BANNER
UNIVERSITY MEDICAL CENTER—
TUCSON CAMPUS
MEDICAL STAFF BYLAWS

BANNER/UNIVERSITY MEDICAL CENTER—TUCSON CAMPUS

BYLAWS OF THE MEDICAL STAFF

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PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Banner/University Medical Center—Tucson Campus and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care and to govern the orderly resolution of those purposes. These Bylaws provide the legal structure for Medical Staff operation and describe relations between the organized Medical Staff and applicants to, and members of, the Medical Staff. These Bylaws along with the Bylaws of Banner Health provide a recognized structure for Medical Staff activities and document the relationship between the Medical Staff and the Board of Directors.

ARTICLE ONE: NAME

1.1 The organizational component of Banner Health to which these Bylaws are addressed is called "The Medical Staff of Banner/University Medical Center—Tucson Campus."

ARTICLE TWO: PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

2.1 **PURPOSES**

The purposes of this Medical Staff are:

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

2.1-2 The primary functions of the organized medical staff are to provide oversight for the quality of care, treatment, and services provided by practitioners with privileges, and to approve and amend medical staff bylaws.

2.1-3 To provide a mechanism for accountability to the Board for the review of the appropriateness of patient care services, professional and ethical conduct, and teaching and research activities of each practitioner appointed to the Medical Staff. This is so that patient care provided at the Medical Center facilities is maintained at that level of quality and efficiency consistent with generally recognized standards of care.

2.1-4 To evaluate clinical processes and outcomes and identify and implement opportunities for professional performance improvement.

2.1-5 To maintain high scientific and educational standards for continuing medical education programs for members of the Medical Staff and other medical professionals.

2.1-6 To serve as the organization through which individual practitioners may obtain prerogatives and clinical privileges at the Medical Center and through which they fulfill the obligations of staff appointment.

2.1-7 To provide an orderly and systematic means by which staff members can give input to the Board and CEO on medico-administrative issues and on Medical Center policymaking and planning processes.

2.2 **RESPONSIBILITIES**

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

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

(a) Evaluating practitioner and institutional performance through measurement systems based on objective, clinically-sound criteria and taking action to decrease morbidity and mortality;
(b) Engaging in the ongoing monitoring of patient care practices;
(c) Evaluating practitioners' credentials for appointment and reappointment to the Medical Staff and for the delineation of clinical privileges; and
(d) Promoting the appropriate use of Medical Center resources; and
(e) Complying with the Banner Care Management Initiatives.

2.2-2 To make recommendations to the Board concerning appointments and reappointments to the staff, including category, department and section assignments, clinical privileges, corrective action, and termination of membership.

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

2.2-4 To develop and maintain Bylaws and Policies consistent with sound professional practices, and to enforce compliance with them.

2.2-5 To take action, as necessary, to enforce the Medical Staff Bylaws, Rules and Regulations and policies.

2.2-6 To participate in the Medical Center's long range planning activities.

2.2-7 To assist in identifying community health needs and to participate in developing and implementing appropriate institutional policies and programs to meet those needs.

2.2-8 To exercise through its officers, committees, and other defined components, the authority granted by these Bylaws, to fulfill these responsibilities in a timely and proper manner, and to account thereon to the Board.

ARTICLE THREE: MEMBERSHIP

3.1 **GENERAL QUALIFICATIONS**

Every practitioner who seeks or enjoys staff membership must, at the time of application and continuously thereafter, demonstrate, to the satisfaction of the Medical Staff and the Board, the following qualifications and any additional qualifications and procedural requirements as are set forth in these Bylaws or in department rules and regulations:

3.1-1 **LICENSURE**

Evidence of a currently valid license issued by the State of Arizona to practice medicine, dentistry, podiatry, or psychology. A teaching license is acceptable with documentation of the College of Medicine Dean’s approval and invitation to demonstrate and perform

identified medical procedures and surgical techniques. A teaching permit is acceptable for housestaff members.

3.1-2 PROFESSIONAL EDUCATION AND TRAINING

(a) Graduation from an approved medical, osteopathic, dental, podiatric or psychology school or attainment of a PhD. degree in a recognized scientific field from an accredited university; or certification by the Educational Council for Foreign Medical Graduates; or Fifth Pathway certification and successful completion of the Foreign Medical Graduate Examination in the Medical Sciences.

