BYLAWS OF THE

BANNER BAYWOOD MEDICAL CENTER
MEDICAL STAFF

June 6, 2019

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PREAMBLE

WHEREAS, Banner Baywood Medical Center is owned and operated by Banner Health, a non-profit corporation; and

WHEREAS, it is recognized that the Staff is primarily responsible for the quality of patient care and for reporting with respect to the quality of patient care to the Board, education and research in the hospital and must accept and discharge this responsibility in all of those areas in which clinical judgment and the evaluation of professional competence and ethical conduct are involved; and

WHEREAS, it is recognized that the hospital has a duty to rely upon the judgment and recommendations of the Staff in such matters, subject to the ultimate authority of the hospital's Board of Directors; and

WHEREAS, it is the objective of the Medical Staff, Administration and the Board of Banner Health that high quality, cost-effective care be delivered in and through the Hospital's Medical Staff programs, through mutually cooperative efforts of the Staff, the Administration and the Board.

THEREFORE, the Physicians, Dentists and Affiliate Staff members practicing in this hospital shall be organized into a Staff in conformity with these Bylaws.

1 DEFINITIONS

1.1 "Active Participant" means a staff member who actively provides patient care at a specific campus.

1.2 "Administrator" means the CEO of Banner Baywood Medical Center, or his/her designated representative.

1.3 "Affiliate Staff" means those providers of health care services (currently podiatrists and clinical psychologists) who: (1) are permitted by the laws of the State of Arizona to provide independent health care services, not under the direct supervision of a licensed physician, (2) apply for this category, (3) are not eligible for other Staff categories, and (4) are granted and exercise independent practice clinical privileges in accordance with these Bylaws and the Rules and Regulations of the Medical Staff.

1.4 "Advanced Practice Providers/Allied Health Professionals" means those individuals who are authorized to provide health care services within the Hospital, but only under the supervision of a qualified Staff appointee as defined in a Scope of Practice approved by the Executive Committee and the Board. Members of the "Advanced Practice Providers/Allied Health Professionals", as defined in Section **11.4.2.2**, category are not members of the Medical Staff, and shall only have those rights granted by the Executive Committee or the Board in accordance with these Bylaws.

1.5 "Attending," "attendance" or "attended" refers to clinical services rendered to a Hospital patient, including emergency room services, admitting patients, giving primary care, co-managing patients, performing or assisting at surgery (either inpatient or outpatient procedures), performing consultations and rendering laboratory or diagnostic imaging services, and cardiac catheterization laboratory procedures. Contract physicians are excluded from physician activity requirements.

1.6 "Board", "governing body", "Governing Board", or "Board of Directors" means the Board of Directors of Banner Health.

1.7 "Chair" means vice chair or delegee, in the event of absence or conflict.

1.8 "Clinical privileges" or "privileges" means the permission granted to Staff members to provide patient care and includes non-discriminatory access to those Hospital' resources (including equipment, facilities and personnel) necessary to exercise those privileges effectively.

1.9 "Dental Staff" means all dentists duly licensed in the State of Arizona who are privileged to attend patients in the Hospital.

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

1.11 "Executive session" means a special, confidential session of a committee. It is required for the discussion of professional practices of specific individuals in order to promote candor in the monitoring and evaluation of patient care. Attendance at executive sessions is limited by the respective chairmen to preserve the confidentiality of the proceedings, records and materials of executive sessions. Separate minutes are kept for executive sessions.

1.12 "Ex-officio member" means a member of a committee who shall have all of the rights and obligations of regular committee members except they shall not be counted in determining the existence of a quorum and they cannot vote on any issues brought before the committee.

1.13 "Fair Hearing Plan" means that Plan contained in these Bylaws which governs the conduct of the hearing and appeals relating to those recommendations and decisions of the Staff and Board of Directors for which a right of hearing and appeal is provided.

1.14 "Hospital" means Banner Baywood Medical Center.

1.15 “Hospitalist” means a physician whose practice is limited solely to hospital care and who does not have an outpatient practice.

1.16 "Medical Staff" means all physicians duly licensed in the State of Arizona who are privileged to attend patients in the Hospital.

1.17 "Physician" means a person currently licensed by the State of Arizona to practice allopathic medicine or osteopathic medicine in good standing as defined by and pursuant to Chapter 13 or Chapter 17 of Title 32 of the Arizona Revised Statutes.

1.18 "Practitioner" means a duly-licensed physician, dentist, podiatrist, psychologist, or other Affiliate Staff appointee.

1.19 “President”, unless the context indicates otherwise, means vice president or other officer in direct line of succession, when the President is absent or has a conflict.

1.20 "Reappointment period" means the term of reappointment lasting a maximum of two years. "Reappointment year" means the final year in the reappointment period.

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

1.22 "Service" means a multi-disciplinary organization of the Staff supervising, through a Staff committee, a function or functions of the Hospital, usually within a multi-disciplinary Hospital department, with privileges open to any qualified member of the Staff.

1.23 "Special Notice" means written notification by personal (hand) delivery with signed acknowledgment of receipt; by certified mail, return receipt requested; or by e-mail with confirmation of receipt.

1.24 "Specialty Board" means that Specialty or Subspecialty Board, governed by the rules, regulations and program protocols of the Accreditation Council for Graduate Medical Education, which grants specialty or sub-specialty certification upon successful completion of an approved residency program, prescribed experience and examining procedures, or a specialty board approved by the American Osteopathic Association, or a specialty board approved by the Royal College of Physicians and Surgeons (Canada).

1.25 "Staff" means the Medical Staff and includes all physicians, dentists and Affiliate Staff appointees.

1.26 "Staff Year" means the period from January 1 to December 31.

2 NAME

2.1 The name of this organization shall be "The Medical Staff of Banner Baywood Medical Center", owned and operated by Banner Health.

3 PURPOSE

3.1 The Medical Staff is organized for the purpose of fulfilling the objectives stated in the Preamble hereto, and to such end it shall:

3.1.1 Strive for a high level of professional performance by all appointees of the Staff authorized to practice in the Hospital through the appropriate delineation of the privileges and by an ongoing review and evaluation of each member of the Staff's performance in the Hospital;

3.1.2 Initiate and maintain Bylaws and Rules and Regulations for self-government of the Medical Staff;

3.1.3 Organize into departments, sections, services and committees in order to review the professional practices of physicians, and others granted health care privileges within the Hospital for the purposes of reducing morbidity and mortality. Such review shall include assessment of and formulation of reports and/or recommendations concerning the nature, quality and necessity of the care provided. These Bylaws have been adopted by the Staff and approved by the Board of Banner Health in order to provide a mechanism for such review, which will be in accordance with applicable Federal and State statutes and regulations relating to peer review and quality improvement. It is the intention of these Bylaws that the actions of the Medical Staff, in conducting such review, including, without limitation, the action of its officers, representatives, committees and consultants (including persons who are not members of the Medical Staff, but who are requested by any duly authorized officer or committee of the Staff to participate in such review), shall be afforded immunity from civil liability to the fullest extent permitted by applicable Federal and State statutes and regulations including, but not limited to, the provisions of A.R.S. 36-441 and 36-445.02. Furthermore, it is the intention of these Bylaws that the proceedings of the Staff relating to such review (including, without limitation, reports of consultants, minutes of committees, and transcripts of hearings) shall be held in strictest confidence and shall not be subject to discovery, production, or subpoena except as is specifically compelled by applicable Federal and State statutes and regulations, and shall be entitled to the fullest protection afforded by A.R.S. 36-445.01;

3.1.4 Further the professional education of all personnel;
3.1.5 Provide a means whereby issues of medical-administrative nature may be discussed and resolved;
3.1.6 Make provision for medical care for mass casualty in the event of a disaster in the community;
3.1.7 Promote and supervise appropriate research activities of the Staff.

4 STAFF MEMBERSHIP

4.1 Nature of Staff Membership

4.1.1 Appointment on the Staff of the Banner Baywood Medical Center and granting of hospital specific privileges is a privilege granted by the Board of Banner Health only to professionals who continuously meet the qualifications, standards and requirements set forth in these Bylaws which are established to fulfill the obligations stated in the Preamble and Article 2 and to further quality healthcare.

4.1.2 Appointment to and/or clinical privileges on the Staff of the Banner Baywood Medical Center shall not be denied or limited on the basis of sex, race, creed, color, national origin or any other criterion lacking professional justification.

4.2 Qualifications for Staff Membership

4.2.1 Only practitioners properly licensed, certified or otherwise qualified who can document their background, relevant experience and training and demonstrated current competence, ability to perform privileges requested, their adherence to the ethics of their profession, their good reputation and their ability to work with others, with sufficient adequacy to insure the Staff and the Board that any patient attended by them in the Hospital will be given high quality care, is eligible for appointment to the Staff.

4.2.2 No practitioner shall be entitled to appointment to the Staff or to the exercise of privileges in the Hospital merely by virtue of the fact that he or she is properly licensed, certified or otherwise qualified to practice in the State of Arizona or any other state, or that he is a member of any professional organization or that he has had, or presently has, such privileges at another hospital.

4.2.3 Appointment to the Medical Staff, and hospital specific delineated clinical privileges granted based upon the applicant's qualifications and in consideration of the procedures and types of services performed and provided within the hospital and in accordance with these Bylaws, constitute privileges which may be withdrawn or otherwise restricted by action of the Staff and/or the Board acting in accordance with these Bylaws.

4.2.4 Appointment and clinical privileges shall be extended only to those physicians, dentists and persons qualified to serve as appointees of the Affiliate Staff, who, on an ongoing basis consistent with these Bylaws, demonstrate that they meet the standards and qualifications for membership required by these Bylaws and the Rules and Regulations of the Staff.

4.2.5 In addition to the qualifications required by the preceding paragraphs each appointee to the Staff must continually meet all of the following minimum qualifications.

4.2.6 License: Each appointee to the Staff must possess a current unrestricted license to practice medicine. This license must be issued by the appropriate Arizona Licensing Board.

4.2.7 Education.

4.2.7.1 Physicians. Graduation from an approved school of medicine or Osteopathic medicine; or certification by the Educational Council for Foreign Medical Graduates; or fifth pathway certification and successful completion of the foreign medical graduate examination in the medical sciences. “Approved school” means fully accredited during the entire time of the practitioner's attendance by the Liaison Committee on Medical Education of the Council on Medical Education of the American Medical Association and the American Medical Colleges (LCME), or the American Osteopathic Association (AOA).

4.2.7.2 Dentists. Graduation from an approved school of dentistry. “Approved school” means fully accredited during the entire time of the practitioner’s attendance by the Commission on Dental Accreditation of the American Dental Association.

4.2.7.3 Clinical Psychologists. A doctorate degree in psychology from an approved program.. "Approved program" means fully accredited during the entire time of the practitioner's attendance by the American Psychological Association.

4.2.7.4 Podiatrists. Graduation from an approved school of podiatric medicine. "Approved school" means fully accredited during the entire time of the practitioner's attendance by the Council on Podiatric Medical Education.

4.2.8 Post-Graduate Education: Each medical doctor or doctor of osteopathic medicine shall have successfully completed one (1) year of a graduate medical education program which, at the time of the practitioner's participation therein, was accredited by the Accreditation Council for Graduate Medical Education or the Liaison Committee for Graduate Education, or by the American Osteopathic Association; or successfully completed one year of a graduate medical education program comparable to one accredited by the Accreditation Council for Graduate Medical Education, or by the American Osteopathic Association. It is the responsibility of all applicants to provide the information necessary to assess the content and quality of education and training, including the type and content of course work. Each doctor of podiatric medicine shall have successfully completed one year of a postgraduate medical education program which, at the time of the practitioner's participation therein, was accredited by the American Board of Podiatric Surgery.

4.2.9 Board Certification.

4.2.9.1 Board certified or qualified for Board certification. Where membership and privileges are granted on the basis of Board qualification, certification must be obtained within five years of completion of training. Failure to become certified within the time allowed under these Bylaws or failure to pass the Board certification exam on the third attempt shall result in the voluntary, automatic relinquishment of Medical Staff membership and privileges.

For purposes of this section, "Board certification" or "Board certified" means certified by a board approved by the appropriate American Board, the Advisory Board for Osteopathic Specialists, the Royal College of Physicians and /Surgeons of Canada, the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, the American Dental Association or the American Board of Professional Psychologists or by a board determined by the department and Executive Committee to be equivalent. For purposes of this section, "Board qualification" or "Board qualified" means the applicant has completed the training necessary to be accepted to become, has applied for and has been accepted to become an active candidate for certification as determined by the appropriate board. Where the board requires a period of practice prior to submitting an application for certification, the applicant will be deemed qualified during this time period if the director of his/her training program certifies that the applicant has met all training requirements for qualification by the appropriate board.

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

(a) where a practitioner had membership and privileges as of the date of approval of these bylaws and based upon bylaws then in effect, the practitioner was not required to be certified (September 20, 2007);

(b) where a particular field or specialty of the department does not have a Board certification:

(c) where privileges are limited to surgical assisting or referring only;

(d) to applicants/members where there is a shortage of qualified Medical Staff members in the practitioner's specialty necessary to meet the Medical Center's demand for services where the Medical Executive Committee has determined that the practitioner's training and experience approximates as nearly as possible those assured by Board certification.

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

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

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

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

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

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

4.2.9.4 Subspecialty Certification. Subspecialty certification is not required for Staff membership.

4.2.9.5 Re-certification. Members, as delineated in 4.2.9.1, are required to remain board certified. Maintenance of certification shall not apply to those members who were appointed on or before September 20, 2007. Maintenance of certification may be accepted by the National Board of Physicians and Surgeons. Failure to maintain certification shall result in the voluntary, automatic relinquishment of membership and clinical privileges. The Executive Committee may consider extending membership within the current appointment term, under the following circumstances for maintenance of certification:

(A) A practitioner has taken the exam, and is awaiting results or has exam scheduled and provides evidence; or

(B) A practitioner has submitted evidence of a particular medical, physical, family, or financial hardship in which they were unable to become recertified within the required time frame. In this instance, the practitioner must sit for the next available board exam to become recertified. In the event the practitioner fails to certify or does not take the exam, it shall result in the voluntary, automatic relinquishment of membership and clinical privileges.

4.2.10 The practitioner must document good physical and mental health so as not to compromise the care of patients.

4.2.11 The practitioner must demonstrate current clinical competence and judgment that meets or exceeds the standards required by the Staff for the same or similar clinical privileges.

4.2.12 The practitioner must satisfy the ethical requirements of his/her profession and national organization (American Medical Association, American Osteopathic Association, American Dental Association) and shall have a good reputation in the community with regard to the care of patients and the practice of his/her profession.

4.2.13 Each practitioner must possess and demonstrate an ability to work with others for the cooperative delivery of safe, quality and efficient health care. Practitioners evidencing "disruptive behavior" shall not be qualified for appointment on the Staff. For the purpose of these Bylaws, a practitioner is deemed to be engaging in "disruptive behavior" when his/her actions and interactions with others, including practitioners, patient care services personnel, hospital employees, and patients, is of such a nature as to interfere with, threaten or compromise others' efforts to deliver safe, quality and efficient health care in the Hospital. Please refer to Policy on Disruptive Physician Conduct.

4.2.14 Establishing "standards" for granting Staff appointment and clinical privileges involves an examination of several facets of a practitioner's education, training, experience, health, skills and personal attitude. In the process of evaluating practitioners for appointment and reappointment to the Staff, it is the intent of these Bylaws that the appropriate committees of the Staff and the Board may examine and evaluate not only the practitioner's written qualifications, such as formal education, postgraduate training and participating in professional organizations, but also certain other aspects of a practitioner's qualifications which may be difficult to demonstrate on paper. These qualifications include an examination of the practitioner's physical and mental health and skills, his/her overall clinical judgement and his/her ability to work with others. It is recognized that certain factors, such as health, age and substance abuse, may adversely affect a practitioner's ability to safely perform the privileges granted, even though his/her qualifications otherwise appear acceptable.

4.2.15 These impediments to good practice must be considered by the Staff and Board. Even though the Staff accepts responsibility for reviewing its appointees in an effort to scrutinize qualifications and maintain quality health care, nothing contained in these Bylaws shall be interpreted as a representation or guarantee by the Staff as to the skills, qualifications or competence of any individual appointee.

4.2.16 The Executive Committee may require, for Staff appointment or reappointment, evidence of recent participation in emergency life-saving techniques when it is specifically required by a department.

4.2.17 Whenever a practitioner is excluded from Medicare, AHCCCS or other state or federally funded healthcare programs, the excluded practitioner will not be permitted to provide items or services to patients enrolled in these programs according to the Banner Health Excluded Practitioners policy.

4.3 Conditions and Duration of Appointment and Reappointment

4.3.1 Initial appointments and reappointments to the Staff shall be made by the Board. The Board shall act on appointments, reappointments or revocation of appointments only after there has been a recommendation from the Staff as provided in these Bylaws; provided that in the event of unwarranted delay on the part of the Staff in complying with these Bylaws, after at least 30 days notice of its intent to so, the Board may act without such recommendation on the basis of documented evidence of an applicant's or Staff appointee's professional and ethical qualifications obtained from reliable sources other than the Staff.

4.3.2 Initial appointments to the Staff shall be "provisional" for at least twelve months and shall be governed by the provisions of these Bylaws. Reappointments shall be for a period not exceeding twenty-four (24) months.

4.3.3 As a condition of membership on the Staff, each practitioner shall acknowledge his/her obligations (1) to provide continuous care and supervision of his/her patients; (2) to abide by these Bylaws; (3) to accept consultation and monitoring assignments; (4) to successfully complete the MEC-approved Electronic Medical Records Training course and Banner's electronic New Practitioner Orientation that is described in Section 7.1.1 prior to exercising privileges and within six months of appointment (exceptions: members who are (i) ineligible for privileges or (ii) eligible solely for Remote Privileges); and (5) to participate in rotating call in the Emergency Department in accordance with established Rules and Regulations.

4.3.4 Effective 10/1/2003, it shall be a condition of initial and continued Staff appointment that each practitioner provide evidence of freedom from infectious tuberculosis as required.

4.4 Professional Liability Insurance. It shall be a condition of Staff appointment, except for Honorary Staff, and a condition to the exercise of any clinical privileges, that the practitioner shall have in full force and effect a policy or policies of professional liability insurance as the Governing Board shall, from time to time, determine with the consultation of the Executive Committee.

4.4.1 Each appointee to the Staff, with the exception of the Honorary members, shall file a statement with the Medical Staff Services Department containing the following regarding his/her professional liability insurance: (1) name and address of insurance carrier or carriers (including all excess carriers), (2) policy numbers, (3) policy coverage periods (inception and expiration dates), and (4) policy limits, together with a brief summary of the type of coverage afforded, including a statement as to whether the insurance has been issued on an "occurrence" or "claims made" basis.

4.4.2 Failure by a practitioner to file the required statement or failure to maintain the required coverage in effect shall be adequate grounds for automatic suspension of the practitioner's clinical privileges, and, if such failure continues for a period of thirty (30) days, shall be deemed adequate grounds for termination of the practitioner's Staff appointment and clinical privileges.

4.4.3 Each appointee to the Staff shall file a statement with the Medical Staff Services Department regarding any change in his/her professional liability coverage within ten (10) days of such change.

4.4.4 These statements concerning professional liability insurance coverage of Staff members shall be accessible to all members of the Staff through the Medical Staff Services Department.

4.4.5 Each appointee to the Staff shall be required to report the outcome of their involvement in any professional liability (malpractice) action/claim to the Staff through the Medical Staff Services Department.

4.4.6 At such time that the Board of Directors deems it prudent to change the professional liability insurance requirements (i.e., raise the required limits or change the form of the required policy), the Board shall provide the Executive Committee a minimum of three (3) months written notice of the proposed change. The Executive Committee shall be afforded the opportunity to convey to the Board its comments, suggestions, or preference regarding the proposed change. The Board shall, in good faith, consider the input of the medical staff prior to implementation of the change.

4.5 Continuing Medical Education Each appointee to the Staff shall maintain current qualifications of continuing medical education as required by the appropriate Arizona State Licensing Board.

4.6 DEA Except for members of the Honorary Staff and the Pathology Department and for those Department members who exercise only remote privileges and do not prescribe medications, it shall be a condition to the exercise of any clinical privilege, that the practitioner shall have in full force and effect a current Drug Enforcement Agency (DEA) number in good standing. Failure of a practitioner to file the required documentation with Medical Staff Services shall be adequate grounds for automatic suspension in accordance with Bylaws section 8.6.2.

4.7 Contract Physicians

4.7.1 Definition: The term "Contract Physicians" for the purposes of these Bylaws means any properly credentialed and appointed member of the Staff with appropriate privileges who provides professional services, full or part-time, in the Hospital pursuant to a contract with the Hospital. For the purposes of these bylaws, the designation of full-time Contract Physician shall mean those members whose medical practice outside of the contractual obligations are insubstantial relative to such contractual obligations. The provisions of Section 4.5 shall not apply to practitioners who are employed by the Hospital in a purely administrative function, without clinical responsibility; whose responsibilities do not impact quality of patient care; and who do not apply for Staff appointment.

