BYLAWS
OF THE
MEDICAL STAFF

Medical Staff Services
480-412-7720
December, 2020

Banner Health Desert Medical Center
Banner Children's at Desert
1400 S. Dobson Road
Mesa, AZ 85202

BANNER DESERT MEDICAL CENTER
CARDON CHILDREN'S MEDICAL CENTER

BYLAWS INDEX

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BANNER DESERT MEDICAL CENTER

PREAMBLE

WHEREAS, Banner Desert Medical Center is owned and operated by Banner Health, an Arizona nonprofit corporation; and

WHEREAS, the purpose of the Medical Center is to serve as a general hospital providing quality patient care, education and research; and

WHEREAS, the Medical Staff of the Medical Center is primarily responsible for overseeing and reporting to the Board on the quality of patient care, education and research at the Medical Center in those areas in

which clinical judgment and evaluation of professional competence and ethical conduct are involved; and

WHEREAS, the Medical Center relies upon the judgment and recommendations of its Medical Staff in such matters, subject to the ultimate authority and responsibility of the Banner Health Board of Directors; and

WHEREAS, the mutually cooperative efforts of the Medical Staff, the Medical Center Administrator and the Banner Health Board of Directors are necessary to fulfill the Medical Center's obligation to provide quality patient care;

THEREFORE, these Bylaws are intended to provide the Medical Staff with the structure for its organization and self-government and for its relations with the Banner Health Board of Directors, and with applicants to and members of the Medical Staff.

DEFINITIONS

1. "Ad Hoc Hearing Committee" or "Hearing Committee" means the committee appointed under the Fair Hearing Plan to hear a request for an evidentiary hearing properly filed and pursued by a respondent.

2. "Administrator" means the individual appointed to act on behalf of BH in the overall management of the Hospital. In the performance of specific duties described in these Bylaws, it may also signify the administrator on call or the relevant associate administrator.

3. "Affiliate Staff" means all dentists (other than oral and maxillofacial surgeons), clinical psychologists and podiatrists duly licensed in the State of Arizona who have been granted Affiliate Staff membership.

4. "Allied Health Professionals" OR "AHP" shall include non-medical staff professionals who, because of their training, experience and current competence, have been approved by the Board to practice in specified capacities in the hospital and function in a medical support role to members of the Medical Staff.

5. "Appeals Subcommittee" means a subcommittee of the BH Quality Assurance Committee named by the chair of the BH Quality Assurance Committee and designated by the Board to hear an appeal properly filed and pursued by a respondent.

6. "Attendance" means admission or discharge; primary clinical responsibility for an inpatient or outpatient; or consultations, including in-emergency-room responses to emergency call, in accordance with Medical Staff Rules and Regulations. Visits alone do not constitute separate "attendances," nor do the routine expected daily visits to patients by a covering physician in the absence of their primary physician.

7. "BH" means Banner Health.

8. "Board" or "Governing Body" or "Board of Directors" means the Board of Directors of Banner Health, Phoenix, Arizona, or its Executive Committee.

9. "Chairman" shall signify vice chair or delegee, if absence or conflict prevents the chairman from performing his/her duties.

10. "Days" means regular working days, i.e., excluding Saturdays, Sundays and holidays.

11. "Department" means a major subdivision of the Staff according to traditional major medical services. A department may be further divided into "sections" according to specialties of medical practice.

12. "Exclusive Contract" means [1] an agreement by BH, pursuant to a contract for the provision of

professional medical services, not to contract with another entity for the provision of the same services that are the subject of the exclusive contract, for the term of the contract, or [2] an agreement that would preclude any otherwise qualified Medical Staff member (or applicant) from exercising the same clinical privileges as those covered by the contract.

13. "Executive Committee" means the Executive Committee of the Staff, unless specific reference is made to the Executive Committee of the Board.

14. "Hospital" means the Banner Desert Medical Center, Mesa, Arizona.

15. "Medical Staff" or "Staff" means the organization with the delegated responsibility for overseeing and reporting to the Board on the quality of professional services and patient care provided in the Hospital pursuant to these Bylaws.

16. "Medical Staff Services Office" or "Medical Staff Services Department" means that Hospital department charged with assisting the Medical Staff in performing its responsibilities.

17. "Medical Staff Year" or "Staff Year" means the period from January 1 to December 31. "Reappointment Year" means the second year of a two-year term of appointment.

18. "Physician" for purposes of these Bylaws, means a person licensed in Arizona to practice medicine or osteopathy or a person certified by the American Board of Oral and Maxillofacial surgery and licensed in Arizona to practice dentistry.

19. "Practitioner" means a physician, dentist or paramedical clinician properly licensed or certified in the State of Arizona.

20. "President" shall signify vice president or other officer in direct line of succession, in the event of absence or conflict.

21. "Primary Care" means Family Medicine and non-specialized Internal Medicine and Pediatrics.

22. "Related Facility" means a health care institution that is operated under a license issued pursuant to Arizona Revised Statutes Title 36, Chapter 4, and that is either (1) located on the Hospital campus (bounded by Dobson Road, U.S. 60, Southern Avenue and the canal), or (2) if not on campus, under the legal authority of the Hospital (by governance, ownership or contract).

23. "Respondent" means any applicant to the Staff or any member of the Staff who is responding to an investigation or adverse recommendation with respect to Staff membership or privileges.

24. "Scientist" means a person who is qualified by advanced training in a medical or dental field in a recognized institution of higher learning.

25. "Service" means a multi-disciplinary organization of the Staff that supervises, through a Staff committee, a function or functions of the Hospital, usually within designated Hospital departments, and involving more than one Staff department.

26. "Special Notice" means written notification sent by certified mail, return receipt requested, or by personal delivery with signed acknowledgment of receipt.

ARTICLE I: NAME

The name of this organization shall be "The Medical Staff of Banner Desert Medical Center."

ARTICLE II: PURPOSE

The Medical Staff of Banner Desert and Cardon Children’s Medical Center is organized to promote quality

care for all patients admitted to the Hospital or treated in the Outpatient and Emergency Departments. This purpose shall be accomplished by:

2.1 Promoting a high level of professional performance of all members of the Staff authorized to practice in the Hospital through the appropriate delineation of privileges that each member of the Staff may exercise in the Hospital and by continuing review and evaluation of health care provided in the Hospital; and by

2.2 Initiating and maintaining Bylaws, Rules and Regulations, Policies and Procedures for self-government of the Medical and Affiliate Staffs; and by

2.3 Furthering the professional education of all personnel; and by

2.4 Providing a means whereby problems of a medical-administrative nature may be discussed and resolved; and by

2.5 Promoting and supervising appropriate research activities of the Staff; and by

2.6 Developing necessary and appropriate health care procedures; and by

2.7 Participating in education of patients and families.

ARTICLE III: STAFF MEMBERSHIP

3.1 NATURE OF STAFF MEMBERSHIP

3.1.1 Membership on the Medical and Affiliate Staff is a privilege which shall be extended only to professional, competent practitioners and scientists who continuously meet the qualifications, standards and requirements set forth in these Bylaws. No practitioner shall be entitled to Staff membership or practice privileges merely by virtue of being properly licensed, certified or otherwise qualified to practice in Arizona or any other state; or a past or present member of any professional or other organization. These qualifications, standards and requirements shall be established to fulfill the obligations stated in the Preamble and to further quality health care.

3.1.2 Membership and/or practice privileges on the Staff shall not be denied or limited on the basis of sex, race, creed, color, national origin, or any other criterion lacking professional justification.

3.2 QUALIFICATIONS FOR STAFF MEMBERSHIP. Every applicant for Medical and Affiliate Staff Membership must document the following to the satisfaction of the Medical Staff and the Board:

3.2.1 General. Background, experience, training and demonstrated competence, adherence to professional ethics, good reputation, health status so as not to compromise the care of patients, and ability to work with others.

3.2.2 Communication. Electronic communication is the Medical Center's primary method of communication with the Medical Staff. All applicants and members of the Medical Staff must provide a current email address for communication of regular Medical Center business. All applicants and members are responsible for reading email notifications and responding timely to Medical Center business. Electronic communication will follow Banner Health's policies and procedures regarding confidentiality/disclosure of protected health information.

3.2.3 Education.

3.2.3.1 Physicians. Graduation from an approved school of medicine or Osteopathic medicine; 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.

3.2.3.2 Dentists. Graduation from an approved school of dentistry.

3.2.3.3 Clinical Psychologists. A doctorate degree in psychology from an approved program.

3.2.3.4 Podiatrists. Graduation from an approved school of podiatric medicine.

3.2.4 Definition. Except as described in the next paragraph, an "approved" school (or program, in the case of psychologists) is one fully accredited during the entire time of the practitioner's attendance by the Liaison Committee on Medical Education of the Council on Medical Education of the American Medical Association and the American Medical Colleges (LCME), the American Osteopathic Association (AOA), the Commission on Dental Accreditation of the American Dental Association, the American Podiatric Medical Association, or the American Psychological Association. Post-graduate medical training programs (**3.2.5, 3.2.6**) must be accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the AOA.

3.2.5 Licensure. Licensure to practice medicine, dentistry, clinical psychology, or podiatry in the State of Arizona.

3.2.6 Training. Specific training requirements for physicians, dentists, podiatrists and clinical psychologists are established in departmental policies and procedures.

3.2.7 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 within five years of completion of training or sooner as required by the department or the American Board of Medical Specialties (ABMS), the American Osteopathic Board (AOA), or the Royal College of Physicians and Surgeons of Canada within 5 years of completion of training. Failure to become certified within the time allowed under these Bylaws or failure to pass the Board certification exam on the third attempt shall result in the voluntary, automatic relinquishment of Medical Staff membership and privileges.

For purposes of this section, “Board certification” or “Board certified” means certified by a board approved by the American Board of Medical Specialties**,** or the Advisory Board for Osteopathic Specialists**,** the Royal College of Physicians and Surgeons of Canada, the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, the American Dental Association or the American Board of Professional Psychologists or by a board determined by the department and Executive Committee to be equivalent. For purposes of this section, “Board qualification” or “Board qualified” means the applicant has completed the training necessary to be accepted to become, has applied for and has 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 the applicant has met all training requirements for qualification by the appropriate board

b) Exceptions to achieving board certification may be considered in the following circumstances as determined by the Medical Executive Committee:

a. where a practitioner had membership and privileges as of the date of approval of these bylaws and based upon bylaws then in effect, the practitioner was not required to be certified:
b. where a particular field or specialty of the department does not have a Board certification:;
c. where the applicant’s privileges are limited to surgical assisting or referring only
d. to applicants/members where there is a shortage of qualified Medical Staff members in the practitioner’s specialty necessary to meet the Medical Center’s demand for services where the Medical Executive

Committee has determined that the practitioner's training and experience approximates as nearly as possible those assured by Board Certification.

e. where a practitioner has obtained a level of training experience and expertise commensurate with board certification through an alternative pathway that does not offer board certification. (Examples would include training through a foreign training program.) 75% of the Medical Executive Committee must recommend approval of the waiver.

c) Extensions to achieving board certification may be considered in the following circumstances as determined by the Medical Executive Committee:

a. a practitioner has taken the exam, and is awaiting results or has applied to take the next available exam and provides evidence of this; or

b. a practitioner has submitted evidence of extraordinary circumstances, including a particular medical, physical, family, or financial hardship in which they were unable to become certified or recertified within the required time frame. In this instance, the practitioner must sit for the next available board exam to become certified or recertified.

c. the appropriate American Board of Medical Specialties (ABMS), the American Osteopathic Board (AOA), the Royal College of Physicians and Surgeons of Canada, the American Board of Podiatric Surgery or American Board of Podiatric Orthopedic and Primary Podiatric Medicine, the American Dental Association or the American Board of Professional Psychologists allow for a longer period of time within which to become certified.

In the event the practitioner fails to certify or does not take the exam, the practitioner will be deemed to have resigned.

d) Exceptions to Board Recertification. Members are expected to maintain board certification. If the member fails to obtain board recertification within the time frames described by their boards, he or she shall have no more than an additional three years to regain certification. Failure to become recertified within the time allowed under these Bylaws shall result in the automatic relinquishment of Medical Staff membership and privileges.

3.3 Contract Physicians

3.3.1 The term, "Contract Physicians," for the purposes of these Bylaws means any properly credentialed and appointed member of the Staff with appropriate privileges who provides professional services pursuant to an Exclusive Contract; who contracts to provide full-time professional services; or who contracts to provide medical services in an outreach clinic that is identified or intended to be perceived as an extension of the Hospital.

3.3.2 Initial appointment and biannual review for determination of Staff membership, category and privileges for Contract Physicians shall be by the same procedures as for other Staff members, as provided in Articles 4, 5 and 6, except that:

3.3.2.1 Attendance requirements as provided in Article IV.

3.3.2.2 a Contract Physician shall be a member of one Medical Staff category in accordance with Article IV but need not be a member of the Active Staff unless he or she desires the privileges and obligations of that category;

3.3.2.3 a Contract Physician may be granted privileges other than those essential to the

performance of their duties as provided in the Policies and Procedures of their department by making application to and receiving approval from the appropriate department or section granting privileges. Such granting of privileges outside the scope of the contract duties shall subject Contract Physicians to the Attendance requirements of Article IV.

3.3.3 For purposes of these Bylaws, the designation of full-time Contract Physician shall mean those Staff members whose medical practice outside of the contractual obligations are insubstantial relative to such contractual obligations.

3.3.4 Before seeking to contract for physician services, the Hospital will obtain the advice of the Executive Committee based on documented patient care needs and objective professional criteria necessary to meet those needs, in accordance with Section **9.2.3.2.k**.

3.3.5 Medical Directors of Staff and Departments

3.3.5.1 When the duties of the President of the Staff become too time consuming, the Administrator may create the position of Medical Director of the Staff, upon recommendation and approval of the Executive Committee and approval of the Active Staff by a majority by mail ballot. The Medical Director of the Staff shall be administratively responsible to the Administrator and provide Staff support to the President of the Staff.

3.3.5.2 When the duties of the chairman of a department or section become too time consuming, the Administrator may create the position of department or section Medical Director, upon recommendation and approval of the Executive Committee and approval of the Active members of the department or section by a majority by mail ballot. The Medical Director of that department or section shall be administratively responsible to the Administrator, through the Medical Director of the Staff if there is one employed, and provide Staff support to the Chairman of the department or section.

3.3.5.3 Termination of appointment of individual physicians in these positions shall be made by the Administrator following consultation with the Executive Committee.

3.3.5.4 The Medical Director of the Staff shall serve as an ex-officio member of all committees of the Staff, except the Education, Research and Professional Library Committee, of which he shall be a member.

3.3.5.5 The Medical Director of a department or section shall serve as an ex-officio member of the committee of the department or section to which he is assigned, and such other committees as the Executive Committee deems appropriate.

3.3.5.6 The duties of the Medical Director of the Staff or of a department or section when related to the Medical Staff shall be recommended by the Executive Committee and the appropriate department or section committee and shall be a part of the appropriate Rules and Regulations, policies and procedures.

3.4 HARASSMENT PROHIBITED

3.4.1 Medical Staff Policy. Harassment by a Medical Staff member against any individual on the basis of sex, age, race, religion, color, national origin, or disability will not be tolerated by the Medical Staff. All reports of harassment shall be promptly and thoroughly investigated and, if confirmed, will result in appropriate corrective action. Retaliation against a complainant or witness is prohibited and illegal.

