Banner Thunderbird®
Medical Center

MEDICAL STAFF BYLAWS

Revised: March 14, 2019

BANNER THUNDERBIRD MEDICAL CENTER

Glendale, Arizona

BYLAWS OF THE MEDICAL STAFF

TABLE OF CONTENTS

BANNER THUNDERBIRD MEDICAL CENTER

Glendale, Arizona
BYLAWS OF THE MEDICAL STAFF

ARTICLE ONE: NAME

1.1 NAME

The name of this organization is "The Medical Staff of Banner Thunderbird Medical Center."

ARTICLE TWO: PURPOSES

2.1 PURPOSES

The purposes of the Medical Staff are:

2.1-1 To continually seek to provide quality care for all patients admitted to, or treated in, any facilities, departments, or service of Banner Thunderbird Medical Center (the "Medical Center").

2.1-2 To provide a mechanism for accountability to the Banner Health ("BH") Board of Directors ("Board"), through defined organizational structures, for the review of the appropriateness of patient care services, professional and ethical conduct and teaching and research activities of each practitioner appointed to the Medical Staff, so that patient care provided at the Medical Center's facilities is maintained at that level of quality and efficiency consistent with generally recognized standards of care.

2.1-3 To provide an appropriate educational setting and to maintain high scientific and educational standards for continuing medical education programs for residents, fellows and Members of the Medical Staff ("Members" or "Staff Members").

2.1-4 To serve as the organization through which individual practitioners may obtain prerogatives and clinical privileges at the Medical Center and through which they fulfill the obligations of Staff appointment.

2.1-5 To provide an orderly and systematic means by which Staff Members can give input to the Board and the Medical Center's chief executive officer ("CEO") on medico-administrative issues and on Medical Center policy-making and planning processes.

2.2 RESPONSIBILITIES

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

2.2-1 To participate in performance improvement and utilization review programs by conducting all activities necessary for assessing, maintaining, and improving the quality and efficiency of care provided in the Medical Center, including:

(a) Evaluating practitioner and institutional performance through measurement systems based on objective, clinically-sound criteria;

(b) Engaging in the ongoing assessment and monitoring of patient care and safety practices; including assessing processes, conducting Significant Clinical Event root cause analyses to improve patient care and safety practices, and monitoring the effectiveness of such improvements.

(c) Evaluating practitioners' credentials for appointment and reappointment to the Medical Staff and for the delineation of clinical privileges; and

(d) Promoting the appropriate use of Medical Center resources.

2.2-2 To make recommendations to the Board concerning appointments and reappointments to the Staff, including category and department assignments, clinical privileges, and corrective action.

2.2-3 To participate in the development, conduct, and monitoring of medical education programs and clinical research activities.

2.2-4 To develop and maintain Bylaws, Rules and Regulations and Policies that are consistent with sound professional practices, and to take action, as necessary, to enforce them.

2.2-5 To participate in the Medical Center's long-range planning activities, to assist in identifying community health needs, and to participate in developing and implementing appropriate institutional policies and programs to meet those needs.

2.2-6 To exercise through its officers, committees, departments and other defined components, the authority granted by these Bylaws, to fulfill these responsibilities in a timely and proper manner, and to account thereon to the Board.

ARTICLE THREE: MEMBERSHIP

3.1 QUALIFICATIONS

Staff membership is a privilege extended to practitioners who continuously meet standards and requirements set forth in these Bylaws. Every practitioner who seeks or enjoys Staff membership must, at the time of application and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board, the following qualifications and any additional qualifications and procedural requirements as set forth in these Bylaws or in department rules and regulations.

3.1-1 Licensure

Applicants for Medical Staff membership ("Applicants") and Members must have evidence of a currently valid license issued by the State of Arizona to practice either medicine and surgery, dentistry, podiatry, optometry or psychology.

3.1-2 Professional Education and Training

a. Applicants must have graduated from an approved medical, dental, podiatric school or school of osteopathy or attainment of a Ph.D. degree in psychology. Foreign Medical Graduates must be certified by the Educational Council for Foreign Medical Graduates, or must have successfully completed the Foreign Medical Graduate Examination in the Medical Sciences. For purposes of this section, an "approved" or "accredited" school is one fully accredited for the entire time of the practitioner's attendance by the Accreditation Council for Graduate Medical Education (*"ACGME"*), by the American Osteopathic Association (*"AOA"*), by the Royal College of Physicians and Surgeons of Canada, by the Commission on Dental Accreditation, by the American Podiatric Medical Association's accrediting body, the Council on Podiatric Medical Education, or by a successor agency to any of the foregoing; and

b. Applicants (other than podiatrists, dentists, optometrists and psychologists) must demonstrate satisfactory completion of postgraduate training in an internship or residency accredited by the ACGME, the AOA, or the Royal College of Physicians and Surgeons of Canada, with such postgraduate training to be in a field or specialty appropriate and acceptable to the department to which the applicant would be assigned if appointed to the Staff. Applicants must provide evidence that he/she is within the board examination system or board certified in the specialty in which privileges have been requested; and

c. Applicants for the Affiliate Staff who are optometrists must complete a four year post-graduate degree program in Optometry from an accredited school or college of Optometry recognized by the Accreditation Council on Optometric Education (ACOE) AND completion of a one year residency program associated with an accredited school or college of Optometry or equivalent experience.

d. Applicants for the Affiliate Staff who are podiatrists and dentists must demonstrate satisfactory completion of a postgraduate training program accredited by the American Podiatric Association's accrediting body, the Council on Podiatric Medical Education or the Commission on Dental Accreditation; and

e. Applicants for the Affiliate Staff who are psychologists must possess a Ph.D. degree in psychology from a program approved by the American Psychological Association, possess certification by the American Board of Professional Psychologists, be currently listed in the National Register of Health Services Providers in Psychology, or meet the educational requirements for licensure in the State of

Arizona. Applicants must also demonstrate at least one year full-time experience or its equivalent in an inpatient setting (either pre- or post-doctoral) or in a mental health care setting.

3.1-3 **Clinical Performance**

Applicants and Members must have current experience, clinical results and utilization practice patterns, documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency. Each Clinical Department is responsible for developing and describing in its Rules and Regulations the process for the delineation of clinical privileges to individual practitioners.

3.1-4 **Attitude**

Applicants and Members must display a willingness and capability to work with others in a cooperative, professional manner appropriate to quality patient care with full participation in the discharge of appropriate Staff obligations.

3.1-5 **Disability**

Applicants and Members must be free from, or exhibit adequate control of, any significant physical, mental or behavioral impairment that may adversely affect the ability to provide quality patient care or to satisfy the other qualifications for membership.

3.1-6 **Professional Ethics and Conduct**

(a) Applicants and Members must demonstrate high moral character and adherence to generally recognized standards of medical and professional ethics including, but not limited to, refraining from paying or accepting commissions or referral fees for professional services, or delegating the responsibility for diagnosis or care of patients to a practitioner or allied health professional not qualified to undertake that responsibility; seeking appropriate consultation when medically indicated; providing or arranging for appropriate and timely medical coverage and care for patients for whom the practitioner is responsible; and obtaining informed patient consent to perform procedures and treatments.

(b) Members must maintain the confidentiality of peer review activities of the Medical Staff. Members may make no voluntary disclosures of such information except to persons authorized to receive it in the conduct of Medical Staff affairs.

3.1-7 **Board Certification**

(a) Membership on the Medical Staff does not require board certification. However, except as specially provided below, having Medical Staff privileges to practice at the Medical Center requires the applicant and Members to either be board certified or board qualified followed by board certification in the area of practice for which the applicant or Member is requesting Medical Staff privileges, as provided in Section 3.1-7(c) by one of the following:

Physician	The American Board of Medical Specialties, the American Osteopathic Association or the Royal College of Physicians and Surgeons of Canada;
Podiatrist	The American Board of Podiatric Medicine; or The American Board of Foot and Ankle Surgery;
Dentist	A specialty recognized by the American Board of Dental Specialties or the American Board of Pediatric Dentistry; or
Psychologist	The American Board of Professional Psychologists.

(b) For purposes of this section, "board qualification" or "board qualified" means the applicant or Member has completed the training necessary to be accepted to become, and has applied for and been accepted to become, an active candidate for board certification as determined by the appropriate board. Where the board requires a period of practice prior to submitting an application for board certification, the applicant will be deemed qualified during this time period if the director of his/her training program certifies that he/she has met all training requirements for qualification by the appropriate board.

(c) Where Medical Staff privileges are granted on the basis of being board qualified certification must be obtained within five 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 the Member's Medical Staff privileges.

For purposes of this section, "Board certification" or "Board certified" means certified by a board approved by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, the Royal College of Physicians and Surgeons of Canada, the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery, the American Dental Association or the American Board of Professional Psychologists or by a board determined by the department and Medical Executive Committee to be equivalent.

(d) Members are required to remain board certified if they wish to maintain their privileges. Recertification must be obtained within three years from the expiration of board certification or recertification. Failure to become recertified within the time allowed under these Bylaws shall result in the voluntary, automatic relinquishment of Medical Staff privileges.

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

1. Those Members of the Medical Staff as of January 10, 1995, as long as they continuously qualify for and maintain membership as otherwise specified in these Bylaws or the Rules and Regulations of the applicable department; 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;
2. Where a particular field or specialty does not have a board certification;
3. Where privileges are limited to surgical assisting; or
4. To applicants or 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 and where the Medical Executive Committee has determined that the practitioner's training and experience approximates as nearly as possible those required to obtain board certification.

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

1. 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
2. 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. In the event the

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

3. Members of the Medical Staff who are within the initial board qualification stage after training and whose board allows for a longer period of time within which to become board certified.

(f) Any Member who is granted a waiver must obtain a minimum of fifty (50) hours of continuing medical education each year in order to remain a Member of the Medical Staff. Evidence of such continuing medical education shall be submitted to the Medical Staff Services Office of the Medical Center each year on or before the anniversary date of such Member's date of appointment to the Medical Staff. The failure by a Member who has been granted a waiver pursuant to this Paragraph to obtain required CME will result in the voluntary relinquishment of Medical Staff privileges.

(g) Members of the Medical Staff who have never been board certified, who are no longer board qualified and who were Members of the Medical Staff as of June 11, 2009 may request and be granted a waiver in the manner specified above.

3.1-8 **Communication Skills**

Applicants and Members must be able to read and understand the English language and to communicate in writing and verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible manner.

3.1-9 **Effect of Other Affiliations**

No practitioner shall be automatically entitled to appointment, reappointment or the exercise of particular clinical privileges merely because of:

(a) Licensure to practice in this or in any other State; or
(b) Certification by a clinical board; or
(c) Staff appointment or privileges at another healthcare facility or in another practice setting; or
(d) Prior Staff appointment or any particular privilege at Banner Thunderbird Medical Center (the "Medical Center").

3.1-10 **Discrimination**

No aspect of Medical Staff appointment or particular clinical privileges shall be denied on the basis of age, sex, race, creed, color, national origin, a handicap unrelated to the ability to fulfill patient care and required Staff obligations or any other criterion unrelated to the delivery of quality and efficient patient care at the Medical Center.

3.1-11 **Professional Liability Insurance**

Members must maintain professional liability insurance with liability limits in an amount as determined from time to time by the Board and with an insurance company that is acceptable to the Board. Members without clinical privileges are not required to maintain professional liability insurance.

Professional qualifications, community need and the Medical Center's purposes, needs and capabilities may influence Medical Staff appointment or particular clinical privileges.

3.2 RIGHTS OF INDIVIDUAL STAFF MEMBERSHIP

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

(a) The right to meet with the Medical Executive Committee in the event he/she is unable to resolve a difficulty working with his/her respective department chairman. The member must submit a written request to the Chief of Staff at least two weeks in advance of the meeting;
(b) The right to initiate the scheduling of a general staff meeting by following the procedures set forth in Section 13.1-3;
(c) The right to challenge any rule or policy established by the Executive Committee by following procedures set forth in Section 14.9-1;
(d) The right to request conflict resolution of any issue by presentation to the Medical Executive Committee of a petition signed by 20% of the Active Staff. Upon receipt of such a petition, the Executive Committee will schedule a meeting to discuss the issue;
(e) The right to request a department meeting when a majority of members in a section or specialty believe that the department has not acted appropriately;
(f) The right to request a hearing pursuant to the Fair Hearing Plan in the event that reviewable corrective action is taken;
(g) The right to request a review by the Medical Executive Committee in the event that non-reviewable corrective action is taken.

3.3 BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP

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

(a) Provide patients with care at the level of quality and efficiency generally recognized as appropriate;
(b) Abide by the BH Bylaws, these Bylaws, Department Rules and Regulations, Code of Conduct approved by the Medical Executive Committee, and all other standards and policies of the Medical Staff and Medical Center;
(c) Discharge such Staff, committee, section, department and Medical Center function for which he or she is responsible;
(d) Avoid conduct which reflects adversely on the practitioner's professional fitness;
Cooperate in any review of a practitioner's (including one's own) credentials, qualifications o compliance with these Bylaws, and refrain from directly or indirectly interfering, obstructing or hindering any such review, whether by threat of harm or liability, by withholding information, by refusing to serve or participate in assigned responsibilities, or otherwise;
(f) Comply with the requests from any two of the following: The Chief Executive Officer, Chief of Staff, Department Chairmen, Section Chairmen or their respective designees, to confirm their current physical and mental capacity to practice medicine and their freedom from, or adequate control of, any physical, mental or behavioral impairment, including substance abuse;
(g) Demonstrate the ability to work cooperatively and professionally with the Medical Center, its professional staff and the Medical Staff, and refrain from disruptive behavior which undermines the culture of safety or the operation of the Medical Center and its Medical Staff;
(h) Prepare and complete in a timely fashion, according to these Bylaws and the Medical Center's policies, the medical and other required records for all patients to whom the practitioner provides care in the Medical Center, or within its facilities, services or departments;
(i) Abide by the ethical principles of the profession including arranging for appropriate and timely medical coverage and caring for patients for whom he or she is responsible and obtaining consultation when necessary for the safety of those patients;
(j) Treat as confidential any information discussed in executive session;
(k) Participate in mandatory call coverage (or pay appropriate assessments, if so permitted by the Executive Committee) and participate in supervisory or consultation panels if, as and when it may be determined necessary by the applicable department(s), the Executive Committee or the Board. Participation in mandatory call coverage is an obligation, and not a right, of membership on the Medical Staff. No one denied the right of such

participation shall have a right to claim damages from the Medical Center or any of its employees or from the Medical Staff or any Staff Member.

(l) Immediately notify the Chief Executive Officer and the Chief of Staff of the revocation or suspension of his/her professional license, the imposition of terms of probation or limitation of his/her practice by any state licensing agency, including any stipulation; the cancellation or restriction of his/her professional liability coverage; or the revocation, suspension or voluntary relinquishment of his/her DEA number; and

(m) Immediately notify the Chief Executive Officer and the Chief of Staff of his/her denial or loss of staff membership or denial, loss, curtailment or restriction of privileges at any hospital or other healthcare institution; any adverse determination by a peer review organization concerning his/her quality of care; the commencement of a formal investigation or the filing of charges by the Department of Health and Human Services or any law enforcement agency or regulatory agency of the United States, the State of Arizona, or any other state; or the denial or loss of his/her right to participate in any federal or state program, including the Medicare and Medicaid (AHCCCS) Programs.

(n) To annually provide Medical Staff Services, on or before the expiration date, written documentation evidencing such practitioner's current licensure, controlled substances registration and professional liability insurance.

Failure to meet these obligations may result in non-reappointment or the imposition of corrective action as provided in these Bylaws.

3.4 TERMS OF APPOINTMENT

Each appointment to the Staff shall be for two years. The appointment of each Member shall expire every two years.

3.5 LEAVE OF ABSENCE

A Staff Member may obtain a voluntary leave of absence for a period not to exceed one (1) year by giving written notice to the applicable department chairman. In no event may a Staff Member be on a voluntary leave of absence for more than one (1) year. During the period of the leave, the Staff Member may not serve as an officer of the Staff and his or her clinical privileges, prerogatives and responsibilities, (including payment of Staff dues) are suspended. The request for such leave shall be transmitted to the Medical Executive Committee, which shall forward its recommendation on the request to the Board for final action.

3.5-1 Reactivation

The Staff Member must request reactivation by sending written notice to Medical Staff Services. The Staff Member must either submit a written summary of his/her relevant activities during the leave or complete an application for reappointment if the term of his/her appointment has expired during the leave of absence. The Staff Member must also provide evidence of current clinical competence, licensure, DEA registration and professional liability insurance. If the Staff member has been on a leave of absence for medical reasons, documentation satisfactory to the Medical Staff including, if requested, a report from a physician selected by the Medical Staff to perform an independent medical examination of the Staff Member's ability to return to his or her former activities shall be provided. Medical Staff Services shall forward the request for reactivation and supporting documentation (and, if applicable, the completed reappointment application) to the department, which shall process the request in accordance with the procedures set forth in Section 7.5.

3.6 REINSTATEMENT

A practitioner may request reinstatement of his/her Medical Staff membership and clinical privileges for up to one (1) year following voluntary resignation from the Medical Staff. A practitioner who requests reinstatement must complete a reappointment application which will be processed in accordance with the procedures outlined in Section 7.5. A practitioner who requests reinstatement more than one (1) year following his/her voluntary resignation from the Medical Staff must submit an application which will be processed in accordance with the procedures outlined in Section 7.4.