4.7.2 Review: Contractual agreements between the Hospital and Contract Physicians or groups providing Contract Physicians shall be consistent with the provisions of these Bylaws. Such agreements shall not be made or terminated without prior consultation with the Executive Committee, except in emergency situations.

4.7.3 Appointment and Reappointment of Contract Physicians: Initial appointment and bi-annual review for determination of Staff appointment, category, and clinical privileges for Contract Physicians shall be by the same procedures as for other Staff appointees, as provided in these Bylaws, except that:

4.7.3.1 Attending requirements as provided in these Bylaws for Staff membership categories shall not apply except as noted below:

4.7.3.1.1 Each Contract Physician shall be a member of one Medical Staff category in accordance with these Bylaws but need not be a member of the Active Staff unless desiring the privileges of that category.

4.7.4 Executive Committee Representation: No more than fifty percent (50%) of the Executive Committee shall be full-time Contract Physicians or hospital-employed physicians.

4.7.5 Privileges: Contract Physicians may be granted privileges other than those essential to the performance of their contract duties by applying to and receiving approval from the appropriate department or section granting privileges. Such granting of privileges outside the scope of contract duties shall subject the Contract Physician to the attendance requirements of these Bylaws for Provisional and Active Staff.

4.7.6 Definition: For the purposes of these Bylaws, the designation of Contract Physicians and the full or part-time status of employed physicians shall be made by the Executive Committee on report and/or recommendation of the Credentials Committee.

4.8 Medical Directors of Staff, Departments, Sections and Committees

4.8.1 The Medical Director of the Staff shall be administratively responsible to the CEO and/in a Staff relation, to the President of the Staff.

4.8.2 When the duties of the Chairman of a department or section become too manifold and/or time consuming, the Board may create the position of Medical Director of the department or section upon the recommendation of the Executive Committee and approval of the Active Staff appointees of the department or section by a two-thirds (2/3) majority vote by mail or electronic ballot. The Medical Director of that department or section shall be administratively responsible to the CEO, through the Medical Director of the Staff, if there is one employed, and in a staff relation, to the Chairman of the Department or Section Committee.

4.8.3 Appointment and termination of appointment of individual practitioners to these positions shall be made only upon the approval of the Executive Committee. The Credentials Committee shall act as a screening committee to make recommendations to the Executive Committee for the position of Medical Director of the Staff and for granting reappointments. Department and section committees shall serve the same function for Medical Directors of their department or section.

4.8.4 The Medical Director of the Staff shall serve as an ex-officio appointee to all committees of the Staff.

4.8.5 The Medical Director of a department or section, when employed full-time, shall serve as an ex-officio member of appointee to the committee of the department or section to which he or she is assigned, and of the Executive Committee, and he or she shall be a voting appointee to the such other committees as the Executive Committee deems appropriate.

4.8.6 The duties of the Medical Director of the Staff or of a department or section, shall be determined by Administration and shall be a part of appropriate Rules and Regulations and may include evaluation and supervision of work of the Staff, graduate education, or continuing education of the Staff.

4.8.7 Appointments as Medical Director of the Staff, Medical Director of a department, section or

service shall automatically be granted Active Staff category unless clinical privileges are requested in which event the Staff category shall be Provisional.

4.9 Emergency Department Physicians

4.9.1 Emergency Department physicians shall be required to be appointees of the Staff and they shall be eligible for all categories of the Staff as provided in these Bylaws, with the following special provisions:

4.9.1.1 The attending requirements as provided in these Bylaws, for certified Active Staff membership shall be waived.

4.9.1.2 Physicians employed in the Emergency Department shall not establish or maintain private offices in the service area of the Hospital, and shall have not privileges other than those essential to the performance of their duties, as provided in the Rules and Regulations of the Department of Emergency Medicine.

4.9.1.3 Emergency Department physicians shall be assigned to the Department of Emergency Medicine and shall be subject to all the Rules and Regulations and administrative functions of that department and shall comply with the attendance requirements of these Bylaws.

4.9.1.4 The supervision of the Emergency Department physicians shall be by the Department of Emergency Medicine Committee, as provided in these Bylaws.

4.9.1.5 Reports and/or recommendations for Staff category and clinical privileges for Emergency Department physicians shall be submitted to the Credentials Committee by the Department of Emergency Medicine.

4.9.1.6 At least one (1) member of the Department of Emergency Medicine Committee and at least one (1) member of the Hospital Disaster Planning Committee shall be an Emergency Department physician.

4.10 Leave of Absence

4.10.1 Leave of Absence. The Executive Committee may recommend that the Board grant any member of the Staff a leave of absence for a period of at least three (3) months, but not to exceed three (3) years including extensions. A member on leave of absence shall have none of the privileges or obligations of his/her appointment.

4.10.2 Request for Leave of Absence. Requests for leave of absence must be submitted in writing to Medical Staff Services for action by the appropriate department committee and the Executive Committee at their next regular meetings. The request shall include a description of the nature of the activity.

4.10.3 Request for Reactivation. To reactivate privileges and membership, the member must submit a written request at least thirty (30) days before the expiration of the leave that is still within the same reappointment period; to Medical Staff Services for review by the member's department committee and the Executive Committee. The request must include a summary of all relevant activities during the leave and a consent to the release of relevant information concerning the leave period. Such information shall be confidential and privileged, as described in Section **6.5.1**. The Executive Committee shall make a recommendation to the Board concerning reactivation.

4.10.4 If no letter of resignation or reinstatement is received from the appointee, upon the expiration of the appointee's leave of absence, this lack of communication shall be considered a voluntary resignation from the Staff.

4.10.5 Application for Reappointment. A practitioner whose leave of absence has extended beyond the reappointment period must apply for reappointment. The application may be for his/her previous category with his/her previous privileges and must be submitted at least thirty (30) days before the expiration of the leave. A practitioner whose leave of absence has expired must apply for initial appointment and observed privileges. An application for appointment or reappointment shall be processed and require documentation in accordance with Article 6. In addition the applicant shall include documentation concerning professional and other activities while on leave of absence.

4.11 Dues and Assessments

4.11.1 Executive Committee Determination. Annual dues and special assessments for all Staff categories will be determined by the Executive Committee on an annual basis at the January meeting. These dues and special assessments shall be paid to the Staff Secretary/Treasurer. Honorary and LOA Staff appointees shall not be required to pay annual dues and assessments.

4.11.2 Non-Payment. Non-payment of dues by April 1st of each year shall cause automatic suspension of Membership and of all clinical privileges. The Executive Committee will notify the appointee by Special Notice that he or she has thirty (30) days to pay dues or his/her appointment will be automatically terminated and the Staff appointee will have to reapply.

4.11.3 Special Assessments. If the need should arise for a special assessment, as determined by the Executive Committee, such special assessment shall not be levied unless approved by a majority vote of the Active Staff attending any regular or special Staff meeting.

4.11.4 Expenditures. Expenditures of dues and all assessments shall be determined by the Executive Committee, taking into consideration the expressed wishes of the Staff.

4.12 Treatment of Family Members. Practitioners may not treat immediate family members in Banner Baywood Medical Center absent an emergency or the unavailability of another practitioner with similar privileges. Immediate family members means the spouse, natural or adopted children, father, mother, brothers and sisters of the practitioner and the natural or adopted children, father, mother, brothers and sisters of the practitioner's spouse.

5 CATEGORIES OF THE STAFF

5.1 Administrative Categories: For administrative purposes, the Staff shall be divided into categories.

5.2 Practice Categories: Medical/Dental Staff The Medical and Dental Staff shall be divided into Provisional, Active, Courtesy, Consulting, Adjunctive, Referring, and Honorary categories, each of which shall have specific privileges and obligations. Exceptions to category assignment and requirements may be made under unusual circumstances upon the recommendation of the Executive Committee.

5.2.1 Provisional Staff

5.2.1.1 The Provisional Staff shall consist of all physicians and dentists initially appointed to the Staff.

5.2.1.2 Consistent with its department rules and regulations, each clinical department shall monitor and evaluate the Provisional member's performance by establishing a monitoring plan for a focused review (FPPE – focused professional practice evaluation). The required number of monitored cases shall be completed within six (6) months of the Provisional Staff member's initial appointment to the Staff, except for good cause. If the Provisional Staff member has insufficient activity to adequately evaluate his/her performance, the FPPE period may be extended for an additional monitoring period not to exceed twenty-four (24 months). For those Provisional Staff members with minimal activity during the initial FPPE period (who only provide occasional coverage at the hospital) the Executive Committee may, on the recommendation of the Department Chairman, modify or waive the FPPE requirements with the provision that his/her peer references at first reappointment attest to the physician's competence in performing the privilege requested.

5.2.1.3 Upon successful completion of FPPE, and after at least one (1) year as a Provisional Staff appointee, the Provisional Staff appointee shall be advanced to the appropriate Staff category as specified below.

5.2.1.4 Provisional Staff members may not vote or hold office in this Staff organization, but shall be appointed to specific departments or sections, and shall be eligible to serve on department, section or service committees and may vote on matters before such committees except as otherwise provided in these Bylaws.

5.2.2 Active Staff

5.2.2.1 The Active Staff shall conduct all of the business of the Staff, except those duties and functions specifically delegated to departments, sections, services and committees of the Staff in these Bylaws.

5.2.2.2 The Active Staff shall consist of physicians and dentists who are eligible for this category after having successfully completed the requirements of Provisional Staff appointment and who are located close enough to the Hospital, in terms of travel time, to provide continuous care to their patients and to assume all the functions and the responsibility reasonably assigned by the Officers of the Staff, including, where appropriate, committee assignments, Emergency Room care and consultation assignments.

5.2.2.3 Active Staff members shall be appointed to specific departments or sections, and shall be eligible to vote, to hold office in this Staff organization and to serve on Staff committees.

5.2.2.4 For appointment or reappointment to the Active Staff, appointees of the Staff shall be required to have attended twenty (20) or more patients in the Hospital during the preceding year.

5.2.2.5 Exceptions to these requirements and obligations are provided for under 4.7 for Contract Physicians and may be granted at the discretion of the Executive Committee, upon recommendation of a Department Chairman, because of extenuating circumstances.

5.2.3 Courtesy Staff

5.2.3.1 The Courtesy Staff shall consist of physicians and dentists who are eligible for this category after successfully completing the requirements of Provisional Staff appointment, and who have attended at least one (1) patient, but fewer than twenty (20) patients, in the Hospital during the preceding year.

5.2.3.2 Courtesy Staff members who attend twenty (20) or more patients in the Hospital in any one (1) year shall automatically be advanced to Active Staff at the next reappointment. An appointee to the Courtesy Staff who has not attended any patient in the Hospital for two (2) consecutive years shall be notified by the

Chairman of the Credentials Committee when the member's reappointment review is made, that he or she is not eligible for reappointment because of failure to use Hospital facilities, unless he or she makes a written request for reappointment that satisfies the Executive Committee of his/her intention to use the hospital facilities. This request must be received by the Executive Committee prior to the meeting at which the Executive Committee is scheduled to act upon the member's reappointment to the Staff.

5.2.3.3 Courtesy Staff appointees shall be appointed to specific departments or sections, but shall not be eligible to vote or hold office in the Staff organization.

5.2.3.4 Appointees to the Courtesy Staff may be appointed to committees and, if so, may vote on matters before such committees.

5.2.4 Consulting Staff

5.2.4.1 The Consulting Staff shall consist of physician and dental Staff members who provide consultative services on patients admitted by other Staff members. Consulting Staff shall not admit patients to the Hospital. The Consulting Staff shall include those Staff members whose specialties are underserved on the Staff, including those whose patient care services are provided solely through Remote Privileges (See **7.4** and 7.7).

5.2.4.2 Consulting Staff shall be appointed to specific departments or sections but shall not be eligible to vote or hold Staff offices.

5.2.4.3 Appointees of the Consulting Staff may be appointed to committees and, if so, may vote on matters before such committees.

5.2.5 Adjunctive Staff

5.2.5.1 The Adjunctive Staff shall consist of physician and dental Staff members who do not admit patients to the Hospital, but who desire limited clinical privileges for the purpose of assisting in clinical procedures performed by Active and Courtesy Staff members.

5.2.5.2 Adjunctive Staff appointees shall be appointed to specific departments or sections but shall not be eligible to vote or hold Staff offices.

5.2.6 Referring Staff

5.2.6.1 The Referring Staff shall consist of physicians who do not treat patients at the Hospital and have no BBMC clinical privileges, but who request Hospital services for their patients and access to their patients' health information.

5.2.6.2 Referring Staff may order outpatient diagnostic services for patients, may make courtesy visits to patients, and must maintain the confidentiality of patient information, computer passwords and access codes.

5.2.6.3 Referring Physicians are not eligible to vote or hold Staff office but they may be appointed to committees and vote on matters presented at committees on which they serve unless otherwise provided in these Bylaws or the Committee's Rules and Regulations, attend general staff meetings, and attend BBMC Continuing Medical Education programs.

5.2.6.4 Because Referring Physicians have no clinical privileges, denial or revocation of appointment to this Staff category does not trigger Article 9 due process rights. Physicians who believe their appointment was wrongly denied or revoked may submit information to the MEC demonstrating why the denial or termination was unwarranted. The MEC, in its sole discretion, shall decide whether to review the submission, and the MEC's action on the submission shall be final and not subject to review under these Bylaws.

5.2.7 Telemedicine Staff

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

5.2.7.2 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 department 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 or she is a member; nor hold office at any level in the staff organization.

5.2.7.3 A telemedicine staff member must, in addition to meeting the basic obligations set forth in these Bylaws, contribute to the organizational, administrative and medico-administrative, quality review, patient safety and utilization management activities of the Medical Staff; and pay all staff assessments.

5.2.7.4 Failure of a telemedicine staff member to satisfy the qualifications or obligations of the telemedicine staff category for any reappointment period may result in a practitioner being dropped from the medical Staff.

5.2.8 Honorary Staff

5.2.8.1 The Honorary Staff shall consist of physicians and dentists who are not active in the Hospital, but who are honored by emeritus positions, and wish to preserve a continuing relationship with the Staff. These Staff appointees are those who have retired from active hospital practice with an outstanding reputation, but who are not necessarily still residing in the community.

5.2.8.2 Honorary Staff appointees shall not be eligible to admit or attend patients, to vote, to hold office, or to serve on Staff committees. They may serve as advisory, non-voting members of committees. They shall not be required to carry professional liability insurance or to pay Staff dues. They shall be encouraged to attend Staff meetings. Honorary Staff members shall be automatically reappointed.

5.3 Practice Category: Affiliate Staff

5.3.1 The Affiliate Staff shall consist of those who: (1) are permitted by the laws of the State of Arizona to provide independent health care services, not under the direct supervision of a licensed physician; (2) apply for this category, (3) are not eligible for other Staff categories; and (4) are granted independent practice clinical privileges by the Staff and the Board under these Bylaws. Currently licensed podiatrists and clinical psychologists are eligible to apply for Affiliate Staff category.

5.3.2 Appointees to the Affiliate Staff shall be assigned, either individually or through an Affiliate Staff section, as provided in the Bylaws, to specific departments or sections of the Medical Staff, but appointees to the Affiliate Staff shall not be eligible to vote or hold office. Affiliate Staff members may vote in committees to which they are appointed.

5.3.3 All initial appointments to the Affiliate Staff shall be provisional in nature. Upon approval by the Executive Committee, the provisional nature of the Affiliate Staff appointees' appointment shall be concluded.

5.3.4 An appointee to the Affiliate Staff who has not attended any patient in the Hospital for two (2) consecutive years shall be notified by the department when the member's reappointment review is made, that he or she is not eligible for reappointment because of failure to use Hospital facilities, unless he or she makes a written request for reappointment which satisfies the Executive Committee of his/her intention to use the Hospital's facilities. This request must be received by the Executive Committee prior to the meeting at which the Executive Committee is scheduled to act upon the member's reappointment to the Staff.

6 APPOINTMENT, REAPPOINTMENT AND RESIGNATION

6.1 Application For Initial Appointment and Privileges

6.1.1 The Application Form

6.1.1.1 Written Form. All applications for appointment to the Staff shall be in writing, shall be signed by the applicant, and shall be submitted to the Medical Staff Office on forms prescribed by the Board, after consultation with the Executive Committee.

6.1.1.2 Applicant's Burden. The applicant is responsible for producing sufficient information to allow a proper evaluation of the applicant's qualifications and to resolve any doubts about such qualifications. The application form is authorized to state applicant's responsibility to:

A. clearly specify the Staff category, department and privileges for which he or she is applying;

B. identify all hospitals, ambulatory surgery centers, urgent care centers and practices where the applicant has ever provided, or had privileges to provide, or was employed to provide patient care.

C. provide names of three peers who have personal knowledge of the applicant's current clinical competence, ability to work cooperatively with others and ethical character;

D. assure that the applicant has mental and physical ability to exercise the requested privileges without posing a health or safety risk to patients or others in the Hospital;

E. provide detailed information about:

i) professional qualifications, including education, training, experience and current competency;

ii) currently pending challenges and challenges that resulted in a denial, revocation, suspension, reduction, probation or stipulation, whether voluntary or involuntary, of (i) any licensure or certification to practice; (ii) staff membership and/or clinical privileges at any hospital or other organization; (iii) membership in any local, state or national professional society; (iv) federal controlled substances certificate.

iii) judgments, settlements, claims, suits or arbitration proceedings in professional liability actions involving the applicant and any denial or cancellation of professional liability insurance;

iv) any felony conviction;

v) exclusion by Medicare currently in effect;

F. provide documentation of:

i) current and past professional liability insurance coverage;

ii) evidence of freedom from infectious pulmonary tuberculosis pursuant to Arizona law and Banner policy;

iii) all current and previous state licenses and federal controlled substances certification;

G. disclose whether the applicant is currently undergoing treatment or monitoring for substance abuse, and/or whether the applicant's license, privileges or scope of practice is currently under any restriction, limitation, stipulation or probation because of an impairment or otherwise.

6.1.1.3 Agreements. Each applicant shall sign a written agreement consenting to:

A. the inspection of all records and documents that may be material to the applicant's professional qualifications and current competence;

B. the release of information from other hospitals and organizations with which the applicant has been associated and from past and present malpractice insurance carrier(s);

C. the use of any material misstatement in or omission from the application as grounds for denial or revocation of appointment;

D. the consultation by duly authorized representatives of the Hospital and Medical Staff with representatives of other hospitals, organizations and medical staffs for information bearing on the applicant's qualifications;

and agreeing to:

E. appear for interviews;

F. be bound by these Bylaws and the Rules and Regulations of the Staff if granted membership and/or privileges and to be bound by the terms thereof in all matters relating to the consideration of the application whether or not membership and/or privileges are granted, including the scope of review, should the applicant appeal and Adverse Action;

G. provide continuous care for applicant's patients and to abide by the applicant's professional code of ethics and State Board's professional conduct requirements;

H. fulfill continuing medical education requirements for continuing licensure;

I. notify the Medical Staff through Medical Staff Services within three (3) days of any lapse or change in professional liability coverage, and promptly of any other circumstances arising after submission of the application that materially change information provided in the application;

J. exhaust the administrative remedies afforded by these Bylaws before initiating any litigation;

K. release from any liability those persons and organizations identified in Section **6.6** for all actions described in Section **6.6**;

L. be screened for tuberculosis as may be required by law and these Bylaws (or Banner policy).

M. become trained in the use of Banner Health's electronic medical records system.

6.1.1.4 Informing the Applicant. The application shall inform the applicant:

A. that all information with respect to any practitioner that is submitted, collected, or prepared by any representative of this or any other health care facility, organization, or medical staff for the purpose of achieving and maintaining the quality of patient care; and all deliberations and recommendations regarding each applicant in accordance with these Bylaws shall be privileged and, to the fullest extent permitted by law, confidential and shall not be disseminated or used in any way except as provided herein or as required by law.

B. of the full scope and extent of the authorization, release and consent provisions, and of the immunity provisions contained in these Bylaws.

C. that the exercise of initially granted privileges shall be delayed until the new member has completed the MEC-approved EMR training course described in 7.1.1.

6.1.2 "Completed Application." No application is processed unless deemed to be a "completed application." In addition to the information required from the applicant by the form and listed in Section **6.1.1**, a completed application must:

6.1.2.1 include all required signatures of the applicant, the application fee, receipt of the required documentation and references and their preliminary verification, including satisfactory reconciliation of inconsistencies and gaps; and

6.1.2.2 demonstrate that the applicant satisfies all objective membership criteria; and

6.1.2.3 document the existence or offer of employment by the contracted group, if application is for initial appointment or grant of privileges in a closed department.

6.2 Appointment Process

6.2.1 Verification. Once the applicant has provided all the information requested on the application form, verification of the application information is sought from licensing boards, state and federal agencies, other institutions' medical staff offices, insurance carriers, the National Practitioner Data Bank and personal references.

6.2.2 Referral to Credentials Committee. The Medical Staff Office shall submit the completed application file to the Credentials Committee.

