REV: 8/21/12

Banner Good Samaritan
Medical Center

PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Banner Good Samaritan 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 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 binding relationship between the Medical Staff and the Board of Directors.

INDEMNIFICATION

Indemnification for Medical Staff activities shall be provided by Banner Health pursuant to the policy adopted by the Board with input from the Medical Staff.

ARTICLE ONE: NAME

The organizational component of Banner Health to which these Bylaws are addressed is called "The Medical Staff of Banner Good Samaritan 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 seek to provide quality care for all patients admitted to, or treated in, any facilities, departments, or service of Banner Good Samaritan Medical Center.

2.1-2 To provide a mechanism for accountability to the Board, through defined organizational structures, 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 provide an appropriate educational setting and to maintain the highest scientific and educational standards for graduate and continuing medical education programs for residents, fellows, and members of the medical staff.

2.1-4 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.

2.1-5 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 and utilization review programs by conducting all activities necessary for assessing, measuring, and improving the quality and efficiency of care, treatment and services provided in the Medical Center, including:

(a) Evaluating and communicating practitioner and institutional performance through measurement systems based on objective, clinically-sound criteria;
(b) Engaging in the ongoing monitoring of patient care processes including education of patients and families;
(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;
(e) Providing leadership in activities related to patient safety;
(f) Providing oversight in the process of analyzing and improving patient satisfaction;
(g) Recommending which clinical services are appropriately delivered via telemedicine and ensuring clinical services offered via telemedicine are consistent with commonly accepted quality standards.

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 compatible and compliant with law and regulation;

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.

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 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, by the Commission on Dental Accreditation, 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. Where membership and privileges are granted on the basis of Board qualification, certification must be obtained prior to the expiration of Board qualification or sooner as required by the department or section. Failure to become certified or remain certified (if applicable) 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 be grounds for termination of membership.

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 by a board determined by the department to be equivalent. For purposes of this section, "Board qualification" or "Board qualified" means the applicant has 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) Exceptions may be granted where a particular field or specialty of the department does not have an American Board certification or for the General Practice Section of the Department of Family Practice, provided that such applicant's privileges are limited to surgical assisting and consulting only.

(c) Individual departments may require board recertification for those staff members whose board certification has expired.

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 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 per BGSMC Professional Health and Disruptive Conduct policies. It is the policy of BGSMC 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 clinical privileges in at least one department or section.

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 to treatments.

3.1-9 **DISABILITY**
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.

3.1-10 **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.

3.1-11 **PROFESSIONAL LIABILITY INSURANCE**
Evidence of professional liability insurance of a kind and in an amount satisfactory to the Board upon the recommendation of the Executive Committee.

3.1-12 **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 Banner Good Samaritan Medical Center;
(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 this Medical Center.

3.1-13 **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's purposes, needs and capabilities, or to community need.

3.1-14 **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 staff, affiliate staff, inactive staff, or house staff.

3.2 **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 BH Bylaws, these Bylaws, department rules and regulations, and all other standards and policies of the medical staff and Medical Center;
(c) Discharge such staff, committee, department, section, and Medical Center functions for which he or she is responsible;
(d) Prepare and complete timely, accurate and legible medical and other required records according to these Bylaws and to Medical Center policies, for all patients to whom the practitioner provides care in the Medical Center, or within its facilities, services, or departments;
(e) 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;
(f) Participate in continuing education programs; and
(g) Participate in emergency service coverage and supervisory or consultation panels as may be determined by the departments or sections.
(h) Use confidential information only as necessary to provide patient care, 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's business information designated as confidential by Banner Health or its representatives prior to disclosure.
(i) Refrain from disclosing confidential information to anyone unless authorized to do so; and
(j) Protect access codes and computer passwords and to ensure confidential information is not disclosed.

3.3 **RIGHTS OF INDIVIDUAL STAFF MEMBERSHIP**

All staff members with clinical privileges, 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 7.5-3 and/or Section 8.5-4;
(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 challenge any rule or policy established by the Executive Committee by presentation to the Executive Committee of a petition signed by 10% of the Active Staff and the basis for the challenge, including any recommended change to the rule or policy;
(e) The right to send proposed amendments to Bylaws, the Fair Hearing Plan, the Credentials Manual, Rules and Regulations, and Allied Health Rules directly to the Board as set forth in Sections 13.4 and;
(f) The right to request conflict resolution of any issue by presentation to the Executive Committee of a petition signed by 10% of the Active Staff;
(g) The right to request a hearing pursuant to the Fair Hearing Plan in the event that reviewable corrective action is taken.
(h) The right to request review by the Executive Committee in the event that nonreviewable corrective action is taken.

(i) 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 the 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.

3.4 **TERM OF APPOINTMENT**

Appointments to the medical staff and grants of clinical privileges are for a period of two years, except that:

(a) New members of the staff are placed in the appropriate reappointment cycle as determined by the Medical Center's system of staggered reappointment; and

(b) The Board, after considering the recommendations of the Executive Committee, may set a more frequent reappraisal period for the exercise of particular privileges in general or for a staff member who has an identified impairing disability or has been the subject of disciplinary action.

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. All recommendations for reappointment should be presented to the Board prior to the expiration of the appointment period.

3.5 **PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT**

3.5-1 **QUALIFICATIONS AND SELECTION**

A practitioner, who is or who will be providing specified professional 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.

(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, termination of such employment or contracts shall not result in automatic termination of medical staff membership and privileges.

3.5-2 **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.

3.6 **MEDICO-ADMINISTRATIVE OFFICERS**

A medico-administrative officer is a practitioner engaged by the hospital or medical staff either full or part-time in an administrative capacity whose activities also include clinical responsibilities such as direction of medical education programs, direct patient care, research, teaching, or supervision of the patient care activities of other practitioners under the officer's direction. Contracts with an individual or a group shall be subject to review, prior to execution, by all affected departments. The contracts (exclusive of compensation or benefits) shall be made available to the departments. This function may be waived at the discretion of the departmental committee.

3.6-1 **REVIEW OF POSITIONS**

(a) Prior to the establishment of a part-time or full-time position (either through employment or contract) in any of the various departments, such proposed position

shall be submitted to the appropriate department for input regarding the impact the establishment of the position would have on the quality of patient care to be provided within the department.

(b) If a proposed physician position is directly related to a medical education program, the position shall also be subject to the approval of the Medical Education Committee.

3.6-2 **STAFF APPOINTMENT, CLINICAL PRIVILEGES, AND OBLIGATIONS**

A medico-administrative officer must continuously satisfy the qualifications and complete the requirements set forth in Section 3.4. A practitioner who does not admit patients may fulfill the supervision requirements by being supervised in a teaching or administrative role.

3.6-3 **MEDICAL PROGRAMS**

Except as may be prohibited by law, any medical program to be undertaken by the Medical Center will be disclosed by Medical Center administration to the appropriate medical staff department or section and the Medical Staff Executive Committee. The purpose of the disclosure shall be for information only. Prior to the initiation of such program, individual medical staff members are free to provide the Medical Center administration with their input, but medical staff approval of the proposed medical program shall not be required.

3.7 **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.

3.8 **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.

3.9 **CREDENTIALING PROCESS**

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

ARTICLE FOUR MEDICAL STAFF CATEGORIES

4.1 **CATEGORIES**

There will be eight categories of appointment to the staff: active, associate, consulting, affiliate, inactive, honorary, and house staff.

4.2 **ACTIVE STAFF**

4.2-1 **QUALIFICATIONS FOR ACTIVE STAFF**

The active staff shall consist of physicians and dentists who:

(a) Demonstrate a genuine concern, interest, and activity in the Medical Center through substantial involvement in the affairs of the medical staff or Medical Center or regularly admit patients to, or are regularly involved in the care of patients in the Medical Center facilities. The volume of patient contacts necessary to achieve and maintain active staff shall be set forth in the general rules and regulations of the medical staff; and

(b) Satisfy the meeting attendance, special appearance requirements and any board certification requirements of these Bylaws and as established in the assigned department's rules and regulations.

