

**BYLAWS
OF THE
MEDICAL STAFF**

**Medical Staff Services
480-412-7720
September, 2018**



Banner Desert®
Medical Center



Banner Children's
Cardon Children's
Medical Center

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

BANNER DESERT MEDICAL CENTER
CARDON CHILDREN'S MEDICAL CENTER

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BYLAWS OF THE MEDICAL STAFF

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 **10.2.3.2.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.

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.

5.8.2 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, 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.

5.12.1 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.

5.13.2 Duration. As soon as the immediate situation is under control but in no event longer than three days, the disaster privileges expire. The practitioner may request temporary privileges upon provision of the credentials and the verification process required under Section 5.10.1. Denial of the request and termination of any temporary privileges do not give rise to any rights of appeal. The CEO, CMO or Chief of Staff may terminate any or all of a practitioner's disaster privileges on the discovery of any information or the occurrence of any event of a nature that raises a question about a practitioner's professional qualifications. In the event of such termination, the practitioner's patients then in the Hospital will be assigned to another practitioner.

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. 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:

5.13.1 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.

5.13.2 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.

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

5.13.4 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 ninety (90) 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. Affected practitioners may request reinstatement during a period of 30

calendar days following suspension upon presentation of evidence of Professional Liability Insurance. Failure to make a timely request for reinstatement shall result in automatic relinquishment of membership and privileges.

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. 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. If the dues are paid within 30 calendar days of notification of suspension, the practitioner shall be reinstated. Failure to pay dues within the reinstatement shall result in automatic relinquishment of membership and privileges.

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. Affected practitioners may request reinstatement during a period of 60 calendar days following suspension upon presentation of evidence of freedom of TB. Failure to make a timely request for reinstatement shall result in automatic relinquishment of membership and privileges.

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.

ARTICLE VII: FAIR HEARING PLAN

7.1 INITIATION OF HEARING

7.1.1 Triggering Events Any Adverse Action (adverse action(s) or recommendation(s) by the Executive Committee or Board), except as expressly provided in these Bylaws, that would deny, revoke, suspend, reduce or otherwise limit the membership and/or non-temporary privileges of a member shall entitle the member to a hearing upon timely and proper request, unless such limitation constitutes non-reviewable corrective action pursuant to these Bylaws.

7.1.2 Non-Reviewable Actions. Not every adverse action gives rise to an Article VII hearing right; for example:

- 7.1.2.1 actions listed in 6.2.3.2 (investigatory tools);
- 7.1.2.2 actions taken pursuant to 6.3.4 (administrative safeguards);
- 7.1.2.3 actions taken pursuant to 6.4.2.2(A) & (B) (letters of admonition, retrospective chart review);
- 7.1.2.4 automatic suspension, except as provided in 6.6;
- 7.1.2.5 denial, termination or limitation of temporary privileges, as provided in 5.8;
- 7.1.2.6 non-appointment or non-reappointment for failure to complete an application for appointment or reappointment (5.2 & 5.3);
- 7.1.2.7 actions taken pursuant to Section 7.8;
- 7.1.2.8 any recommendation voluntarily imposed or accepted by a practitioner;
- 7.1.2.9 interim reappointment, as provided in 5.3.3.2 and 5.4.4.3.
- 7.1.2.10 failure to become board certified, recertified or to maintain board certification, as provided in 3.2.

7.1.3 Notice of Adverse Action The Administrator shall promptly notify the respondent by Special Notice of a reviewable Adverse Action. The notice shall:

- 7.1.3.1 Advise the respondent of the Adverse Action; and contain a concise statement of the respondent's alleged acts or omissions, a list of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the Adverse Action;

7.1.3.2 Advise the respondent of his or her right to a hearing upon timely and proper request, and specify that the respondent has 30 calendar days after receiving the notice within which to submit a written request for a hearing to the Administrator;

7.1.3.3 State that the failure to submit a timely and proper request for a hearing within the above stated time period and in the proper manner constitutes a waiver of rights to any hearing or appellate review on the matter that is the subject of the notice and may result in certain specified reporting obligations;

A) Arizona law requires that certain adverse privilege actions be reported to State licensing boards (e.g., Arizona Medical Board), which may in turn report this information to all Arizona health care institutions and the Arizona Health Care Cost Containment System, together with the reason for the adverse action. The same reporting and disclosure obligations pertain to a Medical Staff member's resignation of privileges or Staff membership, once an investigation has commenced or in lieu of an investigation.

B) Federal law requires certain adverse privilege actions to be reported to the National Practitioner Data Bank. Thereafter, all qualifying health care institutions in the United States may obtain such information. The same reporting and disclosure obligations pertain to a Medical Staff member's resignation of privileges or Staff membership, once an investigation has commenced or in lieu of an investigation.

7.1.3.4 Specify the hearing rights to which the respondent is entitled;

7.1.3.5 State that after receipt of the request for a hearing, the respondent will be notified of the date, time and place of the hearing, and the witnesses expected to testify on behalf of the Executive Committee.

7.1.4 Amendments. The Executive Committee may modify the Adverse Action or its grounds any time before the conclusion of the Hearing, provided the Administrator promptly notifies Respondent of any additions or deletions and Respondent is given a reasonable opportunity to respond.

7.1.5 Request for Hearing. The respondent shall have 30 calendar days after receiving a notice under paragraph 7.1.2.1 to deliver to the Administrator a written request for a hearing.

7.1.6 Waiver by Failure to Request a Hearing. A respondent who fails to request a hearing within the time and in the manner specified in Section 7.1.3 shall be deemed to have waived his or her right to any hearing or appellate review to which he or she might otherwise have been entitled and to have accepted the Adverse Action. Such waiver shall apply only to the matters that were the basis for the Adverse Action triggering the notice and shall be transmitted to the Board for a final decision. The Administrator shall as soon as reasonably practicable send the respondent notice of the Board's decision.

7.1.7 Reporting of Adverse Action. If, as a result of the respondent's waiver of a hearing, the respondent's clinical privileges or membership are adversely affected, the Executive Committee shall report such adverse action to the Administrator, who shall make statutorily required reports.