3.4.2 Definition. "Sexual harassment" means unwelcome verbal or physical conduct of a sexual

nature when (1) such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment, (2) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, or (3) submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual. "Sexual harassment" violates state and federal law.

ARTICLE IV: CATEGORIES OF THE STAFF

4.1 MEDICAL STAFF CATEGORIES

The Staff shall be divided into the Physician Staff and the Affiliate Staff. Each member of the Staff shall be a member of one Staff Department and (other than Honorary Staff) shall pay dues, as determined by the Executive Committee.

4.1.1 Staff Categories.

4.1.1.1 With Practice Privileges:
- A) Active
- B) Courtesy
- C) Consulting
- D) Affiliate

4.1.1.2 Without Practice Privileges
- A) Referral
- B) Honorary
- C) Teaching and Administrative

4.1.2 Changes. Changes in Physician Staff category are made only at reappointment.

4.1.3 Community Based. Is a status that can be granted to physicians who wish to be affiliated with the Medical Center. This status does not have any membership or privileges.

4.1.4 Active Staff

4.1.4.1 Eligibility. For initial appointment to the Active Staff physicians must have successfully completed one year of Staff membership, be located close enough to the Hospital in terms of time to provide continuous care to their patients, and have attended at least 15 patients in the prior Staff year. For Reappointment, a member must have attended at least thirty (30) patients during the preceding two (2) year reappointment period. Failure to do so will place the member on the Courtesy Staff at the start of the new term of reappointment. Return to the Active Staff shall be automatic with reappointment; if the member has attended thirty or more patients in a reappointment period. The attendance requirement may be waived by the Executive Committee on request upon its determination that the member's specialty does not ordinarily involve admission of patients, such as in the case of Dermatology.

4.1.4.2 Authority, Responsibilities. The Active Staff shall conduct all of the business of the Staff, except those duties and functions specifically delegated to departments, sections, services and committees of the Staff in these Bylaws. Members of the Active Staff shall be eligible to vote, to hold office in this Staff organization, and to serve on Staff committees, and shall comply with existing meeting attendance requirements.

4.1.5 Courtesy Staff

4.1.5.1 Eligibility. The Courtesy Staff shall consist of physicians who admit patients to the Medical Center only on an occasional basis or those recently appointed to the staff. Physicians, who, in any two-year period, have more than thirty (30) patients contacts, shall be recommended for Active Staff membership in the following term of appointment. Contacts are defined in the roles of Attending, Admitting, Anesthesiologist, Consultant and/or Surgeon.

4.1.5.2 Responsibilities, Prerogatives Courtesy Staff members shall not be eligible to vote or hold office in this Staff organization. Members of the Courtesy Staff may be appointed to committees and if so, may vote on matters before such committees.

4.1.6 Consultant Staff

4.1.6.1 Eligibility Consulting Staff members may not admit but may consult on patients, write orders or document a recommended plan of care in the patient record.

4.1.6.2 Responsibilities, Prerogatives. Consultant Staff members shall not be eligible to vote or to hold Staff office. Members of the Consultant Staff may be appointed to committees and if so, may vote on matters before such committees.

Consultant Staff may not admit or assume primary responsibility as the Attending Physician for the care and treatment of a Hospitalized Patient and may not exercise privileges that may be granted only to members with admitting privileges in the interests of patient safety and welfare.

4.1.7 Honorary Staff

4.1.7.1 Eligibility: The Honorary Staff shall consist of members who are not active in the Hospital, or who are honored by emeritus positions, and who wish and deserve a continuing relationship with the Staff. These may be those who have retired from active Hospital practice or who are of outstanding reputation, not necessarily residing in the community. This category may be applied for and granted at any time during a Staff Year. The Honorary Staff shall also include those Dentists who were Honorary Staff members as of January 11, 1990.

4.1.7.2 Responsibilities, Prerogatives Honorary Staff members shall not be eligible to admit or attend patients, to vote, or to hold office. They may serve as advisory members of standing committees without a vote unless specifically authorized to vote by the Committee.

4.1.8 Teaching and Medical-Administrative Staff

4.1.8.1 Eligibility Physicians in Medical-Administrative positions for Hospital Departments or programs who do not exercise clinical privileges and physicians in full-time teaching directorships at Banner Desert Medical Center or affiliate institutes must be appointed to this Staff category if ineligible for another category. Members must be board-certified and currently licensed to practice medicine in Arizona.

4.1.8.2 Responsibilities, Prerogatives Members of the Teaching and Medical-Administrative Staff category may not be granted clinical privileges. They shall be ineligible to vote in General Staff matters and may not hold office. They shall be accountable to both the Administrator and the Executive Committee (delegee).

4.1.9 Community Based Physician

4.1.9.1 Eligibility. Community Based Physicians are physicians who request Medical

Center services for their patients and who wish to be affiliated with the Medical Center. Community Based Physicians are not members of the Medical Staff and do not have privileges in the hospital.

4.1.9.2 Qualifications. Physicians seeking Community Based affiliation must apply for Community Based affiliation and provide evidence of the following qualifications:

a) Arizona licensure in good standing with the Arizona Medical Board or the Arizona Board of Osteopathic Examiners:
b) Have the ability to relate in a professional manner with Medical Center staff and physicians;
c) Demonstrate professional ethics and conduct.

4.1.9.3 Prerogatives. The prerogatives of Community Staff physicians are to:

a) Receive their patients' medical records;
b) Order Outpatient diagnostic services for patients;
c) Make courtesy visits to patients, but may not initiate orders or document in the medical record.
d) Attend General Staff meetings, without vote;
e) Attend Continuing Medical Education programs at the Medical Center.

4.1.9.4 Responsibilities. Community Based Physicians agree to use Medical Center patient information only as necessary for treatment, payment, or healthcare operations in accordance with HIPAA laws and regulations. They shall not be eligible to vote or to hold staff office, but may be appointed to committees and if so, may vote on matters before such committees.

4.1.9.5 Denial or Termination of Community Based Status. Community Based Status physicians or physicians seeking Community Based 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 and act on it accordingly. The physician has not appeal or other rights in connection with the Executive Committee's decision.

4.1.9.6 Request for Change of Status. Community Based Status physicians requesting a change in Medical Staff Status to another category, must meet the Qualifications for Staff Membership as outlined in Article 3 of these Bylaws.

4.1.10 Affiliate Staff

4.1.10.1 The Affiliate Staff shall consist of dentists (other than oral and maxillofacial surgeons), clinical psychologists and podiatrists.

4.1.10.2 Eligibility of categories of practitioners for Affiliate Staff requires amendment of these Bylaws and approval of the Board.

4.1.10.3 Members of the Affiliate Staff shall be assigned either individually or through an Affiliate Staff Section as provided in Section **9.2** to specific departments or sections of the Medical Staff but shall not be eligible to vote or hold office or be appointed to committees of the Staff organization except as provided in Section **9.2**.

4.1.10.4 A member of the Affiliate Staff who has not attended any patient in the Hospital

for two (2) consecutive years may be dropped from the Medical Staff.

4.1.11 Telemedicine Staff

4.1.11.1 Eligibility. The Telemedicine Staff shall consist of practitioners who provide services to Medical Center patients exclusively through the use of telemedicine. The Telemedicine Staff category is for members who provide diagnostic treatment delivered primarily through a telemedicine medium. Specific delineation of privileges for Telemedicine shall define the ability to write orders and/or manage direct patient care. Members of the Telemedicine Staff shall not serve as the attending, admitting, or surgeon of record for any patient. As Members of the Medical Staff, Telemedicine Staff shall be fully credentialed. Telemedicine Staff members are subject to focused professional practice evaluation and ongoing professional practice evaluations.

4.1.11.2 Responsibilities. Members of the Telemedicine Staff may not vote in General Staff meetings and shall be ineligible to hold office in this Staff organization, but shall be eligible to serve on department, section, or service committees and shall vote on matters before such committees, except as may be provided in Section 9.2. Members of the Telemedicine Staff shall comply with existing meeting attendance requirements as defined in the medical staff bylaws and department policies and procedures.

4.1.11.3 Advancement from Telemedicine Staff. Members of the Telemedicine Staff will be placed in other staff categories if they provide patient care services while physically located at the Medical Center.

4.1.11.4 Automatic Expiration of Membership and Privileges. The membership and privileges of members of the Telemedicine Staff will automatically expire if their relationship terminates with the group with which Medical Center contracts, if their privileges terminate at their distant primary site. A physician who believes his or her telemedicine privileges were wrongly denied, terminated or limited may submit information to the Medical Executive Committee demonstrating why the denial, limitation or termination was unwarranted. The Medical Executive Committee, in its sole discretion, shall decide whether to review the submission. The physician has no appeal or other rights in connection with the Executive Committee's decision.

4.1.11.5 DUES. Annual medical staff dues will be assessed at a rate determined by the MEC.

ARTICLE V: PRIVILEGES

5.1 PRIVILEGES RESTRICTED. No practitioner may provide a patient care service unless duly authorized by the Board on recommendation of the Medical Staff. Every member of the Staff shall be entitled to exercise only those privileges approved by the Board except as otherwise provided in these Bylaws.

5.2 PROCESS FOR "DISTANT SITE" CREDENTIALING OF TELEMEDICINE PROVIDERS
For purposes of this section, Distant Site is defined as the site where the practitioner providing the telemedicine service is located.

Where the Medical Center has a contract with a Joint Commission accredited facility Distant Site approved by the Medical Executive Committee, the Medical Center will accept the credentialing and privileging decisions of the Distant Site for applicants who provide telemedicine services and are credentialed at the Distant Site. Privileges at the Medical Center shall be identical to those granted at the Distant Site, except for services which the Medical Center does not perform.

Privileges shall be granted and renewed for the same period as have been granted by the Distant Site. Board approval of privileges at the Distant Site qualifies as Board approval at the Medical Center.

5.3 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, 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, 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.

5.4 PROCESS FOR CREDENTIALING AND PRIVILEGING ALLIED HEALTH PROFESSIONALS
Completed applications for allied health membership for initial appointment and scopes of practice will be submitted to the Credentials Committee, Department, and Executive Committee for review and action prior to submission to the Board. Completed applications for reappointment are submitted to the Department, and Executive Committee, subject to final approval by the Board. The process for appointment and reappointment to the Allied Health Staff is set forth in further detail in the Allied Health Rules and Regulations.

5.5 PRIVILEGES GRANTED

5.5.1 Privileges may not be exercised at the Medical Centers until the practitioner has successfully completed Banner's New Provider Orientation (NPO), electronic medical record/computer assisted order entry training (CPOE) and Identity (ID) Verification. Except in an emergency, a practitioner providing clinical services at the Medical Centers may exercise only those clinical privileges specifically granted.

5.5.2 Every application for Staff appointment, reappointment and every application for change in privileges, must request the specific privileges desired by the applicant. Such requests are subject to clarification upon interview. The granting of a specific clinical privilege carries with it the privilege to use, on a nondiscriminatory basis, available Hospital personnel, instruments and facilities necessary to the exercise of the clinical privilege, unless otherwise provided by specific contract terms.

5.5.3 The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence and judgment, references and other relevant information, including an appraisal by the department and section committees in which such privileges are sought. All requests for clinical privileges will be processed in accordance with the procedures set forth in Article V, except that requests submitted after the initial granting of membership shall not require review by the Credentials Committee.

Information that is submitted, collected or prepared in connection with the evaluation of an application for privileges shall, to the fullest extent permitted by law, be confidential and shall not be disseminated or used in any way except as provided herein or as required by law.

5.6 BASIS FOR PRIVILEGES DETERMINATIONS
Clinical privileges shall be granted in accordance with education and training, experience, utilization practice patterns, current health status, and demonstrated competence and judgment to provide quality and appropriate patient care in an efficient manner as documented and verified in each practitioner's credentials file. Additional factors that may be used in determining privileges include those qualifications set forth in Section 3.2. Where appropriate, review of the records of patients treated in other hospitals or practice settings may also serve as the basis for privileges determination(s). In reappointment determinations, results of quality and performance improvement and utilization review, peer review, supervised cases, and where appropriate,

practice at other hospitals and or practice settings 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.

5.7 PRIVILEGE DECISION NOTIFICATION

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

5.8 ADMITTING PRIVILEGES

5.8.1 Members of the Medical Staff may admit patients according to privileges granted by a department or section, except as provided in these Bylaws. Rules and Regulations 8.0 govern the documentation and timeframes in place for history and physicals.

5.8.2 HISTORIES AND PHYSICALS

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

5.8.3 Members of the Affiliate Staff may co-admit patients to the departments or sections in which they have been granted admitting privileges. Prior to all admissions, arrangements shall have been made for co-admission with a member of the Medical Staff with admitting privileges who shall be responsible for a medical appraisal, including a medical history and physical examination within 24 hours of admission and prior to any surgical procedure, and for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization.

5.9 RESEARCH AND EDUCATION PRIVILEGES

5.9.1 The scope and extent of research that each member of the Staff may perform shall be delineated.

5.9.2 All members of the Staff shall have the privileges and obligation to participate in general education activities involving the Staff, its various categories and paraprofessional personnel.

5.9.3 The scope and extent of responsibilities that a member of the Staff may assume in a formal educational activity involving medical school, internship or residency program shall be delineated.

5.9.4 The Board may grant research and formal educational privileges to any member upon recommendation of the department or section in which the member has privileges, the Education and Research Committee, the Credentials Committee and the Executive Committee. Research involving new and/or experimental drugs must also have the approval of the Pharmacy and Therapeutics Committee.

5.9.5 Supervision and recommendation for redetermination of research and formal education privileges shall be the dual responsibility of the department or section in which the member has privileges and the Research and Education Committee.

5.10 REDETERMINATION OF PRIVILEGES. Redetermination and the increase or curtailment of privileges of a Staff member shall be based upon education, training and experience, information

resulting from ongoing, forward and other evaluations of the member's performance in patient care, research or education functions in the Hospital, review of patient records in this or other hospitals, any reasonable evidence of current ability to perform the requested privileges that may be requested by the Executive Committee, and records of the Staff in this or other hospitals which document the evaluation of the member's performance as described in this Section.

5.10.1 Periodic redetermination of privileges shall be done no less than every two years, as provided under 5.3 or Article 6.

5.10.2 Application for additional privileges must be submitted in writing on forms furnished by the Hospital, on which the type of changes and privileges desired are outlined and the applicant's relevant training and/or experience are documented by certificate of achievement, letters from supervisors or other appropriate means. Such applications shall be processed in the same manner as applications for initial appointment and privileges.

5.10.3 Reapplication for clinical procedures that have been previously denied, terminated, or resigned as a result of investigation or adverse recommendation concerning Staff membership or privileges must be accompanied by documentation of subsequent successful completion of formal training in the requested clinical procedure.

5.10.4 Reapplication for clinical privileges that have previously been denied, terminated, or resigned as a result of investigation or adverse recommendation concerning Staff membership or privileges must be accompanied by documentation of additional training in a program approved by the pertinent American Board in the areas of which the physician has been adjudged deficient. Satisfactory completion of the training must be evidenced by a letter of recommendation from the program director stating that said physician has completed the course and has competence equal to or better than a resident completing that program before consideration is given toward granting or restoring privileges. Reapplication for clinical privileges will not be considered by the relevant department for such period of time (after the effective date of the prior denial, termination or resignation in return for not conducting a professional review proceeding) as prescribed by such department's policies and procedures.