For purposes of this section, an "approved" or "accredited" school or university is one fully accredited during the time of the practitioner's attendance by the Accreditation Council for Graduate Medical Education, by the American Osteopathic Association, by the Commission on Dental Accreditation, by the American Board of Podiatric Surgery, the Council on Podiatric Medical Education of the American Podiatric Medical Association, by the American Psychological Association, or by a successor agency to any of the foregoing or by an accrediting agency on file with the U.S. Secretary of Education.

(b) Satisfactory completion of an approved postgraduate training program. An "approved" postgraduate training program is one fully accredited throughout the time of the practitioner's training by the Accreditation Council for Graduate Medical Education (ACGME), by the American Osteopathic Association, by the Commission on Dental Accreditation, by the American Board of Podiatric Surgery, by the Council on Podiatric Medical Education of the American Podiatric Medical Association, by the American Psychological Association, or by a successor agency to any of the foregoing, or a program equivalent to one accredited by the ACGME.

(c) For Affiliate Staff, graduation from an approved advance practice or physician assistant school.

3.1-3 FACULTY APPOINTMENT

Faculty appointment or a faculty title is required for medical staff membership to participate in the teaching program. Effective February 28, 2016, all applicants must have a faculty appointment or title from the Dean to be eligible for membership and privileges.

All physicians who are on the medical staff prior to or on February 28, 2016 must receive faculty appointment or title to remain on the medical staff by February 28, 2019. Failure to maintain and obtain a faculty title shall result in the automatic relinquishment of medical staff membership and privileges.

For physicians who were on the medical staff on or before February 28, 2016 and are determined by the Dean to be unable to obtain a faculty appointment or title by February 28, 2019, the Academic Management Council may approve a “grandfathering” status to remain on the medical staff on a case by case basis.

An exemption may be granted to categories of physicians as determined by the Academic Management Council. Temporary privileges may be granted without a faculty appointment or title.

3.1-4 **BOARD CERTIFICATION**

(a) Board certified or qualified for Board certification. Where membership and privileges are granted on the basis of Board qualification, certification must be obtained within five years of completion of training or sooner as required by the department or the American Board of Medical Specialties (ABMS) or the American Osteopathic Board (AOA). by the earlier of the timeframe specified by the American Board of Medical Specialties (ABMS) or the American Osteopathic Board (AOA) following completion of training or expiration of the period specified by the applicable Department Rules and Regulations in which to obtain certification, Recertification must be granted within three years from the expiration of original Board certification or recertification. Failure to become certified or recertified within the time allowed under these Bylaws, as required by the appropriate Board, or Rules and Regulations of the applicant's department or section, 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 and/or shows active participation in the Maintenance of Certification (MOC) program, if applicable, by a board approved by the American Board of Medical Specialties or the Advisory Board for Osteopathic Specialists or by a board determined by the department to be equivalent. For purposes of this section, "Board qualification" or "Board qualified" means the applicant has completed the training necessary to be accepted to become/applied for and been accepted to become an active candidate for certification as determined by the appropriate board. Where the board requires a period of practice prior to submitting an application for certification, the applicant will be deemed qualified during this time period if the director of his/her training program certifies that he/she has met all training requirements for qualification by the appropriate board.

(b) Exceptions to achieving board certification may be considered in the following circumstances as determined by the Medical Executive Committee:
   a. Where a practitioner trained outside the country with training deemed equivalent to that required for board certification;
   b. 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;
   c. where a particular field or specialty of the department does not have a Board certification:
   d. where privileges are limited to surgical assisting or referring only; or
   e. 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.

(c) Members are required to remain board certified. Failure to become recertified within three years from the expiration of original Board certification or recertification shall result in the voluntary, automatic relinquishment of Medical Staff membership and privileges. Members with subspecialty certification, practicing within their subspecialty, may allow their primary certification to lapse. Where a practitioner had

membership and privileges as of the date of approval of these bylaws and was not required to maintain board certification, recertification is not required.

(d) The Medical Executive Committee may consider extending membership within the current appointment term, under the following circumstances for initial certification or maintenance of certification:
   a. a practitioner has taken the exam, and is awaiting results or has exam scheduled and provides evidence of this; or
   b. a practitioner has submitted evidence of 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.

