



Banner Gateway
Medical Center

MEDICAL STAFF BYLAWS

BANNER GATEWAY MEDICAL CENTER

Gilbert, Arizona

BYLAWS OF THE MEDICAL STAFF

TABLE OF CONTENTS

ARTICLE ONE:	NAME	
1.1	NAME.....	7
ARTICLE TWO:	PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF	
2.1	PURPOSES.....	7
2.2	RESPONSIBILITIES.....	8
ARTICLE THREE:	MEMBERSHIP.....	8
3.1	GENERAL QUALIFICATIONS.....	8
	3.1-1 Licensure.....	9
	3.1-2 Professional Education and Training.....	9
	3.1-3 Board Certification.....	9-10
	3.1-4 Clinical Performance.....	10
	3.1-5 Cooperativeness.....	10
	3.1-6 Satisfaction of Membership Obligations.....	11
	3.1-7 Satisfaction of Criteria for Privileges.....	11
	3.1-8 Professional Ethics and Conduct.....	11
	3.1-9 Participation in Government Programs.....	11
	3.1-10 Health Status.....	11
	3.1-11 Verbal and Written Communication Skills.....	11
	3.1-12 Professional Liability Insurance.....	11
	3.1-13 Effects of Other Affiliations.....	11
	3.1-14 Nondiscrimination.....	12
	3.1-15 Exemptions from Qualifications.....	12
3.2	RIGHTS OF INDIVIDUAL STAFF MEMBERSHIP.....	12
3.3	BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP.....	12-13
3.4	TERM OF APPOINTMENT.....	13
	3.4-1 Expiration.....	13
3.5	EXHAUSTION OF ADMINISTRATIVE REMEDIES.....	13
3.6	LIMITATION OF DAMAGES.....	14
3.7	PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT.....	14
	3.7-1 Qualifications.....	14
	3.7-2 Approval of Positions.....	14
	3.7-3 Supervision.....	14
3.8	EXCLUSIVE CONTRACTS.....	14
	3.8-1 Review of Positions.....	15
3.9	MEDICAL DIRECTORS.....	15
	3.9-1 Role.....	15
	3.9-2 Chief Medical Officer.....	15
3.10	CREDENTIALING PROCESS.....	16
ARTICLE FOUR:	MEDICAL STAFF CATEGORIES.....	16
4.1	CATEGORIES.....	16

4.2	ACTIVE STAFF	16
	4.2-1 Qualifications	16
	4.2-2 Prerogatives	16
	4.2-3 Obligations	16
	4.2-4 Failure to Satisfy Qualifications	17
4.3	ASSOCIATE STAFF.....	17
	4.3-1 Qualifications	17
	4.3-2 Prerogatives	17
	4.3-3 Obligations	17
	4.3-4 Change in Staff Category	17
4.4	COMMUNITY BASED PHYSICIAN STAFF.....	17
	4.4-1 Qualifications	17
	4.4-2 Prerogatives	18
	4.4-3 Obligations	18
	4.4-4 Change in Staff Category	18
	4.4-5 Denial or Termination of Membership	18
4.5	HONORARY STAFF	19
	4.5-1 Qualifications	19
	4.5-2 Prerogatives	19
ARTICLE FIVE:	PROCESS FOR CREDENTIALING FOR MEMBERSHIP AND PRACTICE OF PRIVILEGES	19
5.1	PROCESS FOR CREDENTIALING FOR MEMBERSHIP AND PRIVILEGES.....	19
5.2	PROCESS FOR CREDENTIALING AND PRIVILEGING ALLIED HEALTH PROFESSIONALS	19
5.3	EXERCISE OF PRIVILEGES.....	19
	5.3-1 In General	19
	5.3-2 Privileges in Emergency Situations	20
	5.3-3 Experimental Procedures	20
	5.3-4 Remote Privileges.....	20
	5.3-4.1 Conditions	20
	5.3-4.2 Rights of the Practitioner.....	20
5.4	PROCEDURE FOR DELINEATING PRIVILEGES	21
	5.4-1 Requests.....	21
	5.4-2 Supervision	21
5.5	BASIS FOR PRIVILEGES DETERMINATIONS.....	21
5.6	PRIVILEGE DECISION NOTIFICATION.....	21
5.7	PRIVILEGES FOR NEW PROCEDURES	21
5.8	ESTABLISHMENT OF PRIVILEGES FOR INTERDISCIPLINARY PROCEDURES	22
	5.8-1 Request for Privileges.....	22
	5.8-2 Determination of Appropriateness.....	22
5.9	SPECIAL CONDITIONS	22
	5.9-1 Oral Surgeons, Dentists and Podiatrists.....	22
5.10	TEMPORARY PRIVILEGES	22
	5.10-1 Conditions.....	22
	5.10-2 Circumstances.....	23
	5.10-3 Termination	24
	5.10-4 Rights of the Practitioner.....	24
5.11	DISASTER PRIVILEGES	24
ARTICLE SIX:	CORRECTIVE ACTION	24
6.1	CRITERIA FOR INITIATING CORRECTIVE ACTION	24
6.2	PROCEDURES FOR INITIATING AN INVESTIGATION LEADING TO POSSIBLE CORRECTIVE ACTION.....	24-25
6.3	PROCEDURE FOR PROFESSIONAL REVIEW.....	25
6.4	SUMMARY SUPERVISION	26

6.4-1	Initiation	26
6.4-2	Review by the Professional Review Committee.....	26
6.5	SUMMARY SUSPENSION	26
6.5-1	Initiation	26
6.5-2	Review by the Professional Review Committee.....	27
6.5-3	Expedited Hearing Rights.....	27
6.5-4	Alternative Coverage.....	27
6.6	AUTOMATIC SUSPENSION OR LIMITATION.....	27
6.6-1	License.....	27
6.6-2	Controlled Substance Registration.....	28
6.6-3	Medical Records.....	28
6.6-4	Professional Liability Insurance	28
6.6-5	Freedom from Infectious Tuberculosis.....	28
6.6-6	Exclusion from Medicare/State Programs	28-29
6.6-7	Failure to Satisfy Special Appearance Requirement.....	29
6.6-8	Failure to Pay Staff Dues.....	29
6.6-9	Failure to Execute Releases and/or Provide Documents	29
6.6-10	Failure to Participate in an Evaluation.....	29
6.6-11	Failure to Complete Assessments and Provide Results	29
6.6-12	Failure to Become Board Certified.....	29
6.6-13	Failure to Complete CPOE Training	30
6.7	NONREVIEWABLE ACTION	30-31
6.8	HEARING AND APPEAL RIGHTS.....	31
6.8-1	Hearing and Appeals	31
6.8-2	Fair Hearing Plan.....	31
6.8-3	Hearing Plan	31
6.8-4	Scheduling the Hearing	31
6.8-5	Hearing Process	31
6.8-6	Scheduling the Appeal.....	31
6.8-7	Appeal Process	32
ARTICLE SEVEN: GENERAL STAFF OFFICERS		32
7.1	GENERAL OFFICERS OF THE STAFF.....	32
7.1-1	Identification.....	32
7.1-2	Qualifications	32
7.2	TERM OF OFFICE.....	33
7.3	ELIGIBILITY FOR RE-ELECTION.....	33
7.4	NOMINATIONS	33
7.4-1	Nominating Committee	33
7.5	ELECTIONS, VACANCIES, AND REMOVALS.....	33
7.5-1	Election Process.....	33-34
7.5-2	Vacancies in Elected Offices.....	34
7.5-3	Resignations and Removal from Office.....	34
7.6	DUTIES OF OFFICERS.....	34
7.6-1	Chief of Staff	34-35
7.6-2	Vice Chief of Staff.....	35
7.6-3	Immediate Past Chief of Staff.....	35
7.6-4	Secretary-Treasurer	35
ARTICLE EIGHT: CLINICAL DEPARTMENTS.....		35
8.1	CURRENT CLINICAL DEPARTMENTS.....	35
8.2	ASSIGNMENT TO DEPARTMENTS.....	35
8.3	FUNCTIONS OF DEPARTMENTS	35-36
8.4	DEPARTMENT OFFICERS	37
8.4-1	Qualifications	37
8.4-2	Selection	37

8.4-3	Term of Office	37
8.4-4	Removal.....	37
8.4-5	Duties.....	38
ARTICLE NINE: COMMITTEES		38
9.1	DESIGNATION	38-39
9.2	GENERAL PROVISIONS.....	39
9.2-1	Ex Officio Members	39
9.2-2	Subcommittees	39
9.2-3	Special or Standing Interdisciplinary Committees	39
9.2-4	Appointment of Members and Chairmen	39
9.2-5	Term, Prior Removal and Vacancies	39
9.2-6	Voting Rights.....	40
9.3	EXECUTIVE COMMITTEE.....	40
9.3-1	Composition	40
9.3-2	Elections, Terms, Vacancies, and Removals	40
9.3-3	Duties.....	40-41
9.3-4	Meetings	41
9.3-5	Attendance Requirements.....	42
9.4	PROFESSIONAL REVIEW COMMITTEE	42
9.4-1	Composition	42
9.4-2	Qualifications	42
9.4-3	Selection and Review Process	42
9.4-4	Duties.....	42-43
9.5	COMMUNITY BASED PHYSICIAN COMMITTEE.....	43
9.5-1	Composition	43
9.5-2	Duties.....	43
9.6	CREDENTIALS COMMITTEE.....	43
9.6-1	Composition	43
9.6-2	Duties.....	43
9.7	BYLAWS COMMITTEE	43
9.7-1	Composition	43
9.7-2	Duties.....	43-44
9.8	PROFESSIONAL HEALTH COMMITTEE	44
9.8-1	Composition	44
9.8-2	Duties.....	44
ARTICLE TEN: MEETINGS		44
10.1	MEDICAL STAFF MEETINGS	44
10.1-1	Regular Meetings.....	44
10.1-2	Special Meetings.....	44
10.2	CLINICAL DEPARTMENT AND COMMITTEE MEETINGS	45
10.2-1	Regular Meetings.....	45
10.2-2	Special Meetings.....	45
10.2-3	Executive Session	45
10.3	ATTENDANCE REQUIREMENTS	45
10.3-1	Chart Review	45
10.3-2	Clinical Conference	45
10.3-3	Special Appearance	45
10.4	QUORUM	46
10.4-1	General Staff Meetings.....	46
10.4-2	Committee Meetings.....	46
10.4-3	Department Meetings	46
ARTICLE ELEVEN: CONFIDENTIALITY, IMMUNITY AND RELEASES		46
11.1	AUTHORIZATIONS AND RELEASES	46

11.2	CONFIDENTIALITY OF INFORMATION	47
11.3	ACTIVITIES COVERED	47
11.4	RELEASES AND DOCUMENTS.....	47
11.5	CUMULATIVE EFFECT	47
11.6	INDEMNIFICATION.....	47
ARTICLE TWELVE: GENERAL PROVISIONS		48
12.1	MEDICAL STAFF RULES AND REGULATIONS.....	48
12.2	DEPARTMENT RULES AND REGULATIONS	48
12.3	STAFF DUES	48
12.4	SPECIAL NOTICE.....	48
12.5	CONSTRUCTION OF TERMS AND HEADINGS.....	48
12.6	PARLIAMENTARY PROCEDURE.....	48-49
12.7	CONFLICT RESOLUTION	49
	12.7-1 Staff Member Challenge.....	49
	12.7-2 Executive Committee Review	49
	12.7-3 Conflict Resolution Resources and Board Responsibility	49
12.8	HISTORIES AND PHYSICALS	49
ARTICLE THIRTEEN: ADOPTION AND AMENDMENT		49
13.1	MEDICAL STAFF AUTHORITY AND RESPONSIBILITY	49
13.2	PERIODIC BYLAWS REVIEWS.....	50
13.3	MEDICAL EXECUTIVE COMMITTEE PROCESS	50
13.4	MEDICAL STAFF PROCESS	50
13.5	CREDENTIALS PROCEDURE MANUAL, FAIR HEARING PLAN, MEDICAL STAFF RULES AND REGULATIONS AND ALLIED HEALTH RULES AND REGULATIONS	51
	13.5-1 Periodic Review.....	51
	13.5-2 Communication to the Medical Staff.....	51
	13.5-3 Medical Staff Amendments	51
13.6	BOARD OF DIRECTORS ACTION.....	51
	13.6-1 When Favorable to Medical Staff Recommendation.....	51
	13.6-2 Board Concerns	51
13.7	JOINT CONFERENCE COMMITTEE.....	51
13.8	TECHNICAL AND EDITORIAL AMENDMENTS	52

PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Banner Gateway Medical Center and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care and to govern the orderly resolution of those purposes. These Bylaws provide the legal structure for Medical Staff operation and describe relations between the organized Medical Staff and applicants to, and members of, the Medical Staff. These Bylaws along with the Bylaws of Banner Health provide a recognized structure for Medical Staff activities and document the relationship between the Medical Staff and the Board of Directors.

ARTICLE ONE: NAME

The organizational component of Banner Health to which these Bylaws are addressed is called "The Medical Staff of Banner Gateway Medical Center."

ARTICLE TWO: PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

2.1 PURPOSES

The purposes of this Medical Staff are:

- 2.1-1 To continually provide quality care for all patients admitted to, or treated in, any facilities, departments, or service of Banner Gateway Medical Center.
- 2.1-2 To provide a mechanism for accountability to the Board for the review of the appropriateness of patient care services, professional and ethical conduct, and teaching and research activities of each practitioner appointed to the Medical Staff, so that patient care provided at the Medical Center facilities is maintained at that level of quality and efficiency consistent with generally recognized standards of care.
- 2.1-3 To evaluate clinical processes and outcomes and identify and implement opportunities for professional performance improvement.
- 2.1-4 To maintain high scientific and educational standards for continuing medical education programs for members of the Medical Staff.
- 2.1-5 To serve as the organization through which individual practitioners may obtain prerogatives and clinical privileges at the Medical Center and through which they fulfill the obligations of staff appointment.
- 2.1-6 To provide an orderly and systematic means by which staff members can give input to the Board and CEO on medico-administrative issues and on Medical Center policy-making and planning processes.