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, section, 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 Section 3.2:

(a) Contribute to the organizational, administrative and medico-administrative, quality review, and utilization management activities of the medical staff; be willing to serve in medical staff, department, and section offices and on Medical Center and medical staff committees, and faithfully perform the duties of any office or position to which elected or appointed;
(b) Participate equitably and appropriately in the discharge of staff functions such as training, research, and continuing education programs; serve when necessary on the on-call roster for charity, unassigned, and emergency patients; review and supervise the performance of other practitioners and fulfill such other staff functions as may be reasonably required;
(c) Satisfy the meeting attendance and special appearance requirements of the medical staff and the assigned department and section; and
(d) 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 moved 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 and dentists 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 and section meetings unless otherwise limited by these Bylaws or by department rules and regulations.

4.3-3 **OBLIGATIONS**

An associate staff member must, in addition to meeting the basic obligations set forth in Section 3.2:

(a) Satisfy the special appearance requirements of the medical staff and the assigned department and section;
(b) Serve when necessary on the on-call roster for charity, unassigned, and emergency patients; and
(c) Pay all staff dues and assessments.

4.3-4 **CHANGE IN STAFF CATEGORY**

Associate members may be advanced to the active staff category at the time of reappointment if the qualifications set forth in 4.2-1 are satisfied. Failure to use or participate in the services or programs provided by the Medical Center during an entire reappointment period may result in expiration of privileges or placement in the inactive staff category.

4.3-5 **FAILURE TO SATISFY QUALIFICATIONS OR OBLIGATIONS**

Failure of an associate staff member to satisfy the qualifications or obligations of the associate 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 moved from the associate staff category may request reconsideration of the change by the Executive Committee.

4.4 CONSULTING STAFF

4.4-1 **QUALIFICATIONS**

The consulting staff shall consist of physicians and dentists who do not admit patients but who consult or otherwise provide service to patients in the Medical Center only on an occasional basis. Physicians who exclusively practice remotely, will be appointed to the Consulting category, i.e. Telemedicine and e-ICU.

4.4-2 **PREROGATIVES**

A consulting staff member may:

(a) Exercise such clinical privileges, excluding the privilege to admit, as have been granted by the Board;
(b) Be appointed to committees unless otherwise provided by these Bylaws; and
(c) Vote on matters presented at committees to which he or she has been appointed and at department and section meetings unless otherwise limited by these Bylaws or by department rules and regulations.

4.4-3 **OBLIGATIONS**

A consulting staff member must, in addition to meeting the basic obligations set forth in Section 3.2:

(a) Satisfy the special appearance requirements of the medical staff and the assigned department and section; and
(b) Pay all staff dues and assessments.

4.4-4 **CHANGE IN STAFF CATEGORY**

Consulting staff members may be advanced in staff category if the qualifications for that staff category are met and if admitting privileges are granted by the Board. Failure to use or participate in the services or programs provided by the Medical Center during an entire reappointment period may result in expiration of privileges or placement in the inactive staff category.

4.5 AFFILIATE STAFF

4.5-1 **QUALIFICATIONS**

The affiliate staff shall consist of podiatrists, psychologists, and other doctoral-degree professionals who meet the basic qualifications for staff membership as stated in Section 3.1 and who provide services to patients in the Medical Center, but who can never be

solely responsible for managing a patient. Affiliate staff are not eligible for advancement to other staff categories.

4.5-2 **PREROGATIVES**

An affiliate staff member may:

(a) Attend general staff and department meetings;
(b) Be appointed to committees unless otherwise provided by these Bylaws;
(c) 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; and
(d) Exercise such privileges as have been granted by the Board.

4.5-3 **OBLIGATIONS**

An affiliate staff member must, in addition to meeting the basic obligations set forth in Section 3-2:

(a) Satisfy the special appearance requirements of the medical staff and the assigned department and section; and
(b) Pay all staff dues and assessments.

4.5-4 **FAILURE TO SATISFY QUALIFICATIONS**

Failure to utilize the Medical Center during an entire reappointment period may result in a practitioner being placed in the inactive staff category.

4.6 **COMMUNITY BASED PHYSICIAN**

4.6-1 **QUALIFICATIONS**

Community Based Physicians are those who request Medical Center Services for their patients and wish to be affiliated with the Medical Center. Community Based Physicians may request access to their patients' health information through clinical connectivity. Community Based physicians are not members of the Medical Staff and do not have clinical privileges at the Medical Center. Physicians seeking to affiliate with the Medical Center must apply for Community Based status and provide evidence of the following qualifications:

(a) Current Arizona license 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.

4.6-2 **PREROGATIVES**

The prerogatives of affiliated physicians are to:

(a) Order outpatient diagnostic services for patients;
(b) Make courtesy visits to patients;
(c) Be appointed to committees unless otherwise prohibited by these Bylaws;
(d) 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;
(e) Attend general staff meetings;
(f) Attend Medical Center Continuing Medical Education programs; and
(g) Access Medical Center information via Clinical Connectivity for their patients.
(h) Receive Medical Staff Newsletters and other BGSMC publications.

Members who wish to exercise privileges at the Medical Center must request a change in staff category. The Community Based Physician Staff shall not be eligible to vote on matters presented to the staff nor to hold elected office.

4.6-3 **OBLIGATIONS**

The Community Based Physician must agree to use Medical Center patient information only as necessary for treatment, payment or healthcare operations regarding their own

patients in accordance with HIPAA laws and regulations and maintain the confidentiality of patient information, computer passwords and access codes.

4.6-4 **CHANGE IN STAFF CATEGORY**

The Community Based Physician providers may apply to the Active, Associate, Affiliate, Consulting or Inactive Staff.

(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.

4.6-5 **DENIAL OR TERMINATION OF COMMUNITY BASED STATUS**

Community Based physicians or those seeking affiliated status are not entitled to due process rights under the Fair Hearing Plan. A physician who believes he or she was wrongly denied Community Based 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 rights or other rights in connection with the Executive Committee's decision.

4.7 INACTIVE STAFF

4.7.1 QUALIFICATIONS

The inactive staff shall consist of those staff members who have retired from the active practice of medicine or have relinquished their clinical privileges, but desire to remain as members of the medical staff. The general qualifications for staff membership as stated in Section 3.1 may be waived for members of the inactive staff as appropriate. Assignment to the inactive staff may be requested by the staff member and must be recommended by the Executive Committee and approved by the Board. An inactive staff member who wishes to regain clinical privileges must provide evidence that all general qualifications for staff membership are met, must complete a delineation of privileges form, and must demonstrate current clinical competence.

4.7-2 PREROGATIVES

An inactive staff member may:

(a) Attend general staff and department meetings but cannot vote on matters presented at such meetings; and
(b) Participate in education programs.

4.7-3 OBLIGATIONS

Inactive staff members who have retired from the active practice of medicine are not required to pay staff dues or any special assessments.

4.8 HONORARY STAFF

4.8-1 QUALIFICATIONS

Membership on the honorary staff is by invitation and is restricted to staff members for whom, upon retirement from practice, 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 (members of the honorary staff who were appointed to this category prior to May, 1986 shall retain all rights and privileges previously held and must maintain a current license and malpractice insurance as long as they continue to be in practice).

4.8-2 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 (unless they remain in practice as provided for above); 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 (unless they remain in practice as provided for above).

4.9 HOUSE STAFF

4.9-1 QUALIFICATIONS

The house staff (residents and fellows) shall consist of physicians who are participating in accredited graduate medical education programs of the Medical Center. Physicians in this staff category are exempt from the requirements to be licensed by the State of Arizona; house staff members must, however, be registered in accordance with the Arizona Board of Medical Examiners. The Medical Education Committee is responsible for all policies and procedures relating to graduate medical education which are approved by the Executive Committee and are in substantial compliance with the Accreditation Council for Graduate Medical Education. Policy and procedure for appointment are established by the Medical Education Committee and approved by the Executive Committee and the Board. Appointment shall be for a period of one year, and may be renewed for successive one year terms upon the recommendation of the director of the department training program and Medical Education Committee, and subject to the approval of the Executive Committee and the Board.

