Officer questions that are directly related to evaluating their

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

4.14 Rules of Evidence

Formal judicial rules of evidence and procedure relating to the conduct of the hearing, examination or 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.

4.15 Miscellaneous Rules

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

4.16 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 member shall be obligated to present evidence in response.

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

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

4.17 Adjournment and Conclusion

The Hearing Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Both the MSEC and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral

and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

4.18 Basis for Decision

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

4.19 Presence of Hearing Committee Members and Vote

A majority of the Hearing Committee must be present throughout the hearing and deliberations. In unusual circumstances when a Hearing Committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent. The final decision of the Hearing Committee must be sustained by a majority vote of the number of members appointed.

4.20 Decision of the Hearing Committee

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

Section 5. Appeal

5.1 Time for Appeal

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

5.2 Ground for Appeal

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

5.3 Appeal Board

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

5.4 Time, Place and Notice

If an appellate review is to be conducted, the Appeal Board shall, within 30 days after receiving a notice of appeal, schedule a review date and cause each side to be given notice with special notice to the member of the time, place, and date of the appellate review. The date of appellate review shall not be less than thirty (30) days, not more than sixty (60) days from the date of the request for appellate review; however, when a request for appellate review concerns a member who is under suspension that is then in effect, the appellate review should commence with 45 days from the date the request for appellate review was received. The time for appellate review may be extended by the Appeal Board for good cause.

5.5 Appeal Procedure

The proceeding by the Appeal Board shall be an appellate hearing based upon the record of hearing before the Hearing Committee, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Hearing Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing; or the Appeal Board may remand the matter to the Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel or any other representative designated by that party in connection with the appeal. The appealing party shall submit a written statement concisely stating the specific grounds for appeal. In addition, each party shall have the right to present a written statement in support of his, her or its position on appeal. The Appellate Hearing Officer may establish reasonable time frames for the appealing party to submit a written statement and for the responding party to respond. Each party has the right to appear personally and to make oral argument. The Appeal Board may then, at a time convenient to itself, deliberate outside the presence of the parties.

5.6 Decision

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

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

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

(d) The Appeal Board shall forward copies of this decision to each side involved in the hearing. The decision shall be in writing, shall specify the reasons for the action taken, and shall be forwarded to the Chief of Staff, and the MSEC, the member, and the President of UCLA Health

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

5.7 Right to One Hearing

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

5.8 National Practitioner Data Bank

The authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action and only using the description set forth in the final action as adopted by the Governing Body. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

Section 6. Confidentiality

To maintain confidentiality in the performance of peer review, disciplinary and credentialing functions, participants in any stage of the hearing or appellate review

process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws.

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

Section 7. Exceptions to Hearing Rights

7.1 Allied Health Professionals

Allied Health professionals (AHPs) are not entitled to the same hearing rights set forth in this Article.

7.2 Failure to Meet the Minimum Qualifications

Members shall not be entitled to any hearing or appellate review rights if their membership, privileges, applications or requests are denied because of their failure to have a current California license to practice medicine, dentistry or podiatry; to maintain an unrestricted Drug Enforcement Administration certificate (when it is required under these Bylaws or the rules); to maintain professional liability insurance; or to meet any of the other basic standards or regulatory requirements specified in Sections 3.1 and 7.11, or to file a complete application.

7.3 Automatic Suspension or Limitation of Privileges

No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Section 7.11.1. In other cases described in Section 7.11, the issues that may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or the Drug Enforcement Administration was unwarranted, but only whether the member may continue to practice in the Hospital despite the limitations imposed.

7.4 Failure to Meet Minimum Activity Requirements

Members shall not be entitled to the hearing and appellate review rights if their membership or privileges are denied, restricted or terminated or their medical staff categories are changed or not changed because of a failure to meet the minimum activity requirements set forth in the Medical Staff Bylaws.

ARTICLE XIV – REVIEW, REVISION, ADOPTION AND AMENDMENT OF BYLAWS, RULES AND REGULATIONS AND POLICIES

Section 1. Medical Staff Responsibility

The medical staff shall have the responsibility to formulate, review, and recommend to the Governing Body any medical staff bylaws, rules, regulations, policies, procedures and amendments as needed. Amendments to the bylaws and rules and regulations shall be effective when approved by the Governing Body. The medical staff must exercise this responsibility regarding bylaws through direct vote of its membership. The medical staff can exercise this responsibility regarding rules and regulations and policies through its elected

and appointed leaders or through direct vote of its membership. Such responsibility shall be exercised in good faith and in reasonable, responsible, and timely manner.