3.7 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

3.7-1 Qualifications

All Practitioners rendering professional services at the Medical Center pursuant to contracts or employment with the Medical Center, including all practitioners rendering professional services on behalf of third party payers with which the Medical Center contracts, shall be required to maintain Medical Staff membership and privileges in good standing under the provisions of these Bylaws. Unless otherwise specifically provided in the contracts for professional services, termination of such contract shall not result in automatic termination of Medical Staff membership and privileges. The Department of Surgery shall have the primary departmental responsibility for the Pathologists with respect to appointment, reappointment and the delineation of privileges.

3.7-2 Approval of Positions

Prior to the establishment by the Medical Center or the CEO of any part-time or full-time employed physician position at the Medical Center or any of the departments, such proposed position, including a detailed description of the qualifications required for and the functions of the person who will hold such position, shall be discussed with the applicable department(s) and the Physician Advisory/Contracts Committee, whose comments and recommendations regarding the impact of establishing such position(s) would have on the quality of patient care provided in the Medical Center shall be submitted to the CEO prior to the position being created. In addition, prior to the Medical Center or the CEO filling any such physician position, the Physician Advisory/Contracts Committee shall be entitled to review the qualifications of all candidates for such position and, if the Physician Advisory/Contracts Committee deems it appropriate, to interview all candidates for such position prior to its being filled.

3.8 EXCLUSIVE CONTRACTS

The Medical Center may enter into an Exclusive Agreement with members of the Medical Staff which limit the rights of other practitioners to exercise some or all of the clinical privileges and/or the rights and prerogatives of Medical Staff membership previously granted to them. Such Agreements may only be entered into after a determination that expected improvements to and or continuation of the quality of care, coverage, cost-efficiency and service excellence will outweigh the anticompetitive effect of the Agreement, as required by the Board's Physician Exclusive Agreements policy. No reporting is required under federal or state law when a practitioner's privileges or membership are limited because an Exclusive Agreement is entered into, and no such reports shall be made.

3.9 REVIEW OF POSITIONS

(a) Prior to entering into an Exclusive Agreement for a program or service not previously covered by an Exclusive Agreement, and prior to renewing or transferring an Exclusive Agreement, the CEO shall explain to the Medical Executive Committee the need for, and expected benefits of, the Exclusive Agreement.

(b) The Medical Executive Committee shall give Medical Staff members whose privileges may be adversely affected by the establishment or modification of the Agreement an opportunity to submit written information to the Medical Executive Committee regarding the impact the

establishment of the Agreement would have on the quality of patient care to be provided and/or why the Agreement is not necessary to achieve the expected benefits.

(c) In its discretion, the Medical Executive Committee may submit information to and seek advice and recommendations from the Physician Advisory/Contracts Committee on the issues described in this Section relating to Exclusive Agreements.

(d) The Medical Executive Committee shall be given an opportunity to report its findings to the CEO before the Exclusive Agreement is entered into, renewed or transferred. The report shall be limited to information relating to the impact the Agreement would have on quality of care, including information relating to the qualifications of the practitioners who would be providing services under the Agreement, and whether the Agreement is necessary to achieve the expected benefits. The report must be submitted, if at all, within 60 days of when the CEO provided the Medical Executive Committee with an explanation of the need for, and expected benefits of, the Agreement. The CEO is ultimately responsible for determining, in his/her discretion, whether to enter into, renew or transfer the Agreement.

(e) In the event the Medical Executive Committee disagrees with the decision of the CEO to enter into, renew or transfer an Exclusive Agreement, the Medical Executive Committee may request that the decision be reviewed by a Joint Conference Committee as set forth in Section 17.1. The request must be made, if at all, within 10 days of when the Medical Executive Committee's receives notification of the CEO's decision.

3.10 EXHAUSTION OF ADMINISTRATIVE REMEDIES

Every applicant to and Member of the Medical Staff agrees that when corrective action is initiated or taken or when a recommendation is made by any peer review committee, including the Medical Executive Committee, the effect of which is to deny, revoke, suspend or otherwise limit the privileges or membership of the applicant or Staff Member, he or she shall exhaust the administrative remedies afforded in these Bylaws and the Fair Hearing Plan prior to initiating any legal action.

3.11 LIMITATION OF DAMAGES

Neither the Medical Center, the Medical Staff nor any person involved in carrying out peer review duties or functions for the Medical Center or the Medical Staff may be liable for damages to any applicant to or Member of the Medical Staff who is denied membership on the Medical Staff or privileges to practice in the Medical Center or whose membership or privileges are denied, suspended, limited or revoked. The only legal action which may be maintained by an applicant to or Member of the Medical Staff based on the performance or nonperformance of such duties or functions, or any other violation of these Bylaws, is an action for injunctive relief seeking to correct an erroneous decision or procedure. The review shall be limited to a review of the record. If the record shows that the denial, revocation, limitation or suspension of membership and/or privileges is supported by substantial evidence, no injunction shall issue. In such actions, the prevailing party shall be awarded taxable costs, but no other monetary relief and no attorney's fee shall be awarded.

ARTICLE FOUR: MEDICAL STAFF CATEGORIES

4.1 CATEGORIES

For administrative purposes, the Staff shall be divided into the Medical Staff and Affiliate Staff. Members of the Medical Staff (MD, DO) shall be a member of one of the Staff categories consisting of Active Medical, Courtesy Medical, Honorary Medical, Retired Medical, Remote Medical and Community Based Provider.

4.2 ACTIVE MEDICAL STAFF

4.2-1 Qualifications

The Active Medical Staff shall consist of physicians who are regularly involved in the care of patients or who demonstrate by way of other substantial involvement in Medical Staff or hospital activities, a genuine interest in the Medical Center. Regular involvement in patient

care shall mean admitting, referring or consulting on at least 48 patients. Substantial involvement in Medical Staff or hospital activities can be demonstrated by attending at least one-third of his or her department and/or committee meetings and one General Staff meeting. For purposes of satisfying the patient care requirements described above, being involved in the care of patients treated at outpatient surgical centers affiliated with the Medical Center shall be counted. For purposes of satisfying the attendance requirements described above attendance at a CME conference sponsored by the Medical Center shall be counted as attendance at a committee meeting. Continuation of membership on the Active Medical Staff may be forfeited by any Member who fails to comply with these Bylaws, Rules and Regulations or any other departmental requirements. Active Staff status may be requested, when qualifications are met, anytime after the first provisional year.

4.2-2 **Prerogatives**

An Active Medical Staff Member may:

(a) Admit patients, except as set forth in department Rules and Regulations and Medical Center admission policies;

(b) Exercise such clinical privileges as are granted by the Board;

(c) Vote on all matters presented at general and special meetings of the Medical Staff and of the department and committees of which he or she is a member;

(d) Hold office at any level in the Staff organization and be chairman or a member of a committee, provided the specific qualifications for the position involved are met and except as otherwise provided in these Bylaws or by resolution of the Medical Executive Committee; and

(e) Attend any general meeting of the department or committee of which he/she is not a member, with the consent of the chairman.

4.2-3 **Obligations**

An Active Medical Staff Member, must in addition to meeting the basic obligations set forth in these Bylaws:

(a) Contribute to the organizational, administrative, quality and peer review and utilization management activities of the Medical Staff; be willing to serve in Medical Staff, department offices and on Medical Staff committees; and faithfully perform the duties of any office or position to which elected or appointed;

(b) Participate equitably and appropriately in the discharge of Staff functions, such as continuing education programs; serve on the on-call roster for charity, unassigned and emergency patients as determined by the assigned department and subject to the qualifications set forth in these Bylaws; review and supervise the performance of other practitioners, and fulfill such other Staff functions as may be reasonably required;

(c) Satisfy the meeting attendance and special appearance requirements of the Medical Staff and the assigned department and committee(s); and

(d) Pay all Staff dues and assessments.

4.2-4 **Failure to Satisfy Qualifications**

Failure of an Active Medical Staff Member to satisfy the qualifications or obligations of the Active Medical Staff category for any reappointment period or portion thereof may result in reassignment to another Staff category. The physician will be notified by certified mail or mail, return receipt required. A Medical Staff Member who feels he or she has unjustly been moved from the Active Medical Staff category may request reconsideration of the change by the Medical Executive Committee, but shall not receive the benefit of the Fair Hearing Plan.

4.3 COURTESY MEDICAL STAFF

4.3-1 **Qualifications**

(a) The Courtesy Medical Staff shall consist of physicians who admit patients to the Medical Center only on an occasional basis or who act as consultants.

(b) New appointees to this category shall be on a provisional status for at least one year and but not more than two (2) years. Observation requirements may be imposed by the department at the time of initial appointment and failure to comply with the observation requirements, as required by the department, may result in voluntary relinquishment of his/her staff appointment and privileges.

4.3-2 **Prerogatives**

A Courtesy Medical Staff Member may:

(a) Admit patients, except as set forth in department rules and regulations and Medical Center admission policies;

(b) Exercise such clinical privileges as are granted by the Board;

(c) Be appointed to the committees unless otherwise specified by these Bylaws;

(d) Vote on all matters presented at committees to which he or she has been appointed; and

(e) Attend General Staff and assigned department meetings, without vote.

4.3-3 **Obligations**

A Courtesy Medical Staff Member must, in addition to meeting the basic obligations set forth in these Bylaws:

(a) Demonstrate their continued clinical competency to provide care to patients treated at the Medical Center by providing information regarding current experience, clinical results and utilization practice patterns at either the Medical Center or other hospitals or outpatient surgical centers.

(b) Satisfy the special appearance requirements of the Medical Staff and the assigned department;

(c) Serve on the on-call roster for charity, unassigned and emergency patients as determined by the assigned department and subject to the qualifications set forth in these Bylaws; and

(d) Pay all Staff dues and assessments.

4.3-4 **Change in Staff Category**

Courtesy Medical Staff Members shall be advanced to the Active Medical Staff category at the time the qualifications set forth in Section 4.2-1 are satisfied.

4.4 HONORARY MEDICAL STAFF

4.4-1 **Qualifications**

Membership on the Honorary Medical Staff is by invitation. It is restricted to practitioners for whom, upon retirement from practice, the Medical Executive Committee recommends and the Board approves this status in recognition of significant, prolonged service or other noteworthy contributions to the Medical Center. Honorary Medical Staff Members shall receive a lifelong appointment to the Medical Staff. Specific qualifications under Article 3.1 are waived for the Honorary Medical Staff.

4.4-2 **Prerogatives**

Honorary Staff Members are not eligible to vote or to hold an elected office, and are not required to pay dues or assessments. Honorary Staff Members are not allowed to participate in patient care.

4.5 TELEMEDICINE STAFF

4.5-1 Qualifications

The telemedicine staff shall consist of physicians providing care, treatment and services of patients only via electronic communication link. These physicians are subject to the credentialing and privileges process of the Medical Center.

4.5-2 Prerogatives

A telemedicine staff member may treat patients via electronic communication link, except as set forth in department rules and regulations, privilege criteria and Medical Center policies; exercise such clinical privileges as are granted by the Board; be appointed to committees unless otherwise provided by these Bylaws; and vote on matters presented at committees to which he or she has been appointed unless otherwise limited by these Bylaws or by departmental rules and regulations. A telemedicine member may not vote on matters presented at general and special meetings of the Medical Staff or of the department of which he she is a member; nor hold office at any level of the staff organization.

4.5-3 Obligations

Telemedicine Staff Members must meet the applicable basic obligations set forth in these Bylaws, including the applicable provisions in Section 3.2, pay all staff dues and assessments as determined by the Medical Executive Committee.

4.6 COMMUNITY BASED PROVIDER STAFF

4.6-1 Qualifications

The Community Based Provider Staff shall consist of physicians who are qualified for Medical Staff membership in accordance with Section 3.1 of these Bylaws. Community Based Provider Staff are exempt from board certification requirements and providing ongoing evidence of malpractice insurance. Community Based Provider Staff request services for their patients at the Medical Center, but do not treat patients at the Medical Center. These providers may have access to their patients' health information. Community Based Provider Staff have no clinical privileges.

4.6-2 Prerogatives

The Community Based Provider Staff may:

(a) Order outpatient diagnostic services for patients;
(b) Make courtesy visits to patients, but may not document in the medical record;
(c) Be appointed to committees, including the Community Based Provider Committee, unless otherwise specified by these Bylaws. Community Based Provider Staff may not hold an elected office.
(d) Vote on matters presented at committees to which he or she has been appointed, unless otherwise specified by these Bylaws or by applicable Rules and Regulations;
(e) Attend General Staff meetings, without vote; and
(f) Attend Medical Center continuing medical education programs.

4.6-3 Obligations

The Community Based Provider Staff must satisfy the basic obligations for membership set forth in Section 3.2 of these Bylaws, with the exception of mandatory call noted in Section 3.2-11.

4.6-4 **Change in Staff Category**

Members of the Community Based Provider Staff who wish to exercise clinical privileges at the Medical Center must request a change in staff category and submit requested documentation, including evidence of current clinical competence to perform the privileges requested.

4.6-5 **Denial or Termination**

Members of the Community Based Provider Staff or physicians seeking Community Based Provider Staff status are not entitled to due process rights under the Fair Hearing Plan unless the denial or termination of such status will be reported to the physician's state licensing board or the National Practitioner Data Bank. A physician who believes he or she was wrongly denied Community Based Provider Staff status or was wrongly terminated may submit information to the Executive Committee demonstrating why the denial or termination was unwarranted. The Executive Committee, in its sole discretion, shall decide whether to review the submission. The physician has no appeal or other rights in connection with the Executive Committee's decision.

4.7 CONSULTING STAFF

4.7-1 **Qualifications**

The Consulting Staff shall consist of specialty physicians in select specialties such as dermatology, allergy and immunology, and endocrinology and as approved by the Medical Executive Committee who are qualified for Medical Staff membership in accordance with Section 3.1 of these Bylaws and who treat an average of 10 or fewer patients per year at the Medical Center. Consulting Staff members may not admit but may consult on patients, write orders or document a recommended plan of care in the patient record.

4.7-2 **Prerogatives**

The Consulting Staff may:

(g) Consult and recommend plan of care for patients;

(h) Be appointed to committees unless otherwise specified by these Bylaws. Consulting Staff may not hold an elected office.

(i) Vote on matters presented at committees to which he or she has been appointed, unless otherwise specified by these Bylaws or by applicable Rules and Regulations;

(j) Attend General Staff meetings, without vote; and

(k) Attend Medical Center continuing medical education programs.

4.7-3 **Obligations**

The Consulting Staff must satisfy the basic obligations for membership set forth in Section 3.2 of these Bylaws, with the exception of mandatory call noted in Section 3.2-11. Consulting Staff are exempt from paying Medical Staff dues.

4.7-4 **Change in Staff Category**

Members of the Consulting Staff who no longer meet the low volume requirements must request a change in staff category and submit requested documentation, including evidence of current clinical competence to perform the privileges requested.

4.8 LIMITATION OF PREROGATIVES

The prerogatives set forth under each Staff category are general in nature and may be subject to further limitation by special conditions attached to a practitioner's Staff appointment, by other sections of these Bylaws, by department Rules and Regulations, and by other policies of the Medical Staff or Medical Center.

ARTICLE FIVE: AFFILIATE STAFF CATEGORIES

5.1 CATEGORIES

For administrative purposes, the Staff shall be divided into the Medical Staff and Affiliate Staff. Members of the Affiliate Staff (DPM, DDS, DMD, OD, PhD) shall be a member of one of the Staff categories consisting of Active Affiliate, Courtesy Affiliate, Honorary Affiliate and Retired Affiliate.

5.2 ACTIVE AFFILIATE STAFF

5.2-1 Qualifications

The Active Affiliate Staff shall consist of practitioners who are podiatrists, dentists or Ph.D. psychologists who are involved in the care of twenty-four (24) or more patients at the Medical Center during each calendar year and who attend at least one-third of his or her department and/or committee meetings and one General Staff meeting. For purposes of satisfying the attendance requirements described in the preceding sentence, being involved in the care of patients treated at outpatient surgical centers affiliated with the Medical Center shall be counted. For purposes satisfying the attendance requirements described above, attendance at a CME conference sponsored by the Medical Center shall be counted as attendance at a committee meeting. Active Affiliate Staff Members shall demonstrate a genuine interest in the activities at the Medical Center through substantial involvement in the affairs of the Medical Staff. Each Affiliate Staff Member must meet the above criteria during the previous calendar year to achieve and maintain Active Affiliate Staff membership. Any Affiliate Staff Member who has been involved in the care of twenty-four (24) or more patients at the Medical Center or at affiliated outpatient surgical centers but who has failed to satisfy the meeting attendance requirements described above during any calendar year may submit documentation of other activities demonstrating substantial involvement in the affairs of the Medical Staff and/or the Medical Center to the Medical Executive Committee and request to be granted or continued on Active Affiliate Staff membership. The Medical Executive Committee, or its designee, shall in its discretion determine if such other activities are sufficient to satisfy the requirements necessary to achieve or maintain Active Affiliate Staff membership. Continuation of membership on the Active Affiliate Staff may be forfeited by any Member who fails to comply with these Bylaws, Rules and Regulations or any other departmental requirements.

5.2-2 Prerogatives

An Active Affiliate Staff Member may:

(a) Attend General Staff and department meetings;

(b) Hold office at any level of the Staff organization and be chairman or a member of a committee, provided the specific qualifications for the position involved are met and except as otherwise provided in these Bylaws or by resolution of the Medical Executive Committee.

(c) Vote on all matters presented at general or special meetings of the General Staff and of any department or committee of which he or she is a member; and

(d) Exercise such clinical privileges as are granted by the Board.