2.2 **RESPONSIBILITIES**

The responsibilities of the Medical Staff through its departments, committees, and officers include:

- 2.2-1 To participate in the performance improvement, patient safety and utilization review programs by conducting all activities necessary for assessing, maintaining, and improving the quality and efficiency of care provided in the Medical Center, including:
 - (a) Evaluating practitioner and institutional performance through measurement systems based on objective, clinically-sound criteria and taking action to decrease morbidity and mortality;
 - (b) Engaging in the ongoing monitoring of patient care practices;
 - (c) Evaluating practitioners' credentials for appointment and reappointment to the Medical Staff and for the delineation of clinical privileges; and
 - (d) Promoting the appropriate use of Medical Center resources.
- 2.2-2 To make recommendations to the Board concerning appointments and reappointments to the staff, including category, department and section assignments, clinical privileges, and corrective action.
- 2.2-3 To participate in the development, conduct, and monitoring of medical education programs and clinical research activities.
- 2.2-4 To develop and maintain Bylaws and policies that are consistent with sound professional practices, and to enforce compliance with them.
- 2.2-5 To participate in the Medical Center's long-range planning activities, to assist in identifying community health needs, and to participate in developing and implementing appropriate institutional policies and programs to meet those needs.
- 2.2-6 To exercise through its officers, committees, and other defined components, the authority granted by these Bylaws, to fulfill these responsibilities in a timely and proper manner, and to account thereon to the Board.
- 2.2-7 To take action, as necessary to enforce the Medical Staff Bylaws, rules and regulations, and policies.

ARTICLE THREE: MEMBERSHIP

3.1 **GENERAL QUALIFICATIONS**

Every practitioner who seeks or enjoys staff membership must, at the time of application and continuously thereafter, demonstrate, to the satisfaction of the Medical Staff and the Board, the following qualifications and any additional qualifications and procedural requirements as are set forth in these Bylaws or in department rules and regulations:

3.1-1 **LICENSURE**

Evidence of a currently valid license issued by the State of Arizona to practice either medicine, dentistry, podiatry, or psychology. Applicants must provide evidence of an unrestricted license.

3.1-2 **PROFESSIONAL EDUCATION AND TRAINING**

- (a) Graduation from an approved medical, osteopathic, dental, or podiatric school or attainment of a PhD. degree in a recognized scientific field from an accredited university; or certification by the Educational Council for Foreign Medical Graduates; or Fifth Pathway certification and successful completion of the Foreign Medical Graduate Examination in the Medical Sciences.

For purposes of this section, an "approved" or "accredited" school or university is one fully accredited during the time of the practitioner's attendance by the Accreditation Council for Graduate Medical Education, by the American Osteopathic Association, by the Commission on Dental Accreditation, by the American Board of Podiatric Surgery, the Council on Podiatric Medical Education of the American Podiatric Medical Association, by the American Psychological Association, or by a successor agency to any of the foregoing or by an accrediting agency on file with the U.S. Secretary of Education.

- (b) Satisfactory completion of an approved postgraduate training program. An "approved" postgraduate training program is one fully accredited throughout the time of the practitioner's training by the Accreditation Council for Graduate Medical Education (ACGME), by the American Osteopathic Association, by the Commission on Dental Accreditation, by the American Board of Podiatric Surgery, by the Council on Podiatric Medical Education of the American Podiatric Medical Association, by the American Psychological Association, or by a successor agency to any of the foregoing, or a program equivalent to one accredited by the ACGME.

3.1-3 **BOARD CERTIFICATION**

- (a) Board certified or qualified for Board certification in the specialty to which privileges are granted or applied for. Where membership and privileges are granted on the basis of Board qualification, certification must be obtained within five years of completion of training or sooner as required by the department or within three years from the expiration of original Board certification or recertification. Failure to become certified within the time allowed under these Bylaws, as required by the appropriate Board, or Rules and Regulations of the applicant's department or section, shall result in the voluntary, automatic relinquishment of Medical Staff membership and privileges.

For purposes of this section, "Board certification" or "Board certified" means has been/is certified by a board approved by the American Board of Medical Specialties or the Advisory Board for Osteopathic Specialists or by a board determined by the department to be equivalent. For purposes of this section, "Board qualification" or "Board qualified" means the applicant has completed the training necessary to be accepted to become/applied for and been accepted to become an active candidate

for certification as determined by the appropriate board. Where the board requires a period of practice prior to submitting an application for certification, the applicant will be deemed qualified during this time period if the director of his/her training program certifies that he/she has met all training requirements for qualification by the appropriate board.

- (b) Members are required to remain board certified. Recertification must be obtained within three years from the expiration of Board certification or recertification. Failure to become recertified within the time allowed under these Bylaws shall result in the voluntary, automatic relinquishment of Medical Staff membership and privileges.
- (c) Exceptions to board eligibility/certification/recertification may be granted in the following circumstances:
 - i. Where a particular field or specialty of the department does not have a Board certification:
 - ii. Where the applicant's privileges are limited to surgical assisting or referring only:
 - iii. To applicants seeking membership prior to the opening of the Medical Center who are currently members of the medical staff of another Banner hospital and have been members for at least five years where the Executive Committee has determined that the practitioner's training and experience approximates as nearly as possible those assured by Board certification; or
 - iv. To applicants/members where there is a shortage of qualified Medical Staff members in the practitioner's specialty necessary to meet the Medical Center's demand for services where the Executive Committee has determined that the practitioner's training and experience approximates as nearly as possible those assured by Board certification.

3.1-4 CLINICAL PERFORMANCE

Current experience, clinical results, and utilization patterns, documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency.

3.1-5 COOPERATIVENESS

Demonstrated ability and willingness to work with and relate to others in a cooperative, professional manner that is essential for maintaining an environment appropriate to quality and efficient patient care and patient and employee satisfaction. It is the policy of Banner Gateway Medical Center and this Medical Staff, that all individuals within its facilities be treated courteously, respectfully, and with dignity. To that end, all Medical Staff members, and other practitioners must conduct themselves in a professional and cooperative manner. Failure to do so may constitute disruptive behavior. Disruptive behavior by any practitioner against any individual (e.g., against another Medical Staff member, house staff, hospital employee or patient) shall not be tolerated. If a practitioner fails to conduct himself/herself appropriately, corrective action, including summary suspension, may be taken.

- 3.1-6 **SATISFACTION OF MEMBERSHIP OBLIGATIONS**
Satisfactory compliance with the basic obligations accompanying appointment to the staff and equitable participation, as determined by Medical Staff and Board authorities, in the discharge of staff obligations specific to staff category.
- 3.1-7 **SATISFACTION OF CRITERIA FOR PRIVILEGES**
Evidence of satisfaction of the criteria for the granting of, and maintenance of, clinical privileges in at least one department.
- 3.1-8 **PROFESSIONAL ETHICS AND CONDUCT**
Demonstrated high moral character and adherence to generally recognized standards of medical and professional ethics which include refraining from: paying or accepting commissions or referral fees for professional services; delegating the responsibility for diagnosis or care to a practitioner or allied health professional not qualified to undertake that responsibility; failing to seek appropriate consultation when medically indicated; failing to provide or arrange for appropriate and timely medical coverage and care for patients for whom the practitioner is responsible; and failing to obtain appropriate informed patient consent for treatment.
- 3.1-9 **PARTICIPATION IN GOVERNMENT PROGRAMS**
Ability to participate in Medicare/AHCCCS and other federally funded health programs.
- 3.1-10 **HEALTH STATUS**
Freedom from or adequate control of any significant physical or mental health impairment and freedom from abuse of any type of substance or chemical that may affect cognitive, motor, or communication ability in a manner that interferes with the ability to provide quality patient care or the other qualifications for membership, and freedom from infectious tuberculosis.
- 3.1-11 **VERBAL AND WRITTEN COMMUNICATION SKILLS**
Ability to read and understand the English language, to communicate in writing and verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible manner.
- 3.1-12 **PROFESSIONAL LIABILITY INSURANCE**
Evidence of professional liability insurance of a kind and in an amount satisfactory to the Board.
- 3.1-13 **EFFECTS OF OTHER AFFILIATIONS**
No practitioner shall be entitled to appointment, reappointment, or the exercise of particular clinical privileges merely because of:
- (a) Licensure to practice;
 - (b) Completion of a postgraduate training program at any Banner facility;
 - (c) Certification by any clinical board;
 - (d) Membership on a medical school faculty;
 - (e) Staff appointment or privileges at another health care facility or in another practice setting; or
 - (f) Prior staff appointment or any particular privileges at Medical Center.

3.1-14 NONDISCRIMINATION

No aspect of Medical Staff appointment or particular clinical privileges shall be denied on the basis of age, sex, race, creed, color, national origin, a handicap unrelated to the ability to fulfill patient care and required staff obligations, or any other criterion unrelated to the delivery of quality and efficient patient care in the Medical Center, to professional qualifications, to the Medical Center' purposes, needs and capabilities, or to community need.

3.1-15 EXEMPTIONS FROM QUALIFICATIONS

Any or all of the above stated requirements for Medical Staff membership may be waived for those practitioners appointed to the honorary and community based physician staff and as otherwise provided in these Bylaws.

3.2 RIGHTS OF INDIVIDUAL STAFF MEMBERSHIP

Each staff member, regardless of assigned staff category, shall have the following rights:

- (a) The right to meet with the Executive Committee in the event he/she is unable to resolve a difficulty working with his/her respective department chairman. The member must submit written notice to the Chief of Staff at least two weeks in advance of the regular meeting;
- (b) The right to initiate a recall election of a Medical Staff Officer and/or a department chairman by following the procedures set forth in Section 7.5 and/or Section 8.4;
- (c) The right to initiate the scheduling of a general staff meeting by following the procedures set forth in Section 10.1-2;
- (d) The right to request conflict resolution of any issue by presentation to the Executive Committee of a petition signed by 20% of the Active Staff. Upon receipt of such a petition, the Executive Committee will schedule a meeting to discuss the issue.
- (e) The right to request a department meeting when a majority of members in a section or specialty believe that the department has not acted appropriately;
- (f) The right to request a hearing pursuant to the Fair Hearing Plan in the event that reviewable corrective action is taken.
- (g) The right to request review by the Executive Committee in the event that nonreviewable corrective action is taken.
- (h) The right to request that the Executive Committee request a Joint Conference Committee meeting with the Board to resolve concerns regarding medical staff bylaws, credentialing recommendations, policies or other issues which such medical staff has been unable to resolve through informal processes with the CEO, senior management, the Medical Staff Subcommittee, the Care Management and Quality Committee, or the Board of Directors

3.3 BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP

Each staff member, regardless of assigned staff category, and each practitioner exercising temporary privileges under these Bylaws, shall:

- (a) Provide patients with continuous care at the level of quality and efficiency generally recognized as appropriate;
- (b) Abide by the Banner Health Bylaws, these Bylaws, department rules and regulations, and all other standards and policies of the Board, the Medical Staff and Medical Center;

- (c) Discharge such staff, committee, department, and Medical Center functions for which he or she is responsible, including review and supervise the performance of other practitioners;
- (d) Serve on the on-call roster for charity, unassigned, and emergency patients as determined by the applicable department, the Medical Executive Committee and the CEO;
- (e) Prepare and complete in timely fashion, according to these Bylaws and to Medical Center policies, the medical and other required records for all patients to whom the practitioner provides care in the Medical Center, or within its facilities, services, or departments;
- (f) Communicate with patients and make entries in hospital medical records solely in accordance with, and to the extent authorized by, Medical Staff Rules and Regulations;
- (g) Arrange for appropriate and timely medical coverage and care for patients for whom he or she is responsible and to obtain consultation when necessary for the safety of those patients;
- (h) Participate in continuing education programs;
- (i) Use confidential information only as necessary for treatment, payment or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities, or to perform Medical Staff responsibilities. For purposes of these Bylaws, confidential information means patient information, peer review information, and Banner Health's business information designated as confidential by Banner Health or its representatives prior to disclosure;
- (j) refrain from disclosing confidential information to anyone unless authorized to do so;
- (k) Protect access codes and computer passwords and to ensure confidential information is not disclosed;
- (l) Disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or the Medical Center;
- (m) Refrain from making treatment recommendations/decisions for economic benefit of the practitioner and unrelated to needs of the patient;
- (n) Comply with all applicable state and federal law in disclosing to a patient any direct financial interest that the practitioner, his/her group or his/her employer has in a separate diagnostic or treatment facility prior to transferring the patient to such facility.

3.4 **TERM OF APPOINTMENT**

Appointments to the Medical Staff and grants of clinical privileges are for a period not to exceed two years. The Board, after considering the recommendations of the Executive Committee, may establish a shorter appointment period for the exercise of particular privileges in general or for a staff member who has an identified impairing disability, has been the subject of disciplinary action, or is under investigation or where further evaluation is pending.

3.4-1 **EXPIRATION**

The appointment of each staff member shall expire every two years on the last day of the birth month of the practitioner, except as provided in this Section.

3.5 **EXHAUSTION OF ADMINISTRATIVE REMEDIES**

Every applicant to and member of the Medical Staff agrees that when corrective action is initiated or taken or when a recommendation is made by any committee or any person

acting on its behalf, the effect of which is to deny, revoke, or otherwise limit the privileges or membership of the applicant or staff member, such applicant or member shall exhaust the administrative remedies afforded in these Bylaws (and Fair Hearing Plan) prior to initiating litigation.

3.6 LIMITATION OF DAMAGES

Every applicant to and member of the Medical Staff agrees that his or her sole remedy for any adverse or corrective action for failure to comply with these Bylaws shall be the right to seek injunctive relief pursuant to ARS 36-445 et. seq. An alleged breach of any provision of these Bylaws and/or Fair Hearing Plan shall provide no right to monetary relief from the Medical Staff, the Medical Center or any third party, including any employee, agent or member of the Medical Staff or the Medical Center and any person engaged in peer review activities.

3.7 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

3.7-1 QUALIFICATIONS

A practitioner, who is or who will be providing professional direct patient care services pursuant to a contract or employment with the Medical Center, must meet the same appointment qualifications, must be evaluated for appointment, reappointment, and clinical privileges in the same manner, and must fulfill all of the obligations of the assigned category as any other staff member. For purposes of this section, practitioners providing specified professional services does not include outside practitioners assisting the Medical Staff with its peer review functions.