4.9-2 PREROGATIVES

(a) The members of the house staff shall participate in the teaching and patient care programs of the Medical Center, as described in the Housestaff Manual for the current academic year and the manual of individual department graduate medical education programs.

(b) If invited, house staff members may attend the meetings of the staff and the department and serve on committees when so appointed as ex officio members, without vote. Members of the house staff shall have no voting rights and may not hold elected office.

(c) The house staff appointment does not confer the privilege of admitting patients to the Medical Center. Housestaff must be supervised as set forth by policies and procedures approved by the Medical Education Committee and Executive Committee.

(d) The procedures permitted or required by Article 6 and the Fair Hearing Plan are not applicable to members of the house staff. House staff members are afforded due process as described in the Disciplinary Actions and Grievance Policies and Procedures section of the Housestaff Manual for the current academic year, and must exhaust these administrative remedies prior to initiating litigation.

(e) House staff members are excused from paying dues and assessments.

4.9-3 OBLIGATIONS

House staff members must meet the basic duties, responsibilities and the obligations as set forth in the Housestaff Manual established by the individual residency programs.

4.10 LIMITATION OF PREROGATIVES

The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a practitioner's staff appointment, by other sections of these Bylaws, by department rules and regulations, associated program manuals and by other policies of the medical staff or Medical Center.

ARTICLE FIVE: DELINEATION OF 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 Advanced Practice Nurse Credentials Committee, or 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 [or for scopes of practice] is set forth in further detail in the Allied Health Policy.

5.3 **EXERCISE OF PRIVILEGES**

5.3-1 **IN GENERAL**

Except in an emergency, a practitioner providing clinical services at the Medical Center may exercise only those clinical privileges specifically granted.

5.3-2 The following must be successfully completed, **as applicable,** prior to exercising privileges at the Medical Center;

a) Banner's electronic medical record/computerized physician order enter (CPOE) training; and

b) Banner's electronic New Provider Orientation. Exceptions may be made for practitioners granted temporary or disaster privileges.

5.3-3 **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 included under the 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.

5.3-4 **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.

5.4 **BASES 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 assurance and utilization 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.

5.5 ESTABLISHMENT OF PRIVILEGES FOR INTERDISCIPLINARY PROCEDURES

5.5-1 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.

5.5-2 DETERMINATION OF APPROPRIATENESS

The Chief of Staff, with the approval of the Executive Committee, will establish an interdisciplinary Ad Hoc Committee and appoint its chairman to evaluate the request. The chairman of the interdisciplinary Ad Hoc Committee shall be a disinterested party currently not performing these procedures. The Ad Hoc Committee shall give the affected practitioner and other interested persons the right to meet with the committee. After receipt of the report of the Ad Hoc Committee, the Executive Committee will recommend to the Board whether inter-disciplinary privileges are appropriate and, if applicable, the criteria for granting such privileges.

5.5-3 DELAYS

Any practitioner who believes that his or her request for privileges has been improperly delayed may request the Chief of Staff to investigate the reason for such delay.

5.6 SPECIAL CONDITIONS

5.6-1 ORAL SURGEONS AND DENTISTS

Surgical procedures performed by oral surgeons and dentists are under the overall supervision of the chairman of the Department of Surgery. An oral surgeon 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 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 and the physician consultant. The chairman of the Department of Surgery will decide the issue in case of dispute.

5.6-2 PODIATRISTS

Surgical procedures performed by a podiatrist are under the overall supervision of the chairman of the Department of Orthopedic Surgery. Podiatrists with clinical privileges may co-admit and perform history and physical examinations, however, the Podiatrist must meet all requirements and have an arrangement with a cooperative physician on the BGSMC Medical Staff who agrees to perform physician services which are outside the scope of practice of the Podiatrist for any patient who requires such services. This would include appropriate care for patients who develop postoperative complications or require unplanned admission to the hospital.

5.7 PRIVILEGES IN EMERGENCY SITUATIONS

In case of an emergency defined as:

a) Circumstances of disaster(s), in which the hospital disaster plan has been activated and the organization is unable to meet immediate patient care needs, the chief executive officer, chief of staff or their designee(s) may grant emergency privileges; or
b) Circumstances 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, 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, to the degree permitted by the practitioner's license but 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.

5.8 TEMPORARY PRIVILEGES

5.8-1 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, department chairman, or section chief. 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.

5.8-2 CIRCUMSTANCES

Upon the recommendation of the Chief of Staff, department chairman, or section chief, the CEO or his/her designee may grant temporary privileges in the following circumstances:

(a) Pendency of Application (After approval by the Credentials Committee*): to an applicant for staff membership who has requested temporary privileges to fulfill an important patient care need, only upon verification of such information contained in the application as deemed appropriate, but at least the following:

- Verification of current licensure
- Relevant training or experience
- Current competence
- Ability to perform the privileges requested
- Results of the NPDB have been queried and obtained

The applicant has:

- A complete application
- No current or previously successful challenge to licensure or registration
- Not been subject to involuntary termination of medical staff membership at another organization
- Not been subject involuntary limitation, reduction, denial, or loss of clinical privileges

*Temporary privileges may be granted on completed applications prior to review by the Credentials Committee if the applicant completed training less than three months prior to applying and has not been in practice.

Temporary privileges may be granted to an applicant for an initial period not to exceed 120 days. Under no circumstances may such privileges be granted 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. Temporary privileges for a non-staff practitioner must be requested by a member of the BGSMC Medical Staff. The requested practitioner must submit a copy of both appropriate licensure and adequate professional liability insurance coverage. Such temporary privileges may not be granted in more than two 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) Locum Tenens: to a practitioner who will be serving as a locum tenens for a staff member or to fulfill an important patient care need, but only after receipt of a complete application for appointment as a locum tenens, including a request for specific privileges; confirmation of appropriate licensure, DEA/controlled substances registration, and adequate professional liability insurance coverage; and a complete, written reference specific to the requested privileges from responsible medical staff authorities. The locum tenens lasts for 90 days in length and may be renewed for one additional 90 day period upon approval of the department chairman. A locum tenens may not be granted more than once in any 12 month period.

(d) Disaster Management: to a practitioner who is volunteering in the event of a disaster, but only after the identity of the practitioner is verified. The minimum acceptable sources of identification for the physician providing emergency care include a current license to practice in the state of AZ accompanied by a) a valid government issued picture ID issued by a state or federal agency, b) verification of the practitioner's identity by a current hospital or medical staff member, (DMAT) or d) identification indicating the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity). Volunteer practitioners will be issued a temporary identification badge. The medical staff will begin the verification process of the credentials and privileges of individuals who receive disaster privileges as soon as the immediate situation is under control. The verification process will be the same described in Section 5.6-2(b). Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed with 72 hours from the time the volunteer practitioner presents to the organization. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of disaster privileges initially granted. Temporary privileges may last for the duration of the disaster or 90 days, whichever occurs first. The medical staff will oversee the professional performance of volunteer practitioners who receive disaster privileges by performing clinical record review of cases in which they are involved.

5.8-3 **TERMINATION**

The CEO, Chief of Staff, department chairman, or section chief 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 by the department chairman or section chief. The wishes of the patient will be considered, where feasible, in choosing a substitute practitioner.

5.8-4 **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.

5.9 **TELEMEDICINE AND TELERADIOLOGY PRIVILEGES**

5.9-1 The Medical Executive Committee shall determine which patient care, treatment, and services may be provided by practitioners through a telemedicine link. The clinical services offered must be consistent with commonly accepted quality standards. In addition, Telemedicine and Teleradiology services may be used in the event of a disaster when the emergency management plan has been activated, and the organization is unable to meet immediate patient needs with resources on hand. Under such circumstances, the requirements in 5.7 above shall apply.