5.2-3 Obligations

An Active Affiliate Staff Member must, in addition to meeting the basic obligations set forth in these Bylaws:

(a) Satisfy the meeting attendance and special appearance requirements of the Affiliate Staff and the assigned department and committee(s);
(b) Serve on the on-call roster for charity, unassigned and emergency patients as determined by the assigned department and subject to the qualifications set forth in these Bylaws; and
(c) Pay all Staff dues and assessments.

5.2-4 **Failure to Satisfy Qualifications**

Failure of an Active Affiliate Staff Member to satisfy the qualifications or obligations of the Active Affiliate Staff category for any reappointment period or portion thereof may result in reassignment to another Staff category. The practitioner will be notified by certified mail. An Affiliate Staff Member who feels he or she has unjustly been moved from the Active Affiliate Staff category may request reconsideration of the change by the Medical Executive Committee, but shall not receive the benefit of the Fair Hearing Plan.

5.3 COURTESY AFFILIATE STAFF

5.3-1 **Qualifications**

(a) The Courtesy Affiliate Staff shall consist of practitioners who treat patients at the Medical Center only on an occasional basis.
(b) New appointees to this category shall be on a provisional status for at least one (1) year but not to exceed two (2) years. Observation requirements may be imposed by the department at the time of initial appointment and failure to comply with the observations requirements of the department may result in voluntary relinquishment of his/her staff appointment and privileges.

5.3-2 **Prerogatives**

A Courtesy Affiliate Staff Member may:

(a) Exercise such clinical privileges as are granted by the Board;
(b) Be appointed to the committees unless otherwise specified by these Bylaws;
(c) Vote on all matters presented at committees to which he or she has been appointed; and
(d) Attend General Staff and assigned department meetings, without vote.

5.3-3 **Obligations**

A Courtesy Affiliate Staff Member must, in addition to meeting the basic obligations set forth in these Bylaws:

(a) Demonstrate their continued clinical competency to provide care to patients treated at the Medical Center by providing information regarding current experience, clinical results and utilization practice patterns at either the Medical Center or other hospitals or outpatient surgical centers;
(b) Satisfy the special appearance requirements of the Affiliate Staff and the assigned department;
(c) Serve on the on-call roster for charity, unassigned and emergency patients as determined by the assigned department and subject to the qualifications set forth in these Bylaws; and
(d) Pay all Staff dues and assessments.

5.3-4 **Change in Staff Category**

Courtesy Affiliate Staff Members shall be advanced to the Active Affiliate Staff category at the time of reappointment if the qualifications set forth in Section 5.2-1 are satisfied.

5.4 HONORARY AFFILIATE STAFF

5.4-1 **Qualifications**

Membership on the Honorary Affiliate Staff is by invitation. It is restricted to practitioners for whom, upon retirement from practice, the Medical Executive Committee recommends and the Board approves this status in recognition of significant, prolonged service or other noteworthy contributions to the Medical Center. Honorary Affiliate Staff Members shall receive a lifelong appointment to the Affiliate Staff. Specific qualifications under Article 3.1 for the Staff categories are waived for the Honorary Affiliate Staff.

5.4-2 **Prerogatives**

Honorary Affiliate Staff Members are not eligible to vote or to hold an elected office, are not required to pay dues or assessments and are not allowed to participate in patient care.

ARTICLE SIX: ALLIED HEALTH PROFESSIONALS

6.1 ALLIED HEALTH PROFESSIONALS DEFINED

Allied Health Professionals (AHPs) are individuals who provide services in the Medical Center, who are not members of the Medical Staff, but whose practice fits in one of the categories listed in Section 6.2 of these Bylaws and who:

6.1-1 Are qualified by training, experience and current competence in a discipline permitted to practice in the Hospital;

6.1-2 Function in a medical support role to physicians who have agreed to work with such AHPs;

6.1-3 Qualify for a category of AHPs approved by the Medical Executive Committee and the Board;

6.1-4 Meet the applicable qualifications set forth in Section 3.1; and

6.1-5 Follow established hospital policies and procedures.

6.2 CATEGORIES OF AHPs CURRENTLY AUTHORIZED TO FUNCTION IN THE MEDICAL CENTER

The following categories of AHPs are authorized to provide services in the Medical Center: Advanced Practice Professionals (APP) and Ancillary Staff (AS). If and when appropriate, the Medical Executive Committee may recommend the addition or elimination of categories of AHPs authorized to provide services in the Medical Center. Such recommendation shall become effective upon Board approval and shall not require formal amendment of these Bylaws.

6.3 PROCESS FOR ALLIED HEALTH PROFESSIONALS TO APPLY FOR PRIVILEGES

Completed applications by AHP (APPs and Ancillary Staff) applying for initial appointment and privileges (scope of practice) must be submitted to, or as otherwise directed by, the Medical Center's Medical Staff Department (MSSD), who will then submit the application to the Interdisciplinary Practice Committee (IPC) for review and action in accordance with the applicable Rules and regulations and Credentialing and Privileging Policy applicable to AHPs (the AHP Policy). After review by the IPC, applications of APPs are reviewed by the applicable Department Chair prior to being forwarded to the Credentials Committee, the Medical Executive Committee and the Board for action in accordance with the AHP Policy. After review by the IPC, applications of Ancillary Staff are forwarded to the Medical Executive Committee and the Board for action in accordance with the AHP Policy. Completed applications for reappointment must be submitted by AHPs to, or as otherwise directed by, the MSSD who will process such applications in accordance with the AHP Policy, which requires such applications to be reviewed and acted upon by the same bodies that act on AHPs' initial applications.

ARTICLE SEVEN: APPOINTMENT PROCEDURES

7.1 APPLICATION

Applications for appointment to the Staff shall be in writing and signed by the applicant on the form approved by the BH Board. At the time an application is requested, the Applicant will be provided with a copy of the BH Bylaws and the Medical Staff Bylaws, Rules and Regulations. An applicant shall provide complete information in all areas called for by the application and shall list all specific privileges requested. An Applicant shall agree in writing that he or she will abide by the Medical Staff Bylaws, Rules and Regulations and the BH Bylaws in all matters concerning the application, regardless of the outcome of the application process, and in all later relations with the Medical Center and Medical Staff.

7.2 EFFECT OF APPLICATION

The Applicant must personally sign the application and in so doing:

(a) Attests to the correctness and completeness of all information furnished;
(b) Provides evidence of current licensure and discloses any prior denials, suspensions or revocations of licensure, currently pending challenges to such licensure or the voluntary or involuntary relinquishment of such licensure;
(c) Provides evidence of current DEA registration and discloses any prior denials, suspensions or revocations of DEA registration, currently pending challenges to such registration or the voluntary or involuntary relinquishment of such registration;
(d) Provides information regarding any denial or voluntary or involuntary termination of Medical Staff membership; any denial or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital or licensed health care facility; or any recommendation by any committee of a Medical Staff that any such action be taken;
(e) Provides evidence of current professional liability insurance and specifies any involvement in a professional liability action, including a description of the current status (if pending) or final resolution of such action;
(f) Signifies willingness to appear for interviews in connection with the application;
(g) Agrees to abide by the terms of the Medical Staff Bylaws, Rules and Regulations, the Medical Center's policies and procedures and the BH Bylaws;
(h) Agrees to maintain an ethical practice and provide continuous care to his or her patients;
(i) Authorizes and consents to hospital representatives consulting with any individual who, or entity which, may have information bearing on the applicant's qualifications, and consents to the inspection of all records and documents that may be material to evaluating such qualifications;
(j) Agrees to work with others in the Medical Center in a cooperative, professional manner appropriate to quality patient care and to fully participate in the discharge of appropriate Staff obligations;
(k) Releases from any liability BH, the Board, the Medical Center and their employees, Medical Staff Members, and all others who review, act upon or provide information regarding the Applicant and his/her competence, professional ethics, character, health status and other qualifications for Staff appointment and clinical privileges; and
(l) Provides information regarding the denial or loss of the right to participate in any federal or state programs, including the Medicare, Medicaid (AHCCCS) or TriCare Programs, or any pending investigation that could result in such an exclusion or expulsion.
(m) Provides evidence of freedom from infectious pulmonary tuberculosis pursuant to R9-10-207.

7.3 MEMBERSHIP FEE

A membership fee in the amount established by the Medical Executive Committee must be submitted by the Applicant prior to the application being processed.

7.4 PROCESSING THE APPLICATION

7.4-1 Applicant's Burden

The Applicant has the sole burden of producing adequate information and documentation or a proper evaluation for his or her qualifications and for resolving any doubts related thereto required for Staff membership, the requested Staff category, department assignment or clinical privileges, and of satisfying any reasonable requests for information or clarification (including health examinations).

7.4-2 Verification of Information

The application shall be submitted to Medical Staff Services or its designee. Representatives of Medical Staff Services, or their designees, shall collect and verify from primary source, education, relevant training, current competency, licensure, National Practitioner Data Bank, peer and/or faculty recommendations and other qualification evidence submitted and notify the applicant of any problems in obtaining the required information. Upon such notification, it is the Applicant's obligation to obtain or assist Medical Staff Services to obtain the required information. Prior to practicing at the medical center each provider is required to present to any Banner Health Medical Staff Services Department to present legible Federal/State government issued photo identification (ie: driver's license, passport, etc.) prior to privileges being activated. When collection and verification of all necessary information is accomplished, the application shall be deemed to be complete and shall then be acted on through the Medical Staff process within 180 days.

7.4-3 Credentialing and Privileging of Telemedicine Physicians

When BTMC has a contract for the provision of telemedicine services that meets the requirements of MS.13.01.01.01 and is approved by the MEC, BTMC shall accept the credentialing and privileging decisions of the primary facility for applicants who provide such telemedicine services and are privileged and credentialed at the primary facility. The primary facility shall make available to BTMC the name, delineation of clinical privileges, and affirmation of Arizona licensure for each applicant who is privileged and credentialed at the primary site and will be providing telemedicine services at BTMC. Privileges at BTMC shall be identical to those granted at the primary facility, except for services not performed at BTMC. Privileges shall be for no more than two years per period and shall expire no later than concurrent to the expiration date of clinical privileges at the primary facility.

7.4-3 Credentials Committee Action

The Credentials Committee shall, at its next regularly scheduled meeting, review the completed application, the supporting documentation, and any other relevant information and determine if the Applicant meets all of the necessary qualifications for Staff membership and the requirements of the applicable department(s). The Credentials Committee shall transmit its written recommendations regarding Staff appointment and category of Staff membership to the next regularly scheduled meeting of the requested department. The Credentials Committee may conduct an interview with the Applicant or may designate a committee to conduct such interview.

Expedited Review of Application

In order to increase efficiency of the credentialing process, all applications will be categorized into a Category One or Category Two. Applications deemed as Category One will be eligible for expedited review and will be processed in an expeditious manner once the file is

determined to be complete. Applications deemed as Category Two will be processed through the traditional process. Expedited review eligibility is distinct from eligibility for temporary privileges.

Category One: An initial application can be expedited through the Credentials Committee Chairman and the Department Chairman and on to MEC if the applicant meets the qualifications for membership and privileges as outlined in the Bylaws and all information contained within the application is found to be current and complete, identification has been verified and there are no suggestions in the verified materials of potential problems or issues to resolve; no significant malpractice actions, no reports of disciplinary action; and no license restrictions or any type of investigation.

Category Two: An initial application not meeting the above criteria, any bylaws or rules and regulations requirement, or determined to need further review by the Medical Staff leadership will be classified as Category Two. Files classified as Category Two require that the file be processed through the traditional process.

7.4-4 **Departmental Action**

Each department in which the applicant seeks privileges shall review the application and its supporting documentation and make recommendations as to the scope of clinical privileges to be granted. The applicable department(s) or subcommittee(s) thereof may conduct an interview with the Applicant. The recommendation of the department chair regarding whether to grant the privileges requested shall be forwarded to the Medical Executive Committee. Upon its election, the department may refer specific credentialing issues to the Credentials Committee for additional consideration before making its recommendation.

Where the member has successfully completed all observation requirements, the Department Chair may grant unsupervised privileges, subject to ratification by the Medical Executive Committee and the Board.

7.4-5 **Medical Executive Committee Action**

The Medical Executive Committee, at its next regularly scheduled meeting, shall review the application, the supporting documentation, the reports and recommendations from the department(s), the department chairman, and the Credentials Committee, and any other relevant information available to it. The Medical Executive Committee shall prepare a written report with recommendations as to approval or denial, or any special limitations on Staff appointment, category of Staff membership and prerogatives, department affiliation and scope of clinical privileges, or defer action for further consideration.

7.4-6 **Effect of Medical Executive Committee Action**

(a) Favorable Recommendation: A Medical Executive Committee recommendation that is favorable to the applicant in all respects shall be promptly forwarded, together with all supporting documentation to the Board.

(b) Conditional Recommendation. A Medical Executive Committee recommendation that is favorable to the applicant, but that is conditional, shall be promptly forwarded, together with all supporting documentation, to the Board. A conditional appointment or reappointment is not a reduction or limitation of membership or privileges, does not constitute an adverse recommendation or corrective action, and does not entitle the applicant to the procedural rights provided by the Bylaws and the Fair Hearing Plan. Where conditional appointment/reappointment is recommended, the Medical Executive Committee will specify the conditions of appointment/reappointment and the consequences if those conditions are not met.

(c) Adverse Recommendation: An adverse Medical Executive Committee recommendation shall entitle the Applicant to the procedural rights provided in these Bylaws and the Fair Hearing Plan.

(d) Deferral: Action by the Medical Executive Committee to defer the application for further consideration shall be followed up at its next regular meeting following its receipt of adequate information with its recommendations as to approval or denial of, or any special limitations on Staff appointment, Staff category, department affiliation and scope of clinical privileges.

7.4-7 **Board**:

At its next meeting following the Medical Executive Committee's recommendation, the Board (or a designated committee of the Board) may adopt or reject, in whole or in part, the recommendation of the Medical Executive Committee or refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for such referral. Favorable action by the Board is effective as its final decision; the applicant will be notified within 30 days. If the Board's action is adverse to the applicant in any respect, the Chief Executive Officer shall, by special notice (as outlined in the Fair Hearing Plan), inform the applicant who is then entitled to the procedural rights provided in these Bylaws and the Fair Hearing Plan if not previously afforded to the applicant. Board action after completion of the procedural rights provided in the Bylaws and the Fair Hearing Plan, or after waiver of these rights, is effective as its final decision. If the Board's intended action differs from the recommendation of the Medical Executive Committee, if requested by the Medical Executive Committee, a Joint Conference Committee meeting shall be held in accordance with the Fair Hearing Plan before the Board finalizes a decision that is contrary to that of the Medical Executive Committee.

7.4-8 **Term of Appointment:**

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

(a) New members of the staff granted privileges are subject to a period of focused professional practice evaluation.

(b) The Board, after considering the recommendations of the Executive Committee, may establish a shorter appointment period for the exercise of particular privileges in general or for a staff member who has an identified impairing disability, has been the subject of disciplinary action, or is under investigation.

7.4-9 **Expiration**

The appointment of each staff member shall expire every two years on the last day of the birth month of the Staff Member, except where an earlier expiration date has been established by the board.

7.5 REAPPOINTMENT PROCEDURES

7.5-1 **Information Collection and Verification from Staff Member**

(a) Medical Staff Services (or its designee) shall send each Staff Member an application for reappointment and notice of the date on which membership and privileges will expire. The application for reappointment must be submitted on the form designated by the Medical Executive Committee and approved by the Board. The application shall include information to demonstrate the Member's continued compliance with the qualifications for Medical Staff membership and privileges.

(b) Failure to timely return the satisfactorily completed forms shall be deemed a voluntary resignation from the Staff and shall result in automatic termination of membership at the expiration of the current term.

(c) Medical Staff Services (or its designee) shall verify the information provided on the reappointment form and notify the Staff Member of any specific information inadequacies or verification problems. The Staff Member has the burden of producing all required information and documentation.

7.5-2 **Information Collection and Verification**

(a) Medical Staff Services (or its designee) shall collect all relevant information regarding the individual's professional and collegial activities, performance and conduct in the Medical Center. Such information shall include:

1) Relevant practitioner-specific data as compared to aggregate data, when available, from the quality review and utilization management activities;
2) Recommendations from peers for continued Medical Staff membership and for delineation of clinical privileges;
3) Participation in relevant continuing education activities or other training programs;
4) Level of clinical activity at the Medical Center;
5) Any prior denial, suspension or revocation of, or currently pending challenges to, licensure or the voluntary or involuntary relinquishment of such licensure;
6) Any prior denial, suspension or revocation of, or currently pending challenges to, DEA registration or the voluntary or involuntary relinquishment of such registration;
7) Any prior exclusions or expulsions from any state or federal program, including the Medicare, Medicaid (AHCCCS) and TriCare Programs and any pending investigations by any of such Programs.
8) Verification of other hospital Staff memberships and any denial or voluntary or involuntary termination of Medical Staff membership; any denial or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital or licensed health care facility; or any recommendation by any committee of a Medical Staff that any such action be taken.
9) Any involvement in a professional liability action, including a description of the current status (if pending) or final resolution of such action;
10) Information from the National Practitioner Data Bank;
11) Documentation as to the applicant's health status;
12) Attendance at required Medical Staff and department meetings;
13) Service on Medical Staff, department and Medical Center committees;
14) Timely and accurate completion of medical records;
15) The manner in which the individual cooperates and works with other practitioners and Medical Center personnel;
16) General attitude toward patients and the Medical Center; and
17) Compliance with all applicable Medical Staff Bylaws, Rules and Regulations, Medical Center policies and procedures and BH Bylaws.