7.2 HEARING PREREQUISITES

7.2.1 Notice of Time and Place for Hearing

7.2.1.1 Scheduling the Hearing. Upon receiving a timely and proper request for hearing, the Administrator shall deliver the request to the President of the Staff, who shall

schedule the hearing. At least 30 calendar days before the hearing, the Administrator will send the respondent Special Notice (1) of the date, time and place of the hearing, and (2) of the witnesses expected to testify at the hearing on behalf of the Executive Committee. The hearing date shall be set for not less than 30 calendar days nor more than 90 calendar days after the Administrator receives respondent's written request for a hearing.

7.2.1.2 Scheduling Expedited Hearing. A respondent who is under suspension then in effect may request that the hearing be expedited. The Administrator must provide 7.2.1.1 information within ten (10) days of the Administrator's receipt of the written request for the expedited hearing. The expedited hearing must be held as soon as the arrangements may reasonably be made, but not later than thirty (30) calendar days after the Administrator's receipt of the written request for the expedited review.

7.2.1.3 Adjustments. The President or his designee shall meet with the respondent at the earliest opportunity to adjust all other deadlines leading to a final action. Furthermore, any respondent, with the consent of the President, can waive the above stated time requirements in order to expedite the hearing process.

7.2.2 Appointment of Hearing Committee

7.2.2.1 By the Executive Committee A hearing shall be conducted by an Ad Hoc Hearing Committee ("Hearing Committee") of at least three (3) members appointed by the President. The President shall designate one of the appointees as chairman of the Hearing Committee. If the President is disqualified by reason of conflict of interest or bias (for reasons including being in direct economic competition or having a formal business or professional association with the respondent), the President-Elect, Secretary-Treasurer or remaining members of the Executive Committee (in that order) shall appoint the committee members and chairman. No person in direct economic competition or having a formal business or professional association with the respondent shall participate in the selection of the Hearing Committee or its chairman.

7.2.2.2 Service on Hearing Committee No person who has actively participated in the consideration of the Adverse Action, who has a formal business or professional association with the respondent, who is in direct economic competition with the respondent, or who is biased regarding the matter, shall serve on the Hearing Committee. Members of the Hearing Committee shall be physicians duly licensed by one of the fifty states and may, but need not be members of the Banner Desert Medical Staff. The members should include one individual with a license or certification comparable to that of the respondent.

7.2.2.3 Hearing Officer. The President, at his/her discretion or upon request of the affected practitioner, may appoint a hearing officer. The hearing officer shall serve as the Presiding Officer; maintain decorum, and rule on matters of law, procedure, and the admissibility of evidence, including the admissibility of testimony and exhibits. The hearing officer may participate in the deliberations and assist in the preparation of a written decision, but may not act as an advocate or advisor for either party and may not vote. The hearing officer need not be a member of the Medical Staff or a physician and may not be in direct economic competition or affiliation with the practitioner.

7.2.2.4 Legal and Administrative Review and Participation Prior to appointing Hearing Committee members, the appointing Executive Committee member shall submit to the Administrator the names of, and available information pertaining to the criteria set forth in paragraphs (1) and (2) of this Section about the proposed

appointees and the appointing member, so that the proposed appointments may be reviewed by BH legal counsel for compliance with federal and state law and with these and BH Bylaws. The Administrator, upon advice of BH legal counsel, shall promptly inform the appointing Executive Committee member of any reason why any proposed member should not serve. Seven days after the appointing Executive Committee member submits the available information to the Administrator, or such longer time as may be agreed to by the Administrator and the President, BH legal counsel and the Administrator shall waive further objections to the proposed appointments on the basis of that information. During the entire hearing process, the Administrator and BH legal counsel shall assess the hearing process and advise the Medical Staff representatives who have any part in the hearing process of legal requirements, deficiencies in the process, conflicts of interest, problems with competitors, biases and other matters, which in the opinion of legal counsel present substantial risk to either the participants or the Board of Directors by virtue of the Board's indemnification of Medical Staff members. Participants in the hearing process shall make every effort to comply with recommendations of BH legal counsel. Legal counsel shall make no recommendations that interfere with clinical opinions of Medical Staff members but may comment on the relevancy, effectiveness, and appropriateness of the evidence to be considered.

7.2.2.5 Respondent's Right to Object The Administrator shall apprise the respondent of the names of the committee members, and the respondent may, within 10 days of the notification, object to the appointment of any member(s). Such objection must be in writing and must include the basis for the objection. If the President or the designee who appointed the Hearing Committee determines that the objection is reasonable, he or she may designate alternative member(s) and shall notify the respondent of such new member(s). The respondent may object to any new member(s) by giving written notice of the objection and the reasons therefor.

7.2.3 List of Witnesses At least 10 days prior to the scheduled hearing date (or at least 3 days in the event of an expedited review), each party shall give the other a list of the names of the individuals, who, as far as is reasonably known, will give testimony or evidence in support of the party at the hearing. Witnesses shall be limited to individuals who will provide testimony relevant to the grounds for the Adverse Action. Such list and the list of the Executive Committee's witnesses shall be amended as soon as possible when additional witnesses are identified. The Hearing Committee may permit a witness who has not been listed in accordance with this Section to testify if it finds that the failure to list such witness was justified, that such failure did not prejudice the party entitled to receive such list, or that the testimony of such witness will materially assist the Hearing Committee in making its report and recommendation under Section 7.4.1.

7.2.4 Preliminary Statements in Support, Exhibits If a statement and/or exhibits in support of a party's position are to be submitted to the Hearing Committee, such party shall supply seven copies of such statement and/or exhibits to the Medical Staff Office at least 5 days prior to the scheduled hearing commencement date. The Medical Staff Office shall deliver two of the seven copies of the statement and/or exhibits to the other party and his or her representative at least five (5) days before the scheduled hearing date. The Medical Staff Office shall distribute copies of the statements and/or exhibits to members of the Hearing Committee at least three (3) days prior to the scheduled hearing date. Nothing in this paragraph shall preclude the Executive Committee or its representatives from submitting procedural information to the Hearing Committee.