5.9-2 Practitioners providing care, treatment, and services of a patient via telemedicine link are subject to the credentialing and privileging processes of BGSMC. The practitioner may be privileged at BGSMC using credentialing information from the distant site if the distant site is a Joint Commission-accredited organization and if the application from the distant site meets quality standards as determined by the BGSMC Medical Staff. Under this

option, BGSMC would obtain and utilize the distant site's primary source\verified information including, but not limited to, licensure, education, training, the ability to perform privileges requested, and health status. BGSMC will re-verify licensure and perform a query of the National Practitioner Data Bank and Criminal Background Screening. The information will be used for decision making in regard to granting of telemedicine privileges. The application approval process outlined in the Credentialing Procedures Manual, Section 1.6, will apply.

5.9-3 The Medical Executive Committee shall continually evaluate BSGMC's ability to provide these services safely, and must evaluate the performance of the services by practitioners at ongoing professional practice evaluation, reappointment, renewal, or revision of clinical privileges.

5.9-4 The provider at the distant site may have total or shared responsibility for patient care, treatment, and services as determined by the patient's attending physician.

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

6.2-1 PROFESSIONAL REVIEW INITIATED OUTSIDE THE DEPARTMENT

(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) An ad hoc committee of the Executive Committee shall consider the request and determine if an investigation is warranted. If the request is warranted, the Executive Committee shall delegate the responsibility for the investigation to the appropriate medical staff department or committee which shall follow the procedures set forth in Section 6.3. In certain instances, the Executive Committee may conduct its own investigation following the procedures set forth in Section 6.3.

6.2-2 PROFESSIONAL REVIEW INITIATED WITHIN THE DEPARTMENT

Certain matters that may lead to corrective action are routinely considered by each medical staff department as a part of its ongoing quality assurance, clinical, administrative, and educational functions. When, as a result of fulfilling these functions, information comes to the attention of the department that may suggest an investigation or corrective action is warranted, the department or the appropriate section of the department shall determine whether an investigation is warranted. If an investigation is warranted, the Department or Section shall begin the investigation and either conduct the investigation in accordance with Section 6.3 of these Bylaws or designate an investigating committee to conduct such an investigation. The Executive Committee will be kept informed of the status of such investigations.

6.3 PROCEDURE FOR PROFESSIONAL REVIEW

(a) Within 60 days of the department's receipt of a request for corrective action, or within 60 days of the determination by the department that corrective action may be warranted, the department or the investigating committee designated by the department shall conclude an investigation and document its findings. If the findings warrant the recommendation that corrective action be taken, the department chairman shall forward a recommendation for such action to the Executive Committee. Prior to making an adverse recommendation to the

Executive Committee, the affected practitioner shall have an opportunity for an interview with the investigating 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. A record of such interview shall be made by the investigating committee and included with its report. In certain instances, an investigation may not be concluded within 60 days. In such instances, the investigating committee shall report the status of the investigation and the date the investigation is expected to be concluded to the Executive Committee. The investigation shall be concluded as soon as reasonably practicable. The affected practitioner shall have no procedural rights arising out of such delay.

(b) In the event that corrective action is recommended and the recommendation of the investigating committee differs from the recommendation of the department, the chairman of the investigating committee shall be invited to discuss the findings of the investigating committee with the Executive Committee.

(c) At its next scheduled meeting, the Executive Committee shall consider the recommendation for corrective action. After its deliberations, the Executive Committee may uphold, modify, or reject the recommendation and shall forward any adverse recommendation to the Board. If the type of corrective action is reviewable, the affected practitioner shall be given notice and a right to a hearing as set forth in these Bylaws. Upon making a recommendation to deny, revoke, suspend or limit the privileges of a physician because of medical incompetence, inability to practice safely or unprofessional conduct, notice shall be forwarded to the licensing board.

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 in concert 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) Applicable department chairman or designee, acting as a member of and on behalf of the applicable department committee
(c) Chief Executive Officer, acting on behalf of the BH Board of Directors
(d) Executive Committee member, acting as a member of and on behalf of the Executive Committee

6.4-2 REVIEW BY THE DEPARTMENTAL COMMITTEE

A practitioner whose clinical privileges have been placed under summary supervision by any two individuals identified in Section 6.4-1 shall be entitled to request a review of the summary supervision, by the Departmental Committee or a subcommittee designated by the Departmental Committee, having no less than 5 members. The review must be requested within 15 business days of the practitioner's receipt of notice of the supervision. Such review shall take place within 30 days of the request for review. Upon deliberation, the Departmental Committee or subcommittee acting for the Departmental Committee 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 one of the following shall have the right to summarily suspend membership and all or any portion of the clinical privileges of a practitioner:

(a) Chief of Staff, acting as a member of and on behalf of the Executive Committee
(b) Applicable department chairman, acting as a member of and on behalf of the applicable department committee
(c) Chief Executive Officer, acting on behalf of the BH Board of Directors

(d) Executive Committee member, acting as a member of and on behalf of the Executive Committee
(e) BH Board of Directors

A summary suspension is effective immediately upon imposition and shall be followed promptly by special notice to the affected practitioner.

6.5-2 **REVIEW BY THE EXECUTIVE COMMITTEE**
A practitioner whose clinical privileges have been summarily suspended shall be entitled to request a review of the summary suspension by the Executive Committee or a subcommittee of the Executive Committee having no less than 5 members who shall be appointed by the Chief of Staff. The review must be requested within 15 business days of the practitioner's receipt of notice of the suspension. Such review shall take place within 15 business days of the request for review. Upon deliberation, the Executive Committee or subcommittee acting for the Executive Committee may direct that summary suspension be terminated or continued.

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 an expedited hearing pursuant to the Fair Hearing Plan.

6.5-4 **ALTERNATIVE COVERAGE**
Immediately upon imposition of summary suspension, the Chief of Staff, department chairman, or section chief shall have the authority to provide for alternative medical coverage for the patients of the suspended practitioner who remain in the Medical Center. Patient's wishes shall be considered in the selection of an alternative practitioner.

6.6 **AUTOMATIC SUSPENSION OF PRIVILEGES**
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. The Chief of Staff will notify the practitioner of the suspension and may assign care of the patients to other practitioners. 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.

6.6-2 **CONTROLLED SUBSTANCES REGISTRATION**
Whenever a practitioner's DEA or other controlled substances registration is revoked, restricted, or suspended, 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.

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 **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.

6.6-6 **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 10.3-2, 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.

6.6-7 **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.

6.6-8 **FAILURE TO COOPERATE**

A practitioner who fails to cooperate with the appointment or reappointment or process or an evaluation or investigation under Article 6. of these Bylaws, including by refusing to authorize a release of information or provide information or documentation when requested by the Chief of Staff, the Credentials Committee, an Ad-Hoc evaluation Committee and Investigating Committee or a Department Chairman shall automatically be suspended. If the releases executed or the information or documentation is provided within 30 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.

6.6-9 **FAILURE TO ESTABLISH FREEDOM FROM INFECTIOUS TB**
A practitioner's medical staff membership and clinical privileges shall be immediately suspended for failure to establish freedom from infectious TB whenever such evidence is requested. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension, upon presentation of proof of freedom from infectious TB. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

6.6-10 **FAILURE TO MEET ONGOING REQUIREMENTS OF THE DEPARTMENT**
Where a department has established ongoing education and training requirements necessary to exercise one or more privileges, those privileges shall be immediately suspended if the practitioner fails to meet the education/training requirements. The practitioner may request reinstatement of the affected privileges upon presentation of proof of meeting the education/training requirements.

6.6-11 **FAILURE TO COMPLETE CPOE TRAINING**
The failure to complete CPOE training within six months of appointment to the Medical Staff or Allied Health Staff after November 11, 2010 will be deemed to have voluntarily resigned from the staff. Practitioners will be advised of the training requirement at or prior to appointment and reminded of the requirement five (5) months from the date of appointment. Exceptions will be made on a case by case basis to be determined by the facility Chief Executive Officer or Chief of Staff.

6.7 **HEARING AND APPEAL RIGHTS**

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6.7-1 **HEARINGS AND APPEALS FOR MEDICAL STAFF MEMBERS AND APPLICANTS FOR MEMBERSHIP**
Hearings and appeals will be conducted in accordance with Fair Hearing Plan.