7.5-3 **Department Action**

Acting on behalf of the department(s) in which the Member holds privileges, the department chairman or his designee shall review the reappointment application and all supporting information and documentation and evaluate the information for continuing satisfaction of the qualifications for Staff appointment, the category of assignment and the privileges requested. The department chairman may recommend approval of the reappointment application and may make recommendations to the Medical Executive Committee as to the scope of clinical privileges to be granted. The department chairman may refer specific credentialing issues,

including matters which may cause the department chairman to consider making a negative recommendation, to the department or the Credentials Committee for additional consideration before making a recommendation.

7.5-4 **Medical Executive Committee Action**

The Medical Executive Committee shall review the department reports, and any other relevant information available to it and either make a recommendation for reappointment or non-reappointment and for the Staff category and department assignment and clinical privileges, or defer action for further consideration.

7.5-5 **Final Processing and Board Action**

Final processing of reappointments shall follow the procedures set forth in Sections 7.4-6 and 7.4-7. For purposes of reappointment, the terms "Applicant" and "appointment" as used in those Sections shall read respectively as "Staff Member" and "reappointment".

7.5-6 **Expiration**

The reappointment of each member shall expire every two years on the last day of the birth month of the practitioner, except as where an earlier expiration date has been established by the Board.

7.6 APPLICATION AFTER ADVERSE DECISION

An Applicant or Staff Member who has received a final adverse decision or resigned during the pendency of the application process or a corrective action investigation or proceeding or after an adverse recommendation regarding appointment, Staff category, department assignment or clinical privileges is not eligible to reapply to the Medical Staff or for the denied category, department or privileges for a period of twelve (12) months from such decision or resignation. Any such reapplication shall be processed as an application for initial appointment and the Applicant must submit such additional information as the Staff or the Board may require to demonstrate that the basis for the earlier investigation, adverse action or recommendation no longer exists.

7.7 DELAYS

Any Applicant or Staff Member who believes that his or her request for membership and/or privileges has been improperly delayed may request the Chief of Staff to investigate the reason for such delay. The Chief of Staff shall inform the practitioner of the reasons for the delay, if a delay has occurred, and shall notify the practitioner of the additional time expected to be necessary to act upon the practitioner's request.

7.8 REQUESTS WHILE ADVERSE RECOMMENDATION IS PENDING

No Applicant or Staff Member may submit a new application for appointment, reappointment, Staff category, a particular department assignment, or clinical privileges while an adverse recommendation is pending. The Medical Executive Committee shall submit to the Board any additional recommendations it may make regarding a practitioner while an adverse recommendation is pending before the Board.

ARTICLE EIGHT: PRACTICE PRIVILEGES

8.1 BASIS FOR PRIVILEGES DETERMINATIONS

Clinical practice privileges shall be granted in accordance with the practitioner's qualifications and demonstrated current competence. In reappointment determinations, results of quality assurance and utilization review and, where appropriate, supervised cases and practice will also be considered. In review of requests for additional privileges, evidence of appropriate qualifications must be documented.

8.1-1 **Privileges For New Procedures**

Departments will consider new technologies and procedures to determine whether the privilege to use such technologies or perform such procedures is subsumed under existing core or other privileges or requires additional education and training, experience and demonstrated competence. Practitioners desiring to utilize new technologies or perform new procedures may apply for privileges to do so following the process set forth in Article Seven of these Bylaws after the Department has either created new criteria for such privileges or determined that no new criteria is necessary. The department's determination is subject to ratification by the Executive Committee and the Board.

8.2 EXERCISE OF PRIVILEGES

8.2-1 **In General**

a) The following must be successfully completed, as applicable, prior to exercising privileges at the Medical Center:
   - Banner's electronic medical record/computerized physician order entry (CPOE) training; and
   - Banner's electronic New Provider Orientation.

b) Provider's privileges will be pended until CPOE training, New Provider Orientation and/or the ID verification is completed.

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

8.3 PRIVILEGE DECISION NOTIFICATION

The decision to grant, limit or deny an initially requested or an existing privilege petitioned for renewal is communicated to the requesting practitioner once the Board has taken 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.

8.4 EMERGENCY PRIVILEGES IN A DISASTER SITUATION

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

8.4-1 In the event that the Hospital Emergency Management Plan is activated and the organization is unable to meet immediate patient needs, the Hospital's CEO or Chief of Staff, or their respective designees, may grant emergency privileges during the disaster to volunteer licensed independent practitioners or allied health professionals who are not then members of the Medical Staff. Oversight of the professional performance of volunteer practitioners who receive disaster privileges will be the responsibility of the Chief of Staff, Chief Medical Officer, or the appropriate Department Chair or other designee. Such volunteer practitioner's credentials shall be verified by Medical Staff Services Department as soon as the immediate situation is under control and completed within 72 hours from the time the volunteer presents to the Hospital or, under extraordinary circumstances, as soon as possible. Volunteers must provide a valid photo identification issued by a state or federal agency and at least one of the following: (1) current hospital photo ID card, (2) current medical license verified through primary source, (3) valid photo ID issued by a state, federal, or regulatory agency, (4) an ID that certifies the physician is a member of a state or federal disaster medical assistance team,

(5) an ID that certifies the physician has been granted authority by a federal, state or municipal entity to administer patient care in emergencies; and/or (6) verification by a current hospital or medical staff member who can attest to physician's identity. The procedure for granting emergency privileges during a disaster shall be in accordance with the Disaster Credentialing for Patient Care Provider Policy. Termination of these emergency privileges, regardless of reasons, shall not give rise to a hearing or review.

8.5 SPECIAL CONDITIONS FOR ORAL SURGEONS AND DENTISTS

Surgical procedures performed by oral surgeons and dentists are under the overall supervision of the Department of Surgery. An oral surgeon with qualifications approved by the Department of Surgery may be granted the privilege of performing an admission history and physical examination and assessing the medical risks of the proposed procedure to the patient, but only in those instances where the patient has no known current medical problems. In all other circumstances, a physician member of the Medical Staff must perform a basic medical appraisal on an oral surgery or dental patient, must determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient, and must be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization. When a significant medical condition is present, the final decision on whether to proceed with the surgery must be agreed upon by the oral surgeon or dentist and the physician consultant. The chairman of the Surgery Section will decide the issue in case of a dispute.

8.6 SPECIAL CONDITIONS FOR PODIATRISTS

Surgical procedures performed by a podiatrist are under the overall supervision of the Department of Surgery. A podiatrist may write orders and co-admit patients with a physician member of the Medical Staff, who must perform a basic medical appraisal for each patient immediately after admission, be responsible for the care of any medical problems that may be present at admission or that may arise during hospitalization, and determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient.

8.7 SPECIAL CONDITIONS FOR OPTOMETRISTS

Optometrists with clinical privileges must meet all requirements and have an arrangement with an admitting physician on the Medical Staff who agrees to perform the history and physical and provide physician services outside the scope of the practice of the Optometrist.

8.8 TEMPORARY PRIVILEGES

8.8-1 Conditions

Temporary privileges may be granted only under the conditions described below, to an appropriately licensed practitioner. Special requirements of consultation and reporting may be imposed by the Chief of Staff or chairman of the applicable department(s). Under all circumstances, the practitioner requesting temporary privileges must agree and shall be deemed to have agreed to abide by the Medical Staff Bylaws, Rules and Regulations, the Medical Center's policies and the BH Bylaws.

8.8-2 Circumstances

Temporary privileges may be granted in the following circumstances:

(a) Pendency of Application

Requests for temporary privileges during the pendency of the application may be granted by the Chief Executive Officer or designee upon review and approval of a complete application by the Credentials Committee chairman or designee, the department chairman or designee and the Chief of Staff or designee. A completed application includes; verification of current licensure and DEA, relevant training or

experience, current competence, ability to perform the privileges requested and other such criteria as set forth in these Bylaws, rules and regulations; the results of the National Practitioner Data Bank query; and one that has no current or previously successful challenges to licensure or registration, has not been subject to involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization. When requested, temporary privileges may be granted in this circumstance until final action is taken but not greater than 120 days, on the application or until such privileges are terminated as set forth in Section 8.6-3. Temporary privileges may be granted only when the information available supports a favorable determination regarding the practitioner's application for membership and privileges. Under no circumstances may temporary privileges be granted if the application is pending because the Applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

(b) Care of Specific Patient

Temporary privileges may be granted to a practitioner when there is an important patient care need for of a specific patient, but only after receipt of a request for the specific privileges desired and telephone confirmation or receipt of a copy of appropriate licensure and DEA/controlled substances registration. Requests for temporary privileges of this nature may be granted by the Chief Executive Officer and one of the following: applicable department chairman, Chief of Staff, or their respective designees. Temporary privileges of this nature may not be granted in more than two (2) instances in any 12 month period (except in the event of a disaster). Such temporary privileges are restricted to the specific patients for whom they are granted.

(c) 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 staff membership, but only after receipt of a completed and verified application for Staff appointment, including a request for specific privileges; confirmation of appropriate licensure, DEA/controlled substances registration; education and training; current clinical competency; evidence of freedom from infectious tuberculosis and recent flu vaccination, when applicable; denial or loss of privileges at practitioner’s primary facility; freedom from government sanctions; completion of CPOE training, NPO and photo ID verification; and NPDB query response. Temporary privileges shall be granted under this provision only under exceptional circumstances and never solely for the sake of the physician convenience. Requests for temporary privileges of this nature may be granted by the Chief Executive Officer upon review and approval of the completed application by the Credentials Committee chairman or designee and one of the following department chairman, Chief of Staff, or their respective designees. The temporary privileges granted to a practitioner may be considered on an individual basis for a period not exceed 60 days in length and may be extended for a period not to exceed 60 days. Any such extension shall be made by the department chair when the information available continues to support a favorable determination regarding the practitioner’s application for membership and privileges. If a practitioner is serving as a locum tenens for one week or less, temporary privileges during this period may be granted by the CEO after consultation with the Chief of Staff and the department chairman, and verification of licensure and Staff membership and privileges in good standing at one other acute care hospital.

(d) Privileges for Additional Procedures

Temporary privileges to perform specific procedures which have been approved to be performed at the Medical Center for which the Member has not previously been granted privileges may be granted, but only after receipt of a request for the specific

additional privileges desired and/or documentation of appropriate training and current clinical competence. Requests for temporary privileges of this nature may be granted by the Chief Executive Officer or designee and either the applicable department chair or the Chief of Staff, or their respective designee. Temporary privileges for specific additional procedures may not be granted more than once and may not be granted for a period of more than sixty (60) days. If the Member wishes to perform such procedure after the expiration of his or her temporary privileges, the Member must apply for full privileges to perform such procedures.

(e) Temporary privileges may be granted to a medical staff member with a routine application where the Banner Board Medical Staff Subcommittee has recommended reappointment to the Board.

8.8-3 **Termination of Temporary Privileges**

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

8.8-4 **Rights of Practitioner**

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

ARTICLE NINE: GENERAL STAFF OFFICERS

9.1 GENERAL OFFICERS

9.1-1 **Identification**

The general officers of the Staff are the Chief of Staff, Vice Chief of Staff, Secretary/Treasurer, Past Chief of Staff and two members-at-large.

9.1-2 **Eligibility Criteria**

Each officer shall

(a) be a member of the Active Staff and in good standing at the time of nomination and election and remain as such during his or her term of office;
(b) have demonstrated ability through experience and prior participation in staff activities and be recognized for a high level of clinical competency;
(c) have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
(d) have demonstrated an ability to work well with others;
(e) have actively and constructively participated in Medical Staff affairs;
(f) be willing to attend continuing education relating to Medical Staff leadership or credentialing functions and;
(g) be able and willing to faithfully discharge the duties and responsibilities of the position and work with other department officers of the Medical Staff, the Chief Executive Officer and the Board.

In addition, the Chief of Staff shall be board certified by an approved board and have served as a general officer, department officer, or chairman of a standing committee of the Medical Staff.

9.1-3 **Compensation**

The Medical Staff acknowledges that the Medical Executive Committee may compensate general Staff officers as it deems appropriate.

9.2 TERM OF OFFICE

The term of office for each general Staff officer shall be two years. Officers shall assume office on the first day of January following their election, except that an officer appointed to fill a vacancy shall assume office immediately upon appointment and serve for the remainder of the unexpired term. Each officer shall serve until the end of his or her term and until a successor is elected and takes office, unless such officer sooner resigns or is removed from office. No officer shall hold the same office for more than two consecutive terms. No Staff Member shall hold more than one general Staff office at a single time and no Staff Member may serve simultaneously as a general Staff officer and as a department or section chairman.

9.3 NOMINATIONS

9.3-1 The Nominating Committee shall consist of the current Chief of Staff (if he/she is not seeking re-election), and two additional Active Staff Members selected by the Medical Executive Committee. The Chief of Staff shall serve as Chairman unless he/she is seeking re-election in which event he/she shall appoint one of the other members to serve. The Chief Executive Officer will be an ex officio member of the Nominating Committee, without vote.

9.3-2 The Active Medical and Active Affiliate Staff members will receive notice of the election and the appointment of the Nominating Committee approximately six months before the end of the term.

9.3-3 Each candidate must be contacted to discuss the obligations of the office, consent to be nominated and must disclose any relationships which the candidate has that may constitute a conflict of interests between the candidate and the Medical Staff and/or the Medical Center. The information to be disclosed shall include, but not be limited to, whether he/she is employed by and or has a contractual relationship with the Medical Center, BH or any of its affiliates; whether he/she has an ownership or other financial interest in or an employment relationship with any facility which competes with the Medical Center or with any entity that has a vendor or other business relationship with the Medical Center,; and a description of any such relationship(s).

9.3-4 The Nominating Committee will accept further nominations made by the Active Medical or Active Affiliate Staff member by petition signed by ten percent of the Active Medical and Active Affiliate Staffs. Nominations must be received sixteen days prior to the election in order to be considered. Prior to being placed on the ballot, the Chairman of the Nominating Committee will contact the nominee to discuss the obligations of the office and evidence must be presented that the potential nominee(s) meets the qualifications for office and consents to the nomination and makes the disclosure of any actual or potential conflict of interest as contemplated by Section 9.3-2 of these Bylaws.

The Committee shall present to the Secretary/Treasurer a slate with one or two candidates for each of the open general Staff offices: Chief of Staff, Vice Chief of Staff, Secretary/Treasurer and the two members-at-large from the Active Medical Staff.

9.4 ELECTION

The Chief of Staff, Vice Chief of Staff, Secretary/Treasurer and two members at large shall be elected by ballot.

9.4-1 An official ballot for voting on the election of officers shall be mailed or emailed by Medical Staff Services to each Active Medical and Active Affiliate Staff Member within a reasonable time after nominations have closed. Instructions shall include an announcement that the ballots must be received in the Medical Staff Services office by 5:00 p.m. on the date specified for counting ballots which shall be at least fourteen (14) days after the ballots are mailed or emailed. The official ballot shall contain the names of all persons nominated for each office by the Nominating Committee and by petition pursuant to Section 9.3-3 of these Bylaws. The official ballot shall contain or be accompanied by information containing a description of any actual or potential conflict of interest that a candidate has with the Medical Staff and/or the Medical Center.

9.4-2 Each Active Medical and Active Affiliate Staff Member must complete his/her ballot. To be counted, the ballot must be received by the Medical Staff Services office by 5:00 p.m. on the date that the ballots are to be counted.

9.4-3 The ballot shall be counted by the Medical Executive Committee or by a group of tellers authorized by the Medical Executive Committee. At least one (1) member of the Medical Executive Committee shall be present at the counting of the ballots.

9.4-4 In order to have a valid election, Medical Staff Services must receive the number of ballots equivalent to a quorum of a meeting of the General Staff. In order to be elected, a candidate must receive a majority vote of the Active Medical and Active Affiliate Staff Members who return a ballot. If no candidate for an office receives a majority vote on the first ballot, a runoff election shall be held by mail or email between the two (2) candidates receiving the highest number of votes.

9.4-5 In the event of a runoff election, Medical Staff Services shall mail or email out a new ballot containing the names of the two (2) candidates receiving the highest number of votes to each Active Medical and Active Affiliate Staff Member in the manner described above. Such ballot shall be mailed or emailed within seven (7) days after the ballots were counted in the initial election. The ballots for the runoff election shall include instructions which shall include an announcement of when the ballots must be received to be counted. The ballots shall be processed and counted in the same manner as described above for the initial election. In order to have a valid runoff election, Medical Staff Services must receive that number of ballots equivalent to a quorum of a meeting of the General Staff. The candidate receiving the highest number of votes shall be declared the winner. In the event of a tie or if not enough ballots are returned to constitute a valid election, a majority vote of the Medical Executive Committee shall decide the election.

9.5 VACANCIES IN ELECTED OFFICES

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

9.6 RESIGNATIONS

Any officer may resign at any time by giving written notice to the Medical Executive Committee. Such resignation takes effect on the date of receipt or at any later time specified in the notice.