6.2.3 Credentials Committee Assessment. At its next regular meeting, the Credentials Committee shall make a thorough, impartial and objective evaluation of the character, professional competence, qualifications and ethical standing of the applicant based on the completed application and other sources available to the committee.

The Committee shall refer its recommendations for approval, denial or deferral of the appointment and/or requested privileges to all the departments and sections in which membership and/or privileges are sought. The Credentials Committee may conduct an interview with the applicant or designate a member or members of the Committee to do so on its behalf.

6.2.4 Department and Section Action.

6.2.4.1 The chairman of the respective department and chief of the section, if applicable, in which the applicant seeks privileges shall review the application and its supporting documentation and forward to the Medical Executive Committee the recommendations as to the scope of clinical privileges to be granted.

6.2.4.2 Prior to submitting a recommendation to the Medical Executive Committee, the chairman of the department and section chief, if applicable, shall determine whether an application is expedited or routine. Applications meeting any of the following criteria will not be eligible for expedited review:

- Where the application is incomplete.
- Where there is a current challenge or previously successful challenge to an applicant's licensure or registration.
- Where the applicant has received an involuntary termination of membership at another organization.
- Where the applicant has received involuntary limitation, reduction, denial or loss of clinical privileges.
- Where the applicant has voluntarily agreed to the restriction of exercising privileges during pendency of an investigation.
- Where the Credentials review determines that there has been either an unusual pattern of liability actions brought against the applicant, or an excessive number of professional liability actions resulting in a final judgment against the applicant.
- Where the applicant has been convicted of, or pleads guilty or no contest to, a felony related to the practice of medicine.
- Where there is adverse information on reference letters, or comments or other information suggesting potential problems.

6.2.4.3 Applications determined to be eligible for expedited review shall be forwarded to the Medical Executive Committee; those determined to be routine, according to the above criteria, shall be reviewed at the next regularly scheduled meeting of the department prior to being forwarded to the Medical Executive Committee. A department chairman or section chief may conduct an interview with the applicant or designate a committee to conduct such interview.

6.2.4.4 Where the applicant maintains that his or her postgraduate training program or board certification is equivalent to that required in these Bylaws, the appropriate department will assess the supporting documentation to determine equivalency.

6.2.5 Executive Committee Recommendation. The Executive Committee may either

6.2.5.1 recommend to the Board at the next meeting that the applicant be provisionally appointed to the Staff and be granted specified privileges, or denied Staff membership. Recommendations to grant privileges may be qualified by, for example, requiring observation, consultation or supervision; or

6.2.5.2 defer its recommendation to the Board and return the application to the appropriate committee for further consideration. When the recommendation of the Executive Committee is to defer the application for further consideration it must be followed within sixty (60) days with a subsequent recommendation for provisional appointment with specific privileges, or for denial of Staff membership.

6.2.6 Process for "Distant Site" Credentialing of Telemedicine Providers. Where the Medical Center

("Originating Site") has a contract with a Joint Commission accredited facility ("Distant Site") approved by the Medical Executive Committee, the Medical Center will accept the credentialing and privileging decision of the Distant Site for applicants who provide telemedicine services and are credentialed at the Distant Site. Privileges at the Originating Site shall be identical to those granted at the Distant Site, except for services which the Medical Center does not perform. Privileges shall be granted and renewed for the same period as have been granted by the Distant Site. Board approval of privileges at the Distant Site qualifies as Board approval at the Medical Center.

6.2.7 Term of Appointment. Appointments to the Medical Staff and grants of clinical privileges are for a period not to exceed two years. The appointment of each Staff member shall expire every two years on the last day of the birth month of the practitioner, except as provided in Section **6.3.3.2**.

6.3 Periodic Reappointment & Reprivileging

6.3.1 Reappointment Form. The reappointment application form shall state the applicant's responsibility to provide all information and documentation necessary to bring the initial application up to date and to allow a proper evaluation of the applicant's current competency. Exception: Applicants for reappointment need to supply the names and contact information of at least one rather than three peers who have personal knowledge of the applicant's current clinical competence, ability to work cooperatively with others and ethical character.

6 .3.2 Mailing the Application Form: Deadlines; Effect. Approximately six (6) months before the expiration of the (re)appointment period, Medical Staff Services (delegee) shall mail a new reappointment application form to each practitioner holding BBMC clinical privileges and request the applicant to return the form, completed with all releases signed. Reminders are sent after three months. If the completed application is not received at least thirty (30) days before the expiration of the reappointment period, the practitioner shall be notified by Special Notice of the deadline and of the consequences of failing to meet the deadline. If the completed application has not been received, together with all required information by the expiration of the appointment period, the practitioner is deemed to have resigned both appointment and privileges with no appeal rights other than to determine whether the notices were provided as required by this Section.

6.3.3 Basis of Reappointment; Process. The reappointment review process shall be as described in Section **6.2**, except that:

6.3.3.1 reappointment and reprivileging recommendations shall take into consideration (in addition to the information required by the completed application) information about the applicant's clinical performance derived from duly adopted Hospital and Medical Staff quality assessment, peer review and medical records activities; and about the applicant's compliance with Medical Staff Bylaws, Rules and Regulations and policies and procedures; and procedures; and

6.3.3.2 in lieu of deferral (**6.2.6, 6.2.8.2**) the Medical Staff may recommend a "limited reappointment" (e.g., three months). Such a recommendation must state the reason for the limited reappointment (e.g., pending the conclusion of an evaluation or investigation under Article 8), and any subsequent reappointment must be based on an updated credentials file. Limited reappointments do not give rise to an Article 9 Hearing right.

6.4 Resignation. All resignations from the Staff shall be made in writing. Resignations shall become effective only after completion of all medical records, resolution of any pending disciplinary actions, payment of any outstanding dues and assessments, arrangement of any required coverage, and Board action.

6.5 General.

6.5.1 Confidentiality: Information with respect to any practitioner that is submitted, collected, or prepared by any representative of this or any other health care facility, organization, or medical staff, and each recommendation made for the purpose of monitoring, evaluating, improving and/or maintaining the quality of patient care at the Hospital shall, to the fullest extent permitted by law, be confidential, shall be deemed a privileged communication, and no one may disseminate or use it in any way except as provided herein, which includes the

sharing of credentials and peer review information between Banner Baywood Medical Center, or as required by law. This information shall not become part of any particular patient's file or of the general records of the Hospital; shall be maintained in a secure fashion by the Medical Staff Services Department; and disclosed and collected only pursuant to procedures approved by the Executive Committee. By applying for appointment and reappointment to the Staff and as a condition to appointment and the exercise of privileges at the Hospital, the applicant/practitioner authorizes the Hospital or their agents to provide, to the extent permitted by law and Hospital policies, non-privileged [as defined by Staff policies] credentialing and professional review information to third party payors or their representative management entities as may be required for the purpose of auditing the credentialing and professional review activities of the Hospital or their agents.

6.5.2 Substantial Evidence. In acting in matters of appointment, reappointment and privileging, all Staff members and other practitioners, all appropriate Hospital personnel, including members of the Board and Administration, shall be acting pursuant to these Bylaws. Each Medical Staff committee participating in the review process shall make a finding whether substantial evidence exists to support a finding that the applicant does or does not meet the appointment and privileging standards and criteria. If the standards and criteria were established consistent with Section **14.6.2**, actions based on such substantial evidence are deemed to be taken:

6.5.3.1 in the reasonable belief that the recommendation is in furtherance of quality health care;

6.5.3.2 after a reasonable effort to obtain the facts of the matter; and

6.5.3.3 in the reasonable belief that the recommendation is warranted by the facts known after reasonable effort to obtain such facts.

6.5.3 Deadlines; Effect of Delay.

6.5.3.1 If an application is not a "completed application" as defined in **6.1.2** three (3) months after submission, the application will be deemed withdrawn, and the applicant shall have no hearing rights. The applicant may reapply as an initial applicant. The Medical Staff and Board may extend the deadline for good cause.

If the application is not a "completed application" two (2) months after submission, Medical Staff Services will notify the applicant of the deadline and why the application is incomplete and unable to be processed. The applicant is responsible for expediting submission of the requested information.

6.5.3.2 Medical Staff Services shall take reasonable steps to see that final action is taken on completed applications within 120 days.

6.5.3.3 If reappointment is delayed for any reason other than untimely submission of a completed application, because of, for example, a pending evaluation or investigation, the Medical Staff shall recommend to the Board short-term "limited reappointment(s)" for a period anticipated to be adequate to resolve pending matters (**6.1.1.2**). A member granted a limited reappointment must update the credentials file prior to any subsequent reappointment.

6.5.4 Breach. Breach of any agreement in the application required by these Bylaws is a breach of these Bylaws.

6.5.5 Reapplication for Appointment.

6.5.5.1 Reapplication for appointment to the Medical Staff will not be considered for twelve (12) months following the effective date of any prior appointment (1) termination or resignation resulting from investigation or adverse recommendation concerning Staff membership or privileges, other than for non-utilization or non-advancement; or (2) denial. Such applications must document that the basis for the denial, termination or resignation no longer exists.

6.5.5.2 Initial Application. Every application for appointment following any prior denial, termination or resignation of Staff membership shall be an initial application.

6.6 Release of Liability

6.6.1 By applying for appointment or reappointment to the Staff and/or as a condition to appointment and the exercise of privileges or to being granted the authority to provide services pursuant to a Scope of Practice at

this Hospital, the applicant/practitioner certifies and agrees that he or she does hereby release, acquit and forever discharge Banner Health, Banner Baywood Medical Center, its Staff and the Staff's individual appointees, and officers, agents, directors, employees and assigns from any and all liability, causes of action, claims for relief, damages, costs, penalties and injuries, except for an action for injunctive relief only which seeks judicial review of a final administrative decision by the Board under these Bylaws adversely affecting the applicant's Staff appointment, clinical privileges or scope of practice, arising out of any recommendation or decision to deny, limit, suspend, revoke or terminate the applicant's Staff appointment, clinical privileges or scope of practice, in accordance with these Bylaws.

6.6.2 This release and discharge shall be automatic and shall not require the execution of any separate or additional documents or writings.

6.6.3 In addition to those persons and entities listed in these Bylaws, the release and discharge from liability provided in these Bylaws shall extend to, and include, all of the following: appointees of the Staff participating in any Staff committee review, and appointees of the Staff participating in such review at the request of a Staff committee, or officer including, but not limited to, those persons assigned investigating and evaluating responsibilities; persons from other hospitals or professional organizations who supply information to or serve on any committee of the Staff at the request of a Staff committee or officer; the administrative personnel of the Hospital who assist in the Staff review procedures; physicians, expert witnesses, nurses and other professionals who are requested to give information or appear before a committee of the Staff and give testimony concerning any of the matters at issue before any Staff committee under the terms of these Bylaws.

6.7 Indemnification

6.7.1 Covered Activities. The Board provides indemnification for each and every Staff appointee, both present and future, from all civil liability arising out of the activities of the Staff in connection with:

6.7.1.1 quality improvement, utilization review, and/or the process of determining Staff membership, clinical privileges, scopes of practice or corrective action toward a Staff appointee or other persons whose competency or qualifications are evaluated by this or any Staff;

6.7.1.2 the process of monitoring, evaluating or supervising patient care practice of the Staff and other persons whose competency or qualifications are evaluated by this or any Staff; and

6.7.1.3 any other duties or responsibilities directly or indirectly delegated by the Board to the Staff and performed by the Staff.

6.7.2 Excluded Activities. The indemnification described in this Section shall not be available to a member of the Staff in any claim in which the plaintiff prevails because of the member's willful or malicious intent to harm the plaintiff.

6.7.3 Covered Payments The Hospital will pay on behalf of any appointee of the Staff:

6.7.3.1 all sums which the appointee shall become legally obligated to pay as damages because of any claim or claims made against the appointee while carrying out any of the activities described above. Payment of such sums shall not include sums resulting out of patient care, unless such patient care was undertaken because of the appointee's participation in any of the above-described activities. This indemnification shall be primary to any valid and collectible insurance of the Staff appointee.

6.7.3.2 all costs required to defend any claim, including, without limitation, all attorneys fees and expenses in accordance with Section **6.7.3**. above, all costs taxed against an appointee, all interest on any judgment, premium on appeal bonds, and reasonable expenses incurred by the appointee.

6.7.4 Defense.

6.7.4.1 The Hospital shall defend each claim or suit arising out of the activities described above, even though wholly without merit and even though malice, fraud, criminality, or bad faith is alleged, brought against any Staff appointee to enforce any liability imposed by law and seeking payment of damages or other legal remedy

or equity. This duty to defend shall not pertain to suits arising out of patient care, unless such patient care is alleged to have arisen because of an appointee's participation in any of the activities described above.

6.7.4.2 Neither the Hospital nor the Staff appointee shall enter into a settlement agreement in connection with any claim or suit covered by this Section without the consent of the other. Consent will not be unreasonably withheld.

6.7.4.3 Whenever any claim presents a potential conflict of interest between the Staff appointee and the Hospital, the Hospital shall promptly provide the Staff appointee with separate counsel of the Staff appointee's choice, at no expense to the Staff appointee.

6.7.5 Repayment of Advances. The Hospital will pay expenses incurred in defending any action, suit, claim or proceeding described in this Section in advance of its final disposition, if (a) the Medical Staff member delivers to the Hospital an executed, written undertaking to repay the advance if it is ultimately determined that the member is not entitled to indemnification under **this** Section and (b) if the amount is to be paid in settlement, the Board determines that the amount is reasonable.

6.7.6 Duration. The duty to indemnify pursuant to this Section shall survive the termination of Staff appointment and clinical privileges for all activities described above undertaken while the appointee acted as an appointee of this Staff.

6.8 Medical Staff Conflict of Interest Policy ("Policy")

6.8.1 Conflicts. Conflicts of interest among the Medical Staff leaders are not completely avoidable since they often indicate broad experience, accomplishments and diversity. The goals of the Medical Staff are therefore to identify and manage interests that could conflict with fulfilling the Medical Staff's responsibilities (see e.g., Preamble) and to ensure the integrity of Medical Staff decision making

6.8.2 Disclosure. Elected and appointed Medical Staff leaders, entrusted with fulfilling the Medical Staff's responsibilities and with decision-making authority on behalf of the Medical Staff, shall use good faith to disclose material financial and personal interests that may potentially lead to a conflict to the Medical Staff as described below. Candidates for elected and appointed Medical Staff leadership positions shall disclose material financial and personal interests with potential for conflicts to the MEC prior to election and appointment.

6.8.3 Means. When relevant to a deliberation or decision on behalf of the Medical Staff (e.g., during a committee meeting), Medical Staff leaders should disclose interests verbally to the relevant Medical Staff body.

6.8.4 Confidentiality. Any documentation of disclosures shall be maintained by Medical Staff Services as privileged and confidential, pursuant to Medical Staff-approved policy and not be accessible or used for other purposes.

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

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

6.8.5.2 Recusal from the decision-making process.

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

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

6.8.7 Failure to disclose. The MEC may take appropriate action when a leader has failed to disclose,

abstain or recuse as required by this Policy.

7 PRIVILEGES

7.1 Clinical Privileges Restricted

7.1.1 Each appointee to the Staff shall be entitled to exercise only those clinical privileges specifically granted to him or her by the Board. Because recent evidence ties use of electronic medical records (EMR) to improved quality of care, exercise of any clinical privileges initially granted by the Board after its approval of this provision will require the new member to complete the EMR training program of up to five hours that has been approved by the MEC as effective based on Banner-provided effectiveness data and as reasonable (in terms of time and accommodation of disabilities of otherwise qualified practitioners). Exercise of any clinical privileges initially granted by the Board after its approval of this provision will require the new member to complete the electronic New Provider Orientation. Exceptions may be made for practitioners granted temporary or disaster privileges. Except as permitted under **5.2.6** and **5.2.7**, termination of all clinical privileges will result in an automatic termination of medical staff membership.

7.1.2 Every application for Staff appointment and reappointment must contain a request for hospital specific clinical privileges desired by the applicant on such form as the Board may require after consultation with the Executive Committee. The evaluation of such requests shall be based upon the applicant's compliance with the standards required by these Bylaws and departmental rules and regulations, and an appraisal by the clinical department or departments in which privileges are sought in accordance with Section **6.5.2**. The applicant shall have the burden of establishing his/her qualifications, current competency and ability to perform the clinical privileges he or she requests.

7.1.3 The nature of clinical privileges includes non-discriminatory access to equipment, facilities, and hospital personnel that are necessary to carry out such clinical privileges. Staff members who have been granted clinical privileges are entitled to full due process rights upon any attempt to abridge those clinical privileges by a closure through the grant of exclusive contracts. Full due process rights mean that privileges may be withdrawn only for good cause, in accordance with the provisions of the Corrective Action section, if applicable, and the provisions of the Fair Hearing Plan.

7.2 Additional Privileges; Privileges for New Procedures.

7.2.1 Members may request additional privileges at any time. Members must comply with all requirements for the requested privileges, including training and supervision requirements established by the applicable department, which is responsible for evaluating the member's competence to perform the requested privilege. When the documentation of training is attached and complete, processing of requests for additional privileges is considered to be completed within a reasonable time, if the board acts on the application no more than 120 days after Departmental review of the completed application and documentation of training.

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

7.3 Admitting and Co-Admitting Privileges

7.3.1 Physician Medical Staff members may be granted admitting privileges as delineated on their privileges checklist and in accordance with their departments and sections Rules & Regulations.

7.3.2 Medical Staff members who are either certified or in the active process of certification by the American Board of Oral and Maxillofacial Surgery may perform the dental admission, requisites, dental inpatient care and the dental discharge responsibilities of their dental patients without a physician Medical Staff co-admitter.

7.3.3 Affiliate Staff members and Dentist members not described above may be granted co-admitting privileges pursuant to departmental rules. If so privileged, they must arrange for co-admission by a physician Medical Staff member prior to the admission. Affiliate and Dentist members shall be responsible for the patient's care and H&P within the scope of their license; the co-admitting physician member shall be responsible for a medical appraisal, including a medical history and physical examination, and for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization. Both parts of the H&P must be completed prior to the procedure and in compliance with the requirements set forth in the General Rules. For outpatient podiatric procedures, an anesthesiologist may perform and document the medical portion of the H&P.

7.4 History and Physical Privileges

7.4.1 Physicians and Oromaxillofacial surgeons. Physicians and Oromaxillofacial surgeons who have admitting privileges as described in 7.3.1 and 7.3.2 are privileged to conduct, update and document histories and physicals. For Oromaxillofacial surgical patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the medical staff with history and physical privileges must conduct or directly supervise the admitting history and physical examination, except the portion related to oromaxillofacial surgery, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the oromaxillofacial surgeon's lawful scope of practice.

7.4.2 Affiliate Staff and Dentists. Affiliate Staff and Dentists not described in 7.4.1 must fulfill their H&P responsibilities described in 7.3.3.

7.4.3 Basic Rules Relating to H&Ps. The General Rules and Regulations of the BBMC Medical Staff describe in detail H&P requirements, and are part of these Bylaws (see Bylaws 15.1). In short: Every patient receives a history and physical within twenty-four hours of admission, unless a previous history and physical performed within thirty days of admission (or registration if an outpatient procedure) is on record, in which case that history and physical will be updated within twenty-four hours of admission. Every patient admitted for surgery must have a history and physical within 24 hours prior to surgery, unless a previous history and physical performed within thirty days prior to the surgery is on record, in which case that history and physical will be updated within twenty-four hours of the surgery.

7.5 Remote Privileges

7.5.1 Remote privileges may be granted to those physician specialists and subspecialists:

A. who are duly appointed, privileged and otherwise credentialed in accordance with these Bylaws; and

B. whose remote patient care, treatment and services are provided to a BBMC patient by means of electronic communication.

7.5.2 Remote privileges must have been determined by the MEC to be:

A. for clinical services that are appropriate to be provided from a remote location and that will enhance the quality of patient care or clinical services at BBMC; and

B. exercisable by a specific electronic means that will not compromise accuracy, reliability, or professional judgment.

7.6 Surgical Privileges. All surgery performed in the Hospital shall be under the overall supervision of the chairman of the Medical Staff Surgery Department and Committee, except that which falls under the jurisdiction of the Cardiovascular Department. Practitioners wishing to exercise privileges granted by the Board to perform

invasive procedures requiring moderate sedation or anesthesia anywhere in the Hospital must have Admitting Privileges (or co-admitting in the case of Affiliate Staff). Exceptions: emergency department privileges.

7.7 Redetermination of Privileges

7.7.1 Basis of Redetermination. Redetermination and the increase or curtailment of privileges shall be based on additional education, training and experience, information resulting from ongoing and other evaluations consistent with these Bylaws of the member's professional practice, performance in patient care, research or education functions in the Hospital, review of patient and other records that document the member's current clinical competence, ability to perform procedures, including information concerning the individual member's judgment.