6.7-2 **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.

6.7-3 **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.

6.7-4 **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.

6.7-5 **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.

6.7-6 **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.

6.7-7 **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.

6.8 **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 non-reviewable 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.
(f) Termination of any contract with or employment by the Medical Center.
(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 the minimum supervisory requirements 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) Expiration of membership and privileges for failure to become board certified or remain (if applicable) board certified within the required timeframe.
(m) Expiration of privileges for failure to use or participate in the services or programs provided by the Medical Center during an entire reappointment period.
(n) Refusal of the credentials committee, department, or Executive Committee to consider a request for appointment, reappointment, staff category, department or section assignment, or privileges within one year of a final adverse decision regarding such request.
(o) Removal or limitation of Emergency Department call obligations.
(p) Removal or limitation of participation in the Teaching Service.
(q) Any requirement to complete an educational assessment or training program.
(r) Imposition of a consultation requirement pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.
(s) Any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.
(t) Retrospective chart review.
(u) Granting of conditional appointment or appointment for a limited duration.
(v) Failure to verify identification and obtain a badge through the Security Department within 90 days of original notification.

Where an action that is not reviewable under the Fair Hearing Plan (other than Section 6.7 (o)*) has been taken against a practitioner, the affected practitioner may request that the Executive Committee of the Medical Staff review the action, and the practitioner may submit information demonstrating why the action is unwarranted. The Executive Committee, in its sole discretion, shall decide whether to review

the submission and whether to take or recommend any action, and the affected practitioner shall have no appeal or other rights in connection with the Executive Committee's decision.

*Decisions relating to participation in the teaching service will be made in accordance with requirements imposed by the applicable Residency Advisory Committee (RAC). An affected practitioner may request that the RAC reconsider its decision. The practitioner shall have no appeal or other rights in connection with the RAC's decision.

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

Each general officer must:

(a) 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.
(b) Have demonstrated ability through experience and prior participation in staff activities and be recognized for a high level of clinical competence.
(c) Be board certified or demonstrate comparable competence.
(d) Have demonstrated a high degree of interest in and support of the medical staff and the Medical Center.
(e) 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.

A practitioner may not hold simultaneously two or more general staff offices.

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) A nominating committee, consisting of the immediate past Chiefs of Staff still in the active practice of medicine and four members of the Medical Staff appointed by the Chief of Staff and approved by the Executive Committee to serve on the nominating committee; shall, at the September general staff meeting, submit a slate of nominees which shall include at least one candidate for each office. In the event there are not three past Chiefs of Staff who are in the active practice of medicine, an appointment will be made by the Chief of Staff with the approval of the Executive Committee. Prior to presentation at the General Staff meeting, 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, by mail, fax or electronic mail, 7 days prior to the September general staff meeting.

(b) Further nominations may be made from the floor by any voting member of the medical staff at the September general staff meeting if evidence is presented that the potential nominee meets the qualifications for office and consents to the nomination.

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) The Secretary shall mail one official ballot and two official envelopes, with instructions, to each active staff member of the medical staff within 14 days after nominations are completed. 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.

(b) 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.

(c) A majority of the votes cast for any office shall be necessary to elect any officer. If more than two nominees appear on the ballot and no nominee receives a majority of the votes cast, a second vote shall be conducted in the manner stated above between the two candidates receiving the highest number of votes.

(d) In the case of a tie, when only two nominees appear on the ballot, 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 assume the duties of the Chief of Staff 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 CEO or his 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, and meetings of the Medical Council;

(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 the Board in all matters of mutual concern within the Medical Center;
(f) represent the views and policies of the medical staff to the Board and 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; and
(i) serve as an ex officio member of the Board and on designated Board committees.

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, shall serve as chairman of the Credentials 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, shall determine that accurate and complete minutes of all Executive Committee and medical staff meetings are maintained. As treasurer, shall receive and 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.

7.7 **MEMBERS-AT-LARGE**
The Executive Committee shall include three (3) Members-at-Large. The selection and removal process shall follow procedures for officers as described in Articles 7.1-2 – 7.5-3.

ARTICLE EIGHT CLINICAL DEPARTMENTS AND SECTIONS

8.1 **CURRENT CLINICAL DEPARTMENTS AND SECTIONS**
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 it functions, 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 and their respective sections are:

- Anesthesiology and Peri-Operative Medicine
  - Cardiovascular Anesthesia
  - Obstetrical Anesthesia
- Cardiovascular Services
  - Cardiology
  - Cardiothoracic Surgery
  - Endovascular Services
- Emergency Medicine
  - Toxicology
- Family Medicine
  - General Practice

- Medicine
  - Allergy and Immunology
  - Dermatology
  - Endocrinology and Metabolism
  - Gastroenterology
  - Hematology
  - Hospitalist
  - Infectious Disease
  - Internal Medicine
  - Nephrology
  - Neurology
  - Oncology
  - Pulmonary Disease
  - Rheumatology
- Obstetrics and Gynecology
  - Gynecology
  - Gyn Oncology
  - Maternal/Fetal Medicine
  - Reproductive Endocrinology & Infertility
- Orthopedic Surgery
  - Podiatry
- Pathology
- Pediatrics
- Physical Medicine and Rehabilitation
- Psychiatry
  - Psychology
- Radiology
- Surgery
  - Colon and Rectal Surgery
  - General Surgery
  - Neurosurgery
  - Ophthalmology
  - Oral Surgery and Dentistry
  - Otolaryngology, Head and Neck Surgery
  - Pediatric Surgery
  - Plastic and Reconstructive Surgery
  - Transplant
  - Trauma
  - Urology

8.2 **ASSIGNMENT TO DEPARTMENTS AND SECTIONS**

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

8.3 **FUNCTIONS OF DEPARTMENTS**

Departments shall perform continuous assessment and improvement of the quality of care, treatment and services provided through an effective and efficient peer review process as defined by medical staff policy.

(a) Each medical staff department conducts timely peer review by physician peer reviewers. In addition, each medical staff department develops and approves clinically relevant quality and appropriateness criteria that identify variances, which trigger an evaluation of the care by a physician reviewer.

Criteria/indicators are reviewed annually and approved by the department committee. These include: medical assessment and treatment processes including medication use, blood use, operative/invasive review, unexpected deaths, and identification of known or potential problems that have an adverse effect on the patient as well as appropriateness of clinical practice patterns and significant departures from those established patterns of clinical

practice. Variations in care identified by the medical staff will be reviewed in order to evaluate and identify opportunities to improve care.

(b) develop recommendations for the qualifications 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) adopt its own 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. They shall be appended to the Medical Staff Rules and Regulations. 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.

(e) meet at least quarterly to consider the results of the review for quality and appropriateness of patient care and any other review and evaluation activities, and to provide a forum which includes hospital administration and nursing representation for discussion of matters of concern to its members.

(f) be responsible for the conducting of postgraduate education, continuing education, research and orientation programs, within the department.

(g) coordinate the professional services of its members with those of other departments and with Medical Center nursing and support services including but not limited to recommendations for a sufficient number of qualified and competent persons to provide care or service.

(h) report and make recommendations regarding clinical, quality review, and administrative activities to the Executive Committee.

(i) participate in budgetary planning pertaining to department activities including but not limited to space and resources with Medical Center administration.

(j) 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 **FUNCTIONS OF SECTIONS**

Subject to approval by the Executive Committee, each section shall perform the functions assigned to it by the department chairman. Such functions may include review and evaluation of patient care practices, development of criteria for privileges; credentials and privileges recommendations; and education and research programs. The section shall transmit regular reports to the department chairman on the conduct of its assigned functions.

8.5 **DEPARTMENT OFFICERS**

8.5-1 **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; be board certified by an appropriate specialty board or demonstrate comparable competence 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.

8.5-2 **SELECTION**

A department chairman shall be elected every 2 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. Ballots must be mailed within 14 days after the department meeting. Nominations may also be made at the meeting, so long as the nominee is qualified and has consented to the nomination. 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.