9.7 REMOVAL FROM OFFICE

A General Staff officer may be removed from office for failure to perform his/her duties as required by these Bylaws, for conduct detrimental to the interests of the Medical Center and/or Medical Staff, an infirmity that renders the individual incapable of fulfilling the duties of that office, or failure to

continuously satisfy the criteria for officers set forth in these Bylaws. The Medical Executive Committee may remove a General Staff Officer. A meeting to consider the removal of a General Staff officer may be initiated by the Medical Executive Committee. If removal is initiated by the Medical Staff a petition must be signed by at least one-third (1/3) of the Active Medical and Active Affiliate Staff Members. If the required signatures are obtained, such removal shall be discussed at a general or special meeting of the General Staff. Within fourteen days of such meeting, Medical Staff Services shall mail or email official ballots to all Active Medical and Active Affiliate Staff Members. The voting procedures shall be in accordance with Section 9.4. Removal shall require two-thirds (2/3) vote of the Active Medical and Active Affiliate Staff and shall be effective immediately upon tabulation of the vote by the Medical Executive Committee or its designee.

9.8 DUTIES OF OFFICERS

9.8-1 Chief of Staff

The Chief of Staff shall serve as the highest elected officer of the Medical Staff and be responsible to:

(a) Enforce the Bylaws and implement sanctions where indicated;
(b) Call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and of the Medical Executive Committee;
(c) Serve as an ex-officio member of all other Staff committees without vote, unless his or her membership in a particular department or committee is required by these Bylaws;
(d) Appoint, with the consultation of the Medical Executive Committee, members for all standing and special Medical Staff, or multi-disciplinary committees, and designate the chairmen of these committees;
(e) Interact with the CEO and the Board in all matters of mutual concern within the Medical Center;
(f) Represent the views and policies of the Medical Staff to the Board and to the CEO;
(g) Be a spokesperson for the Medical Staff in external professional affairs;
(h) Perform such other functions as may be assigned to him or her by these Bylaws, by the Medical Staff, or by the Medical Executive Committee;
(i) Serve as an ex-officio member of the BH Board and on designated Board committees.

9.8-2 Vice Chief of Staff

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in his or her absence. The Vice Chief of Staff shall be a member of the Medical Executive Committee and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the Medical Executive Committee. The Vice Chief serves as an ex-officio member of all Staff committees without vote. The Vice Chief shall be entitled to vote on any committee of which the Vice Chief is already a member.

9.8-3 Immediate Past Chief of Staff

The immediate Past Chief of Staff shall be an ex-officio member of the Medical Executive Committee, shall serve on the Nominating Committee, and perform such duties as may be assigned by the Chief of Staff or delegated by these Bylaws or by the Medical Executive Committee.

9.8-4 Secretary/Treasurer

The Secretary/Treasurer shall be a member of the Medical Executive Committee. As Secretary, he or she shall determine that accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings are maintained. As Treasurer, he or she

shall receive and safeguard all funds of the Medical Staff. The Secretary/Treasurer shall perform all other duties that ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or by the Medical Executive Committee.

9.8-5 **Members-at-Large**

The members-at-large shall be members of the Medical Executive Committee and shall perform such duties as may be assigned by the Chief of Staff or delegated by these Bylaws or by the Medical Executive Committee.

ARTICLE TEN: CLINICAL DEPARTMENTS

10.1 CURRENT CLINICAL DEPARTMENTS

The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a chairman entrusted with the authority, duties and responsibilities as specified in this Article. When appropriate, the Medical Executive Committee may recommend the creation, elimination, modification, or combination of departments. Such recommendation shall be ratified by two-thirds of the Active Staff members present at the next General Staff meeting and shall become effective upon Board approval and shall not require formal amendment of these Bylaws. The current clinical departments are:

1. Anesthesia Department
2. Cardiology Department
3. Emergency Medicine Department
4. Medicine Department
5. OB/GYN Department
6. Pediatrics Department
7. Radiology Department
8. Surgery Department

10.2 ASSIGNMENT TO DEPARTMENTS

Each member of the Medical Staff shall be assigned membership in one department. A practitioner may be granted clinical privileges in more than one department. The exercise of clinical privileges within the jurisdiction of any department is always subject to the Rules and Regulations of that department. The Department of Surgery shall have the primary departmental responsibility for the Pathologists with respect to appointment, reappointment and delineation of clinical privileges.

10.3 FUNCTIONS OF DEPARTMENTS

Each department shall:

10.3-1 Conduct reviews to analyze and evaluate the quality and appropriateness of care and treatment provided by practitioners with privileges in the department and make recommendations on the results of these reviews;

10.3-2 Develop recommendations for the qualifications appropriate to obtain and maintain clinical privileges in the department;

10.3-3 Establish and implement clinical policies and procedures, and monitor its members' adherence to them;

10.3-4 Adopt its own Rules and Regulations to clarify or expand these Bylaws to meet the needs of its particular area of practice. Department Rules and Regulations shall not conflict with these Bylaws and shall be subject to approval by the Medical Executive Committee and the Board. They shall be appended to the Medical Staff Rules and Regulations;

10.3-5 Meet at least quarterly or more if necessary to consider the results of the review for quality and appropriateness of patient care and any other review and evaluation activities, and to provide a forum for discussion of matters of concern to its members;

10.3-6 Conduct, participate in and make recommendations regarding continuing education programs pertinent to department clinical practice;

10.3-7 Coordinate the professional services of its members with those of other departments and with Hospital nursing and support services;

10.3-8 Report and make recommendations regarding clinical, quality review and administrative activities to the Medical Executive Committee;

10.3-9 Establish a department committee and any subcommittees as are necessary to perform functions required of it. The composition and method of selection of the department committee and subcommittee members shall be defined within the department Rules and Regulations.

10.4 DEPARTMENT OFFICERS

10.4-1 Qualifications

Each department shall have a Chairman who shall be and remain during his or her term a member in good standing of the Active Medical Staff; shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the department; and shall demonstrate a high degree of interest in and support of the Medical Staff and Medical Center. All department officers must also be board certified or satisfy the criteria established by the applicable department necessary to demonstrate comparable competence. Departments may also have a Vice Chair or other officers as defined in the department's Rules and Regulations.

10.4-2 Selection and Term

Department chairmen shall be elected every other year by the Active Staff Members of the departments. For this election, each department chairman shall announce a nominating committee of three Active Staff Members approximately six months before the end of the term. The recommendations of the nominating committee shall be presented to members of the Department. Before the nominating committee presents a slate of candidates, each candidate must consent to be nominated and must disclose any relationships which the candidate has that may constitute a conflict of interest between the candidate and the Medical Staff and/or the Medical Center. The information to be disclosed shall include, but not be limited to, whether he/she is employed by and/or has a contractual relationship with the Medical Center, BH or any of its affiliates; whether he/she has an ownership or other financial interest in or an employment relationship with any facility which competes with the Medical Center or with any entity that has a vendor or other business relationship with the Medical Center; and a description of such relationship(s). Nominations may also be made by Active Staff Members as long as the nominee is qualified and has consented to the nomination. A candidate running unopposed shall be elected by a majority vote of active department members at the department meeting. Vacancies in elected department offices due to any reason shall be filled for the unexpired term through a special election held for that purpose at a meeting of the department. Selection of any additional officers defined by the department shall follow this same procedure.

10.4-3 Election Ballots

Election ballots will be mailed or emailed to all eligible voting members in the department unless a candidate is running unopposed. The official ballot shall contain or be accompanied by information containing a description of any actual or potential conflict of interest that a candidate has with the Medical Staff and/or the Medical Center. Marked ballots must be received at the Medical Staff Services Office no later than 5:00 p.m. on the day

prior to the day the ballots are to be counted. Election of the department chairman shall be by a majority of ballots received. If no candidate receives a majority of the votes, the need for a runoff election between the two candidates receiving the highest number of votes will be announced within seven (7) days after the ballots were counted in the initial election. The runoff election will be conducted by mail or email ballot. Election shall be by a majority vote of those Active Staff Members who return a ballot.

In the event of a tie vote in the runoff election, a second vote by secret ballot will be conducted. In the event of a tie in the second voting, the tie shall be broken by a vote of the Medical Executive Committee.

10.4-4 **Removal**.

A department chairman may be removed by the Medical Executive Committee for failure to satisfy the qualifications or perform the duties required of the department chairman, for conduct detrimental to the interests of the Medical Center and/or Medical Staff or for an infirmity that renders the individual incapable of fulfilling the duties of the office. Removal may also be initiated by petition of one-third (1/3) of the Active Members of the department. Removal by the Active Members of the department shall require a two-thirds (2/3) vote of the Active Members of the department, such vote to occur by written ballot in the same manner as that used in the election of department officers. A physician who has been removed as a department chairman is not eligible to be reelected or reappointed a department chairman for a period of twelve (12) months from such removal. Any physician who wishes to be reelected as a department chairman after having been removed must submit such information as the Executive Committee or the Active Members of the department may require to demonstrate that the basis for the earlier removal no longer exists.

10.4-5 **Duties**

Each department chairman shall have the following roles and responsibilities:

(a) Clinically related activities of the department;
(b) Administratively related activities within the department, unless otherwise provided by the hospital;
(c) Continuing surveillance of the professional performance of all practitioners with clinical privileges in the department;
(d) Recommend to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;
(d) Recommending the clinical privileges for each member of the department;
(e) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or organization;
(f) Integration of the department or service into the primary functions of the organization;
(g) Coordination and integration of interdepartmental and intradepartmental services
(h) Development and implemention of policies and procedures that guide and support the provision of care, treatment, and services;
(i) Make recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;
(j) Determine the qualifications and competence of department or service personnel who are not licensed independent practitioners who provide patient care, treatment, and services;
(k) Continuously assess and improve the quality of care, treatment and services.

(l) Maintenance of quality control programs, as appropriate;
(m) Orientation and continuing education to practitioners in the department or service
(n) Recommending space and other resources needed by the department or service

ARTICLE ELEVEN: COMMITTEES

11.1 DESIGNATION

The committees described in this Article are the current standing committees of the Medical Staff. In addition, special or ad hoc committees may be appointed for specific purposes by the Chief of Staff. Such appointment will cease upon the accomplishment of the purposes of the committee. Such special or ad hoc committees shall report to the Medical Executive Committee.

11.2 GENERAL PROVISIONS

11.2-1 Ex-Officio Members

The Chief of Staff and the CEO or their respective designees are ex-officio members of all standing and special committees of the Medical Staff.

11.2-2 Subcommittees

Any standing committee may elect to perform any of its specifically designated functions by appointing a subcommittee which reports its recommendations to the parent committee. Any such subcommittee may include individuals other than members of the standing committee as appointed by the committee chairman.

11.2-3 Appointment of Members and Chairman

Except as otherwise provided, the Chief of Staff shall appoint the members and chairmen of any Medical Staff committee formed to accomplish Medical Staff functions. The chairman of any standing committee shall be offered the opportunity to serve as a member of that committee in the year following his or her chairmanship.

11.2-4 Term, Prior Removal and Vacancies

(a) Except as otherwise provided, committee members and chairmen shall be appointed by the Chief of Staff for a term of one year, unless such member or chairman sooner resigns or is removed from the committee.
(b) A Medical Staff Member serving on a committee, except one serving ex-officio, may be removed from the committee for failure to remain a Member of the Staff in good standing, for failure to satisfy the attendance requirements specified in these Bylaws, or by action of the Medical Executive Committee. Any ex-officio member of a Medical Staff committee ceases to be such if he or she ceases to hold a designated position which is the basis of ex-officio membership.
(c) Except as otherwise provided, a vacancy in any committee is filled for the unexpired portion of the term in the same manner in which the original appointment was made.

11.2-5 Voting Rights

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

11.3 MEDICAL EXECUTIVE COMMITTEE

11.3-1 **Composition**

The Medical Executive Committee shall include physicians and may include other licensed practitioners. Membership shall consist of the following:

(a) Chief of Staff, who shall serve as Chairman;
(b) Vice Chief of Staff;
(c) Immediate Past Chief of Staff;
(d) Secretary/Treasurer;
(e) Chairmen of the following departments:
    1) Anesthesia
    2) Cardiology
    3) Emergency Medicine
    4) Medicine
    5) Obstetrics/Gynecology
    6) Pediatrics
    7) Radiology
    8) Surgery
(f) Two Members at Large;
(g) The Chairman of the Credentials Committee;
(h) The Chairman of the Bylaws Committee;
(i) The Chairman of the Pharmacy and Therapeutics Committee;
(j) The Chairman of the Bioethics Committee;
(k) The Chair of the Hospitalist Committee;
(l) The Chairman of the Quality Improvement Committee;
(m) The Chairman of the Physician Advisory/Contracts Committee;
(n) The Chairman of the Professional Review Committee;
(o) The Chairman of the Professional Health and Wellness Committee;
(p) The Chief Executive Officer (ex officio member, without vote);
(q) Other representation as necessary may be appointed by the Chief of Staff and approved by the majority vote of the Medical Executive Committee. (With vote, Active status not required)

11.3-2 **Elections and Terms**

The Medical Staff officers serving on the Medical Executive Committee shall be elected in the manner prescribed in Sections 9.4 and 10.4.

11.3-3 **Duties**

The duties and authority of the Medical Executive Committee are to:

(a) Act on behalf of the Medical Staff, except for the election or removal of general Staff officers;
(b) Receive and act upon reports and recommendations from Medical Staff departments and committees;
(c) Coordinate and implement the professional and organizational activities and policies of the Medical Staff;
(d) Make recommendations to the CEO and to the Board regarding the organized Medical Staff structure, and the process used to review credentials and delineate privileges;
(e) Review the qualifications, credentials, performance and professional competence and character of Medical Staff applicants and Members and make recommendations to the Board regarding such matters;
(f) Account to the Board for the quality and efficiency of medical care provided to patients in the Medical Center, including a summary of specific findings, actions and results:

(1) Formulate and seek approval by the Board of plans for maintaining quality patient care within the Medical Center ("Quality Improvement Plan");

(2) Formulate and seek approval by the Board of the plans for maintaining appropriate utilization of services within the Medical Center ("Utilization Management Plan");

(3) Perform or delegate such duties and responsibilities as are delineated in the Quality Improvement Plan;

(g) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of the Medical Staff Members;

(k) Participate in the Corrective Action and Fair Hearing Plan procedures described in these Bylaws and in the Fair Hearing Plan;

(h) Designate such committees as may be appropriate to assist in carrying out the duties and responsibilities of the Medical Staff;

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

11.3-4 **Meetings**

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

11.4 CREDENTIALS COMMITTEE

11.4-1 **Composition**

The Credentials Committee shall be composed of at least five members of the Active Staff who shall serve two year terms. Approximately one half of the members shall be appointed every year. When possible, the Chief of Staff shall appoint a Past Chief of Staff to serve as Chairman and shall appoint additional Past Chiefs of Staff to the committee.

11.4-2 **Responsibilities**

The Credentials Committee shall review applications for appointment to the Staff, coordinate with the appropriate departments in connection with privilege requests and prepare recommendations on appointment for submission to the Medical Executive Committee. At the request of the Medical Executive Committee, the Credentials Committee shall undertake corrective action investigations. A majority of the members shall constitute a quorum.

11.4-3 **Duties**

The duties of the Credentials Committee shall be to examine the qualifications of each applicant to determine whether all qualifications for Staff membership have been met. It shall meet as often as necessary and shall make a written recommendation to the Medical Executive Committee in accordance with Article 7.

11.5 BYLAWS COMMITTEE

11.5-1 **Composition**

The Bylaws Committee shall consist of at least three Members of the Active Staff. The Chairman shall be appointed by the Chief of Staff.

11.5-2 **Duties**

The Bylaws Committee shall annually review the Medical Staff Bylaws and Rules and Regulations and, when necessary, recommend revision to the Bylaws and Rules and Regulations. The Bylaws Committee shall review all proposed amendments to the Bylaws or

the Rules and Regulations prior to the Medical Executive Committee's consideration of such amendments. The Committee shall meet as needed, but shall meet at least once a year upon notice to all of its members. The Committee shall report as necessary to the Medical Executive Committee.

11.6 PHARMACY AND THERAPEUTICS COMMITTEE

11.6-1 Composition

The Pharmacy and Therapeutics Committee shall be a multi-disciplinary committee reporting to the Quality Committee. It shall consist of at least three Members of the Medical Staff, representatives from administration and nursing, and the Medical Center pharmacist. The Physician Chairman shall be designated by the Chief of Staff. It shall meet as often as necessary.

11.6-2 Duties

The Committee shall monitor and evaluate the use of drugs and shall formulate policies in order to improve patient care. Its specific purpose and functions will be:

(a) To create policies and procedures to address adequate oversight for the safe administration and monitoring of medications utilized in clinical settings;
(b) To recommend and maintain a list of drugs accepted for use in the Medical Center;
(c) Serve in an advisory capacity to the Medical Staff and Pharmacy Department in the selection or choice of medications which meet the most effective therapeutic quality standards;
(d) Evaluation objectively the clinical data regarding new medications or agents proposed for use in the hospital;
(e) To evaluate clinical data concerning new drugs and preparations requested for use in the Medical Center.

11.7 NOMINATING COMMITTEE

The composition and duties of the Nominating Committee are set forth in Section 9.3 of these Bylaws.

11.8 BIOETHICS COMMITTEE

11.8-1 Composition

The Bioethics Committee shall consist of physicians and such other Staff Members as the Medical Executive Committee may deem appropriate. It may also include nurses, lay representatives, social workers, clergy, ethicists, attorneys, administrators and representatives from the board of directors.

11.8-2 Duties

The Bioethics Committee may participate in the development of guidelines for consideration of cases having bioethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment of such cases; retrospective review of cases for the evaluation of bioethical policies; consultation with concerned parties to facilitate communication and aid conflict resolution; and education of the Medical Center staff on bioethical matters. The Committee shall meet as often as necessary at the call of its chairman. It shall maintain a record of its activities and report to the Medical Executive Committee.