5.10.5 If terminations, denials, or resignations as a result of investigation or adverse recommendation concerning Staff membership or privileges are occasioned by issues of patient safety other than competency, the Executive Committee may be asked to determine at the time of its initial action in this regard the interim conditions to be met before consideration of re-application.

5.11 TEMPORARY PRIVILEGES

5.11.1 Grant, Termination of Temporary Privileges

5.11.1.1 Review Any prerequisite approval for the grant of temporary privileges is entirely discretionary, and neither denial nor termination of temporary privilege triggers any right to a hearing or other review.

5.11.1.2 Grant, Denial. The process for granting each kind of temporary privilege is upon recommendation by the Credentials Committee Chairman (if applicable), President of the Medical Staff, Chairman of the Department, Section or Service or their respective designees and the CEO or designee. In exercising such privileges, the applicant shall act under the observation of the chairman (or designee) of the department or section to which he is assigned. Temporary privileges may be granted for up to one hundred twenty (120) days.

5.11.1.3 Termination. The CEO, Medical Staff President or Department, Section or Service Chairman may, at any time terminate any or all of an applicant’s temporary privileges effective immediately. Where it is determined that the life or health of a patient would be endangered by continued treatment by a

practitioner with temporary privileges, the termination of temporary privileges may be imposed by any person entitled to impose a summary suspension pursuant to these Bylaws and the same shall be effective immediately. The appropriate department or section chairman, or in his absence, the Chairman of the Executive Committee, shall assign an appropriate member of the Staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the Hospital. The wishes of the patient(s) shall be considered where feasible in the selection of such substitute practitioner. The applicant shall have no recourse or rights of appeal of such action regarding temporary privileges.

5.11.2 Temporary Privileges to Applicants Awaiting Approval by the Executive Committee and Governing Board. An applicant for Staff membership and privileges whose completed application has not yet been approved by the Department Committee, Executive Committee and the Board but has been approved by the Credentials Committee without adverse recommendations or unresolved issues may request temporary privileges. Such applicant shall request temporary privileges and shall agree to be bound by the terms of the Staff Bylaws, Rules and Regulations, and applicable Policies and Procedures in all matters relating to his temporary privileges.

5.11.3 Temporary Privileges to Care for Specific Patient

Temporary privileges for the care of a specific patient may be granted only after the Medical Staff Office has received a request for the specific privileges desired; confirmed appropriate licensure and professional liability insurance coverage; favorable results of the National Practitioner Data Bank Query and ensures that the practitioner fulfills requirements to be a member of the appropriate department of the Medical Staff. Temporary privileges granted under this section shall [1] be supervised by the relevant department/section chairman (designee), [2] be considered on an individual basis for a period not to exceed 60 days. One extension may be granted for an additional period not to exceed 60 days. Any such extension shall be made by the department chairman when the information available continues to support a favorable determination regarding the practitioner's application for membership and privileges. [3] not be granted to an individual more than two (2) times in any twelve (12) month period.

5.11.4 Temporary Privileges Coverage of Service In special circumstances where a service is not adequately covered to meet patient care needs, temporary privileges may be granted to an applicant for staff membership upon receipt of application and verification of the following information: appropriate licensure; adequate professional liability insurance; DEA registration, (if applicable); current clinical competency; education and training; evidence of freedom from infectious tuberculosis and recent flu vaccination, when applicable; no involuntary termination of Medical Staff membership, or involuntary limitation, reduction, denial or loss of privileges at the practitioner’s primary facility; freedom from government sanctions; and NPDB query responses as required to meet privilege criteria. Temporary privileges shall be granted under this provision only under exceptional circumstances and never solely for the sake of physician convenience. Temporary privileges will be considered on an individual basis for a period not to exceed 60 days upon completion of CPOE training. One extension may be granted for an additional period not to exceed 60 days. Any such extension shall be made by the department, section or service chairman when the information available continues to support a favorable determination regarding the practitioner's application for membership and privileges.

5.12 EMERGENCY PRIVILEGES. In the case of emergency, any qualified physician, regardless of privileges or Staff status, or lack of it, shall be permitted and assisted to do everything possible to

save the life of a patient, using every facility of the Hospital necessary or desirable. When an emergency situation no longer exists, the physician must request the privileges necessary to continue to treat the patient or in the event such privileges are not appropriate, denied, or he does not desire to request privileges, the patient shall be assigned by the department or section chairman to an appropriate member of the Staff. For the purposes of this Section, an "Emergency" is defined as a condition in which serious permanent harm would result to a patient, or in which the life of a patient is in immediate danger, and any delay in administering treatment would add to that danger.

5.13 DISASTER PRIVILEGES.

5.13.1 Grant. When a disaster has been officially declared pursuant to the Hospital's emergency management plan, and either the CEO or Medical Staff President has determined that the Hospital is unable to meet its immediate patient needs, the CEO (or delegee) or Medical Staff President (or delegee) may, on a case by case basis, grant specialty-specific disaster privileges to a physician, dentist, PA or NP (practitioner).

Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:

- A current picture identification card from a health care organization that clearly identifies professional designation.
- A current license to practice.
- Primary source verification of licensure.
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESARVHP), or other recognized state or federal response hospital or group.
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances.
- Confirmation by a licensed independent practitioner currently privileged by the hospital or a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

When the practitioner is not a member of an Arizona Hospital, a staff member or practitioner currently privileged by the hospital must recommend the granting of such privileges.

5.13.2 Duration. Primary source verification of license will begin as soon as the immediate situation is under control, and must be completed within 72 hours (or as soon as possible) from the time the volunteer begins working at the hospital. If not verified within 72 hours, the reason must be documented.

5.13.3 Oversight. Oversight of the professional performance of volunteer practitioners who receive disaster privileges (e.g. direct observation, mentoring, clinical record review) will be the responsibility of the Medical Staff President or Chief Medical Officer or appropriate Department chairman or other designee. An assessment will be conducted within 72 hours to determine continuation of disaster privileges. This decision is based upon information regarding the professional practice of the volunteer. The CEO, CMO or Medical Staff President may terminate any or all of a practitioner's disaster privileges on the discovery of any information or occurrence of any event of a nature that raises a question about the practitioner's professional qualifications. In the event of such termination, the practitioner's patients then in the Hospital will be assigned to another practitioner.

5.13.4 Expiration. Such privileges expire within thirty (30) days or upon the termination of the disaster or completion of inpatient care. A practitioner is not entitled the procedural rights afforded by these Bylaws either due to request for disaster privileges is refused, or such privileges are terminated or otherwise limited.

5.13.5 Volunteer. Volunteer practitioners functioning under disaster privileges will be identified as such by wearing an identification badge provided upon the granting of privileges.

5.14 ALLIED HEALTH PROFESSIONALS' HOSPITAL PRACTICE. Allied Health Professionals shall:

5.14.1 Be granted authorization to perform in specified capacities in accordance with Bylaws Sections V.1 and V.10 and Policies and Procedures adopted pursuant to section **10.5.1** ("Allied Health Professional Committee"). Such authorization shall be for a period of two years, unless sooner terminated.

5.14.2 Be assigned to either a hospital or a medical staff department and subject to that department's policies and procedures. 5.10.3 Be subject to the identical professional liability insurance requirements as medical staff members.

5.14.3 Have such procedures for review of corrective actions as may be described in duly adopted policies and procedures.

5.14.4 Shall follow established hospital mechanisms and procedures to be clearly identified as non-physicians.

PROCESS FOR CREDENTIALING AND PRIVILEGEING ALLIED HEALTH PROFESSIONALS
Completed applications for allied health membership for initial appointment, reappointment and scopes of practice will be submitted to the Allied Health Committee and Executive Committee for review and action prior to submission to the Board. The process for appointment and reappointment to the Allied Health Staff is set forth in further detail in the Allied Health Rules and Regulations.

5.15 TELEMEDICINE PRIVILEGES

5.15.1 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. Telemedicine services may also 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 5.11 shall apply.

5.15.2 Practitioners providing care, treatment, and services of a patient via telemedicine link are subject to the credentialing and privileging processes of BDMC. The practitioner may be privileged at BDMC 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 BDMC Medical Staff. Under this option, BDMC may 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. BDMC will re-verify licensure over 180 days old, perform a query of the National Practitioner Data Bank and the CVO will perform a Criminal Background Screening. The information will be used for decision making in regard to granting of Practitioners telemedicine privileges.

5.15.3 The Medical Executive Committee shall continually evaluate the Medical Center's ability to provide these services safely, and must evaluate the performance of the services by practitioners at reappointment, renewal, or revision of clinical privileges.

ARTICLE VI: PEER REVIEW AND CORRECTIVE ACTION

6.1 DEFINITION, GROUNDS

6.1.1 Definitions.

6.1.1.1 “Corrective action" means any action by the Staff (except as otherwise specified and excluding adverse actions described in Credentials Manual and Articles 6) to terminate, suspend or otherwise restrict membership or non-temporary privileges of any member of the Staff.

6.1.1.2 “External Review” is a review conducted by an unbiased physician or other practitioner in an appropriate specialty or subspecialty who is actively in practice or has recently retired, but who is not a member of the Medical Staff. Refer to Banner Health External Peer Review Policy.

6.1.1.3 “Focused Review or Focused Professional Practice Evaluation (FPPE) is a time-limited process whereby the Medical Staff evaluates the privilege-specific competency of the Providers or the Providers’ ability to provide safe, high quality patient care and/or conduct themselves professionally. Refer to Banner Health Medical Staff Focused Professional Practice Evaluation Policy.

6.1.1.4 “Investigation":

a) An Investigation is a targeted evaluation of the competence or conduct of a practitioner which is triggered by a determination by the Medical Executive Committee, a Department or a standing peer review committee, that there is a substantial likelihood that the practitioner’s competence or conduct fails to meet applicable standards of care or behavior.
b) If a determination as stated in (a) is made, the investigation is deemed to be initiated when the practitioner is informed in writing that an investigation is being undertaken.
c) Routine peer review activities and focused professional practice evaluation (FPPE) as part of initial appointment or privileging does not constitute investigation.
d) FPPE undertaken to determine whether a substantial likelihood exists that a practitioner’s competence or conduct fails to meet required standards does not constitute an investigation.
e) FPPE undertaken following a determination that a substantial likelihood exists that a practitioner’s competence or conduct fails to meet applicable standards, for the purpose of determining the nature and/or extent of such substandard performance, shall constitute an investigation and notice of the initiation of the investigation shall be given to the practitioner in writing.
f) Once begun, an investigation does not conclude until the medical staff takes a final action or recommendation, or a decision is made to close the investigation. When closed, the practitioner is informed of the closure of the investigation.

6.1.1.5 “On-going Professional Practice Evaluation” (OPPE) is a process to identify professional practice trends and provide on-going evaluation of performance impacting clinical care and patient safety. Refer to Banner Health Medical Staff Ongoing Professional Practice Evaluation Policy.

6.1.1.6 “Peer Review” is the objective measurement, assessment and evaluation, by Peer Reviewers or Peer Review Committees, of the quality of care provided and/or conduct exhibited by individual Providers, as well as the identification of opportunities to improve care and report the Committee’s conclusions and recommendations to other Peer Review Committees and/or the Medical Executive Committee for appropriate action.

6.1.1.7 “Peer Reviewer” is a qualified practitioner who performs Peer Review and who possesses the appropriate clinical judgment based on training, education, and experience.

6.1.1.8 “Peer Review Committee” is a department, committee or subcommittee charged under the Medical Staff Bylaws with responsibility for conducting Peer Review.

6.1.1.9 “Support Staff” The Medical Staff recognizes that the organizational structure required to carry out the credentialing, peer review and corrective action processes of the Medical Staff requires the support of certain members of the administrative staff of the Medical Center and of Banner who may or may not be members of the Medical Staff including, but not limited to, the Medical Center’s CEO, Chief Medical Officer, Chief Nursing Officer and/or designees, and Quality Management, members of the Medical Staff Services Department, members of the Banner Board and Banner leadership, members of the Legal Department and members of the Risk Management Department, including Loss Control and Claims and Litigation Management staff (collectively “Support Staff”). All activities of such Support Staff provided in support of the Medical Staff’s credentialing, peer review and corrective action activities shall be conducted in a confidential manner and shall be afforded all of the immunities and evidentiary privileges available to members of the Medical Staff performing such activities under these Bylaws and under applicable state and federal law. The activities of the Support Staff covered by this provision include, but are not limited to, all support provided to assist the Medical Staff in reviewing practitioner applications, reviewing practitioners’ care in and outside of the Medical Center, participating in the conduct of investigations, identifying trends, participating in the resolution of issues involving Medical Staff members and other practitioners working in the Medical Center, and any other activities as may be requested from time to time by the officers or committees of the Medical Staff.

6.1.2 Grounds. Grounds for corrective action shall include, without limitation: conduct below the standards of the Staff or conduct, either within or outside the Hospital, this is detrimental to patient care or that violates these Bylaws or the Rules and Regulations or Policies and Procedures.

6.2 INITIATION OF INVESTIGATION

An investigation or a 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 Rules, Regulations or policies, or if the practitioner is or may be engaged in a course 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.

6.3 PROCEDURES FOR INITIATING AN INVESTIGATION LEADING TO POSSIBLE CORRECTIVE ACTION

6.3.1 Any medical staff committee, medical staff officer, Chief Executive Officer or designee, or the Board may request an investigation.

6.3.2 All recommendations for corrective action shall be made in writing to the Executive Committee, and specifically describe the conduct that constitutes the grounds for the recommendation.

6.3.3 The President of the Medical Staff shall promptly advise the practitioner of the request for corrective action.

6.4 PROCEDURE FOR CORRECTIVE ACTION

6.4.1 Investigation and Timely Action. Unless a practitioner is under summary suspension, at its next meeting after receipt of a request for corrective action, the Executive Committee shall take action upon the request. If it deems necessary, the Executive Committee may also recommend administrative protective measures pending final resolution of the matter. If the Executive Committee believes an investigation should be conducted, it may appoint a committee to conduct

a prompt, thorough investigation of the practitioner's performance/conduct before considering the recommendation. The practitioner shall be given an opportunity to make an appearance before the Executive Committee prior to its taking action. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto.

6.5 SUMMARY SUSPENSION/SUPERVISION/CONSULTATION

6.5.1 Criteria for Initiation: Suspension. Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient; any two of the following individuals or their designees in concert: The President of the Staff, the chairman of the member's department, the Administrator or an Executive Committee member may summarily suspend all or any portion of the privileges of the member. Unless otherwise stated, such summary suspension shall become effective immediately, and remains until such time as a final determination is made regarding his/her privileges. Unless otherwise indicated by the terms of the summary suspension, the member's patients shall be promptly assigned to another member by the department chairman or by the President, considering where feasible, the wishes of the patient in the choice of a substitute member.

6.5.2 Criteria for Initiation: Supervision/Consultation. Whenever criteria exist for initiating corrective action pursuant to the Article, the practitioner may be summarily placed under concurrent supervision and/or consultation concurrently with the initiation of professional review activities and until such time as a final determination is made regarding his/her privileges. Any two of the following individuals or their designees in concert shall have the right to impose supervision and/or consultation: The President of the Staff, the chairman of the member's department, the Administrator or an Executive Committee member.