7.7.2 Frequency. Periodic redetermination of privileges shall be done at the time of biannual renewal of privileges and may be done between times of renewal, as indicated through program of ongoing data collection. Practitioners may request increase or curtailment of privileges at any time through the appropriate clinical committee.

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

7.8 Temporary Privileges

7.8.1 Agreement: By requesting temporary privileges, the practitioner shall agree to the following:

7.8.1.1 that the temporary privileges are granted as a matter of courtesy and accommodation to the practitioner, and that the granting or denial thereof shall vest no right, privilege or procedural entitlement in the practitioner; and

7.8.1.2 that once granted, temporary privileges may be withdrawn at any time, for any or no reason, without notice, at the absolute and uncontrolled discretion of the Administrator, the President of the Staff, or his or her designee, and the Department Chairman; and

7.8.1.3 that the practitioner does release from all liability every person or legal entity involved, in any way, with the granting or withdrawing of the practitioner's temporary privileges.

7.8.2 Application: Requests for temporary clinical privileges shall be in writing, on forms furnished by the Hospital, addressed to the Administrator and shall state the reasons for requesting temporary privileges, the specific privileges requested, acknowledgement that the applicant has received, read and understood the Staff Bylaws and that he or she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges and that he or she has complied with the Bylaws provision regarding Professional Liability Insurance.

7.8.3 Temporary Privileges For Staff Applicants: An applicant for Staff membership and privileges whose Completed Application has not yet been approved by the Department Committee, Executive Committee and the Board but has been approved by the Credentials Committee without adverse recommendations or unresolved issues may request temporary privileges. Pending final action on the application for appointment, the Administrator may grant, upon the concurrence of the Chairman of the Credentials Committee, and either the President of the Staff or the Chairman of the appropriate clinical department or departments temporary clinical privileges for sixty (60) days; provided, however, that no temporary privileges may be granted to an applicant until he or she has successfully completed the MEC-approved EMR training program; and that in exercising such privileges, the applicant shall act under the supervision of the Chairman of the department or departments to which he or she is assigned, and must comply with the program of monitoring established by the department or departments. No more than one sixty-day extension may be granted.

7.8.3.1 Temporary privileges may be granted to a medical staff member with a routine

application where the Banner Board Medical Staff Subcommittee has recommended appointment or reappointment to the Board.

7.8.4 Temporary Privileges to Treat a Specific Patient: For practitioners who do not intend to become members of the Staff, temporary clinical privileges for the care of a specific patient may also be granted by the Administrator with the approval of the Chairman of the Credentials Committee, the President of the Staff or the Chairman of the appropriate clinical department under the following terms and conditions:

7.8.4.1 The applicant shall furnish proof of current licensure and DEA certification (consistent with the requirements of these Bylaws), verification that applicant exercises the relevant privileges at applicant's current principal hospital and that applicant satisfies membership requirements of the relevant Medical Staff department; and proof of adequate professional liability insurance coverage; and

7.8.4.2 The applicant shall furnish the name, address and telephone number of a peer who can attest to his/her current clinical competence for the privilege requested.

7.8.4.3 The applicant may not be granted such temporary privileges for more than four (4) patients in any calendar year. Practitioners who exceed this limitation shall be required to apply for, and be granted appointment on the Staff before being allowed to attend additional patients.

7.8.5 Temporary Privileges for Locum Tenens: The CEO may grant temporary privileges to a physician serving as a locum tenens only after receipt of a completed application, the requisite documentation pertaining thereto, and the concurrence of the President of the Staff, the Chairman of the Credentials Committee and concerned Departmental chairman.

7.8.6 Coverage of Physician Services: Where the Physician service is not adequately covered to meet patient care needs, temporary privileges may be granted to an applicant for staff membership upon receipt of application and verification of the following information: appropriate licensure, adequate professional liability insurance, DEA registration (if applicable), current clinical competency, education and training, and NPDB query responses. Privilege criteria for the requested privilege(s) must be met. Temporary privileges shall be granted under this provision only under exceptional circumstances as determined by the Medical Executive Committee and never solely for the sake of physician convenience. Temporary privileges will be considered on an individual basis for a period not to exceed 60 days upon completion of CPOE/EMR training. One extension may be granted for an additional period not to exceed 60 days.

7.8.7 Revocation: Revocation of temporary privileges shall not be subject to review by any committee of the Staff or the Board of Directors, nor shall such revocation be the subject of any proceedings under 9 of these Bylaws or under the Fair Hearing Plan. Where appropriate or necessary, the President of the Staff shall be responsible for:

7.8.6.1 Evaluating the needs of inpatients then under the care of the practitioner whose temporary privileges have been terminated;

7.8.6.2 Making arrangements for meeting such needs, including the assignment of other members of the Staff to care for the patient on a temporary basis, with the patient's consent; and

7.8.6.3 Communicating with the patient concerning the transition and responsibility for the patient's care, and the options available to the patient under the circumstances.

7.9 Emergency Privileges

7.9.1 In the event of a life threatening emergency, any Staff appointee, to the degree permitted by his/her license and regardless of privileges or Staff category, shall be permitted to do everything reasonably possible to save the life of a patient, using every available facility of the hospital.

7.9.2 When an emergency situation no longer exists, the patient shall be assigned to a Staff appointee with appropriate privileges, by the President of the Staff.

7.10 Disaster Privileges

7.10.1 Grant. When a disaster has been officially declared pursuant to the Hospital's emergency management plan and either the CEO, CMO or the Medical Staff President has determined that the Hospital is unable to meet its immediate patient needs, the CEO, CMO or Medical Staff President (delegees) may, on a case by case basis, grant specialty-specific disaster privileges to a physician or other licensed independent practitioner or PA or NP (practitioner) who has provided any of the following:

7.10.1.1 a current professional license to practice and a valid picture ID issued by a state or federal regulatory agency; or

7.10.1.2 a picture identification evidencing that the practitioner is a member of a medical staff of an Arizona or Federal military hospital; or

7.10.1.3 recommendation or a current Banner Baywood employee or Medical Staff member with personal knowledge of the practitioner's identity.

7.10.2 Duration. As soon as the immediate situation is under control, primary source verification of licensure will occur, and is completed within 72 hours from the time the practitioner presents to the organization. Denial of the request and termination of any temporary disaster privileges do not give rise to any rights of appeal.

7.10.3 Oversight. Cases performed by a practitioner exercising disaster privileges will be reviewed in accordance with the Medical Staff & Allied Health Professional Peer Review for Quality of Care policy

8 PEER REVIEW: PERFORMANCE IMPROVEMENT, INVESTIGATION AND CORRECTIVE ACTION

8.1 Definitions

8.1.1 "Corrective Action" means any action by the Staff, Hospital or Board (other than those in Article 6 (Appointment)), to restrict, suspend, revoke or otherwise reduce Staff membership or the exercise of non-temporary privileges.

8.1.2 "Investigation"

(a) An investigation is a targeted evaluation of the competence or conduct of a practitioner which is triggered by a determination by the Medical Executive Committee, a Department or a standing peer review committee, that there is a substantial likelihood that the practitioner's competence or conduct fails to meet applicable standards of care or behavior.

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

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

(d) FPPE undertaken to determine whether a substantial likelihood exists that a practitioner's competence or conduct fails to meet required standards does not constitute an investigation.

(e) FPPE undertaken following a determination that a substantial likelihood exists that a practitioner's competence or conduct fails to meet applicable standards, for the purpose of determining the nature and/or extent of such substandard performance, shall constitute an investigation and notice of the initiation of the investigation shall be given to the practitioner in writing.

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

8.1.3 "Evaluation tools" are used to evaluate and/or help improve a practitioner's performance. They include such mechanisms as (1) observation (concurrent or retrospective chart review), (2) simulation assessment, (3) supervision (in-person oversight by a second physician), and (4) consultation (prior approval of medical decisions by a second physician).

8.1.4 "Peer Review" is the objective measurement, assessment and evaluation by Peer Reviewers or Peer Review Committees of the quality of care provided by individual practitioners, including identification of opportunities to improve care; and reporting the Committee's conclusions and recommendations to the Department Committee and/or MEC for appropriate action.

8.1.4.1 "Peer Reviewer" is a licensed practitioner engaged in peer review who possesses appropriate and relevant clinical judgment based on training, education and experience. A Peer Reviewer may not be involved in the case under review and must comply with the Medical Staff's Conflict of Interest Policy (Sec. 6.8).

8.1.4.2 A "Peer Review Committee" is made up of Peer Reviewers to conduct Peer Review. See examples in 8.2.2. At least one Peer Reviewer on the Committee must be actively practicing in the same (sub)specialty as the practitioner under review; be currently qualified and competent in the specific treatment or procedure under review; and be board-certified, unless the specialty has no certifying board.

8.2 Routine Performance Monitoring, Evaluation and Improvement. All BBMC physicians, dentists, psychologists and podiatrists are subject to evaluation based on medical staff peer review criteria adopted in accordance with these Bylaws and intended to be fair and objective and to result in consistent and credible data. Departmental peer review of privileged practitioners shall be performed on an ongoing basis in accordance with these Bylaws, and members are kept apprised of reviews of their performance.

8.2.1 Chart Review, Case Review, Reported Concerns. Variations in performance or outcomes are

identified on an ongoing basis:

8.2.1.1 by the QM Department through mechanisms such as application of Medical Staff-approved quality indicators (screens) and departmental requests for collection of specified data types and

8.2.1.2 by concerns reported internally to the Medical Staff President or Medical Staff Services about a practitioner's professional performance or conduct.

8.2.2 Peer Review Committees. Cases offering opportunity for performance improvement, data from ongoing professional practice evaluation showing a variation that cannot be explained without a focused review, and questions regarding a practitioner's ability to provide safe, high quality patient care are referred to (a) Department committees, (b) standing Department peer-review Subcommittees, or (c) Ad Hoc Review committees (either Specialty or Multi-Specialty), at the chair's discretion or pursuant to Departmental policy. Cases and data may also be referred for External Review as described below. All reviews are privileged and reported through the Department Committee to the MEC.

8.2.2.1 Ad hoc committees. Ad hoc committees may be used to evaluate professional performance in complex cases or to evaluate credibility of unsolicited reports from other facilities.

8.2.2.2 Multi-specialty ad hoc committees. Multi-specialty ad hoc committees may be used for efficient evaluation of performance in cases involving more than one specialty. The chair of each relevant department shall appoint up to three members, subject to the approval of the Medical Staff President who may appoint additional members. Multi-specialty ad hoc committees report to the MEC through the Department committees.

8.2.2.3 External Review. Review by a licensed External Reviewer (not a BBMC Medical Staff member) should not replace Medical Staff review but can be helpful to ensure credible, well informed Medical Staff review. External Reviews must be obtained as described below. Only the Practitioner's department chair, Peer Review Committee chair, the Medical Staff President or the MEC are authorized to obtain an External Review.

(a) Request. A request for an External Review must be made to the Practitioner's department chair, Peer Review Committee chair, Medical Staff President or the MEC; and may be made by the CEO or the CMO. A Practitioner under review may also seek External Review by making a request to the MEC, which may grant the request at its discretion. An External Review may be requested at any reasonable time, including, for example, prior to a Focused Review. The MEC will be advised of the request for External Review as well as the conclusions and recommendations of the External Reviewer. A contract will be entered into with the External Reviewer before sharing medical records or other information.

(b) An External Reviewer

(i) is actively exercising the privileges for the procedures or services which are the subject of the review;

(ii) has no personal, financial, or professional relationship that would render him/her biased, or would create the appearance of bias; and

(iii) shall be selected by the Department chair or Medical Staff President or Vice President.

(c) Basis. The MEC, Department Committee or chair may find an External Review advisable because of (i) lack of internal expertise (such as clinical specialists with training in new technology or knowledge of best practices and expectations); (ii) lack of internal resources due to, for example, specialists' unavailability, conflicts of interest or reluctance to perform the required review; (iii) ambiguity of prior review conclusions; (iv) lack of prior reviews' credibility due to possible conflicts of interest potentially affecting process, conclusions; (iv) legal concerns such as when due process action is expected; or (v) bench-marking, such as when external sources are needed to identify best practices or expectations.

8.2.3 Notice. Medical Staff Services shall provide the involved practitioner written notice regarding the specific identified concerns to be reviewed and request the practitioner to respond to the Committee's concerns in writing or in person, at the practitioner's option. The notice to the practitioner shall be provided at least fourteen (14) days in advance of the review.

8.2.4 Department Committee Action Options. After evaluation, a department committee may:

8.2.4.1 Dismiss, Trend. If a department committee concludes that its performance-improvement objective has been achieved and there is no further opportunity for improvement, it shall document its conclusion and action in its records, and report its action to the MEC for information.

8.2.4.2 Continue Evaluation. If the practitioner's performance requires further evaluation, the Committee, taking patient safety into account, should agree on a minimally intrusive but efficient "evaluation tool." Evaluation tools are effective when imposed by the department committee, but supervision and consultation require MEC ratification, modification or reversal at its next meeting. Department Committees report ongoing evaluations at least quarterly to the MEC. The Committee shall adopt a performance monitoring plan:

(a) that sets forth the measures to be employed to determine whether performance issues require further improvement or to establish current competency

(b) that specifies the duration; more than 90 days of monitoring must be justified to the MEC for its approval; any extensions of time must be for good cause and made by the MEC.

8.2.4.3 Initiate Preliminary Investigation; Request Corrective Action. If the matter cannot be resolved to the mutual satisfaction of the committee and the member, the committee initiates a preliminary investigation or requests Corrective Action pursuant to Sections 8.3 and 8.4.

8.2.4.4 Adopt Self-Evaluation Plan.

(a) If the department committee has effectuated any changes or identified any opportunities for improvement, it shall adopt a plan to monitor the effectiveness of its action to improve care, and so inform the MEC.

(b) If the practitioner agrees to the Committee's performance-improvement recommendations, the Committee shall record the agreement and report on it to the MEC for information.

8.3 Preliminary Investigation

8.3.1 Initiation. Whenever a matter may merit investigation, any Staff member, the Administrator or the Board may make a request to the Staff President for a preliminary investigation; the request must specifically describe the grounds for the request.

8.3.2 Grounds for Preliminary Investigation. Grounds for preliminary investigation include questions or concerns regarding a Staff member's compliance with the Bylaws or Rules, behavior or clinical competence (e.g., negative results of focused reviews), or care or treatment of a particular patient. Preliminary investigations are distinct from ongoing, routine monitoring and evaluations (8.2), peer review of charts identified by screens. Resolution of any controversy or request for a preliminary investigation shall, if possible, be accomplished by an informal, intra-professional review.

8.3.3 Investigating Committee; Time Frame. The President shall arrange for the investigation by a committee of not less than two (2) Active Staff appointees. The President may use any standing committee or appoint an ad hoc committee. Multi-specialty ad hoc committees shall be constituted as described in 8.2.2.2. The committee shall complete its preliminary investigation within two (2) weeks of its appointment.

8.3.4 Committee Recommendations.

8.3.4.1 To close the investigation: If the committee concludes the matter does not merit serious attention, has been resolved to the committee's satisfaction or can be resolved through policy amendment, the committee may recommend in writing to the Staff President, either before or after meeting with the practitioner, that the investigation be closed with no further action. The Staff President will arrange any meeting between the practitioner and the committee, which shall be informal (no Article 9 procedural rules apply).

8.3.4.2 To continue the preliminary investigation: If the committee concludes, after meeting with the practitioner, that a more detailed investigation is necessary to determine the existence or seriousness of a matter, it shall promptly notify the Staff President in writing and obtain his/her concurrence and the concurrence of the department committee. Investigatory tools include observation (concurrent or retrospective chart review) and/or supervision (physical presence of proctor during procedure), provided their use is short-term and the least-intrusive

manner of determining the (non)existence of a problem. Because investigatory tools are not an adverse action, are not intended to "correct" a problem, the practitioner's cooperation is required. Refusal to cooperate shall result in immediate precautionary suspension of relevant privileges; review under 8.5 and appeal under Article 9 will be solely on the grounds of (1) whether the proposed investigatory tool was reasonable under the circumstances to determine the (non)existence of the problem and (2) whether the Medical Staff member violated the Bylaws by refusing to cooperate.

8.3.4.3 To initiate corrective action: If the matter cannot be resolved to the satisfaction of the committee, the Committee may recommend that a corrective action be initiated as provided in the next Section.

8.4 Corrective Action Procedure (Formal Investigation)

8.4.1 Grounds for Corrective Action, Formal Investigation: Grounds include incompetence; unethical or unprofessional conduct; conduct below the standards of the Staff as stated in these Bylaws and the Rules and Regulations; conviction of a felony; persistent disruptive behavior as defined in Section 4.2.13; violation of these Bylaws or the Rules and Regulations; falsification of a patient's record; or false or misleading information in an application.

8.4.2 Written Request: Corrective action is initiated by a written request through the Administrator to the MEC that specifies the type of corrective action requested and the grounds. The request may be made by:

8.4.2.1 any Staff committee that has been unable to resolve a matter as described in 8.2 or 8.3;
8.4.2.2 the Staff President
8.4.2.3 the Administrator
8.4.2.4 the Chairman of the Board, or
8.4.2.5 the Executive Committee, as described in 8.5

8.4.3 Notice. The Administrator shall promptly inform the member by Special Notice of the request.

8.4.4 Investigation and Timely Action. Unless the practitioner is under suspension (See 8.5.3), the MEC shall act on the recommendation at its next meeting. If it believes further effort should be made to obtain the facts on which to base a corrective action recommendation, the MEC may appoint a committee (e.g., a department committee) to conduct a prompt, thorough investigation of the practitioner's performance and report its conclusions and recommendations to the MEC. Before taking action, the MEC shall provide the practitioner an opportunity to appear. This appearance is informal and does not constitute a hearing and no Article 9 procedural rules shall apply, and the practitioner shall appear without representation.

8.4.5 Suspension: An investigation does not in itself necessitate suspending the practitioner.

8.4.6 Basis of Executive Committee Action on Request: The MEC shall take action on the request, once it concludes that reasonable efforts were made to obtain the facts of the matter and reasonably believes its recommendation is warranted by the facts and furthers quality health care. If the MEC determines that:

8.4.6.1 Substantial Evidence Does Not Warrant Corrective Action: It will record its conclusion, together with the department's report and any supporting documentation in the executive session minutes and dismiss the matter.

8.4.6.2 Substantial Evidence Warrants Only Corrective Action That Does Not Substantially Restrict Privileges: it may, without limitation:

(a) place a letter of warning or reprimand in the practitioner's file;
(b) require reasonable, short-term 100% retrospective chart review, observation or supervision of certain or all privileges (without requiring prior consultation with or approval by the observer or supervisor);
(c) impose terms of probation;
(d) require psychiatric or physical evaluation or counseling, provided its advisability

is determined in consultation with Practitioner Health Committee;

(e) require simulation or other means of skills assessment;
(f) require continuing education or retraining.
(g) require advance notice of all non-emergency patient admissions.

8.4.6.3 Substantial Evidence Warrants Restriction of Privileges: It may recommend to the Board, without limitation:

(a) requiring consultation prior to patient treatment;
(b) restriction, suspension, or reduction of privileges;
(c) modification of Staff category; and/or
(d) revocation of Staff membership.

8.4.7 Administrative Implementation: The Administrator shall promptly notify the Staff member of findings and recommendations made pursuant to 8.3 and of any Article 9 hearing rights, and make any statutorily required reports.

8.5 Precautionary [Summary] Actions

8.5.1 Precautionary [Summary] Suspension.

8.5.1.1 Grounds, Authority for Precautionary Suspension: Precautionary suspension of all or any portion of a practitioner's clinical privileges may be imposed only when such immediate action appears necessary to reduce a substantial threat and/or imminent likelihood of significant impairment or injury to anyone's life, health, safety or well-being or pursuant to 8.1.5. A precautionary suspension is an interim precautionary step in the professional review activity related to the ultimate professional review action; it does not in itself imply a final finding of responsibility for the circumstances giving rise to the suspension. Two or more of the following have the authority to impose precautionary suspension:

(a) Staff President
(b) the relevant department committee or chair
(c) the Administrator (CMO, in Administrator's absence)
(d) the MEC
(e) the Chairman of the Board

8.5.1.2 Notice. Precautionary suspension is effective immediately upon notice to the practitioner. Immediate written notice must also be provided, signed by the suspending parties and clearly delineating the suspended privileges and the reasons. A copy of the written notice must be provided immediately to the President and the Administrator. The Administrator shall take all administrative action necessary to carry out the suspension, comply with statutory reporting requirements and inform the practitioner of his/her rights for a hearing.

8.5.1.3 Prompt Review: The MEC will promptly meet to hear the suspended practitioner and review the grounds of the suspension. The review shall take place as soon as possible, no later than within five days unless waived by the practitioner. The practitioner may show why the suspension should not continue and respond to questions. This meeting is informal and preliminary in nature; it is not a "hearing," and none of Article 9 procedural rules with respect to hearings and appeals shall apply. Within two working days of the meeting, the MEC must notify the practitioner of its decision; the MEC may continue or terminate the suspension; or impose less restrictive precautionary measures, such as required consultation, direct supervision, 100% chart review and suspension of specific privileges.