- (a) Practitioners rendering professional services pursuant to employment or contracts with the Medical Center shall be required to maintain Medical Staff membership and privileges.
- (b) Unless otherwise provided in the contract for professional services or in an exclusive contract, termination of such employment or contracts shall not result in automatic termination of Medical Staff membership and privileges.

3.7-2 APPROVAL OF POSITIONS

Prior to the establishment of a full-time or part-time contracted or employed physician or group position, the CEO will discuss with the Executive Committee the proposed position, including a detailed description of the qualifications required for and the functions of the person who, or group which, will hold such position. Within 60 days, the Executive Committee will submit its comments and recommendations regarding the impact of establishing such position(s) would have on the quality of patient care provided in the Medical Center prior to the position(s) being created.

3.7-3 SUPERVISION

The practitioner must complete the supervision requirements as set forth in the department rules and regulations unless a waiver of supervision has specifically been recommended by the Executive Committee and approved by the Board.

3.8 EXCLUSIVE CONTRACTS

The Medical Center may enter into an Exclusive Agreement with members of the Medical Staff which limit the rights of other practitioners to exercise clinical privileges and/or the

rights and prerogatives of Medical Staff membership. Such Agreements may only be entered into after a determination that expected improvements to the quality of care, coverage, cost-efficiency and/or service excellence will outweigh the anticompetitive effect of the Agreement as required by the Board's Physician Exclusive Agreements policy. No reporting is required under federal or state law when privileges or membership is limited because an Exclusive Agreement is entered into, and no such reports shall be made.

3.8-1 **REVIEW OF POSITIONS**

- (a) Prior to entering into or transferring an Exclusive Agreement for a program or service not previously covered by an Exclusive Agreement, the CEO shall explain to the Executive Committee the need for, and expected benefits of, the Exclusive Agreement.
- (b) The Executive Committee shall give Medical Staff members whose privileges may be adversely affected by the establishment or modification of the Agreement an opportunity to submit written information to the Executive Committee regarding the impact the establishment of the Agreement would have on the quality of patient care to be provided and/or why the Agreement is not necessary to establish the expected benefits.
- (c) The Executive Committee shall be given an opportunity to report its findings to the CEO before the Exclusive Agreement is entered into or transferred. The report shall be limited to information relating to the impact the Agreement would have on quality of care and whether the Agreement is necessary to establish the expected benefits. The report must be submitted, if at all, within 60 days of the CEO's explanation of the need for, and expected benefits of, the Agreement to the Executive Committee. The CEO is ultimately responsible for determining, in his/her discretion, whether to enter into the Agreement.
- (d) In the event the Executive Committee disagrees with the decision of the CEO to enter into an exclusive contract, the Executive Committee may request a Joint Conference Committee as set forth in Section 13.5. The request must be made, if at all, within ten days of notification by the CEO's decision.

3.9 **MEDICAL DIRECTORS**

3.9-1 **ROLE**

A medical director is a practitioner engaged by the hospital either full or part-time in an administrative capacity. Where provided for by contract, a medical director's responsibilities shall include assisting the Medical Staff and/or the Care Management Council to carry out its peer review and quality improvement activities. Medical Directors shall serve as ex-officio appointee with vote on all committees of the Medical Staff consistent with the scope of their responsibilities. Medical Directors must continuously satisfy the qualifications and complete the requirements set forth in Section 3.1. The Executive Committee shall determine the voting rights of medical directors.

3.9-2 **CHIEF MEDICAL OFFICER**

The Chief Medical Officer shall automatically be granted Active Staff membership. The Chief Medical Officer need not remain in the active practice of medicine, and need not comply with the applicable requirements in Section 3.1.

3.10 **CREDENTIALING PROCESS**

Applicants for appointment and reappointment will be processed in accordance with the Credentialing Procedures Manual.

ARTICLE FOUR: MEDICAL STAFF CATEGORIES

4.1 **CATEGORIES**

There will be four categories of appointment to the staff: active, associate, community based and honorary.

4.2 **ACTIVE STAFF**

4.2-1 **QUALIFICATIONS FOR ACTIVE STAFF**

The active staff shall consist of physicians, dentists, podiatrists and psychologists who demonstrate a genuine concern, interest, and activity in the Medical Center through substantial involvement in the affairs of the Medical Staff or Medical Center and/or are regularly involved in the care of patients in the Medical Center facilities. The volume of annual patient contacts and involvement in the affairs of the Medical Staff or Medical Center necessary to achieve and maintain active staff shall be established by the Executive Committee.

4.2-2 **PREROGATIVES OF ACTIVE STATUS**

An active staff member may:

- (a) Admit patients, except as set forth in department rules and regulations and Medical Center admission policies.
- (b) Exercise such clinical privileges as are granted by the Board.
- (c) Vote on all matters presented at general and special meetings of the Medical Staff and of the department and committees of which he or she is a member; and
- (d) Hold office at any level in the staff organization and be chairman or a member of a committee provided the specific qualifications for the position involved are met and except as otherwise provided in these Bylaws or by resolution of the Executive Committee.

4.2-3 **OBLIGATIONS OF ACTIVE STATUS**

An active staff member must, in addition to meeting the basic obligations set forth in these Bylaws, including in Section 3.3:

- (a) Contribute to the organizational, administrative and medico-administrative, quality review, patient safety and utilization management activities of the Medical Staff, and faithfully perform the duties of any office or position to which elected or appointed; and
- (b) Pay all staff dues and assessments.

4.2-4 **FAILURE TO SATISFY QUALIFICATIONS**

Failure of an active staff member to satisfy the qualifications or obligations of the active staff category for any reappointment period may result in reassignment to another staff category or corrective action where appropriate. A practitioner who feels he or she has unjustly been removed from the active staff category may request reconsideration of the change by the Executive Committee.

4.3 **ASSOCIATE STAFF**

4.3-1 **QUALIFICATIONS**

The Associate Staff shall consist of physicians, dentists, podiatrists and psychologists who admit patients to the Medical Center only on an occasional basis.

4.3-2 **PREROGATIVES**

An Associate Staff member may:

- (a) Admit patients, except as set forth in department rules and regulations and Medical Center admission policies;
- (b) Exercise such clinical privileges as have been granted by the Board;
- (c) Be appointed to committees unless otherwise provided by these Bylaws; and
- (d) Vote on matters presented at committees to which he or she has been appointed and at department meetings unless otherwise limited by these Bylaws or by department rules and regulations.

4.3-3 **OBLIGATIONS**

An Associate Staff member must meet the basic obligations set forth in these Bylaws, including in Section 3.3, and pay all staff dues and assessments.

4.3-4 **CHANGE IN STAFF CATEGORY**

Associate members will be advanced to the active staff category at the time of reappointment or at any time during the first year of appointment if the qualifications set forth in 4.2-1 are satisfied. Failure to utilize the Medical Center during an entire reappointment period may result in a practitioner being dropped from the Medical Staff or moved to the Community Based Physician Staff. A practitioner who feels he or she has unjustly been moved from the Associate Staff category may request reconsideration of the change by the Executive Committee.

4.4 **COMMUNITY BASED PHYSICIAN STAFF**

4.4-1 **QUALIFICATIONS**

The Community Based Physician Staff shall consist of physicians who do not treat patients at the Medical Center but who request Medical Center services for their patients and who require access to their patients' health information. Access to patients' health information is available through clinical connectivity. Community Based Physician Staff have no clinical privileges and are therefore exempt from CPOE training. Community Based Providers must apply for Medical Staff Membership and provide evidence of the following qualifications:

- (a) Arizona licensure in good standing;
- (b) Ability to participate in Medicare/AHCCCS and other federally funded health programs;
- (c) Ability to relate in a professional manner with Medical Center staff and physicians; and
- (d) Professional ethics and conduct.

4.4-2 **PREROGATIVES**

The Community Based Physician Staff Members may:

- (a) Serve on the Community Based Physician Committee;
- (b) Order outpatient diagnostic services for patients;
- (c) Make courtesy visits to patients;
- (d) Be appointed to committees unless otherwise provided by these Bylaws;
- (e) Vote on matters presented at committees to which he or she has been appointed and unless otherwise limited by these Bylaws or by department rules and regulations;
- (f) Attend general staff meetings; and
- (g) Attend Medical Center Continuing Medical Education programs.

Community Based Physician staff members are not allowed to admit or treat or consult on patients admitted as inpatients in the Medical Center. Such members who wish to exercise privileges at the Medical Center must request a change in staff category and submit requested documentation, including evidence of current clinical competence to perform the privileges requested. The Community Based Physician Staff shall not be eligible to vote on matters presented to the staff nor to hold elected office.

4.4-3 **OBLIGATIONS**

The Community Based Physician Staff must maintain the confidentiality of patient information, computer passwords and access codes. The Community Based Physician Staff must pay staff dues and assessments if and as established by the Executive Committee.

4.4-4 **CHANGE IN STAFF CATEGORY**

The Community Based Physician Staff Members may be elevated to the Active Staff if they:

- (a) Meet all qualifications for Staff Membership set forth under Section 3.1, including the Board Certification requirement;
- (b) Are regularly involved in the care of Medical Center patients in the outpatient setting; and
- (c) Demonstrate a genuine concern and interest in the Medical Center through substantial involvement in the affairs of the Medical Staff or Medical Center. . The involvement in the affairs of the Medical Staff or Medical Center shall be established by the Executive Committee.

4.4-5 **DENIAL OR TERMINATION OF MEMBERSHIP**

As physicians seeking or who have been granted Community Based Physician Staff status have no clinical privileges, they are not entitled to due process rights under the Fair Hearing Plan. A physician who believes he or she was wrongly denied Community Based Physician Staff status or whose status was terminated may submit information to the Executive Committee demonstrating why the denial or termination was unwarranted. The Executive Committee, in its sole discretion, shall decide whether to review the submission. The physician has no appeal or other rights in connection with the Executive Committee's decision.

4.5 **HONORARY STAFF**

4.5-1 **QUALIFICATIONS**

Membership on the honorary staff is by invitation and is restricted to staff members for whom the Executive Committee recommends and the Board approves this status in recognition of long-standing service to the Medical Center or other noteworthy contributions to its activities.

4.5-2 **PREROGATIVES**

Honorary staff members shall not be eligible to vote on matters presented to the staff nor to hold elected office; are not required to have malpractice insurance or a license to practice; and are not required to pay dues or assessments. Honorary staff members may serve on committees and may vote on matters presented at committees of which they are members. Honorary staff members are not allowed to admit or treat patients or to consult.

ARTICLE FIVE: PROCESS FOR CREDENTIALING FOR MEMBERSHIP AND PRACTICE PRIVILEGES

5.1 **PROCESS FOR CREDENTIALING FOR MEMBERSHIP AND PRIVILEGES**

Completed applications for membership and privileges are submitted at the time of initial appointment to the Credentials Committee, Department, Section as appropriate, and Executive Committee, subject to final approval by the Board. Expedited applications may be submitted directly to the Chairmen of the Credentials Committee, Department and Section, to the Executive Committee, and to the Board. Completed applications for reappointment are submitted to the Department, Section as appropriate, and Executive Committee, subject to final approval by the Board. The process for appointment and reappointment to the Medical Staff is set forth in further detail in the Credentialing Procedures Manual.

5.2 **PROCESS FOR CREDENTIALING AND PRIVILEGING ALLIED HEALTH PROFESSIONALS**

Completed applications for allied health membership for initial appointment and scopes of practice will be submitted to the Credentials Committee, Department, Section (if applicable) and Executive Committee for review and action prior to submission to the Board. Completed applications for reappointment are submitted to the Department, Section as appropriate, and Executive Committee, subject to final approval by the Board. The process for appointment and reappointment to the Allied Health Staff is set forth in further detail in the Allied Health Rules and Regulations.

5.3 **EXERCISE OF PRIVILEGES**

5.3-1 **IN GENERAL**

Privileges may not be exercised at the Medical Center until the practitioner has successfully completed Banner's practitioner orientation, which includes electronic medical record/computer assisted order entry training (CPOE training). Except in an emergency, a practitioner providing clinical services at the Medical Center may exercise only those clinical privileges specifically granted.

5.3-2 **PRIVILEGES IN EMERGENCY SITUATIONS**

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger and any delay in administering treatment could add to that danger, any practitioner is authorized to the degree permitted by the practitioner's license, when better alternative sources of care are not available within the necessary time frame, to do everything possible to save the patient's life or to save the patient from serious harm, regardless of department affiliation, staff category, or privileges. A practitioner providing such emergency services outside the scope of granted privileges is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up care.

5.3-3 **EXPERIMENTAL PROCEDURES**

Experimental drugs, procedures, or other therapies or tests (Experimental Procedures) may be performed only after approval of the involved protocols by the Institutional Review Board. Any Experimental Procedure may be performed only after the regular credentialing process has been completed and the privilege to perform or use such procedure has been granted to the practitioner.

5.3-4 **REMOTE PRIVILEGES**

Remote privileges may be granted to physicians who do not come to the Medical Center but who treat Medical Center patients through electronic communications. Such physicians whose only privileges at the Medical Center are remote privileges are not members of the Medical Staff.

5.3-4.1 **CONDITIONS**

Remote privileges may be granted only to physicians practicing in those specialties where the Executive Committee determines that [i] services can be appropriately provided from a remote location; [ii] and that such services will enhance the quality of care or services at the Medical Center. Practitioners providing care, treatment, and services of a patient via an electronic communication link are subject to the credentialing and privileging process of BGMC. If the type or extent of clinical services which may be provided to Medical Center inpatients from a remote location, is limited by the Executive Committee or the CEO, the practitioners privilege to provide this service via an electronic communication link will automatically expire upon 30 day written notification of this decision by the Medical Executive Committee or the CEO.

5.3-4.2 **RIGHTS OF THE PRACTITIONER**

Physicians seeking or who have been granted remote privileges are not entitled to due process rights under the Fair Hearing Plan if remote privileges are denied or terminated unless such action is reportable to the National Practitioner Data Bank or the Arizona Medical Board. A physician who believes he or she was wrongly denied remote privileges or whose remote privileges were terminated or limited may submit information to the Executive Committee demonstrating why the denial, limitation or termination was unwarranted. The Executive Committee, in its sole discretion, shall decide whether to review the submission. The physician has no appeal or other rights in connection with the Executive Committee's decision.