6.5.3 Review by the Executive Committee. A practitioner whose clinical privileges has been summarily suspended or who has been placed under summary concurrent supervision and/or consultation shall be entitled to request a review of the summary suspension by the Executive Committee or a subcommittee thereof having no less than three (3) members. The review must be requested, if at all, 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. The practitioner shall be allowed to attend and to show reason why such suspension/supervision/consultation should not continue and to respond to any other grounds for the recommendation for corrective action. Upon deliberation, the Executive Committee or subcommittee thereof may direct that summary suspension/supervision/consultation be terminated or continued. Such meeting shall not constitute a formal hearing and none of the procedural rules provided in these Bylaws with respect to hearings shall apply.

6.6 AUTOMATIC SUSPENSION. Automatic suspension shall be ordered by the Chief Executive Office or designee for reasons that are provided in this Section and that are consistent with Bylaws, with notification of the President of the Staff and the chairman of the appropriate department, who shall cooperate with the Administrator in enforcing the suspension. Such suspension shall be final without a right to hearing or further review. Where a bona fide dispute exists as to whether the circumstances have occurred, the practitioner shall have the right to submit information to the Executive Committee which shall review the submission. Automatic suspension imposed under this Section shall terminate and the suspended privileges shall be restored upon correction of the deficiency, except as otherwise provided in this Section. Affected practitioners may request reinstatement during a period of thirty (30) calendar days following suspension upon presentation of the required documentation. Failure to make a timely request for reinstatement shall result in automatic relinquishment of membership and privileges.

6.6.1. Professional Liability Insurance. A practitioner's privileges will be automatically suspended if the practitioner fails to maintain adequate Professional Liability Insurance as required in Article 3.3.3. of these Bylaws.

6.6.2 Medical Records. A temporary suspension of a practitioner's privileges, effective until medical records are complete, shall be imposed automatically after warning for delinquency for failure to comply with Rules and Regulations regarding completion of records. The number of suspensions for this reason shall be recorded and kept in the practitioner's file for consideration at time of reappointment. Notwithstanding the provisions of Section 6.6, continuous suspension for incomplete medical records for longer than sixty (60) days shall result in automatic relinquishment of membership and privileges.

6.6.3 Licensure. Action by a State Board of Examiners revoking or suspending a member's license shall automatically suspend all of the member's Hospital privileges. Action by a State Board of Examiners limiting or restricting privileges of a member shall automatically cause that member to have the same limitations or restrictions of his or her hospital privileges. Whenever a member is placed on probation by a State Board of Examiners, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation.

6.6.4 Controlled Substances. Whenever a member's DEA certificate is revoked, limited or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term. Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

6.6.5 Failure to Pay Staff Dues. Non-payment of dues by April 1 of each year shall cause immediate suspension of Staff membership.

6.6.6 PECOS (Effective when required by CMS). Practitioners who provide Hospital Services to Medicare Patients but who are not enrolled in PECOS or who have not Opted Out shall have their clinical privileges suspended after having been given notice and opportunity to enroll by Banner.

6.6.7 Exclusion from Medicare/State Programs. The CEO with notice from 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 acceptable to the Medical Center whereby he/she agrees not to provide items or serves to patients enrolled Medicare/State Programs. 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 Services, or Tricare (formerly Champus).

6.6.8 Freedom from Infectious Tuberculosis. A practitioner’s Medical Staff appointment and clinical privileges shall be immediately suspended for failure to provide evidence of freedom from infectious tuberculosis as required by law and Hospital policy.

6.6.9 The failure to complete electronic medical record/computer assisted order entry training (CPOE), Banner’s New Provider Orientation (NPO) and Identity (ID) Verification within 6 months of appointment to the Medical Staff shall result in automatic relinquishment of membership and privileges.

6.6.10 Failure to Execute Releases and/or Provide Documentation. A practitioner who fails to execute a general or specific release and/or provide documents, during a term of appointment when requested by the President of the Medical Staff, department chairman or designee shall automatically be suspended. If the release is executed and/or documents provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Failure to make a

timely request for reinstatement shall result in automatic relinquishment of membership and privileges.

6.6.11 Failure to Participate in an Evaluation. A practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership and/or privileges shall automatically be suspended. If, within 30 days of the suspension, the practitioner agrees in writing to participate in the evaluation and does participate constructively, the practitioner shall be reinstated. Failure to make a timely request for reinstatement shall result in automatic relinquishment of membership and privileges.

6.6.12 Failure to Complete Assessments and Provide Results. A practitioner who fails to complete a required educational assessment and/or training program and/or health (including psychiatric/psychological health) assessment and follow-up treatment or to provide a report of such findings shall automatically be suspended. If the report is provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Failure to make a timely request for reinstatement shall result in automatic relinquishment of membership and privileges.

6.7 HEARING AND APPEAL RIGHTS

6.7.1 HEARING AND APPEALS

The hearing will be conducted in accordance with Fair Hearing Plan. The appeal will be conducted in accordance with the Board's Appellate Review Policy.

6.7.2 FAIR HEARING PLAN

When hearing rights are triggered, the practitioner is notified of the grounds for the adverse action or determination 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 determination 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 mad
e 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 Medical Executive Committee has the initial obligation to present evidence in support of the adverse action or determination. Thereafter, the practitioner has the right to submit evidence and testimony to challenge the adverse determination 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 determination or action was arbitrary, capricious, or not supported by substantial evidence based upon the Hearing Record. Thereafter, the Medical Executive Committee may present evidence in support of the reconsidered determination or action.

6.7.8 NONREVIEWABLE ACTIONS

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

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

ARTICLE VII: OFFICERS AND OTHER MEDICAL STAFF REPRESENTATIVES

7.1 GENERAL OFFICERS OF THE STAFF: The General Officers of the Staff shall be the President, the President-Elect, the Treasurer, the Immediate Past President, the Transitional Vice President

and the Cardon Children's Officer.

7.2 QUALIFICATIONS OF GENERAL OFFICERS: Each General Officer must:

7.2.1 Be a member of the Active Staff at the time of nomination and election and remain an Active Staff member in good standing during his/her term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

7.2.2 Have demonstrated executive and administrative ability through experience and prior constructive participation in Staff activities and be recognized for a high level of clinical competence. Candidates must have served actively and effectively on at least two standing committees, within this or another medical staff, preferably as chairman of a committee or in some other leadership position. Additional qualifications noted below.

7.2.3 Have demonstrated, by Staff tenure and level of clinical activity, a high degree of interest in and support of the Medical Staff and the Hospital.

7.2.4 Agree to and, if elected, faithfully discharge the duties and exercise the authority of the office; and work with the other general and departmental officers of the Staff, the Administrator, the Board and its committees.

7.2.5 Not simultaneously hold two or more Staff offices, or a Staff office and a department or service chairmanship at this or another Hospital.

7.2.6 Additional Qualifications

7.2.6.1 Transitional Vice President

The Transitional Vice President must have leadership experience serving as chair of a committee or department at BDMC/CCMC.

7.2.6.2 Cardon Children's Officer

a. The Cardon Children's Officer must possess administrative and leadership ability, preferably as chair of a Desert/Cardon department, or Pediatric Surgery Peer Review, chair of the Pediatric Quality/Performance Improvement Committee (PQ/PIC) or has served as an active and effective member on at least two standing committees.
b. The Cardon Children's Officer should be engaged in the direct care of children at Cardon Children's as a consultant and/or attending in at least the past 3 consecutive years.

7.3 TERMS OF OFFICE

7.3.1 The President shall serve a term of three (3) years commencing on the first day of January.

7.3.2 The President-Elect shall serve a term of six (6) months commencing on the first day of July. He/she shall assume the office of President if the President is unable to serve for any reason.

7.3.3 The Transitional Vice President shall serve a term of eighteen (18) months commencing on the first day of January following the Immediate Past President's term of office. The Transitional Vice President is to be appointed by the President in collaboration with and with the approval of the MEC.

7.3.4 The Immediate Past President shall serve a term of one (1) year following his/her term as president.

7.3.5 The Treasurer shall take office on the first day of the next Staff year immediately following

an election and shall serve a two (2) year term.

7.3.6 Cardon Children's Officer shall be an appointed position and shall begin his/her term of office on January 1 of odd numbered years and shall serve a term of two years.

7.3.7 In the event that a General Officer is elected or appointed to fill a vacancy, he/she shall assume office immediately upon election or appointment.

7.4 NOMINATION AND ELECTION OF OFFICERS AND OTHER REPRESENTATIVES

7.4.1 Nomination Process

7.4.1.1 Department Chair

a) *Tenure:* A department chair shall be elected every two years by the active staff members of the department. The chairs of the departments of Anesthesia, Obstetrics/Gynecology, Pediatric Medicine and Radiology shall begin their terms in even-numbered years. The chairs of the departments of Cardiovascular Disease, Emergency Medicine, Medicine, Orthopedics, Pathology, Pediatric Surgical Subspecialties and Surgery shall begin their terms in odd-numbered years.

b) *Selection:* Each department chair shall appoint a Department Nominating Committee of at least two members to develop a slate of nominees to be approved by the department at it's June or July meeting.

c) *Notification:* At least 30 days prior to the June or July meeting, the Active Staff Members of the department will be sent an email notification that nominations will be presented at the meeting and that additional nominations may be made at the meeting, so long as the nominee is qualified and has consented to the nomination.

d) *Oversight:* The slate of nominees approved by the department must be forwarded to the Executive Nominating Committee, as referenced in 7.4.3, for review and comment at an August meeting.

7.4.1.2 President Elect

a) *Tenure:* President Elect shall be elected every three (3) years by the Active Staff Members.

b) *Selection*: An Executive Nominating Committee, as referenced in 7.4.3, shall prepare a slate of nominees. Nominees must meet the qualifications and have consented to the nomination.

c) *Notification:* Email notice of presentation of nominations must be sent to the all Active Staff Members at least 30 days prior to the Executive Committee meeting at which the nominees are approved. Nominations may also be made at the Medical Executive Committee meeting, so long as the nominee is qualified and has consented to the nomination.

7.4.1.3 Treasurer

a) *Tenure:* Treasurer shall be elected every two (2) years by the Active Staff Members.

b) *Selection*: An Executive Nominating Committee, as referenced in 7.4.3, shall prepare a slate of nominees. Nominees must meet the qualifications and have consented to the nomination.

c) *Notification:* Email notice of presentation of nominations must be sent to the all

Active Staff Members at least 30 days prior to the Executive Committee meeting at which the nominees are approved. Nominations may also be made at the Medical Executive Committee meeting, so long as the nominee is qualified and has consented to the nomination.

7.4.1.4 Banner Children's at Desert Officer

a) Nomination of Officer A meeting comprised of Pediatric Leaders will be formed in July of the year prior to the new term. Meeting invites will be extended to: the Past Cardon Children's Officer, Cardon Children's Officer, chairs of Pediatric Medicine and Surgery departments, chairs of Pediatric Medicine and Surgery Peer Review committees, Cardon CEO, and Cardon CMO. Any physician(s) seeking a nomination to this position shall be excluded from the meeting. A minimum of two nominees will be brought forth to the Cardon Children's Officer Nominating Committee. A committee will be formed and convened in September of the year prior to the new term.

b) Cardon Children's Officer Nominating Committee Composition The Cardon Children's Officer Nominating Committee shall consist of the President of the Medical Staff, Treasurer, Immediate Past President/President-elect or the appointed Vice-President (as dictated by the current officer composition), a selected past President of the Medical Staff, Desert CEO, Cardon CEO, Cardon CMO, and the current Cardon Children's Officer (or the Past Cardon Children's Officer if the Cardon Children's Officer is seeking another term).

c) Function The role of the Cardon Children's Officer Nominating Committee is to review the list of candidates and choose a minimum of two acceptable candidates. The committee shall confirm that each nominee meets the criteria established by these Bylaws and has expressed his/her willingness to serve in the particular office. The President of the Medical Staff will then prioritize and offer the position to a designated candidate and proceed down the list of candidates as needed. Should the committee be unable to agree on two candidates or should the nominated candidates decline, the President of the Medical Staff will reconvene the Cardon Children's Officer Nominating Committee.

7.4.1.5 Service Excellence Officer

Service Excellence Officer shall be appointed by the President and CEO, with Medical Executive Committee approval.

7.4.2 Executive Nominating Committee

7.4.2.1 *Composition:* The Executive Nominating Committee shall consist of the President, Transitional Vice President, the Treasurer, Cardon Children's Officer, any two (2) department chairmen appointed by the Executive Committee and the five (5) most recent Immediate Past Presidents, if they remain active members of the medical staff. The Executive Committee may add additional members to replace any Immediate Past Presidents that are retired or otherwise choose not to serve. The President shall serve as chairman. Members will declare any potential conflict of interests. Incumbents and those with a conflict of interest should recuse themselves from appropriate portions of the discussion.

7.4.2.2 *Functions:*

a) Review and comment on selection of nominees for Department Chair.
b) Selection of nominees for President Elect and Treasurer.
c) Succession planning to identify future leaders
d) Presentation of completed slates of nominees to the Executive Committee.

7.4.3 Elections

a) Nominees shall disclose in writing to the Executive Committee any material financial and personal, interests that could foreseeably conflict with their Medical Staff responsibilities. Once elected, members have a continuing responsibility to the Medical Staff to disclose such interests when relevant and to follow the Medical Staff Conflict of Interest Policy; and
b) Prior to ballots being sent, nominees may provide a 150-word maximum biographical statement indicating why they feel they are qualified to serve in the position
c) Ballots shall be sent only to Active Staff members. The deadline for return of the ballots shall be not less than fourteen (14) days after the distribution of the ballots. Electronic ballots will be processed utilizing a confidential/secure software program approved by the Treasurer.
d) Ballots must be returned within the timeframe specified 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.
e) If there is a solo candidate on the slate of nominations, the election will be conducted by the majority vote of members present at the Executive Committee meeting in which the slate of candidates is presented. This election shall constitute the election of the solo candidate. A formal written ballot will not be sent. Following the meeting, notification will be sent to the entire department/Executive Committee informing them of the solo candidate and announcing his/her election.
f) The candidate receiving the highest number of votes is elected. In the case of a tie, a majority vote of the Executive Nominating Committee shall decide the election.

7.5 REMOVAL FROM OFFICE. The President, President-Elect, Immediate Past President and Treasurer, Transitional Vice President and the Cardon Children's Officer may be removed from office for any reason including failure to perform duties required by the Bylaws. Removal of an officer may be done by:

7.5.1 two-thirds (2/3) majority vote (ballots received) of the total Active Staff membership. This action can be taken at any regular meeting of the Staff, or at a special meeting of the Staff called for that purpose,~~.~~ but no such removal shall be effective unless and until it has been approved by the Executive Committee; or

7.5.2 two-thirds (2/3) majority vote of the full membership of the Executive Committee at any regular meeting or special meeting called for that purpose.

7.6 VACANCIES IN OFFICERS AND OTHER REPRESENTATIVES

7.6.1 A vacancy in office during a term of office, except for the President or President-Elect, will stay vacant unless the Executive Committee determines the position be filled by appointment of the MEC for the remaining duration of term.

7.6.2 If there is a vacancy in the office of the President, the Immediate Past President, Transitional Vice President or President Elect shall serve out the remaining term.

7.6.3 If there is a vacancy in the office of President-Elect, A nominating committee will be convened as outlined above to select candidates for a new President Elect.