The failure to take the examination or to become certified or maintain certification shall result in the voluntary, automatic relinquishment of Medical Staff membership and privileges.

3.1-5 **CLINICAL PERFORMANCE**
Current experience, clinical results, and utilization patterns, documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency.

3.1-6 **COOPERATIVENESS**
Demonstrated ability and willingness to work with and relate to others in a cooperative, professional manner that is essential for maintaining an environment appropriate to quality and efficient patient care and patient and employee satisfaction. It is the policy of the Medical Center and this Medical Staff, that all individuals within its facilities be treated courteously, respectfully, and with dignity. To that end, all Medical Staff members, and other practitioners must conduct themselves in a professional and cooperative manner. Failure to do so may constitute disruptive behavior. Disruptive behavior by any practitioner against any individual (e.g., against another Medical Staff member, house staff, hospital employee, patient or visitor) shall not be tolerated. If a practitioner fails to conduct himself/herself appropriately, corrective action, including summary suspension, may be taken.

3.1-7 **TEAMWORK**
Demonstrated ability to work as a member of the healthcare team, exhibiting the skills, communication practices and behaviors of a team leader.

3.1-8 **SATISFACTION OF MEMBERSHIP OBLIGATIONS**
Satisfactory compliance with the basic obligations accompanying appointment to the staff and equitable participation, as determined by Medical Staff and Board authorities, in the discharge of staff obligations specific to staff category.

3.1-9 **SATISFACTION OF CRITERIA FOR PRIVILEGES**
Evidence of satisfaction of the criteria for the granting of, and maintenance of, clinical privileges in at least one department.

3.1-10 **PROFESSIONAL ETHICS AND CONDUCT**
Demonstrated high moral character and adherence to generally recognized standards of medical and professional ethics which include refraining from: paying or accepting commissions or referral fees for professional services; delegating the responsibility for diagnosis or care to a practitioner or allied health professional not qualified to undertake

that responsibility; failing to seek appropriate consultation when medically indicated; failing to provide or arrange for appropriate and timely medical coverage and care for patients for whom the practitioner is responsible; and failing to obtain appropriate informed patient consent for treatment.

3.1-11 **PARTICIPATION IN GOVERNMENT PROGRAMS**
Ability to participate in Medicare/AHCCCS and other federally funded health programs.

3.1-12 **HEALTH STATUS**
Freedom from or adequate control of any significant physical or mental health impairment and freedom from abuse of any type of substance or chemical that may affect cognitive, motor, or communication ability in a manner that interferes with the ability to provide quality patient care or the other qualifications for membership, and freedom from infectious tuberculosis.

3.1-13 **VERBAL AND WRITTEN COMMUNICATION SKILLS**
Ability to read and understand the English language, to communicate in writing and verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible manner.

3.1-14 **PROFESSIONAL LIABILITY INSURANCE**
Evidence of professional liability insurance of a kind and in an amount satisfactory to the Board.

3.1-15 **EFFECTS OF OTHER AFFILIATIONS**
No practitioner shall be entitled to appointment, reappointment, or the exercise of particular clinical privileges merely because of:
(a) Licensure to practice;
(b) Completion of a postgraduate training program at any Banner facility;
(c) Certification by any clinical board;
(d) Membership on a medical school faculty;
(e) Staff appointment or privileges at another health care facility or in another practice setting; or
(f) Prior staff appointment or any particular privileges at Medical Center.

3.1-16 **NONDISCRIMINATION**
No aspect of Medical Staff appointment or particular clinical privileges shall be denied on the basis of age, sex, race, creed, color, national origin, a handicap unrelated to the ability to fulfill patient care and required staff obligations, or any other criterion unrelated to the delivery of quality and efficient patient care in the Medical Center, to professional qualifications, to the Medical Center's purposes, needs and capabilities, or to community need.

3.1-17 **EXEMPTIONS FROM QUALIFICATIONS**
Any or all of the above stated requirements for Medical Staff membership may be waived for those practitioners appointed to the honorary staff and as otherwise provided in these Bylaws. The Board certification may be waived for Associate Members who do not have privileges and will be waived for Affiliate Members.