5.4 **PROCEDURE FOR DELINEATING PRIVILEGES**

5.4-1 **REQUESTS**

Each application for appointment and reappointment must contain a request for the specific clinical privileges desired by the practitioner. Specific requests must also be submitted for modifications of privileges in the interim between reappointment periods. All requests for clinical privileges will be processed in accordance with the procedures set forth in the Credentialing Manual, except that requests submitted after the initial granting of membership shall not require review by the Credentials Committee.

5.4-2 **SUPERVISION**

Whenever a practitioner requests clinical privileges not previously granted to the practitioner by the Board, the practitioner must arrange for the number and types of cases to be reviewed or observed as required in the department rules and regulations, unless a waiver of supervision has specifically been recommended by the department and the Executive Committee and approved by the Board. After the completion of such supervision, the practitioner may be granted unsupervised privileges.

5.5 **BASIS FOR PRIVILEGES DETERMINATIONS**

Clinical privileges shall be granted in accordance with education and training, experience, utilization practice patterns, current health status, and demonstrated competence and judgment to provide quality and appropriate patient care in an efficient manner as documented and verified in each practitioner's credentials file. Additional factors that may be used in determining privileges include those qualifications set forth in Section 3.1. Where appropriate, review of the records of patients treated in other hospitals or practice settings may also serve as the basis for privileges determination(s). In reappointment determinations, results of quality and performance improvement and utilization review, peer review, supervised cases, and where appropriate, practice at other hospitals will also be considered. In review of requests for changes in privileges, evidence of appropriate training and experience and current clinical competence must be documented.

5.6 **PRIVILEGE DECISION NOTIFICATION**

The decision to grant, limit or deny an initially requested privilege or an existing privilege petitioned for renewal is communicated to the requesting practitioner within three (3) weeks of the Board's action. In case of privilege denial, the application is informed of the reason for denial. The decision to grant, deny, revise or revoke privilege(s) is disseminated and made available to all appropriate internal and/or external persons or entities.

5.7 **PRIVILEGES FOR NEW PROCEDURES**

Departments will consider new technologies and procedures to determine whether the privilege to use such technologies or perform such procedures is subsumed under existing core or other privileges or requires additional education and training, experience and demonstrated competence and/or new staff competencies. Physicians desiring to utilize new technologies or perform new procedures may do so once the Executive Committee has considered and approved the department's recommendation to create/not create new criteria for privileges and, where new criteria are established, has determined that the physician has demonstrated that he/she has the necessary qualifications. The Executive Committee's determination is subject to ratification by the Banner Board.

- 5.8 **ESTABLISHMENT OF PRIVILEGES FOR INTERDISCIPLINARY PROCEDURES**
- 5.8-1 **REQUEST FOR PRIVILEGES**
As a result of emerging technology, practitioners in different specialties may be qualified by training, demonstrated competence and judgment to perform procedures traditionally under the jurisdiction of one department. In the event that a practitioner requests privileges to perform a procedure not currently within the jurisdiction of his or her department, the practitioner will notify the Chief of Staff in writing. The notice must contain basis for such practitioner's determination that he or she is qualified for the requested privileges, including proof of training and number of procedures performed.
- 5.8-2 **DETERMINATION OF APPROPRIATENESS**
The Chief of Staff, with the approval of the Executive Committee, will establish an interdisciplinary Ad Hoc Committee or request the Professional Review Committee to evaluate the request. The chairman of the Committee shall be a disinterested party currently not performing these procedures. The Committee shall give the affected practitioner and other interested persons an opportunity for an interview. After receipt of the Committee's report, the Executive Committee will recommend to the Board whether inter-disciplinary privileges are appropriate and, if applicable, the criteria and process for granting such privileges.
- 5.9 **SPECIAL CONDITIONS**
- 5.9-1 **ORAL SURGEONS, DENTISTS AND PODIATRISTS**
Surgical procedures performed by oral surgeons and dentists and podiatrists are under the overall supervision of the chairman of the Department of Surgery. An oral surgeon or podiatrist who meets the requisite qualifications may be granted the privilege of performing a history and physical examination and assessing the medical risks of the proposed procedure to the patient but only in those instances where the patient has no known current unrelated medical problems. Where any medical problems exist, a physician member of the Medical Staff must perform a basic medical appraisal on such patient, must determine the risk and effect of any proposed surgical or special procedure, and must be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization. When significant medical abnormality is present, the final decision whether to proceed must be agreed upon by the oral surgeon or dentist or podiatrist and the physician consultant. The chairman of the Department of Surgery will decide the issue in case of dispute. Where the patient is an inpatient, the oral surgeon or dentist or podiatrist must arrange for a physician member of the Medical Staff to be an attending physician.
- 5.10 **TEMPORARY PRIVILEGES**
- 5.10-1 **CONDITIONS**
Temporary privileges may be granted only in the circumstances and under the conditions described below, only to an appropriately licensed practitioner, only when the information available substantially supports a favorable determination regarding the requesting practitioner's qualifications, and only after the practitioner has satisfied the professional liability insurance requirement of these Bylaws. Special requirements of supervision and reporting may be imposed by the Chief of Staff or department chairman. Under all circumstances, the practitioner requesting temporary privileges must agree to abide by these Bylaws and the policies of the Medical Staff and Medical Center.

5.10-2 **CIRCUMSTANCES**

Upon the recommendation of the Chief of Staff, department chairman, and Credentials Committee chairman or their respective designees, the CEO or designee may grant temporary privileges in the following circumstances:

- (a) Pendency of Application: While awaiting review and recommendation by the Medical Executive Committee and approval by the Board, to an applicant for staff membership who has submitted a complete application and has requested temporary privileges, but only (i) upon verification of such information contained in the application as deemed appropriate including at least the following: Verification of current licensure, relevant training or experience, current competence, and ability to perform the privileges requested; and (ii) where the application and results of the National Practitioner Data Bank query demonstrate no current or previously successful challenge to licensure or registration, no involuntary termination of Medical Staff membership at another organization, and no involuntary limitation, reduction, denial, or loss of clinical privileges.

Temporary privileges may be granted to an applicant for an initial period not to exceed 60 days upon completion of CPOE training. One extension may be granted for an additional period not to exceed 60 days. Any such renewal shall be made by the department chairman when the information available continues to support a favorable determination regarding the practitioner's application for membership and privileges. Under no circumstances may such privileges be granted or renewed if the application is still pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

- (b) Care of Specific Patient: to a practitioner for the care of a specific patient but only after receipt of a request for the specific privileges desired and confirmation of both appropriate licensure and adequate professional liability insurance coverage and favorable results of the National Practitioner Data Bank query. Such temporary privileges may not be granted in more than (4) four instances in any 12 month period after which the practitioner must apply for staff appointment, and are restricted to the care of specific patients for which they are granted.
- (c) Coverage of Services: In special circumstances where a service is not adequately covered to meet patient care needs, temporary privileges may be granted to an applicant for staff membership upon receipt of application and verification of the following information: appropriate licensure, adequate professional liability insurance, DEA registration (if applicable), current clinical competency, education and training, and NPDB query responses as required to meet privilege criteria. Temporary privileges shall be granted under this provision only under exceptional circumstances and never solely for the sake of physician convenience. Temporary privileges will be considered on an individual basis for a period not to exceed 60 days upon completion of CPOE training. One extension may be granted for an additional period not to exceed 60 days.

5.10-3 TERMINATION

The CEO, Chief of Staff, department chairman, or Credentials chairman may terminate any or all of a practitioner's temporary privileges on the discovery of any information or the occurrence of any event of a nature that raises a question about a practitioner's professional qualifications. In the event of such termination, the practitioner's patients then in the Medical Center will be assigned to another practitioner. The wishes of the patient will be considered, where feasible, in choosing a substitute practitioner.

5.10-4 RIGHTS OF THE PRACTITIONER

A practitioner is not entitled to the procedural rights afforded by these Bylaws because a request for temporary privileges is refused in whole or in part or because all or any portion of the temporary privileges are terminated, not renewed, restricted, suspended, or limited in any way.

5.11 DISASTER PRIVILEGES

In the event of an officially declared emergency or disaster, any physician, dentist, nurse practitioner, or physician assistant may be granted temporary disaster privileges upon recommendation of the CEO, Chief Medical Officer, Chief of Staff or incident commander handling the disaster provided that the care, treatment, and services provided are within the scope of the individual's license. Such practitioner shall provide evidence of a valid professional license, with the practitioner's license number, or picture identification evidencing that such practitioner is a member of an Arizona hospital's Medical Staff or a member of a Medical Staff at a federal military hospital. Where the practitioner is not a member of an Arizona hospital's Medical Staff, a current Hospital employee or Medical Staff member must recommend the granting of such privileges. Such privileges expire within thirty (30) days or upon the termination of the disaster or completion of inpatient care, whichever occurs first, and may be terminated in accordance with Section 5.7.-3. A practitioner is not entitled the procedural rights afforded by these Bylaws because a request for temporary privileges is refused or because such privileges are terminated or otherwise limited.

ARTICLE 6: CORRECTIVE ACTION

6.1 CRITERIA FOR INITIATING CORRECTIVE ACTION

Corrective action may be initiated against a practitioner if it appears that the practitioner does not meet the standards required by these Bylaws or any applicable Medical Staff policies, or if the practitioner is or may be engaged in a course of conduct, either within or outside the Medical Center, that is detrimental to patient care or lower than the standards or aims of the Medical Staff.

6.2 PROCEDURES FOR INITIATING AN INVESTIGATION LEADING TO POSSIBLE CORRECTIVE ACTION

- (a) A request for an investigation and/or corrective action may be submitted to the Chief of Staff by any member of the Medical Staff, the CEO, or the Board. The request must be in writing and must be supported by reference to the specific activities or conduct forming the basis for the request.
- (b) The Professional Review Committee or subcommittee thereof ("Professional Review Committee") shall consider the request and determine if an investigation is warranted. The Professional Review Committee may use one or more "evaluation tools" described below to determine if an investigation is warranted or, where an investigation is

found to be warranted, to determine whether corrective action is necessary. Evaluation tools include an interview with the practitioner, concurrent or retrospective chart review, concurrent observation and/or consultation requirements. A practitioner's refusal to cooperate in an evaluation constitutes grounds for automatic suspension pursuant to Section 6.6-10 of these Bylaws. The practitioner has the right to an interview if he/she believes the Professional Review Committee should reconsider the use of any such evaluation tool. However, the practitioner is not entitled to the procedural rights afforded by these Bylaws because of the use of such tools. The Executive Committee will be kept informed of the status of such investigations.

- (c) Certain matters that may lead to corrective action are routinely considered by each Medical Staff department and/or the Professional Review Committee as a part of their ongoing quality and performance improvement, clinical, administrative, and educational functions. When, as a result of fulfilling these functions, information comes to the attention of the department or the Professional Review Committee, the Professional Review Committee shall conduct a review as set forth herein, and no request for an investigation and/or corrective action is required.

6.3 **PROCEDURE FOR PROFESSIONAL REVIEW**

- (a) Within 60 days of the determination by the Professional Review Committee that corrective action may be warranted, the Professional Review Committee shall conclude an investigation and document its findings. If the findings warrant that corrective action be taken, the affected practitioner shall have an opportunity for an interview with the Professional Review Committee. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws shall apply thereto, including the right to be accompanied by counsel. A record of such interview shall be made and included with its report. In certain instances, the Professional Review Committee may not be concluded within 60 days. In such instances, the investigation shall be concluded as soon as reasonably practical. The affected practitioner shall have no procedural rights arising out of such delay. After its deliberations, the Professional Review Committee will make its recommendation, and if adverse, shall forward it to the Executive Committee.
- (b) If the Professional Review Committee recommends that corrective action be taken, the Executive Committee shall review the recommendation to determine whether it is supported by substantial evidence and whether the Bylaws were followed. Prior to recommending reviewable corrective action, the Executive Committee shall give the affected practitioner an opportunity for an interview. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws shall apply thereto, including the right to be accompanied by counsel. If the Executive Committee recommends corrective action that is reviewable, the affected practitioner shall be given notice and a right to a hearing as set forth in these Bylaws.

6.4 **SUMMARY SUPERVISION**

6.4-1 **INITIATION**

Whenever criteria exist for initiating corrective action pursuant to this Article, the practitioner may be summarily placed under supervision concurrently with the initiation of professional review activities and until such time as a final determination is made regarding his or her privileges. Any two of the following individuals shall have the right to impose supervision:

- (a) Chief of Staff or designee, acting as a member of and on behalf of the Executive Committee;
- (b) Chief Medical Officer;
- (c) Member of the Professional Review Committee, acting on behalf of the Professional Review Committee;
- (d) Applicable department chairman or designee, acting as a member of and on behalf of the applicable department committee;
- (e) Chief Executive Officer or designee;
- (f) Executive Committee member, acting as a member of and on behalf of the Executive Committee;
- (g) Chairman of the Banner Board of Directors

6.4-2 **REVIEW BY THE PROFESSIONAL REVIEW COMMITTEE**

A practitioner whose clinical privileges have been placed under summary supervision by any two individuals identified in Section 6.4-1 (and not by the Professional Review Committee pursuant to Section 6.2) shall be entitled to request a review of the summary supervision by the Professional Review Committee or subcommittee thereof, having no less than three (3) members. The review must be requested, if at all, within 10 business days of the practitioner's receipt of notice of the supervision. Such review shall take place within 10 days of the request for review. Upon deliberation, the Professional Review Committee or subcommittee thereof may direct that summary supervision be terminated or continued.

6.5 **SUMMARY SUSPENSION**

6.5-1 **INITIATION**

Whenever immediate action must be taken in the best interest of patient care in the Medical Center or to prevent imminent danger to the health of any individual, any two of the following individuals shall have the right to summarily suspend membership and all or any portion of the clinical privileges of a practitioner:

- (a) Chief of Staff or designee, acting as a member of and on behalf of the Executive Committee;
- (b) Chief Medical Officer;
- (c) Member of the Professional Review Committee, acting on behalf of the Professional Review Committee;
- (d) Applicable department chairman or designee, acting as a member of and on behalf of the applicable department committee;
- (e) Chief Executive Officer or designee;
- (f) Executive Committee member, acting as a member of and on behalf of the Executive Committee;
- (g) Chairman of the Banner Board of Directors

A summary suspension is effective immediately upon imposition and until such time as a final decision is made regarding the practitioner's privileges. Summary suspension shall be followed promptly by special notice to the affected practitioner.