7.6.4 If a special election is held, the Executive Committee shall specify the election proceedings.

7.7 RESPONSIBILITIES OF OFFICERS

7.7.1 President: The President shall serve as the chief administrative officer of the Staff to:

7.7.1.1 act in coordination and cooperation with the Administrator in all matters of mutual concern within the Hospital;

7.7.1.2 call, preside at, and be responsible for the agenda of all regular and special meetings of the Staff;

7.7.1.3 call, preside at and be responsible for the agenda of all regular and special meetings of the Executive Committee;

7.7.1.4 take all reasonable steps to insure enforcement of Staff Bylaws, Rules and Regulations, and policies and procedures for implementation of sanctions where these are indicated, and for Staff compliance with procedural safeguards in all instances where corrective action has been requested against a member;

7.7.1.5 designate the chairperson of all Staff committees consistent with these Bylaws and appoint committee members after consultation with the chairpersons;

7.7.1.6 to ensure effective communication through all levels of governance, represent the views, policies, needs and grievances of the Staff to the Board and to the Administrator;

7.7.1.7 receive and convey the policies of the Board and of the Banner Corporation to the Staff for its input (and approval as appropriate) and report to the Board on the performance and maintenance of quality with respect to the Staff's delegated responsibility for the quality of care provided to Hospital patients and for the ethical and professional practices of practitioners who provide patient care;

7.7.1.8 be the spokesperson for the Staff in its external professional and public relations;

7.7.1.9 delegate staff support duties and supervise those activities of the Medical Director of the Staff, if that position is filled, as provided in Section 3.4;

7.7.1.10 serve as ex-officio member of all other Staff committees without vote;

7.7.1.11 perform such functions and duties as are required under the BH Bylaws; and

7.7.1.12 be accountable to the Executive Committee of the Staff for official actions and to take all reasonable steps to ensure that such official actions comply with these Bylaws.

7.7.2 President-Elect: The President-Elect is the Vice President of the Medical Staff. In the absence of the President, and when a conflict disqualifies the President from performing any duty, the President-Elect shall assume all of the duties and have the authority of the President. He shall be a member of the Executive Committee.

The responsibilities of the President Elect include but are not limited to the following:

- Develop relationships with the facility CEOs and CMOs
- Attend department and committee meetings to understand role and function.
- Develop a written list of goals for the Medical Executive Committee in the upcoming year to submit and present to the Medical Executive Committee.
- Identify physicians to lead the appointed committee chair positions for the upcoming year.
- Attend: MEC, pre-MEC, Desert Admin/Officers meeting, Bylaws, Credentials and Contracts Committee.

7.7.3 Immediate Past President: The Immediate Past President is the Vice President of the Medical Staff and shall assume the duties and have the authority of the President when the latter is unable to serve for any reason (e.g., conflict or absence).

The responsibilities of the Immediate Past President include but are not limited to the following:

- Attend: MEC, Desert Admin/Officers meeting, Bylaws and Contracts Committee.
- Serve as an active resource to the President of the Medical Staff.

7.7.4 Transitional Vice President: The Transitional Vice President is the Vice President of the Medical Staff and shall assume the duties and have the authority of the President when the latter is unable to serve for any reason (e.g., conflict or absence).

The responsibilities of the Transitional Vice President include but are not limited to the following:

- Attend: MEC, Bylaws, BDMC and CCMC Quality Committees, Desert Admin/Officers meeting and other meetings as requested by the President.
- Participate in facility Serious Reportable Event Investigations and interdepartmental concerns that may arise.
- Lead projects as assigned by the President of the Medical Staff.
- Serve as Vice-chairman of Bylaws or Credentials Committee (whichever position is not selected by the Treasurer).

7.7.5 Treasurer: The responsibilities of the Treasurer include but are not limited to the following:

- Facilitate officer elections,
- Perform such other responsibilities as ordinarily pertain to this office.
- Subject to Executive Committee approval or ratification, he/she shall be responsible for maintaining and investing all Medical Staff funds including initial and annual dues, special assessments, and investment income, and shall make quarterly reports of these funds to the Executive Committee.
- Shall assume the duties and have the authority of the Vice President whenever a conflict or absence prevents the latter from performing.
- Attend: MEC, pre-MEC, Desert Admin/Officers meeting
- Serve as Vice-chairman of Bylaws or Credentials Committee
- Serve as a member of two of the following committees: Credentials, Bylaws or Contracts Committee.
- Participate in facility SRE Investigations and interdepartmental concerns that may arise.
- Lead projects as assigned by the President of the Medical Staff.

7.7.6 Cardon Children's Officer

The responsibilities of the Cardon Children's Officer include but are not limited to the following:

- Engage in quality and safety matters pertinent to Cardon Children's.
- Act as a liaison from the CCMC administration to the BDMC/CCMC MEC, providing monthly updates on pediatric quality and safety issues
- Report directly to the BDMC/CCMC President of the Medical Staff.
- Chair the Pediatric Quality and Performance Improvement Committee.
- Serve as a member of one of the following committees: Bylaws, Contracts, or Credentialing.
- Involvement in the interview process for pediatric medical director candidates; meet at least annually with them. In conjunction with administration, will discuss progress and

set goals.

- Participate in Cardon service line design, development, implementation and process improvement
- Assist with questions and concerns related to credentialing, peer review and corrective action, however the chain of command process related to these concerns will follow the process outlined in the Medical Staff Bylaws. The President of the Medical Staff has final authority and responsibility for all such matters as outlined in the Medical Staff Bylaws.
- Attend: Pediatric Medicine, Pediatric Surgery, Pediatric Quality and Performance Improvement, CCMC officer, BDMC officer, pre MEC, MEC, Banner PRC, and one of the following: Bylaws, Credentials or Contracts.

7.7.7 Service Excellence Officer

The responsibilities of the Service Excellence Office include but are not limited to the following:

- Serves as the subject matter expert for service excellence, maintaining an active understanding of programs and innovative interventions regarding the patient experience
- Participates in the design, development and implementation of programs which create a positive patient experience and promote services excellence
- Participates in designing and facilitating activities which reinforce the priority of excellence in service delivery and support culture change
- Utilizes creative and innovative methods to ensure staff commitment to high quality service delivery standards and patient experience in every aspect of the hospital experience
- Continuously reviews performances, accomplishments and evaluates operations to make recommendations to the Medical Executive Committee and Administration to eliminate barriers for success and positive results.
- Participates as an ad-hoc member on facility and medical staff committees based on patient experience needs and input.
- Reports directly to the BDMC/CCMC President of the Medical Staff.
- Attends: CCMC officer, BDMC officer, pre MEC and MEC meetings

7.8 MEDICAL STAFF CONFLICT OF INTEREST POLICY

7.8.1 Conflicts. Conflicts of interest among the Medical Staff leaders are not completely avoidable since they often indicate broad experience, accomplishments and diversity. The goals of the Medical Staff Policy are therefore to *identify* and *manage* interests that could conflict with fulfilling the Medical Staff's organization responsibilities and to ensure the integrity of Medical Staff decision making.

7.8.2 Disclosure. Medical Staff leaders shall use good faith to disclose material financial and personal interests that may potentially lead to a conflict.

7.8.3 Leaders' Responsibility. Elected and appointed Medical Staff leaders entrusted with fulfilling the Medical Staff's responsibilities and with decision-making authority on behalf of the Medical Staff must comply with this Policy.

7.8.4 Means. Material financial and personal interests shall be disclosed to the MEC by candidates for elected and appointed Medical Staff leadership positions. Medical Staff leaders should disclose such interests verbally whenever relevant to a deliberation or decision on behalf of the Medical Staff, E.G., during a Committee meeting.

7.8.5 Confidentiality. Any documentation of disclosures shall be maintained by Medical Staff Services as privileged and confidential, pursuant to Medical Staff-approved policy and not

accessible or used for other purposes.

7.8.6 Action on the Disclosure. Whether a disclosed interest constitutes a conflict (and, if so, its nature and scope) is determined by the deliberating Medical Staff Committee. If a conflict is identified, the Committee shall take the least disruptive action(s) in order to manage the conflict and to preserve (to the extent feasible and appropriate) the leader's ability to carry out his/her leadership responsibilities, E.G,:

7.8.6.1 Abstention from voting on the matter to which the conflict relates.
7.8.6.2 Recusal from the decision-making process.
7.8.6.3 Non-receipt of written and/or verbal information related to the matter to which the conflict relates.

7.8.7 Failure to Disclose. The MEC may take appropriate action when a leader has failed to disclose, abstain or recuse as required by this Policy.

ARTICLE VIII: DEPARTMENTALIZATION OF THE STAFF

8.1 THE MEDICAL STAFF

8.1.1 Organization: The Medical Staff shall be organized into clinical departments. Each department shall have a minimum of five (5) Active Staff members; if at any time the Active Staff membership falls below the minimum, the department shall automatically be dissolved and its members shall become members of an appropriate clinical department, as determined by the Executive Committee, which department shall assume the functions of the dissolved department, as necessary. Each department shall have a chairman 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 the function, and that shall have a Section Chief selected and entrusted with the authority, duties and responsibilities specified in this Article.

8.1.1.1 Clinical Departments. The current clinical departments are:

1) Anesthesiology
2) Cardiology
3) Emergency Medicine
4) Medicine
5) Obstetrics and Gynecology
6) Orthopedics
7) Pediatric – Medicine
8) Pediatric Surgical Subspecialties
9) Surgery
10) Pathology
11) Radiology

8.1.2 Assignment to Departments and Sections. Each member of the Medical Staff shall be assigned membership in at least one department and shall comply with the policies and procedures of each such department. Membership may be granted in one or more sections of a department. Membership in each department shall be granted to those members of the Staff who exercise one or more clinical privilege governed by the policies and procedures of the department and who apply for and are granted such privileges by the Board as provided in Article 6.

8.1.3 Functions of Departments and Sections

8.1.3.1 Functions of the Departments: Each department shall:

A) Conduct periodic patient care reviews to analyze and evaluate quality and

appropriateness of care and treatment provided in the Hospital. The department shall develop objective criteria for use in evaluating patient care;

B) Recommend guidelines for granting clinical privileges within the department and for evaluating applicants for appointment and reappointment. In developing privileging criteria, the department shall make findings on whether the guidelines were established after a reasonable effort to obtain relevant facts and in the reasonable belief that they are warranted by the facts and further quality health care and the objectives and purposes stated in the Preamble;

C) Conduct and make recommendations regarding continuing education programs pertinent to departmental clinical practice;

D) Adopt policies and procedures and monitor its members' adherence to them;

E) Coordinate professional services within the department with those of other departments, medical center nursing and ancillary patient care services;

F) Submit written reports to Executive Committee concerning the department's review and evaluation activities, actions and recommendations for improving patient care within the department and the Hospital;

G) Establish, together with its sections and the support of appropriate Hospital departments or sections, upon approval of the Executive Committee, specific methods of patient care review which may include data displays of patient information; chart review of selected cases; and consideration of deaths, extended morbidity, unimproved patients, patients with infections, complications, questionable diagnosis or treatment, inadequate consultations, tissue reports from the Department of Pathology, record quality, utilization of Hospital facilities including beds, diagnostic, nursing and therapeutic resources, and any other reports believed important for adequate patient care evaluation;

H) Establish department committees and subcommittees necessary to the department's performance of its functions and take action on the recommendations of such committees; The composition and method of selection of the department committee and subcommittee members shall be defined within the department rules and regulations; and

I) Participate in Banner Clinical Initiative and assist with the adoption of appropriate clinical standards to facilitate improved aggregated clinical outcomes and patient safety as determined by the Medical Staff and Banner

J) Develop, for approval by the Executive Committee and the Board, specific policies and procedures that (1) delineate the scope of permissible supervised patient care responsibilities of residents/fellows and the nature and degree of supervision, (2) establish a framework for the department's residency/fellowship program responsibility, (3) ensure appropriate interdepartmental communication among all departments affected by any residency/fellowship program, (4) provide a grievance procedure for residents/fellows. Department must review their policies annually and forward them to the Executive Committee for approval.

8.1.3.2 Organization and Functions of Sections. Each section shall perform the functions assigned to it by the department in addition to those described in Section 8.1.3.1 above. Such functions may include review and evaluation of patient care practices, development of criteria for privileges and credentials, and recommendations for privileges and education programs. Each section reports regularly to its department chairman on the conduct of its assigned functions. Sections of special clinical interest or specialties may be organized within a department for the purposes of education, peer review, and self-government by

the following procedure:

A) Five or more Active Staff members of the department with similar clinical interests shall submit to the department committee a written proposal of organization, structure, policies and procedures for the governing of the section consistent with the overall department, Staff and Hospital policies. They shall indicate their willingness to serve as a committee for the section until the next election.

B) If approved by the department committee, the petition, proposed organizational structure, and the policies and procedures shall be submitted to the Executive Committee. Upon approval by the Executive Committee, the new section shall be established.

8.1.4 Qualifications, Selection and Tenure of Department and Section Service Chairs

8.1.4.1 Qualifications: Each department and section chairperson must:

A) Be a member of the Active Staff at the time of nomination and election and remain an Active Staff member in good standing during his/her term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.
B) Have demonstrated executive and administrative ability through experience and prior constructive participation in Staff activities and be recognized for a high level of clinical competence.
C) Have demonstrated, by Staff tenure and level of clinical activity, a high degree of interest in and support of the Medical Staff and Hospital.
D) Agree to and, if elected, faithfully discharge the duties and exercise the authority of the office; and work with the other general and departmental officers of the Staff, the Administrator, the Board and its committees.
E) Not simultaneously hold two or more Staff offices, or a Staff office and a department or service chairmanship at this or another hospital.

8.1.4.2 Selection, Tenure and Removal

A) Each department and chairman shall take office on the first day of the next Staff year immediately following the election and shall serve a two (2) year term from that date until a successor is elected or appointed, or unless he/she sooner resigns or is removed from office. The chairman of the departments of Anesthesia, Obstetrics/Gynecology, Pediatric Medicine and Radiology shall begin their terms in even-numbered years. The chairman of the departments of Cardiovascular Disease**,** Emergency Medicine, Medicine, Orthopedics, Pathology, Pediatric Surgical Subspecialties and Surgery shall begin their terms in odd-numbered years.
B) Each section chair shall be elected by the Active Staff members of the section as specified in Article 9 in which a chair has been elected for its jurisdictional department. Section chair shall serve a two (2) year term from that date or until a successor is elected or appointed.
C) Department and section chair may be removed for any reason including failure to perform duties required by the Bylaws. Removal of a department or section chairman may be done by:

i) a two-thirds (2/3) vote of the Active Staff (ballots received) membership of the department or section. This action can be taken at any regular meeting or a special meeting called for that

purpose, but no such removal shall be effective unless and until it has been approved by the Executive Committee; or

ii) two-thirds (2/3) majority vote of the full membership of the Executive Committee at any regular meeting or special meeting called for that purpose.

D) Vacancies during a term of office shall be filled as provided in Section 8.6

8.1.5 Duties of the Department and Section Chair

8.1.5.1 Each department and section chair shall be responsible for the performance of the functions of his respective department or section as set forth in Section 9.1.3.

8.1.5.2 In addition, department and section chair shall:

A) take all reasonable steps to improve the performance of all professional and administrative activities within his department or section;

B) maintain continuing review of the professional performance of all members with clinical privileges in his department or section and report regularly thereon to the Executive Committee, if a department chairman; to the department chairman, if a section chairman;

C) represent the interests of his department/section as a member of the Executive Committee, if a department; of the department, if a section chairperson;

D) participate in the administration of his department or section through cooperation with the Nursing Service and the Administrator in matters affecting patient care, including personnel, supplies, special regulations and standing orders or technique;

E) delegate those duties that relate to Medical Staff to the Medical Director of the department, if such a position is filled, as provided in Section **3.4**;

F) be responsible for the teaching, education and research programs in his department, section; and

G) assist in the preparation of such annual reports, including budget planning, pertaining to his department, section or service as may be required by the Executive Committee, the Administrator or the Board.