3.2 **RIGHTS OF INDIVIDUAL STAFF MEMBERSHIP**
Each staff member, regardless of assigned staff category, shall have the following rights:
(a) The right to meet with the Medical Executive Committee in the event he/she is unable to resolve a difficulty working with his/her respective department Clinical Service Chief. The

member must submit written notice to the Chief of Staff at least two weeks in advance of the regular meeting;

(b) The right to initiate a recall of an elected Medical Staff Officer by following the procedures set forth in Section 7.5.

(c) The right to initiate the scheduling of a general staff meeting by following the procedures set forth in Section 10.1-2;

(d) The right to challenge any rule or policy established by the Medical Executive Committee by presentation to the Medical Executive Committee of a petition signed by 40% of the Active Staff. Upon receipt of such a petition, the Medical Executive Committee will provide information clarifying the intent of the rule or policy or schedule a meeting to discuss the issue;

(e) The right to request conflict resolution of any issue by presentation to the Medical Executive Committee of a petition signed by 40% of the Active Staff. Upon receipt of such a petition, the Medical Executive Committee will schedule a meeting to discuss the issue.

(f) The right to request a department meeting when a majority of members in a section or specialty believe that the department has not acted appropriately;

(g) The right to request a hearing pursuant to the Fair Hearing Plan in the event that reviewable corrective action is taken.

(h) The right to request review by the Medical Executive Committee in the event that nonreviewable corrective action is taken.

(i) The right to request that the Medical Executive Committee request a Joint Conference Committee meeting with the Board to resolve concerns regarding medical staff bylaws, credentialing recommendations, policies or other issues which such medical staff has been unable to resolve through informal processes with the CEO, senior management, the Medical Staff Subcommittee, the Performance Improvement Council, or the Board of Directors.

3.3 BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP

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

(a) Provide patients with continuous care at the level of quality and efficiency generally recognized as appropriate;

(b) Abide by the Banner Health Bylaws, these Bylaws, department rules and regulations, and all other standards and policies of the Board, the Medical Staff and Medical Center;

(c) Discharge such staff, committee, department, and Medical Center functions for which he or she is responsible, including review and supervise the performance of other practitioners;

(d) Serve on the on-call roster for charity, unassigned, and emergency patients as determined by the applicable department, the Medical Executive Committee and the CEO;

(e) Prepare and complete in timely fashion, according to these Bylaws and to Medical Center policies, the electronic medical record and other required records for all patients to whom the practitioner provides care in the Medical Center, or within its facilities, services, or departments;

(f) Using the Banner electronic medical record, complete hospital medical records solely in accordance with, and to the extent authorized by, Medical Staff Rules and Regulations;

(g) Arrange for appropriate and timely medical coverage and care for patients for whom he or she is responsible and obtain consultation when necessary for the health or safety of those patients;

(h) Participate in continuing education programs to meet all licensing requirements and as are appropriate to the practitioner's specialty;

(i) Use confidential information only as necessary for treatment, payment or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities, or to perform Medical Staff responsibilities. For purposes of these Bylaws, confidential information means patient information, peer review information, and Banner

Health's business information designated as confidential by Banner Health or its representatives prior to disclosure;

(j) Refrain from disclosing confidential information to anyone unless authorized to do so;
(k) Protect access codes and computer passwords and to ensure confidential information is not disclosed;
(l) Disclose to the Medical Staff when requested any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or the Medical Center;
(m) Refrain from making treatment recommendations/decisions for economic benefit of the practitioner and unrelated to needs of the patient;
(n) Comply with all applicable state and federal law in disclosing to a patient any direct financial interest that the practitioner, his/her group or his/her employer has in a separate diagnostic or treatment facility prior to transferring the patient to such facility.
(o) Participate in Banner training program for the electronic medical record (EMR) prior to exercising clinical privileges and to remain current with regard to relevant changes, upgrades and enhancements to the EMR.
(p) Participate in the Banner Medical Staff Orientation Program.
(q) Report final malpractice judgments or settlements to the Medical Staff Services Office promptly;
(r) Report immediately to the Chief of Staff any failure to comply with the General Qualifications including but not limited to:
    i. Any restriction of the Member's license to practice in any state or any stipulation or probation imposed by a licensing board;
    ii. Any restriction of the Member's DEA;
    iii. Any restriction of the Member's privileges to practice in any healthcare facility or any action taken or stipulation or probation imposed by a medical staff.
(s) Report to the Chief of Staff any health care provider or staff member who is or might be mentally or physically unable to safely perform privileges or duties to interact safely with patients or staff.
(t) Self-report problems in one's physical or mental well-being, including problems with alcohol or drugs which might impair the performance of clinical duties and privileges.