8.5.1.4 Care of Suspended Individual's Patients: Immediately upon imposing precautionary suspension, the practitioner's department chair (or Staff President in his/her absence) shall assign to another Staff member with appropriate clinical privileges (with priority for a practice partner of the practitioner) the responsibility for care of the suspended practitioner's hospital patients until the patients are discharged. The patient's wishes should be considered in selecting alternative coverage.

8.5.2 Precautionary Supervision, Consultation. If deemed advisable for patient safety or welfare, at least two of the following: [1] department chair, [2] Medical Staff President, [3] Administrator, may impose, subject

to MEC ratification at its next meeting, summary supervision, observation or consultation until a final determination is made regarding the practitioner's privileges. The practitioner in question may appear before the MEC to discuss the action. Concurrent summary supervision and consultation trigger the right to expedite any review of the corrective action recommendation provided for in these Bylaws.

8.6 Automatic Suspension: Clinical privileges and/or Staff membership are automatically suspended by the Administrator for the reasons and to the extent provided below, with written notification to the practitioner, the Medical Staff President and the practitioner's department chair, who shall cooperate with the Administrator in enforcing the automatic suspension. Any hearing if properly requested in accordance with Article 9, is limited to determining whether the grounds for the automatic suspension have occurred.

8.6.1 Licensure: Staff membership and clinical privileges are automatically revoked upon revocation of a practitioner's license or certification to practice. Clinical privileges are automatically limited or restricted consistent with, and for the duration of, any limitation or restriction on the practitioner's license or certification to practice. When a licensing board or certifying authority places a practitioner on probation, the practitioner's membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation for the duration of the probation. When a practitioner's license to practice in this State expires, staff membership and clinical privileges shall automatically be suspended and failure to renew within thirty (30) days following the suspension will result in automatic termination of membership and privileges.

8.6.2 Controlled Substances: Whenever a member's DEA certification is expired, revoked, limited or suspended, the member's clinical privileges shall automatically be suspended. Privileges shall be reinstated when evidence of current DEA certification is provided. Whenever a member's DEA certification is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

8.6.3 Medical Records: A practitioner's privileges shall be temporarily suspended until medical records are completed, in accordance with the Medical Staff Rules and Regulations.

8.6.4 Failure to Pay Dues by April 1: Failure to pay Staff membership dues by April 1 results in automatic suspension of clinical privileges. The MEC will notify the appointee by Special Notice that he/she has thirty [30] days to pay dues or his/her appointment will be automatically terminated and the Staff appointee will have to reapply.

8.6.5 Termination of Professional Liability Insurance Coverage: Staff membership and/or relevant privileges shall immediately be suspended upon termination of professional liability insurance coverage until the Administrator has been notified of its reinstatement or replacement provided such notice is within thirty [30] days. Failure to file the statement required under 4.4 within thirty days shall result in termination of Staff membership and privileges.

8.6.6 Failure to Establish Freedom from Infectious TB: Failure to establish freedom from infectious tuberculosis at time of initial appointment and thereafter as required, results in automatic suspension of membership and clinical privileges. Failure to provide such evidence within thirty (30) days following the suspension will result in automatic termination of membership and privileges.

8.6.7 Exclusion from Medicare/State Reimbursement Programs. Current listing by the Office of Inspector General, U.S Department of Health and Human Services as an "Excluded Individual" (barred from participation in any federal or state program including Medicare, AHCCCS, Indian Health Service or CHAMPUS) shall result in automatic suspension of privileges until the excluded practitioner agrees in writing (a) not to provide items or services to patients enrolled in affected federal or state programs and (b) to indemnify the hospital and Medical Staff for any liability solely the result of a breach of the agreement. (See Banner policy)

8.6.8 Failure to Appear. The privileges of a practitioner who fails without good cause to appear at a meeting when so required by a Medical Staff committee conducting a performance or conduct review pursuant to this article shall automatically be suspended (except in emergencies) until satisfying the required appearance.

8.6.9 Failure to execute releases and/or provide documents. The privileges of a practitioner who fails to execute a general or specific release and/or to provide documents when required pursuant to these Bylaws and requested by the President, department chair shall be suspended until the release is executed or documents are provided, up to 30 days. Thereafter, the practitioner is deemed to have resigned voluntarily from the Staff.

8.6.10 Failure to Obtain Influenza Vaccination. Staff practitioners, who practice within the facility, who fail to provide evidence of annual influenza vaccination or medical or religious exemption, shall automatically be suspended. Privileges shall be reinstated when evidence is provided or when flu season is deemed to have ended.

8.6.11 Failure to Maintain Required Certification. Failure to provide evidence of current ACLS, ATLS, BLS, CNOR, CPR, PALS, and/or APLS certification for specific privileges as required by Department Rules, Privilege Delineation Forms, or Advanced Practice Provider/Allied Health Professional Scopes of Practice shall result in the automatic suspension of those privileges. Privileges shall be reinstated when evidence is provided.

8.7 Non-Reviewable Actions: Not every Adverse Action gives rise to an Article 9 Hearing Right. For example:

8.7.1 using Evaluation Tools listed in 8.1.3 consistent with 8.2.3.3;
8.7.2 limiting reappointments as described in 6.3.3.2;
8.7.3 actions taken under 8.4.6.2 (letters of warning, retrospective chart review);
8.7.4 precautionary supervision and precautionary consultation under 8.5.5;
8.7.5 automatic suspension, except as provided in 8.6;
8.7.6 revocation of temporary privileges under 7.7;
8.7.7 non-(re)appointment for failure to complete a (re)appointment application (6.3.2);
8.7.8 actions taken pursuant to the Practitioner Health Program (8.8);
8.7.9 any recommendation voluntarily accepted by a practitioner; and
8.7.10 failure to complete provisional staff requirements within allotted time-frame (5.2.1.2).

8.8 Practitioner Health Program

8.8.1 Definitions.

8.8.1.1 "Impaired practitioner" is a practitioner whose performance and/or judgment has been deemed impaired by a physical, mental, psychological, behavioral or emotional impairment and/or drugs and/or alcohol by the Practitioner Health Committee ("PHC") pursuant to this Section.

8.8.1.2 "Credible information" of impairment means information of an eyewitness to acts or other relevant information providing a factual basis for a reasonable belief that a practitioner is impaired.

8.8.2 Program Objectives: The objectives of the Practitioners Health Program are (a) to safeguard patients, and (b) to assist impaired practitioners able to practice safely with minimal impairment to their ability to practice their profession, while satisfying the requirements of state and federal law. PHC recommendations solely relating to impairment are not disciplinary and do not in themselves give rise to Art. 9 hearing rights or hospital NPDB-reporting obligations; PHC evaluations are not investigations.

8.8.3 Program Initiation:

8.8.3.1 Credible information: Admission of impairment and credible information of impairment and disruptive or harassing conduct should be brought to the Medical Staff Services Director or the Staff President by all members, other practitioners and Hospital personnel. The Staff President will convene the PHC. (When immediate action is required under 8.5, the 8.5.3 prompt review and subsequent actions are implemented by the Medical Staff President rather than the MEC).

8.8.3.2 Deliberation of the PHC: The PHC will meet promptly and interview the reporter, any witnesses and the practitioner in question to make a determination of impairment. The PHC shall have discretionary authority to require an independent physical or psychiatric evaluation at the Hospital's expense, provided the advisability of such evaluation in light of the information is determined in consultation with Hospital legal counsel.

8.8.3.3 PHC Action Options. If the PHC concludes that on balance all the information does not support a conclusion of impairment, it shall dismiss the case. If the PHC concludes that, on balance, the information supports a conclusion that the practitioner is impaired, it shall recommend to the practitioner a program of such evaluation, treatment, counseling and/or voluntary leave of absence and/or voluntary, temporary curtailment of the practitioner's practice at all Banner Facilities that the PHC reasonably believes is in the best interest of patients and the practitioner. The Administrator shall make any statutorily required reports.

8.8.3.4 Recommendation Accepted: If the practitioner agrees to the recommended Program it will be implemented on approval of the Medical Staff President, and information developed in connection with the Program will not be used against the practitioner in subsequent department corrective action proceedings unrelated to the impairment. If the recommendation includes a voluntary leave in order to undergo treatment, Section 4.10 leave procedures will not apply, and the PHC will reactivate privileges, once the practitioner has presented information of satisfactory completion of the approved program, and otherwise satisfied 8.8.4

8.8.3.5 Recommendation Rejected: If the practitioner rejects the PHC recommendation or subsequently fails to comply with the Program recommendations, the PHC shall so report to the President and refer the matter with all documentation to the practitioner's department committee for further action consistent with Sections 8.2, 8.3 and 8.5; and the confidentiality provision in the previous paragraph will not apply.

8.8.4 Program Monitoring: Practitioners whose licenses are under stipulation because of impairment must demonstrate their fitness to exercise their clinical privileges; the PHC shall develop and propose for MEC adoption reasonable mechanisms by which such practitioners may be monitored after successful completion of the approved treatment program.

8.9 General Provisions

8.9.1 Confidentiality: Every individual obtaining privileged information pursuant to this Article is required to preserve its confidentiality and not to disclose or use the information except as authorized in these Bylaws or required by law.

8.9.2 Reports to Licensing Boards: On request, Hospital legal counsel shall advise the MEC and Staff President of requirements to report to state and federal agencies pursuant to state and federal law. All such reports shall be made by the Administrator, and the subjects of the reports shall be given notice thereof.

8.9.3 Report to NPDB. A summary suspension or other Adverse Action is not reported to the National Practitioner Data Bank until taken as a “final action” by the Board after exhaustion of the practitioner’s hearing rights, or is already in effect and lasts longer than 30 days.

8.9.4 Peer Review Files: No correspondence, reports or other materials relating to complaints, peer review, quality review, investigations or corrective action about a Staff member pertaining to Section 8 may be placed into the member's peer review file without the member having been provided a reasonable opportunity to respond in writing to the information.

8.9.5 Regaining Medical Staff Membership and/or Privileges: Medical Staff membership and privileges may be the subject of suspension, revocation, termination, lapse or interruption for a number of reasons. Medical Staff membership and/or privileges may be regained as follows:

8.9.5.1. A member who voluntarily resigns Medical Staff membership or any clinical privilege, in the absence of any concerns related to competence or conduct, may reapply for membership or privileges at any time. If reapplication is made within one year of the voluntary resignation, the member may apply for

reappointment. If application is made later than one year following the resignation, the application shall be considered an initial application.

8.9.5.2. Following voluntary resignation or involuntary termination of membership or any clinical privilege, or following voluntarily refraining from exercising any clinical privilege, during the pendency of any concern related to competency or conduct, the member may regain membership and/or clinical privileges by:

a) requesting reinstatement;
b) providing satisfactory evidence that the concerns regarding the member's competency or conduct have been satisfactorily resolved;
c) if within one year of the voluntary action, completing the reappointment process; and
d) if later than one year following the voluntary action, completing the initial application process.

8.9.5.3. Following automatic suspension, limitation or revocation pursuant to Section 8.6, by:

a) requesting reinstatement; and
b) satisfactorily demonstrating that the conditions upon which the automatic action was based have been met, or the circumstances upon which the automatic action was based have been satisfactorily resolved.

9 FAIR HEARING PLAN

9.1 Right to Hearing and Appeal

9.1.1 Triggering Events: An appointee or an applicant shall have a right to a hearing and/or appeal when properly requested in accordance with these Bylaws upon any adverse action or recommendation by the Executive Committee or any adverse action by the Board (collectively: "Adverse Action"), except as expressly provided in these Bylaws, that would deny, revoke, suspend, reduce or otherwise restrict membership and/or non-temporary privileges, including any of the following:

9.1.1.1 Denial of initial Staff appointment
9.1.1.2 Denial of reappointment
9.1.1.3 Suspension of Staff appointment
9.1.1.4 Revocation of Staff appointment
9.1.1.5 Denial of requested advancement to non-provisional category
9.1.1.6 Limitation of the right to admit patients
9.1.1.7 Denial of requested department or service affiliation
9.1.1.8 Denial of requested clinical privileges
9.1.1.9 Reduction in clinical privileges
9.1.1.10 Suspension of clinical privileges
9.1.1.11 Revocation of clinical privileges
9.1.1.12 Involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional status)

9.1.2 Notice of Adverse Action and of Right to Hearing: The Administrator shall give the Respondent Special Notice of any Adverse Action giving rise to a right to the Hearing described in this Article. This notice shall state:

9.1.2.1 the proposed action to be taken against the Respondent;
9.1.2.2 the reasons for the proposed action;
9.1.2.3 thirty (30) day period to request a hearing on the proposed action;
9.1.2.4 a summary of the rights in the hearing;
9.1.2.5 that failure to submit a proper request for a hearing within 30 days constitutes a waiver of hearing and appeal rights; and the consequences of a final Adverse Action (Section **9.1.4**); and
9.1.2.6 that the Administrator will notify the Respondent of the date, time and place of the hearing and the witnesses then expected to testify in support of the Adverse Action upon receipt of the Respondent's request.

9.1.3 Request for Hearing or Appeal: The right to any hearing or appeal is expressly conditioned upon the Respondent's proper and timely request for the hearing. To be effective, the request must be in writing, delivered by Special Notice to the Administrator within thirty (30) days of the Respondent's receipt of the notice of the Adverse Action.

9.1.4 Waiver by Failure to Request a Hearing: Failure to make a timely and proper request shall constitute consent by the Respondent to final action by the Board without a hearing or appeal. The waiver shall apply only to the matters that were the basis of the Adverse Action triggering the notice. The Administrator shall transmit notice of the Respondent's waiver to the Board, and, as soon as reasonably practicable, shall send the Respondent notice of the Board's final action.

9.1.5 Nature of Hearing: The hearing shall be a hearing de novo by which the Hearing Committee reviews all of the information available to the Executive Committee/Board and such other evidence as may be presented in accordance with this Article, and reaches an independent determination; and the Hearing Committee's recommendations, if taken in accordance with this Section, are deemed to be based

9.1.5.1 on the reasonable belief that the recommendation is in furtherance of quality healthcare;

9.1.5.2 after a reasonable effort to obtain the facts of the matter; and

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

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

9.2 Scheduling the Hearing

9.2.1 Notice of Time and Place for Hearing: The Administrator shall deliver a timely and proper request to the Staff President (or Board chairman, if Board's Adverse Action), who shall schedule the hearing. At least thirty (30) days before the hearing, the Administrator will send the Respondent Special Notice of the date, time and place of the hearing. Best efforts shall be used to schedule the hearing to commence not less than thirty (30) days nor more than sixty (60) days after the Administrator receives the Respondent's written request.

9.2.2 Expedited Hearing: A Respondent under precautionary suspension may request an expedited hearing. The Administrator must provide the required information within ten (10) days of receiving the written request for the expedited hearing. The expedited hearing must be held as soon as the arrangements may reasonably be made, but not later than sixty (60) days after the Administrator's receipt of the written request for the expedited review. If requested by the Respondent, the Staff President or Board chair shall meet with the Respondent at the earliest opportunity to adjust all other deadlines leading to a final action.

9.2.3 Adjustments. If requested by the Respondent, the President (or Board chairman, if Board's Adverse Action) or designee shall meet with the respondent at the earliest opportunity to adjust all other deadlines leading to a final action. Furthermore, any respondent, with the consent of the President/Board chairman, can waive the above stated time requirements in order to expedite the hearing process.

9.3 Appointment of Hearing Committee

9.3.1 Composition of Hearing Committee: The Hearing Committee shall be composed of at least three persons. The committee members may not be in direct economic competition or have a formal business or professional association with the Respondent; have other significant bias as to the outcome of the Hearing; or have actively participated in the consideration of the Adverse Action. The person appointing the Committee shall designate one of its members as chair.

9.3.2 Appointment of Hearing Committee and Chair by President of the Medical Staff: The President shall appoint the Hearing Committee when the Hearing is triggered by an Adverse Action of the Executive Committee. The President shall appoint one of the Hearing Committee members to serve as chair. Members of the Hearing Committee shall be physicians duly licensed by one of the fifty states and may, but need not be Staff members. The Committee members should include one with a license or certification comparable to that of the Respondent. If the President is in direct economic competition with the Respondent, he or she is disqualified from selecting Committee members, and the Vice President, Secretary/Treasurer or remaining members of the Executive Committee (in that order) shall appoint the Committee members and chair.

9.3.3 Appointment of Hearing Committee by Board Chair: The Board chair shall appoint the Hearing Committee when a Board Adverse Action triggered the Hearing. A majority of the Committee shall be members of the Board, but other qualified persons may serve.

9.3.4 Concurrent Hearings: Where the Executive Committee and other Banner Executive Committees make an adverse recommendation against the same practitioner, the Chief of Staff may, in his/her sole discretion, elect to participate in a concurrent hearing. The Chiefs of Staff of the participating Medical Centers shall

collectively determine the members of the hearing committee.

9.3.5 Hearing Officer: The President (or Board chair, if Board's Adverse Action), at his/her discretion may appoint a hearing officer. The hearing officer shall serve as the Presiding Officer; maintain decorum, and rule on matters of law, procedure, and the admissibility of evidence, including the admissibility of testimony and exhibits. The hearing officer, at his or her discretion, may hold one or more prehearing conferences with the parties' attorneys (or the Respondent him or herself if Respondent has not retained an attorney) to address and resolve procedural and evidentiary matters. The hearing officer may participate in the Hearing Committee's deliberations and assist in the preparation of a written decision, but may not act as an advocate or advisor for either party and may not vote. The hearing officer need not be a member of the Medical Staff or a physician and may not be in direct economic competition or affiliation with the practitioner.

9.3.6 Respondent's Right to Object: The Administrator shall promptly inform the Respondent of the names of the Committee members and the hearing officer. The Respondent shall have ten (10) days following a notification, within which to object to the appointment of any member(s) or the hearing officer, as the case may be, in writing and stating the basis for the objection. If the person who appointed the Committee members/hearing officer determines that the objection is reasonable, he or she may name new member(s)/hearing officer and notify the Respondent thereof. The Respondent may object to any new members/hearing officer as before.

9.4 Prehearing Proceedings

9.4.1 Exhibits. At least one (1) week prior to the scheduled hearing commencement date, each party shall give the other party and the Medical Staff Services office a copy of all exhibits, as far as is then reasonably known, which will be introduced during the hearing. Documents previously provided to a party need not be re-supplied. Upon request, the Medical Staff Services office shall distribute the exhibits (if any) to members of the Hearing Committee at least three (3) days prior to the scheduled hearing commencement date. The Presiding Officer may permit the introduction of an exhibit which has not been provided in accordance with this Section if he/she finds that the failure to provide such exhibit was justified, that such failure did not prejudice the non-offering party, and that the exhibit will materially assist the Hearing Committee in making its report and recommendation.

9.4.2 Witness List. At least ten (10) days prior to the scheduled hearing commencement date, each party shall give the other party a list of the names of the individuals who, as far as is then reasonably known, will give testimony or evidence at the hearing. Such lists of witnesses shall be amended as soon as possible when additional witnesses are identified. The Presiding Officer may permit a witness who has not been listed in accordance with this Section to testify if he or she finds that the failure to list such witness was justified, that such failure did not prejudice the party entitled to receive such list, and that the testimony of such witness will materially assist the hearing committee in making its report and recommendation under Section **9.6.1**. The practitioner and the representative of the Medical Executive Committee shall be permitted to testify regardless of whether they are listed as a witness.

9.4.3 Statements in Support: A party who wishes to, may submit a written statement to the other party and the Hearing Committee by supplying five (5) copies of the statement to Medical Staff Services at least five (5) days before the scheduled hearing commencement date. Medical Staff Services shall distribute the copies to members of the Hearing Committee and the other party, at least three (3) days before the scheduled hearing commencement date. Nothing in this paragraph precludes the Board/Executive Committee from submitting procedural information to the Hearing Committee.

9.4.4 Duty to Notify of Noncompliance: If the practitioner becomes aware that there has been a deviation from the procedures required by the Bylaws or applicable law, the practitioner must promptly notify the Chief of Staff of such deviation, including the Bylaws or applicable law citation. If the Chief of Staff agrees that a deviation has occurred and is substantial and has created demonstrable prejudice, he/she shall correct such deviation.

9.5 Conduct of Hearing

9.5.1 Personal Presence: The Respondent is required to be personally present throughout the hearing. The presence of the Respondent's counsel or other representative does not constitute the personal presence of the Respondent. Failure without good cause to be present throughout the hearing shall be deemed a waiver of rights in the same manner and with the same consequence as provided in Section 9.1.4. The Hearing Committee shall determine what constitutes "good cause."

9.5.2 Presiding Officer: In the absence of a Hearing Officer **(9.3.4)** the Hearing Committee chair shall be the Presiding Officer. The Presiding Officer shall maintain decorum and assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence. The chair shall be entitled to participate in Hearing Committee deliberations and vote.