7.3 HEARING PROCEDURE

7.3.1 Nature of Hearing. The hearing shall be a hearing de novo, by which the Hearing Committee (1) reviews all of the information available to the Executive Committee and any other relevant evidence presented to the Hearing Committee pursuant to this Article; and, in accordance with either Section 5.4.3 or 6.4.2 (depending on the context of the triggering Adverse Action), (2)

reaches an independent determination and (3) makes its recommendations. Actions taken in accordance with this Section are deemed to be taken in the furtherance of quality health care, after a reasonable effort to obtain the facts of the matter and in the reasonable belief that the actions are warranted by the facts.

7.3.2 Order of Presentation; Burden of Proof. The Executive Committee or Board (whoever initiated the Adverse Action) shall first present evidence in support of the Adverse Action. Thereafter an applicant for initial appointment or privileges has the burden of demonstrating that the Adverse Action lacks any substantial factual basis or is otherwise arbitrary, unreasonable or capricious. In all other cases the Executive Committee/Board bears the burden of proving by a preponderance of evidence that the Adverse Action is reasonable and warranted.

7.3.3 Personal Presence The right to a hearing shall be waived if the respondent fails, without good cause, to appear. The personal presence of the respondent is required throughout the hearing. The presence of the respondent's counsel or other representative does not constitute the personal presence of the respondent. A respondent who fails without good cause to appear and be present throughout the hearing shall be deemed to have waived his or her rights in the same manner and with the same consequence as provided in Sections **7.1.5** and **7.1.6**. The Hearing Committee shall determine what constitutes "good cause."

7.3.4 Presiding Officer In the absence of a Hearing Officer (7.2.2.3), the Hearing Committee chairperson shall be the Presiding Officer. The Presiding Officer shall maintain decorum and assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence. (The chairman shall be entitled to vote.)

7.3.5 Decorum. The right to a hearing shall be waived, if in the opinion of the Presiding Officer, the Respondent's conduct (and/or the conduct of any representative of Respondent) prevents the hearing from proceeding effectively and expeditiously. The Presiding Officer must provide the Respondent an opportunity to correct the circumstances prior to ruling that Respondent's hearing rights have been waived. Examples of conduct sufficient to give rise to waiver include: refusal to be sworn in or to answer questions posed by the Hearing Committee; failure to abide by a ruling of the presiding officer. Waiver under this provision shall have the same consequence as provided in Sections **7.1.5** and **7.1.6**. A Respondent ruled to have waived hearing rights may submit a written request and supporting material within 10 days of the ruling to the Executive Committee; the Executive Committee's ruling shall be final, and not subject to appeal.

7.3.6 Representation The respondent may be represented at the hearing by legal counsel or any other person of the respondent's choice. The Executive Committee shall appoint an Active Staff member to represent it and may also be represented by legal counsel.

7.3.7 Rights of Parties During a hearing, each party shall have the following rights, subject to the rulings of the Presiding Officer on the admissibility of evidence and provided that such rights shall be exercised in a manner so as to permit the hearing to proceed effectively and expeditiously to:

- 7.3.7.1 Call, examine and cross-examine witnesses;
- 7.3.7.2 Present relevant evidence;
- 7.3.7.3 Rebut any evidence;
- 7.3.7.4 Submit a concluding written statement in support of such party's position at the close of the hearing;
- 7.3.7.5 Have a record made of the proceedings, copies of which may be obtained by the respondent upon payment of any reasonable charges associated with the preparation thereof.

Upon completion of the hearing, the parties have the right to receive the written recommendation of the Hearing Committee and the reconsidered recommendation of the Executive Committee, both of which must include a statement of the basis for the decision.

7.3.8 Procedure and Evidence The hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. At the discretion of the Presiding Officer any relevant matter or evidence may be considered. (Peer review information on any other practitioner is neither admissible nor relevant.) In addition, the respondent may be examined by the Executive Committee representative and the Hearing Committee regardless of whether the respondent testifies on his or her own behalf. Before the hearing and at the close of the hearing each party shall be entitled to submit a written statement concerning relevant issues of law or fact, and those statements shall become part of the hearing record. The Hearing Committee may ask questions of witnesses, call additional witnesses, or request documentary evidence if deemed appropriate. The Presiding Officer may order that oral evidence be taken only on oath. A Respondent who reasonably believes hearing procedures substantially deviate from the requirements of this Article shall promptly so notify the presiding officer, to provide an opportunity to correct.

7.3.9 Hearing Record A record of the proceedings shall be kept either by a court reporter or by electronic recording device, e.g., tape. Respondent may receive a copy within a reasonable time after the conclusion of the proceedings upon payment of any reasonable charges associated with the preparation thereof. The Hospital is not responsible for any expedited costs, e.g., for a daily transcription.

7.3.10 Postponement Requests for postponement or continuance of a hearing may be granted by the Presiding Officer only upon a timely showing of good cause.

7.3.11 Recesses and Adjournment The Hearing Committee may, without special notice, recess and reconvene for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. The Hearing Committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

7.3.12 Proposed Findings and Recommendations. At the conclusion of the hearing, the parties may submit proposed findings and recommendations to be considered by the Hearing Committee during deliberations.

7.3.13 Deliberations. In reaching its conclusions of fact and making its recommendations, the Hearing Committee must act:

7.3.13.1 In the reasonable belief that the recommendation is in furtherance of quality health care.

7.3.13.2 After a reasonable effort to obtain the facts of the matters; and

7.3.13.3 In the reasonable belief that its recommendations are warranted by the facts known after reasonable effort to obtain such facts.

7.4 HEARING COMMITTEE REPORT AND FURTHER ACTION

7.4.1 Hearing Committee Report Within 10 days after adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations including a statement of the basis for the recommendations, consistent with Section 7.3.1. This report, accompanied by the record and other documentation shall be forwarded to the Executive Committee.

7.4.2 Action on Hearing Committee Report At its next regularly scheduled meeting after receipt of the Hearing Committee report and other documentation, the Executive Committee shall affirm, modify or reverse its previous recommendation or action, consistent with Section 7.3.1. The chairman of the Hearing Committee or his designee shall be present to discuss the findings and recommendations of the Hearing Committee.

7.4.3 Notice and Effect of Result

7.4.3.1 Notice As soon as is practicable, but in no event longer than ten (10) days after the Executive Committee makes its recommendation based on the hearing, the Administrator shall send the respondent a copy of the Hearing Committee's report and the reconsidered recommendation of the Executive Committee including a statement of its basis.