3.4 TERM OF APPOINTMENT

Appointments to the Medical Staff and grants of clinical privileges are for a period not to exceed two years. The Board, after considering the recommendations of the Medical Executive Committee, may establish a shorter appointment period for the exercise of particular privileges in general or for a staff member who has an identified impairing disability, has been the subject of disciplinary action, or is under investigation or where further evaluation is pending.

3.4-4 EXPIRATION

The appointment of each staff member shall expire every two years, except as provided in this Section.

3.5 EXHAUSTION OF ADMINISTRATIVE REMEDIES

Every applicant to and member of the Medical Staff agrees that when corrective action is initiated or taken or when a recommendation is made by any committee or any person acting on its behalf, the effect of which is to deny, revoke, or otherwise limit the privileges or membership of the applicant or staff member, such applicant or member shall exhaust the administrative remedies afforded in these Bylaws and Fair Hearing Plan prior to initiating litigation.

3.6 LIMITATION OF DAMAGES

Every applicant to and member of the Medical Staff agrees that his or her sole remedy for any adverse or corrective action for failure to comply with these Bylaws shall be the right to seek

injunctive relief pursuant to ARS 36-445 et. seq. An alleged breach of any provision of these Bylaws and/or Fair Hearing Plan shall provide no right to monetary relief from the Medical Staff, the Medical Center or any third party, including any employee, agent or member of the Medical Staff or the Medical Center and any person engaged in peer review activities.

3.7 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

3.7-1 QUALIFICATIONS

A practitioner who is or who will be providing professional direct patient care services pursuant to a contract or employment with the Medical Center must meet the same appointment qualifications, must be evaluated for appointment, reappointment, and clinical privileges in the same manner, and must fulfill all of the obligations of the assigned category as any other staff member. For purposes of this section, practitioners providing specified professional services does not include outside practitioners assisting the Medical Staff with its peer review functions.

(a) Practitioners rendering professional services pursuant to employment or contracts with the Medical Center shall be required to maintain Medical Staff membership and privileges.

(b) Unless otherwise provided in the contract for professional services or in an exclusive contract, termination of such employment or contracts shall not result in automatic termination of Medical Staff membership and privileges.

3.8 EXCLUSIVE CONTRACTS

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

3.8-1 REVIEW OF POSITIONS

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

(b) The Medical Executive Committee shall give Medical Staff members whose privileges may be adversely affected by the establishment or modification of the Agreement an opportunity to submit written information to the Medical Executive Committee regarding the impact the establishment of the Agreement would have on the quality of patient care to be provided and/or why the Agreement is not necessary to establish the expected benefits.

(c) The Medical Executive Committee shall be given an opportunity to report its findings to the CEO and/or Dean before the Exclusive Agreement is entered into or transferred. The report shall be limited to information relating to the impact the Agreement would have on quality of care and whether the Agreement is necessary to establish the expected benefits. The report must be submitted, if at all, within 60 days of the CEO's and/or Dean's explanation of the need for, and expected benefits of, the Agreement to the Medical Executive Committee. The CEO and Dean is

ultimately responsible for determining, in his/her discretion, whether to enter into the Agreement.

(d) In the event the Medical Executive Committee disagrees with the decision of the CEO and/or Dean to enter into an exclusive contract, the Medical Executive Committee may request a Joint Conference Committee as set forth in Section 13.5. The request must be made, if at all, within ten days of notification by the CEO's and Dean's decision.

3.9 TEACHING LICENSES

Prior to issuing a letter of support to an applicant and prior to the applicant seeking an education teaching license from the Arizona Medical Board, the Dean of the College of Medicine/designee should explain to the Medical Executive Committee the need for, and expected benefits of, training to be provided by the identified candidate.

