Medical Staff Bylaws
UC San Diego Health

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PREAMBLE

These Bylaws are adopted in recognition of the University of California San Diego Health Medical Staff's responsibility for overseeing, on behalf of the Governing Body, the quality of patient care, treatment, and services provided by Practitioners at the University of California San Diego Health ("UCSDH").

The Medical Staff acknowledges that the Governing Body must act to protect the quality of medical care provided to patients and the competency of the Medical Staff. The Regents have delegated authority for governance of UCSDH to the Chancellor of the University of California San Diego. The Chancellor has delegated this authority further to the Vice Chancellor for Health Sciences. The Vice Chancellor further delegates governing body responsibilities to the Executive Governing Body, which serves as the Governing Body of UCSDH for purposes of Medicare Conditions of Participation for Hospitals, Title 22 of the California Code of Regulations, and The Joint Commission governance standards.

These Bylaws apply to all UC San Diego Health facilities licensed under the general acute care hospital license. These Bylaws also apply to any UC San Diego Health facilities as directed by the Governing Body.

The Bylaws address the Medical Staff's rights and responsibilities with respect to self-governance, in conformity with federal and state regulatory requirements, The Joint Commission accreditation standards, and the guiding principles set forth in these Bylaws. The Medical Staff is subject to the ultimate authority of The Regents of the University of California. In particular, these Bylaws address the Medical Staff's responsibility to establish criteria and standards for Membership and Privileges, and mechanisms to enforce those criteria and standards. The Medical Staff establishes clinical criteria and standards to oversee and manage peer review activities, quality assurance, utilization review, and other Medical Staff activities, and the Bylaws establish a process for periodic meetings of the Medical Staff, its committees, and Services. The self-governing Bylaws address the standards and procedures for selecting and removing Medical Staff Officers; the respective rights and responsibilities and accountabilities of the Medical Staff and the Executive Governing Body; and the manner in which the Medical Staff may amend or supplement these Bylaws.

DEFINITIONS

Academic Medical Center refers to the UCSDH Hillcrest and Jacobs campuses, whose primary mission is to advance and promote academic teaching and instruction.

Advanced Practice Professional (APP) means an individual, other than a licensed physician (M.D. or D.O.), dentist, clinical psychologist, or podiatrist, who exercises independent judgment within the areas of their professional competence and the limits established by the Executive Governing Body, the Medical Staff, and the applicable state practice act, who is qualified to render direct or indirect medical, dental, or podiatric care under the supervision or direction of a Member possessing Privileges to provide such care at UCSDH in conformity with the Bylaws, Policies, Plans, and Rules. APPs are not eligible for Membership.

Associate Chief Medical Officer for Medical Staff Affairs (ACMO) means the individual appointed by the Chief Medical Officer and CEO to serve as a liaison between the Medical Staff and Health System Administration.

Bylaws or Medical Staff Bylaws means the Bylaws as approved by the Executive Governing Body, and as may be amended from time to time.

Care as it relates to qualification for Staff Categories, is defined as documentation of any admission (which must include the preparation of a history and physical report), evaluation and/or consultation (inpatient, observation, ambulatory/outpatient, or in the Emergency Department), procedure (inpatient or outpatient), or interpretation of diagnostic tests and procedures performed within General Acute Care Hospital (GACH) licensed space at UCSDH. It shall not include referrals for care, or diagnostic or laboratory tests. Care may also include other aspects of patient care as defined by Medical Staff Policies and/or Privilege forms.

Chief Executive Officer (CEO) means the Chief Executive Officer, University of California San Diego Health, who has been appointed by the Vice Chancellor on the recommendation of the Chancellor. The CEO is responsible for the overall management of UCSDH. The CEO also serves as Co-Chair of the Executive Governing Body and reports to the Vice Chancellor Health Sciences.

Chief Medical Officer (CMO) means the individual appointed by the CEO to serve as a liaison between the Medical Staff and Health System Administration.

Clinical Privileges or Privileges means the permission granted by the Executive Governing Body to a Practitioner to provide specific patient care services within General Acute Care Hospital (GACH) licensed space at UCSDH, based on the individual Practitioner's license, education, training, experience, competence, health status, and professional judgment.

Clinical Psychologist means a provider of clinical psychology services who completed an APA approved internship program, received a Ph.D. or Psy.D. in clinical psychology from an APA approved college or university program, and has a valid license to practice clinical psychology by the California Board of Psychology and/or Division of Allied Health Professions of the Medical Board of California. Clinical Psychologists are Members and may admit patients if granted the specific Privilege to admit.

Clinical Service or Service are the different services of the Medical Staff. The Clinical Services will be determined by the Medical Staff.

Conflict of Interest means a personal, professional, or financial interest, or conflicting fiduciary obligation on the part of a Practitioner or their immediate family member (including a spouse, domestic partner, child or parent) that may impact, as a practical matter, the Practitioner's ability to act in the best interests of the Medical Staff without regard to the individual's private or personal interest, or creates the impression of such a conflict. A Conflict of Interest depends on the situation and not on the character of the individual.

Date of Receipt means the date any Notice, Special Notice, or other communication was delivered personally; or if such Notice, Special Notice, or communication was sent by mail, it shall mean seventy two (72) hours after the Notice, Special Notice, or communication was deposited, postage prepaid, in the United States mail; or if such Notice, Special Notice, or communication was sent by e-mail, it shall mean following notification (*e.g*. read receipt) that the e-mail was received. *[See also, the definitions of **Notice**.]*

Day is defined as a calendar day, not including weekend days and National Holidays, unless otherwise specified herein.

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

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

Divisions are the different areas of expertise and/or specialties within the Clinical Services of the Medical Staff. The Divisions will be determined by the Medical Staff upon recommendation of the Service.

Division Chief means the Member of the Active Staff who is responsible for the clinical work of a Division.

East Campus Chief Medical Officer (EC CMO) means the individual appointed by the Chief Executive Officer to serve as a liaison between the Medical Staff, the CMO's Office, and East Campus Medical Center.

East Campus Medical Center is the UCSDH hospital located in East County, San Diego. Its primary mission is to serve the greater San Diego community as a community hospital.

East Campus Medical Staff Council (ECMSC) is a physician-lead leadership committee that reports to the MSEC.

East Campus Medical Staff Council Chair (ECMSC Chair) is the Chair of the East Campus Medical Staff Council.

East Campus Medical Staff Service Representative means the Member of the Active Staff who

is responsible for the clinical work of a specific practice area or specialty at East Campus Medical Center. The Representative shall participate on the ECMSC.

Ex Officio means service by virtue of office or position held. An *Ex Officio* appointment is without vote unless specified otherwise.

Executive Governing Body (EGB) means the Governing Body of UCSDH for purposes of Medicare Conditions of Participation for Hospitals, Title 22 of the California Code of Regulations, and The Joint Commission governance standards. As used throughout these Bylaws, the Executive Governing Body shall also refer to the Executive Committee of the Governing Body of UCSDH, who, as set forth in the Executive Committee Charter, has been delegated executive oversight authority by the Executive Governing Body.

Focused Professional Practice Evaluation (FPPE) is the process used to evaluate, for a time-limited period, a specific Practitioner's clinical performance and/or professionalism. FPPE may include an evaluation of a Practitioner's quality of care, patient safety, and/or unprofessional behavior.

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

Health Record refers to the official written medical or health record and/or any patient specific information stored electronically or in paper format, for purposes of patient care.

Health System Administration means the Executive leadership of UCSDH.

House Staff means a physician in-training who is participating in a UC San Diego approved residency or fellowship program and who is not a Member.

In Good Standing means that a Member is not currently under suspension, or serving with any limitation of their Membership, Privileges, voting, or other prerogatives imposed by operation of the Bylaws.

Investigation means a process formally commenced by the MSEC to determine the validity, if any, of a concern or complaint raised against a Practitioner or Member. An Investigation is ongoing until either formal action is taken or the Investigation is closed. An Investigation does not include routine or general monitoring, OPPE, or activities of the Physician Well-Being Committee. A Practitioner subject to an Investigation must be notified.

Joint Conference Committee is an *ad hoc* committee of the Medical Staff. The Committee can be constituted and convened in case of conflict between the Medical Staff and the Executive Governing Body. The Joint Conference Committee can also be convened if there is a disagreement between the MSEC and ECMSC.

Leave of Absence or Leave is an excused period of time away from a Practitioner's clinical duties. The reasons for such a leave include, but are not limited to, a sabbatical, to care for a family member with a serious health condition, a leave for childbirth and/or parental bonding, and/or a leave to address any issue related to the Practitioner's physical or mental health (including related to their ability to care for patients safely and competently). During the period of the Leave, the Member shall not exercise privileges at UCSDH, and membership rights and responsibilities shall be inactive; however, the obligation to pay dues and assessments, if any, shall continue unless waived by the MSEC.

Medical Disciplinary Cause or Reason means a basis for corrective action involving that aspect of a Practitioner's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care, as defined in California Business & Professions Code, Section 805.

Medical Staff means the organizational component of UCSDH that includes all licensed Physicians, Dentists, Clinical Psychologists, and Podiatrists, who meet the eligibility requirements for Membership outlined in these Bylaws and may be Privileged to attend to patients at UCSDH. The term Medical Staff shall also be deemed to refer to the "organized medical staff" as that term may be used in various laws and regulations, and in any applicable standards of The Joint Commission.

Medical Staff Administration means the department that provides support to the Medical Staff and processes all initial and reappointment applications for Membership, and credentialing and Privileging for Members. Medical Staff Administration also processes all initial and reappointment applications for credentialing and Privileging of APPs.

Medical Staff Executive Committee or MSEC means the Executive Committee of the Medical Staff.

Medical Staff Service Chief (MSSC) means the Member of the Active Staff who is responsible for the clinical work of the Service.

Member means any individual who has been appointed to the Medical Staff.

National Practitioner Data Bank or NPDB is a web-based repository of reports containing information on certain adverse actions related to health care practitioners, providers, and suppliers. Pursuant to Title IV of the Health Care Quality Improvement Act of 1986 (HCQIA), Public Law 99-660, the Medical Staff is required to report certain actions to the NPDB.

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

Ongoing Professional Practice Evaluation (OPPE) is the routine monitoring of the current competency of Practitioners who have been granted Privileges. As part of OPPE, data is collected for the purpose of assessing each Practitioner's clinical competence and professional behavior.

Past President of Medical Staff means the individual who previously served as President of Medical Staff and who succeeds to the office of the Past President of Medical Staff after their term as President of Medical Staff.

President of Medical Staff (POMS) means the chief officer of the Medical Staff elected by the Members to act on their behalf.

Plan means a Medical Staff guideline, practice, or protocol that can be amended from time to time by the applicable committee and upon approval by the MSEC and notification to the Executive Governing Body.

Peer Review means the process employed to review the basic qualifications, Privileges, medical outcomes, or professional conduct of Practitioners in order to assess and improve the quality of care rendered by Practitioners and, when appropriate, to determine whether the Practitioners may practice or continue to practice at UCSDH, and, if so, to determine the parameters of that practice.

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

Podiatrist means an individual with a D.P.M., degree or its equivalent and a valid license to practice podiatry in the State of California.

Policy means a Medical Staff guideline, practice, plan, or protocol that can be amended from time to time by the applicable committee and upon approval by the MSEC and notification to the Executive Governing Body.

Practitioner means, unless otherwise expressly limited, any currently licensed Physician, Dentist, Clinical Psychologist, Podiatrist, or APP.

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

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

Proctoring refers to the method by which Practitioners are evaluated for clinical competence in the areas in which they have Privileges or are applying for Privileges.

Officers of the Medical Staff or Officer refers to the President of Medical Staff, Vice President of Medical Staff, and Past President of Medical Staff.