8.5-3 **TERM OF OFFICE**

Elected department chairmen and other department officers, if any, shall serve a two-year term terminating on December 31 of odd-numbered years 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.

8.5-4 **REMOVAL**

Removal of an elected department officer may 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.

8.5-5 **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 professional, clinical and administrative activities within the department;
(c) Continuous surveillance and evaluation of the quality appropriateness of patient care and professional performance rendered by practitioners with clinical privileges in the department;
(d) Recommend to the Executive Committee and implement department rules and regulations, criteria for clinical privileges that are relevant to the care provided in the department, programs for continuing medical education, and improvement in quality of care and utilization management;
(e) Be a member of the Executive Committee where so designated in Section 9.3, give guidance on overall medical policies of the Medical Center, and make specific recommendations regarding the department;
(f) 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, and corrective action specific to practitioners with privileges within the department;
(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) Assess and recommend to the C.E.O. off-site sources for needed patient care, treatment and services not provided by the department or Medical Center.
(k) Integration of the department into the primary functions of the Medical Center.
(l) Coordination and integration of interdepartmental and intradepartmental services.
(m) Development and implementation of policies and procedures that guide and support the provision of care, treatment and services.
(n) Recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services.
(o) Determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services.

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(p) Provide orientation and continuing education of all persons in the department or service.
(q) Appoint such committees as are necessary to conduct the functions of the department;
(r) Appoint such chairmen or committee members as required by these Bylaws and department rules and regulations; and
(s) Perform such other duties as may, from time to time, be reasonably requested by the Chief of Staff or the Executive Committee.

8.6 **SECTION CHIEFS**

8.6-1 **QUALIFICATIONS**

Each section shall have a chief who shall be a member of the active staff, a member of the section and qualified by training, experience, and demonstrated current ability in the clinical area covered by the section, and be board certified by an appropriate specialty board or demonstrate comparable competence.

8.6-2 **SELECTION**

Each section chief shall be selected by the department chairman with the approval of the Executive Committee except those sections where the Section Chief serves as such under contract with the medical center. Vacancies due to any reason shall be similarly filled.

8.6-3 **TERM OF OFFICE**

Each section chief shall serve a two-year term which shall coincide with the term of the department chairman or until a successor is chosen, unless he or she sooner resigns, is removed from office, or fails to maintain the qualifications in Section 8.6-l. Section chiefs shall be eligible to succeed themselves.

8.6-4 **REMOVAL**

A section chief may be removed by the department chairman with the approval of the Executive Committee. Removal may also be initiated by petition of one-third of the active members of the section; removal in this circumstance shall require a two-thirds vote of the active members of the section. Such vote shall occur by written ballot in the same manner as that used in the election of department officers.

8.6-5 **DUTIES**

Each section chief shall:
(a) act as presiding officer at section meetings.
(b) in cooperation with the department chairman, assist in the development and implementation of programs to carry out any quality review, monitoring, and evaluation functions assigned to the section;
(c) monitor and evaluate the quality and appropriateness of patient care and professional performance rendered by practitioners with clinical privileges in the section;
(d) conduct investigations and submit reports and recommendations to the department chairman regarding the criteria for granting clinical privileges and the clinical privileges to be exercised within the section by members of or applicants to the medical staff; and
(e) perform such other duties as may, from time to time, be reasonably requested by the department chairman, the Chief of Staff, or the Executive Committee.

ARTICLE NINE - COMMITTEES

9.1 **DESIGNATION**

The committees described in this Article 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. 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 and the CEO or their respective designees are ex officio members of all standing and special committees of the medical staff.

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 **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 chairman of all standing committees shall be members of the active staff. Chairmen of special or ad hoc committees may be appointed from the associate or honorary staff.

9.2-4 **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 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.

9.2-5 **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) Three at-large members of the active staff
(f) Chairmen of the following departments:
    Anesthesiology and Peri-Operative Medicine
    Diagnostic Imaging, Nuclear Medicine, Radiation Oncology and Allied Sciences (one representative)
    Emergency Medicine
    Family Practice
    Medicine
    Obstetrics and Gynecology
    Orthopedic Surgery

Pathology
Physical Medicine & Rehabilitation
Psychiatry
Surgery

(g) Three Section Chiefs from the Cardiovascular Services Department as designated by the Chief of Staff
(h) The Chief(s) of the Hospitalist Section of the Department of Medicine
(i) Chief Academic Officer (ex officio with vote)
(j) Chief Medical Officer (ex-officio with vote)
(k) Chief Executive Officer (ex officio without vote)
(l) Other representation as necessary, may be appointed by the Chief of Staff

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 8.5. At-large members shall be nominated and elected in the same manner as prescribed for the election of general staff officers.

(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 and at-large members shall serve terms that terminate December 31 in even numbered years. Department chairmen shall serve terms that terminate December 31 in odd-numbered years. 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 of even-numbered years.

(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 8.5, respectively. At-large members may be removed in the manner prescribed for removal of a general staff officer. Vacancies among at-large members will be filled in the manner prescribed for general staff officers.

9.3-3 **DUTIES**

(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 its 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;
(d) Make recommendations to the CEO and to the Board on Medical Center matters including but not limited to medical staff structure, mechanism used to review credentials and to delineate individual clinical privileges, corrective action including termination of medical staff membership, fair hearing procedures, and participation of the medical staff in organizational performance and improvement activities;
(e) Review the qualifications, credentials, performance, and professional competence and character of medical staff applicants and members and make recommendations to the Board regarding membership and privileges;
(f) Account to the Board for the quality and efficiency of medical care provided to patients in the Medical Center, including a summary of specific findings, actions, and results and including an assessment of the quality of services rendered pursuant to contract;
(g) Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of staff members;

(h) 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
(i) Assist in obtaining and maintaining accreditation of the Medical Center.

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 a minimum of 50% of the Executive Committee meetings. If attendance does not meet the minimum, the Chief of Staff may appoint a representative for the Executive Committee to replace that member.

9.3-6 **MEDICAL STAFF ADVISORY COMMITTEE**

The Medical Staff Advisory Committee shall function as a subcommittee under the direction of the Medical Staff Executive Committee.

(a) Composition: The Medical Staff Advisory Committee shall be composed of not less than five (5) nor more than ten (10) members of the active staff, three (3) of whom must be current members of the Executive Committee, including the Vice-Chief of Staff who shall chair the committee. Members shall be appointed by the Chief of Staff with the approval of the Executive Committee. The committee may utilize additional members of the medical staff as it deems necessary to provide expertise in reviewing various issues. Members shall serve a two (2) year term.
(b) The Committee shall meet as needed with the CEO and his/her designees, to be involved in long term planning for Banner Good Samaritan Medical Center in an advisory capacity. Issues for consideration shall include strategic planning for expansion and the addition or deletion of programs. Minutes of the Executive Committee of the Board, including Board Committee reports, shall be available for review in the Corporate Office.

9.4 **CREDENTIALS COMMITTEE**

9.4-1 **COMPOSITION**

The credentials committee shall consist of the vice chief of staff as chairman, five active staff members appointed by the Chief of Staff and a representative of Medical Center administration.

9.4-2 **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.

9.5 **BYLAWS COMMITTEE**

9.5-1 **COMPOSITION**

The Bylaws Committee shall consist of the Secretary/Treasurer as chairman and at least five members.

9.5-2 **DUTIES**

The duties of the Bylaws Committee shall include:

(a) conducting an annual review of the Bylaws or a more frequent review 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.

9.6 **MEDICAL EDUCATION COMMITTEE**

9.6-1 **COMPOSITION**

The Medical Education Committee shall consist of the Senior Administrator of Medical Education and at least 10 other members. Members shall include the directors of the BGSMC residency programs, house staff from BGSMC residency programs, and other members outside of the BGSMC medical staff essential to the functioning of the medical education programs. The members may, but need not be, members of the Medical Staff. The Chief of Staff, in consultation with the Senior Administrator for Medical Education and Research, shall appoint the members of the Medical Education Committee and its Chair.