7.4.3.2 Effect of Favorable Result When the recommendation of the Executive Committee is favorable to the respondent, the Administrator shall promptly forward it, together with all supporting documentation to the Board where appropriate.

7.4.3.3 Effect of Adverse Result

- A) If, after the Executive Committee has considered the Hearing Committee report, the Executive Committee's reconsidered recommendation continues to be adverse, the Administrator shall promptly notify the respondent by Special Notice of the Executive Committee's adverse recommendation, the respondent's appeal rights and any consequences of waiving those rights. The Administrator shall also forward the Executive Committee's recommendation and supporting documentation to the Board. The Board shall not take any action thereon until after the respondent has exercised or has been deemed to have waived his right to an appellate review.
- B) The Administrator shall notify the appropriate licensing authority and make such other notifications as may be required by law regarding the recommendations and the grounds therefor and of the respondent's pending appeal rights, as set forth in Section **7.1.5**.

7.5 APPELLATE REVIEW.

7.5.1 Request for Appellate Review

7.5.1.1 A practitioner shall have 10 days after receiving notice of the right to appellate review of the Executive Committee's Reconsidered Adverse Recommendation to file a written request for appellate review by an Appeals Subcommittee of the Board of Directors of BH. The written request for appellate review shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal.

7.5.1.2 The grounds for appeal shall be that 1) the hearing was not in substantial compliance with the procedures required by the Medical Staff bylaws, or applicable law, and created demonstrable prejudice; or 2) the adverse recommendation or action was arbitrary, capricious, or not supported by substantial evidence based upon the Hearing Record.

7.5.1.3 If the practitioner desires to present an oral statement in favor of his or her position, the notice must include a request to appear before the Appeals Subcommittee.

7.5.1.5 The request for appellate review must be delivered to the Administrator and may include a request for a copy of hearing transcript, upon payment of any reasonable charges associated with the preparation thereof.

7.5.2 Waiver by Failure to Request Appellate Review or Appearance or by Failure to Participate Constructively. Failure to make a timely and proper request for appellate review shall constitute

consent by the practitioner to final action by the Board of Directors without an appeal. A practitioner who fails to request an appearance before the Appeals Subcommittee shall be deemed to have waived the right to make an oral statement and to appear before the Appeals Subcommittee. A practitioner who fails to participate constructively in the appellate review process shall be deemed to have waived the right to appellate review.

7.5.3 Notice of Time and Place for Appellate Review. The Administrator shall promptly deliver a request for appellate review to the General Counsel of BH, who shall schedule the appellate review as soon as practicable.

7.5.4 Appeals Subcommittee. The Appeals Subcommittee shall be appointed as prescribed in the BH Bylaws.

7.6 APPELLATE REVIEW PROCEDURE AND FINAL ACTION

7.6.1 Nature of Proceedings. The Appeals Subcommittee shall consider the Hearing Record and, if the practitioner has requested the opportunity to appear, oral statements from the practitioner and representatives of the Executive Committee. At the discretion of the Chairman of the Quality and Care Management Committee, the appellate review may be conducted telephonically. These proceedings are not judicial in nature, but rather provide a forum for the evaluation of a professional to render healthcare services. The rules of law relating to the presentation of evidence do not apply.

7.6.2 Representation. The practitioner may be represented by legal counsel or any other person of the practitioner's choice. The Executive Committee shall appoint a representative to represent it and may also be represented by legal counsel.

7.6.3 Written Statements. The practitioner and the Executive Committee may each submit a written statement in support of their respective positions, which may cover only such matters raised at the hearing. If the parties choose to submit written statements, at least five copies must be submitted to the General Counsel or his or her designee at least 5 days prior to the date of the scheduled review. If submitted, the General Counsel or his or her designee shall distribute such statement to members of the Appeals Subcommittee and to the parties' representatives at least 3 days prior to the scheduled date of the review.

7.6.4 Oral Statements. If an oral statement has been requested, the Appeals Subcommittee shall allow the practitioner and representatives of the Executive Committee to make oral statements in favor of their respective positions. Any party or representative appearing shall be required to answer questions asked by any member of the Appeals Subcommittee.

7.6.5 Presiding Officer. The chairman of the Appeals Subcommittee is the presiding officer. He or she shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

7.6.6 Consideration of New or Additional Matters. New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the Hearing Record may not be introduced at the appellate review.

7.6.7 Recesses and Adjournments. The Appeals Subcommittee may recess and reconvene the proceedings without special notice for the convenience of the participants or for the purpose of obtaining consultation. At the conclusion of the oral statements, the appellate review shall be adjourned. The Appeals Subcommittee shall then, at a time convenient to its members, conduct its deliberations outside the presence of the parties.

7.6.8 Deliberations. In reaching its conclusions of fact and making its recommendations, the Appeals Subcommittee must satisfy itself that there has been a reasonable effort to obtain the facts and must act:

7.6.8.1 In the reasonable belief that the recommendation is in furtherance of quality healthcare; and

7.6.8.2 In the reasonable belief that the action is warranted by the facts known after reasonable effort to obtain such facts.

7.6.9 Action Taken. As soon as practicable after adjournment of the appellate review, the Appeals Subcommittee shall prepare its report and recommendation. The General Counsel shall send a copy of the report and recommendation to the practitioner and to the President/Chief of the Medical Staff for transmittal to the Executive Committee. The report and recommendation will be presented to the Medical Staff Subcommittee, which will make a recommendation to the BH Quality and Care Management Committee. The President/Chief of the Medical Staff will be invited to attend the presentation of the report and recommendation to the Medical Staff Subcommittee, but may not remain for the deliberations or the vote.

7.6.9.1 Appeals Subcommittee in Accord with the Executive Committee. If the Appeals Subcommittee's recommendation is in accord with the Executive Committee's last recommendation in the matter, the Medical Staff Subcommittee shall promptly forward its recommendation to the Quality and Care Management Committee along with all relevant documentation.

7.6.9.2 Appeals Subcommittee Not in Accord With the Executive Committee. If the Appeals Subcommittee's recommendation differs from the Executive Committee's last recommendation, the Medical Staff Subcommittee may make a recommendation to the Quality and Care Management Committee or refer the matter back to the Executive Committee for further consideration.