6.5-2 **REVIEW BY THE PROFESSIONAL REVIEW COMMITTEE AND EXECUTIVE COMMITTEE**

A practitioner whose clinical privileges have been summarily suspended shall be entitled to request a review of the summary suspension by the Professional Review Committee or a subcommittee thereof having no less than three (3) members. The review must be requested within 10 business days of the practitioner's receipt of notice of the suspension. Such review shall take place within 10 business days of the request for review. Upon deliberation, the Professional Review Committee or subcommittee thereof may direct that summary suspension be terminated or continued. Where the suspension is continued, the affected practitioner shall be entitled to request a review of the summary suspension by the Executive Committee or a subcommittee thereof having no less than three (3) members. The review must be requested within 10 business days of the practitioner's receipt of notice of the Professional Review Committee's decision. Such review shall take place within 10 business days of the request for review.

6.5-3 **EXPEDITED HEARING RIGHTS**

In the event summary suspension is continued, special notice of the decision shall be sent to the affected practitioner who may request a hearing or an expedited hearing pursuant to the Fair Hearing Plan.

6.5-4 **ALTERNATIVE COVERAGE**

Immediately upon imposition of summary suspension, the Chief of Staff, Chief Medical Officer, CEO, department chairman or their respective designees shall have the authority to provide for alternative medical coverage for the patients of the suspended practitioner who remain in the Medical Center. Patients' wishes shall be considered in the selection of an alternative practitioner.

6.6 **AUTOMATIC SUSPENSION OR LIMITATION**

When grounds exist for automatic suspension, the privileges of the practitioner will be automatically suspended without prior action by the Executive Committee or the Board. Alternative medical coverage will be provided for patients as set forth in Section 6.5-4. In addition, further corrective action may be recommended in accordance with the provisions contained within these Bylaws whenever any of the following actions occur:

6.6-1 **LICENSE**

- (a) Revocation: Whenever a practitioner's license to practice in this State is revoked, Medical Staff appointment and clinical privileges are immediately and automatically revoked.
- (b) Restriction: Whenever a practitioner's license is limited or restricted in any way, those clinical privileges that are within the scope of the limitation or restriction are similarly immediately and automatically restricted.
- (c) Suspension: Whenever a practitioner's license is suspended, Medical Staff appointment and clinical privileges are automatically suspended for the term of the licensure suspension.
- (d) Probation: Whenever a practitioner is placed on probation by a licensing authority, his or her membership status and clinical privileges shall become subject to the same terms and conditions of the probation.
- (e) Expiration: Whenever a practitioner's license becomes expired.

- 6.6-2 **CONTROLLED SUBSTANCES REGISTRATION**
Whenever a practitioner's DEA or other controlled substances registration is revoked, restricted, suspended, or has expired, the practitioner's right to prescribe medications covered by the registration is similarly revoked, restricted, or suspended.
- 6.6-3 **MEDICAL RECORDS**
A temporary suspension of privileges to admit new patients or to schedule new procedures shall be imposed for failure to complete medical records within the time periods established by the Executive Committee. Such suspension shall not apply to patients admitted or already scheduled at the time of the suspension, to emergency patients, or to imminent deliveries. Temporary suspension shall be lifted upon completion of the delinquent records. Temporary suspension shall become automatic permanent suspension for failure to complete delinquent records within 30 calendar days. Affected practitioners may request reinstatement during a period of 30 calendar days following permanent suspension if the delinquent records have been completed. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges. A practitioner who is on temporary medical records suspension three (3) times in any six month period may be removed from Emergency Room call by the Executive Committee, the CEO or the Board.
- 6.6-4 **PROFESSIONAL LIABILITY INSURANCE**
A practitioner's Medical Staff appointment and clinical privileges shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required under Section 3.1-11 of these Bylaws. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension, upon presentation of proof of adequate insurance. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.
- 6.6-5 **FREEDOM FROM INFECTIOUS TUBERCULOSIS**
A practitioner's Medical Staff appointment and clinical privileges shall be immediately suspended for failure to provide evidence of freedom from infectious tuberculosis as required by law and Hospital policy. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension upon presentation of evidence of freedom from TB. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.
- 6.6-6 **EXCLUSION FROM MEDICARE/STATE PROGRAMS**
The CEO with notice to the Chief of Staff will immediately and automatically suspend the Medical Staff privileges of an Excluded Practitioner. The CEO will restore limited privileges to an Excluded Practitioner upon his/her signing an agreement whereby he/she agrees (a) not to provide items or services to patients enrolled in Medicare/State Programs and (b) to indemnify the hospital and the Medical Staff for any liability they might have solely as a result of a breach of this agreement. An "Excluded Practitioner" is a practitioner whose name is listed on the then current "list of Excluded Individuals/Entities" maintained by the Office of Inspector General, Department of Health and Human Services or who has been barred from participation in any Medicare/State

Program. A "Medicare/State Program" is any federal or state program, including Medicare, Medicaid, AHCCCS, Indian Health Service, or CHAMPUS program.

6.6-7 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A practitioner who fails without good cause to appear at a meeting where his or her special appearance is required, in accordance with Section 10.3-3, shall automatically be suspended from exercising all clinical privileges with the exception of emergencies and imminent deliveries. Failure to appear within 3 months of the request to appear shall result in revocation of staff membership and privileges. Thereafter, the affected practitioner must reapply for staff membership and privileges.

6.6-8 FAILURE TO PAY STAFF DUES

A practitioner who fails to pay staff dues as set forth in Section 12.3 shall automatically be suspended from the Medical Staff. If the dues are paid within 30 calendar days of notification of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.6-9 FAILURE TO EXECUTE RELEASES AND/OR PROVIDE DOCUMENTS

A practitioner who fails to execute a general or specific release and/or provide documents, as set forth in Section 11.4, during a term of appointment when requested by the Chief of Staff, department chairman or designee shall automatically be suspended. If the release is executed and/or documents provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.6-10 FAILURE TO PARTICIPATE IN AN EVALUATION

A practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership and/or privileges as required by Section 11.2 shall automatically be suspended. If, within 30 days of the suspension, the practitioner agrees in writing to participate in the evaluation and does participate constructively, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.6-11 FAILURE TO COMPLETE ASSESSMENTS AND PROVIDE RESULTS

A practitioner who fails to complete a required educational assessment and/or training program and/or health (including psychiatric/psychological health) assessment and follow-up treatment or to provide a report of such findings shall automatically be suspended. If the report is provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.6-12 FAILURE TO BECOME BOARD CERTIFIED

Whenever a practitioner's time period in which to become board certified expires, the practitioner is deemed to have immediately and voluntarily relinquished his/her Medical Staff appointment and clinical privileges.

6.6-13 FAILURE TO COMPLETE CPOE TRAINING

The failure to complete CPOE training within 6 months of appointment to the Medical Staff will result in automatic relinquishment of membership and privileges.

6.7 NONREVIEWABLE ACTION

Not every action entitles the practitioner to rights pursuant to the Fair Hearing Plan. Those types of corrective action giving rise to automatic suspension as set forth in Section 6.6 are not reviewable under the Fair Hearing Plan. In addition, the following occurrences are also nonreviewable under the Fair Hearing Plan:

- (a) Imposition of supervision pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.
- (b) Issuance of a warning or a letter of admonition or reprimand.
- (c) Imposition of monitoring of professional practices, other than direct supervision, for a period of 6 months or less.
- (d) Termination or limitation of temporary privileges.
- (e) Supervision and other requirements imposed as a condition of granting privileges.
- (f) Termination of any contract with or employment by the Medical Center(s).
- (g) Any recommendation voluntarily imposed or accepted by a practitioner.
- (h) Denial of membership and privileges for failure to complete an application for membership or privileges.
- (i) Removal of membership and privileges for failure to complete supervision within the time period granted by these Bylaws.
- (j) Removal of membership and privileges for failure to submit an application for reappointment within the allowable time period.
- (k) Reduction or change in staff category.
- (l) Refusal of the credentials committee, department, or Executive Committee to consider a request for appointment, reappointment, staff category, department assignment, or privileges within two years of a final adverse decision regarding such request.
- (m) Removal or limitation of Emergency Department call obligations.
- (n) Any requirement to complete an educational assessment or training program.
- (o) Imposition of a consultation requirement pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.
- (p) Any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.
- (q) Retrospective chart review.
- (r) Denial, removal or limitation of membership and/or privileges as a result of (1) the decision of the CEO to enter into, terminate or modify an exclusive contract for certain clinical services; or (2) the termination or modification of the practitioner's relationship with the exclusive provider.
- (s) Grant of conditional appointment or appointment for a limited duration.
- (t) Termination or limitation of Remote membership or privileges based upon the failure to maintain Active Staff membership in good standing at another Banner hospital.

- (u) Termination or limitation of Remote membership or privileges based upon a limitation in the type or extent of clinical services which may be provided to Medical Center inpatients from a remote location.

Where an action that is not reviewable under the Fair Hearing Plan has been taken against a practitioner, the affected practitioner may request review of the action and may submit information demonstrating why the action is unwarranted. Depending upon the nature of the action and the Committee or individual who took the action, the Executive Committee, the Professional Review Committee or the CEO shall consider the request and decide, in its/his/her sole discretion, whether to review the submission and whether to take or recommend any action. The affected practitioner shall have no appeal or other rights in connection with the Executive Committee's, Professional Review Committee's or CEO's decision.

6.8 HEARING AND APPEAL RIGHTS

6.8-1 HEARINGS AND APPEALS

The hearing will be conducted in accordance with Fair Hearing Plan. The appeal will be conducted in accordance with the Board's Appellate Review Policy [as such policy is included in the Fair Hearing Plan].

6.8-2 FAIR HEARING PLAN

When hearing rights are triggered, the practitioner is notified of the grounds for the adverse action or recommendation and his/her right to request a hearing by submitting a written request to the CEO within 30 days.

6.8-3 HEARING PANEL

When a hearing is requested, the hearing will be conducted by a committee composed of at least three members. No person in direct economic competition with the practitioner or who has participated in the adverse recommendation shall participate. Members of the hearing committee shall be physicians and may, but need not, be members of the medical staff.

6.8-4 SCHEDULING THE HEARING

Except when the practitioner has the right to request an expedited hearing and has requested such a hearing, the CEO shall send the practitioner notice of the date, time, and place of the hearing at least 30 calendar days prior to the hearing. Efforts will be made to schedule the meeting to commence not less than 30 calendar days nor more than 90 calendar days after the CEO sends special notice to the practitioner. Upon receipt of a written request by a practitioner for an expedited hearing, the hearing must be held as soon as the arrangements may reasonably be made. The above stated time periods may be modified upon the mutual agreement of the practitioner and the Chief of Staff.

6.8-5 HEARING PROCESS

The Executive Committee has the initial obligation to present evidence in support of the adverse action or recommendation. Thereafter, the practitioner has the right to submit evidence and testimony to challenge the adverse recommendation or action provided that the procedures set forth in the Fair Hearing Plan have been followed.

6.8-6 SCHEDULING THE APPEAL

Upon receipt of a timely and proper request for appellate review, the General Counsel of Banner shall schedule the appellate review as soon as practicable.

The General Counsel will attempt to schedule the review at a date and time acceptable to the practitioner, representatives of the Medical Staff and members of the Appeals Subcommittee.

6.8-7 **APPEAL PROCESS**

The practitioner has the burden of demonstrating, by preponderance of the evidence, that the hearing was not in substantial compliance with the procedures required by the Medical Staff Bylaws, or applicable law, and created demonstrable prejudice; or the adverse recommendation or action was arbitrary, capricious, or not supported by substantial evidence based upon the Hearing Record. Thereafter, the Executive Committee may present evidence in support of the reconsidered recommendation or action.

ARTICLE SEVEN: GENERAL STAFF OFFICERS

7.1 **GENERAL OFFICERS OF THE STAFF**

7.1-1 **IDENTIFICATION**

The general officers of the staff are:

- (a) Chief of Staff
- (b) Vice Chief of Staff
- (c) Immediate Past Chief of Staff (ex officio)
- (d) Secretary-Treasurer

7.1-2 **QUALIFICATIONS**

- (a) Each general officer must:
 - i. Be a member of the active staff at the time of nomination and election and remain a member in good standing during his or her term of office.
 - ii. Have demonstrated ability through experience and prior participation in staff activities and be recognized for a high level of clinical competence.
 - iii. Have demonstrated a high degree of interest in and support of the Medical Staff and the Medical Center.
 - iv. Be able and willing to fully discharge the duties and exercise the authority of the office held and work with the other general and department officers of the Medical Staff, the CEO, and the Board.
 - v. Not have a disabling conflict of interest with the Medical Staff or Medical Center as determined by the Executive Committee.
- (c) Candidates for the Chief of Staff must meet the qualifications for general officers and must also have served on the Executive Committee.
- (d) A practitioner may not hold simultaneously two or more general staff offices.
- (e) The provisions of this Article relating to qualifications, nomination, and election do not apply to the initial general staff officers.

7.2 **TERM OF OFFICE**

The term of office of general staff officers is two years. Officers shall assume office on the first day of January following their election, except that an officer appointed to fill a vacancy assumes office immediately upon appointment and serves for the remainder of the unexpired term. Each officer serves until the end of his or her term and until a successor is elected, unless such officer sooner resigns or is removed from office.

7.3 **ELIGIBILITY FOR RE-ELECTION**

A general staff officer is eligible for nomination and re-election in succeeding terms.