9.6-2 **DUTIES**

The duties of the Medical Education Committee include:

(a) Ensuring compliance with ACGME Institutional Requirements and relevant ACGME Program Requirements;

(b) Reviewing, modifying, submitting for Executive Committee approval and implementing the House Staff Manual and all other policies relating to graduate medical education.

(c) Submitting to the Executive Committee for approval housestaff selections and advancements;

(d) Submitting to the Executive Committee for approval policies and procedures for house staff appointments, advancement, graduation, evaluation, disciplinary action and internal review of all programs;

(e) Receiving and acting upon recommendations from the BGSMC Residency Advisory Committees, which are subcommittees of the Medical Education Committee;

(f) Through the Continuing Medical Education Subcommittee, developing and presenting educational programs for members of the BGSMC Medical Staff and for other physicians and approving for continuing medical education credit properly authorized educational programs, and

(g) Other duties as outlined by the ACGME and/or assigned by the Executive Committee.

9.7 **ADVANCED PRACTICE NURSE CREDENTIALING COMMITTEE**

9.7-1 **COMPOSITION**

The Advanced Practice Nurse Practitioner Credentials Committee shall consist of the Director of Professional Nursing Practice (chair), Director of Medical Staff Services (co-chair), representatives from the advanced practice nursing staff credentialed by this Committee, quality management staff, human resources staff, Chief Medical Officer and the Chairman of Credentials Committee or Chairman's designee. .

9.7-2 **DUTIES**

The duties of the Advanced Practice Nurse Credentials Committee shall be to examine the qualifications of each application and reappointment application to determine whether all qualifications for advanced practice staff membership have been met. It shall forward applications recommended for privileges to the clinical departments or sections in which a scope of practice has been requested. This Committee will also serve as a peer review body to review activities that could adversely affect patient care or safety. The Medical Executive Committee has delegated this Committee to serve as a resource to the Medical Staff in privileges and scope of care guidelines.

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 BH Board. The Chief of Staff will call for such a meeting upon petition by any 10 members of the active staff.

10.2 **CLINICAL DEPARTMENT, SECTION, AND COMMITTEE MEETINGS**

10.2-1 **REGULAR MEETINGS**

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

10.2-2 **SPECIAL MEETINGS**

A special meeting of any department, section, or committee may be called by the chairman or chief thereof, and must be called by the chairman or chief 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, section, or committee.

10.2-3 **EXECUTIVE SESSION**

Any department, section, 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 may remain during such session. Separate minutes must be kept of any executive session.

10.3 **ATTENDANCE REQUIREMENTS**

10.3-1 **GENERALLY**

In addition to satisfying the special appearance requirements of Section 10.3-2, each member of the active staff is expected to attend the annual and general staff meetings, meetings of his or her department or section, and meetings of committees on which he or she serves. Other staff members who serve on committees have these same attendance expectations for the committees to which they have been appointed.

10.3-2 **SPECIAL APPEARANCE OR CONFERENCES**

(a) 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 department, section, or 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.

(b) Whenever a department or section 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 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.

(c) Whenever deviation from standard practice is identified or suspected with respect to a practitioner's performance, the Chief of Staff, the applicable department chairman, or section chief 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 therefor. Failure of a practitioner to appear at any such meeting may result in the initiation of corrective action proceedings.

10.4 **QUORUM**

10.4-1 **GENERAL STAFF MEETINGS**

The presence of 25 qualified 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 3 voting members shall constitute a quorum at any other committee meeting.

10.4-3 **DEPARTMENT MEETINGS**
Each department shall establish what constitutes a quorum for the transaction of business before the department as a whole.

ARTICLE ELEVEN CONFIDENTIALITY, IMMUNITY AND RELEASES

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, 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 to other BH facilities where the practitioner has or requests membership or privileges.

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) risk management activities; and
(j) 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**

Each practitioner shall, upon request of the Medical Center, execute general and specific releases in accordance with the tenor and import of this Article. Execution of such releases is not a prerequisite to the effectiveness of this Article. Failure to execute such releases 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 upon request during a term of appointment to the staff shall result in automatic suspension as provided in Section 6.6-7.

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.

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.

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 or 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 annually; any changes must be approved by the Executive Committee and the Board.

12.3 **CONFLICT RESOLUTION**

12.3-1 STAFF MEMBER CHALLEGE

Any member of the ACTIVE 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 10% of members of the Medical Staff and the basis for the challenge, including any recommended changes to the rule or policy.

12.3-2 EXECUTIVE COMMITTEE REVIEW

The Executive Committee will consider the challenge at its next meeting and will determine what changes, if any, 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. Where a subcommittee is appointed, the Executive Committee will review the subcommittee's 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.

12.3-3 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.*

12.4 **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 6.6-6. 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. The honorary staff shall be exempt from payment of dues and assessments. The inactive staff shall be exempt from special assessments.

- Exemption from Staff Dues:
  Elected officers, department chairmen and appointed section chiefs will be exempted from paying annual staff dues during their tenure in that role.

12.5 **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. 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.

12.6 **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.

12.7 **PARLIAMENTARY PROCEDURE**

The rules contained in the current edition of Roberts Rules of Order shall govern the medical staff in all cases to which they are applicable, in all cases which they are not inconsistent with these Bylaws, and any special rules of order the medical staff may adopt.

12.8 HISTORIES AND PHYSICALS

A history and physical examination ("H&P") in all cases shall be completed by a physician, oral surgeon, podiatrist 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 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. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. The content of complete H&P is delineated in the Rules and Regulations.

12.9 Organized Health Care Arrangement; HIPAA Compliance

The Medical Center and all members of the Medical Staff shall be considered member of, and shall participate in the Medical Center's Organized Healthcare Arrangement ("OHCA") formed for the Purpose of implementing and complying with the Standards of Privacy of Individually Identifiable Health Information. An OHCA allows the Medical Center to share information with practitioners and their offices for purposes of payment and practice operations. Each Medical Staff member, practitioner with temporary privileges and Allied Health Professional with practice prerogatives agrees to comply with the Medical Center's policies as adopted from time to time regarding use and disclosure of protected health information ("PHI"), as those members are defined by HIPAA.

ARTICLE THIRTEEN ALLIED HEALTH PROFESSIONALS

13.1 **ALLIED HEALTH PROFESSIONALS DEFINED**

Allied Health shall be governed by the Allied Health Professional Rules & Regulations.

Allied health professionals (AHPs) are individuals who:

(a) are qualified by training, experience, and current competence in a discipline permitted to practice in the hospital; and

(b) function in a medical support role to physicians who have agreed to be responsible for such AHPs.

AHPs are not members of the medical staff.

13.2 **CATEGORIES OF AHPs CURRENTLY CREDENTIALED BY THE MEDICAL STAFF AND AUTHORIZED TO FUNCTION IN THE MEDICAL CENTER**

The following are the only categories of AHPs currently authorized to provide services in the Medical Center:

- Clinical perfusionists,
- Nurse practitioners,
- Physician's assistants, and
- Non-physician/first assistants

The Executive Committee may recommend for Board approval other categories of AHPs to be given authorization to provide services in the Medical Center.

13.3 **QUALIFICATIONS OF ALLIED HEALTH PROFESSIONALS**

A statement of qualifications and competence for each category of allied health professionals shall be developed by the department to which the AHP would be assigned, subject to approval by the Executive Committee and the Board. Each statement must:

(a) Be developed with input, as applicable, from the physician director of the clinical unit or service involved, the physician supervisor of the AHP, and other representatives of the medical staff, Medical Center management, and other professional staff;

(b) Require the individual AHP to hold a current license, certificate or such other credential, if any, as may be required by state law; and

(c) Satisfy the qualifications as are set forth for medical staff appointment, including appropriate professional liability insurance coverage, or for Medical Center employment, as applicable.