11.9 QUALITY COMMITTEE

11.9-1 **Composition**.

The Quality Committee shall consist of such Members as may be designated by the Medical Executive Committee including, insofar as possible, at least one representative from each department, Members of the Staff serving in the capacity of a medical director, and other Staff Members as deemed appropriate by the Chairman of Quality Committee. The Chairman shall be appointed by the Chief of Staff with approval by the Medical Executive Committee.

11.9-2 **Duties**

The Quality Committee shall report periodically to the Medical Executive Committee. Its specific duties shall be to:

(a) Provide oversight and consultation to the Medical Center with respect to plans for improving the quality of care provided and assist the Medical Center in prioritization of clinical process improvement efforts;

(b) Monitor the quality assessment and improvement activities and the results thereof throughout the Medical Center;

(c) Provide oversight and consultation to the departments with respect to plans for improving the quality of care provided;

(d) Monitor and report on the Medical Staff's quality improvement activities;

(e) Establish appropriate systems to ensure identification and resolution of patient care issues;

(f) Provide oversight and consultation to the Medical Center's medical director in his/her duties as they relate to quality of care;

(g) Establish appropriate processes and policies to ensure the integrity of the peer review process and adherence to confidentiality provisions of these Bylaws and all applicable laws;

(h) Provide oversight and consultation to the Medical Center's Health Information Management Services Department;

(i) Coordinate and monitor the Medical Staff's data gathering and analysis components of the quality improvement program;

(j) Monitor the Medical Staff's review activities, including but not limited to, surgical case review, medical records, blood usage and drug usage.

(k) Monitor the quality of services provided pursuant to contracts for clinical service.

(l) Review and make recommendations to the Medical Executive Committee on the quality of sources of medical care provided to hospital patients outside of the hospital.

(m) Review and make recommendations to the Medical Executive Committee on clinical policies and procedures of the Medical Center that affect the Medical Staff.

11.10 PHYSICIAN ADVISORY/CONTRACTS COMMITTEE

11.10-1 **Composition**

The Physician Advisory/Contracts Committee shall consist of the Chief of Staff, Vice-Chief of Staff and other members of the Active Staff appointed by the Chief of Staff. The CEO shall be an ex officio member of the Committee, without vote.

11.10-2 **Duties**

The Physician Advisory/Contracts Committee shall be given the opportunity, at its request:

(a) To review and make recommendations to the CEO regarding quality of care and clinical performance issues relating to position descriptions, qualifications functional responsibilities and reporting structure for all full or part-time Medical Director and hospital based physician positions, whether employed or contracted, at the Medical Center;

(b) To review the qualifications and interview candidates for Medical Director and hospital based physician positions, whether employed or contracted, at the Medical Center and made recommendations to the CEO with respect to such candidates;

(c) To periodically review and make recommendations to the CEO regarding the quality of care and clinical performance of Medical Directors and hospital based physicians, whether employed or contracted, providing services at the Medical Center;

(d) To periodically review the quality of care and clinical performance of all practitioners and groups of practitioners filling full and part-time Medical Director and hospital based physician positions, whether employed or contracted, and make recommendations to the CEO regarding the practitioners filling such positions;

(e) To make recommendations to the CEO with respect to quality of care and clinical performance issues relating to the Medical Center's managed care contracting relationships; and

(f) As requested by the Executive Committee, to review the role and responsibilities of Medical Staff Members and allied health professionals providing services in the Medical Center and make recommendations to the Medical Executive Committee and/or CEO.

(g) As requested by the Medical Executive Committee, to review information submitted to it pursuant to Section 3.7-1(c) relating to Exclusive Agreements and make recommendations to the Medical Executive Committee relating to such Exclusive Agreements.

11.11 PROFESSIONAL REVIEW COMMITTEE

11.11-1 Composition and Authority

The Professional Review Committee (PRC) shall consist of an adequate number of voting members to meet the needs of the committee including the Chief Medical Officer who shall serve as Chair. The Chief Executive Officer, or his/her designee, the Chief of Staff, Vice Chief of Staff, and the Chief Nursing Officer shall serve as ex-officio members of the PRC without vote. The PRC will maintain a broad representation of specialties.

11.11-2 Authority

The PRC will have authority to direct educational assessments, additional education (of two weeks or less in duration) concurrent monitoring, or consultation. PRC will also have the authority to direct practitioners to the Professional Health Committee (PHC) for health assessments and will receive a report from the PHC. PHC may be asked to assist the PRC with concerns related to the practitioner. The PRC will recommend to MEC supervision, extended education, or the limitation, suspension or termination of medical staff privileges. MEC will take action on tie votes of the PRC.

11.11-3 Membership Selection Process

The Medical Staff members will be notified of a vacancy or projected vacancy on the PRC. Any member of the Medical Staff who meets the qualifications in section 11.12-4 may ask to be nominated. Prospective members may also be recommended by a PRC member, a Department or Committee Chair, or Chief of Staff and will be interviewed by the PRC.

Recommendations and interviews shall be conducted when there is a vacancy or projected vacancy within a three months period.

New members shall be nominated by 2/3 approval of all members of PRC. Current voting members seeking subsequent terms may be reselected with 2/3 approval of all remaining members. Voting on existing members will be conducted by closed ballot. Nominated members are then appointed by a majority vote of MEC. Members will be appointed for three year terms and may be appointed to successive terms.

11.11-4 **Qualifications**

PRC members must continuously satisfy the qualifications and complete the requirements set forth in Article 3. Members shall be on the Staff, in good standing, and be willing to serve on a consistent basis. Members must demonstrate leadership skills and may not have any disabling conflict of interests. If an ad hoc member is needed for clinical expertise, the Active Staff status may be required.

11.11-5 **Removal**

Voting members of PRC who do not meet the required meeting attendance, unless there are extenuating circumstances, will be automatically removed from the PRC. The Chief of Staff and CMO may jointly recommend to MEC that a member of the PRC be removed. Removal shall be confirmed by MEC and is effective immediately. Reasons for removal would include untimely review of assigned cases, disruption of the Committee, violations of confidentiality, or promotion of personal agenda and bias.

11.11-5 **Duties**

The Professional Review Committee shall:

(a) Within the scope of its authority as granted in these Bylaws, enforce the Bylaws, rules and regulations, and policies of the Medical Staff, departments and the Medical Center.
(b) Review sentinel events, near misses, and complex clinical issues.
(c) Investigate, review and resolve reports of behavioral or disruptive conduct involving any member of the Medical or AHP staff. The PRC will trend information and take/recommend further action, if warranted.
(d) Review potential conflicts of interest, ethical and moral issues and recommend actions to address actual conflicts impacting clinical quality.
(e) Monitor and evaluate quality and appropriateness of patient care and professional performance of Medical Staff and Allied Health Staff members.
(f) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of Medical and Allied Health Staff Members.
(g) Review professional competence issues as identified through ongoing quality and performance improvement activities, clinical, and operational functions or as referred by Medical Directors, Department Chairs or others.
(h) Review aggregate quality performance data of individual practitioners and make recommendations for quality improvement in the context of peer review.
(i) Implement investigative and precautionary tools as required, including required education/health assessments, consultation, supervision as warranted.
(j) Recommend to the Medical Executive Committee, as required, the limitation, revocation or termination of Medical Staff membership and/or privileges.
(k) Track and monitor actions and recommendations of the MEC to ensure they are being complied with.
(l) Share information with the Departments and Committees to provide opportunities for learning and process improvement.

(m) Seek peer review assistance from qualified sources, including practitioners on the Medical Staff and/or practitioners not on the Medical Staff, if and when the PRC/CMO determines that such assistance is appropriate and/or necessary.

11.11-6 **Duties of the Chair**

The PRC Chair may appoint qualified professionals, including non members of the PRC, to review specific matters before the PRC and provide input to the PRC.

11.11-7 **Miscellaneous Provisions**

a) Meetings: The PRC is scheduled to meet twice monthly to conduct its business. The meetings shall be conducted in executive session and the minutes shall be recorded as privileged and confidential pursuant to A.R.S. 36-445 et seq.
b) Confidentiality of Records: The confidentiality of the PRC records will be strictly maintained.
c) Attendance Requirements:
   (1) Voting members are required to attend 75% of all meetings. Attendance via telephone may be acceptable.
   (2) Compliance with this requirement shall be reviewed every six (6) months.
(d) Quorum: A quorum shall consist of at least 50% of the voting members.

11.12 PROFESSIONAL HEALTH and WELLNESS COMMITTEE

11.12-1 **Composition**

The Professional Health and Wellness Committee will have a Chairman appointed by the Chief of Staff. The Committee shall consist of at least three members chosen by the Chief of Staff upon recommendation of the Chairman of the Professional Health and Wellness Committee. Members shall serve a two year term. When possible, the Committee shall include professionals who are recovering from chemical or alcohol dependency, or emotional or physical impairment.

11.12-2 **Responsibilities**

The Professional Health and Wellness Committee shall be responsible for identifying and managing matters of individual physician and allied health professionals (AHP) health by offering assistance, support and guidance in retaining/regaining optimal professional health and functioning. The Committee shall assist in the assessment of members of the Medical and AHP Staffs who have been identified as impaired or potentially impaired and to monitor such member's participation in treatment until such time as rehabilitation or any disciplinary process is complete. The Committee shall have no disciplinary authority and shall report directly to the Medical Executive Committee.

11.12-3 **Duties**

The Professional Health and Wellness Committee shall:

a) provide ongoing education to the Medical Staff and Administration on physician and AHP health and impairment recognition, on types and levels of impairment and associated problems of impairment; and on resources available for the diagnosis, prevention, treatment and rehabilitation of such impairments;
b) determine the credibility of reports of impairment;
c) establish a means for referral and/or self referral of or by an affected practitioner to the appropriate internal or external professional resources for diagnosis and treatment;
d) assist the Medical Staff in evaluating potential illness and impairment and in monitoring ongoing compliance with treatment recommendations; and

e) assist the Medical Staff leadership with an intervention, when so requested by a department chairman or Chief of Staff/designee.

11.12-4 **Miscellaneous Provisions**

a) Meetings: The Professional Health and Wellness Committee will meet as often as necessary to conduct business. The meeting shall be conducted in executive session and the minutes shall be recorded as privileged and confidential pursuant to A.R.S. 36-445 et seq.

b) Confidentiality of records: The confidentiality of the Professional Health and Wellness Committee records will be strictly maintained, except to comply with state and federal reporting requirements and/or when maintaining confidentiality threatens the safety of patients or identified third parties. A file separate from the credential file will be maintained by Medical Staff Services for practitioners whose activities have come before the Professional Health and Wellness Committee.

11.13 INTERDISCIPLINARY PRACTICE COMMITTEE

11.13.1 **Composition**:

The Interdisciplinary Practice Committee (IPC) shall be a multi-disciplinary committee reporting to the Medical Executive Committee. It shall consist of at least seven members, including representatives of the Allied Health Staff, Medical Staff, Human Resources, Nursing Staff, Medical Staff Services Department, Clinical Performance Assessment and Improvement (CPAI) and the Chief Medical Officer.

11.13.2 **Duties:**

The IPC shall:

a) make recommendations regarding privileges and/or scope of care guidelines for the AHPs;
b) review the qualifications and performance of the AHPs;
c) make recommendations regarding granting, modifying, suspending, revoking and/or denying privileges or scope of care for Allied Health Professionals to the Credentials Committee;
d) develop and periodically review all AHP policies and report their recommendations to the Medical Executive Committee.

11.14 UTILIZATION MANAGEMENT COMMITTEE

11.14-1 **Composition:**

The UMC shall consist of at least three medical staff members appointed by the Chief of Staff in Collaboration with Administration. Required participation shall include the Medical Director of Care Coordination, Chief Nursing Officer, the Director of Case Management, Director of HIMs, Director of Quality Management (or their designee), the Chief Medical Officer and representatives from Finance.

11.14-2 **Duties:**

The Utilization Management Committee (UMC) reviews and evaluates the use of hospital resources. The UMC reviews data that could include:

a)Hospital admissions; b)Level of Care;
c)Continued stays; d)Procedures;
e)Testing and treatment; f)Discharges and transfers;
g)Avoidable days; h)Readmissions;
i)Reimbursement; j)Denials.

11.14-3 **Meetings;**

The UMC will meet monthly, at least eight times per year, and is accountable to the Medical Executive Committee.

ARTICLE TWELVE: CORRECTIVE ACTION

12.1 CRITERIA FOR INITIATING AN INVESTIGATION OR CORRECTIVE ACTION

An investigation or corrective action may be initiated against a practitioner if it appears that the practitioner does not meet the standards and qualifications required by these Bylaws or the Medical Staff Rules, Regulations or policies, or if the practitioner is or may be engaged in a course of conduct, either within or outside the Medical Center, that is detrimental to patient care, lower than the standards or aims of the Medical Staff, or that is inconsistent with the provisions of Section 3.1-4 of these Bylaws.

12.2 PROCEDURES FOR INITIATING AN EVALUATION OR INVESTIGATION LEADING TO POSSIBLE CORRECTIVE ACTION

Whenever a practitioner is requested to refrain from practice because of concerns about his/her ability to engage safely in the practice of medicine, the Chief of Staff or CMO or their designee will request that the practitioner refrain from practice at all Banner facilities.

Investigation:

(a) An investigation is a targeted evaluation of the competence or conduct of a practitioner by the Medical Executive Committee, a Department or a standing peer review committee.

(b) If a determination as stated in (a) is made, the investigation is deemed to be initiated when the practitioners is informed in writing that an investigation is being undertaken.

(c) Routine peer review activities and focused professional practice evaluations (FPPE) as part of initial appointment or privileges does not constitute an investigation.

(d) FPPE undertaken to determine whether a substantial likelihood exists that a practitioners' 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.

Once begun, an investigation does not conclude until the medical staff takes a final action of recommendation, or a decision is made to close the investigation. When closed, the practitioner is informed of the closure of the investigation.

12.2-1 Request for Investigation/Corrective Action

A request for an evaluation, investigation or corrective action may be submitted to the Chief of Staff or Vice Chief of Staff by any Member of the Medical Staff, the Chief Executive Officer or his or her designated administrator, or the Board. The request must be in writing and must be supported by reference to the specific activities or conduct forming the basis for the request. The Chief of Staff shall notify the practitioner of the general nature of the request and may communicate additional information regarding the request. The Chief of Staff may notify the Medical Executive Committee if the matter is, in his or her opinion, plainly without merit. The Medical Executive Committee may dismiss such a matter with notation on its record to that effect. If the matter may have merit, the Chief of Staff shall refer the request to the Professional Review Committee.

12.2-2 Determination Whether an Investigation is Warranted

(a) Within 30 days, the Professional Review Committee shall consider the request and determine whether or not an investigation is warranted. The Professional Review Committee may use one or more of the "evaluation tools" described below to determine if an investigation is warranted. The use of these evaluation tools does not constitute an investigation. Evaluation tools include an interview with the practitioner, concurrent or retrospective chart review and/or consultation requirements. A practitioner's refusal to cooperate in an evaluation constitutes grounds for automatic suspension of privileges pursuant to Section 12.5-7 of these Bylaws. The affected practitioner has the right to an interview with the Professional Review Committee if such practitioner believes the Professional Review Committee should reconsider the use of any such evaluation tools. However, the practitioner is not entitled to the procedural rights afforded by these Bylaws because of the use of such evaluation tools.

(b) If it appears that an investigation is warranted, the Professional Review Committee shall notify the Chief of Staff and Department Chairman and shall initiate the investigation. In certain instances, the Medical Executive Committee may conduct its own investigation directly or through a designated ad hoc committee.

12.2-3 **Procedure for Professional Review**

(a) Within 60 days after a determination that an investigation is warranted, the Professional Review Committee shall conclude its investigation, document its findings and make a report and recommendations to the Department Chairman and Medical Executive Committee for dealing with the request. If the Professional Review Committee deems it necessary and appropriate, the Professional Review Committee may use persons not on the Medical Staff to assist it in evaluating matters that it is investigation. Prior to making any adverse recommendation to the Department Chairman and Medical Executive Committee, the affected practitioner shall be notified of the general nature of the complaint and he or she shall have the opportunity for an interview with the Professional Review Committee. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws or the Fair Hearing Plan shall apply thereto.

(b) A record of such interview shall be made by the Professional Review Committee and included with its report and recommendation which shall be forwarded to the Department Chairman and the Medical Executive Committee by the Professional Review Committee chairman.

(c) In certain instances, an investigation may not be concluded within 60 days. In such instances, the investigation shall be conducted as soon as reasonably practicable and a 60 day interim report from the Professional Review Committee chairman must be made to the department chairman and the Medical Executive Committee stating the estimated completion date. The affected practitioner shall have no procedural rights arising out of such delay.

(d) In the event that the Professional Review Committee recommends that corrective action is warranted, the Chairman of the Professional Review Committee and the affected practitioner shall be invited to discuss the findings of the Professional Review Committee with the Medical Executive Committee.

(e) The Medical Executive Committee shall consider the report and recommendation of the Professional Review Committee. After its deliberations, the Medical Executive Committee may uphold, modify or reject the recommendation and shall forward any adverse recommendation to the Board. If the recommendation includes reviewable corrective action, the affected practitioner shall be given notice and a right to a hearing

as set forth in these Bylaws and the Fair Hearing Plan to be held, if timely requested, before the Board takes action.