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

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

School of Medicine means the School of Medicine at the University of California San Diego.

School of Medicine Department Chair or Department Chair means the individual designated by the Dean of the School of Medicine as the head of an academic department in the School of Medicine.

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

Standardized Procedures means the written policies and protocols formulated by the Interdisciplinary Practice Committee that is accountable to the MSEC as defined in the Bylaws, and/or Medical Staff Rules, Plan, and/or Policies, and approved by an authorized administrator. The standardized procedures delineate the conditions pursuant to which an APP may render specific patient care functions that otherwise would be considered medical functions, including but not limited to, specifying any required training or supervision.

Teaching Affiliation means a Practitioner who holds a teaching role or similar affiliation with UCSDH. A teaching role includes Practitioners in MSP roles with teaching responsibilities, those who practice at Jacobs and/or Hillcrest pursuant to an agreement for coverage and/or services, and those in Faculty positions (including Voluntary Clinical Faculty).

Telemedicine is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

UCOP means The University of California Office of the President.

UCSD means the University of California San Diego.

UCSD Health or UCSDH means all UC San Diego Health facilities licensed under the general acute care hospital license. UCSDH also includes any UCSDH facilities identified by the Governing Body to be under the purview of the Medical Staff.

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

Vice President of Medical Staff means the individual elected by the Medical Staff, who shall become the President of Medical Staff after the current President of Medical Staff's term concludes or is otherwise unable to fill the position.

ARTICLE 1
RESPONSIBILITIES OF THE MEDICAL STAFF

1.1 Overview

The Medical Staff's responsibilities are:

A. To provide a system for self-governance and accountability to the Executive Governing Body for the quality of patient care at UCSDH provided by its Members, by ensuring and supporting the following:

1) A valid and reliable on-going process to review and evaluate the quality of patient care provided by Members consistent with the generally recognized standards of the profession;

2) A credentialing program, including mechanisms of appointment, reappointment, and/or assigning of Privileges to be exercised, consistent with requirements as set by the Medical Staff and subject to the Executive Governing Body approval;

3) A continuing education program based, at least in part, on needs demonstrated through a medical care evaluation program; and

4) A utilization review program to provide for the appropriate use of all clinical services.

B. To recommend to the Executive Governing Body action with respect to appointments, reappointments, staff category, Privileges, and corrective action;

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

D. To establish and amend, from time to time as needed, the Bylaws, Plans, Policies, and Rules for the effective performance of Medical Staff responsibilities, as further described in these Bylaws;

E. As appropriate, to assess Medical Staff funds and fees, and utilize Medical Staff funds and fees for the purposes of the Medical Staff;

F. To exercise the Medical Staff's rights and responsibilities in a manner that is consistent with UCSDH's mission and legal responsibilities; and

G. To conduct peer review activities and patient safety processes to measure, assess, and improve peer performance at UCSDH and to prevent, detect, and resolve actual and potential problems through routine monitoring, education, and counseling, but with the recognition that, when circumstances warrant, the Medical Staff is responsible to embark on informal corrective measure and/or formal corrective action as necessary to achieve and assure quality of care and patient safety.

ARTICLE 2
QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP AND PRIVILEGES

2.1 Qualifications for Membership

To be eligible to apply for initial appointment or reappointment to the Medical Staff, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform any Privileges requested, in accordance with state law, including scope of practice laws.

A. Membership and Privileges shall be extended only to individuals who are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Bylaws and the Credentials Policy.

B. An applicant must demonstrate and provide adequate information, as determined by the Medical Staff, to meet all the basic qualifications set forth in this Article in order to have an application for Membership considered and accepted for review. The applicant must:

1) Qualify under California law to practice as follows:

a) Physicians (M.D. or D.O.) must hold a current, unrestricted certificate or license (without probation, conditions, or restrictions) to practice medicine in the State of California or are otherwise authorized to practice pursuant to California law, or hold a valid registration to practice medicine issued by the Medical Board of California pursuant to Business & Professions Code Section 2111, 2113, or 2168.

b) Active duty military physicians (M.D. or D.O.) who hold a valid unrestricted license (without probation, conditions, or restrictions) to practice in any state may apply so long as the Privileges they are requesting are pursuant to an active agreement between UCSDH and the Department of Defense.

c) Dentists must have an unrestricted license (without probation, conditions, or restrictions) to practice dentistry by the California Board of Dental Examiners.

d) Podiatrists must have an unrestricted license (without probation, conditions, or restrictions) to practice podiatry by the California Board of Podiatric Medicine.

e) Clinical Psychologists must have an unrestricted license (without probation, conditions, or restrictions) to practice clinical psychology by the California Board of Psychology and/or Division of Allied Health Professions of the Medical Board of California.

2) Provide accurate information, to the satisfaction of the Medical Staff, to assess initial or continued qualifications for Membership and Privileges, which include all of the following:

a) Validation of the applicant's current professional license to practice in any state or other professional registration/license;

b) Be a member, employee, or subcontractor of the group or person that holds the contract, if requesting Privileges only in settings operated under an exclusive contract;

c) Adhere to the ethics of their respective profession;

d) Provide current information regarding federal or state criminal charges and convictions. Notification must occur within fifteen (15) calendar days of the charges. Failure to provide such notification is cause to discontinue processing an application for appointment or reappointment, or if warranted, automatic suspension, termination, or corrective action by the MSEC if previously granted;

e) Agree to work cooperatively and harmoniously with others and comply with all policies, rules, and plans of the Medical Staff, and any UCSDH, UCSD, and UC policies;

f) Agree to comply with the Health Insurance Portability and Accountability Act ("HIPAA") and California Confidentiality of Medical Information Act ("CMIA"), and otherwise keep confidential, as required by law, all protected patient information, medical information, or medical records; and

g) Agree to participate in and properly discharge all responsibilities of the Medical Staff, including participation in peer review activities, in a confidential manner.

Additional details regarding Membership, categories of the Medical Staff, and procedures for appointment to the Medical Staff are set forth in the Credentials Policy.

2.2 Additional Membership Qualifications for Applicants to the Active, Courtesy, Consulting, Active TL Staff, and UCSD Practicing Physician with Clinical Privileges

A. An applicant seeking Membership in the Active, Courtesy, Consulting, Active TL, or UCSD Practicing Physician Staff category (if requesting Clinical Privileges) must provide evidence that they meet the following qualifications set forth in this Section in order to have an application for Membership considered and accepted for review. The applicant must provide accurate information, to the satisfaction of the Medical Staff, to assess the following qualifications:

1) DEA registration, if applicable to the Member's practice, (DEA Certificate must include schedules 2, 2N, 3, 3N, 4 and 5) issued with a State of California local address;

2) Proof of continuous professional liability insurance with minimum limits as required by the EGB, to include an explanation of endorsements and any limitations;

3) Be located within sufficient proximity to the Member's primary location of practice in order to provide timely response to call and care to their patients;

4) If not contractually affiliated with UCSDH or a member of the UCSD faculty, provide the contact information of an Active Staff Member with similar clinical privileges who will provide coverage for the Practitioner;

5) Regardless of the applicant's status, timely and sufficiently respond to any and all questions, inquiries, and requests to document their adequate experience, education, and training in the requested Privileges; current professional competence; adherence to professional ethics; and no health problems exist that could affect their ability to perform the Privileges requested;

6) Adequate documentation of background, education, experience, training, and current competence sufficient to assure, in the judgment of the appointing authorities, that any patient admitted to or treated at UCSDH shall be treated with quality professional care and skill;

7) Meet all requirements on the Privilege Form for any Privileges requested;

8) Except as otherwise provided in these Bylaws and the Credentials Policy, be certified or currently qualified to take the board certification examination of a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Podiatric Medicine, the American Board of General Dentistry, the American Board of Pediatric Dentistry, The Royal College of Physicians and Surgeons of Canada or a board or association with equivalent requirements approved by the MSEC in the specialty that the Member will practice at UCSDH. This requirement is applicable as follows:

   (i) For applicants to the Medical Staff after January 1, 2021, successfully attain and maintain board certification as outlined in this Section, in the area(s) in which Privileges are requested within seven (7) years of completion of final training program.

   (ii) For Members who joined the Medical Staff between September 1, 2011 and December 31, 2020, successfully attain and maintain board certification as outlined in this Section, in the area(s) in which

Privileges are requested within five (5) years of initial appointment.

(iii) The requirement for board certification does not apply to the following:

a. Applicants and/or Members who are internationally trained and as a result, do not otherwise qualify for Board Certification. This includes Members practicing in California pursuant to Business and Professions Code Section 2111, 2113, and 2168. However, if the Applicant and/or Member's education and/or training does not preclude them from obtaining board certification from a board listed in this section, then this exception does not apply; and

b. Podiatrists or clinical psychologists.

(iv) These minimum requirements do not preclude stricter requirements for specified privileges at the discretion of the Service. Any such additional requirement(s) must be approved by the Service, Credentials Committee, MSEC, and EGB.

2.3 Qualifications for Clinical Privileges

Subject to the approval of the MSEC and Executive Governing Body, each Service will be responsible for developing criteria for granting specific Privileges at each location: Academic Medical Center and East Campus Medical Center. These criteria endeavor to assure uniform quality of patient care, treatment, and services at each location. The Practitioner must also meet all requirements on the Privilege Form to be eligible to apply for Clinical Privileges.

Initial requests for Privileges shall be evaluated, as applicable, on the basis of the applicant's license, education, training, experience, demonstrated professional competence, judgment and clinical performance, and health status. Initial Privilege determinations shall also be based on pertinent information concerning clinical and professional performance obtained from other sources, especially other institutions and health care settings where an applicant exercised or currently exercises privileges. Applicants must meet all requirements on the Privilege Form for any Privilege requested.

When renewing Privileges, a review of the individual's performance within UCSDH shall be completed. Peer recommendations shall be obtained and include written information regarding the individual's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.

There will be a determination by the applicable Service and/or Division as to whether a sufficient number of procedures each year are performed to develop and maintain the applicant's skills and knowledge, and compliance with any specific criteria. The Medical

Staff shall conduct adequate privileging activities, including but not limited to queries with the NPDB, the Medical Board of California, and other relevant agencies.

For Privileges at the Academic Medical Center, a Teaching Affiliation is required. For APPs practicing at the Academic Medical Center, they or their supervising physician must have a Teaching Affiliation. Details regarding Privileging and re-Privileging are set forth in the Credentials Policy.

2.4 Advanced Practice Professionals (APPs) Qualifications for Clinical Privileges

APPs may render services within the scope of their licensure and within the limitations and conditions set by the Interdisciplinary Practices Committee, the Credentials Committee, and the MSEC. APPs may participate in the direct management of a patient's care either under the supervision and direction of a Member and/or in accordance with state law. Individuals classified as APPs shall be assigned to a Service for supervision and performance evaluation purposes and shall be subject to all applicable Service, Medical Staff, and UCSDH Policies, Rules, and Plans. Attendance at and participation in Service meetings shall be as determined by the appropriate Medical Staff Service Chief and by law.

2.5 Waiver of Qualifications

Any qualification requirements in this Article or any other Article of the Bylaws not required by law or governmental regulation may be waived at the discretion of the Executive Governing Body upon recommendation of the MSEC, when there is a determination that such waiver will serve the best interests of the patients of UCSDH.