Section 2. Rules and Regulations

The MSEC shall adopt such general 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 required of each practitioner in the Medical Center.

Each department shall review its Rules and Regulations annually. Department rules and regulations and amendments thereto shall be proposed by each department committee and submitted to the MSEC for approval

Section 3. Initiation of Amendments

Proposed amendments may be originated by the MSEC or a petition signed by twenty-five percent (25%) of the voting members of the medical staff.

Procedure - Bylaws

When proposed by the MSEC, there will be communication of the proposed amendment to the medical staff at least 30 days before a vote is taken by the medical staff. The notice shall include the exact wording of the existing bylaw language, if any, and the proposed change(s).

When proposed by the medical staff, there will be communication of the proposed amendment to the MSEC at least 30 days before a vote is taken by the voting members of the medical staff. The notice shall include the exact wording of the existing bylaw language, if any, and the proposed change(s).

If the voting members of the medical staff vote to recommend directly to the Governing Body an amendment to the bylaws that is different from what has been recommended by the MSEC, the conflict resolution process referred to in Article XIV Section 4 shall be followed within 30 days of the vote.

Procedure – Rules and Regulations

Proposed new or amendments to these rules and regulations may be originated by the MSEC or by a petition signed by twenty-five percent (25%) of the voting members of the medical staff. When proposed by the medical staff, there will be communication of the proposed amendment to the MSEC. If the MSEC approves of the proposed rule or regulation, the MSEC will forward the proposed rule or regulation to the Governing Body noting approval by both the MSEC and the medical staff.

If the MSEC does not approve of the proposed rule or regulation, the MSEC will implement the Conflict Resolution process in Article XIV, Section 4.

Procedure – Policies and Procedures

When the MSEC adopts a policy or amendment thereto, there will be communication of the medical staff for comment within seven days of the date of the notice. The policy will become final at the end of the comment period unless at least twenty-five percent (25%) of voting members express opposition to the policy in writing.

If the medical staff disagrees with a policy or procedure enacted by the MSEC, it can utilize the Conflict Resolution process.

Provisional Amendments to the Rules and Regulations

The MSEC may adopt such provisional revisions to the Rules and Regulations, Policies and Procedures that are in the MSEC's and Governing Body's judgments necessary for legal or regluatory compliance. After adoption, these provisional revisions will be communicated to the medical staff for their review and opportunity for comments within 30 days of the date of the notice. The revision will become final at the end of the comment period unless twenty-five percent (25) of voting members express opposition to the revision in writing.

If the medical staff approves of the provisional revisions, the revisions will stand. If the medical staff does not approve of the provisional revision, it will be resolved using the conflict resolution process noted in Section 3.

Section 4. Conflict Resolution

Each staff member may challenge any bylaw, rule or policy established by the MSEC through the following process:

1. Submission of written notification to the chief of staff of the challenge and the basis for the challenge, including any recommended changes to the bylaw, rule or policy.

2. Following such notification, the MSEC shall discuss the challenge at their next meeting and if determine of any changes will be made to the bylaw, rule or policy.

3. If changes are adopted, they will be communicated to the medical staff, at such time each medical staff member in the Active category may submit written notification of any further challenge(s) to the bylaw, rule or policy to the chief of staff.

4. In response to a written challenge to a bylaw, rule or policy, the MSEC may, but is not required to, appoint a task force to review the challenge and recommend potential changes to address concerns raised by the challenge.

5. If a task force is appointed, following the recommendations of such task force, the MSEC will take final action on the bylaw, rule or policy.

6. Once the MSEC has taken final action in response to the challenge, with or without recommendations from a task force, any medical staff member my submit a petition signed by 25% of the members of the Active category requesting review and possible change of a bylaw, rule, regulation, policy or procedure. Upon presentation of such a petition, the adoption procedure outlined in Section 3 will be followed.

At any point in the process of addressing a disagreement between the medical staff and the MSEC regarding the bylaws, rules and regulations, or policies, the medical staff, MSEC or Governing Body shall each have the right to recommend utilization of an outside resource to assist in addressing the disagreement. The final decision regarding whether or not to use an outside resource, and the process that will be followed in so doing, is the responsibility of the Governing Body.