7.6.10 Special Joint Conference Review. Prior to a recommendation by the Medical Staff Subcommittee or the Quality and Care Management Committee or a decision by the Board that differs from the Executive Committee's last recommendation, the Executive Committee will be permitted to request review by a special Joint Conference Subcommittee; provided however that the Executive Committee is entitled to only one Joint Conference review with respect to the adverse recommendation against the practitioner. As soon as practicable after receiving a matter referred to it, a special Joint Conference Subcommittee shall convene to consider the matter and submit its recommendations to the Board.

7.6.11 Number of Appellate Reviews. No practitioner is entitled as a right to more than one appellate review with respect to the subject matter that is the basis of the adverse recommendation or action triggering the right.

7.6.12 Definitions. In Sections 8.5 and 8.6, the following definitions apply:

7.6.12.1 "Administrator" means the administrator or Chief Executive Officer of the applicable BH facility.

7.6.12.2 "President/Chief of the Medical Staff" means the President or the Chief of Staff of the applicable BH facility.

7.6.12.3 "Executive Committee" means the medical executive committee of the Medical Staff that made the adverse recommendation against the practitioner.

7.6.12.4 "Hearing Record" means the transcript with all exhibits thereto, the written report of the ad hoc hearing committee, the Reconsidered Adverse Recommendation of the Executive Committee, and the written statements to the Appeals Subcommittee submitted by the practitioner and the Executive Committee.

7.6.12.5 The "Joint Conference Subcommittee" means the committee composed of equal numbers of medical staff and Board members selected in the manner prescribed in the Banner Health Bylaws.

7.6.12.6 "Reconsidered Adverse Recommendation" means the recommendation made by the Executive Committee after consideration of the written report of the ad hoc hearing committee.

7.7 GENERAL PROVISIONS

7.7.1 Number of Hearings and Reviews Notwithstanding any other provision of these Bylaws, no respondent has a right to request more than one evidentiary hearing and appellate review with respect to the subject matter that is the basis of the Adverse Action triggering the right.

7.7.2 Release By requesting a hearing or appellate review, a respondent agrees to be bound by the provisions of the Bylaws, including those provisions relating to confidentiality, releases and immunity from liability.

7.8 EXCEPTIONS TO HEARING RIGHTS

7.8.1 Appropriateness of Exclusive Contracts

7.8.1.1 Privileges may be reduced or terminated by a Board decision to permit only practitioners with Exclusive Contracts to exercise certain privileges ("closure"). Such closure of a department, section or service pursuant to an Exclusive Contract, or transfer of an existing Exclusive Contract requires prior Executive Committee review of the quality of care issues raised by the proposed closure or transfer. The Executive Committee shall make a finding of appropriateness of the closure or transfer on the basis of available relevant information following notice and opportunity to comment as set forth below. The Board shall report to the Executive Committee the bases for a decision to close or transfer that is contrary to the Executive Committee finding.

- A) The Executive Committee shall find closure of a department, section or service pursuant to an Exclusive Contract to be appropriate where:
 - i) a failure to provide full coverage of a needed service cannot be remedied by less extreme measures, such as mandated call schedules; or
 - ii) irreconcilable differences within an existing department, section or service adversely affecting quality of care have not been resolved by less extreme measures; or
 - iii) closure would produce demonstrable efficiencies that would result in maintaining or improving the ability of the Medical Staff to dispense quality care, which would not have been accomplished through less extreme measures.
- B) The Executive Committee shall find transfer of an existing Exclusive Contract to be appropriate only when
 - i) continued closure of the department, section or service pursuant to an existing contract is found appropriate pursuant to paragraph (1) above, and
 - ii) quality of care is maintained or improved by the transfer.

7.8.1.2 The Medical Staff member(s) whose privileges may be adversely affected by the Executive Committee's finding of appropriateness of the closure of a department, section or service pursuant to an Exclusive Contract, or transfer of an Exclusive Contract, may request a hearing before the Executive Committee provided that:

- A) The hearing shall be limited to the following issues:
 - i) whether the Executive Committee's finding of appropriateness is supported by the evidence;
 - ii) whether the Executive Committee followed its requirement for notice and comment on the issue of appropriateness;
 - iii) in cases of transfer, whether the Executive Committee's determination of effect on quality of care was appropriate.
- B) All requests for such a hearing will be consolidated. Should an affected medical Staff member request a hearing under this subsection, the Executive Committee's recommendation regarding the Exclusive Contract would be deferred, pending the outcome of the hearing before the Executive Committee.
- C) A Medical Staff member providing professional services under a contract with the Hospital shall not have his/her privileges terminated for reasons pertaining to the quality of care provided by the Medical Staff member without the same rights of hearing and appeal that are available to all members of the Medical Staff.
- D) Unless an existing Exclusive Contract is transferred pursuant to this Section 7.8.1. or unless the Exclusive Contract provides otherwise, a decision to terminate an Exclusive Contract shall not affect the privileges of Medical Staff members who were performing services pursuant to that contract, except that their privileges shall no longer be exclusive.
- E) Except as provided in Section 7.8.1.2(D), terms of this Section 7.8.1. will take precedence over any inconsistent terms in a contract between a member of the Medical Staff and the Hospital.

7.8.2 Automatic Suspension or Limitation of Practice Privileges No hearing is required when a member's privileges have been revoked or suspended as set forth in Section 6.6 except as provided in that Section.

7.8.3 Department/Service Formation or Elimination

7.8.3.1 A Medical Staff or Hospital department or service may be formed or eliminated only following expeditious Executive Committee review of the effects on quality of care in the Hospital and/or community by the proposed formation or elimination. The Executive Committee shall make a finding of appropriateness of formation or elimination on the basis of available relevant information following notice and opportunity to comment. The Board shall report to the Executive Committee the bases for an administrative decision to form or eliminate that is contrary to the Executive Committee finding.

7.8.3.2 The Medical Staff member(s) whose privileges may be adversely affected by an Executive Committee finding of appropriateness of department/service elimination may request an interview before the Executive Committee, provided that:

- A) the interview shall be limited to the following issues:
 - i) whether the Medical Staff finding of appropriateness is supported by the evidence, and
 - ii) whether the Medical Staff followed its requirements for notice and comment on the issue of appropriateness.
- B) all requests for such an interview will be consolidated. Should an affected Medical Staff member request an interview under this subsection, the Medical Staff recommendation regarding the department/service elimination would be deferred, pending the outcome of the interview.