12.2-4 **Indemnification**

Prior to the appointment of hearing committee members, the appointing Medical Executive Committee member shall submit to the Administrator the names of the proposed hearing committee members. The Administrator, upon advice of BH legal counsel, shall promptly inform the appointing Executive Committee member of any reasons why any proposed member should not serve. Such reasons shall be based upon federal or state law restrictions or requirements. During the entire hearing process, the Administrator and BH legal counsel shall assess the hearing process and shall 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 or other matters which in the opinion of legal counsel present substantial risk to the Medical Center and the BH 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 which interfere with clinical opinions of Medical Staff Members but may comment on the relevancy, effectiveness and appropriateness of the evidence to be considered. In exchange for this right of participation, BH will defend, indemnify and hold harmless all physicians participating in the corrective action and hearing processes from any and all claims or liability arising out of their participation in such actions or processes.

12.3 SUMMARY SUPERVISION

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

(a) Chief of Staff, or designee
(b) Applicable department chairman or vice chairman
(c) Chief Executive Officer or designated administrator

12.4 SUMMARY SUSPENSION

12.4-1 **Initiation**

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

(a) Chief of Staff, or designee
(b) Applicable department chairman, or vice chairman
(c) Chief Executive Officer or designated administrator

A summary suspension is effective immediately upon imposition and shall be followed promptly by special notice to the affected practitioner, which notice shall include a description of the grounds for the suspension.

12.4-2 **Review by the Medical Executive Committee**

The Medical Executive Committee or a subcommittee of the Medical Executive Committee, having no less than four members appointed by the Chief of Staff, shall review the summary suspension within ten days. The affected practitioner shall be notified of the date and time of the review and shall be given the opportunity to present evidence in his or

her defense. The Chief of Staff may request persons not on the Medical Executive Committee to provide clinical assistance to the Committee or subcommittee. After deliberation, the Medical Executive Committee or a subcommittee may direct that the summary suspension be terminated or continued. Summary supervision may be imposed pending completion of an ongoing investigation.

12.4-3 **Expedited Hearing Rights**

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

12.4-4 **Alternative Coverage**

Immediately upon imposition of summary suspension, the Chief of Staff or the department chairman shall arrange alternative medical coverage for the patients of the suspended practitioner who are in the Medical Center. Patients' wishes shall be considered in the selection of an alternative practitioner.

12.5 AUTOMATIC SUSPENSION OR LIMITATION

In the event any of the conditions described in Section 12.5.1 through 12.5.3 herein occurs, the affected practitioner shall immediately notify the Chief Executive Officer or designated administrator of such condition and the reasons therefore. Automatic suspension shall be immediately imposed under the conditions described in this Section 12.5 without prior action by the Medical Executive Committee or the Board. The Chief of Staff shall notify the practitioner of the suspension. Alternative coverage will be provided for patients as set forth in Section 12.4-4. In addition, further corrective action may be recommended in accordance with the provisions contained in these Bylaws under any of the following conditions described in this Section 12.5.

A staff member may be reinstated following automatic suspension by complying with the requirements that triggered suspension. Where a staff member is suspended or asked to refrain because of concerns relating to professional conduct or competence or impairment, the staff member must request reinstatement and provide evidence that the concerns were satisfactorily resolved. Members on suspension or who have been asked to refrain will not be reappointed while such status is pending. Within one year of suspension or being asked to refrain, they may request reinstatement and submit a completed reappointment application. Reappointment will be processed in accordance with the procedures set forth in the Bylaws. Reinstatement is effective once approved by the Medical Executive Committee and the Board.

12.5-1 **License**

(a) Revocation

Whenever a practitioner's license to practice in this state is revoked, his or her Medical Staff appointment and clinical privileges shall be immediately and automatically revoked.

(b) Restriction

Whenever a practitioner's license is limited or restricted in any way, his or her clinical privileges that are within the scope of the limitation or restriction shall be similarly, immediately and automatically restricted.

(c) Suspension

Whenever a practitioner's license is suspended, his or her Medical Staff appointment and clinical privileges shall be immediately and automatically suspended for the term of the licensure suspension.

(d) Probation

Whenever a practitioner is placed on probation by a licensing authority, his or her membership status and clinical privileges shall become subject to the same terms and conditions of the probation.

12.5-2 **Controlled Substances Registration**

Whenever a practitioner's DEA or other controlled substances registration is revoked, restricted or suspended, the practitioner's right to prescribe medications covered by the registration shall be immediately and automatically revoked, restricted or suspended.

12.5-3 **Professional Liability Insurance**

Whenever a practitioner is no longer covered by professional liability insurance that is acceptable to the Board, his or her clinical privileges shall be immediately and automatically suspended for the time the practitioner fails to have acceptable professional liability insurance in force.

12.5-4 **Medical Records**

A suspension of certain privileges shall be imposed for failure to complete medical records within the time periods established in the Rules and Regulations. Temporary suspension shall be lifted upon completion of the delinquent records. Repeated suspensions for failure to complete medical records may result in removal from the Medical Staff.

12.5-5 **Failure to Satisfy Special Appearance Requirement**

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

12.5-6 **Failure to Cooperate**

A practitioner who fails to cooperate with the appointment or reappointment process or an evaluation or investigation under Article Twelve of these Bylaws, including by refusing to authorize a release of information or provide information or documentation when requested by the Chief of Staff, the Credentials Committee, an ad hoc evaluation committee, an Investigating Committee or a department chairman shall automatically be suspended. If the release is executed or the information or documentation is provided within 30 days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the Staff and must reapply for Staff membership and privileges.

12.5-7 **Failure to Provide Evidence of Licensure, and Professional Liability Insurance, Current Office Location and Covering Physician**

A practitioner who fails to provide Medical Staff Services written documentation evidencing such practitioner’s current licensure, professional liability insurance, current practice location and/or covering physician within (30) days of a request shall automatically be suspended from the Medical Staff. If the written documentation is provided within thirty (30) days of notification of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the Staff and must reapply for Staff membership and privileges.

12.5-8 **Failure to Establish Freedom from Infectious TB**

A practitioner’s medical staff membership and clinical privileges shall be immediately suspended for failure to establish freedom from infectious TB whenever such evidence is

requested. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension, upon presentation of proof of freedom from infectious TB. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

12.5-9 **FAILURE TO OBTAIN NPI AND ENROLL IN PECOS/OPT OUT OF MEDICARE**

If and when required by CMS, a practitioner who has not obtained a National Provider Identification Number (NPI) shall automatically be suspended. A practitioner who is not enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS) or who has not submitted the required affidavit to the Medicare Carrier to opt out of the Medicare Program and who fails to enroll or opt out within 10 business days of being requested by Banner to enroll or opt out shall automatically be suspended. If evidence that the practitioner has enrolled or has opted out is provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

The provisions in this Section12.5-9 shall not be effective unless and until CMS adopts requirements that obligate practitioners to obtain an NPI and/or be enrolled in PECOS or opt out of the Medicare Program.

12.6 NONREVIEWABLE CORRECTIVE ACTION

Not every form of corrective action entitles the practitioner to the procedural rights provided by the Bylaws and the Fair Hearing Plan. Those types of corrective action giving rise to automatic suspension or limitation as set forth in Section 12.5 are not reviewable pursuant to the Fair Hearing Plan. In addition, the following actions or occurrences are also nonreviewable:

12.6-1 Imposition of observation pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.

12.6-2 Issuance of a warning or a letter of admonition or reprimand.

12.6-3 Imposition of monitoring of professional practices, other than direct observation, for a period of less than 180 days.

12.6-4 Denial, termination or limitation of temporary privileges.

12.6-5 Supervision and other requirements or limitations imposed during the practitioner's provisional period.

12.6-6 Termination of any employment or independent contractor contract with the Medical Center.

12.6-7 Any recommendation accepted by a practitioner.

12.6-8 Denial of membership and privileges for failure to complete an application for member-ship or privileges.

12.6-9 Removal of membership and privileges for failure to complete observation within the time period granted by these Bylaws or any applicable Rules and Regulations.

12.6-10 Removal of membership and privileges for failure to submit an application for reappointment within the allowable time period.

12.6-11 Removal of membership and privileges for failure to pay staff dues.

12.6-12 Reduction or change in Staff category. A Medical Staff Member who feels he or she has unjustly been moved from the Active Staff category may request reconsideration of the change by the Medical Executive Committee.

12.6-13 Refusal of the Credentials Committee, department or the Medical Executive Committee to consider a request for appointment, reappointment, Staff category, department/section assignment, or privileges within one year of a final adverse decision of a substantially similar request.

12.6-14 Recommendation by the Medical Executive Committee that a practitioner obtain CME in his specialty or ACLS certification.

12.6-15 Termination of Medical Staff membership for excessively or repeatedly delinquent medical records in accordance with the provisions as set forth in the Medical Staff Rules and Regulations.

12.6-16 Denial of a Staff Member's request to be put on, or the removal of a Staff Member from, the on call roster.

12.6-17 Any requirement to complete an educational assessment or training program.

12.6-18 Any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.

12.6-19 Failure to become board certified or maintain board certification in compliance with these bylaws or applicable department rules and regulations.

12.6-20 Denial, termination or limitation of membership and/or privileges as a result of: (1) a decision by the Medical Center to enter into, terminate or modify an Exclusive Agreement for certain professional services; or (2) the termination or modification of the practitioner's relationship with the practitioner or group of practitioners with whom the Medical Center has an Exclusive Agreement.

Where an action that is not reviewable under the Fair Hearing Plan has been taken against a practitioner, the affected practitioner may request that the Medical Executive Committee review the action, and the practitioner may submit information demonstrating why the action is unwarranted. The Medical Executive Committee, in its sole discretion, shall decide whether to review the submission and whether to take or recommend any action, and the affected practitioner shall have no appeal or other rights in connection with the Medical Executive Committee's decision.

12.7 HEARING AND APPEAL RIGHTS

12.7-1 HEARINGS AND APPELLATE REVIEW

When a reviewable action has been taken against an applicant or member of the Medical Staff, such practitioner shall be afforded the rights set forth in the Fair Hearing Plan, including a right to a hearing and appellate review in accordance with the terms of the Fair Hearing Plan and Banner Health's Appellate Review Policy (as such Policy is included in the Fair Hearing Plan).

12.7-2 REQUEST FOR HEARING

When a practitioner's hearing rights are triggered, the practitioner shall be notified of the grounds for the adverse action or recommendation and his/her right to request a hearing by submitting a written request to the CEO within 30 days, all as is further set forth in the Fair Hearing Plan.

12.7-3 HEARING PANEL

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

12-7.4 SCHEDULING THE HEARING

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

12.7-5 HEARING PROCESS

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

12.7-6 **SCHEDULING THE APPELLATE REVIEW**

Upon receipt of a timely and proper request for appellate review, the General Counsel of Banner Health shall schedule the appellate review as soon as practicable. The General Counsel will attempt to schedule the review at a date and time acceptable to the practitioner, representatives of the Medical Staff and members of the Appeals Subcommittee.

12.7-7 **APPELLATE REVIEW PROCESS**

The practitioner and the Medical Executive Committee may submit written and oral statements in support of their respective positions in accordance with the terms of the Fair Hearing Plan. The practitioner has the burden of demonstrating, by a preponderance of the evidence, that the hearing was not in substantial compliance with the procedures required by the Medical Staff Bylaws, the Fair Hearing Plan or applicable law, and created demonstrable prejudice; or that the adverse recommendation or action was arbitrary, capricious, or not supported by substantial evidence based upon the Hearing Record.

ARTICLE THIRTEEN: MEETINGS

13.1 MEDICAL STAFF MEETINGS

13.1-1 **Medical Staff Year**

The Medical Staff business year shall begin on January 1 and end on December 31 of that year.

13.1-2 **Regular Meetings**

An annual Staff meeting shall be held each year. The Medical Executive Committee may authorize the holding of additional general Staff meetings. The Staff Members shall receive written notice of all Staff meetings specifying the place, date and time for the meeting at least two weeks before each meeting.

13.1-3 **Special Meetings**

A special meeting of the Medical Staff may be called by the Chief of Staff, and must be called by the Chief of Staff at the written request of the Board, the Medical Executive Committee, or by ten members of the Active Staff. The Staff shall receive written notice of such special meetings no less than one week in advance of each meeting.

13.2 CLINICAL DEPARTMENT AND COMMITTEE MEETINGS

13.2-1 **Regular Meetings**

Clinical departments or committees may, by resolution, provide the time for holding regular meetings. No notice other than notice of such regular meetings is required. A department must meet at least quarterly.

13.2-2 **Special Meetings**

A special meeting of any department or committee may be called by the chairman thereof, and must be called by the chairman at the written request of the Chief of Staff, the Medical Executive Committee, or ten members of the department or committee. Notice of such special meeting will be given to all members of the department or committee at least 48 hours prior to the time set for the special meeting.

13.2-3 **Executive Session**

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

13.3 ATTENDANCE REQUIREMENTS

13.3-1 **Special Appearance or Conferences**

(a) A practitioner whose patient's clinical course of treatment is scheduled for case discussion as part of regular quality review activities may be required by the department or committee to present the case. If the practitioner has been so notified, his or her attendance will be mandatory at the meeting at which the case is to be discussed.

(b) Whenever an education program or clinical conference is prompted by findings of quality review, risk management, utilization management or other monitoring activities, the practitioner whose patterns of performance prompted the program will be notified by the department chairman of the time, date and place of the program, the subject matter to be covered, and its special applicability to the practitioner's practice. Attendance is mandatory. Failure to attend may result in initiation of corrective action proceedings or automatic suspension pursuant to Section 12.5-5.

(c) Whenever deviation from standard practice is identified or suspected with respect to a practitioner's performance, the Chief of Staff or the applicable department chairman may require the practitioner to confer with him or her or with the department or committee considering the matter. The practitioner will be notified of the date, time and place of the conference, and the reasons therefor. Failure of a practitioner to appear at any such meeting may result in the initiation of corrective action proceedings or automatic suspension pursuant to Section 12.5-5.

13.4 QUORUM

13.4-1 **General Staff Meetings**
A quorum is not required.

13.4-2 **Committee Meetings**
The presence of 25% of the members of the Medical Executive Committee shall constitute a quorum. The presence of two voting members shall constitute a quorum at any other committee meeting.

13.4-3 **Department Meetings**
Each department shall establish what constitutes a quorum for the transaction of business at meetings of the department.

13.5 PARLIAMENTARY PROCEDURES

The rules contained in the current edition of "Robert's Rules of Order Newly Revised" shall govern the Medical Staff in all cases to which they are applicable and in which they are not inconsistent with these Bylaws and the Fair Hearing Plan and any special rules of order the Medical Staff may adopt.

13.6 INTERFACILITY MEDICAL STAFF COMMITTEE ACTIVITIES

With approval from the Chief of the Medical Staff and Department or Committee Chairman, representatives of a Banner Thunderbird 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.

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

ARTICLE FOURTEEN: GENERAL PROVISIONS

14.1 DEPARTMENT RULES AND REGULATIONS

Each department will formulate written Rules and Regulations for the conduct of its affairs and the discharge of its responsibilities, all of which must be consistent with these Bylaws and the BH Bylaws. These department Rules and Regulations must be reviewed annually and, when formulated or amended, must be approved by the Medical Executive Committee and the BH Board.

14.2 STAFF DUES

Annual dues for all categories of Staff membership of the Medical Center will be determined by the Medical Executive Committee on an annual basis. Community Based Provider Staff are exempt from paying dues. Annual dues shall be paid within 60 days of the written dues notice. Thereafter, if unpaid, the practitioner will be charged a $200 late fee. The practitioner will be notified by certified mail, return receipt requested, that Staff membership will be terminated unless full payment of such annual dues and late fee is received within 30 days following the mailing of such notification. The practitioner shall be deemed to have resigned voluntarily from the Medical Staff and must reapply for Staff membership and privileges.

14.3 SPECIAL NOTICE

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

14.4 CONSTRUCTION OF TERMS AND HEADINGS

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

14.5 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 require the support of certain members of the administrative staff of the Medical Center who may or may not be members of the Medical Staff including, but not necessarily limited to, the Medical Center's CEO, Chief Medical Officer, Chief Nursing Officer and/or designees, and Quality Management, and members of the Medical Staff Services Department, and Litigation Attorneys from the BH Risk Management Department (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 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 not limited to, activities involved 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 delegated from time to time by the officers or committees of the Medical Staff.

14.6 CHIEF MEDICAL OFFICER

The Chief Medical Officer shall have Medical Staff leadership and peer review responsibilities as delegated by the Medical Executive Committee including, but not limited to, responsibility for reviewing care, conducting investigations, indentifying trends and resolving issues.

14.7 CONFLICT RESOLUTION

14.7-1 **STAFF MEMBER CHALLENGE**

Any member of the Medical Staff may challenge any rule or policy established by the Medical Executive Committee by submitting to the Chief of Staff written notification of the challenge. Any such challenge must be supported by a petition signed by 20% of the members of the Active Medical Staff, and must set forth the basis for the challenge and recommended changes to the rule or policy.

14.7-2 **MEDICAL EXECUTIVE COMMITTEE REVIEW**

The Medical Executive Committee will consider the challenge at its next meeting and will determine whether and to what extent to change the rule or policy or may, in its discretion, whether to appoint a subcommittee to review the challenge and recommend potential changes to address the challenge. The Medical Executive Committee may use internal or external resources to assist in determining how best to address the challenge. If applicable, the Medical Executive Committee will review the subcommittee's recommendations and take final action on whether and to what extent to change the challenged rule or policy, subject to Board approval as required. The Medical Executive Committee will communicate all changes to its rules and/or policies made pursuant to this Section 14-9.2 to the Medical Staff.