2.6 Temporary Clinical Privileges

Temporary Privileges may be granted by the CEO or authorized designee, upon recommendation of the Service Chief or their designee, the Credentials Committee Chair, and the President of Medical Staff or their designee, for a limited time not to exceed a period of one hundred twenty (120) consecutive calendar days in the following circumstances:

A. To fulfill an important patient care need if the Practitioner has the necessary skills to provide care to a patient that Members currently Privileged do not possess, to assist in a surgical procedure, or is serving as locum tenens for a Member following verification of current licensure and current competence; or

B. When an applicant seeking new privileges has submitted a complete application that raises no concerns and is awaiting review and approval of the MSEC and Executive Governing Body after verification of the following:

   1) Current licensure under California law;

   2) Current professional liability insurance coverage;

   3) Relevant training and/or experience for the Privileges requested;

4) Current competence in the Privileges requested;

5) Ability to perform the Privileges requested;

6) A query and evaluation of information obtained from the NPDB;

7) No current or previously successful challenge to licensure or registration;

8) No current or prior involuntary restriction or termination of Medical Staff membership at another organization;

9) No current or prior involuntary limitation, reduction, denial, or loss of Privileges at another organization;

10) No current or prior involuntary limitation, reduction, denial, or loss of employment at another organization; and

11) Other criteria listed in the Credential Policy regarding initial appointments.

Details of Temporary Clinical Privileging are outlined in the Credentials Policy.

2.7 Disaster Privileges

When the Disaster Plan has been implemented and UCSDH is unable to handle the immediate patient needs, the CEO or their designee may use a modified credentialing process to grant Disaster Privileges to volunteer licensed independent practitioners after verification of the volunteer's identity and licensure. The details of Disaster Privileging are outlined in the Credentials Policy.

ARTICLE 3
CATEGORIES OF THE MEDICAL STAFF

3.1 Categories

Each Member shall be assigned to a Medical Staff category based upon the qualifications outlined below. The Members of each Medical Staff category shall have the prerogatives and shall carry out the duties defined in the Bylaws. Action may be initiated to change a Medical Staff category or to terminate the Membership of any Member who fails to meet the qualifications or fulfill the duties described herein. There are no grounds for the hearing rights set forth in Article 10 when changing a category or reassigning a category due to UCSDH or Service need that is unrelated to a Medical Disciplinary Cause or Reason.

The Categories of the Medical Staff are:

Active
Active Time Limited ("Active TL")
Consulting
Courtesy
Honorary
Refer and Follow
UCSD Practicing Physician

A category shall be assigned for each location in which the Member holds Privileges. The requirements for a category may be met by combining care provided at each location where the Member holds privileges. Members may also request a specific category at a specific location (*e.g*. Refer and Follow at the Academic Medical Center) if they do not otherwise qualify for privileges at that location.

3.2 Active Staff

Active Staff have Privileges and are involved in the Care of at least twenty (20) or more cases every two (2) years. Care is defined as any documentation of any admission (which must include the preparation of a history and physical report), evaluation and/or consultation (inpatient, observation, outpatient/ambulatory, or in the Emergency Department), procedure (inpatient or outpatient), or interpretation of diagnostic tests and procedures within GACH licensed space at UCSDH. It shall not include referrals for diagnostic or laboratory tests. Care may also include other aspects of patient care as defined by Medical Staff Policies and/or Privilege forms. Duties and responsibilities:

A. Active Staff are permitted to admit, treat, consult, and refer inpatients and outpatients;

B. Active Staff may be assigned to the Emergency Department call list;

C. Active Staff are permitted to serve as Officers;

D. Active Staff are permitted to serve on Medical Staff committees and may serve as Chairs of Medical Staff committees;

E. Active Staff are encouraged to attend Medical Staff meetings;

F. Active Staff are eligible to vote on matters affecting the Medical Staff and the Service of which they are a member; and

G. Active Staff shall pay application fees as required by the Medical Staff.

Members of the Active Staff may be transferred to a different category upon failure to meet the number of required cases or applicable Service's criteria for continuance on the Active Staff.

3.3 Courtesy Staff

Courtesy Staff have Privileges .and are involved in the Care of between two (2) and nineteen (19) cases every two (2) years. Care is defined as any documentation of any admission (which must include the preparation of a history and physical report), evaluation and/or consultation (inpatient, observation, outpatient/ambulatory, or in the Emergency Department), procedure (inpatient or outpatient), or interpretation of diagnostic tests and procedures within GACH licensed space at UCSDH. It shall not include referrals for diagnostic or laboratory tests. Care may also include other aspects of patient care as defined by Medical Staff Policies and/or Privilege forms. Duties and responsibilities:

A. Courtesy Staff are permitted to admit, treat, consult, and refer inpatients and outpatients;

B. Courtesy Staff may be assigned to the Emergency Department call list;

C. Courtesy Staff are not eligible to serve as Officers;

D. Courtesy Staff are permitted to serve on Medical Staff committees. Courtesy Staff are not eligible to serve as Chairs of Medical Staff committees unless expressly set forth in the Organizational Policy;

E. Courtesy Staff are encouraged to attend Medical Staff meetings;

F. Courtesy Staff are not eligible to vote on matters of the Medical Staff or the Service of which the individual is a Member; and

G. Courtesy Staff shall pay application fees as required by the Medical Staff.

3.4 Consulting Staff

Consulting Staff shall consist of Members who meet the general provisions for Membership in accordance with these Bylaws, and who meet the following criteria: (a) have an Active Staff (or the equivalent) appointment at another CMS accredited hospital; and (b) provide coverage at UCSDH on behalf of a UCSDH Service. In order to be considered for this category, Consulting Staff members must provide (a) evidence of satisfactory clinical performance at a CMS accredited hospital and ability to appropriately exercise privileges in such form as may be requested; and (b) documentation evidencing the need for Practitioner's services based on the Service's coverage model. If a Member fails to provide the requisite documentation they will be deemed ineligible to apply for this category. Duties and responsibilities:

A. Consulting Staff are only permitted to treat, consult, and refer inpatients and outpatients;

B. Consulting Staff are not permitted to admit inpatients;

C. Consulting Staff are not assigned to the Emergency Department call list;

D. Consulting Staff are not eligible to serve as Officers;

E. Consulting Staff are permitted to serve on Medical Staff committees. Consulting Staff are not eligible to serve as Chairs of Medical Staff committees unless expressly set forth in the Organizational Policy;

F. Consulting Staff are encouraged to attend Medical Staff meetings;

G. Consulting Staff are not eligible to vote on matters of the Medical Staff or the Service of which the individual is a Member; and

H. Consulting Staff shall pay application fees as required by the Medical Staff.

3.5 UCSD Practicing Physician Staff

The UCSD Practice Physician category shall consist of Physicians who hold faculty appointments in the UCSD School of Medicine, are employed by UCSD, are members of the UCSD Physician Group, and/or who regularly care for patients in outpatient UCSDH facilities (non GACH licensed space). All such physicians shall be Members of the Medical Staff, and will be assigned to a Clinical Service for the purpose participating in that Service's peer review, quality assurance, and performance improvement activities.

Members assigned to this Category may, but are not required to have Clinical Privileges. For Members in the UCSD Practicing Physician Staff category to have Clinical Privileges, they must be involved in the Care of between two (2) and nineteen (19) cases every two (2) years. Care is defined as any documentation of any admission (which must include the preparation of a history and physical report), evaluation and/or consultation (inpatient, observation, outpatient/ambulatory, or in the Emergency Department), procedure (inpatient or outpatient), or interpretation of diagnostic tests and procedures within GACH licensed space at UCSDH. It shall not include referrals for diagnostic or laboratory tests. Care may also include other aspects of patient care as defined by Medical Staff Policies and/or Privilege forms.

The duties and responsibilities of the UCSD Practicing Physician Staff Category are as follows:

A. UCSD Practicing Physician Staff are permitted to serve on Medical Staff committees. They are not eligible to serve as Chairs of Medical Staff committees unless expressly set forth in the Organizational Policy;

B. UCSD Practicing Physician Staff are not eligible to serve as Officers;

C. UCSD Practicing Physician Staff are encouraged to attend Medical Staff meetings;

D. Unless expressly set forth in these Bylaws, UCSD Practicing Physician Staff are not eligible to vote on matters of the Medical Staff or the Medical Staff Service of which the individual is a Member; and

E. UCSD Practicing Physician Staff shall pay application fees as required by the Medical Staff.

UCSD Practicing Physician Members with Privileges shall also have the following duties and responsibilities:

A. UCSD Practicing Physician Staff with Clinical Privileges are permitted to admit, treat, consult, and refer inpatients and outpatients; and

B. UCSD Practicing Physician Staff with Clinical Privileges may be assigned to the Emergency Department call list.

3.6 Honorary Staff

Honorary Staff shall consist of Members who are clinically inactive (retired with no regular office or office hours for seeing patients) and who are recommended for appointment to the Honorary Staff by their Service Chief and the MSEC on the basis of distinguished service to UCSDH. Prerogatives and Responsibilities:

A. Honorary Staff are not eligible to admit, consult, or refer inpatients or outpatients, or to exercise Privileges;

B. Honorary Staff are not permitted to take Emergency Department call;

C. Honorary Staff are not eligible to serve as Officers;

D. Honorary Staff are permitted to serve on Medical Staff committees. Honorary Staff are not eligible to serve as Chairs of Medical Staff committees unless expressly set forth in the Organizational Policy;

E. Honorary Staff are encouraged to attend Medical Staff meetings;

F. Honorary Staff are not eligible to vote on matters affecting the Medical Staff or the Service to which they are associated; and

G. After a Practitioner is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the Practitioner to submit a reappointment application or pay application fees.

3.7 Refer and Follow Staff

The Refer and Follow Staff shall consist of those Members who desire to be associated with, but who do not intend to establish a practice at UCSDH. The primary purpose of the Refer and Follow Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these Members to access UCSDH services for their patients by referral of patients to Active Staff or Courtesy Staff Members for admission and Care. Prerogatives and Responsibilities:

A. Refer and Follow Staff are encouraged to visit their hospitalized patients and review their health records but may not admit patients, attend to patients, or exercise any clinical privileges. They may not write orders or progress notes;

B. Refer and Follow Staff are not eligible to serve as Officers;

C. Refer and Follow Staff are not eligible to serve on Medical Staff Committees or as Chairs of Medical Staff Committees;

D. Refer and Follow Staff are encouraged to attend Medical Staff meetings;

E. Refer and Follow Staff are not eligible to vote on matters of the Medical Staff or the Service of which the individual is a Member; and

F. Refer and Follow Staff shall pay application fees as required by the Medical Staff.

3.8 Active Time Limited Staff ("Active TL")

Active TL Medical Staff, also known as Active Time Limited Staff, shall consist of Members who are House Staff participating in a training program for subspecialty training. Active TL Staff are privileged in the same manner as other applicants to the Medical Staff. Qualifications for Active TL Staff are determined by the residency director and/or the

appropriate Service Chief, the Credentials Committee, the MSEC, and the EGB. Prerogatives and Responsibilities:

A. Active TL Staff are eligible to admit, treat, consult, or refer inpatients and outpatients;

B. Active TL Staff may be assigned to the Emergency Department call list;

C. Active TL Staff are not eligible to serve as Officers;

D. Active TL Staff are not eligible to serve on Medical Staff Committees or as Chairs of Medical Staff Committees;

E. Active TL Staff are encouraged to attend Medical Staff meetings;

F. Active TL Staff are not eligible to vote on matters of the Medical Staff or the Service of which the individual is a Member; and

G. Active TL Staff shall pay application fees as required by the Medical Staff.

ARTICLE 4
APPOINTMENT AND REAPPOINTMENT

4.1 Process for Credentialing and Privileging, Appointment, and Reappointment to the Medical Staff

Except as otherwise provided in the Bylaws or the Credentials Policy, every Member providing direct clinical Services at UCSDH shall be entitled to exercise only those specific Privileges approved for them by the MSEC and EGB. Specific procedures related to privileging are more fully set forth in the Credentials Policy of the Medical Staff.