7.4 **NOMINATIONS**

7.4-1 **NOMINATING COMMITTEE**

- (a) The General Officers of the Staff and department chairs shall serve as the nominating committee. The Nominating Committee will develop a slate of nominees, which shall include at least one candidate for each office. Nominees for the Chief of Staff must have served on the Executive Committee for at least two years. Nominees must disclose interests that potentially compete with the interests of the Medical Staff and/or the Medical Center, including ownership and financial interests in competing facilities or employment or contractual relationships with the Medical Center or with competing facilities. At the July meeting of the Executive Committee, the Nominating Committee shall present for information the list of nominations to the Executive Committee and the CEO. The Secretary shall give written notice of the nominations to all active staff members of the Medical Staff 30 days prior to the July meeting.
- (b) Nominations may also be made before the July Executive Committee meeting by any voting member of the Medical Staff if evidence is presented that the potential nominee meets the qualifications for office and consents to the nomination. Such nominees must also disclose potential conflicts of interest.

7.5 **ELECTIONS, VACANCIES, AND REMOVALS**

7.5-1 **ELECTION PROCESS**

The Executive Committee shall conduct all elections, both regular and special, and shall be in charge of all matters pertaining thereto.

- (a) If there is a solo candidate on the slate of nominations, that candidate will be deemed approved; a formal written ballot will not be sent.
- (b) If there is more than one candidate on the slate of nominations the ballots must be mailed within 14 days after the July MEC meeting. The Secretary shall mail one official ballot and two official envelopes, with instructions, to each active staff member of the Medical Staff. Potential conflicts of interest shall be noted on the ballot or in a notice enclosed with the ballot. The name of the voting member shall appear on the official outer envelope.
The sealed ballot must be returned on or before the date specified in the instructions, which shall be no more than 14 days after the mailing of the ballots. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the election.
- (c) The Secretary, or his designee, shall identify the outer envelope as containing the vote of a qualified voter and shall deposit the sealed inner envelope into the ballot box. On the date designated in the ballot

instructions, the inner envelopes shall be opened and the ballots counted by the Executive Committee or its designee.

- (d) The candidate receiving the highest number of votes is elected. In the case of a tie, a majority vote of the Executive Committee shall decide the election.

7.5-2 VACANCIES IN ELECTED OFFICES

In the event of a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall serve for the remainder of the unexpired term. A vacancy in any other general staff office shall be filled by appointment by the Chief of Staff with the approval of the Executive Committee.

7.5-3 RESIGNATIONS AND REMOVAL FROM OFFICE

- (a) Resignations: any officer may resign at any time by giving written notice to the Executive Committee. Such resignation takes effect on the date of receipt or at any later time specified in the notice.
- (b) Removals: removal from office may be initiated only by the Executive Committee or by petition signed by at least one-third of the active staff members, for failure to maintain qualifications of the office as outlined in Bylaws Section 7.1-2 and/or uphold the duties of the office as outlined in Bylaws Section 7.6 or for any other reason. Such removal shall be considered at a special meeting of the Medical Staff as provided in Section 10.1-2, for the purpose of considering and acting upon the request for removal. Removal shall require a two-thirds vote of the voting members present at the special meeting and shall be effective immediately upon tabulation of the vote by the Secretary or his/her designee.

7.6 DUTIES OF OFFICERS

7.6-1 CHIEF OF STAFF

The chief of staff shall serve as the highest elected officer of the Medical Staff to:

- (a) enforce the Bylaws and implement sanctions where indicated;
- (b) call, preside at, and be responsible for the agenda of all general staff meetings, meetings of the Executive Committee;
- (c) serve as an ex officio member of all other staff committees without vote. If membership in a particular committee is specified by these Bylaws, he or she shall have a vote;
- (d) appoint, with the consultation of the Executive Committee, members for all standing and special Medical Staff or multi-disciplinary committees, and designate the chairman of these committees;
- (e) interact with the CEO and Chief Medical Officer in all matters of mutual concern within the Medical Center;
- (f) represent the views and policies of the Medical Staff to the CEO;
- (g) be a spokesman for the Medical Staff in external professional affairs;
- (h) perform such other functions as may be assigned to him or her by these Bylaws, by the Medical Staff, or by the Executive Committee;
- (i) Receive and act upon requests of the Board to the Staff; and
- (j) Report to the Board on the performance and maintenance of quality with respect to the Staff's delegated functions to promote quality patient care;
- (k) Meet and discuss with the Board Subcommittee any matters of concern to the Medical Staff.

7.6-2 **VICE CHIEF OF STAFF**

The vice chief of staff shall assume all duties and authority of the Chief of Staff in his or her absence. The vice chief of staff shall be a member of the Executive Committee, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the Executive Committee.

7.6-3 **IMMEDIATE PAST CHIEF OF STAFF**

The immediate past chief of staff shall be an ex officio member of the Executive Committee and shall perform such duties as may be assigned by the Chief of Staff or delegated by these Bylaws or by the Executive Committee.

7.6-4 **SECRETARY-TREASURER**

The secretary-treasurer shall be a member of the Executive Committee. As secretary, he/she shall determine that accurate and complete minutes of all Executive Committee and Medical Staff meetings are maintained. As treasurer, he/she shall safeguard all funds of the Medical Staff. The secretary-treasurer shall perform all such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or the Executive Committee.

ARTICLE EIGHT: CLINICAL DEPARTMENTS

8.1 **CURRENT CLINICAL DEPARTMENTS**

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a chairman selected and entrusted with the authority, duties, and responsibilities as specified in this Article. A department may be further divided into Sections that shall be directly responsible to the department within which they function, and that shall have a Section chief selected and entrusted with the authority, duties, and responsibilities specified in this Article. When appropriate, the Executive Committee may recommend the creation, elimination, modification, or combination of departments or sections. Such recommendation shall become effective upon Board approval and shall not require formal amendment of these Bylaws. The current clinical departments are:

- Anesthesiology
- Diagnostic Imaging
- Emergency Medicine
- Medicine (Medicine Subspecialties, Family Practice, Hospitalists)
- Obstetrics/Gynecology
- Oncology Services
- Surgery
- Pediatrics
- Pathology

8.2 **ASSIGNMENT TO DEPARTMENTS**

Each member with privileges shall be assigned membership in one department. A practitioner may be granted clinical privileges in more than one department; the exercise of clinical privileges within the jurisdiction of any department is always subject to the rules and regulations of that department.

8.3 **FUNCTIONS OF DEPARTMENTS**

Departments shall continually seek to improve quality of care for all patients through an effective peer review process as defined by Medical Staff policy. Each department shall:

- (a) develop, approve and review annually clinically relevant quality and appropriateness parameters and criteria/indicators and recommend appropriate action to the Executive Committee.
- (b) develop recommendations for the qualifications and credentialing criteria appropriate to obtain and maintain clinical privileges in the department and its sections.
- (c) establish and implement clinical policies and procedures, and monitor its members' adherence to them.
- (d) identify and engage in opportunities for education and process improvement.
- (e) participate in Banner clinical initiatives and assist with the adoption of appropriate clinical standards to facilitate improved aggregated clinical outcomes and patient safety as determined by the Medical Staff and Banner;
- (f) adopt rules and regulations to clarify or expand these Bylaws to meet the needs of its particular area of practice. Department rules and regulations shall not conflict with these Bylaws and shall be subject to approval by the Executive Committee and the Board. Any rule, regulation or policy that may be temporarily adopted on an emergency basis shall be approved by the Chief of Staff prior to communication or enforcement.
- (g) review the aggregated results of the review for quality and appropriateness of patient care and make recommendations relating thereto to the Executive Committee.
- (h) Meet at least quarterly to consider the results of the aggregated quality/appropriateness review and any other review and evaluation activities, and to provide a forum for discussion of matters of concern to its members.
- (i) Work with the Executive Committee and CEO to assure adequate on-call coverage for emergency patients consistent with the physician resources available within the department.
- (k) be responsible for the conducting of continuing education within the department.
- (l) coordinate the professional services of its members with those of other departments and with Medical Center nursing and support services.
- (n) participate in budgetary planning pertaining to department activities with Medical Center administration, including the review of new technologies.
- (o) support the utilization management program by conducting reviews for appropriateness of:
 - i. Admissions
 - ii. Level of care
 - iii. Continued stays
 - iv. Procedures
 - v. Testing and Treatment
 - vi. Discharges
 - vii. Transfers
- (n) establish a department committee and any subcommittees as are necessary to perform functions required of it. The composition and method of selection of the department committee and subcommittee members shall be defined within the department rules and regulations.

8.4 DEPARTMENT OFFICERS

8.4-1 QUALIFICATIONS

Each department shall have a chairman who shall be and remain, during his or her term, a member in good standing of the active Medical Staff; shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the department; and shall demonstrate a high degree of interest in and support of the Medical Staff and Medical Center. Departments may also have a vice-chairman or other officers as defined in the department's rules and regulations.

8.4-2 SELECTION

A department chairman shall be elected every two years by the active staff members of the department except those departments where the department chairman serves as such under contract with the Medical Center. For this election, each department chairman shall appoint a nominating committee of at least two members at least 30 days prior to the mailing of the ballots. The recommendations of the nominating committee shall be presented at a department meeting. Nominations may also be made at the meeting, so long as the nominee is qualified and has consented to the nomination. If there is a solo candidate on the slate of nominations, the election will be conducted by the majority vote of active staff members present at the department meeting in which the slate of candidates is presented. This election shall constitute the election of the solo candidate; a formal written ballot will not be sent. If there is more than one candidate on the slate of nominations the ballots must be mailed within 14 days after the department meeting. Vacancies in elected department offices due to any reason shall be filled for the unexpired term through a special election held for that purpose at a meeting of the department. Selection of any additional officers defined by the department shall follow this same procedure.

8.4-3 TERM OF OFFICE

Elected department chairmen and other department officers, if any, shall serve a two-year term terminating on December 31 or until their successors are chosen, unless a vacancy occurs for any reason. Department officers shall be eligible to succeed themselves. The term of office of a contract department chairman is as specified in the contract or employment arrangement with the Medical Center.

8.4-4 REMOVAL

An elected department officer may be removed for failure to maintain the qualifications of the office as required by these Bylaws. Removal must be initiated by petition signed by at least one-third of the active staff members of the department. Such vote shall occur by written ballot conducted in the same manner as that used in the election of department officers. Removal shall require a two-thirds vote of the active staff members of the department. Removal of a contract department officer is governed by the terms of the contract or employment arrangement with the Medical Center; the counsel of the Executive Committee shall be sought prior to the removal of such contract officer.

8.4-5 **DUTIES**

Each chairman shall have the authority, duties, and responsibilities listed below:

- (a) Act as presiding officer at department meetings;
- (b) Account to the Executive Committee for all administrative activities within the department;
- (c) Recommend to the Executive Committee and implement department rules and regulations, criteria for credentials review and privileges delineation, programs for continuing medical education, and improvement in quality of care, treatment, services and utilization management;
- (d) Be a member of the Executive Committee, give guidance on overall medical policies of the Medical Center, and make specific recommendations regarding the department;
- (e) Transmit to the Executive Committee the department's recommendations concerning the clinical privileges and staff category of practitioners who are members of or applying to the department;
- (f) Refer to the Professional Review Committee issues relating to professional conduct and the quality and appropriateness of patient care and professional performance.
- (g) Enforce the Bylaws, rules and regulations, and policies of the department and the Medical Center;
- (h) Implement, within the department, actions directed by the Executive Committee or the Board;
- (i) Participate in every phase of administration of the department, including cooperation with the nursing service and Medical Center administration;
- (j) Appoint such committees as are necessary to conduct the functions of the department;
- (k) Appoint such chairmen or committee members as required by these Bylaws and department rules and regulations; and
- (l) Perform such other duties as may, from time to time, be reasonably requested by the Chief of Staff or the Executive Committee.
- (m) Assess and recommend to the Executive Committee and the CEO off-site sources for needed patient care, treatment, and services not provided by the department or the Medical Center.
- (p) Assess and recommend to the Executive Committee and the CEO a sufficient number of qualified number of qualified and competent persons to provide care, treatment, and service.
- (q) The determination of the qualifications and competence of department or service personnel who are not LIPs and who provide patient care, treatment, and services.

ARTICLE NINE: COMMITTEES

9.1 **DESIGNATION**

The committees described in this Article or in the Medical Staff Rules and Regulations shall be the standing committees of the Medical Staff. The Chief of Staff may appoint other standing committees for specific purposes, the descriptions of which will be contained in the Medical Staff Rules and Regulations. When appropriate, the Executive Committee may recommend the creation, elimination, modification, or combination of committees. Such recommendation shall become effective upon Board approval and shall not require formal amendment of these Bylaws. In addition, special or ad hoc committees may be appointed for specific purposes by the Chief of Staff; such

appointment will cease upon the accomplishment of the purpose of the committee. Such special or ad hoc committees shall report to the Executive Committee.

9.2 **GENERAL PROVISIONS**

9.2-1 **EX OFFICIO MEMBERS**

The Chief of Staff, Chief Medical Officer, and the CEO or their respective designees are ex officio members of all standing and special committees of the Medical Staff. Professional Review Committee members are ex officio members of all standing and special committees within the scope of their responsibilities.

9.2-2 **SUBCOMMITTEES**

Any standing committee may elect to perform any of its specifically designated functions by appointing a subcommittee which reports its recommendations to the parent committee. Any such subcommittee may include individuals appointed by the committee chairman who are not members of the standing committee.

9.2-3 **SPECIAL OR STANDING INTERDISCIPLINARY COMMITTEES**

When a procedure or group of procedures is performed on a regular basis by members of more than one clinical department, the Executive Committee may create a committee to recommend privileges and develop regulations in regards to the performance of those procedures. The formed committee may also carry out peer review and make recommendations back to the members department or directly to Executive Committee with notification made to the department.

9.2-4 **APPOINTMENT OF MEMBERS AND CHAIRMEN**

Except as otherwise provided, the Chief of Staff shall appoint, in consultation with the Executive Committee, the members and chairman of any Medical Staff committee formed to accomplish Medical Staff functions. The chairmen of all committees, except the Community Based Physician Committee, shall be members of the Active Staff.

9.2-5 **TERM, PRIOR REMOVAL, AND VACANCIES**

- (a) Except as otherwise provided, committee members and chairmen shall be appointed by the Chief of Staff for a term of two years which shall coincide with the term of the Chief of Staff or until the member's successor is appointed, unless such member or chairman sooner resigns or is removed from the committee.
- (b) A Medical Staff member serving on a committee, except one serving ex officio, may be removed by the Chief of Staff from the committee for failure to remain as a member of the staff in good standing, for failure to satisfy the attendance requirements specified in Section 10.3, or by action of the Executive Committee. A committee member removed by the Chief of Staff or the Executive Committee action shall have the right to an appearance before the Executive Committee to request reconsideration of the removal.
- (c) A vacancy in any committee is filled for the unexpired portion of the term in the same manner in which the original appointment was made.