14.7-3 **CONFLICT RESOLUTION RESOURCES AND BOARD RESPONSIBILITY**

A recommendation to use either internal or external resources to resolve a conflict between the Medical Staff and the Medical Executive Committee may be made by the Board, the CEO, the Medical Executive Committee, or members of the Medical Staff. Any conflict regarding the use of such resources or the process to be followed will be decided by the Board through the Medical Staff Subcommittee. The Board has final authority to resolve any conflicts between the Medical Staff and the Medical Executive Committee that cannot be resolved by such bodies.

14.8 HISTORIES AND PHYSICALS

A history and physical examination (H&P) shall be completed and put in the medical record in all cases within 24 hours after admission by a physician, oral surgeon, or Allied Health Professional who is approved by the Medical Staff to perform admission H&Ps. The completed H&P must be on the medical record prior to the start of any surgery or invasive procedure or any procedure in which conscious sedation or general anesthesia 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 what must be included in a completed H&P is delineated in the Rules and Regulations.

ARTICLE FIFTEEN: CONFIDENTIALITY, IMMUNITY & RELEASES

15.1 AUTHORIZATION AND RELEASES

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

15.1-1 Authorizes representatives to solicit, provide and act upon information bearing on or reasonably believed to bear upon the practitioner's professional ability, utilization practices and qualifications;

15.1-2 Agrees to be bound by these Bylaws and the Fair Hearing Plan regardless of whether membership or clinical privileges are denied or granted or are subsequently limited;

15.1-3 Acknowledges that the provisions of this Article 15 are express conditions to an application for, or acceptance of, Medical Staff membership and the continuation of such membership and

the exercise of clinical privileges or provision of specified patient care services at the Medical Center;

15.1-4 Agrees to release from legal liability and hold harmless any person who acts in connection with peer review or corrective action activities at the Medical Center;

15.1-5 Agrees that his/her sole remedy for any action taken with respect to the practitioner's application and any corrective action taken or recommended by the Medical Center or the Medical Staff, or any of their committees, shall be the right to seek injunctive relief;

15.1-6 Agrees to release from legal liability and hold harmless any person who, or entity which, provides information regarding the practitioner to the Medical Center, the Medical Staff, or their representatives; and

15.1-7 Agrees to release from liability and hold harmless the Medical Center, the Medical Staff and all persons engaged in appointment, peer review or corrective action activities which include, but are not limited to, those activities identified in Section 15.1 of these Bylaws, as well as any other Medical Staff functions provided for or permitted in these Bylaws or any applicable federal or state statute or regulation.

15.2 CONFIDENTIALITY OF INFORMATION

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

15.3 ACTIVITIES COVERED

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

(a) Application for appointment, reappointment, clinical privileges or specified services;
(b) Periodic appraisals of clinical privileges or specified services;
(c) Corrective or disciplinary actions;
(d) Hearings or appellate reviews;
(e) Quality review program activities;
(f) Utilization review and management activities;
(g) Claim review activities;
(h) Profiles and profile analyses;
(i) Risk management activities; and
(j) Other Medical Center, Medical Staff, committee or department activities related to monitoring, maintaining and improving quality and efficiency of patient care and appropriate professional conduct.

15.4 RELEASES

Each practitioner shall, upon request of the Medical Center, execute general and specific releases in accordance with the tenor and import of this Article. Failure to execute such releases may result in an application for appointment, reappointment or clinical privileges being deemed voluntarily withdrawn, and it shall not be further processed. Failure to execute such releases upon request during a term of appointment to the Medical Staff shall result in automatic suspension as provided in Article 12.5-7 of these Bylaws.

15.5 CUMULATIVE EFFECT

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

15.6 CONFIDENTIALITY OBLIGATIONS

Members of the Medical Staff who are acting in connection with appointment, peer review and corrective action activities are afforded access to certain confidential information, including but not limited to, peer review information and patient information. In addition, BH's confidential business information may also be shared. Staff Members are required:

(a) To use confidential information only as necessary for treatment, payment and healthcare operations in accordance with HIPAA laws and regulations, or to perform Medical Staff responsibilities, to conduct authorized research activities, or to perform medical staff responsibilities. For purposes of these Bylaws, confidential information means patient information, peer review information, and Banner Health's business information designated as confidential by Banner Health or it representatives prior to disclosure;

(b) To refrain from disclosing confidential information to anyone unless authorized to do so; and

(c) To protect access codes and computer passwords and to ensure confidential information is not disclosed.

ARTICLE SIXTEEN: ADOPTION AND AMENDMENT

16.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Medical Staff shall be responsible for the development, adoption and periodic review of these Bylaws, which must be consistent with BH Bylaws and applicable laws. Except as provided below, the amendment of these Bylaws must be approved by the Active Medical Staff and the Board.

16.2 BYLAWS REVIEW

The Bylaws shall be reviewed and revised as needed, but must be reviewed at least every two (2) years by the Bylaws Committee. When necessary, the Bylaws, will be revised to reflect current practices with respect to Medical Staff organization and functions. Reviews shall also be conducted upon request of the Board.

16.3 PROPOSAL OF AMENDMENTS

The Board or any Active Medical or Active Affiliate Staff Member, department or committee of the Staff may propose amendments to these Bylaws. These Bylaws may be amended only pursuant to this Article, and may not be unilaterally amended or suspended by either the Board or the Medical Staff; provided, however, that the Board may unilaterally amend the Bylaws to assure compliance with state and federal laws if the Medical Staff has failed to do so within a reasonable time. The provisions of the Bylaws shall be interpreted consistent with applicable federal and state laws and regulations. If changes in such laws or regulations require amendment of these Bylaws, the Medical Staff shall expeditiously amend these Bylaws within the period specified by the enactment, or if no period is specified, within a reasonable time.

16.4 STANDARD PROCEDURE FOR SUBMITTING PROPOSED BYLAWS AMENDMENTS

16.4-1 A proposed amendment shall be submitted in writing to either the Chairman of the Bylaws Committee or to the Medical Executive Committee.

16.4-2 The Chairman of the Bylaws Committee may notify the Medical Executive Committee if, in his/her opinion, the proposed amendment is plainly without merit. If the proposal may have merit, the Chairman of the Bylaws Committee shall call a meeting of the Bylaws Committee within sixty (60) days of receiving a proposed amendment at which time each of the following shall take place:

(a) The individual sponsor or the chairman of the sponsoring department or committee, or their designee, shall be given the opportunity to present the proposed amendment and the rationale for the amendment.

(b) The Bylaws Committee shall review with the individual sponsor or chairman of the sponsoring group the proposed amendment so that it:

(1) becomes easily understandable;

(2) accurately conveys the purpose intended; and

(3) interacts with all parts of the Bylaws without conflict.

(c) The Bylaws Committee shall make a recommendation to the Medical Executive Committee for or against the proposed amendment based on its overall benefit to the Staff.

16.4-3 The proposed amendment, with the Bylaws Committee recommendation for or against, shall then be distributed to each member of the Medical Executive Committee at least three days prior to the next Medical Executive Committee meeting.

16.4-4 The Chairman of the Bylaws Committee shall present the proposed amendment for discussion at the first Medical Executive Committee meeting thereafter at which both a quorum of the Medical Executive Committee and the individual sponsor or chairman of the sponsoring group are present. Acceptance, rejection or amendment of the proposed amendment may be made at this time by a majority vote of those present at the meeting of the Medical Executive Committee at which a quorum is present.

16.4-5 When the Medical Executive Committee accepts the proposed amendment in any form it shall be presented to the Active Medical and Active Affiliate Staffs as provided in Section 16.5.

16.5 PRESENTATION OF PROPOSED AMENDMENTS TO THE ACTIVE STAFF

16.5-1 The proposed amendments, as approved by the Medical Executive Committee, shall be mailed or emailed by Medical Staff Services to each Member of the Active Medical and Active Affiliate Staffs at least 14 days prior to the next regular or special meeting called to consider adoption of the proposed amendments.

16.5-2 The proposed amendments shall be submitted accompanied by the recommendations of the Bylaws and Medical Executive Committees. The proposed amendments may be adopted, or modified by a two-thirds vote of the Active Medical and Active Affiliate Staff Members.

16.6 PROCESS OF VOTING ON PROPOSED AMENDMENTS

16.6-1 An official ballot for voting on proposed amendments shall be mailed or emailed by Medical Staff Services to each Active Medical and Active Affiliate Staff Member and shall include an announcement that the ballots must be received in the Medical Staff Services office by 5:00 p.m. on the date specified for counting ballots which shall be at least 14 days after the ballots are mailed or emailed. Members of the Active Medical and Active Affiliate Staff may cast their vote in the Medical Staff Services Department prior to the deadline.

16.6-2 To be counted, the ballot must be delivered personally or received by mail at the Medical Staff Services office before 5:00 pm on the date that the ballots are to be counted.

16.6-3 The ballots shall be counted by the Medical Executive Committee or by a group of tellers authorized by the Medical Executive Committee before midnight the day ballots are to be

counted. At least one member of the Medical Executive Committee shall be present at the counting of the ballots.

16.6-4 Amendment of the Bylaws by mail or email ballot requires the return of that number of ballots equivalent to a quorum of a meeting of the general Staff, and a two-thirds vote of the Active Medical and Active Affiliate Staff Members who return a ballot.

16.7 PROCEDURE FOR THE MEDICAL STAFF SUBMITTING PROPOSED AMENDMENTS TO THE BOARD

The Medical Staff may propose Bylaws or amendments thereto directly to the Board. However, prior to submitting a proposed Bylaw or Bylaw amendment to the Board, any such proposed Bylaw or Bylaw amendment must be supported by a petition signed by at least 20% of the Active Medical and Active Affiliate Staff members and shall be submitted to the Medical Executive Committee. The Medical Executive Committee will review the proposed amendment at its next meeting. The Medical Executive Committee may consider the proposed amendment or refer the proposed amendment to the Bylaws Committee or to an ad hoc committee for its consideration and recommendations, which shall be made to the Medical Executive Committee. If the Medical Executive Committee does not accept the Medical Staff's proposed amendment, and if the representatives of the Medical Staff who submitted the proposed amendment and the Medical Executive Committee do not agree on alternative language for the proposed amendment, the members of the Medical Staff who proposed the amendment may submit the proposed amendment for approval by the Board. If the members of the Medical Staff who proposed the amendment wish it to be considered by the Board, the proposed amendment shall first be submitted to the Active Medical and Active Affiliate Staff for approval in accordance with the ballot process described in Section 16.5. Any ballot shall be accompanied by a copy of the proposed amendment, a summary thereof and comments of the Medical Executive Committee. If a proposed amendment is approved by the Active Medical and Active Affiliate Staff in accordance with Section 16.6, it shall be submitted to the Board for final approval.

16.8 BOARD OF DIRECTORS ACTION

16.8-1 **When Favorable to Medical Staff Recommendation**

Medical Staff recommendations regarding proposed amendments to these bylaws shall be effective upon the approval of the Board.

16.8-2 **Board Concerns**

In the event the Board has concerns regarding any provision or provisions of the Bylaws or proposed amendments thereto, the Board and Medical Staff shall establish a Joint Conference Committee comprised of three representatives of each body to resolve such concerns.

16.9 FAIR HEARING PLAN, MEDICAL STAFF RULES AND REGULATIONS AND ALLIED HEALTH RULES AND REGULATIONS

16.9-1 **PERIODIC REVIEW**

The Fair Hearing Plan, Medical Staff Rules and Regulations, and Allied Health Rules and Regulations shall be reviewed at least every two (2) years by the Medical Executive Committee or its delegated committee and shall be revised as needed. Reviews shall also be conducted upon request of the Board.

16.9-2 **COMMUNICATION TO THE MEDICAL STAFF**

(a) Routine matters. Absent a documented need for urgent action, before amending any of the documents listed in Section 16.9-1, the Medical Executive Committee will communicate to the Medical Staff by mail or email all proposed changes to the documents listed in Section 16.9-1 before submitting such changes to the Board. Members of the Medical Staff may submit comments to the Chief of Staff c/o the Medical Staff Services Department within 10 days. If no comments are received within 10 days, the Medical Executive Committee's recommendation relating to the proposed amendment(s) will be submitted to the Board for approval. If any comments are received by the Chief of Staff, the Medical

Executive Committee will determine whether to approve, modify or reject such proposed amendment(s).

(b) Urgent matters. In cases of a documented need for urgent action, the Medical Executive Committee and Board may provisionally adopt an amendment to one or more of the documents listed in Section 16.9-1 without prior notification to the Medical Staff. The Medical Executive Committee will immediately notify the Medical Staff of the amendment and provide an opportunity for comment in the manner described in Section 16.4-5**.** If comments are not received indicating that at least 20% of the Active Staff oppose the amendment, the Medical Executive Committee will address such comments by utilizing the conflict resolution process set forth in Section 14.9. If required by the Bylaws, a revised amendment will be submitted to the Medical Staff and, if approved, to the Board for action.

16.9-3 The Medical Staff may propose amendments to the Fair Hearing Plan, Medical Staff Rules and Regulations, or Allied Health Rules and Regulations to the Medical Executive Committee or directly to the Board. However, prior to submitting a proposed amendment to any of the documents listed in the preceding sentence to the Board, any such proposed amendment must be supported by a petition signed by at least 20% of the Active Staff members and shall be submitted to the Medical Executive Committee. The Medical Executive Committee will review the proposed amendment at its next meeting. The Medical Executive Committee may refer the proposed amendment to the Bylaws Committee or to an ad hoc committee for its consideration and recommendations, which shall be made to the Medical Executive Committee. If the Medical Executive Committee does not accept the Medical Staff's proposed amendment, and if the representatives of the Medical Staff who submitted the proposed amendment and the Medical Executive Committee do not agree on alternative language for the proposed amendment, the members of the Medical Staff who proposed the amendment may submit the proposed amendment for approval by the Board.

16.10 TECHNICAL AND EDITORIAL AMENDMENTS

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

ARTICLE SEVENTEEN: JOINT CONFERENCE COMMITTEE

17.1 In the event the Medical Executive Committee or the Board have concerns or disagreements regarding credentialing recommendations, Exclusive Agreements with members of the Medical Staff, policies or other issues that have not been able to be resolved through informal processes between the Medical Executive Committee and the Medical Center or Banner Health administration, management or Board, the Board and the Medical Executive Committee shall establish a Joint Conference Committee consisting or three representatives appointed by the Board and three representatives who are members of the Medical Staff appointed by the Chief of Staff to resolve such concerns. The Joint Conference Committee shall conduct its proceedings in the manner specified in the Banner Health Bylaws.

ADOPTION AND APPROVAL

ADOPTED by the Banner Thunderbird Medical Center Medical Staff:

Roberto Hayes, MD, Chief of Staff Date: March 14, 2019

Revised: December, 1989
Revised: November, 1990
Revised: June, 1991
Revised: December, 1991
Revised: December, 1992
Revised: September, 1993
Revised: December, 1995
Revised: September, 1996
Revised: December, 1996
Revised: February, 1998
Revised: November, 1998
Revised: September, 1999
Revised: November, 2010
Revised: May 17, 2011
Revised: November 22, 2011
Revised: January 24, 2012
Revised: July 21, 2014
Revised: June 8, 2017

Revised: January, 1994
Revised: May, 1994
Revised: December, 1994
Revised: June 16, 2005
Revised: July 19, 2007
Revised: March 25, 2008
Revised: April 28, 2009
Revised: July 12, 2018
Revised: July 18, 2018

APPROVED by the Operating Board of Banner Health Arizona upon recommendation of the Medical Staff.

Revised: Medical Executive Committee - 10/2000
Approved: General Staff Meeting - October 2000
Banner Health Arizona Board - January 2001
Revised: General Staff Meeting - August 2003
Approved: Banner Health Board - October 2003
Revised: General Staff - May, 2004
Banner Health Board - June, 2004
Revised: General Staff – November 9, 2004
Approved: Banner Health Board – November 18, 2004
Revised: General Staff – May 17, 2005
Approved: Banner Health Board – June 16, 2005
Revised: General Staff – August 30, 2005
Approved: Banner Health Board – October 20, 2005
Revised: General Staff – August 31, 2007
Approved: Banner Health Board - September 20, 2007
Revised: General Staff – May 20, 2008
Approved: Banner Health Board – June 12, 2008
Revised: General Staff – August 19, 2008
Approved: Banner Health Board – September 11, 2008
Revised: General Staff – May 19, 2009
Approved: Banner Health Board – June 11, 2009
Revised: General Staff – November 16, 2010
Approved: Banner Health Board – November 11, 2010
Revised: General Staff – May 17, 2011
Approved: Banner Health Board – June 9, 2011
Revised: General Staff – November 22, 2011
Approved: Banner Health Board – December 8, 2011
Revised: General Staff – November 20, 2012
Approved: Banner Health Board – December 13, 2012
Revised: Email vote of Active Staff – July 10, 2014
Approved: Banner Health Board – July 21, 2014
Revised: Email vote of Active Staff – July, 2016
Approved: Banner Health Board – August 11, 2016
Revised: Email vote of the Active Staff – May 23, 2017
Approved: Banner Health Board – June 8, 2017
Revised: Email vote of the Active Staff – June15, 2018
Approved Banner Health Board – July 12, 2018
Revised: Email vote of the Active Staff- February 25, 2019
Approved: Banner Health Board – March 14, 2019