8.1.6 Vice Chairs of Departments and Sections

8.1.6.1 Selection: A vice chairperson shall be appointed by the chairperson and shall serve for the same term as the chairman.

8.1.6.2 Duties: When the chairperson is unable to perform any duties because of absence or conflict, the vice chair shall assume the duties and have the authority of the chairperson. With prior notification to the President of the Staff that the chairman is unable to attend an Executive Committee meeting, the vice chairman shall attend the meeting and have whatever voting privileges the chairman would have.

ARTICLE IX: COMMITTEES

9.1 GENERAL PROVISIONS

9.1.1 Committees shall be designated as:

9.1.1.1 The Executive Committee
9.1.1.2 Standing Committees
9.1.1.3 Department, Section and Service Committees
9.1.1.4 Joint Committees

9.1.2 The President of the Staff shall appoint all Committee chairs except as otherwise provided in these Bylaws. Committee chairs may be removed for any reason by the officer(s) required to make the appointment. The President shall also appoint all committee members following the guidelines herein, after consultation with the elected or appointed chairs. Committee members so appointed may be removed for any reason with the concurrence of both the President and the pertinent chair.

9.1.3 Prior to appointment, nominees shall disclose in writing to the Executive Committee any material financial and interests that could foreseeably conflict with their Medical Staff responsibilities. Once appointed, chairs have a continuing responsibility to the Medical Staff to disclose such interests when relevant and to follow the Medical Staff Conflict of Interest Policy (9.8).

9.1.4 Meetings shall be held and conducted as specified in Article 12.

9.1.5 Additional standing committees and department committees may be formed by a change in the Bylaws, as provided in Article 16.

9.1.6 Subcommittees may be formed by committees of the Staff as provided in this Article or as deemed necessary to carry out their functions. Subcommittees shall conduct their meetings in accordance with the provisions of Article 12.

9.1.7 The chair of each committee shall see that appropriate criteria and factors are applied in committee deliberations in accordance with Medical Staff Bylaws, Rules and Regulations, and policies and procedures.

9.1.8 Each committee shall establish and maintain policies and procedures regarding the day-to-day operation of the service or Hospital department under its jurisdiction as provided in Article 16.

9.1.9 Special Committees. The President may appoint special committees, designate the chairmen, and assign specific duties to such special committees. Special committees shall be responsible to the Executive Committee and shall conduct meetings in accordance with the general provisions of this Article and the provisions of Article 12.

9.2 THE EXECUTIVE COMMITTEE

9.2.1 Composition. The members of the Executive Committee shall consist of the following:

- General Officers of the Staff
- Chairpersons of all the Medical Staff departments
- Bylaws Committee Chairman
- Contracts Committee Chairman
- Credentials Committee Chairman
- Quality Initiative Committee (without a vote)
- Core Measure Committee (without a vote)
- Professional Advocacy Committee (PAC) (without a vote)
- Trauma Medical Director (without a vote)
- Member at Large (without a vote)
- The Chief Executive Officers (without a vote)
- Chief Medical Officers (without a vote)
- Chief Nursing Officer (without a vote)
- Chairman of Standing Committees are invited to meetings of the Executive Committee as determined by the Medical Staff President (without vote).

Other members to be appointed by the President of the Staff with the approval of the Executive Committee, without vote. The President of the Staff shall be the Chairman. Vice-chairmen of

departments may assume the duties and responsibilities of chairmen, as provided in Section 8.1.6.

9.2.2 Selection of Executive Committee Members

9.2.2.1 Election of members, who are department chairs, their term of office, qualifications, removal from office and duties shall be as provided in Articles 8 and 9. Selection of other Medical Staff members of the Executive Committee is governed by this Article 10 and Section 3.4.5 for medical directors. The Member at Large shall be appointed by the President with approval by the MEC. The appointment will be for a two-year term. Eligible specialties include Ob/Gyn, Pediatrics, Family Medicine and Internal Medicine. The member at Large will be a non-voting member of the MEC.

9.2.3 Duties of the Executive Committee The authority of the Executive Committee is delegated by the Medical Staff and may be limited by amending these Bylaws or removing any or all members of the Executive Committee pursuant to the removal provision set forth below. The duties of the Executive Committee shall include, without limitation, the following:

9.2.3.1 to represent and to act on behalf of the Staff, subject to such limitations as may be imposed by these Bylaws, and to be accountable to the Staff for all actions by:

a) recommending adoption or amendment of department, section, service and committee policies and procedures;
b) receiving and acting upon department, committee, and service reports;
c) reviewing and approving proposals for inter-departmental programs;
d) reviewing and approving Hospital policies that are implemented by the Medical Staff Office and that directly affect the operations of the Medical Staff at least annually, and recommending action to the Administrator on matters of medical-administrative nature;
e) reporting to all Staff members on the actions of the Executive Committee at all intervening regular and special meetings, excluding executive sessions, with notices for regular Staff meetings;
f) determining dues and assessments of members as may be necessary to carry out the functions of the Staff (assessments require Active Staff approval);
g) being responsible for the investment and expenditure of all Staff funds which shall be exclusively for purposes permitted under IRC Section 501(c)(3) and that are consistent with the responsibilities of the Medical Staff. BH co-signature is required for individual expenditures in excess of $75,000.00;
h) reviewing, when indicated, actions of the President of the Staff, including committee appointments;
i) implementing policies of the Staff not otherwise the responsibility of a department, section, service or committee;
j) making recommendations on Hospital management to the Administrator;

9.2.3.2 to fulfill the Staff's accountability to the Board for the care and safety of patients in the Hospital by:

a) reviewing and making recommendations on patient care evaluations of the departments, services and sections;
b) taking reasonable steps to ensure department performance of responsibilities for patient care and safety, performance review and improvement (e.g., supervision of residents/fellows and allied health practitioners, and monitoring of provisional privileges);
c) providing liaison between the Staff and the Administrator and the Board;

d) reviewing the qualifications and credentials of all applicants and making recommendations for Staff membership, assignments to departments, and delineation of privileges after recommendation from the Credentials Committee as provided in Articles 5 and 6;

e) reviewing periodically available information regarding the performance of Staff members, and as a result of such reviews, making recommendations for reappointment and renewal or changes in clinical privileges for the ensuing year, after receiving recommendations from the Credentials Committee as provided in Articles 5 and 6;

f) taking reasonable steps to assure members' professionally ethical conduct and competent performance, initiating corrective or review measures when warranted, as provided in these Bylaws;

h) taking steps to obtain BH assurance of indemnification of each Staff member, both present and future, who provides records, information or assistance, or takes action or makes any decision or recommendation as an officer, department chairperson, witness or duly selected committee member of the Medical Staff in the course of review of professional practices related, but not limited to: (1) application for appointment or privileges; (2) periodic reevaluation for reappointment or privileges; (3) corrective action, including summary suspension; (4) hearings and appellate reviews; (5) patient care evaluations; (6) utilization reviews, and (7) other Hospital, department, section or committee activities related to quality patient care and inter-professional conduct;

i) determining, with the assistance of BH General Counsel, the Medical Staff's statutory responsibility to report physician conduct;

j) evaluating quality assurance and performance improvement activities and mechanisms of the Hospital and Medical Staff;

k) reviewing and making recommendations with the Quality Management Council to the Board on the quality assurance and performance improvement activities of related facilities that may impact Hospital patients, based on regular reports from the Board about (A) the adequacy of related facilities' QM programs, and (B) each related facility's compliance with its QM program;

l) reviewing and making recommendations to the Administrator and the Board solely regarding the quality of care issues within the Hospital raised by proposed contractual agreements between any entity or person and Banner Health or any of its affiliates, the Administrator or Board shall report to the Executive Committee the bases for contracting contrary to a quality of care finding of the Executive Committee;

m) reviewing and making recommendations to the Administrator, and/or the Board where appropriate, within thirty (30) days unless extended by agreement with the Administrator pursuant to Section 7.8, regarding quality of care issues raised by proposed exclusive arrangements for physician and/or professional services within the Hospital before the following decisions are made: (a) to execute an Exclusive Contract in a previously open department or service; (b) to modify an existing Exclusive Contract where such modification may affect quality of care; and (c) to terminate an Exclusive Contract in any department or service; and

n) performing such other duties as are provided in these Bylaws.

9.2.3.3 Conflict Resolution: The Executive Committee shall initiate a Conflict Management Process to address a disagreement between the Medical Staff and the Executive Committee about an issue relating to the functions of the Medical Staff or Executive Committee including, but not limited to, a proposal to adopt or amend the Medical Staff Bylaws, Rules and Regulations, or Policies. The process must be initiated, if at all, within 30 days of disagreement and may be initiated by:

a) A written petition signed by at least 25% of the voting members of the Medical

Staff, or

b) With respect to an issue concerning only a Department, a written petition signed by at least two-thirds of the Members of the Department, or
c) The initiative of the Executive Committee, or
d) As otherwise specified in these Bylaws.

The Executive Committee shall determine the process that it deems most appropriate to the issues and circumstances in order to provide an efficient and meaningful opportunity for the parties to express their views and to provide a written decision and recommendation by the Executive Committee within a reasonable time. At its discretion, the Executive Committee may utilize third parties to facilitate or mediate the conflict. Nothing in this section is intended to prevent any Medical Staff Member from communicating to the Board of Directors according to such procedures as the Board may specify.

9.3 STANDING COMMITTEES: Each Medical Staff Standing and Service Committee shall be a subcommittee of and shall report to the Executive Committee. It shall also report to appropriate departments and develop policies and procedures as described in Section 15.4.

9.3.1 Bioethics Committee

9.3.1.1 Composition: The Bioethics Committee shall consist of physicians and such other staff as the Executive Committee may deem appropriate, including at least one member of the Department of Pediatric Medicine or the Department of Pediatric Surgical Subspecialties. In may include nurses, lay representatives, social workers, clergy, ethicists, attorneys, administrators and board members. The Chair of the Committee shall be a member of the Active Staff, appointed by the Chief of Staff for a two-year term.

9.3.1.2 Duties: This committee may:
A) participate in development of guidelines for consideration of cases having bioethical implications.
B) develop and implement procedures for the review of such cases.
C) develop and/or review institutional policies regarding care and treatment of such cases.
D) retrospectively review cases for the evaluation of bioethical policies.
E) consult with concerned parties to facilitate communication and aid conflict resolution.
F) educate the hospital staff and medical staff on bioethical matters.

9.3.2 Bylaws Committee

9.3.2.1 Composition: The Bylaws Committee shall be composed of the Immediate Past President, the Secretary-Treasurer and at least three (3) other members, including at least one member of pediatric representative Ex officio members shall include representatives of Administration. The Committee chair is encouraged to include for specific discussions Chairs of Medical Staff Departments, and Committees, and Directors of Hospital Departments affected by proposed amendments.

9.3.2.2 Duties: The Bylaws Committee shall be responsible for a continuing review of Bylaws Credentials Manual and Rules and Regulations of the Staff, and for making recommendations relating to their revision as provided in Article 16. It shall correlate the policies and procedures of the Staff departments, sections, services and committees with the Staff Bylaws, Rules and Regulations prior to their adoption and implementation.

9.3.3 Credentials Committee

9.3.3.1 Composition: The Credentials Committee shall consist of at least six members of the Active Staff who actively exercise clinical privileges. The chairman of the committee shall appoint such persons to ensure representation of the major clinical specialties, the Staff at large, advanced practice professionals and a pediatric representative.

9.3.3.2 Duties: The Credentials Committee shall

A) thoroughly and objectively review the credentials of all applicants for membership, reclassification of category, change in privileges, and reappointment and, as a result of such reviews and considering the recommendations of the department or section committees, make recommendations to the Executive Committee on each applicant for the designation of category, the granting of privileges, and the department assignment, as provided in these Bylaws;

B) assist the Administrator and Executive Committee to assure that physicians of a Joint Venture contract providing any health care to Hospital inpatients meet the same credentialing requirements as Hospital Staff members.

9.3.4 Infection Control Committee

9.3.4.1 Composition: The Infection Control Committee shall be responsible to the Quality Assessment Committee. ICC is a multi-disciplinary committee and shall consist of representatives from the Medical Staff, Administration, Nursing Services, Epidemiology, Micro/Pathology, and Occupational Health. Representatives from other patient care services and/or Medical Staff will serve on a consultative basis when discussions are pertinent to their department. The Chairman shall be a physician. At least one member shall be a pediatric representative from.

9.3.4.2 Duties

A) The Infection Control Committee shall develop a written plan for preventing, tracking and controlling infections, including identifying circumstances for application of control techniques; specifying medical criteria that would prevent practitioners from having direct or indirect patient contact; and establishing criteria for increased TB screening frequency, as outlined in its policies and procedures.

B) Any proposed policy or procedure that may impact the Medical Staff shall be submitted to the Executive Committees for prior approval.

C) The Infection Control Committee shall assist department and section committees to formulate recommendations regarding infection control by providing timely, comprehensible summary information.

D) The Infection Control Committee shall meet at least quarterly.

9.3.5 Operating Room Committee

9.3.5.1 Composition: The Operating Room ("OR") Committee shall be composed of representatives of Anesthesia, Obstetrics-Gynecology, Orthopedics, Surgery, and a pediatric representative as well as leadership representation from the adult, pediatric and cardiovascular OR. Ex officio members of the committee shall include the Administrator (delegee), and O.R. Nursing Director. Representatives of Pathology, Supply Chain Management, Clinical Engineering, Labor & Delivery, Surgery Scheduling, and the Pharmacy Departments shall be invited to attend as needed.

9.3.5.2 Duties. The committee shall review, develop, and periodically revise policies and procedures that govern administrative, nursing and clinical practices in the pre-operative setting, operating and recovery rooms; make recommendations regarding equipment and long-term capital improvements for all aforementioned departments, improve day to day operations and throughout in pre-op, OR and PACU; review performance indicators and efficacy of action plans, encourage healthy nurse/physician relations through problem resolution communication.

9.3.6 Pharmacy and Therapeutics Committee

9.3.6.1 Composition: This committee shall consist of at least five (5) members of the Staff including at least one pediatric representative, and a Clinical Pharmacist voting representative. The voting Clinical Pharmacist representative will be nominated annually by the Pharmacy Staff.

9.3.6.2 Duties: This committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard. The committee shall assist in the formulation of broad professional policies regarding the evaluation appraisal, selection, procurement, storage, distribution, use safety procedures and all other matters relating to drugs in the Hospital. It shall also perform the following specific functions:

A) serve as an advisory committee to the Staff and the Pharmacist on matters pertaining to the choice of available drugs;
B) recommend drugs to be stocked on the nursing unit floors and by other services;
C) develop and review periodically a formulary or drug list for use in the Hospital;
D) prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;
E) evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;
F) establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs; and
G) make recommendations to the Administrator regarding other matters, including budget and personnel, pertaining to the Pharmacy Department.
H) review ongoing appropriateness in the use of medication and drug selection with respect to the open Hospital formulary.