9.2-6 **VOTING RIGHTS**

Each Medical Staff committee member shall be entitled to one vote on committee matters. Medical Center personnel assisting the Medical Staff in performance of the functions of the committee shall have no voting rights.

9.3 **EXECUTIVE COMMITTEE**

9.3-1 **COMPOSITION**

The Executive Committee shall consist of:

- (a) Chief of Staff, as chairman
- (b) Vice-Chief of Staff
- (c) Secretary/Treasurer
- (d) Immediate past chief of staff
- (e) Chairmen of the Departments
- (f) Chair of the Community Based Physician Committee
- (g) Chair of the Credentials Committee
- (h) Medical Director Adult Hospitalist Program (ex officio with vote)
- (i) Chief Medical Officer (ex officio with vote)
- (j) Chief Executive Officer (ex officio without vote)
- (k) Other representation as necessary, may be appointed by the Chief of Staff and approved by the Executive Committee (without vote)
- (l) Chairmen of standing committees are invited to meetings of the Executive Committee (without vote).

9.3-2 **ELECTIONS, TERMS, VACANCIES, AND REMOVALS**

(a) **ELECTIONS**

The Medical Staff officers shall be elected in the manner prescribed in Section 7.5. Department chairmen shall be selected in the manner prescribed in Section 8.4.

(b) **TERMS OF OFFICE**

With the exception of ex officio members, all members of the Executive Committee shall serve a two year term. General staff officers shall serve terms that terminate December 31. Department chairmen shall serve terms that terminate December 31. Department chairmen serving on the Executive Committee by virtue of appointment by the Chief of Staff shall serve two year terms that terminate on December 31.

(c) **REMOVALS AND VACANCIES**

Removals and vacancies of general staff officers and department chairmen will be handled in the manners prescribed in Section 7.5 and Section 8.4, respectively. Vacancies among at-large members will be filled in the manner prescribed for general staff officers.

9.3-3 **DUTIES**

The duties and authority of the Executive Committee are to:

- (a) Act on all matters of Medical Staff business, except for the election or removal of general staff officers and for the approval of Medical Staff Bylaws. The Executive Committee may act on behalf of the Medical Staff between meetings of the Medical Staff within the scope of authority as set forth herein;
- (b) Receive and act upon reports and recommendations from Medical Staff departments and committees;

- (c) Coordinate and implement the professional and organizational activities and policies of the Medical Staff, including but not limited to the review of department and committee policies and procedures, the review of department and committee reports, the determination of dues and assessments of members; responsibility for the investment and expenditure of Staff funds which shall be exclusively for purposes permitted by the IRS and consistent with the responsibilities of the Medical Staff.
- (d) Review aggregate quality performance data and make recommendations for quality improvement;
- (e) Review quality parameters and indicators recommended by departments, Care Management and/or Banner;
- (f) Take all reasonable action to fulfill the Staff's accountability to the Board for the quality and efficiency of medical care provided to patients in the Medical Center and for the other responsibilities delegated by the Board to the Staff;
- (g) Represent the views of the Medical Staff to the Board, and make recommendations to the CEO and to the Board on Medical Center medico-administrative matters;
- (h) Review the qualifications, credentials, performance, and professional competence and character of Medical Staff applicants and members and make recommendations to the Board regarding such matters;
- (i) Review and make recommendations to the CEO about the quality of care issues raised by any proposed decision to enter into or transfer an exclusive contract;
- (j) Review quality issues raised by contracted services as required by JCAHO, including establishing expectations for the performance of the contracted service; communicating the expectations to the provider of contracted services; evaluating the performance of the contracted services in relation to the expectations; taking steps to improve ongoing patient care when contracted services do not meet expectations; and ensuring that ongoing patient care is not disrupted when contractual agreements are altered or terminated.
- (k) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members;
- (l) Designate such committees as may be appropriate to assist in carrying out the duties and responsibilities of the Medical Staff and provide consultation to the Chief of Staff in the appointment of members to such committees; and
- (m) Assist in obtaining and maintaining accreditation of the Medical Center.
- (n) Review and act on information derived from Risk Management, incident reports, and trend analysis, concurrent and retrospective, to effectively maintain a safe patient environment and reduces liability;
- (o) Make recommendations to the Medical Staff for the approval of, use of, and changes in, any format of the medical record;
- (p) Declare a medical record complete for purposes of filing after attempts to contact the responsible physician have failed.
- (q) Provide oversight for the Utilization Review process. Including review and approval of the annual Utilization Review Plan.

9.3-4 **MEETINGS**

The Executive Committee shall meet as often as necessary, but at least six times a year and shall maintain a record of its proceedings and actions.

9.3-5 **ATTENDANCE REQUIREMENTS**

All members of the Executive Committee are required to attend. If any Department Chair is unable to attend, he/she shall arrange in advance for the attendance of the Vice-Chairman of the Department or designee. When a member fails to attend or send a designee to three meetings consecutively or a minimum of 50% of the meetings, he/she will be contacted by the Chief of Staff who may appoint a representative for the Executive Committee to replace that member.

9.4 **PROFESSIONAL REVIEW COMMITTEE**

9.4-1 **COMPOSITION**

The Professional Review Committee shall consist of at least five members, including the Chief Medical Officer who shall serve as Chairman. Members shall be members of the medical staff engaged either full or part-time in an administrative capacity to assist the Medical Staff in the performance of its functions and duties, including its peer review and quality improvement activities. The Chief of Staff and CEO shall serve as ex-officio members of the PRC (without vote). Members shall be appointed for staggered terms of three years and may be appointed for successive terms. For the initial term, members may be appointed for a term less than three years.

9.4-2 **QUALIFICATIONS**

PRC members (except the Chief Medical Officer) must continuously satisfy the qualifications and complete the requirements set forth in Section 3.1. Such members must demonstrate leadership skills and may not have disabling conflicting interests.

9.4-3 **SELECTION AND REVIEW PROCESS**

The Chief of Staff and the Chief Medical Officer shall assemble a committee of six individuals to select the PRC members. The Chief of Staff and Chief Medical Officer shall serve, and shall each select two other individuals to serve, on the selection committee. A majority decision is required to select any PRC member. The Executive Committee will periodically review and make recommendations to the CEO regarding the performance of PRC members.

9.4-4 **DUTIES**

The duties of the Professional Review Committee shall include to:

- (a) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members;
- (b) Enforce the Bylaws, rules and regulations, and policies of the department and the Medical Center;
- (c) Review sentinel events, near misses, and complex clinical issues;
- (d) Investigate, review and resolve complaints of disruptive conduct by any of member of the Medical and AHP Staff;
- (e) Serve as a resource for moral and ethical issues;
- (f) Monitor and evaluate the quality and appropriateness of patient care and professional performance;
- (g) Seek peer review assistance from external sources if and when the PRC determines that such assistance is appropriate and/or necessary.
- (h) Share information with the Departments and Committees to provide opportunities for learning and process improvement;
- (i) Review professional competence issues identified as part of its ongoing quality and performance improvement, clinical, administrative and

educational functions as well as issues referred from a department chair, Medical Director or Chief Medical Officer;

- (j) Implement investigative and precautionary tools as required, including requiring educational/health assessments, supervision, consultation and suspension as warranted
- (k) Recommend to the Medical Executive Committee as required the limitation, revocation or termination of Medical Staff membership and/or privileges;
- (l) Establish a subcommittee or subcommittees as are necessary to perform its duties. Members of subcommittees may include practitioners who are not members of the PRC and/or who are not members of the Medical Staff.

9.5 **COMMUNITY BASED PHYSICIAN COMMITTEE**

9.5-1 **COMPOSITION**

The Community Based Physician Committee will be composed of members of the Community Based Physician Staff as well as the Chief Medical Officer. The members of the Community Based Physician Committee shall elect a chairman, who shall act as presiding officer meeting at committee meetings; serve as a member of the Executive Committee; and account to the Executive Committee for the activities within the Committee. The chairman of Community Based Physician Committee shall be elected every 2 years in the manner specified under Section 8.4. The Committee we meet as often as necessary to conduct business.

9.5-2 **DUTIES**

The duties of the Community Based Physician Committee shall include identifying issues of concern to members of the Community Based Physician Staff and working with Medical Center Administration to address those concerns.

9.6 **CREDENTIALS COMMITTEE**

9.6-1 **COMPOSITION**

The Credentials Committee shall consist of at least five active staff members appointed by the Chief of Staff, one of whom shall be designated by the Chief of Staff as chairman, and a representative of Medical Center administration.

9.6-2 **DUTIES**

The duties of the Credentials Committee shall be to examine the qualifications of each applicant to determine whether all qualifications for staff membership have been met. It shall forward applications recommended for privileges to the clinical departments or sections in which privileges have been requested.

9.7 **BYLAWS COMMITTEE**

9.7-1 **COMPOSITION**

The Bylaws Committee shall consist of at least five members appointed by the Chief of Staff, one of whom shall be designated by the Chief of Staff as chairman.

9.7-2 **DUTIES**

The duties of the Bylaws Committee shall include:

- (a) conducting a review of the Bylaws at least every two (2) years or more frequently when deemed necessary;

- (b) submitting to the Executive Committee recommendations for changes in the Bylaws; and
- (c) receiving and evaluating, for recommendation to the Executive Committee, suggestions for modifying the Bylaws.

9.8 **PROFESSIONAL HEALTH COMMITTEE**

9.8-1 **COMPOSITION**

The Professional Health Committee shall consist of a chairman and at least three members. When possible the Committee shall include at least one member in recovery and one behavioral health professional.

9.8-2 **DUTIES**

The duties of the Professional Health Committee shall include:

- (a) providing ongoing education to the Medical Staff and Administrative leadership on physician and AHP health and impairment recognition issues, on the different kinds and levels of impairment and the problems of impairment, and on resources available for the diagnosis, prevention, treatment and rehabilitation of impairment.
- (b) recommending available resources for diagnosis and/or treatment of physicians and AHP experiencing possible illness and impairment issues;
- (c) serving as a resource for physicians and AHP experiencing illness and impairment issues;
- (d) assisting the Medical Staff in evaluating potential illness and impairment and in monitoring ongoing compliance with treatment recommendations which may include a signed monitoring agreement;
- (e) assisting Medical Staff leadership with an intervention, when so requested by a department chairman or Chief of Staff/designee;
- (f) recommending to the affected practitioner that either a psychological, psychiatric and/or physical examination is obtained;
- (g) ensuring the recommendations of the committee/subcommittee are being followed;
- (h) requiring the affected practitioner to obtain a report from his or her treating physician/psychologist stating the practitioner is able to engage safely in the practice of medicine and obtain subsequent periodic reports from his or her treating physician/psychologist for a period of time specified by the PHC or appropriate department chairman; and
- (i) advising the appropriate Department Chairman/Executive Committee of the affected practitioner's failure to adhere with the recommendations.

ARTICLE TEN: MEETINGS

10.1 **MEDICAL STAFF MEETINGS**

10.1-1 **REGULAR MEETINGS**

General staff meetings will be held at least annually.

10.1-2 **SPECIAL MEETINGS**

A special meeting of the Medical Staff may be called by the Chief of Staff, the Executive Committee, or the Board. The Chief of Staff will call for such a meeting upon petition signed by 10% of the members of the active staff.

10.2 **CLINICAL DEPARTMENT AND COMMITTEE MEETINGS**

10.2-1 **REGULAR MEETINGS**

Clinical departments and committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution is required. A department must meet at least 4 times per year.

10.2-2 **SPECIAL MEETINGS**

A special meeting of any department or committee may be called by the chairman thereof, and must be called by the chairman at the written request of the Chief of Staff, or the Executive Committee. A notice of such special meeting will be sent to all members of the department or committee. Two days advance notice of such special meeting will be given to all members of the department or committee except the Professional Health Committee, the Professional Review Committee and the Executive Committee.

10.2-3 **EXECUTIVE SESSION**

Any department or committee may call itself into executive session at any time during a regular or special meeting. Only the voting members of the applicable group and other individuals who have a legitimate reason to be present including the CEO or his/her designee may remain during such session. Separate minutes must be kept of any executive session.

10.3 **ATTENDANCE REQUIREMENTS**

10.3-1 **CHART REVIEW**

A practitioner whose patient's clinical course of treatment is scheduled for case discussion as part of regular quality review activities may be required by the PRC committee to present the case. If the practitioner has been so notified, his or her attendance will be mandatory at the meeting at which the case is to be discussed. Absent good cause, failure to appear may result in automatic suspension under Section 6.6-7.

10.3-2 **CLINICAL CONFERENCE**

Whenever a department and/or the PRC committee perceives an education program or clinical conference is needed based on the findings of quality review, risk management, utilization management, or other monitoring activities, the practitioners whose patterns of performance prompted the program will be notified by the department chairman and/or PRC committee chairman of the time, date, place of the program, the subject matter to be covered, and its special applicability to their practice. Attendance is mandatory. Failure to attend may result in initiation of corrective action proceedings. Absent good cause, failure to attend may result in automatic suspension under Section 10.6-7.

10.3-3 **SPECIAL APPEARANCE**

Whenever deviation from standard practice is identified or suspected with respect to a practitioner's performance or conduct, the Chief of Staff, or the applicable department chairman and/or PRC committee chairman may require the practitioner to confer with him or her or with the committee considering the matter. The practitioner will be notified of the date, time, and place of the conference, and the reasons therefore. Failure of a practitioner to appear at any such meeting may result in automatic suspension under Section 10.6-7.

10.4 **QUORUM**

10.4-1 **GENERAL STAFF MEETINGS**

The presence of 50 voting members of the staff at any regular or special meeting shall constitute a quorum for the transaction of any business under these Bylaws.

10.4-2 **COMMITTEE MEETINGS**

The presence of 50% of the members of the Executive Committee shall constitute a quorum. The presence of 2 voting members shall constitute a quorum at any other committee meeting.