A. Applications for appointment and reappointment, requests for Privileges, and requests for renewal of Privileges are forwarded to the applicable Medical Staff Division Chief to review the applicant's education, training, and experience. If there is no Division Chief, the file shall be forwarded directly to the Service Chief.

B. Following this first review or if there is no Division Chief, the Service Chief or designee will subsequently review of the applicant's education, training, and experience. The Service Chief may conduct an interview with the applicant at the Service Chief's discretion. The Service Chief or designee prepares a report regarding the applicant's qualifications for Membership and the requested Privileges, and if appointment/reappointment is recommended, as to Membership category, Service affiliation, Privileges to be granted, and any special conditions to be attached. The Service Chief may also request that the MSEC defer action on the application. Any request to defer action must be in writing and must specify the reason for the deferral and the amount of time requested. If a recommendation is made to deny appointment, reappointment, or Privileges, a written report justifying the Service Chief's conclusions must accompany the recommendation.

C. The Credentials Committee reviews the Service Chief's or designee's report, the application, and all supporting materials, and makes a recommendation. The Credentials Committee may elect to interview the applicant and seek additional information. As soon as practicable, the Credentials Committee shall transmit to the MSEC a written report and its recommendations as to appointment and, if appointment/reappointment is recommended, as to membership category, Service affiliation, Privileges to be granted, and any special conditions to be attached to the appointment/reappointment. The Committee may also recommend that the MSEC defer action on the application. Any request to defer action must be in writing and must specify the reason for the deferral and the amount of time requested. If a recommendation is made to deny appointment, reappointment, or Privileges, a written report justifying the Committee's conclusions must accompany the recommendation.

D. The MSEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee and/or Service Chief for further review, or state specific reasons for disagreement with the recommendation of the

Credentials Committee and/or Service Chief. If the recommendation of the MSEC is to grant Membership and/or Privileges, it will be forwarded to the EGB for final action. If the recommendation of the MSEC is unfavorable, the Practitioner will be notified of the decision and the right to request a hearing, if applicable.

E. Documentation of each Practitioner's current Privileges at each location shall be available electronically through Medical Staff Administration.

4.2 Process for Credentialing and Privileging APPs

Except as otherwise provided in the Bylaws or APP Policy, every APP providing direct clinical services at UCSDH shall be entitled to exercise only those specific Privileges approved for them by the MSEC and EGB. Specific procedures related to privileging for APPs are more fully set forth in the APP Policy of the Medical Staff.

A. Requests for initial or renewal of Privileges for APPs are forwarded to the applicable are forwarded to the applicable Medical Staff Division Chief. The review shall include evaluation of the applicant's education, training, and experience.

B. Following this first review or if there is no Division Chief, the Service Chief or designee will subsequently review of the applicant's education, training, and experience. The Service Chief may conduct a personal interview with the applicant at the Chief's discretion. The Service Chief or their designee prepares a report regarding the applicant's qualifications for the requested Privileges, and if Privileges are recommended, as to Service affiliation, Privileges to be granted, and any special conditions to be attached. The Service Chief may also request that the MSEC defer action on the request. Any request to defer action must be in writing and must specify the reason for the deferral and the amount of time requested. If a recommendation is made to deny the requested Privileges, a written report justifying the Service Chief's conclusions must accompany the recommendation. The report is forwarded to the Interdisciplinary Practices Committee (IPC).

C. The IPC reviews the Service Chief's or designee's report, the application, and all supporting materials and makes a recommendation. The IPC may also conduct a personal interview with the applicant. The IPC prepares a report regarding the applicant's qualifications for the requested Privileges, and if Privileges are recommended, as to Service affiliation, Privileges to be granted, and any special conditions to be attached. The IPC may also request that the MSEC defer action on the request. Any request to defer action must be in writing and must specify the reason for the deferral and the amount of time requested. If a recommendation is made to deny the requested Privileges, a written report justifying the IPC's conclusions must accompany the recommendation. The IPC's written recommendation is forwarded, along with the Service Chief's or designee's report, to the Credentials Committee for review and recommendations.

D. The Credentials Committee reviews the Service Chief or designee's report, the IPC report, the application, and all supporting materials and makes a recommendation. The Credentials Committee may conduct a personal interview with the applicant. The Credentials Committee prepares a report regarding the applicant's qualifications for the requested Privileges, and if Privileges are recommended, as to Service affiliation, Privileges to be granted, and any special conditions to be attached. The Credentials Committee may also request that the MSEC defer action on the request. Any request to defer action must be in writing and must specify the reason for the deferral and the amount of time requested. If a recommendation is made to deny the requested Privileges, a written report justifying the Credentials Committee's conclusions must accompany the recommendation. The written recommendation of the Credentials Committee is forwarded, along with the Medical Staff Service Chief's or designee's report and the IPC report, to the MSEC for review and recommendations.

E. The MSEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee, IPC, and/or Service Chief for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MSEC is to grant Privileges, it will be forwarded to the EGB for final action. If the recommendation of the MSEC is unfavorable, the Practitioner will be notified of the determination.

The details of the privileging process for APPs are more fully set forth in the APP Policy of the Medical Staff.

ARTICLE 5
OFFICERS OF THE MEDICAL STAFF AND GOVERNANCE

5.1 Officers of the Medical Staff

A. Identification

1) There shall be the following Officers of the Medical Staff:

a) President of Medical Staff;

b) Vice President of Medical Staff; and

c) Past President of Medical Staff

2) Qualifications – All Officers shall:

a) Understand the purposes and functions of the Medical Staff and demonstrate a willingness to assure that patient safety always takes precedence over other concerns;

b) Understand and be willing to work toward complying with the Bylaws, Policies, Plans, and Rules, and UCSDH's Policies and Procedures;

c) Aptly exercise their administrative ability as required by the respective office;

d) Be able to work with and motivate others to achieve the objectives of the Medical Staff and UCSDH;

e) Demonstrate clinical competence in their field of practice;

f) Have been an Active Staff Member at UCSDH for at least five (5) years;

g) Are currently an Active Staff Member at the Academic Medical Center. The Officer agrees to remain Active Staff at the Academic Medical Center while in office;

h) Currently be In Good Standing. The Officer agrees to remain In Good Standing while in office. In addition, both before and during their time as an Officer, they shall not be subject to a Professionalism Agreement or FPPE (with the exception of Routine FPPE Proctoring), and not be subject to any adverse recommendation that, if it were to become final, would limit the Member's Membership and/or Privileges;

i) Not participate in any activities associated with the office when there is a conflict of interest.

3) Conflict of Interest

All nominees for election or appointment to Medical Staff Offices shall, at least twenty (20) calendar days prior to the date of election or appointment, disclose in writing to the MSEC those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a Conflict of Interest with their activities or responsibilities on behalf of the Medical Staff. The MSEC shall evaluate the significance of such disclosures and shall discuss any significant conflicts with the nominee. If a nominee with a conflict remains on the ballot, the nature of their conflict shall be disclosed in writing and circulated with the ballot. Failure to disclose a significant conflict, as determined by the MSEC, will result in disqualification from the ballot or the elected position.

5.2 Method of Selection of Officers

A. Nominating Committee

Candidates for Vice President of Medical Staff shall be nominated by an *ad hoc* nominating committee of the MSEC which has been appointed by the President of Medical Staff, or by a petition signed by at least five (5) Active Staff. The nominating committee shall prepare a slate of candidate(s) meeting the qualifications of office as described in Article 5.1 from those nominated at least twenty-one (21) calendar days prior to the scheduled election. The nominating committee shall submit no more than five (5) nominees to the MSEC. To the extent there is only one (1) nominee, that individual will be presented to the MSEC prior to the election.

B. Election

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

C. Term of Office

1) The term of office for each Officer shall be two (2) years, beginning July 1st through June 30th. No Officer shall serve consecutive terms in the same position, unless as set forth in this Section.

2) The Vice President of Medical Staff shall be elected by June and shall take office the following July. In the event the Vice President of Medical Staff is not able to take office or serve for the timeframe as elected, the President of Medical Staff may serve in this position at their discretion, or the President of Medical Staff may appoint an interim Vice President of Medical Staff until such time the elected Vice President of Medical Staff is able to serve.

3) In the event that the Vice President of Medical Staff must replace the President of Medical Staff at any time, the Vice President of Medical Staff shall serve a full term as the President of Medical Staff after completing the term of the absent President of Medical Staff.

D. Succession of Vice President of Medical Staff to President of Medical Staff

The Vice President of Medical Staff shall accede to the position of President of Medical Staff upon the President of Medical Staff's completion of their term, provided they continue to meet the qualifications of such position.

E. Succession of President of Medical Staff to Past President of Medical Staff

The President of Medical Staff shall accede to the position of Past President of Medical Staff upon completion of the President of Medical Staff's term, provided they continue to meet the qualifications of such position.

5.3 Duties of Officers

A. President of Medical Staff

The duties of the President of Medical Staff shall include, but not be limited to:

1) Serving as chair of the MSEC;

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

3) Enforcing the Bylaws, promoting quality of care, implementing sanctions when indicated, and promoting compliance with procedural safeguards when corrective action has been requested or initiated;

4) Appointing, in consultation with the MSEC, committee members for all standing or multi-disciplinary committees except where otherwise provided by the Bylaws;

5) Appointing *ad hoc* committees as requested to investigate Members regarding potential corrective action;

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

7) Serving on liaison committees with EGB and Health Center Administration;

8) Regularly reporting to the EGB on the performance of Medical Staff functions and communicating to the Medical Staff any concerns expressed by the EGB;

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

10) Interacting with the Chief Executive Officer and Executive Governing Body in all matters of mutual concern at UCSDH; and

11) Performing such other functions as may be assigned to them by the Bylaws, the Medical Staff, or the MSEC.

B. Vice President of Medical Staff

The Vice President of Medical Staff shall assume all duties and authority of the President of Medical Staff in the absence of the President of Medical Staff. The Vice President of Medical Staff shall be a member of the MSEC, and shall perform such other duties as the President of Medical Staff may assign or as may be delegated by the Bylaws or by the MSEC.

C. Past President of Medical Staff

The Past President of Medical Staff shall be a member of the MSEC, and shall perform such duties as the President of Medical Staff may assign or as may be delegated by the Bylaws or by the MSEC.

5.4 Filling Vacancies

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

A. A vacancy in the office of President of Medical Staff shall be filled by the Vice President of Medical Staff.

B. A vacancy in the office of Vice President of Medical Staff shall be filled as set forth in Article 5.2, or by special election held in general accordance with Article 5.2.

C. A vacancy in the office of Past President of Medical Staff shall not be filled.

5.5 Removal of Officers

An Officer may be removed from office for any valid cause, including, but not limited to, failure to carry out the duties of their office. Except as otherwise provided, recall of an Officer may be initiated by the MSEC or by a petition signed by at least one-third of the voting Members; but removal itself shall require a two-thirds vote of the MSEC or two-thirds vote of the voting Members.

5.6 Conflicts of Interest

If, during an Officer's term, a Conflict of Interest arises, the Officer shall alert the MSEC and/or President of Medical Staff who shall evaluate the significance of such disclosure(s)

and determine what action should be taken, if any, to remove the Officer from any involvement in the issue giving rise to the Conflict of Interest.

In addition, Officers must identify any Conflict of Interest relating to a particular subject matter when that subject is discussed by a Medical Staff committee that the Officer is attending. Prior to participation in any discussion and/or vote regarding the issue, the member shall confer with the committee Chair to discuss the Conflict of Interest. The Officer has the option of recusing themselves from any discussion or action that may be impacted by the Conflict of Interest. Regardless, the Officer will be automatically removed from the discussion if it concerns their Department Chair and/or Service Chief. At the sole discretion of the MSEC, the Officer may remain only if the MSEC affirmatively votes (by a majority vote) to allow the Officer to participate in the discussion.