ARTICLE VIII : OFFICERS AND OTHER MEDICAL STAFF REPRESENTATIVES

8.1 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.

8.2 QUALIFICATIONS OF GENERAL OFFICERS Each General Officer must:

8.2.1 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.

8.2.2 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.

8.2.3 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.

8.2.4 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.

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

8.2.6 Additional Qualifications

8.2.6.1 Transitional Vice President

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

8.2.6.2 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.

8.3 TERMS OF OFFICE

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

8.3.2 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.

8.3.3 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.

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

- 8.3.5 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.
- 8.3.6 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.
- 8.3.6 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.

8.4 NOMINATION AND ELECTION OF OFFICERS AND OTHER REPRESENTATIVES

8.4.1 Nominating Committee

8.4.1.1 Composition The Nominating Committee shall consist of the President, the five (5) most recent Immediate Past Presidents, the Treasurer, Cardon Children's Officer and any two (2) department chairmen appointed by the Executive Committee. The Nominating Committee shall select by vote a chairman from among its members.

8.4.1.2 Function For Medical Staff elections, the Nominating Committee shall prepare ballots of nominees who meet the criteria established by these Bylaws. Succession planning will be an item of topic for the Nominating Committee.

8.4.2 Cardon Children's Officer Nomination Process

8.4.2.1 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.

8.4.2.2 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).

8.4.2.2 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.

8.4.3 Process of Nominating

8.4.3.1 Department Each department shall prepare a slate of nominees for chair at their

respective June meetings according to the policies and procedures for the department. The Nominating Committee shall then prepare a separate ballot for each department electing a chair, which shall consist of the selected nominees.

8.4.3.2 Officers The Nominating Committee shall prepare a slate of nominees during odd-numbered years for President, President-Elect and Treasurer. Separate ballots shall be prepared based upon the timing of each office.

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

8.4.3.3 Before a name is placed on a ballot, the Nominating 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.

8.4.3.4 The Treasurer shall give written notice of the nominations to all active staff members of the Medical Staff 30 days prior to the September MEC meeting for Department Chairs and Treasurer positions and 30 days prior to the May MEC meeting for President-Elect. A written request to place a name on the ballot may also be made by any active staff member and must include evidence that the potential nominee meets the qualifications for office and consents to the nomination. Such petition must be submitted before the September and May Executive Committee meeting for consideration. Such nominees must also disclose potential conflicts of interest.

8.4.3.5 The Nominating Committee shall present the completed slate of nominations to the Executive Committee at the September and May meeting of that Committee and shall assemble when necessary to prepare such slates. The Executive Committee shall approve or modify the ballots.

8.4.3.5 Prior to the election, 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 (8.8).

8.4.3.6 The Treasurer shall then prepare the official ballots consisting of the names of the nominees, along with a 150 word maximum bio prepared by the nominees indicating why they feel they are qualified to serve in the position. The content of the bios must be approved by the Treasurer. The ballot shall also contain a space for a write-in candidate with a line after each for marking of the ballots.

8.4.4 Processing of Balloting

8.4.4.1 Only Active Staff members shall be eligible to vote.

8.4.4.2 Ballots with each department's nominees shall be mailed/**emailed** only to Active Staff members of that department. The official ballots for election of officers shall be mailed/emailed by the Treasurer through the Medical Staff Services Office with a written announcement of the deadline for receipt of the ballots in order to be valid. This date, specified by the Treasurer, shall be not less than two (2) or more than three (3) weeks after the distribution of the ballots. Electronic ballots will be processed utilizing a confidential/secure software program approved by the Treasurer.

8.4.4.3 The 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.

8.4.5 Election of Officers

8.4.5.1 A majority of votes cast on any ballot shall be necessary to elect. If more than two (2) nominees appear on a ballot and no nominee receives a majority of the votes cast on the ballot, all of the nominees except the two (2) highest shall be eliminated, and the Staff shall vote on these two (2) nominees in the same manner as provided in paragraph c of this Section. The nominee then drawing the majority of the votes shall be declared winner.

8.4.5.2 In case the only two (2) nominees for an office receive an equal number of votes, election shall be determined by a vote of the Nominating Committee.

8.5 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:

8.5.1 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

8.5.2 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.

8.6 VACANCIES IN OFFICERS AND OTHER REPRESENTATIVES

8.6.1 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.

8.6.2 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.

8.6.3 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.

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

8.7 RESPONSIBILITIES OF OFFICERS

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

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

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

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

8.7.1.4 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;

8.7.1.5 designate the chairperson of all Staff committees consistent with these Bylaws and

appoint committee members after consultation with the chairpersons;

8.7.1.6 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;

8.7.1.7 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;

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

8.7.1.9 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;

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

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

8.7.1.12 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.

8.7.2 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.

8.7.3 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.

8.7.4 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).

8.7.5 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.

8.7.6 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.

8.7.7 Service Excellence Officer

The responsibilities of the Service Excellence Officer 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

8.8 MEDICAL STAFF CONFLICT OF INTEREST POLICY

8.8.1 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.

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

8.8.3 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.

8.8.4 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.

8.8.5 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.

8.8.6 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.:

8.8.6.1 Abstention from voting on the matter to which the conflict relates.

8.8.6.2 Recusal from the decision-making process.

8.8.6.3 Non-receipt of written and/or verbal information related to the matter to which the conflict relates.

8.8.7 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 IX: DEPARTMENTALIZATION OF THE STAFF

9.1 THE MEDICAL STAFF

9.1.1 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.

9.1.1.1 Clinical Departments. The current clinical departments are:

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

9.1.2 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.

9.1.3 Functions of Departments and Sections

9.1.3.1 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.

9.1.3.2 Organization and Functions of Sections. Each section shall perform the functions assigned to it by the department in addition to those described in Section 9.1.3.1 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.

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

9.1.4.1 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.

9.1.4.2 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

9.1.5 Duties of the Department and Section Chair

9.1.5.1 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.

9.1.5.2 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.