9.3.7 Professional Conduct Committee

9.3.7.1 Composition. The President shall appoint the chair. The Committee shall have six (6) members, majority of which shall be physicians. Committee shall include at least one (1) Allied Health Professional (AHP) and one (1) psychiatrist or psychologist**,** as feasible. Except for initial appointments, each member shall serve a term of four (4) years and the terms shall be staggered as deemed appropriate by the Executive Committee to achieve continuity**.** At the discretion of the chair, the Committee may invite the Nursing Administrator.

9.3.7.2 Duties. The Professional Conduct Committee (PCC) shall have responsibility for investigating and recommending action when a Medical Staff member or an Allied Health Professionals (AHP) has engaged in Inappropriate Conduct that may undermine a culture of safety. Examples of Inappropriate Conduct include, but are not limited to:

A) failing to comply with ethical standards
B) failing to comply with Medical Staff Rules or with expectations

established by the Medical Staff or a Medical Staff Committee;
C) shaming or inappropriately blaming others for negative outcomes;
D) using foul, offensive or abusive language;
E) displaying offensive behavior;
F) arbitrarily side-stepping Medical Staff or Hospital policies;
G) threatening others;
H) belittling staff in front of others;
I) acting disrespectfully or discourteously; or
J) intimidating or abusing others.

Duties of the PCC include:

A) reviewing incident reports alleging Inappropriate Conduct;
B) addressing complaints of inappropriate conduct by Medical Staff members or AHPs;
C) preventing retaliation against anyone who makes a complaint, assists in the investigation or cooperates in an investigation involving Inappropriate Conduct;
D) referring practitioners to the Practitioner Health Committee when such referral is considered appropriate;
E) recommending a Behavioral Stipulation and/or that the practitioner agree to a Plan of Correction with concrete objectives and consequences for a failure to comply;
F) recommending to the Executive Committee that corrective action be taken as contemplated by the Bylaws including, but not limited to, the following:
    1) requiring a leave of absence;
    2) issuing a letter of warning;
    3) suspending privileges for a specific period of time or indefinitely; or
    4) terminating Medical Staff membership/AHP status and privileges.

9.3.7.3 Meetings. The Committee shall meet as often as necessary, but at least quarterly.

9.3.8 Practitioner Wellness Committee

9.3.8.1 Composition. The Practitioner Wellness Committee (PWC) shall be composed of no less than six (6) members, a majority of which shall be physicians. Committee shall include at least one (1) Allied Health Professional (AHP) and one (1) psychiatrist or psychologist, as feasible. Except for initial appointments, each member shall serve a term of four (4) years and the terms shall be staggered as deemed appropriate by the Executive Committee to achieve continuity.

9.8.8.2 Duties.

A) The Committee shall serve as a confidential access point for practitioners which are either referred or who voluntarily seek its assistance to address matters of individual health, including, but not limited to, substance abuse, stress, burnout, age related limitations or other causes of potential or actual impairment of the practitioner's ability to practice.
B) The PWC shall serve as a resource for practitioners to obtain evaluations, therapy, treatment or rehabilitation but shall not itself provide those services.
C) The PWC shall serve as an advocate to aid practitioners to return to full professional practice or to obtain appropriate accommodations to permit limited practice.
D) The PWC shall perform the foregoing duties with confidentiality to the fullest extent authorized by law. It shall make periodic reports of

its activities, in general terms, to the Executive Committee but shall not identify any practitioners with whom it is engaged, with the sole exception of the disclosure obligations set forth in 6.7.2.5.

E) In the event information received by the PWC clearly demonstrates that a practitioners with whom it is engaged poses an unreasonable risk of harm to patients or others, that information must be disclosed to the Executive Committee for investigation and correction action.

F) The PWC may request practitioners to execute appropriate releases and authorizations to enable it to perform its duties.

G) The PWC shall act in an advisory capacity to the Executive Committee regarding the development of educational programs, wellness resources, and other activities intended to address causes of impairment. The PWC shall assist in the implementation of such activities when feasible.

9.3.8.3 Meetings. The PWC shall meet as often as necessary, but at least quarterly. It shall maintain only such records of its meetings and actions as it deems minimally necessary to perform its duties and shall keep the records confidential.

9.3.9 Core Measures Committee

9.3.9.1 Composition: The Core Measure committee shall have diverse specialty representation to be composed of a Chair and representatives ideally from the following specialties:

A) Medicine
B) Pediatrics
C) Surgery
D) Cardiology
E) OB/GYN

The chair shall be appointed by the President and shall serve a (2) two year term. Committee representatives shall be appointed by the Chair of the committee.

9.3.9.2 Duties. The Committee shall be responsible for the peer review of all core measure cases, patient safety indicators and healthcare acquired conditions. Core measures are defined by CMS. Patient safety indictors and healthcare acquired conditions are defined by the Agency for Healthcare Quality. The Banner Health/Peer Review Council annually approves a list of core measures, patient safety indicators and healthcare acquired conditions that will be abstracted or harvested for review by the Banner Health centralized team. Cases will be reviewed and scored by the committee and subsequently shared with the provider unless screened and closed. The committee will endeavor to educate providers in order to facilitate future compliance. A summary of the peer review findings will be forwarded to the appropriate Medical Staff Department Chair and Medical Executive Committee after each meeting. At the request of the department Chair or MEC a case can be asked to undergo further review.

9.3.10 Endovascular Service Committee:

A) Composition: The Endovascular Service Committee shall be composed of a Chair and at least six Active Staff members including balanced representation from Departments whose members wish to exercise privileges to perform Endovascular procedures and representation of other specialties affected by the practice. The chair shall be appointed annually by the President and shall have duly granted Endovascular privileges. Ex Officio members of the Committee shall include the Administrator (Delegee), and an appropriate Nursing Director.

B) Duties. The Committee shall be responsible (with input from relevant

Departments and Banner system structures) for developing credentialing criteria for recommendation to the Board through the Executive Committee to assure uniform performance of all practitioners exercising Endovascular privileges; and for reviewing and evaluating individual Medical Staff members' performance; and making recommendations to the Executive Committee of the actions on those privileges. Each Department whose members wish to exercise Endovascular privileges will delegate its authority to review and take action on Endovascular privileges to this Committee.

C) Peer Review Process: All peer review cases will be screened by the appropriate Department Chair. If the Department Chair feels there is insufficient representation within the Department to conduct the review, the case will be forwarded to the Chair of the Endovascular Committee who will select an appropriate peer reviewer. Appropriate peer reviewers are defined as physicians currently on staff with unsupervised endovascular privileges and other neurointerventional specialists practicing at Banner facilities to be considered as "in-house" consultants. If the Endovascular Chair, in consultation with the Medical Staff President, feels that there is insufficient expertise within Banner to conduct an appropriate review – outside peer review will be utilized. Results of Endovascular peer review cases that have been forwarded to the Endovascular Committee for review will be reported directly to the MEC for acceptance or additional review.

9.3.11 Quality Initiative Committee

9.3.11.1 Purpose:

A) Makes recommendations to the Executive Committee and the BDMC CEO's for collaborative Administration-Medical Staff-Nursing initiatives to improve BDMC's publicly reported and internal patient safety processes.

B)

C) Develops strategies to improve clinical and operational Hospital practices that impact patient care outcomes and their objective measurements.

D) Assesses the effectiveness of initiatives, developing strategic adjustments as necessary.

E) Provides a forum for adult-program medical directors to discuss initiatives with Medical Staff.

9.3.11.2 Composition.

A) Chair. The chair is appointed by the Medical Staff President, for a two (2) year term. The chair shall be a member of the BDMC Active Staff.

B) Vice Chair. The chairman shall appoint a vice chair. The vice chair shall be a member of the BDMC Active Staff.

C) Coordinator. The Director of Clinical Performance Assessment and Improvement Department (CPAI) or designee will fill this position and is responsible for coordinating and distilling data for Committee action, in consultation with the chair.

D) Membership.

1) Medical Staff Voting Members shall include the vice chair or permanent delegate of each of the following Medical Staff departments, services, sections and committees:
    a) Medicine Department
    b) Critical Care Service Committee
    c) Surgery Department
    d) Other subspecialties or Services (as determined by the

Committee)

2) Administration and Nursing Voting Members shall include the (nursing) director, medical director or administrator (permanent delegate) of the following Services, Committees and programs:
    a) Women's Health Program
    b) Nursing Quality Council
    c) Safety Committee
    d) HIMS Department
    e) Nursing
    f) Administration
    g) CPAIDepartment
    h) Infection Prevention
    i) Pharmacy
    j) Service Excellence
3) Invited Members (Non-Voting) hospital staff from departments, areas impacting quality of patient care, invited as determined by the agenda.

9.3.11.3 Responsibilities.

A) Banner Health Board Report. The Committee will make recommendations directly to Medical Staff and Hospital departments and services for initiatives to improve the Hospital's performance showing within the System. ("Acute Medical/Surgical Hospital Care Management and Quality Report")

B) Department Requests. The Committee will respond to requests from Medical Staff and Hospital departments and services to work with them individually or interdepartmentally to develop strategies to achieve improvements in objective measures.

C) Patient Complaints. The Committee may undertake strategies to improve patient satisfaction and prevent key patient complaints.

D) The Committee will provide ongoing reports to the Medical Executive Committee

9.3.11.4 Information Reviewed:

A) Third Party, Publicly-Reported Objective Measures.
1) Publicly-Reported Web-Assessable Comparative Hospital Performance "Scores". The Council will regularly determine (from comparative data showing BDMC performance against national benchmarks and State and System scores) opportunities and priorities for improving clinical and operational processes affecting BDMC patient care outcomes.
2) Banner Desert Initiatives
    a) Recommendation: Based on its determination of opportunities for improving clinical and operational processes affecting patient care outcomes, the Council will recommend initiatives directly to hospital and medical staff departments and services for implementation.
    b) Implementation. Departments and services asked to implement initiatives will report to the Council changes in outcomes resulting from those initiatives.
    c) Evaluation. The Council will annually assess effectiveness of the recommended initiatives.
3) CPAI Reports
    a) Serious Reportable Events and Root Cause Analyses of Sentinel Events
    b) Coordination of complex (multi-department reviews of care of an individual patient.

c) Process Improvement Projects
d) HFMEA and Proactive Risk Assessment
e) Incident Report Summary and Trends
f) Regulatory Readiness and Survey

4) Utilization Review
- Receive reports from the Utilization Management Subcommittee

5) HIMS
a) Data Integrity Reviews
b) Administrative Closures

6) Patient Experience
a) Complaint Summary and Trends

7) Infection Prevention Trends

8) Medication Safety Reviews

B) Banner Health and Banner Desert Responsibilities

1) Banner Health Board Report. The Council will make recommendations directly to Medical Staff and hospital Departments and services for initiatives to improve the Hospital's performance showing within the System. ("Acute Medical/Surgical Hospital Care Management and Quality Report")
2) Department Requests. The Council will respond to requests from Medical Staff and Hospital departments and services to work with them individually or interdepartmentally to develop strategies to achieve improvements in objective measures.
3) Patient Complaints. The Council may undertake strategies to improve patient satisfaction and prevent key patient complaints.

9.3.12 Pediatric Quality and Performance Improvement Committee

9.3.12.1 Purpose:

A) Makes recommendations to the Executive Committee and the CCMC CEO for collaborative Administration-Medical Staff-Nursing initiatives to improve CCMC's publicly reported and internal patient safety processes.
B) Develops strategies to improve clinical and operational Hospital practices that impact patient care outcomes and their objective measurements.
C) Assesses the effectiveness of initiatives, developing strategic adjustments as necessary.
D) Provides a forum for pediatric-program medical directors to discuss initiatives with Medical Staff.

9.3.12.2 Composition:

A) Chair. The chair of the committee is the Cardon Children's Officer.
B) Vice Chair. The chairman shall appoint a vice chair each year to serve for the remainder of the year. The vice chair shall be a member of the CCMC Active Staff.
C) Coordinator. The Pediatric Clinical Nurse Specialist (CNS) or designee and Director of Clinical Performance Assessment and Improvement Department (CPAI) or designee will fill this position and is responsible for coordinating and distilling data for Committee action, in consultation with the chair.
D) Membership.
1) Medical Staff Voting Members shall include the vice chair (permanent delegate) or of each of the following Medical Staff departments, services, sections and committees:
a) Pediatric Medicine Department
b) Pediatric Critical Care Service
c) Pediatric Surgical Specialties Department

d) Emergency Medicine Department
f) Other subspecialties or Services (as determined by the Committee)

2) Administration and Nursing Voting Members shall include the (nursing) director, medical director or administrator (permanent delegate) of the following Services, Committees and programs:
a) Nursing Quality Council
c) Safety Committee
d) Nursing
e) Infection Prevention
f) Administration
g) CPAI Department
i) Pharmacy
j) Service Excellence

3) Invited Members (Non-Voting) hospital staff from departments, areas impacting quality of patient care, invited as determined by the agenda.

4) Invited Community Members (non-voting) to assist in ensuring quality of patient care for the community

9.3.12.3 Responsibilities.

A) The Committee will make recommendations directly to Medical Staff and Hospital departments and services for initiatives to improve the Hospital's performance showing within the System.

B) Department Requests. The Committee will respond to requests from Medical Staff and Hospital departments and services to work with them individually or interdepartmentally to develop strategies to achieve improvements in objective measures.

C) Patient Complaints. The Committee may undertake strategies to improve patient satisfaction and prevent key patient complaints.

D) The Committee will provide ongoing reports to the Medical Executive Committee.

9.3.12.4 Information Reviewed.

A) Third Party, Publicly-Reported Objective Measures.

B) Publicly-Reported Web-Assessable Comparative Hospital Performance "Scores". The Council will regularly determine (from comparative data showing BDMC/CCMC's performance against national benchmarks and State and System scores) opportunities and priorities for improving clinical and operational processes affecting CCMC patient care outcomes.

C) Banner Cardon Children's Initiatives

D) CPAI
1) Serious Reportable Events and Root Cause Analyses of Sentinel Events
2) Coordination of complex (multi-department) reviews of care of an individual patient.
3) Incident Report Summary and Trends

E) Voice Survey
1) Results

F) Quality Safety Councils
1) Pediatric Medicine
2) Pediatric Surgery
3) Hematology/Oncology
4) Neonatal Intensive Care
5) Pediatric Intensive Care
6) Surgery
7) Cardiology/CV Surgery
8) Emergency Medicine

G) Infection Prevention/Infection Control (IPIC)

H) Code Arrest Rapid Response Team (CARRT)

l) Medication Safety Reviews

9.3.13 Trauma Multidisciplinary Peer Review Committees

9.3.13.1 Adult Committee

9.3.13.1.1 Chair: The Trauma Medical Director will chair the Multidisciplinary Peer Review Committee.

9.3.13.1.2 Composition: The committee composition will include all general surgeons participating on the trauma call panel and liaisons from emergency medicine, orthopedics, neurosurgery, anesthesia, radiology and other representatives as identified by the Chair.

9.3.13.1.3 Frequency: The meeting will be held monthly or at a frequency established by the Trauma Medical Director to facilitate the needs of the program.

9.3.13.1.4 Duties: The multidisciplinary trauma peer review committee will systematically evaluate trauma patient care identified through system approved indicators and determine opportunities for improvement. Based on this review process, both the appropriateness and timeliness of care will be reviewed, and opportunities for improvement determined and documented. The Trauma Peer Review committee reports directly to the Medical Executive Committee.