Notwithstanding the above, the Chair or other members of the committee may request that the Officer recuse themselves. To the extent the committee members request that the Officer recuse themselves, a majority vote of the voting members is required to mandate the recusal.

ARTICLE 6
COMMITTEES

6.1 Overview

The MSEC and the other committees described in the Bylaws and the Organizational Policy, shall be the standing committees of the Medical Staff. Special or *ad hoc* committees may be created by the President of Medical Staff, the MSEC, or a Service to perform specified tasks. Any committee, whether standing or otherwise, that is carrying out all or any portion of a function or activity required by the Bylaws, is deemed a duly appointed and authorized committee of the Medical Staff and subject to protections afforded under California Evidence Code, Section 1157. The standing committees of the Medical Staff are more fully set forth in the Organizational Policy.

6.2 Medical Staff Executive Committee

A. Composition

The MSEC shall be composed of the President of Medical Staff; Vice President of Medical Staff; the Past President of Medical Staff; Chief Medical Officer and/or their designee(s); the ACMO; the East Campus CMO; the ECMSC Chair; the Medical Staff Service Chiefs; three (3) members of the Active Staff elected at large by the eligible voting members of the Medical Staff; one (1) elected member of the UCSD Practicing Physician Staff; three (3) members of the Active Staff selected at-large who are representative of the following UCSDH areas: Hospital Medicine, Moores Cancer Center, and the Sulpizio Cardiovascular Institute; a Professionalism Advocate; Chair of the Patient Care and Peer Review Committee; Chair of the Credentials Committee; Chair of Medical Staff Professionalism Committee; Chief Executive Officer; Chief Executive Officer of UCSDH Physician Group; Dean of the School of Medicine; Chief Experience Officer; Vice Dean for Medical Education; Associate Dean of Graduate Medical Education; Chair of the Quality Counsel; Pharmacist-in-Chief; Chief Clinical Innovation Officer, and Chief Clinical Officer.

1) Voting Members

The Past President of Medical Staff, the Vice President of Medical Staff, the Medical Staff Service Chiefs, the ECMSC Chair, the three (3) elected members at large, the three (3) selected members at-large, the elected UCSD Practicing Physician; and the Professionalism Advocate have one vote each. The President of Medical Staff shall chair the MSEC, without a vote, unless a tie needs to be broken. The majority of voting members on the MSEC must be Physicians actively practicing at UCSDH.

2) *Ex Officio* Non-Voting Members

The Chief Medical Officer and/or their designee(s), ACMO, CEO, East Campus CMO, Chief Clinical Innovation Officer, Chair of the Patient Care and Peer

Review Committee, Chair of the Credentials Committee, Chair of Medical Staff Professionalism Committee, Chief Executive Officer of UCSDH Physician Group, Dean of the School of Medicine, Chief Experience Officer, Vice Dean for Medical Education, Associate Dean of Graduate Medical Education, Chair of the Quality Counsel, Pharmacist-in-Chief, and Chief Clinical Officer shall serve as *Ex Officio* Members without vote.

B. Executive/Closed Session

Only voting members of the MSEC may participate and vote in executive/closed sessions. With the exception of the Credentials Committee Chair, CMO, East Campus CMO, and ACMO, *Ex Officio* members do not participate in any executive/closed sessions unless invited by the President of Medical Staff. The Credentials Committee Chair, CMO, East Campus CMO, and ACMO shall participate in executive/closed sessions without vote.

C. Clinical Service Membership

Representatives of each Clinical Service shall participate and vote in executive/closed sessions. Each Service shall have only one vote.

D. Elected Membership for Members At Large From the Active Staff

The procedure for electing the three (3) members at large from the Active Staff to serve on the MSEC is as follows:

1) Nominations

a) A nominating committee, composed of MSEC members selected by the President of Medical Staff, will solicit names of eligible nominees from the Medical Staff. The nominating committee will then review the list of nominees, determine whether they are eligible to serve on the MSEC and are willing to do so, and determine which nominees will be presented to the MSEC. The nominating committee shall submit no more than five (5) nominees to the MSEC.

(i) At the time of nomination, election, and throughout their term, Members At Large must be In Good Standing with their Division, Service, and Medical Staff, not subject to a Professionalism Agreement or FPPE (with the exception of Routine FPPE Proctoring), and not be subject to any adverse recommendation that, if it were to become final, would limit the Member's Membership or Privileges

(ii) Members at Large may only serve if they have been Active Staff Members for at least three (3) years.

(iii) At least one Member At Large must hold privileges at East Campus Medical Center. The Member At Large from East Campus Medical Center must be an Active Staff member, and at the sole discretion of the MSEC, the three (3) year requirement in subsection (ii) may be waived.

(iv) Candidates for Members at Large positions must disclose all Conflicts of Interest.

(v) Members at Large are prohibited from serving on the Executive Governing Body at the same time they serve on the MSEC. If a Member at Large is selected to serve on the EGB while on the MSEC, they will be disqualified as serving as the Member at Large.

b) The MSEC, after receiving recommendations from the nominating committee, will submit to the Medical Staff a list of qualified nominees for the elected positions on the MSEC.

2) Election

The elected Members at Large will be those individuals receiving the highest number of votes of the eligible voting members of the Medical Staff voting in the election, with at least one individual having Privileges at East Campus Medical Center. In the event of a tie, the MSEC will vote to break the tie.

3) The three (3) elected members at large will each serve three (3) year terms. The terms will be staggered. They may not be re-elected until three years has passed since the end of their term.

4) If for any reason the elected Member at Large cannot fulfill their term, the nominee with the next highest number of votes will assume the role for the remainder of the term. If there are no available nominees to serve on the MSEC, a special election will be held, in accordance with the process set forth in Section D, Subsections 1 and 2, to choose a replacement. The replacement nominee will assume the role for the remainder of the term.

E. Selected Membership For Members At Large From Specialty Areas

1) The procedure for selecting the three (3) members of the Active Staff who serve as representatives of Hospital Medicine, Moores Cancer Center, Sulpizio Cardiovascular Institute will be as follows:

a) A nominating committee, composed of MSEC members selected by the President of Medical Staff, will confer with the leadership of the specialty area to solicit the name of the eligible nominee from that specialty area. Each specialty area may determine its own process for

nominating a representative. The nominating committee will then review the nominees, determine whether they are eligible to serve on the MSEC and are willing to do so, and then submit the nominee to the MSEC for approval.

b) At the time of nomination and throughout their term, Members At Large must be In Good Standing with their Division, Service and the Medical Staff, not subject to a Professionalism Agreement or FPPE (with the exception of Routine FPPE Proctoring), and not be subject to any adverse recommendation that, if it were to become final, would limit the Member's Membership or Privileges. Additionally, if the Selected Member no longer holds the leadership position that entitled them to the Member at Large position, they will automatically be removed.

2) The three (3) selected members at large from the specialty areas will each serve three (3) year terms.

If for any reason the selected Member at Large cannot fulfill their term, the MSEC will advise the specialty area and request an eligible replacement nominee. The replacement nominee will assume the role for the remainder of the term.

F. Elected Membership for Member At Large From the UCSD Practicing Physician Staff

The procedure for electing a member at large from the UCSD Practicing Physician Staff to serve on the MSEC is as follows:

1) Nominations

a) A nominating committee, composed of MSEC members selected by the President of Medical Staff, will solicit names of eligible nominees from the UCSD Practicing Physician Staff. The nominating committee will then review the list of nominees, determine whether they are eligible to serve on the MSEC and are willing to do so, and determine which nominees will be presented to the MSEC. The nominating committee shall submit no more than five (5) nominees to the MSEC.

b) At the time of nomination, election, and throughout their term, the member at large must be In Good Standing with their Division, Service, and the Medical Staff, not subject to a Professionalism Agreement or FPPE (with the exception of Routine FPPE Proctoring), and not be subject to any adverse recommendation that, if it were to become final, would limit the Member's Membership or Privileges.

c) The member at large may only serve if they have been a Member of the Active Staff, Courtesy Staff, and/or UCSD Practicing Physician Staff for at least three (3) years.

d) Candidates for the member at large position must disclose all Conflicts of Interest.

e) The member at large is prohibited from serving on the Executive Governing Body at the same time they serve on the MSEC. If a member at large is selected to serve on the EGB while on the MSEC, they will be disqualified as serving as a member at large.

f) The MSEC, after receiving recommendations from the nominating committee, will submit to the UCSD Practicing Physician Staff a list of qualified nominees for the elected position on the MSEC.

2) Election

The elected member at large will be the individual receiving the highest number of votes of the UCSD Practicing Physician Staff members in the election. In the event of a tie, the MSEC will vote to break the tie.

3) The elected member at large will serve a three (3) year term. They may not be re-elected in the same role until three years has passed since the end of their previous term.

4) If for any reason the elected member at large cannot fulfill their term, the nominee with the next highest number of votes will assume the role for the remainder of the term. If there are no available nominees to serve on the MSEC, a special election will be held, in accordance with the process set forth in Section F, Subsections 1 and 2, to choose a replacement. The replacement nominee will assume the role for the remainder of the term.

G. Professionalism Advocate

1) The role of the Professionalism Advocate is intended to advance excellence in patient care through promotion of professional behavior and conduct among members of the Medical Staff.

2) The MSEC will designate a specific role to serve as the Professionalism Advocate. The designated individual must be a Member of the Medical Staff.

3) The failure of the Professionalism Advocate to participate and/or vote in an MSEC meeting, including a special meeting, does not preclude the MSEC from voting and/or taking action as appropriate.

4) The Professionalism Advocate shall be provided with notice of all meetings and special meetings of the MSEC.

H. Quorum

Unless otherwise specified, for meetings of the MSEC, a quorum shall consist of a majority of voting Members. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of Members during the meeting.

I. Duties

The Medical Staff delegates to the MSEC broad authority to oversee the operations of the Medical Staff. With the assistance of the President of Medical Staff, and without limiting this broad delegation of authority, the MSEC shall perform in good faith the duties listed below.

1) Supervise the performance of all Medical Staff functions, which shall include:

a) Receiving reports and recommendations from the Services, committees, and Officers concerning discharge of assigned functions;

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

c) Following-up to assure implementation of all directives.

2) Coordinate the activities of Medical Staff committees and Services.

3) Based on input and reports from the Services and Medical Staff committees, assure that the Medical Staff adopts Bylaws, Rules, Policies, and Plans establishing criteria and standards, consistent with California law, for Membership and Privileges, and for enforcing those criteria and standards in reviewing the qualifications, credentials, performance, professional competence, and professional conduct of applicants and Practitioners.

4) Assure that the Medical Staff adopts, as needed, Bylaws, Rules, Policies, and Plans establishing clinical criteria and standards to oversee and manage peer review activities, medical record review, quality assurance, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of its committees as needed.

5) Evaluate the performance of an applicant/Practitioner's clinical skills whenever there is concern about an applicant's and/or Practitioner's ability to adequately perform requested Privileges.

6) Based upon input from the Service Chiefs and the Credentials Committee, make recommendations to the Executive Governing Body regarding all applications for Medical Staff appointment, reappointment, and Privileges.

7) Based upon input from the Interdisciplinary Practices Committee (IPC) and Credentials Committee, make recommendations to the Executive Governing Body on the qualifications of APPs to provide services, on the degree of supervision required, and regarding APP Privileges.

8) When indicated, initiate Investigations, FPPE, and/or pursue corrective actions affecting Practitioners.