3.10 MEDICAL DIRECTORS

3.10-4 ROLE

A medical director is a practitioner engaged by the hospital either full or part-time in an administrative capacity. Where provided for by contract, a medical director's responsibilities may include assisting the Medical Staff and/or the Care Management Council to carry out peer review and quality improvement activities. Medical Directors may attend department and committee meetings (with the exception of Professional Review Committee and Credentials Committee) and shall serve as ex officio appointees with vote on all committees of the Medical Staff consistent with the scope of their responsibilities. Medical Directors, except for the Medical Director of Care Coordination, must continuously satisfy the qualifications and complete the requirements set forth in Section 3.1.

3.10-5 CHIEF MEDICAL OFFICER

The Chief Medical Officer shall automatically be granted Active Staff membership. The Chief Medical Officer need not remain in the active practice of medicine, and need not comply with the applicable requirements in Section 3.1. The Chief Medical Officer shall have Medical Staff leadership and peer review responsibilities including, but not limited to, responsibility for reviewing care, conducting investigations, identifying trends and resolving issues and such other duties as delegated by the Medical Executive Committee.

3.11 CREDENTIALING PROCESS

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

ARTICLE FOUR: MEDICAL STAFF CATEGORIES/AFFILIATIONS

4.1 CATEGORIES

There will be six categories of appointment to the staff: active, associate, telemedicine, honorary, housestaff, affiliate and one category of non-membership affiliation with the facility: community-based affiliation.

4.2 ACTIVE STAFF

4.2-1 QUALIFICATIONS FOR ACTIVE STAFF

The active staff shall consist of physicians, dentists, podiatrists and psychologists who demonstrate a genuine concern, interest, and activity in the Medical Center through substantial involvement in the affairs of the Medical Staff or Medical Center and/or are

regularly involved in the care of patients in the Medical Center facilities. The volume of annual patient contacts and involvement in the affairs of the Medical Staff or Medical Center necessary to achieve and maintain active staff shall be established by the Medical Executive Committee.

4.2-2 **PREROGATIVES**

An active staff member may:

(a) Admit patients, except as set forth in department rules and regulations: privilege criteria and Medical Center admission policies.
(b) Exercise such clinical privileges as are granted by the Board.
(c) Vote on all matters presented at general and special meetings of the Medical Staff and of the department and committees of which he or she is a member; and
(d) Hold office at any level in the staff organization and be chairman or a member of a committee provided the specific qualifications for the position involved are met and except as otherwise provided in these Bylaws or by resolution of the Medical Executive Committee.

4.2-3 **OBLIGATIONS**

An active staff member must, in addition to meeting the basic obligations set forth in these Bylaws, including in Section 3.3:

(a) Contribute to the organizational, administrative and medico-administrative, quality review, patient safety and utilization management activities of the Medical Staff, and faithfully perform the duties of any office or position to which elected or appointed; and
(b) Pay all staff dues and assessments.

4.2-4 **FAILURE TO SATISFY QUALIFICATIONS**

Failure of an active staff member to satisfy the qualifications or obligations of the active staff category for any reappointment period may result in reassignment to another staff category or corrective action where appropriate. A practitioner who feels he or she has unjustly been removed from the active staff category may request reconsideration of the change by the Medical Executive Committee.

4.3 **ASSOCIATE STAFF**

4.3-1 **QUALIFICATIONS FOR ASSOCIATE STAFF**

The Associate Staff shall consist of physicians, dentists, podiatrists and psychologists who treat patients to the Medical Center only on an occasional basis or are only occasionally involved in the affairs of the Medical Staff or Medical Center.

4.3-2 **PREROGATIVES**

An Associate Staff member may:

(a) Admit patients, except as set forth in department rules and regulations; privilege criteria and Medical Center admission policies;
(b) Exercise such clinical privileges as have been granted by the Board;
(c) Perform educational or administrative duties assigned by the College of Medicine;
(d) Be appointed to committees unless otherwise provided by these Bylaws;
(e) Demonstrate his/her continued clinical competency to provide care to patients treated at the Medical Center by providing information regarding current experience, clinical results and utilization practice patterns at either the Medical Center or other hospitals or outpatient surgical centers;
and
(f) Vote on matters presented at committees to which he or she has been appointed and at department meetings unless otherwise limited by these Bylaws or by

department rules and regulations. Associate members may not vote on matters presented at general or special meetings of the Medical Staff or hold office at any level of the staff organization.