13.4 **PREROGATIVES OF ALLIED HEALTH PROFESSIONALS**

The prerogatives of an AHP are to:

(a) provide such specifically designated patient care services as are granted by the Board upon recommendation of the Executive Committee and consistent with any limitations stated in the Bylaws, the policies governing the AHPs practice in the Medical Center, and other applicable medical staff or Medical Center policies;

(b) serve on committees when so appointed;

(c) attend open meetings of the staff or the department; and

(d) exercise such other prerogatives as the Executive Committee with the approval of the Board may accord AHPs in general or to a specific category of AHPs.

13.5 **OBLIGATIONS OF ALLIED HEALTH PROFESSIONALS**

Each AHP shall:

(a) meet the basic responsibilities required by Section 3.2(a-g) for medical staff members;
(b) retain appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in the Medical Center for whom services are provided;
(c) participate when requested in quality review program activities and in discharging such other functions as may be required from time to time;
(d) when requested, attend meetings of the staff, the department, and the section;
(e) fulfill the applicable attendance requirements of these Bylaws and the rules and regulations of the department to which assigned; and
(f) refrain from any conduct or acts that could be reasonably interpreted as being beyond the scope of practice authorized by the Board.

13.6 **TERMS AND CONDITIONS OF AFFILIATION**

An AHP shall be individually assigned to the clinical department appropriate to his or her professional training and subject to an initial probationary period, formal periodic (every two years) reviews, and disciplinary procedures as determined for the category. An AHP is not entitled to the procedural hearing rights provided in the Fair Hearing Plan.

13.7 **DEFINITION OF SCOPE OF SERVICE DESCRIPTION**

The scope of service that may be provided by any group of AHPs shall be developed by the appropriate department and representatives of management, if applicable, and subject to the recommendation of the Executive Committee and the approval of the Board. For each group, guidelines must include at least:

(a) specifications of categories of patients to whom services may be provided.
(b) a description of the services to be provided and procedures to be performed, including any special equipment, procedures, or protocols that specific tasks may involve, and responsibility for documenting the services provided in the medical record.
(c) a description of the scope of assistance that may be provided to a physician and any limitations thereon, including the degree of physician supervision required.

13.8 **PROCEDURE FOR CREDENTIALING**

The procedures for processing individual applications from AHPs, for reviewing performance during the probationary period, for periodic reappraisal, and for disciplinary action shall be established:

(a) by the department, the Executive Committee, and the Board for AHPs who are not Medical Center employees; or
(b) by the CEO or his designee for AHPs who are Medical Center employees.

ARTICLE FOURTEEN ADOPTION AND AMENDMENT

14.1 **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, BH Bylaws, and applicable laws. The Bylaws and the Rules and Regulations of the medical staff are adopted by the medical staff and approved by the Board prior to becoming effective. Neither body may unilaterally amend the medical staff Bylaws. Further, neither body may take any action which would affect the rights and obligations of the Medical Staff or the Board under the Bylaws, except the Board may do so in order to assure compliance with state and federal laws. The action described in the preceding sentence shall be taken only after consideration of the proposed amendment by an ad hoc committee appointed by the Board composed of selected persons from the Quality Assurance Committee with equal representation from both the medical staff and the Board and

administration, except as provided in Section 14.3-2, the amendment of these Bylaws shall require medical staff action specified below.

14.2 **ADOPTION AND AMENDMENT AND PERIODIC 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.

14.3 **MEDICAL EXECUTIVE COMMITTEE PROCESS**

If a Bylaws amendment is proposed, the Bylaws Committee will send each member of the active medical staff *by mail or email* a notice (the "Notice") containing (1) the Bylaws Committee's recommendations regarding the proposed changes; (2) ballots for the active staff to cast their votes on the proposed amendments; and (3) a deadline for submission of the ballots, which deadline shall be not less than fourteen (*14)* days after the date on which the notice is mailed. *The proposed amendments or a summary thereof will accompany the ballot or be posted online*.

At any time prior to the deadline for submission of ballots, the Chief of Staff may call a special meeting of the active medical staff to discuss a proposed amendment. In addition, if within 10 days after the Notice is sent a group of ten (10) or more members of the active staff petitions the Chief of Staff to call a special meeting to discuss the proposed amendment, the Chief of Staff shall call a meeting for that purpose. If a special meeting is called to discuss any proposed bylaws amendment, votes cast on the ballots distributed prior to the meeting will be void, and the process outlined in the first sentence of this Section will have to be repeated.

A favorable vote of two-thirds of those voting is required on each proposed amendment. 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.

14.3-1 **MEDICAL STAFF PROCESS**

The Medical Staff may propose Bylaws or amendments thereto directly to the Board by submitting a petition seeking approval of proposed amendments signed by at least 10% of the Active Staff members 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. The balloting process set forth in Section 14.3-2 will be followed.

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

14.4-1 ***PERIODIC REVIEW***

The Credentials Procedure Manual, Fair Hearing Plan and Medical Staff Rules and Regulations must be adopted by the Executive Committee and approved by the Board prior to becoming effective. Amendments to these documents may be adopted upon approval of the Executive Committee and the Board. *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.*

14.4-2 **COMMUNICATION TO THE MEDICAL STAFF**

(a) Routine matters. Absent a need for urgent action, before acting, the Executive Committee will communicate to the Staff by mail, facsimile or 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 21 days. The proposed changes and all comments and concerns received timely will be considered by the Executive Committee at its next meeting.
(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 40% of the Active Staff oppose the amendment, the Executive Committee will utilize the conflict resolution process set forth in Section 12.4. If necessary, a revised amendment will be submitted to the Medical Staff, and if approved, to the Board for action.

14.4-3 ***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 10% 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 along with the recommendations of the Executive Committee.

14.5 **MEDICAL STAFF ACTION**

If a bylaws amendment is proposed, the Bylaws Committee will send each member of the active medical staff a notice ("the notice") containing: 1) proposed amendments to the Bylaws, 2) the Bylaws Committee's recommendations regarding the proposed changes, 3) ballots for the Active Staff to cast their votes on the proposed amendments, and for a deadline for submission of the ballots, which deadline shall be not less than 21 days after the date on which the notice is mailed. At any time prior to the deadline for submission of ballots, the Chief of Staff may call a special meeting of the Active Medical Staff to discuss a proposed amendment. In addition, if within 10 days after the notice is sent, a group of 10 or more members of the Active staff petitions the Chief of Staff to call a special meeting to discuss the proposed amendment, the Chief of Staff shall call a meeting for that purpose. If a special meeting is called, to discuss any proposed bylaws amendments, votes cast on the ballots distributed prior to the meeting will be void, and the process outlined in the first sentence of this section will have to be repeated.

A favorable vote of two thirds of those voting is required on each proposed amendment. The ballots must be returned within 21 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

14.6 **ADOPTION AND AMENDMENT**

The Credentials Procedure Manual, Fair Hearing Plan and Medical Staff Rules and Regulations must be adopted by the Executive Committee and approved by the Board prior to becoming effective. Amendments to these documents may be adopted upon approval of the Executive Committee and the Board.

14.7 **BOARD OF DIRECTORS ACTION**

14.7-1 **WHEN FAVORABLE TO MEDICAL STAFF RECOMMENDATION**

Medical staff recommendations regarding proposed Bylaws, Credentials Manual, Medical Staff Rules and Regulations and the Fair Hearing Plan or amendments thereto shall be effective upon the affirmative vote of the Board.

14.7-2 **BOARD CONCERNS**

In the event the Board has concerns regarding any provision or provisions of the proposed Bylaws, Credentials Manual, Medical Staff Rules and Regulations and the Fair Hearing Plan or amendments thereto, the Board and medical staff shall establish a joint conference committee comprised of three representatives of each body to resolve such concerns.

14.7-3 **TECHNICAL AND EDITORIAL AMENDMENTS**

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

REV: 8/21/12

ADOPTION AND APPROVAL

Adopted by the Medical Staff: April 23, 2012

_____
David M. Paul, M.D.
Chief of Staff

Upon recommendation of the Medical Staff, approved by
the BH Board of Directors on May 10, 2012

_____
David Bixby
General Counsel/Secretary