9) With the assistance of the President of Medical Staff, CMO, and ACMO, supervise the Medical Staff's compliance with:

   a) The Medical Staff Bylaws, Rules, Policies, and Plans;

   b) UCSDH, UCSD, and UCOP Policies, Procedures, and Code of Conduct;

   c) State and federal laws and regulations; and

   d) The Joint Commission accreditation requirements.

10) Oversee the development of the Bylaws, Rules, Policies, and Plans, approve or disapprove all such Bylaws, Rules, Policies, and Plans, and oversee the implementation of all such Bylaws, Rules, Policies, and Plans.

11) Implement, as it relates to the Medical Staff, the approved Policies of UCSDH, UCSD, and UCOP.

12) With the Service Chiefs, set objectives for establishing, maintaining, and enforcing professional standards within UCSDH and for the continuing improvement of the quality of care rendered at UCSDH, and assist in developing programs to achieve these objectives including, but not limited to, OPPE.

13) Regularly report to the Executive Governing Body through the President of Medical Staff on at least the following:

   a) The outcomes of Medical Staff quality improvement programs with sufficient background and detail to assure the EGB that quality of care is consistent with professional standards; and

   b) The general status of any Medical Staff disciplinary or corrective actions in progress.

14) Review and make recommendations to the CEO regarding quality of care issues related to exclusive contract arrangements for clinical services.

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

16) Review, recommend, and approve off-site contractors for patient care services.

17) Make recommendations to the Executive Governing Body on all the following:

    A. Organized Medical Staff's structure;

    B. Process used to review credentials and delineate privileges; and

    C. MSEC's review of and actions on reports of Medical Staff committees, Services, and other assigned activity groups.

18) Coordinate the activities and general policies of the various Services.

19) Receive and act upon reports of all the Medical Staff committees.

20) Assure that educational programs address the recommendations and results of the Medical Staff's quality assessment and improvement activities.

21) Prioritize and assure that UCSDH-sponsored educational programs incorporate the recommendations and results of the Medical Staff quality assessment and improvement activities.

22) Establish, as necessary, such *ad hoc* committees that will fulfill particular functions for a limited time and will report directly to the MSEC.

23) Represent and act on behalf of the Medical Staff between regular meetings of the Medical Staff.

24) Take such actions as may reasonably be deemed necessary in the best interests of the Medical Staff and UCSDH.

J. Meetings of the MSEC

The MSEC should meet on a monthly basis and shall meet at least ten (10) times during the calendar year. The MSEC shall maintain a permanent record of its proceedings and actions. Executive/closed sessions may be called to discuss peer review issues or any other sensitive issues requiring heightened confidentiality. Regardless of open or executive/closed session, there will be no participation by telephone or video link at MSEC meetings, unless prior approval is granted by the President of Medical Staff.

K. Removal of MSEC Members

MSEC members must remain In Good Standing as a Member of the Active Staff unless otherwise set forth in these Bylaws. A MSEC member will be automatically removed from the MSEC if any action is taken against the Member by the MSEC including (i) being subject to a Professionalism Agreement or FPPE (with the exception of Routine FPPE Proctoring); (ii) being subject to any adverse recommendation that, if it were to become final, would limit the Medical Staff Service Chief's appointment and/or Privileges; or (iii) that serves as the grounds for a hearing pursuant to Article 10 of the Bylaws. MSEC members who are Selected Members at Large will be automatically removed if they no longer hold the leadership position that entitled them to the Member at Large position. In addition, a Member can be removed from the MSEC by a two-thirds (2/3) majority of those voting members of the Medical Staff who submit a vote. The affected Service, Staff Category, or Selected Member at Large may then select a different designee to represent them on the MSEC.

ARTICLE 7
CLINICAL SERVICES

7.1 Organization of Clinical Services

The Medical Staff is organized into Clinical Services. The current Clinical Services are set forth in the Organizational Policy. Subject to the approval of the Executive Governing Body, the MSEC may create new Clinical Services, eliminate Clinical Services, and otherwise reorganize the Clinical Service structure.

7.2 Assignment to Clinical Services

Each Member shall be assigned to a Clinical Service, but may also be granted Privileges in other Services.

7.3 Functions of Each Clinical Service

The Services shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the Services, and (ii) to monitor the practice of all those with Privileges in each Service.

7.4 Medical Staff Service Chiefs

The Medical Staff Service Chiefs have a number of responsibilities for oversight of Service activities, including, credentials and privileges review, peer review, quality of care, and utilization review.

A. Qualifications

Each Service Chief shall be qualified by training, experience, and demonstrated current ability in clinical care provided by that Service, and shall discharge the functions of their office.

Each Service Chief must be an Active Staff Member and remain In Good Standing as Active Staff while in office. This includes not being subject to a Professionalism Agreement or FPPE (with the exception of Routine FPPE Proctoring), and not be subject to any adverse recommendation that, if it were to become final, would limit the Service Chief's appointment and/or Privileges. This also includes not being subjected to any action that serves as the grounds for a hearing pursuant to Article 10 of the Bylaws.

B. Selection

Unless otherwise provided, each Service Chief shall be the Chairperson of the equivalent Department in the School of Medicine. In the alternative, the School of Medicine Department Chair may appoint a Service Chief to carry out the roles and responsibilities below.

C. Roles and Responsibilities of Service Chiefs:

1) Assist in the development and implementation of expectations and requirements for clinical performance for that Service;

2) Determine and manage the clinically related and administrative activities within the Service;

3) Assist in the formulation and execution of programs to carry out the quality review, evaluation, and monitoring functions assigned to that Service;

4) Assess and recommend to the relevant Officers and Health System Administration off-site sources for needed patient care, treatment, and services not provided at UCSDH;

5) Recommend to the Medical Staff the criteria for Privileges that are relevant to the care provided in the Service;

6) Continuously assess and improve the quality of care, treatment, and services, and maintain quality improvement programs as appropriate;

7) Assist in developing and enforcing the Bylaws, Rules, Policies, and Plans, and UCSDH's Policies that guide and support the provision of patient care, treatment, and services;

8) Communicate to the appropriate individuals or committee the Service's recommendations concerning appointment, reappointment, delineation of Privileges, and corrective action with respect to the Members of the Service;

9) Communicate to the appropriate individuals or committee the Service's recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

10) Monitor the quality of patient care and professional performance rendered by Practitioners holding Privileges in the Service through a planned and systematic process, including but not limited to, OPPE and FPPE;

11) Oversee and monitor functions delegated to the Service by the MSEC in coordination and integration with organization-wide quality assessment and improvement activities;

12) Coordinate with Physician Well Being Committee (PWBC), Patient Care and Peer Review Committee (PCPRC), Medical Staff Professionalism Committee (MSPC) and PARS Peer Messenger Committee (PARS) for Practitioners of the Service who are involved with or supported by the various Committees of the Medical Staff;

13) Undertake or delegate peer review investigations of Practitioners of the Service and submit reports and recommendations to the MSEC or Medical Staff committees;

14) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the President of Medical Staff, and/or the MSEC;

15) Implement within the Service actions taken by the MSEC; and

16) Appoint a Service committee and such other sub-committees or *ad hoc* committees as the Medical Staff Service Chief deems appropriate to perform the required functions.

Additional details of the structure of Clinical Services are set forth in the Organizational Policy of the Medical Staff.

D. Appointment of Designee

If a Service Chief is unavailable for a specific period of time to perform their duties pursuant to these Bylaws, the Credentials Policy, Organizational Policy, the Fair Hearing Plan, and/or any rules, regulations, or policies of the Medical Staff, the Service Chief may appoint a temporary designee to represent the Service. The Service Chief must immediately notify the President of Medical Staff regarding their unavailability, the identity of the temporary designee, and the period of time the designee will be utilized. The temporary designee must meet all of the qualifications set forth in Subsection A.

The temporary designee will assume all of the responsibilities of the Service Chief, as set forth in Subsection C. This includes, but is not limited to, communicating the Service's recommendations concerning appointment, reappointment, delineation of Privileges, and corrective action with respect to the Members and Practitioners of the Service.

The Service Chief may also appoint one designated alternate to review and approve credential and privilege files in their absence. The designated alternate is responsible for communicating the Service's recommendations concerning appointment, reappointment, delineation of Privileges if the Service Chief is unavailable. This individual shall not attend any meetings of the MSEC or be entitled to vote.

E. Removal

Removal of Medical Staff Service Chiefs may occur for cause by the School of Medicine Department Chair. Alternatively, a Medical Staff Service Chief may be removed by the process outlined in Article 6, Section 6.2(J) Removal of MSEC Member.

F. Term of Office

If the Service Chief is the SOM Chairperson of the equivalent Department in the School of Medicine, they will continue in their role for as long as they remain the Chair. If the Service Chief is a designee, the designee shall serve a two (2) year term, unless renewed by the appropriate SOM Chair.

G. Conflicts of Interest

If a Conflict of Interest arises while a Member is serving as a Service Chief, the Member shall alert the MSEC who shall evaluate the significance of such disclosure(s) and shall determine what action should be taken, if any, to remove the Service Chief from any involvement in the issue giving rise to the Conflict of Interest. In addition, Service Chiefs must identify any Conflict of Interest relating to a particular subject matter when that subject is discussed by a Medical Staff committee that the Medical Staff Service Chief is attending. Prior to participation in any discussion and/or vote regarding the issue, the member shall confer with the committee Chair and/or MSEC. The Member has the option of recusing themselves from any discussion or action that may be impacted by the Conflict of Interest. Regardless, the Member will be automatically removed from the discussion if it concerns their Department Chair. At the sole discretion of the MSEC, the Member may remain only if the MSEC affirmatively votes (by a majority vote) to allow the Member to participate in the discussion.

Notwithstanding the above, the Chair or other members of the committee may request that the Member recuse themselves. To the extent the committee members request that the Member recuse themselves, a majority vote of the voting members is required to mandate the recusal.

ARTICLE 8
CONFIDENTIALITY

8.1 Overview

Medical Staff, Service, and committee minutes, files, and records, including information regarding any Member of, or applicant to, this Medical Staff, shall, to the fullest extent permitted by law, be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff committee files and shall not become part of any particular patient's file or of the general UCSDH records. Dissemination of such information and records can be made only where expressly required by law, UC policy, or as otherwise provided in the Bylaws, Policies, Plans, or Rules.

8.2 Breach of Confidentiality

Inasmuch as effective peer review and consideration of the qualifications of Practitioners, Members, and applicants must be based on free and candid discussions, any breach of confidentiality of these discussions or deliberations of Medical Staff committees will be deemed disruptive to the operations of the Medical Staff and UCSDH. If it is determined that such a breach has occurred, the MSEC may undertake such corrective action as it deems appropriate.

ARTICLE 9
PEER REVIEW AND CORRECTIVE ACTION

Peer review activities and the corrective actions of the Medical Staff are more fully set forth in the Fair Hearing Plan.

9.1 Role of Medical Staff in Organization-Wide Quality Improvement Activities

The Medical Staff believes that the interests and well-being of patients are best served by the organized effort and support of the health care professionals to whom patients entrust their care, and that education and research in the health sciences are most effectively advanced by such an organized effort. The Medical Staff is responsible for overseeing the quality of medical care, treatment, and services delivered at UCSDH. An important component of that responsibility is the oversight of care rendered by Members and APPs practicing at UCSDH. The following provisions are designed to monitor and achieve quality improvements through collegial peer review and educative measures whenever possible, but with recognition that, when circumstances warrant, the Medical Staff is responsible for undertaking informal corrective measures and/or corrective action as necessary to ensure that patients are being provided high quality of care, treatment, and services.