9.3.13.2 Pediatric Committee

9.3.13.2.1 Chair: The Pediatric Trauma Medical Director will chair the Pediatric Multidisciplinary Peer Review Committee.

9.3.13.2.2 Composition: The committee composition will include all general surgeons participating on the trauma call panel, pediatric surgeons and liaisons from emergency medicine, orthopaedics, neurosurgery, anesthesia, pediatric critical care, radiology and other representatives as identified by the Chair.

9.3.13.2.3 Frequency: The meeting will be held monthly or at a frequency established by the Pediatric Trauma Medical Director to facilitate the needs of the program.

9.3.13.2.4 Duties: The Pediatric multidisciplinary trauma peer review committee will systematically evaluate trauma patient care identified through system approved indicators and determine opportunities for improvement. Based on this review process, both the appropriateness and timeliness of care will be reviewed, and opportunities for improvement determined and documented. The Pediatric Trauma Peer Review committee reports directly to the Medical Executive Committee.

9.4 JOINT COMMITTEES. Joint Committees are mechanisms to improve communication and collaboration among the Medical Staff, Administration, Board and/or other BH medical staffs.

9.4.1 Joint Conference Committee. This is a joint ad hoc committee of the BDMC Medical Staff and the BH Board. [BH bylaws § VI.9.E; § VII.4]

9.4.2 Purpose: Joint conference subcommittees to the Board's Quality and Care Management Committee are appointed from time to time upon request of a BH

medical staff to resolve concerns regarding medical staff bylaws, credentialing recommendations, policies or other issues which such medical staff has been unable to resolve through informal processes with the institution's administration, senior management, the Medical Staff Subcommittee, the Care Management and Quality Committee, or the Board of Directors.

9.4.3 Composition: The subcommittee shall consist of three representatives appointed by the Chairman of the Quality and Care Management Committee and three members of the medical staff appointed by its President. Representatives of administration or other management may serve on the subcommittee without vote. Recommendations of the subcommittee shall be submitted to the BH regional president, the BH President, the Board's Medical Staff Subcommittee, the Quality and Care Management Committee or the Board of Directors, as appropriate.

9.4.4 Inter-Facility Medical Staff Committee Activities

A. With approval from the President of the Medical Staff and Department or Committee Chairman, representatives of a Banner Desert Medical Staff Department or Committee may participate in joint committees that may conduct medical staff activities, including peer review activities, with representatives of department or committees of other Banner Medical Staffs.

i. Department or committee chairman may assign one or more members to serve on a joint committee.

ii. Recommendations of the joint committee will be presented to the applicable department or committee for approval.

iii. Peer review information relating to the activities of the joint peer review committees may be shared with the joint committees.

B. The President or other Medical Staff Officers may participate in joint committees with officers of other Banner Medical Staffs. Recommendations of such committees will be presented to the Medical Executive Committee for approval, as needed.

ARTICLE X: MEETINGS

10.1 GENERAL STAFF MEETINGS

10.1.1 There shall be an annual General Staff meeting each year, the date and place to be determined by the President. At the discretion of the President, additional meetings may be called. The agenda of all General Staff meetings shall be developed by the President of the Medical Staff, in collaboration with the CEO.

10.1.2 Notice of the time and place of each meeting shall be sent to all members of the Staff by USPS, fax or email at least two (2) weeks before the meeting and posted on appropriate Staff bulletin boards in the Hospital.

10.1.3 The Administrators and/or designee, shall attend regular Staff meetings.

10.1.4 Staff members may invite professional guests to attend these meetings, with approval from the President of the Medical Staff. The President of the Staff may require all who are not members of the Active Staff, to remove themselves from executive sessions of the Staff.

10.2 SPECIAL MEETINGS

10.2.1 General Staff: The President or the Executive Committee may call a special meeting of the Staff at any time. The President shall call a special meeting of the Staff, which shall be held within thirty (30) days after receipt of a written request signed by not

less than one-fourth (1/4) of the Active Staff stating the purpose of the meeting. The President of the Staff shall designate the time and place of all special meetings.

10.2.2 Department, Section, Service or Committee: A special meeting may be called by the chairman, the President of the Staff, or by one-third (1/3) of the department, section, service or committee's members, but not less than two members.

10.2.3 Notice: Notice stating the place, day, hour and purpose of any special meeting shall be delivered by USPS, fax or email to each member of the Active and Associate Staffs at least ten (10) days prior to the date of such meeting. Notice may be extended to other members who may contribute to the business of the meeting. Attendance of a member of the Staff shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

10.3 QUORUM: Quorum requires the presence of members as follows:

10.3.1 Meetings of Departments, Services and Sections: Two members of the department shall constitute a quorum for the transaction of business before the department, services, and sections as-a-whole unless the department establishes a higher quorum requirement in its rules and regulations.

10.3.2 Meetings of Committees: The presence of 50% of the members of the Medical Execute Committee shall constitute a quorum. The presence of 2 voting members shall constitute a quorum for the transaction of any business under these Bylaws.

10.3.3 Meetings of Special and General Staff: The presence of half (1/2) of the voting members of the staff at any general or special meeting shall constitute a quorum for the transaction of any business under these Bylaws. Persons serving under these Bylaws as ex-officio members of a committee shall not be counted in determining the existence of a quorum, cannot vote on any questions brought before the committee and may be excused from executive sessions of the committee.

10.4 MANNER OF ACTION: The action of a majority of the persons entitled to vote who are present at a meeting at which a quorum is present shall be the action of a department, section or committee. Action may be taken without a meeting by written consent (setting forth the action so taken) of 50% or more of the persons entitled to vote on such action. Urgent business may be conducted at a duly called meeting of a Medical Staff Department, Section, Service or Committee in the absence of a quorum, provided the action is later ratified by a quorum of the Department, Section, Service or Committee.

10.5 CONDUCT OF MEETINGS:

10.5.1 Roberts Rules. All meetings shall be conducted according to Robert's Rules of Order, Revised, unless specifically modified by these Bylaws. The chairman may appoint another member of the committee to act as parliamentarian.

10.5.2 Confidentiality.
All agenda items shall be designated as either General or Executive Session matters.

A) Purpose of General Session. General session is for the discussion of administrative matters pertaining to department, Medical Staff, Hospital and patient care matters that are general in nature.

B) Purpose of Executive Session. Executive session is for the discussion of particular professional practices in order to promote candor in monitoring and evaluation of the quality of patient care, to reduce morbidity and

mortality, and to improve patient care. It should also be used for discussion of other (non-peer review) confidential matters. Everyone in attendance in executive sessions is obligated to preserve the confidentiality of the proceedings, communications, records, information and materials. No one may voluntarily disclose privileged information except pursuant to these Bylaws for the purposes for which the information was provided and as may be required by law; unauthorized disclosure of peer review information violates AZ law and these Bylaws and will be reported to the Executive Committee. Disclosure of other confidential information shall conform with relevant policy.

C) Convening/Closing Executive Session. The chair should announce that executive session is convened; and, if general session has been in session that it is formally closed. Once all confidential matters have been treated, the chair should announce the close of executive session (and reconvene general session, if necessary, inviting all those previously excused to return).

D) Attendance in Executive Session. Attendance and participation in peer review Executive Sessions should be limited to the committee's members; medical, administrative and nursing staff and others may be permitted to attend to the extent necessary to assist in the professional practices review. Persons who were present or involved in the situation under review and the Medical Staff member/applicant under review may be invited to provide information to the committee and shall be interviewed separately as follows: They should enter the meeting only after other persons providing information have left, and they should leave once they have provided the information and answered any questions. Any person who has been directly or personally involved in the situation under review should not hear the deliberations or discussions. Attendance and participation in all Executive Sessions is subject to the Medical Staff Conflict of Interest Policy (8.8).

E) Minutes. General and executive session minutes are made and kept separate. In addition, executive session minutes for the review of a physician's conduct or practice must be recorded separately.

10.6 CONFLICT OF INTEREST IN PEER REVIEW:
The Medical Staff adheres to the Banner Conflict of Interest Policy.

10.7 MEETING ATTENDANCE

10.7.1 Record. Meeting attendance will be recorded for all medical staff meetings.

10.7.2 Mandatory Attendance. When an opportunity may exist to improve the performance or behavior of a practitioner, the Medical Staff President or the applicable department chairman and/or peer review committee chairman may require the practitioner to confer with him or her or with the committee considering the matter. The practitioner will be notified and confirmed, of the date, time, and place of the conference, and the reasons therefore. Failure of a practitioner to appear at any such meeting may result in temporary suspension of admitting and surgical/procedure scheduling privileges until the practitioner appears to discuss the concern identified. The practitioner may petition for a one-time, one-meeting postponement by submitting evidence that the absence is unavoidable to the department or section chair (or to the Executive Committee, if the petitioner is a department or section chair). Otherwise, the pertinent information shall be presented and discussed as scheduled.

10.8 MEETING FREQUENCY

10.8.1 The Executive Committee, all department and section committees and all standing committees, with exceptions as specified in these Bylaws, shall hold regular meetings as often as necessary (as determined by medical and input from hospital leadership).

10.8.2 The Nominating Committee shall meet as needed to present the completed official ballot to the Executive Committee at its meeting in September.

10.8.3 Service Committees shall hold regular meetings as necessary.

ARTICLE XI:
IMMUNITY FROM LIABILITY AND INDEMNIFICATION

11.1 IMMUNITY FROM LIABILITY. As a condition to application, membership and the exercise of privileges at this Hospital, each applicant for Staff membership and each Staff member expressly agrees as follows:

11.1.1 that any act, communication, report, recommendation, or disclosure with respect to any such applicant or member, performed or made pursuant to these Bylaws at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

11.1.2 that such privilege shall extend to members of the Staff, the Board, the Administrator and his representatives, and to third parties who supply information in accordance with these Bylaws to any of the foregoing authorized to receive, release or act upon the same. For the purpose of this Article 11, the term, "third parties," means both individuals and organizations from whom information has been requested by an authorized representative of the Board or of the Staff.

11.1.3 that there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

11.1.4 that such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in accordance with these Bylaws in connection with this or any other health care institution's activities related to, but not limited to:

11.1.4.1 application for appointment or privileges
11.1.4.2 periodic reappraisals for reappointment or privileges
11.1.4.3 corrective action, including summary suspension
11.1.4.4 hearings and appellate reviews
11.1.4.5 patient care evaluations
11.1.4.6 utilization reviews, and
11.1.4.7 other Hospital, department, section or committee activities related to quality patient care and inter-professional conduct.

11.1.5 that the acts, communications, reports, recommendations and disclosures referred to in this Article 13 may relate to a member's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics or any other matter that might directly or indirectly have an effect on patient care.

11.1.6 that in furtherance of the foregoing, each member shall, upon request of the Medical Staff, execute releases in accordance with the tenor and import of this Article XII in favor of the individuals

and organizations specified in **11.1.2**, subject to such requirements as may be applicable under the laws of this State.

11.1.7 that the consents, authorizations, releases, rights, privileges and immunities provided by Sections **5.1** and **5.2** for the protection of Hospital and Medical Staff members, and third parties in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article 13.

11.2 INDEMNIFICATION.

11.2.1 The Board provides indemnification from liability for each and every Staff member, both present and future, from all civil liability arising out of activities of the Medical Staff in connection with:

11.2.1.1 quality management, utilization review, and/or the process of determining Staff membership, clinical privileges or corrective action towards a Medical Staff member or other persons whose competency or qualifications are evaluated by a medical staff;

11.2.1.2 the process of monitoring, evaluating or supervising patient care practice of the Medical Staff and other persons whose competency or qualifications are evaluated by a medical staff; and

11.2.1.3 any other duties or responsibilities delegated by the Board to the Medical Staff and performed by the Medical Staff.

11.2.2 The Medical Staff Office shall have on file the Board's indemnification policy. No duly adopted amendment or revocation of the indemnification shall take effect until ninety (90) days after the Executive Committee has received Special Notice of the amendment or revocation, and any such amendment or revocation shall not affect actions taken prior to the effective date of amendment or revocation.

ARTICLE XII:
CREDENTIALS PROCEDURE MANUAL, FAIR HEARING PLAN, MEDICAL STAFF RULES AND REGULATIONS AND ALLIED HEALTH RULES AND REGULATIONS

12.1 Periodic Review. The Credentials Procedure Manual, Fair Hearing Plan, Medical Staff Rules and Regulations and 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.

12. 2 Communication to the Medical Staff.

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

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

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

ARTICLE XIII: DEPARTMENT AND COMMITTEE RULES AND REGULATIONS

13.1. DEFINITION. Rules and regulations are those guidelines for individual departments, sections, services and standing committees necessary to implement the principles of these Bylaws. Rules and Regulations shall be consistent with the policies of the Staff and the Board.

13.2 MANNER OF REVISION. It shall be the responsibility of each department, section, service, and standing committee to review its rules and regulations biannually and to make recommendations pertaining to their functions, unless the function is defined in the Medical Staff Rules and Regulations or Bylaws. Any member of a department, section, service, or standing committee may propose changes at any regular meeting or special meeting (called for the purpose) of the department, section, service or standing committee.

13.3 APPROVAL. Recommendations approved by the department, section, service, or standing committee, shall be forwarded to the Bylaws Committee for its review and recommendations before their submission to the Executive Committee and Board for approval.

ARTICLE XIV: AMENDMENTS

14.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY. The Medical Staff shall be responsible for the development, and adoption of the Bylaws as well as periodic review of the Bylaws to determine consistency with Medical Center policies, Banner Bylaws, and applicable laws. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the CEO, the Board and the community.

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

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

14.4 MEDICAL STAFF PROCESS. The Medical Staff may propose Bylaws or amendments thereto directly to the Board. A petition seeking approval of proposed amendments signed by at least 20% of the Active Staff members shall be submitted to the Executive Committee. The Executive Committee will review the proposed amendments at its next meeting and determine whether to recommend language

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

14.5 URGENT PROCESS. In the event of a documented need for an urgent amendment of the Medical Staff Bylaws to comply with law or regulation or accreditation standards, the Executive Committee may provisionally adopt, and the Board may provisionally approve the urgent amendment without the prior notification of the voting members of the Medical Staff. In such cases, the voting members of the Medical Staff shall be immediately notified by the Executive Committee of the urgent amendment within ten (10) days after the Board has approved the amendment. The voting members of the Medical Staff shall have ten (10) days in which to retrospectively review the amendment and provide written comment to the Executive Committee. If there are no comments opposing the provisional amendment, then the provisional amendment shall become final. If there are comments opposing the provisional amendment, then the Medical Staff process for conflict resolution as referenced in Section 9.2.3.3 shall be implemented, and a revised amendment shall be submitted to the Board. Amendments adopted urgently shall be subject to periodic review pursuant to Section 14.2.

14.6 APPROVAL OF THE BOARD. Amendments made pursuant to the provisions of this Article shall become effective upon approval of the Board.

14.7 TECHNICAL AND EDITORIAL. Upon recommendation of the Bylaws Committee, the Executive Committee may correct typographical, spelling and grammatical or other obvious technical or editorial edits, as deemed necessary.

ARTICLE XV
ADOPTION AND APPROVAL

These Bylaws, together with the current Rules and Regulations of the Staff, shall become effective upon being adopted by the Active Staff and approved by the Board.

Amended by the Board:
August 11, 2016; January 12, 2017, March 9, 2017, May 10, 2018, September 13, 2018, February 13, 2020