10.4-3 **DEPARTMENT MEETINGS**

Two members of the department shall constitute a quorum for the transaction of business before the department as a whole unless the department establishes a higher quorum requirement in its rules and regulations.

ARTICLE ELEVEN: CONFIDENTIALITY, IMMUNITY, RELEASES AND INDEMNIFICATION

11.1 **AUTHORIZATIONS AND RELEASES**

By submitting an application for staff appointment or reappointment or by applying for or exercising clinical privileges or providing specified patient care services at the Medical Center, a practitioner:

- (a) authorizes Medical Center representatives to solicit, provide, and act upon information bearing on or reasonably believed to bear upon the practitioner's professional ability, utilization practices, and qualifications;
- (b) agrees to be bound by these Bylaws regardless of whether membership or clinical privileges are granted or are subsequently limited;
- (c) acknowledges that the provisions of this Article are express conditions to an application for, or acceptance of, staff membership, and the continuation of such membership and the exercise of clinical privileges or provision of specified patient care services at the Medical Center;
- (d) agrees to release from legal liability and hold harmless the Medical Center, Medical Staff, members of the Medical Staff, Medical Staff committees and all persons engaged in peer review activities, which include but are not limited to those activities identified in Article 11.3 of these Bylaws as well as any other Medical Staff functions provided for, or permitted, in the Bylaws or any applicable federal or state statute or regulation; agrees that his/her sole remedy for any corrective action taken or recommended by the Medical Staff, for failure to comply with these Bylaws or the Fair Hearing Plan, or for any other peer review action shall be the right to seek injunctive relief pursuant to ARS 36-445 et seq.
- (e) agrees to release from legal liability and hold harmless any individual who or entity which provides information regarding the practitioner to the Medical Center or its representatives; and
- (f) authorizes the release of information about the practitioner in accordance with the Board's sharing of information policy.

11.2 CONFIDENTIALITY OF INFORMATION

Information obtained or prepared by any representative for the purpose of evaluating or improving the quality and efficiency of patient care, reducing morbidity and mortality, or contributing to teaching or clinical research, shall, to the fullest extent permitted by law, be confidential. Such information shall only be disseminated to the extent necessary for the purposes identified above or except as otherwise specifically authorized by law. Such confidentiality shall also extend to information provided by third parties.

11.3 ACTIVITIES COVERED

The confidentiality and immunity provided by this Article applies to all information obtained or disclosures made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

- (a) applications for appointments, clinical privileges, or specified services;
- (b) periodic reappraisals for reappointment, clinical privileges, or specified services;
- (c) corrective or disciplinary actions;
- (d) hearings and appellate reviews;
- (e) quality review program activities;
- (f) utilization review and management activities;
- (g) claims reviews;
- (h) profiles and profile analysis;
- (i) significant clinical event review;
- (j) risk management activities; and
- (k) other hospital, committee, department, section, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

11.4 RELEASES AND DOCUMENTS

Each practitioner shall, upon request of the Medical Center, execute general and specific releases and provide documents when requested by the Chief of Staff or Chairmen of Department or Committees or their respective designees. Execution of such releases is not a prerequisite to the effectiveness of this Article. Failure to execute such releases or provide requested documentation shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn, and it shall not be further processed. Failure to execute such releases or provide documents upon request during a term of appointment to the staff shall result in automatic suspension as provided in Section 6.6-9.

11.5 CUMULATIVE EFFECT

Provisions in these Bylaws and in application and reapplication forms relating to authorization, confidentiality of information, and immunities from liability are in addition to other protection provided by relevant Arizona and federal law and not in limitation thereof. A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provision or any other provision.

11.6 INDEMNIFICATION

Banner Health shall provide indemnification for Medical Staff activities pursuant to the policy adopted by the Board.

ARTICLE TWELVE: GENERAL PROVISIONS

12.1 MEDICAL STAFF RULES AND REGULATIONS

Subject to approval by the Board, the Executive Committee shall adopt such Medical Staff Rules and Regulations as may be necessary to implement the general principles found in these Bylaws; such rules and regulations shall be consistent with these Bylaws and Medical Center policies. The Executive Committee may act for the staff in adopting or amending them. The Medical Staff Rules and Regulations may not conflict with the Banner Health Bylaws.

12.2 DEPARTMENT RULES AND REGULATIONS

Each department and section will formulate written rules and regulations for the conduct of its affairs and the discharge of its responsibilities, all of which must be consistent with the Bylaws and Medical Center policies. These department rules and regulations must be reviewed and approved by the Executive Committee and the Board as needed, but must be reviewed at least every two (2) years by the department. Any changes affecting qualifications, privileges, supervision, and call coverage must be approved by the Executive Committee and the Board.

12.3 STAFF DUES

The Executive Committee shall establish the amount of annual Medical Staff and allied health professional dues. Notice of dues shall be given to the staff by written notice in January. Dues are payable on or before March 31 of each year. If dues are not paid by April 1, a special notice of delinquency shall be sent to the practitioner and an additional 30 days given in which to make payment. All new staff members shall be billed on a pro rate basis and given 30 days in which to make payment for the current year upon their appointment to the staff. Failure to render payment shall result in automatic suspension as provided in Section 6.7-6. Special assessments may be levied by a majority vote of the active staff, and rules of payment similar to those described above in terms of time frame shall apply.

12.4 SPECIAL NOTICE

When special notice is required, the Medical Staff Office shall send such notice by registered mail, return receipt requested to the address provided by the practitioner; email with confirmation of receipt, hand delivery with confirmation of receipt, or facsimile with confirmation of receipt. If the post office indicates that the letter has been refused, such notice shall be deemed to be delivered on the date delivery was first attempted. If the post office indicates the letter is undeliverable, the Medical Staff Office shall attempt to contact the practitioner at the location last identified by him or her. If such attempt is unsuccessful, notice shall be deemed to be delivered on the date delivery was first attempted.

12.5 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

12.6 PARLIAMENTARY PROCEDURE

All committee meetings will be conducted with the intent of allowing interested parties an opportunity to provide their input and to achieve a fair resolution. Robert's Rules of Order, Newly Revised, shall provide general guidance for the conduct of meetings, but adherence to Robert's Rules of Order shall not be required, and technical or non-

substantive departures from such rules shall not invalidate action taken at such a meeting.

12.7 CONFLICT RESOLUTION

12.7-1 STAFF MEMBER CHALLENGE

Any member of the Medical Staff may challenge any rule or policy established by the Executive Committee by submitting to the Chief of Staff written notification of the challenge, with a petition signed by one third members of the Medical Staff and the basis for the challenge, including any recommended changes to the rule or policy.

12.7-2 EXECUTIVE COMMITTEE REVIEW

The Executive Committee will consider the challenge at its next meeting and will determine what changes will be made to the rule or policy or may, at its discretion, appoint a subcommittee to review the challenge and recommend potential changes to address the concerns. The Executive Committee may use internal or external resources to assist in resolving the conflict. The Executive Committee will review subcommittee recommendations and take final action on the rule or policy, subject to Board approval as required. The Executive Committee will communicate all changes to the Medical Staff.

12.7-3 CONFLICT RESOLUTION RESOURCES AND BOARD RESPONSIBILITY

A recommendation to use either internal or external resources to resolve the conflict may be made by the Board, the CEO, the Executive Committee, or members of the Medical Staff. Any conflict regarding the use of such resources or the process to be followed will be decided by the Board through the Medical Staff Subcommittee. The Board has final authority to resolve differences between the Medical Staff and the Executive Committee.

12.8 HISTORIES AND PHYSICALS

A history and physical examination ("H&P") in all cases shall be completed by a physician, oral surgeon, or Allied Health Professional who is approved by the medical staff to perform admission H&Ps within 24 hours after admission. The completed H&P must be on the medical record prior to surgery or invasive procedure or any procedure in which conscious sedation will be administered or the case will be cancelled unless the responsible practitioner documents in writing that such delay would constitute a hazard to the patient. A legible H&P performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. The content of complete H&P is delineated in the Rules and Regulations.

ARTICLE THIRTEEN: ADOPTION AND AMENDMENT

13.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Medical Staff shall be responsible for the development, adoption, and periodic review of these Bylaws which must be consistent with Medical Center policies, Banner Bylaws, and applicable laws. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the CEO, the Board and the community. These Bylaws may not conflict with the Banner Health Bylaws.

13.2 **PERIODIC BYLAWS REVIEW**

The Medical Staff has responsibility to formulate, review at least biennially, and recommend to the Board Medical Staff Bylaws and amendments as needed. Reviews shall also be conducted upon request of the Board.

13.3 **MEDICAL EXECUTIVE COMMITTEE PROCESS**

The Bylaws of the Medical Staff are adopted by the Medical Staff and approved by the Board prior to becoming effective. Amendments to these Bylaws may be adopted upon approval of the Executive Committee and approval by a majority electronic and/or ballot vote of members of the Active Staff voting. Ballots shall be sent to each Active Staff member by mail *or email*. A copy of the proposed amendments or a summary thereof will accompany the ballot or be posted online. The ballots must be returned within 14 days after their mailing/emailing at which time they will be tallied. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the election.

13.4 **MEDICAL STAFF PROCESS**

The Medical Staff may propose Bylaws or amendments thereto directly to the Board. A petition seeking approval of proposed amendments signed by at least 20% of the Active Staff members shall be submitted to the Executive Committee. The Executive Committee will review the proposed amendments at its next meeting and determine whether to recommend language that is acceptable to the Medical Staff and the Executive Committee. The Executive Committee may create a subcommittee to consider the proposed amendments and make recommendations to the Executive Committee. Where the Executive Committee proposes language, the members of the Medical Staff who proposed the challenge can decide to recommend its language directly to the Board. Ballots shall be sent to each Active Staff member, by mail *or email*, along with the comments of the Executive Committee. A copy of the proposed amendments or a summary thereof will accompany the ballot or be posted online. The ballots must be returned within 14 days after their mailing/emailing at which time they will be tallied. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the election.

13.5 **CREDENTIALS PROCEDURE MANUAL, FAIR HEARING PLAN, MEDICAL STAFF RULES AND REGULATIONS AND ALLIED HEALTH RULES AND REGULATIONS**

13.5 -1 **PERIODIC REVIEW**

The Credentials Procedure Manual, Fair Hearing Plan, Medical Staff Rules and Regulations, Allied Health Rules and Regulations shall be reviewed at least every two (2) years and shall be revised as needed. Reviews shall also be conducted upon request of the Board.

13.5-2 **COMMUNICATION TO THE MEDICAL STAFF**

(a) Routine matters - Absent a documented need for urgent action, before acting, the Executive Committee will communicate to the Staff by email proposed changes to the Credentials Procedure Manual, Fair Hearing Plan, Medical Staff Rules and Regulations, Allied Health Rules and Regulations before approving such changes. Members may submit comments and concerns to the Chief of Staff c/o Medical Staff Services within 10 days. If concerns are not received within 10 days, the Executive Committee's recommendation relating to the proposed changes will be submitted to the Board for approval. If concerns are

received the Executive Committee will determine whether to approve, modify or reject such proposed changes.

- (b) Urgent matters - In cases of a documented need for urgent amendment, the Executive Committee and Board may provisionally adopt an urgent amendment without prior notification of the Medical Staff. The Executive Committee will immediately notify the Medical Staff of the amendment and provide an opportunity for comment. If concerns are not received within 10 days, the amendment stands. If there is a conflict and 20% Of the Active Staff oppose the amendment, the Executive Committee will utilize the conflict resolution process set forth in 13.5. If necessary, a revised amendment will be submitted to the Medical Staff, and if approved, to the Board for action.

13.5-3 **MEDICAL STAFF AMENDMENTS**

The Medical Staff may propose amendments to the Credentials Procedure Manual, Fair Hearing Plan, Medical Staff Rules and Regulations, Allied Health Rules and Regulations to the Bylaws Committee or directly to the Board. To submit the amendments directly to the Board, a petition seeking approval of proposed amendments signed by at least 20% of the Active Staff members shall be submitted to the Executive Committee. The Executive Committee will review the proposed amendments at its next meeting and determine whether to recommend language that is acceptable to the Medical Staff and the Executive Committee. The Executive Committee may create a subcommittee to consider the proposed amendments and make recommendations to the Executive Committee. Where the Executive Committee proposes language, the members of the Medical Staff who proposed the challenge can decide to recommend its language directly to the Board. Ballots shall be sent to each Active Staff member by mail *or email*, along with the comments of the Executive Committee. A copy of the proposed amendments or a summary thereof will accompany the ballot or be posted online. The ballots must be returned within 14 days after their mailing at which time they will be tallied. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the election.

13.6 **BOARD OF DIRECTORS ACTION**

13.6-1 **WHEN FAVORABLE TO MEDICAL STAFF RECOMMENDATION**

Medical Staff recommendations regarding proposed Bylaws or amendments thereto shall be effective upon the affirmative vote of the Board.

13.6-2 **BOARD CONCERNS**

In the event the Board has concerns regarding any provision or provisions of the proposed Bylaws or amendments thereto, the Board shall advise the Medical Staff of its concerns. The Medical Staff may request, and if so requested, the Board will establish, a joint conference committee comprised of three representatives of each body to resolve such concerns.

13.7 **JOINT CONFERENCE COMMITTEE**

The Medical Executive Committee may request a Joint Conference Committee to resolve concerns regarding Medical Staff bylaws, credentialing recommendations, policies or other issues that the Executive Committee has been unable to resolve through informal processes with Medical Center or Banner Health administration, management or Board of Directors. This committee shall consist of three representatives appointed by Banner and

three members of the Medical Staff appointed by the Chief of Staff as specified in the Banner Health Bylaws.

13.8 **TECHNICAL AND EDITORIAL AMENDMENTS**

Upon recommendation of the Bylaws Committee, the Executive Committee shall have the power to adopt such amendments to the Bylaws as are technical or legal modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression. Such amendments shall be effective immediately upon Board approval.

ADOPTION AND APPROVAL

Approved by the BHS Board of Directors on September 21, 2006.

Revised: June 21, 2007
July 19, 2007
August 16, 2007
June 2, 2008 – No vote required - modified meeting composition as allowed under
Article 9
November 12, 2009
April 8, 2010
June 9, 2011