9.1.6 Vice Chairs of Departments and Sections

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

9.1.6.2 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 X: COMMITTEES

10.1 GENERAL PROVISIONS

10.1.1 Committees shall be designated as:

- 10.1.1.1 The Executive Committee
- 10.1.1.2 Standing Committees
- 10.1.1.3 Department, Section and Service Committees
- 10.1.1.4 Joint Committees

10.1.2 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.

10.1.3 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).

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

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

10.1.6 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.

10.1.7 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.

10.1.8 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.

10.1.9 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.

10.2 THE EXECUTIVE COMMITTEE

10.2.1 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 9.1.6.

10.2.2 Selection of Executive Committee Members

10.2.2.1 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.

10.2.3 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:

- 10.2.3.1 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;

10.2.3.2 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

- k) mechanisms of the Hospital and Medical Staff;
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.

10.2.3.3 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.

10.3 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.

10.3.1 Bioethics Committee

- 10.3.1.1 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. It 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.

- 10.3.1.2 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.

10.3.2 Bylaws Committee

10.3.2.1 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.

10.3.2.2 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.

10.3.3 Credentials Committee

10.3.3.1 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.

- 10.3.3.2 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.

10.3.4 Infection Control Committee

10.3.4.1 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.

10.3.4.2 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.

10.3.5 Operating Room Committee

10.3.5.1 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.

10.3.5.2 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.

10.3.6 Pharmacy and Therapeutics Committee

10.3.6.1 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.

10.3.6.2 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.

10.3.7 Professional Conduct Committee

10.3.7.1 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.

10.3.7.2 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.

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

10.3.8 Practitioner Wellness Committee

10.3.8.1 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.

10.3.8.2 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.

10.3.8.3 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.

10.3.9 Core Measures Committee

10.3.8.1 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.

10.3.8.2 **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 indicators 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.

10.3.10 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.

10.3.11 Quality Initiative Committee

10.3.10.1 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) 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 adult-program medical directors to discuss initiatives with Medical Staff.

10.3.10.2 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.

10.3.10.3 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

10.3.10.4 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) Recommendations. 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.

10.3.12 Pediatric Quality and Performance Improvement Committee

10.3.11.1 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.

10.3.11.2 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

10.3.11.3 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.

10.3.11.4 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/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.
 - 2) Banner Cardon Children's Initiatives
 - 3) 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
 - 4) Voice Survey
 - 1) Results
 - 5) 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
 - 6) Infection Prevention/Infection Control (IPIC)
 - 7) Code Arrest Rapid Response Team (CARRT)
 - 8) Medication Safety Reviews

10.3.13 Trauma Multidisciplinary Peer Review Committees

10.3.12.1 Adult Committee

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

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

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

10.3.12.1.4 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.

10.3.12.2 Pediatric Committee

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

10.3.12.2.2 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.

10.3.12.2.3 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.

10.3.12.2.4 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.

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

10.4.1 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]

10.4.2 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.

10.4.3 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.

10.4.4 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 XI: STAFF MEETINGS

11.1 REGULAR MEETINGS

11.1.1 There shall be regular semi-annual meetings of the Staff each year, the date and place to be determined by the President. The last semi-annual meeting shall be designated the Annual Meeting.

11.1.2 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. Minutes of the General Staff meetings will be posted electronically on the physician intranet information page.

11.1.3 The Administrator and/or designee and the Director of Nursing or designee, shall attend regular Staff meetings.

11.1.4 Staff members may invite professional guests to attend these meetings. 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.

11.1.5 Agenda

11.1.5.1 The agenda of all regular Staff meetings shall be developed by the President of the Medical Staff.

11.2 SPECIAL MEETINGS

11.2.1 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.

11.2.2 Notice stating the place, day, hour and purpose of any special meeting of the Staff shall be delivered by mail to each member of the Active and Associate Staffs at least ten (10) days prior to the date of such meeting. Notice of the meeting shall be deemed delivered when deposited, postage prepared, in the U.S. Mail, addressed to each Staff member at his address as it appears on the records of the Hospital. 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.

11.2.3 Agenda at Special Meetings shall be:

- 11.2.3.1 reading of the notice calling the meeting;
- 11.2.3.2 transaction of business for which the meeting was called; and
- 11.2.3.4 adjournment.

11.3 QUORUM OF THE ACTIVE STAFF. The presence of one-third (1/3) or more of the total membership of the Active Staff at any regular or special meeting shall constitute a quorum of Active Staff.

11.4 MANNER OF ACTION. The action of a majority of the Active Staff members present at a meeting at which a quorum is present shall be the action of the Staff, except that a two-thirds (2/3) vote shall be required to override any action of the Executive Committee, and as may otherwise be expressly provided for in these Bylaws.

11.5 CONDUCT OF MEETING. All meetings of the Staff shall be conducted according to Robert's Rules of Order, Revised, unless specifically modified by these Bylaws. The President-Elect of the Staff shall act as Parliamentarian. In his absence, the President shall appoint another member of the Executive Committee to act as Parliamentarian.

11.6 MEETING ATTENDANCE REQUIREMENTS shall be as specified in Article 12.

ARTICLE XII:
DEPARTMENT, SECTION, SERVICE AND STANDING COMMITTEE MEETINGS:
DEPARTMENT AND SECTION MEETINGS

12.1 GENERAL PROVISIONS

12.1.1 Quorum. Quorum requires the presence of members as follows:

- 12.1.1.1 Meetings of Departments and Sections: 50% of Active Staff members, unless otherwise specified in the policies of the Department or Section.
- 12.1.1.2 Meetings of Department Committees and Section Committees: 3 Active Staff members.
- 12.1.1.3 Meetings of Standing and Service Committees: 50% of voting members.
- 12.1.1.4 Affiliate Staff Meetings: 50% of all members.

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.

12.1.2 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.

12.1.3 Conduct of Meetings.

12.1.3.1 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.

12.1.3.2 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.