Section 5. Vote of Active Staff

These Bylaws shall be amended by communication via electronic mail to all voting members (Active Staff) of the Medical Staff. A majority vote of all ballots returned will be required to pass any amendment. If the medical staff does not adopt the MSEC-supported proposed bylaws amendment(s) by vote, then the MSEC-supported proposed bylaws amendment(s) will be deemed withdrawn.

Section 6. Governing Body Approval

Amendments so adopted shall become effective when approved by the Governing Body, and such approval shall not be unreasonably withheld. Members of the Medical Staff shall be notified of revisions and shall be entitled to receive said revisions upon request.

If approval is withheld, the reasons for doing so shall be specified by the Governing Body in writing, and shall be forwarded to the Chief of Staff. The matter may be referred to the conflict management process set forth in Hospital Policy HS 0343 for management of conflicts between the Governing Body and the medical staff.

The Medical Staff Bylaws and the Governing Body Bylaws will not conflict. These bylaws may not be unilaterally amended or repealed by the Medical Staff or Governing Body.

If there is conflict between the Medical Staff Bylaws, Rules and Regulations, Policies and Procedures, the Bylaws shall prevail.

Section 7. Exclusivity

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

Section 8. Successor in Interest

These Bylaws, and privileges of individual members of the Medical Staff accorded under these Bylaws, will be binding upon the Medical Staff, and the Governing Body, except where medical staffs are being combined.

Section 9. Construction of Terms and Headings

The captions or headings in these bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these bylaws. These bylaws apply with equal force to both genders wherever either term is used.

ARTICLE XV – IMMUNITY FROM LIABILITY; CONFIDENTIALITY OF PEER REVIEW

All members of the Medical Staff, Allied Health Professionals, the Vice Chancellor for Health Sciences or designee or designee's representatives, and any other Medical center related parties shall have absolute immunity from any civil liability to the fullest extent permitted by law as follows:

(a) Such immunity shall extend to any act, communication, report, recommendation, or disclosure, with respect to any applicant, Medical Staff member or Allied Health

Professional, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility.

(b) Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activity related to but not limited to:

- Applications for appointment or clinical privileges;
- Periodic reappraisals for reappointment or clinical privileges;
- Corrective action, including summary suspension;
- Hearings and appellate reviews;
- Medical care evaluations;
- Utilization reviews; and
- Other Medical Center, department, service or committee activities related to the quality of patient care and professional conduct.

(c) The acts, communications, reports, recommendations and disclosures referred to in this Article XV may related to professional qualifications, clinical competency, character, conduct, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

(d) The consents and authorizations provided in Article III of these Bylaws for the protection of this Medical Center's Medical Staff members and Allied Health Professionals, other appropriate Medical Center officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XV.

(e) In furtherance of the foregoing, each applicant, Medical Staff member or Allied Health Professional, shall upon request of the Medical center, execute releases from liability in favor of any person or entity furnishing or releasing information concerning the application or Medical Staff status, or for any other purpose of achieving or maintaining quality patient care in this or any other health care facility.

(e) Inasmuch as effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, divisions, or committees, except in conjunction with other Medical Center, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Medical Center. If it is determined that such a breach has occurred, the MSEC may undertake such corrective action as it deems appropriate.

ARTICLE XVI – PARLIAMENTARY PROCEDURE

In the absence of specific rules, Sturgis Manual of Parliamentary Law and Procedure shall govern the rules and deliberations of this organization.

ARTICLE XVII – NON-SUBSTANTIVE CHANGES/ TECHNICAL CORRECTIONS/ CLARIFICATIONS

The MSEC shall have authority to adopt non-substantive changes to the Bylaws, Rules and Regulations, and Policies such as reorganization or renumbering, and technical corrections needed due to errors in punctuation, spelling, grammar or syntax, and/or inaccurate or missing cross-references. Such changes shall not affect the intent of the sections being changed. The MSEC may take action to implement such non-substantive changes by motion, in the same manner as any other motion before the MSEC. After approval by the MSEC, such technical corrections or clarifications shall be communicated promptly in writing to the Governing Body. Such corrections are subject to approval by the Governing Body, which approval shall not be withheld unreasonably. Following approval by the Governing Body, technical corrections will be communicated to the Medical Staff within a time that is reasonable under the circumstances (which may be when the Medical Staff is notified of the next substantive change to the Bylaws, Rules and Regulations, or Policies affected).

APPROVALS

Medical Staff Executive Committee	: May 28, 2019	_____
Active Staff	: June 30, 2019	
Governing Body	: June 30, 2019	_____