4.3-3 **OBLIGATIONS**

An Associate Staff member must meet the basic obligations set forth in these Bylaws, including in Section 3.3, and pay all staff dues and assessments.

4.3-4 **CHANGE IN STAFF CATEGORY**

Associate members will be advanced to the active staff category at the time of reappointment or sooner, upon request, and if the qualifications set forth in 4.2-1 are satisfied. Failure to utilize the Medical Center during an entire reappointment period, unless participating solely in administrative activities, may result in a practitioner being dropped from the Medical Staff or moved to Community-Based Affiliation. A practitioner who feels he or she has unjustly been moved from the Associate Staff category may request reconsideration of the change by the Medical Executive Committee.

4.4 TELEMEDICINE STAFF

4.4-1 **QUALIFICATIONS FOR TELEMEDICINE STAFF**

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.

4.4-2 **PREROGATIVES**

A telemedicine staff member may:

(a) Treat patients via electronic communication link, except as set forth in department rules and regulations, privilege criteria and Medical Center policies.
(b) Exercise such clinical privileges as are granted by the Board.
(c) Be appointed to committees unless otherwise provided by these Bylaws.
(d) 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.

4.4-3 **OBLIGATIONS**

A telemedicine staff member must, in addition to meeting the basic obligations set forth in these Bylaws, including in Section 3.3:

(a) Contribute to the organizational, administrative and medico-administrative, quality review, patient safety and utilization management activities of the Medical Staff; and
(b) Pay all staff assessments, except for dues.

4.4-4 **FAILURE TO SATISFY QUALIFICATIONS**

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.

4.5 HONORARY STAFF

4.5-1 **QUALIFICATIONS FOR HONORARY STAFF**

Membership on the honorary staff is by invitation and is restricted to staff members for whom the Medical Executive Committee recommends and the Board approves this status

in recognition of longstanding service to the Medical Center or other noteworthy contributions to its activities.

4.5-2 **PREROGATIVES**

Honorary staff members shall not be eligible to vote on matters presented to the staff nor to hold elected office; are not required to have malpractice insurance or a license to practice; and are not required to pay dues or assessments. Honorary staff members may serve on committees and may vote on matters presented at committees of which they are members. Honorary staff members are not allowed to admit or treat patients.

4.6 HOUSE STAFF

4.6-1 QUALIFICATIONS FOR HOUSE STAFF

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

4.6-2 PREROGATIVES

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

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

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

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

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

4.6-3 OBLIGATIONS

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

4.7 LIMITATION OF PREROGATIVES

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

4.8 AFFILIATE STAFF

4.8-1 QUALIFICATIONS FOR AFFILIATE STAFF

The affiliate staff shall consist of Allied Health Professionals, including Nurse Practitioners, Certified Registered Nurse Anesthetists, Certified Nurse Midwives, Physicians' Assistants, and Optometrists who are involved in the care of patients in the Medical Center facilities.

4.8-2 PREROGATIVES

An affiliate staff member may:

(a) Exercise such clinical privileges as are granted by the Board.
(b) Perform such teaching activities as are authorized,
(c) Serve on committees to which they have been appointed.
(d) Vote on all matters presented at general and special meetings of the Medical Staff and of the department and committees of which he or she is a member.

4.8-3 OBLIGATIONS

An affiliate staff member must, in addition to meeting the basic obligations set forth in these Bylaws, including in Section 3.3, pay all staff dues and assessments.

4.8-4 LIMITATIONS

Affiliate staff may not:

(a) Serve as an officer of the Medical Staff.

4.9 COMMUNITY-BASED PHYSICIAN AFFILIATION

Community-based physicians are those who request Medical Center services for their patients and wish to be affiliated with the Medical Center. Community-based physicians are not members of the Medical Staff and do not have clinical privileges at the Medical Center. Community-based physicians need not meet all requirements for membership or privileges.

4.9-1 QUALIFICATIONS FOR COMMUNITY-BASED AFFILIATION

Physicians seeking to affiliate with the Medical Center must apply for community-based status and provide evidence of the following qualifications:

(a) Arizona licensure in good standing;
(b) Ability to relate in a professional manner with Medical Center staff and physicians;
(c) Professional ethics and conduct.