9.5.3 Representation: The Respondent and the Executive Committee or Board (whichever originated the Adverse Action) may be assisted at the hearing by legal counsel or other person of the party's choice. Each party shall notify the Administrator of the identity of the party's representative at least three (3) days before the scheduled hearing commencement date, and the Administrator shall promptly convey the information to the other party.

9.5.4 Rights of the Parties: During the hearing, each party shall have the following rights, subject to the rulings of the presiding officer on the admissibility of evidence and provided that the rights are exercised in a way that permits the hearing to proceed effectively and expeditiously to:

9.5.4.1 call, examine and cross-examine witnesses;
9.5.4.2 present relevant evidence;
9.5.4.3 rebut any evidence;
9.5.4.4 submit a written statement in support of the party's position pursuant to **9.4.3**;
9.5.4.5 submit proposed findings of fact and recommendations at the close of the hearing;
9.5.4.6 have a record of the proceedings upon payment of any reasonable charges associated with the preparation thereof; and
9.5.4.7 receive, upon the completion of the hearing, the written Hearing Committee recommendation and the reconsidered Action of the Executive Committee or Board, including a statement of their basis.

9.5.5 Burden of Proof: The initial applicant- Respondent has the ultimate burden of proving his/her qualifications for initial (a) appointment to the Staff and (b) grant of requested clinical privileges and of presenting evidence that the Adverse Action lacks substantial factual basis or is arbitrary, unreasonable or capricious. In all other cases, the Executive Committee/Board has the burden of proving by a preponderance of evidence that the Adverse Action is reasonable and warranted.

9.5.6 Record of the Proceedings: A hearing record shall be kept by court reporter.

9.5.7 Order of Presentation: The body that originated the Adverse Action shall make the first presentation showing the reasons for its action. Thereafter, the Respondent shall have the opportunity to make a responding presentation.

9.5.8 Decorum. The right to a hearing shall be waived, if in the opinion of the Hearing Committee, the Respondent's conduct (and/or the conduct of any representative of Respondent) prevents the hearing from proceeding effectively and expeditiously. The Presiding Officer must provide the Respondent an opportunity to correct the circumstances prior to ruling that Respondent's hearing rights have been waived. Examples of conduct sufficient to give rise to waiver include: refusal to be sworn in or to answer questions posed by the Hearing Committee; failure to abide by a ruling of the Presiding Officer. Waiver under this provision shall have the same consequence as provided in Sections 9.1.4. A Respondent ruled to have waived hearing rights may submit a written request and supporting material within 10 days of the ruling to the Executive Committee; the Executive Committee's

ruling shall be final, and not subject to appeal.

9.5.9 Procedure and Evidence: The hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. At the discretion of the presiding officer any relevant matter may be considered. In addition, the Respondent may be examined by the Executive Committee or Board representative and the Hearing Committee regardless of whether the Respondent testifies on his/her own behalf. The Hearing Committee may ask questions of witnesses, call additional witnesses, or request documentary evidence as it deems appropriate. The presiding officer may order that oral evidence be taken only on oath.

9.5.10 Quorum: At least a majority of the members of the Hearing Committee shall be present when the hearing takes place. No member may vote by proxy, and no member may vote who was not present at the hearing.

9.5.11 Postponement, Timeliness, Recesses and Adjournment: Requests for postponement or continuance of a hearing may be granted by the presiding officer only upon a timely showing of good cause. The Hearing Committee may recess and reconvene for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation, but, absent a finding of good cause, the hearing shall be completed within thirty (30) days of its commencement. Upon conclusion of the presentation of oral and documentary evidence, the hearing shall be adjourned.

9.5.12 Deliberations: After adjourning and receiving any written concluding statements, the Hearing Committee shall meet to deliberate on all matters before it. The Hearing Officer and necessary Medical Staff Services representatives may be present. The Hearing Committee's recommendation shall be based on the evidence produced at the Hearing and made part of the Hearing Record. The Committee shall adopt findings of fact and make its recommendations. In reaching its conclusions and recommendations, the Hearing Committee must act in the reasonable belief that the recommendation is in furtherance of quality healthcare; after a reasonable effort to obtain the facts of the matter; and in the reasonable belief that the action is warranted by the facts known after reasonable effort to obtain such facts.

9.6 Hearing Committee Report and Further Action

9.6.1 Hearing Committee Report: Within ten (10) days after adjournment of the hearing, the Hearing Committee shall submit to the Administrator a written report of its findings and recommendations, which shall be advisory, and include a statement of the basis for the recommendations. The Administrator shall forward the Hearing Committee report to the Executive Committee/Board, depending on whose Adverse Action triggered the hearing.

9.6.2 Action on the Hearing Committee Report: At its next regularly scheduled meeting after receipt and consideration of the Hearing Committee report, the Executive Committee/Board shall affirm, modify or reverse its previous Adverse Action, except that if the reconsidered determination of the Board-approved Hearing Committee is favorable to the Respondent, the Board shall adopt the determination as its final action. The Executive Committee/Board may also refer the matter back to the Hearing Committee for further fact finding and clarification of issues that need resolution before final action is possible. The Hearing Committee chair (designee) shall be present to discuss the findings and recommendations of the Hearing Committee.

9.6.3 Notice and Effect of Result

9.6.3.1 Notice: As soon as practicable, but in no event longer than ten (10) days after the Executive Committee/Board makes its reconsidered determination based on the hearing, the Administrator shall send the Respondent by Special Notice a copy of the Hearing Committee's report and the reconsidered determination of the Executive Committee/Board, including a statement of its basis.

9.6.3.2 Effect of Favorable Result: When the reconsidered determination of the Executive

Committee is favorable to the respondent, the Administrator shall promptly forward it, together with all supporting documentation to the Board where appropriate. The Board shall adopt the Executive Committee determination, if it is supported by substantial evidence. A favorable reconsidered determination of the Board shall be its final action on the matter.

9.6.3.3 Effect of Adverse Result: If the reconsidered determination continues to be adverse, the Administrator shall promptly notify the Respondent by Special Notice of the adverse determination, the Respondent's appeal rights and any consequences of waiving those rights. The Administrator shall forward the Executive Committee's adverse reconsidered determination, with supporting documentation, to the Board, which shall not take action thereon until the Respondent has exercised or waived his/her right to appellate review.

9.7 Appellate Review: The Board shall provide appeal rights to Medical Staff members entitled to such rights under these Bylaws in accordance with Banner Health Appellate Review Policies. Upon Respondent’s request for an appellate review, a copy of the current policy will be provided to the Respondent.

10 OFFICERS

10.1 Officers of the Staff. The officers of the Staff shall be:
President
Vice President
Immediate Past-President
Secretary/Treasurer

10.2 Qualifications of Officers: Officers must be appointees to the Active Staff at the time of nomination and election and must remain Active Staff appointees in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. Within ten (10) working days of nomination, each nominee must submit a biography and position statement which will accompany the official ballot or be removed from the ballot. Not more than fifty percent (50%) of the Executive Committee shall be full-time Contract or hospital-employed Physicians.

10.3 Election of Officers: Officers shall be elected by the appointees to the Active Staff in accordance with the provisions of these Bylaws and written notice of the results shall be distributed to each Staff member after the ballots are counted. All elected officers will be introduced at the last annual Staff meeting of the year.

10.4 Term of Office: The President, Vice President, Immediate Past-President, and Secretary/Treasurer shall take office on the first of January. Terms of office for these officers of the staff shall be for two (2) years. These officers shall serve until the end of his/her term, or until a successor is elected or appointed.

10.5 Removal from Office:

10.5.1 The President, Vice President, Immediate Past-President and Secretary/Treasurer may be removed from office, prior to the expiration of their terms, as provided in these Bylaws.

10.5.2 Removal from office may be initiated only by the Executive Committee or by petition signed by at least 50 Active Staff members. Medical Staff Services will notify the Executive Committee. A ballot will be sent to the Active Staff and contain a one page statement by the Executive Committee or by the Staff member(s) seeking to remove the Officer of the reason for the motion and a one page statement by the individual(s) who is the subject of the motion for removal. The conditions for removal of an officer from office may include: incompetence; unethical or unprofessional behavior; conduct below the standards as stated in these Bylaws and the Rules and Regulations; conviction of a felony; persistent disruptive behavior as defined in Section **4.2.13**; or violation of these Bylaws or Rules and Regulations.

10.5.3 Upon the vote of two-thirds (2/3) of those members of the Active Staff who vote, the President, Vice President, Immediate Past-President, or Secretary/Treasurer may be removed; or

10.5.4 Upon the vote of 75% of the full voting membership of the Executive Committee at any regular meeting or special meeting called for that purpose for reasons of ethical, moral, professional or leadership breach, the President, Vice President, Immediate Past-President, or Secretary/Treasurer may be removed.

10.6 Vacancies in Office:

10.6.1 An office of the Staff shall be deemed "vacant" if the person elected to the official position (1) resigns or is removed from appointment to the Staff, (2) fails to maintain Active Staff status, (3) becomes disabled to the extent that he or she cannot fulfill the duties of his/her office, (4) resigns or is removed from office, or (5) dies.

10.6.2 A vacancy of office, except for the President shall be filled by the Executive Committee of the Staff, by appointment, unless the Executive Committee orders a special election to fill the vacancy. If there is a

vacancy in the office of the President, the vacancy shall be filled as outlined in the Duties of Officers section of these Bylaws.

10.6.2.1 If the office of President becomes vacant for any reason the Vice President shall serve as President for the remainder of that term.

10.7 Duties of Officers:

10.7.1 President: The President shall serve as the highest elected official of the Staff to:

10.7.1.1 act in coordination and cooperation with the Administration in all matters of mutual concern within the Hospital;

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

10.7.1.3 call, serve as a member of, preside at, and be responsible for the agenda of all Executive Committee meetings;

10.7.1.4 take all reasonable steps to enforce Staff Bylaws, Rules and Regulations and Policies and Procedures, to implement sanctions where indicated, and to comply with procedural safeguards once corrective action has been requested against a practitioner;

10.7.1.5 designate the appointees and designate the Chairman of all Staff committees consistent with these Bylaws;

10.7.1.6 represent the views, policies, needs and grievances of the Staff to the Administration and to the Board.

10.7.1.7 receive and interpret the policies and requests of the Board to the Staff and report to the Board on the performance and maintenance of quality with respect to the Staff's delegated responsibility to promote quality of patient care;

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

10.7.1.9 delegate administrative duties and supervise activities of the Medical Director of the Staff, if such a position is filled, as provided Section in **4.8**;

10.7.1.10 serve as ex-officio member without a vote of all other Staff committees.

10.7.2 Vice President:

10.7.2.1 In the absence of the President, the Vice President shall assume all the duties and have the authority of the President. In the absence of both the President and the Acting President, the Immediate Past President shall assume the duties and authority of the President.

10.7.2.2 The Vice President shall be a member of the Executive Committee.

10.7.2.3 The Vice President shall serve as a member of the Nominating Committee.

10.7.3 Immediate Past-President:

10.7.3.1 The immediate Past-President shall be a member of the Executive Committee. In the event the President and the Vice President are to be absent from the community on a temporary basis, the Immediate Past-President shall serve as President on an interim basis.

10.7.4 Secretary/Treasurer:

10.7.4.1 The Secretary/Treasurer shall be a member of the Executive Committee. The Secretary/Treasurer shall keep accurate and complete minutes of all Staff and Executive Committee meetings, call Staff meetings on order of the President, attend to all correspondence, and perform such other duties as ordinarily pertain to his/her office. He or she shall be the Secretary of the Bylaws Committee. He/she shall receive, hold and deposit all Staff dues and assessments in accordance with these Bylaws and shall make reports at least annually of these funds to the general Staff.

10.7.4.2 In the event the President, the Vice President and the Immediate Past President are absent from the community on a temporary basis, the Secretary/ Treasurer shall serve as President on an interim basis. If there is a vacancy in the office of President, the Vice President shall serve as President for the remainder of that term, and the Secretary/Treasurer shall assume the duties of the vacated Vice President position for the

remainder of that term, as well as the duties of the Secretary/Treasurer.

11 COMMITTEES OF THE GENERAL STAFF

11.1 General Provisions.

11.1.1 Standing Committees. In addition to the Executive Committee, the Staff shall have Standing Committees that are responsible to (and make recommendations through) the Executive Committee, unless otherwise provided in these Bylaws

11.1.1.1 Executive Committee
11.1.1.2 Bylaws Committee
11.1.1.3 Credentials Committee
11.1.1.4 Infection Control Committee
11.1.1.5 Medical Ethics Committee
11.1.1.6 Nominating Committee
11.1.1.7 Pharmacy and Therapeutics Committee
11.1.1.8 Practitioner Health Committee
11.1.1.9 Utilization Management Committee

11.1.2 Chairs and Members.

11.1.2.1 Appointment. The chairs and members of Standing committees, unless otherwise designated by these Bylaws, shall be appointed by the President of the Staff, subject to approval by the Executive Committee. Prior to appointment, nominees for chair will disclose to the Executive Committee potential conflicts with Medical Staff responsibilities as described in 6.8.

11.1.2.2 Removal. Committee chairs may be removed for any reason by the President with concurrence of the Executive Committee. Committee members may be removed for any reason with the concurrence of the President and the pertinent chair.

11.1.3 Ad Hoc Committees. Ad Hoc (special) committees may be created for specific purposes by the President of the Staff, and terminated upon the accomplishment of their purposes. They shall report to the Executive Committee.

11.1.4 General Duties of Standing Committees. Each standing committee shall:

11.1.4.1 elect a Vice Chair at the first meeting of the year.

11.1.4.2 meet at least quarterly, unless otherwise provided in these Bylaws, at a time and place determined by the Chair.

11.1.4.3 forward all meeting minutes to the Executive Committee.

11.1.4.4 establish and maintain rules and regulations.

11.1.4.5 act as a budget advisory committee to Administration for relevant Hospital departments.

11.2 Executive Committee

11.2.1 Composition

11.2.1.1 Members: The Executive Committee shall be composed of the President of the Staff, who shall act as Chairman, the Immediate Past-President, the Vice President, the Secretary/Treasurer, the Department chairs, the Credentials Committee chair, the Bylaws Committee chair (if not the Immediate Past-President), Hospitalist Representative, and a member at large, appointed by the President, who shall be a member of the Referring Staff. The President, with approval of the Executive Committee, may appoint additional individuals as non-voting members including, if desired, a Staff Representative to the American Medical Association Organized Medical Staff Section (AMA-OMSS). No more than fifty percent (50%) of the Executive Committee may be full-time Contract or hospital-employed Physicians. Two-thirds of the voting members of the MEC may remove the member-at-large for reasons of conflict of interest or any of the reasons listed at 10.5.2

11.2.1.2 Ex-Officio Members. The chair of the Medical Staff P&T Committee, as well as any other members appointed by the Staff President with the approval of the MEC shall be ex-officio members without

vote and shall attend all meetings unless excused by the President of the Staff. The MEC chair may invite other interested Medical Staff members to attend. The Chief Medical Officer, the CEO and other members of the Hospital Administration as appointed by the CEO shall be ex-officio members without vote.

11.2.2 Duties of the Executive Committee: The duties of the Executive Committee, as delegated to it by the Medical Staff, shall be to meet at least monthly:

11.2.2.1 to be accountable to the organized Medical Staff;

11.2.2.2 to seek out the Medical Staff's view on all appropriate issues, including by periodically making itself directly available to discuss concerns of individual or groups of Medical Staff members;

11.2.2.3 to convey accurately to the governing body the view of the Medical Staff on all issues, including those relating to quality and safety;

11.2.2.4 to take such actions that may be necessary to ensure compliance with the Bylaws, the General Rules and Regulations and other duly adopted Medical Staff Rules and Policies;

11.2.2.5 to make medical staff recommendations directly to the Board for its approval;

11.2.2.6 to represent and to act on behalf of the Staff in the intervals between Medical Staff meetings, in accordance with the duties and powers granted by the Staff and these Bylaws;

11.2.2.7 to recommend adoption, amendment, or repeal of these Bylaws and of the Rules and Regulations pertaining to the general structure and functions of the Staff as provided in Articles 15 and 16 of these Bylaws;

11.2.2.8 to coordinate the activities and general policies of the various departments of the Staff;

11.2.2.9 to receive and act upon all committee reports;

11.2.2.10 to make and implement policies of the Staff not otherwise the responsibility of the departments;

11.2.2.11 to provide liaison between the Staff, the CEO and the Board;

11.2.2.12 to recommend action to the CEO on matters of medical-administrative nature;

11.2.2.13 to make recommendations on hospital management matters to the Board through the CEO;

11.2.2.14 to take all reasonable action to fulfill the Staff's accountability to the Board for the care rendered to patients in the Hospital;

11.2.2.15 to review the minimum professional liability insurance requirements for Staff appointment annually, as provided in these Bylaws;

11.2.2.16 to take such actions that may be necessary to ensure that the Medical Staff's Bylaws, Rules and any proposed amendments reflect applicable legal, certifying and accreditation requirements relating to the medical staff organization and its members, and that the Staff and Board are informed of such requirements and their compliance.

11.2.2.17 to review the credentials of all applicants and to make reports/recommendations for Staff appointment, categories, assignments to departments, and delineation of privileges;

11.2.2.18 to review, using the procedures set forth in these Bylaws, all information available regarding the performance and clinical competence of Staff members, and other practitioners with clinical privileges, and, as a result of such reviews, to make recommendations for reappointments and renewal or changes in clinical privileges;

11.2.2.19 to take all reasonable steps to promote professionally ethical conduct and competent clinical performance on the part of all members of the Staff, including the initiation of and/or participation in Staff corrective action or review measures when warranted; and participate as required by these Bylaws in peer review proceedings;

11.2.2.20 to be responsible for the expenditure of all Staff funds as provided in these Bylaws;

11.2.2.21 to review all actions of the President of the Staff including committee appointments; and

11.2.2.22 to review and make recommendation to the Administrator/Board about the quality of care issues raised by any proposed decision to reduce or terminate privileges and/or Medical Staff appointment by transferring an existing exclusive contractual arrangement. On the basis of available, relevant information following notice and opportunity to comment, the Executive Committee shall find the transfer of an existing exclusive

contractual arrangement to be appropriate only when:

11.2.2.22.1 provision of a needed service cannot be remedied by less extreme measures; or

11.2.2.22.2 differences within an existing department, section or clinical service adversely affecting quality of care have not been resolved by less extreme measures; and

11.2.2.22.3 continued closure of the department, section or clinical service produces demonstrable efficiencies that maintain or improve the ability of the Medical Staff to dispense quality care which cannot be accomplished by "reopening" the department, section or clinical service; and

11.2.2.22.4 quality of care is maintained or improved by the transfer.

11.2.2.23 to make recommendations to CEO and Board, pursuant to policies and procedures developed jointly by the Administrator and the Executive Committee, about the quality of care issues within the Hospital that are raised by agreements involving the Hospital and requiring participation of Staff appointees;

11.2.2.24 to periodically review and approve Medical Staff Services Department policies and procedures affecting the Medical Staff and to take steps to ensure processes are in place to preserve the confidentiality of privileged and confidential information; and

11.2.2.25 to perform such other duties as are provided in these Bylaws.

11.3 Bylaws Committee

11.3.1 Composition: The Bylaws Committee shall be composed of the Immediate Past-President, who shall be the Chairman, the Secretary/Treasurer and at least three (3) other members of the Staff appointed by the President of the Staff. A representative of Administration shall serve as an ex-officio member.

11.3.2 Duties: The Bylaws Committee shall be responsible for a biannual review of the Bylaws, Rules and Regulations and Privilege Checklists, and for consideration of revisions and amendments and for acting upon proposed amendments that may originate from the President of the Staff, the departments, the Executive Committee, or the Active Staff by petition as described in Section 16.1.2.

11.4 Credentials Committee.

11.4.1 Composition: The Credentials Committee shall consist of five (5) to nine (9) appointees of the Staff appointed by the Credentials Committee Chairman upon approval of the President and the Executive Committee, and selected on a basis that will ensure representation of the major clinical specialties and the Staff at large. A representative of Administration shall serve as an ex-officio member.

11.4.2 Duties: The duties of the Credentials Committee shall be to thoroughly and objectively review and make recommendations to the Executive Committee on the credentials of:

11.4.2.1 all applicants for appointment and reappointment to the Medical Staff for membership, privileges and Staff category, consistent with these Bylaws (and to conduct any professional review on any matter referred to it by the Staff President); and

11.4.2.2 all APP/AHP applicants to practice in the Hospital under an approved scope of practice, consistent with the APP/AHP Rules and Regulations, which shall require APP/AHPs to pay dues as determined by the Executive Committee. The Credentials Committee shall maintain and, from time to time, update the APP/AHP Rules.

11.4.3 Meetings: Meetings shall be held at least ten (10) times annually at a date, time and place which shall be determined by the Chairman of the Committee upon notice to all members.