12.1.4 Policy on Conflict of Interest in Peer Review. The Medical Staff policy on conflict of interest in peer review is intended to encourage responsible peer review and to preserve the integrity of the peer review process by promoting impartiality of Medical Staff decision-makers and fairness for Medical Staff members and applicants under review. Medical Staff peer review activities are intended to improve the quality of patient care in the Hospital. Privileging decisions should always be based upon the training, experience and demonstrated competence of candidates; and be made in the reasonable belief that they are appropriate, warranted by the facts and designed to further quality health care. Physicians involved in granting, denying or terminating privileges have an ethical responsibility to be guided primarily by concern for the welfare and best interests of patients. Such physicians should disclose material financial and personal interest whenever relevant that could cause bias or conflict with their peer review responsibilities. Practicing in the same specialty as the practitioner under review does not in itself constitute a financial interest for purposes of this Policy.

12.1.5 Notice of Meetings.

- 12.1.5.1 Regular Meetings. Upon designation of the time and place for regular meetings, no other notice shall be necessary, although mailed reminders shall be mailed

by Medical Staff Services.

12.1.5.2 Special Meetings. Written or oral notice stating the time and place of a special meeting or a change in the schedule for a regular meeting, shall be given to each member of the department, section or committee not less than five (5) days before the time of such meeting, except in instances of Summary and Continuing Suspensions as provided in Section 6.5. If mailed, the notice of the meeting shall be deemed delivered when deposited in the U.S. Mail addressed to the member at his address as it appears on the records of the Hospital with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such a meeting.

12.1.6 Meeting Attendance.

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

12.1.6.3 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.

12.2 DEPARTMENT AND SECTION MEETINGS

12.2.1 Regular Meetings. Departments and sections need not hold regular meetings. All department and section members are invited to attend their respective department or section committee's general sessions.

12.2.2 Special Meetings. A special meeting of a Medical Staff department or section may be called by the chairman, the President of the Staff, or one-third (1/3) of the department or section's Active Staff members. Special meetings of Affiliate Staff sections may be called by the chairman, the President or one-third (1/3) of the section's members. The agenda shall be limited to (a) reading the notice calling the meeting; (b) transacting the business for which the meeting was called; and (c) adjournment.

12.3 COMMITTEE MEETINGS

12.3.1 Meeting Frequency.

12.3.1.1 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).

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

12.3.1.3 Service Committees shall hold regular meetings as necessary, but not less than

semi-annually.

12.3.2 Special Meetings. A special meeting may be called by the chairman, the President of the Staff, or by one-third (1/3) of the committee's members, but not less than two members.

12.3.3 Agenda.

12.3.3.1 Regular Meetings. The agenda shall be determined by the chairman of the committee, but shall include the acceptance of the minutes of the last regular and all special meetings since the last regular meeting. Executive Committee meetings shall include reports from all standing, department, section, service and special committees, and the Administrator.

12.3.3.2 Special Meetings. The agenda for special meetings shall be limited to (a) reading the notice calling the meeting; (b) transacting the business for which the meeting was called; and (c) adjournment.

ARTICLE XIII:
IMMUNITY FROM LIABILITY AND INDEMNIFICATION

13.1 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:

13.1.1 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.

13.1.2 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 13, 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.

13.1.3 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.

13.1.4 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:

- 13.1.4.1 application for appointment or privileges
- 13.1.4.2 periodic reappraisals for reappointment or privileges
- 13.1.4.3 corrective action, including summary suspension
- 13.1.4.4 hearings and appellate reviews
- 13.1.4.5 patient care evaluations
- 13.1.4.6 utilization reviews, and
- 13.1.4.7 other Hospital, department, section or committee activities related to quality patient care and inter-professional conduct.

13.1.5 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.

13.1.6 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 **13.1.2**, subject to such requirements as may be applicable under the laws of this State.

13.1.7 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.

13.2 INDEMNIFICATION.

13.2.1 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:

13.2.1.1 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;

13.2.1.2 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

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

13.2.2 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 XIV: **CREDENTIALS PROCEDURE MANUAL, MEDICAL STAFF RULES AND REGULATIONS AND** **ALLIED HEALTH RULES AND REGULATIONS**

14.1 Periodic Review. The Credentials Procedure Manual, 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.

14.2 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, 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.

14.3 Medical Staff Amendments. The Medical Staff may propose amendments to the Credentials Procedure Manual, 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 XV: POLICIES AND PROCEDURES

15.1. DEFINITION. Policies and Procedures are those guidelines for individual departments, sections, services and standing committees necessary to implement the principles of these Bylaws and the Staff Rules and Regulations.

15.2 DEPARTMENT POLICIES AND PROCEDURES

15.2.1 Manner of Revision. It shall be the responsibility of each department and section committee to review its policies and procedures biannually and to make recommendations to the department or section for passage or amendment of policies and procedures pertaining to the functions of the department or section. Any member of a department or section may propose changes in policies and procedures at any regular meeting or special meeting (called for the purpose) of the department or section.

15.2.2 Board Approval. Policies and procedures governing the qualifications, privileges, restrictions and conduct of individual Staff members, including Affiliate Staff members and sections, shall be formulated and adopted by the departments and sections subject to Board approval.

15.2.3 Consistency. The department and section policies and procedures shall be consistent with the policies of the Staff and the Board.

15.2.4 House Staff. Each department of the Staff that develops a postgraduate physician training program shall formulate and administer policies and procedures providing for the utilization of this house staff within the department. Any Staff member who does not wish to participate in such training program shall not, for this reason alone, be subject to change in status of Staff membership, clinical privileges or other Medical Staff prerogatives. If a Medical Staff policy is formulated that permits patient care orders to be written by members of the house staff, the policy must not be extended to prohibit orders being written by the patient's private physician without his agreement.

15.4 STANDING COMMITTEE POLICIES AND PROCEDURES

16.5.1 It shall be the responsibility of each standing committee to make recommendations to the Executive Committee for passage or amendment of policies and procedures pertaining to its function unless the function is defined in the Medical Staff Bylaws.

16.6.2 When approved by the standing committee, policies and procedures shall be forwarded to the Bylaws Committee for its review and recommendations before their submission to the Executive Committee for action.

ARTICLE XVI: AMENDMENTS

ADOPTION AND AMENDMENT

16.1 **MEDICAL STAFF AUTHORITY AND RESPONSIBILITY.** The Medical Staff shall be responsible for the development, 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.

16.2 **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.

16.3 **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.

16.4 **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.

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

ARTICLE XVII **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