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

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

C. Services and Medical Staff committees are responsible for determining the practice criteria and the type of data to be collected for OPPE in peer review and quality improvement functions. All such activities, whether performed directly or by delegation, shall be incorporated within the Medical Staff's peer review process.

D. External peer review may be used to inform Medical Staff peer review activities as delineated under the Bylaws. In evaluating or investigating an applicant, Member, or APP, an external peer review may be obtained in the following circumstances:

1) When a Medical Staff committee, Service, or Ad Hoc Committee performs a review(s) that could affect an individual's Membership or Privileges, and in the committee or Service's view, would benefit from external input or expertise in the clinical procedure(s) or area(s) under review;

2) When no current Practitioner can provide the necessary expertise in the clinical procedure or area under review;

3) To help promote an impartial peer review; or

4) As deemed necessary by the MSEC or the President of Medical Staff.

9.2 Indications and Process for Recommending Corrective Action

The MSEC may recommend reduction, suspension, or termination of Membership and/or Privileges when an individual demonstrates acts that reasonably appear to be any or a combination of the following:

A. Detrimental to patient safety or to the delivery of quality patient care within UCSDH;

B. Unethical or illegal;

C. Contrary to the Bylaws and/or Medical Staff Policies, Procedures, Plans, and Rules;

D. Care below applicable professional competence;

E. Unprofessional or disruptive conduct as set forth in the Bylaws, Medical Staff Professional Conduct Policy, Medical Staff Policies, Procedures, Plans, and Rules, or other applicable UCSDH, UCSD, and/or or UC policies;

F. Improper use of UCSDH resources;

G. Indictment or information charging a crime, or charge of fraud or abuse relating to any governmental health program or third-party reimbursement;

H. Failure to comply with UCSD's compliance or research program policies and procedures;

I. Below applicable professional standards; or

J. Breach of privacy and/or confidentiality.

Indications and processes for recommending reduction, suspension, or termination of Membership and/or Privileges are more fully set forth in the Fair Hearing Plan.

9.3 Indications and Process for Summary Suspension or Summary Restriction

A. Whenever it appears that the failure to take action may result in imminent danger to the health or safety of any individual, and after a good faith effort to communicate with at least three other individuals with similar authority, any one of: the MSEC, the President of Medical Staff, the Chief Medical Officer, the ACMO, the Medical Staff Service Chief in which the Member is assigned or holds Privileges, and/or the Chief Executive Officer, may immediately restrict or suspend the Membership and/or Privileges of such Member. When none of the individuals identified above is available to summarily restrict or suspend Privileges, the EGB or its designee may immediately restrict or suspend a Member's Privileges if a failure to do so is likely to result in an imminent danger to the health of any individual, provided the EGB has, before the summary restriction or suspension, made reasonable attempts to

contact the MSEC. Without regard to how the suspension is initiated, the applicable Service Chief for the suspended Member shall be notified within 6 hours of the suspension action being noticed to the Member.

1) Unless otherwise stated, such summary restriction or suspension (Summary Action) shall become effective immediately upon imposition.

2) A Summary Action by the CEO or EGB that has not been ratified by the MSEC within two (2) Days, shall terminate automatically.

3) Within two (2) Days of imposition of a Summary Action, the Member shall be provided with written notice of such action.

4) The MSEC, or a subcommittee of at least six (6) MSEC members, will review the reasons for the Summary Action within a reasonable time under the circumstances, not to exceed fourteen (14) calendar days, and reach a final decision or recommendation to continue, modify, or terminate the Summary Action.

5) Prior to, or as part of this review, the Member will be given an opportunity to meet with the MSEC or a subcommittee of the MSEC, as designated by the President of the Medical Staff.

Indications and processes for Summary Action are more fully set forth in the Fair Hearing Plan.

9.4 Indications and Process for Limitation, Termination, or Automatic Suspension.

A. Appointment and/or Privileges may be limited, terminated, or automatically suspended if any of the following occur and as detailed in the Medical Staff Fair Hearing Plan:

1) A Practitioner's professional license, certificate, or permit is revoked, suspended, expired, restricted, or placed on probation;

2) A Practitioner's California DEA certificate is revoked, limited, suspended, expired, or on probation, and the California DEA certificate is necessary to perform the requested Privileges;

3) A Practitioner is excluded from government or third-party payor programs essential to UCSDH;

4) A Practitioner fails to do any of the following:

a) Timely complete health records;

b) Satisfy threshold eligibility criteria;

c) Timely provide requested information requested by the Medical Staff;

d) Complete and/or comply with educational, orientation, or health requirements;

e) Satisfy a special appearance requirement;

f) Pay application fees; or

g) Maintain appropriate professional liability coverage.

5) A Practitioner is convicted of a felony, or pleads guilty or nolo contendere to a felony;

6) A Member remains absent on leave for longer than one (1) year or fails to request reinstatement before the end of the leave. Privileges will automatically expire at the end of the leave or 1 year, whichever occurs first.

7) A Practitioner loses their Covering Practitioner;

8) A Practitioner no longer has a Teaching Affiliation;

9) In the case of an APP: (a) if the Membership or Privileges of the APP's supervising Physician are suspended, resigned, revoked, or terminated; (b) if the supervising Physician declines to continue supervision; or (c) if a UCSDH employed APP is placed on Investigatory Leave or any other disciplinary leave by UCSDH Human Resources, or has any changes to their employment status which affect their ability to provide clinical services at UCSDH.

B. Automatic suspension or limitation shall take effect immediately, and shall continue until the matter is resolved, if applicable.

C. Automatic suspensions which remain in effect for longer than ninety (90) calendar days will result in voluntary withdrawal of Membership and/or Privileges, unless otherwise extended by the MSEC.

Indications and processes for automatic actions are more fully set forth in the Fair Hearing Plan.

ARTICLE 10
HEARINGS AND APPELLATE REVIEWS

The grounds for a hearing, hearing procedures, rights, and appellate reviews are more fully set forth in the Fair Hearing Plan. Additionally, hearing rights for APPs are more fully set forth in the APP Policy.

10.1 Hearing Process for Members

A. Scheduling and Hearing Process

1) After receiving Special Notice of the recommended action, within thirty (30) calendar days of receipt, the Member can request a hearing before a Hearing Panel. Alternatively, the Member can request mediation or arbitration of the dispute.

2) Upon timely request of a hearing, the Member will be provided with a written notice of the proposed action taken or recommended along with the acts or omissions charged, and the time, place and date of hearing.

a) The hearing will commence within sixty (60) calendar days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

b) The hearing panel will consist of at least three (3) Active Members. who shall gain no direct financial benefit from the outcome and who shall not have acted as accuser, investigator, fact finder, initial decision-maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a Member of the Medical Staff from serving as a member of the hearing panel. The President of Medical Staff shall designate the chair of the hearing panel. In the event it is not feasible to appoint a hearing panel from the Active Staff, the President of Medical Staff may appoint Members from other Medical Staff categories or physicians outside the Medical Staff. The hearing panel shall include, when feasible, at least one (1) panel member who has the same healing arts licensure as the Member and who practices the same specialty as the Member. The President of Medical Staff may appoint and designate alternate panel members who meet the standards described above and who can serve if a hearing panel Member becomes unavailable, subject to voir dire by the parties. In the alternative, an arbitrator can act as the hearing panel.

c) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

d) A court reporter will make a record of the hearing.

e) Both sides will have the following rights, subject to reasonable limits as determined by the hearing panel/hearing officer/arbitrator: (i) to be provided with all information made available to the trier of fact; (ii) to have a record made of the proceedings, copies of which may be obtained upon payment by the Member; (iii) to call, examine, and cross examine witnesses; (iv) to present and rebut evidence determined by the hearing panel/hearing officer/arbitrator to be relevant; (v) to submit a written statement at the close of the hearing; (vi) to be represented by counsel; (vii) to obtain a written decision of the trier of fact, including findings of fact, and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached.

f) The affected Member must attend all hearing sessions. The Member may be called and questioned by the Medical Staff.

g) The hearing panel/arbitrator may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

h) Within thirty (30) calendar days after final adjournment of the hearing, the hearing panel/arbitrator shall render a written decision. The final decision of the hearing panel must be sustained by a majority vote of the number of Members sitting on the hearing panel.

3) Length of the Hearing

a) The evidentiary portion of any hearing governed by the Bylaws must be concluded within sixty (60) hours such that each party has a total of thirty (30) hours to present its witnesses and cross examine the other party's witnesses. It is expected that the hearing will be concluded in twelve (12) months from the start of evidence.

b) Only testimony under oath will count towards the sixty (60) hour limit.

c) To the extent the case cannot conclude within sixty (60) hours, the hearing panel/arbitrator is authorized to grant additional time on a showing of good cause. If the hearing officer/arbitrator's unavailability is the cause of the need for an extension, the parties will meet and confer to determine the best and most efficient manner to proceed. This shall include, but is not limited to, appointing a new hearing officer/arbitrator.

d) The parties may stipulate to additional time to conclude the evidentiary portion of the hearing or may agree to stay the hearing to engage in negotiations to resolve the matter. However, any such stipulation shall not exceed six (6) months and must be approved by the hearing panel/arbitrator.

e) If either party seeks additional time beyond the thirty (30) hour limit, that party must make a motion to the hearing panel/arbitrator seeking additional time. Any such motion must include the anticipated number of hours necessary to conclude the party's case, the reasons why the party cannot complete their case within the specified timeframe, the evidence that will be presented during the additional hearing time, and the relevance of any such evidence. The hearing panel/arbitrator must find good cause for granting any such motion and only grant such additional time as is reasonably necessary under all the circumstances.

4) Manner of Presentation of Evidence

The hearing may be conducted in person or via secure video link, so long as all hearing participants are visible and can hear all proceedings throughout the hearing. The MSEC shall have the sole discretion to determine the manner in which the hearing is conducted.

10.2 Appeal Process for Members

A. Scheduling and Appeal Process

1) Within fifteen (15) calendar days after being sent the decision of the hearing panel/arbitrator, either the Member or the MSEC may request an appellate review. If appellate review is not provided or requested within such period, that action or recommendation shall thereupon become the final action of the MSEC.

2) The Appeal Board shall, within thirty (30) calendar 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 appellate review shall be scheduled to occur within sixty (60) calendar days from the date of such notice provided; however, when a request for appellate review concerns a Member who is under suspension that is then in effect, the appellate review should be scheduled to occur within forty-five (45) calendar 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.

3) The Executive Governing Body may sit as the Appeal Board, or it may appoint an Appeal Board composed of not less than three (3) members designated by the Executive Governing Body. In the event the Executive Governing Body delegates some or all of its responsibilities described in this Article to an Appeal Board, the Executive Governing Body shall nonetheless retain ultimate authority to accept, reject, modify or return for further action or hearing the recommendations of the Appeal Board.

a) The proceeding by the Appeal Board shall be an appellate hearing based upon the record of the hearing before the hearing panel/arbitrator.

b) 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, even if the other party elects not to be represented by legal counsel.

c) The Appeal Board may establish reasonable time frames for the appealing parties to submit written statements.

d) Each party has the right to appear and to make oral argument whether in person or secure video link, as directed by the Appeal Board in its sole discretion.

e) The Appeal Board may accept additional relevant and admissible oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the hearing panel/arbitrator in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing.

f) The Appeal Board may then, at a time convenient to itself, deliberate outside the presence of the parties.

g) The Appeal Board shall render a final decision in writing. Final adjournment shall not occur until the Appeal Board has completed its deliberations. 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 panel.

h) The Appeal Board may affirm, modify, reverse the decision, or remand the matter for further review by the hearing panel/arbitrator or any other body designated by the Appeal Board.

i) The Appeal Board shall give great weight to the hearing panel's/arbitrator's decision, and shall not act arbitrarily or capriciously.