11.5 Infection Control Committee

11.5.1 Composition: The Medical Staff members of the Committee shall be selected by the Infection Control Committee Chairman, upon approval of the President of the Staff and the Executive Committee, and shall consist of members of the Medical Staff such that clinical specialties are adequately represented. Ex-officio members shall include at least one administrative representative, a representative from nursing services and the person or persons employed in the management of the infection control program and/or surveillance. Additional hospital-wide members shall be selected by the Chairman based on need for their reports and/or input on a regular basis. When discussions involve housekeeping, central services, laundry, engineering and maintenance, nutrition and food services, pharmacy or surgery, representatives from the relevant areas may attend the meeting (if not

already a member) or be consulted.

11.5.2 Duties: This Committee shall be responsible to the Executive Committee and shall:

11.5.2.1 approve all surveillance activities;

11.5.2.2 take action at Committee meetings as indicated to prevent and control infections among patients and staff (based on evaluation of surveillance reports of infections and infection potential);

11.5.2.3 review, update and/or approve the applicability and appropriateness of all departmental and contract services infection control policies and procedures at least every two years;

11.5.2.4 delegate responsibility to an individual, task force or department to carry out any actions on any recommendations made;

11.5.2.5 annually evaluate effectiveness of the Infection Control Program;

11.5.2.6 approve an annual infection control plan;

11.5.2.7 assist the infection control director in carrying out his/her functions as identified in the OSHA Bloodborne Pathogen Regulation (29-CFR 1910-1030) Exposure Control Plan and the Tuberculosis Prevention and Control Plan;

11.5.2.8 review update and approve the Exposure Control Plan on an annual basis;

11.5.2.9 monitor biological testing results of all sterilizers at all facilities;

11.5.2.10 with the approval of the CEO and the Medical Staff, have the authority to institute surveillance, prevention or control measures or studies when there is reason to believe that any patients or personnel are in danger. If such action should have an impact on a specific patient, every effort to notify the attending physician would be made; and

11.5.2.11 implement and maintain up-to-date recommendations from regulatory agencies and professional organizations, i.e., Center of Disease Control (CDC) and Occupational Safety and Health Administration (OSHA), and the Association for Practitioners in Infection Control (APIC) to reduce patient and employee risk of acquiring infections.

11.6 Medical Ethics Committee

11.6.1 Composition: The Medical Ethics Committee Chairman shall be appointed by the President of the Staff. A Nursing Co-Chairman shall be elected by and from the Committee membership at the first meeting of the term. The Committee shall be composed of physicians, the Risk Managers, a representative of pastoral care, maternal child health, Social Services, hospital Administration, Critical Care Nursing and ancillary services (i.e., Cardiopulmonary Services, Physical Therapy, Occupational Therapy) as well as interested representative members of the community.

11.6.2 Duties: The Medical Ethics Committee shall

11.6.2.1 be available as an ethical resource to physicians, the hospital staff, patients and patients' families.

11.6.2.2 provide education to the hospital staff regarding the field of medical ethics.

11.6.2.3 support the integration of ethical considerations and responsibilities in patient care decisions.

11.6.3 Meetings: Meetings will be held at least semi-annually and on an as needed basis at a date, time and place determined by the chairman.

11.7 Nominating Committee

11.7.1 Composition: The Nominating Committee shall consist of the President of the Staff who shall be the Chairman of the committee, the Vice President of the Staff and the Chairman of each clinical department.

11.7.2 Duties: The Nominating Committee shall propose a slate of candidates as described in Article **13.**

11.7.3 Meetings: The Nominating Committee shall meet at least bi-annually in July, upon notice to all members.

11.8 Pharmacy and Therapeutics Committee

11.8.1 Composition: The Medical Staff members of the Committee shall be selected by the Pharmacy and Therapeutics Committee chairman with the approval of the President and the Executive Committee. Physician membership shall consist of at least five (5) appointees from various clinical departments. Ex-officio members shall

include the Directors of Pharmacy who shall act as secretaries for the Committee, an administrative representative and a representative of Nursing Services. Additional hospital-wide members shall be selected by the chairman based on need for their reports and/or input on a regular basis. When discussions involve other ancillary/clinical departments, representatives from the relevant areas shall be invited to attend the meeting or shall be consulted.

11.8.2 Duties: This Committee shall report to the Executive Committee and shall:

11.8.2.1 be responsible for the development and review of all drug utilization policies and procedures within the Hospital in order to optimize clinical results and minimize potential for hazard;

11.8.2.2 assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use and protection of drugs in the Hospital;

11.8.2.3 serve as an advisory committee to the Medical Staff and hospital administration in all matters pertaining to the use of drugs;

11.8.2.4 serve in an advisory capacity to the Medical Staff and Pharmacy Departments in the selection or choice of drugs which meet the most effective therapeutic quality standards;

11.8.2.5 develop a basic drug list or formulary of accepted drugs for use in the Hospital and to provide for its periodic review;

11.8.2.6 prevent unnecessary duplication of the same basic drug or its combinations in the drug list or formulary;

11.8.2.7 evaluate objectively clinical data regarding new drugs or agents proposed for use in the Hospital;

11.8.2.8 in conjunction with any other appropriate committees, establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

11.8.2.9 define and review all significant adverse drug reactions and make appropriate recommendations;

11.8.2.10 periodically review the use of antibiotics as they relate to patient care within the Hospital;

11.8.2.11 forward the recommendations of the Pharmacy and Therapeutics Committee to the appropriate Medical Staff department for action.

11.9 Practitioner Health Committee ("PHC")

11.9.1 Composition: The PHC shall have four (4) members, including a Psychologist or a Medical Staff member with experience in addiction medicine, and two (2) others selected by the Staff President. The Practitioner's Department Chair may be brought in, in an advisory capacity.

11.9.2 Duties. The PHC reports to the President and shall:

11.9.2.1 implement the Practitioner Health Program described in Bylaws Section **8.8** pursuant to duly adopted policies;

11.9.2.2 develop individualized intervention and monitoring programs for practitioners with physical, mental, psychological, behavioral or emotional impairment and who wish or require assistance maintaining a hospital practice that protects patient welfare;

11.9.2.3 implement the Medical Staff's policy against sexual harassment;

11.9.2.4 maintain the utmost confidentiality allowed by law.

11.10 Utilization Management Committee

11.10.1 Composition: The Utilization Management ("UM") Committee shall consist of between three (3) and five (5) Medical Staff members from various clinical departments. Ex-officio members include the Chief Medical Officer, Chief Financial Officer, Director of Case Management and representatives from Quality Management, HIMS, and Nursing.

11.10.2 Duties: The UM Committee shall

11.10.2.1 determine medical necessity of (1) admissions, (2) continued stays, (3) discharges and (4) use of medical and hospital services by using processes and criteria approved by the MEC on recommendation of the UM Committee.

11.10.2.2 annually review and make recommendations to the MEC for approval of the Hospital's written UM Plan, which shall describe: (1) processes and criteria for determining medical necessity of (a)

admissions, (b) continued stays, (c) discharges and (d) use of medical and hospital services. Criteria adopted for medical necessity determinations should be nationally recognized and evidence-based to withstand payors' medical-necessity decision denials. As required by federal law, reviews and determinations may not be conducted by any individual who (a) has a direct financial interest in, or position with, the hospital (except for the purpose of the reviews); or (b) was professionally involved in the care of the patient whose case is under review; and (2) processes and criteria for identifying factors which may contribute to the effective utilization of the hospital and physician services.

11.10.2.3 refer all information and issues that may be used to evaluate or improve individual practitioners' professional performance to the relevant peer review committee for review;

11.10.2.4 collaborate with the Director of Case Management to implement the Hospital's UM Program;

11.10.2.5 report and make recommendations to the Departments and sections and the MEC for the optimum utilization of hospital resources, commensurate with quality patient care and safety and to ensure regulatory compliance.

11.11 Joint Conference Committee:

11.11.1 Composition: The Joint Conference Committee shall be composed of six members. The President of the Medical Staff shall be one member. The President of the Medical Staff shall select two other Medical Staff members to serve on the Committee. The Board shall select three members to serve on the Committee.

11.11.2 Duties: When there is a disagreement between the Medical Staff and the Board of Directors that cannot otherwise be resolved, a Joint Conference Committee can be called at any time by either the Medical Staff or the Board of Directors for the purpose of addressing the issue.

11.11.3 Attendance of Legal Counsel: Legal Counsel may attend the meeting of the Joint Conference Committee. The President of the Medical Staff shall determine if the Medical Staff wishes to be represented by counsel.

11.12 Multidisciplinary Peer Review Committee:

11.12.1 Composition: The Multidisciplinary Peer Review Committee shall be composed of at least 10 members, including representation from Anesthesia, Cardiovascular, Emergency Medicine, Medical Imaging, Medicine, including one hospitalist and one intensivist, Pathology, Surgery and Orthopedics. Members will be nominated by the appropriate department/committee chair and approved by the Executive Committee. Members will serve two year terms, coinciding with the term of the chair. Members may serve consecutive terms. The Chief Medical Officer shall serve as an ex-officio member. The Vice President will serve as chair.

11.12.2 Duties: The Multidisciplinary Peer Review Committee shall review cases referred from the department/committee chair or from the department peer review committee. Cases referred will either involve multiple departments/committees or be complex. The Multidisciplinary Peer Review Committee will send its findings and recommendations back to the department/committee. The chair may refuse a case and send it back to the department/committee. The Multidisciplinary Peer Review Committee will send a summary report of its findings and recommendations to the Executive Committee on a routine basis.

12 MEETINGS

12.1 Annual Staff Meeting

12.1.1 The Annual Meeting of the Active Staff shall be held in December at such date, time and place as the Executive Committee may determine, at which time the Department Chairmen make annual reports as indicated.

12.1.2 Results of the election of Staff officers shall be announced as provided in these Bylaws.

12.2 Regular Staff Meetings

12.2.1 Schedule: Regular Staff meetings shall be held at least annually at a date, time and place specified by the Executive Committee. Written notice of Regular Staff meetings shall be mailed, e-mailed, faxed, or delivered to each Active Staff appointee at least ten (10) days in advance of the meeting date.

12.2.2 Agenda: The agenda of a Regular Staff meetings shall be:

12.2.2.1 Administrative

12.2.2.1.1 Call to Order;

12.2.2.1.2 corrections to and acceptance of the minutes of the last regular or annual meeting and of all special Staff meetings;

12.2.2.1.3 corrections to and acceptance of the minutes of all Executive Committee meetings held since the previous Staff meeting;

12.2.2.1.4 Secretary/Treasurer's Report;

12.2.2.1.5 Unfinished Business;

12.2.2.1.6 Communications;

12.2.2.1.7 Reports from the CEO

12.2.2.1.8 PHO Report

12.2.2.1.9 Reports of departmental committees;

12.2.2.1.10 Reports of sections/services/committees;

12.2.2.1.11 Introduction of new Staff members; and

12.2.2.1.12 New Business

12.2.2.2 Professional

12.2.2.2.1 Educational or scientific programs;

12.2.2.2.2 Adjournment.

12.2.2.3 Exceptions

12.2.2.3.1 The President may vary the order in which the above agenda is presented.

12.3 Special Staff Meetings: Special meetings of the Staff may be called at any time by the President, the Chairman of the Board, the Executive Committee, or by ten percent (10%) of the Active Staff appointees, provided written notice and an agenda describing the purpose of the meeting is mailed or delivered to each Active Staff appointee at least seven (7) days in advance of the special meeting date. Business transacted at any special meeting shall be limited to the issue(s) stated in the notice of the meeting. Special meetings of the Staff shall be held within thirty (30) days of the request for the meeting.

12.4 Quorum; Action of the Staff:

12.4.1 The attendance of at least twenty five percent (25%) of the appointees of the Active Staff shall constitute a quorum for the purpose of transacting such business of the Staff as is permitted by these Bylaws.

12.4.2 The action of a majority of the Active Staff members present at a meeting at which a quorum is present shall be the action of the Staff, except that a two-thirds (2/3) vote shall be required to override any action of the Executive Committee, not otherwise required by Federal or State law or accreditation requirements.

12.5 Section and Committee Meetings

12.5.1 Each section and committee shall hold regular meetings as required by these Bylaws after giving at

least seven (7) days advance notice in writing. The Chairman may call special meetings after giving notice and an agenda describing the purpose of the meeting at least twenty-four (24) hours in advance of the meeting to the members. He or she shall have the right to postpone or defer any regular or special meeting for no longer than thirty (30) days.

12.5.2 Written minutes shall be kept for all regular and special committee meetings. Minutes shall be maintained by the Medical Staff Services Department within five (5) days after each meeting and a copy of the minutes shall be submitted to the Executive Committee.

12.5.3 The attendance of at least thirty-three percent (33%) of the voting members shall constitute a quorum for the purpose of transacting business.

12.5.4 Attendance. Regular attendance at all committees is encouraged. When a committee member fails to attend three consecutive meetings, he/se may be contacted by the Chair as to interest and commitment in serving on the committee; the Chair may replace the member.

12.6 Clinical Department/Committee Meetings

12.6.1 Each department committee shall hold at least four (4) meetings annually. Attendance records shall be maintained.

12.6.2 The department Chairmen may call special meetings after giving notice and an agenda describing the purpose of the meeting at least twenty-four (24) hours in advance to all members. Department chairmen shall have the right to postpone or defer any regular or special meetings for no longer than thirty (30) days.

12.6.3 Written minutes shall be kept for all regular and special meetings. The original minutes shall be filed in the Medical Staff Services Department, and a copy of the minutes shall be submitted to the Executive Committee.

12.6.4 Attendance.

(a) Quorum, Transacting Business. The attendance of at least thirty-three percent (33%) of the Active Staff committee members of the department shall constitute a quorum for the purpose of transacting any and all business of the department. Voting members shall be appointees to the Active Staff. The attendance of at least thirty-three percent (33%) of the physician appointees of the Staff shall constitute a quorum for the purpose of transacting business of the department committee. All members of the department/committee shall be voting members.

(b) Voluntary Attendance. Department and department committee members are encouraged to attend as specified in Section **12.5.4**.

(c) Mandatory Attendance: Chart Review. A practitioner who has received a two weeks' notice of mandatory attendance because his/her patient's clinical course is scheduled for committee performance review in accordance with these Bylaws must attend. Failure to appear at any such meeting without good cause will result in automatic suspension under Bylaws Section 8.6.8.

(d) Mandatory Attendance: Performance/Conduct Review. Whenever deviation from standard practice is identified or suspected with respect to a practitioner's performance or conduct, the President of the Medical Staff, or the applicable Department Chair, may require the practitioner to confer with him/her or with the committee considering the matter. The practitioner will be notified of the date, time, and place of the conference, and the reasons therefore. Failure to appear at any such meeting without good cause will result in automatic suspension under Bylaws Section 8.6.8.

12.7 Conduct of Meetings

12.7.1 Robert's Rules: All meetings of the Staff and meetings of all departments and committees shall be conducted according to Robert's Rules of Order, Revised, unless specifically modified by these Bylaws. The Vice

President of the Staff shall act as Parliamentarian at all Staff meetings. The Vice Chairman of the departments or committees shall act as Parliamentarian at all departmental, section, service or committee meetings. In his/her absence, the Chairman of the department or committee shall appoint another department or committee member to act as Parliamentarian.

12.7.2 Privilege and Confidentiality: All agenda items should be designated as either General, Quality Improvement or Executive Session matters.

12.7.3 General Sessions: General Sessions are for the discussion of administrative matters pertaining to the department, Medical Staff or Hospital and to patient care matters that are general in nature.

12.7.4 Required Executive Sessions: Executive Sessions must be convened for the discussion of particular persons' professional practices in order to promote candor in the monitoring and evaluation of the quality of patient care in the interest of reducing morbidity and mortality, and improving patient care. To preserve statutory protection, everyone in attendance in Executive Sessions is obligated to preserve the confidentiality of its proceedings, records and materials. No one may voluntarily disclose privileged information except for the purposes for which the information was provided and as may be required by law.

12.7.5 Breach of Confidentiality: If an individual is found to have breached confidentiality with respect to the peer review process, he or she shall be removed as a peer reviewer with respect to the matter as to which he/she breached confidentiality and be reported to Executive Committee.

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

12.7.7 Attendance in Executive Sessions: Attendance during Executive Sessions concerning professional practices should be limited by the chairmen to the committee's members and those medical, administrative or nursing staff to the extent necessary to assist in the professional practices review. Persons who were present or involved in the situation under review and the Medical Staff member/applicant under review shall be invited to provide information separately; they should enter the meeting room only after other persons providing information have left, and they should leave once they have provided the information and answered any questions. No one who has been directly or personally involved in the situation under review shall hear the deliberations. Committee chairmen may excuse Hospital personnel only when Bylaws provisions and Hospital administration is under discussion.

12.7.8 Minutes: General and Executive Session minutes should be made and kept strictly and distinctly separate. In addition, if topics other than the review of a physician's conduct or practice is dealt with in executive session, executive session minutes must also be maintained separately of the review of the physician's conduct or practice.

13 ELECTIONS OF STAFF OFFICERS AND REPRESENTATIVES

13.1 Ballot The names of all candidates nominated for Staff officers by the Nominating Committee shall be placed on a ballot. These shall include the President, Vice President, and Secretary/Treasurer. The election shall be conducted as provided in these Bylaws.

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

13.3 Nominating Committee Actions The Nominating Committee, as provided in these Bylaws, shall submit a slate of nominees for Staff Officers at the August meeting of the Executive Committee. The name of one (1) or more qualified appointees shall be submitted for each elected office.

13.3.1 The Executive Committee shall approve or modify the slate of nominees and present the ballot to the Active Staff which may be via a mail or electronic ballot vote.

13.3.2 Additional nominations may be submitted by members of the Active Staff to the Medical Staff Office within ten (10) days before mailing of the official ballot.

13.3.3 Prior to the election, nominees will disclose to the Executive Committee potential conflicts with Medical Staff leadership responsibilities as described in **6.8**.

13.4 Single Ballot; Eligibility to Vote There shall be no ballot other than the official ballot provided by the Secretary/Treasurer. Ballots for the election of officers shall be distributed to all members of the Active Staff as hereinafter provided. Only the Active Staff members shall be eligible to vote.

13.5 Electronic Balloting The Secretary/Treasurer or designee shall electronically mail one (1) official ballot with instructions to each qualified voter within two (2) weeks after the MEC meets. The instructions shall state the deadline by which the ballot must be returned electronically to the Medical Staff Services Department in order to be valid. The voter's name will be verified as a qualified voter by the Secretary/Treasurer of the Staff or designee. The ballot results will be tallied by the Medical Staff Services Department the same day. For elections, at least one (1) member of the Executive Committee shall be present at the tallying/counting of the ballots.

13.6 Majority required If more than two (2) nominees appear on the ballot, and no nominee receives a majority of the votes cast on the first ballot, all of the nominees except the two highest shall be dropped, and a second ballot shall be mailed to all qualified voters within seven (7) days thereafter to determine by majority vote the winning candidate for said office.

13.7 Tie If the only two (2) nominees for an office receive an equal number of votes, election shall be determined by a flip of a coin, and the person to whose favor it shall result shall be declared duly elected. The flip of the coin shall be done by the President of the Staff and witnessed by the Secretary/Treasurer of the Staff and by the two nominees or their designated representatives.

13.8 Terms of Office Except as otherwise provided in these Bylaws for the filling of vacancies, the initial terms or office shall begin on January 1st and end on December 31st.

14 DEPARTMENTALIZATION OF THE STAFF

14.1 Departments and Sections: The Medical Staff is organized in Departments, and may also have sections and services, as determined by the MEC. The Medical Staff currently consists of the following clinical Departments:

14.1.1 Departments

14.1.1.1 Anesthesiology
14.1.1.2 Cardiovascular
14.1.1.3 Medical Imaging
14.1.1.4 Emergency Medicine
14.1.1.5 Medicine
14.1.1.6 Pathology
14.1.1.7 Orthopedic Surgery
14.1.1.8 Surgery

14.2 Organization of Departments

14.2.1 Each department shall be organized as a unit of the Staff. Department officers shall be the department chairman and vice-chairman, as prescribed in these Bylaws.

14.3 Officers

14.3.1 Responsibilities of Department Chairmen: The Chairman of the department shall be responsible for:

14.3.1.1 recommending to the medical staff the criteria, consistent with the Bylaws, for clinical privileges in the department;

14.3.1.2 recommending clinical privileges for each department member;

14.3.1.3 monitoring initially granted privileges in accordance with 5.2.1.2.

14.3.1.4 ensuring the department determines, with Medical Staff approval, the types of data to be collected by QM for the department's process of evaluating professional practices all individuals with clinical privileges in the department;

14.3.1.5 ensuring the department committee evaluates and improves the quality of care and services provided in the department (a) by reviewing on a regular and ongoing basis pursuant to the bylaws the collected data relating to each individual's practice and using the collected data deemed valid by the department to determine whether to continue or modify existing privileges; and (b) by uniformly investigating and addressing clinical practice concerns (consistent with these bylaws) collected through the medical staff's clearly structured internal reporting process;

14.3.1.6 recommending the necessary qualifications, scope of practice and competence for physician supervised Advanced Practice Providers/Allied Health Professionals;

14.3.1.7 the maintenance of quality control programs as appropriate;

14.3.1.8 the orientation and continuing education of all physicians and Advanced Practice Providers/Allied Health Professionals in the department or services;

14.3.1.9 the integration of the department or service into the primary function of the organization;

14.3.1.10 the coordination and integration of intradepartmental and interdepartmental services;

14.3.1.11 establishing together with medical staff and administration, the type and scope of services required to meet the needs of the patients and the hospital;

14.3.1.12 the recommendations for a sufficient number of qualified and competent persons to provide care or service;

14.3.1.13 assessing and recommending to the relevant hospital authority off- site sources for needed patient care services not provided by the department or the organization;

14.3.1.14 recommendations for space and other resources needed by the department or service;

14.3.1.15 appointing a departmental committee as provided for in these Bylaws;

14.3.1.16 developing and implementing policies and procedures that guide and support the provision of services in the department;

14.3.1.17 annually reviewing with the committee and recommending, as necessary, amendments to the rules and regulations governing the day to day responsibilities and operations of the department;

14.3.1.18 implementation within the department of actions taken by the Executive Committee of the Staff;

14.3.1.19 The Vice Chairman shall assist the department Chairman and shall perform the duties of the Chairman in his/her absence.

14.3.2 Qualifications of Department Officers: Departmental Chairmen and Vice Chairmen shall be Active Staff appointees, qualified by training, experience and demonstrated ability for the position either through certification by their appropriate specialty or possession of comparable competence and shall indicate a willingness to serve.

14.3.3 Elections of Department Chairmen: Departmental Chairmen shall take office on the first day of January. Terms of office for these officers of the staff shall be for two (2) years. These officers shall serve until the end of their term, or until a successor is elected or appointed. As necessary, at the July department meeting the department shall select the names of one (1) or more qualified appointees as nominees for the office of Chairman of the department. The names of the candidates shall be forwarded to the Executive Committee at its August meeting. The Executive Committee shall approve or modify the slate of nominees and present the ballot to the Staff. Additional nominations for department Chairmen may be made by Active Staff appointees to that department, and must be submitted to the Medical Staff Office within ten (10) days of mailing the official ballot. The election of department Chairmen shall be completed by mail or electronic ballot, submitted to Active members of the department as provided by sections **13.4**, **13.5**, **13.6**, and **13.7** of these Bylaws. Department Vice Chairmen shall be elected by the departments at their January meeting.

14.3.4 Term; Filling Vacancies The terms of office for departmental officers shall be two (2) years.

14.3.4.1 If the office of Chairman becomes vacant for any reason, other than as provided by these Bylaws, the Vice Chairman shall succeed to the Chairmanship for the unexpired term.

14.3.4.2 If the office of Vice Chairman becomes vacant for any reason, other than as provided by these Bylaws, the Chairman shall appoint a Temporary Department Vice Chairman for the duration of the unexpired term.

14.3.5 Removal of Department Officer

14.3.5.1 Any department officer may be removed prior to the expiration of his/her term by petition signed by 20%, or if there are less than 10 department members, at least two, of the Active Staff members of the department. Medical Staff Services will notify the Department Committee. A ballot will be sent to the Active Staff of the department and contain a one page statement by the Department Committee of the reason for the motion and a one page statement by the individual(s) who is the subject of the motion for removal. Upon the vote of two-thirds (2/3) of all Active Staff appointees to the department who vote, the Department Officer may be removed.

14.3.5.2 Vacancies created by the removal shall be filled by election in the following manner: the President of the Staff shall appoint a Nominating Committee of three (3) appointees to the Active Staff of the department; the Nominating Committee shall submit a slate of nominees from the Active Staff appointees to the department within fifteen (15) days of the removal of any department officer. Within thirty (30) days thereafter, the election shall be conducted by the Nominating Committee through the use of secret ballots to be cast in the manner provided in these Bylaws. The term of office for the department officer so elected shall commence immediately upon the conclusion of the election process and shall terminate the following December 31st.

14.4 Sections

14.4.1 A section shall be a unit of a department that is answerable to that department. It shall be organized upon recommendation of the department and approval of the Executive Committee when special care, number of patients, and autonomous character of its work and/or the number of Active Staff appointees make it advisable to organize for periodic review of the professional activity of its appointees.

14.4.2 Sections shall be created by the following procedure:

14.4.2.1 Five or more appointees to a department with similar clinical interests shall petition, in writing, the department committee.

14.4.2.2 They shall submit a written proposal of organization, structure, rules and regulations for the governing of the section consistent with the overall department, Staff and Hospital policies.

14.4.2.3 They shall indicate their willingness to serve as a committee for the section until the next election.

14.4.2.4 If approved by the department committee, the Petition and Proposed Organizational Structure, and Rules and Regulations shall be submitted to the Executive Committee for approval. Upon approval by Executive Committee, these documents are forwarded to the Board for final approval.

14.4.2.5 Upon approval of the Executive Committee and the Board, the section may start functioning as provided in this section. The section shall perform the functions contained in these Bylaws.

14.4.2.6 The Chairman of the section shall be appointed by the President of Staff. The Vice Chairman shall be elected by the section members at their January meeting. The Chairman of the section shall make recommendations regarding clinical privileges and changes in Staff category of members of his/her section to the department chairman.

14.4.2.7 Sections shall meet a least quarterly.

14.4.2.8 The Chairman, or his designee, shall keep minutes of all section meetings. Copies of these minutes shall be submitted to the appropriate Clinical Committee, the Administration, the appropriate Department, and the Executive Committee.

14.5 Rules and Regulations

14.5.1 Each department and appropriate sections, services and committees shall adopt its own rules and regulations for the purpose of meeting the needs of its particular area of practice. The rules and regulations so adopted shall not conflict with these Bylaws or the Staff policies and procedures. The rules and regulations of a section shall be approved by the responsible department. Departmentally approved rules and regulations of a department and any section shall be subject to approval by the Executive Committee, the General Staff, which may include a mail or electronic ballot vote, and the Board.

14.5.2 In its rules and regulations, each department and section shall categorize the privileges and shall specify the education, training and performance standards necessary for practitioners to obtain specific categories and privileges. All privileging criteria shall be developed in accordance with these Bylaws and shall require approval by the MEC, the staff and the Board. The Rules shall also describe the department's process for collecting professional practice information, data and concerns as well as the department's responsibility to establish its quality indicators. Decisions limiting the exercise of privileges for members of a department or section as a whole may be appealed by the Department or Section as a whole to the MEC or Board.

14.6 Department Committees

14.6.1 Composition: Department/committees shall be appointed by the department chairmen, subject to the approval of the President of the Staff. The department committees shall consist of at least four (4) members of the Active Staff.

14.6.1.1 The Emergency Department/Committee shall be multi-disciplinary including at least one Emergency Medicine Department physician.

14.6.1.2 The Surgery Department/Committee membership shall include a pathologist to assist the committee in tissue review.

14.6.2 Functions of Department Committees: Each department/committee shall:

14.6.2.1 establish its own criteria, consistent with these Bylaws for the granting of clinical privileges subject to final approval by the Board. In developing privileging criteria, the department committee shall make findings whether they were developed after a reasonable effort to obtain relevant facts and in the reasonable belief that they are warranted by the facts and further quality health care and the purposes stated in the Preamble and Article II of these Bylaws.

14.6.2.2 participate in the implementation of the Hospital's Quality Improvement Programs. In fulfilling the department's quality improvement obligations, the committee shall, on a regular and periodic basis: (1) review, update and approve quality indicators (screens) to be applied by the Hospital's Quality management

Department to identify variations in care; (2) review available data concerning quality issues of a departmental nature. Such reviews shall be ongoing and conducted no less than quarterly, and shall include a consideration of selected deaths, unimproved patients, patients with infections, complications, possible errors in diagnosis and treatment, and such other instances as are believed to be important, such as patients currently in the Hospital with unsolved clinical problems; and (3) assess and report on the committee's performance of its peer review responsibilities; looking, for example, at the time lapsed between first notice of a peer review issue and final action of the committee to address the matter identified; and at the effectiveness of its actions to address the patient care issue.

14.6.2.3 evaluate the professional practice of all individuals with privileges granted by the department by defining the process for making decisions to maintain or modify existing privileges prior to or at the time of renewal; determining the type of data to be collected; using the collected information to evaluate individuals' professional practice; and uniformly investigating and addressing clinical practice concerns (consistent with these bylaws) collected through the medical staff's internal reporting structure.

14.6.3 Meetings: Each department committee shall meet regularly and at least four (4) times per year to review and analyze, on a peer group basis, the clinical work of the department. The Surgery Department shall also conduct comprehensive review for justification of all surgery performed whether tissue was removed or not, and for the acceptability of the procedure chosen. The meeting minutes shall be submitted at least quarterly to the Executive Committee detailing such departmental analysis of patient care records.

14.6.4 Specific departments have additional duties as indicated:

14.6.4.1 Anesthesiology Department: It shall review administration of all anesthesia in the Hospital and in all Hospital outpatient clinics, and shall be responsible for the clinical practice in the Post-Anesthesia Recovery Rooms.

14.6.4.2 Cardiovascular Department: It shall review all cardiology and cardiovascular disease practices and cardiovascular surgery practice in the Hospital. It shall review all pediatric cardiology practices in the Hospital.

14.6.4.3 Medical Imaging Department: It shall review radiology, appropriate nuclear, ultrasonic and related diagnostic and therapeutic methods practiced in the Hospital and shall be responsible for the appointment and supervision of Hospital Radiation Safety Committee. It shall cooperate with other departments in conducting radiology conferences. In the absence of a designated multispecialty committee, it will review and make recommendations for all non-radiologist requests for privileges in the Department.

14.6.4.4 Emergency Medicine Department: It shall review all emergency medical practices in the Emergency Department.

14.6.4.5 Medicine Department: It shall review all adult medicine practices in the Hospital including Allergy and Immunology, Critical Care Medicine, Dermatology, Endocrinology and Metabolic Diseases, Family Medicine, Gastroenterology, Gerontology, Hematology, Hospitalist Medicine, Infectious Diseases, Pulmonology, Oncology, Nephrology, Neurology, Palliative Medicine, Physical Medicine and Rehabilitation, Rheumatology, Psychiatry and Psychology. It shall review all pediatric practices in the Hospital.

14.6.4.6 Pathology Department: It shall review all pathology and appropriate laboratory medicine practice in the Hospital. It shall make reports to the clinical departments and sections of pertinent observations regarding tissues removed during surgery, particularly noting cases in which normal tissue is removed where there is a disparity between pre- and post-operative diagnosis; and autopsy findings.

14.6.4.7 Orthopedic Surgery Department: It shall be responsible for all of the orthopedic surgery and podiatry practices in the Hospital.

14.6.4.8 Surgery Department: The Surgery Department shall review all of the general and sub-specialty surgical, dental and oral-maxillofacial practices in the Hospital, except that which falls under the jurisdiction of the Cardiovascular Department and Orthopedic Surgery Department. The Surgery Department shall be responsible for evaluating all surgical procedures in the departments or sections.

14.7 The Affiliate Staff

14.7.1 Assignments to Departments and Sections: The Executive Committee, upon recommendation of the Credentials Committee, shall assign Affiliate Staff appointees to a Medical Staff Department or section or Affiliate Staff section as provided in these Bylaws.

14.7.2 Affiliate Staff Rules and Regulations

14.7.2.1 Rules and regulations governing the qualifications, privileges, restrictions, and Affiliate Staff sections shall be formulated by, approved by, and become part of the Rules and Regulations of the departments and/or sections to which Affiliate Staff members or sections are assigned.

14.7.2.2 Rules and regulations as provided in these Bylaws shall not be in effect, nor shall Affiliate Staff members exercise clinical privileges granted, until Rules and Regulations have been approved by the department or section committee concerned, the Executive Committee and the Board.

14.7.2.3 Failure of a department or section committee to formulate or approve Rules and Regulations within a reasonable time after an appointee has been assigned to a section or department, shall entitle the Affiliate Staff member to the hearing procedures provided in Article 9 of these Bylaws.

14.7.3 Formation of Affiliate Staff Sections

14.7.3.1 Sections may be organized by Affiliate Staff appointees as provided in these Bylaws.

14.7.3.2 Members of the Affiliate Staff who are members of an Affiliate Staff Section shall serve on the section committee and the Chairman of the Affiliate Staff Section shall be an ex-officio member of the Medical Staff Department or section committee to which the Affiliate Staff Section is responsible.

14.7.3.3 If an Affiliate Staff Section is formed, it shall make recommendations to the Medical Staff Department or section committee to which it is assigned regarding granting and redetermination of clinical privileges for applicants to appointment to the section.

15 INTERN, RESIDENT AND FELLOW ROTATIONS

15.1 Supervision of Interns, Residents and Fellows

Professional Graduate Medical Education Programs wishing to rotate Interns, Residents or Fellows through Banner Baywood Medical Center (BBMC) will require approval by the appropriate Department/Committee, the Medical Executive Committee, the CMO, and the CEO or designee(s). This approval will be based upon information provided by the Graduate Medical Education (GME) training program. Successful completion of training on Banner's electronic medical record is required before start of the assigned rotation.

Interns, Residents and Fellows must be supervised by a supervising physician with appropriate clinical privileges. The scope of their rotation will be delineated by the GME training program. The supervising physician, who is a member in good standing of the BBMC Medical Staff, shall communicate information to the GME training program about the quality of care, treatment, procedures and services provided as well as identified educational needs of the participants he/she supervises.

Interns, Residents and Fellows are not members of the Medical Staff and are not entitled to any of the rights set forth in the Medical Staff Bylaws. By way of example, they may not admit patients, hold elected office, or vote. They are not required to pay staff dues; however, they may attend meetings or serve on committees if invited by the organized Medical Staff.

15.2 Duration of Rotation

Intern, Resident and Fellow rotations are valid only as long as the Intern/Resident/Fellow satisfies all requirements for participation in the program and insurance coverage.

15.3 Documentation by Interns, Residents and Fellows

The supervising physician shall be responsible for each patient's medical record. When Interns, Residents or Fellows are involved in patient care at the Medical Center, sufficient evidence will be documented in the health record to substantiate active participation and supervision of the patient's care by the supervising physician. The supervising physician must personally document his/her participation in 3 key components of the service provided by Interns, Residents or Fellows, (i.e., history, exam, and medical decision making.)

15.4 Orders

Interns, Residents and Fellows approved for rotation through BBMC, who are registered with the appropriate Arizona licensing board, and who are participants in an accredited training program, may enter patient care orders as determined by the supervising physician. The physician may modify a statement recorded by the Intern, Resident or Fellow and authenticate change or addendum. The supervising physician will be notified of incomplete or delinquent records assigned to Interns, Residents, or Fellows he/she supervises. Final responsibility for care of the patient rests with the supervising physician or his/her designee.

15.5 Procedures and Operative Reports

The respective Medical Staff Department/Committee will identify which procedures are permitted and approved under the direction of the supervising physician. The supervising physician must be present during all critical or key portions of the approved procedure. During non-critical or non-key portions of the approved procedure, if not physically present, the supervising physician must be immediately available to return to the procedure. If circumstances prevent a supervising physician from being immediately available, then he/she must arrange for another qualified physician to be immediately available to assist with the procedure, if needed. If designated by the supervising physician, Interns, Residents or Fellows may be responsible for operative reports for procedures performed by the physician they have assisted.

16 RULES AND REGULATIONS

16.1 General Rules and Regulations of the Medical Staff. The Medical Staff shall adopt and maintain General Rules and Regulations to guide its members in fulfilling their patient care responsibilities in the Hospital, consistent with professional ethics, state and federal law and these Bylaws and which shall be incorporated into, and be part of, these Bylaws. Adoption, amendment and periodic review of the General Rules and Regulations of the Medical Staff shall be according to the process described in Article XVI.

16.2 Department, Section, and Committee Rules and Regulations

16.2.1 Responsibility, Content. It shall be the responsibility of each department, section, and committee to develop and maintain, pursuant to Section 14.5, its own rules and regulations that are consistent with these Bylaws and the General Rules and Regulations of the Medical Staff. Each department's, section's and committee's rules and regulations shall at a minimum specify the body's functions, authority, responsibilities and membership criteria. Department and section rules and regulations shall also specify privileging criteria.

16.2.2 Approval Process. Department, section and standing committee rules and regulations must be approved by the body subject to their requirements and the MEC. Section and Service rules and regulations shall also be submitted for approval to the committee of the department of which it is a part.

16.2.3 If the Executive Committee fails to approve the proposed changes in the rules and regulations of a department or section, the committee of the department or section may appeal the decision to the Board.

16.2.4 Those department, section and committee rules and regulations that govern the qualifications, privileges, restrictions and conduct of individual Staff appointees, including Affiliate Staff appointees, require approval of the department, Executive Committee, Active Staff, which may utilize a mail or electronic ballot vote, and the Board to become effective.

17 AMENDMENTS

17.1 Amendment Process Requirements. The MEC shall review and make recommendations to the Active Staff about adoption of proposed bylaws amendments forwarded by the Bylaws Committee. The MEC shall review each amendment for consistency with these Bylaws and Medical Staff Rules and its recommendations shall be informed by an attorney engaged at Medical Staff expense. Amendments require approval by a majority mail or electronic ballot vote of members of the Active Staff voting. Ballots shall be sent to each appointee to the Active Staff, accompanied by a copy of the proposed amendments or a summary thereof, which summary has been approved by the Executive Committee and by a written statement of the Medical Staff's attorney on the costs and benefits to the Medical Staff organization of the proposed amendment(s). New Bylaws or any amendments to these Bylaws shall become effective only upon approval by the Board. Neither the Board nor the Medical Staff may unilaterally amend these Bylaws, provided however, that the Board may do so to assure compliance with state and federal laws and accreditation requirements (a) after the Medical Staff has failed to do so within a reasonable time of a Board request and (b) after consideration of the Board's proposed amendment by a special Joint Conference Committee consisting of an equal number of members appointed by the Medical Staff President and by the Board pursuant to Board bylaws Section VI.9.E. The provisions of these Bylaws shall be interpreted consistent with applicable federal and state laws. 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.

17.1.2 Amendment by Petition.

17.1.2.1 Initiation. Active Staff members may initiate the amendment process by submitting a petition signed by at least twenty percent (20%) of all Active Staff members. The petition must:

a. provide the language and specify the location in the document to be amended.
b. identify on each page of the petition the two Active Medical Staff members who will represent the petitioners at meetings of the Medical Staff, the MEC and the Bylaws Committee.
c. be submitted to Medical Staff Services to be placed on the agenda for the next regularly scheduled Bylaws Committee meeting that meets no less than ten days after submission.

17.1.2.2 Bylaws Committee Review. The Bylaws Committee will:

a. help petitioners (through their representatives) to ensure that the provision is clearly articulated and harmonized with the document and is not already addressed; and
b. refer the provision for the MEC's consideration at its next regular meeting.

17.1.2.3 MEC Action. The MEC shall determine whether it supports or opposes the proposed amendment in whole or in part. If the MEC

a. supports or does not oppose the proposed amendment(s), it will forward the amendment to the Active Staff for a vote as described in 16.1.1, and the ballot shall include petitioners' statement in support of the proposed amendment.
b. does not support or opposes any part of the proposed amendment(s), the President will promptly call for a Special Meeting of the General Medical Staff pursuant to 12.3. In addition to the requirements of 12.3, the notice of the Special Meeting shall include:
    i. a statement that the meeting is to discuss (with representatives of the petitioners) an amendment proposed by petition of the Active Staff (and the number of petitioners),
    ii. the exact wording of the proposed amendment in such a way that the members can see how it affects other provisions (deletions, additions, renumbering)
    iii. petitioners' statement in support of the proposed amendment
    iv. MEC's statement regarding the proposed amendment

17.1.2.4 Special Meeting on the Petitioned Amendment. Minutes shall be kept of the meeting, and no quorum shall be required. After the meeting, the Petitioners may submit their proposed amendment for a vote as described in 16.1, or may modify or withdraw the proposed amendment.

The Bylaws Committee shall review any modification for compatibility with the Bylaws and Rules. The ballot shall include the items enumerated in 16.1.2.3(b)(ii-iv), updated as necessary.

17.2 Required Updating Bylaws shall be reviewed and revised as necessary at least every two years to reflect major changes in current practices.

17.3 Exception to Process Purely editorial amendments shall become effective on approval of the Executive Committee and do not require any further action. "Editorial amendments" include corrections to the following:

16.3.1 spelling
16.3.2 titles, names
16.3.3 numbering
16.3.4 headings of paragraphs and subparagraphs

18 ADOPTION

18.1 These Bylaws were adopted by a mail or electronic ballot vote of the Active Staff of Banner Baywood Medical Center, and became effective subject to final approval of the Board.

Approved by the Banner Health Board: June 6, 2019
Editorial Amendments Approved by MEC: December 1, 2011
Editorial Amendments Approved by MEC: January 5, 2012
Editorial Amendments Approved by MEC: May 5, 2016