ARTICLE 11
GENERAL PROVISIONS

11.1 History and Physical (H&P) Examination Requirement

All Practitioners are responsible for timely completion of medical records, including documentation of medical histories and physical examinations.

Patients requiring an H&P will receive a full H&P, an abbreviated H&P, or an interval H&P as defined in these Bylaws and the Rules and Regulations, by a Physician or other Practitioner in accordance with state law, the Bylaws, Rules and Regulations, and UCSDH policy:

A. Full H&P

Unless an abbreviated H&P or interval H&P is permitted as set forth in these Bylaws, all patients admitted for inpatient care will have a complete medical history and physical examination (full H&P) performed by a Practitioner who has been granted such Privileges, by the earlier of (i) twenty-four (24) hours of admission or (ii) the initiation of a surgical or other procedure requiring moderate or deep anesthesia.

A full H&P is also required for any outpatient procedures that are high-risk and/or require anesthesia, monitored sedation, or post-procedure observation in the hospital.

B. Abbreviated H&P

Abbreviated H&P's are permitted for outpatient procedures requiring moderate sedation.

C. Interval Assessments for H&P

An H&P performed within thirty (30) calendar days prior to the procedure is acceptable provided an interval assessment is performed by a Practitioner who has been granted such Privileges, which includes a physical assessment of the patient to update components of the patient's current medical status that may have changed since the prior H&P and addresses any areas where more current data is available. The interval assessment shall be completed by the earlier of (i) twenty-four (24) hours of admission; or (ii) the initiation of a surgical or other procedure requiring moderate or deep anesthesia. This assessment should also address the care plan and confirm the necessity for admission, procedures, or surgery. The depth of the assessment should reflect the patient's condition and any co-morbidities and indication for admission.

If a patient is readmitted within thirty (30) calendar days of a previous discharge for the same or a related condition, an interval assessment may be performed

provided a copy of the prior admission's complete H&P is attached to the interval assessment.

D. APPs and House Staff

All or part of the full H&P, abbreviated H&P, or interval H&P may be delegated to a qualified Practitioner or House Staff in accordance with the Bylaws, Medical Staff policies and rules, state law, and UCSDH Policy. The supervising Practitioner assumes full responsibility for the H&P.

If performed by a Practitioner or House Staff, it must be authenticated by the supervising Practitioner by the earlier of (i) twenty-four (24) hours of admission or (ii) prior to the initiation of a surgical or other procedure requiring moderate or deep anesthesia.

11.2 Relationship of Medical Staff to House Staff

House Staff are not Members or Practitioners of the Medical Staff, and the provisions of the Bylaws do not apply. The responsibility of Members to the House Staff are identified in the UCSD House Officer Policy and Procedure Document (HOPPD); Academic Policies, Procedures, and Guidelines (APPG); and in the UCSD Graduate Medical Education Supervision Policy.

The Designated Institutional Official (DIO) has established a Graduate Medical Education Committee responsible for the oversight of graduate medical education at UCSDH. The GMEC and/or the DIO will periodically communicate directly with Members of the Medical Staff who are involved with House Staff regarding trainee supervision policies, and the safety and quality of patient care provided by House Staff.

To the extent any residency program receives citations from the ACGME or other accreditation or review body, the MSEC will be advised of the citations and the program's plan to remedy the issues of concern.

11.3 Forms

Application forms and any other prescribed forms required by the Bylaws, Policies, Plans, and Rules for use in connection with Medical Staff appointments, reappointments, delineation of Privileges, corrective action, notices, recommendations, reports and other matters shall be approved by the MSEC.

11.4 Application Processing Fees and/or Dues

The MSEC shall have the discretion to establish reasonable application processing fees and/or Dues, if any, for each category of Membership, and to determine the manner of expenditure of such funds received; however, such expenditures must be appropriate to the purposes of the Medical Staff and shall not jeopardize the nonprofit tax-exempt status of UCSDH.

11.5 Legal Counsel

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

11.6 Authority to Act

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

11.7 No Discrimination or Retaliation

There shall be no discrimination on the basis of race, color, national origin, religion, creed, gender, physical or mental disability, medical condition, ancestry, marital status, age, sexual orientation, gender identity, sex, genetic information, citizenship or status as a covered veteran, or by source of payment, subject to state and federal laws, and regulations. Neither the Medical Staff, its Members, Practitioners, committees, Medical Staff Service Chiefs, nor any other agent of the Medical Staff, shall retaliate in any manner against any patient, UCSDH employee, Member of the Medical Staff, Practitioner, or any other individual at UCSDH because that person has done any of the following:

A. Presented a grievance, complaint, or report to UCSDH, to an entity or agency responsible for accrediting or evaluating UCSDH, or the Medical Staff, or to any other governmental entity; or

B. Has initiated, participated, or cooperated in an investigation or administrative proceeding related to any Medical Staff function.

11.8 Disputes with the Executive Governing Body

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

A. Invoking the Dispute Resolution Process

1) The MSEC may invoke formal dispute resolution upon its own initiative or upon written request of twenty-five (25) percent of Active Staff.

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

B. Dispute Resolution Forum

Ordinarily, the forum for dispute resolution shall be the Joint Conference Committee, which shall meet and confer as further described in the Organizational Policy.

C. If the parties cannot resolve the dispute, the Executive Governing Body shall make its final determination, giving great weight to the actions and recommendations of the MSEC. The Executive Governing Body's decision shall not be arbitrary or capricious, and shall affirm its legal responsibilities to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of UCSDH.

11.9 Disputes Between MSEC and ECMSC

In the event of a dispute between the MSEC and the ECMSC relating to a proposed or adopted Bylaw, Policy, Plan, Rule; corrective action for a specific Practitioner; appointment or reappointment of a specific Practitioner; or other issue of significance to the MSEC or ECMSC, the following procedures shall apply.

A. Invoking the Dispute Resolution Process

1) The MSEC or ECMSC may invoke formal dispute resolution upon its own initiative or upon written request of twenty-five (25) percent of Active Staff.

2) In the event the MSEC or ECMSC declines to invoke formal dispute resolution, such process shall be invoked upon written petition of fifty (50) percent of Active Staff.

B. Dispute Resolution Forum

Ordinarily, the forum for dispute resolution shall be the Joint Conference Committee, which shall meet and confer as further described in the Organizational Policy.

C. If the parties cannot resolve the dispute, the EGB shall make its final determination. The EGB's decision shall not be arbitrary or capricious, and shall affirm its legal responsibilities to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of UCSDH.

11.10 Disputes Between Medical Staff and MSEC

In the event of conflict between the MSEC and the Medical Staff (as represented by written petition signed by at least fifty (50) Active Staff) regarding a proposed or adopted Bylaw, Policy, Plan, Rule, or other issue of significance to the Medical Staff, the President of Medical Staff shall convene a meeting with the petitioners' representative(s). The foregoing petition shall include a designation of up to five (5) Active Staff who shall serve as the petitioners' representative(s). The MSEC shall be represented by an equal number of MSEC members. The MSEC's representative(s) and the petitioners' representative(s) shall exchange

information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the MSEC, and the safety and quality of patient care at UCSDH. Resolution at this level requires a majority vote of the MSEC's representatives at the meeting and a majority vote of the petitioner's representatives. Unresolved differences shall be submitted to the Executive Governing Body for its consideration in making a final decision with respect to the proposed Bylaw, Policy, Plan, Rule or issue.

11.11 Unified and Integrated Medical Staff

If multiple UCSDH certified hospitals who are part of the UC system elect to have a unified and integrated medical staff for its member hospitals, after determining that such a decision is in accordance with all applicable State and local laws, each separately certified hospital must demonstrate that the medical staff members of each separately certified hospital in the system have voted by majority, in accordance with their Bylaws, either to accept a unified and integrated medical staff structure or to opt out of such a structure and to maintain a separate and distinct medical staff for their respective hospital.

The unified and integrated medical staff must have bylaws, rules, and requirements that describe its processes for self-governance, appointment, credentialing, privileging, and oversight, as well as its peer review policies and due process rights guarantees, and which include a process for the members of the medical staff of each separately certified hospital to be advised of their rights to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their hospital.

The unified and integrated medical staff must be established in a manner that takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital.

The unified and integrated medical staff must establish and implement policies and procedures to ensure that the needs and concerns expressed by members of the medical staff, at each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated medical staff has mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed.

ARTICLE 12
ADOPTION AND AMENDMENT OF BYLAWS, POLICIES, RULES, AND PLANS OF THE MEDICAL STAFF

12.1 Adoption and Amendments of Bylaws

A. Medical Staff Responsibility

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

B. Periodic Review

The Bylaws shall be reviewed periodically and amended, as necessary, to reflect UCSDH's current practices with respect to the Medical Staff organization and functions.

C. Initiation of Bylaws or Amendments to Bylaws

Proposals for Bylaws or amendments to Bylaws may be initiated by: (a) the Bylaws Committee; (b) the MSEC; or (c) a Member through petition signed by at least ten (10) percent of the Active Staff. All proposed Bylaws and amendments to Bylaws shall be submitted to the MSEC for review. The MSEC can then forward the proposed amendment to the Bylaws Committee for evaluation and recommendation. The Bylaws Committee will evaluate the proposed amendment and forward any recommendation to the MSEC.

D. Referral to MSEC

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

E. Vote of Medical Staff

Medical Staff Bylaws may be adopted, amended, or repealed by the following actions:

1) The affirmative vote of a majority of the Active Staff members who cast a ballot, provided that: (1) at least fourteen (14) calendar days in advance of the vote notice has been given accompanied by the proposed Bylaws and/or alterations; and (2) a minimum of 10% of voting members cast ballots; and

2) The approval of the EGB, provided that such approval shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the EGB in writing and shall be forwarded to the President of Medical Staff, MSEC, and the Bylaws Committee.

F. No Unilateral Amendment

The Bylaws may not be unilaterally amended by the Medical Staff, Officers, MSEC, or EGB, or in a manner that is inconsistent with the Bylaws, Policies, Plans, or Rules, and/or Standing Orders of The Regents.

G. Required Conditions

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

H. Conflict

If there is a conflict between the Bylaws and the Policies, Plans, or Rules, the Bylaws shall prevail.

12.2 Technical and Editorial Amendments

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

All Bylaws, Policies, Plans, and Rules that are in effect immediately preceding the adoption of the Bylaws, and that are not inconsistent with these Bylaws, will be considered the governing Bylaws, Policies, Plans, and Rules in effect until amended pursuant to these Bylaws.

12.3 Amendments to Medical Staff Policies, Plans, and Rules

A. In addition to the Bylaws, there shall be Policies, Plans, and Rules that are applicable to all members of the Medical Staff. The Policies, Plans, and Rules shall be considered an integral part of the governing documents of the Medical Staff, but amended in accordance with this Section.

1) An amendment to the Medical Staff Credentials Policy, Organizational Policy, the Fair Hearing Plan, and APP Policy may be made by a majority vote of the members of the MSEC present, when voting at any scheduled meeting of the MSEC where a quorum exists. All other Policies and Rules of the Medical Staff may be adopted and amended by a majority vote of the MSEC, when voting at any meeting of the MSEC where a quorum exists. Amendments to Medical Staff Policies, Plans, and Rules may also be proposed by a petition signed by at least twenty-five (25) percent of the Active Staff. Any such proposed amendments will be reviewed by the MSEC, which may comment on the amendments before they are forwarded to the EGB for its final action.

2) Adoption of and changes to the Medical Staff Credentials Policy, Organizational Policy, Fair Hearing Plan, APP Policy, and other Medical Staff policies will become effective only when approved by the EGB.