4.9-2 PREROGATIVES

The prerogatives of community-based affiliated physicians are to:

(a) Order Medical Center outpatient diagnostic services for patients;
(b) Access Medical Center information, via Clinical Connectivity, for their own patients;
(c) Attend Continuing Medical Education programs at the Medical Center.
(d) Receive Medical Staff Newsletters and other Medical Center Publications.

4.9-3 OBLIGATIONS

Community-based physicians must agree to use Medical Center patient information only as necessary for treatment, payment or healthcare operations regarding their own

patients in accordance with HIPAA laws and regulations. Inappropriate use of patient information will result in loss of affiliation and Clinical Connectivity.

4.9-4 **DENIAL OR TERMINATION OF AFFILIATION**

Community-based physicians or those seeking affiliated status are not entitled to due process rights under the Fair Hearing Plan. A physician who believes he or she was wrongly denied community-based physician status or whose status was terminated may submit information to the Medical Executive Committee demonstrating why the denial or termination was unwarranted. The Medical Executive Committee, in its sole discretion, shall decide whether to review the submission. The physician has no appeal or other rights in connection with the Medical Executive Committee's decision.

ARTICLE FIVE: DELINEATION OF PRACTICE PRIVILEGES

5.1 **PROCESS FOR CREDENTIALING FOR MEMBERSHIP AND PRIVILEGES**

Completed applications for membership and privileges are submitted at the time of initial appointment to the Credentials Committee after Department clinical service chief or section chief review, if applicable, and then to the Medical Executive Committee, subject to final approval by the Board. Completed applications for reappointment are submitted to the Credentials Committee, and Medical Executive Committee, subject to final approval by the Board. The process for appointment and reappointment to the Medical Staff is set forth in further detail in the Credentialing Procedures Manual.

5.2 **PROCESS FOR CREDENTIALING AND PRIVILEGING ALLIED HEALTH PROFESSIONALS**

Completed applications for allied health membership for initial appointment and privileges will be submitted to the Credentials Committee, after Department clinical service chief or section chief review, if applicable, and then to the Medical Executive Committee for review and action prior to submission to the Board. Completed applications for reappointment are submitted to the Credentials Committee and Medical Executive Committee, subject to final approval by the Board. The process for appointment and reappointment to the Allied Health Staff is set forth in further detail in the Allied Health Rules and Regulations.

5.3 **PROCESS FOR "DISTANT SITE" CREDENTIALING OF TELEMEDICINE PRACTITONERS**

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.

5.4 **EXERCISE OF PRIVILEGES**

5.4-1 **IN GENERAL**

Privileges may not be exercised at the Medical Center until the practitioner has successfully completed Banner's CPOE/EMR (Computer Physician Order Entry/Electronic Medical Record) training and orientation. Except in an emergency, a practitioner providing clinical services at the Medical Center may exercise only those clinical privileges specifically granted.

5.4-2 PRIVILEGES IN EMERGENCY SITUATIONS

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

5.4-3 EXPERIMENTAL PROCEDURES

Experimental drugs, procedures, or other therapies or tests (Experimental Procedures) may be performed only after approval of the involved protocols by the Banner Institutional Review Board. Any Experimental Procedure may be performed only after the regular credentialing process has been completed and the privilege to perform or use such procedure has been granted to the practitioner.

5.4-4 FOCUSED PROFESSIONAL PRACTICE EVALUATIONS

Focused Professional Practice Evaluation (FPPE) shall be conducted in accordance with Joint Commission requirements and department and Banner policies

5.5 TELEMEDICINE AND TELERADIOLOGY PRIVILEGES

5.5-1 SERVICES

The Medical Executive Committee shall determine which patient care, treatment, and services may be provided by practitioners through a telemedicine link. The clinical services offered must be consistent with commonly accepted quality standards. Telemedicine and Teleradiology services may also be used in the event of a disaster when the emergency management plan has been activated, and the organization is unable to meet immediate patient needs with resources on hand. Under such circumstances, the requirements in 5.13 shall apply.

5.5-2 CREDENTIALING

Practitioners providing care, treatment, and services of a patient via telemedicine link are subject to the credentialing and privileging processes of Medical Center. The practitioner may be privileged at Medical Center using credentialing information from the distant site if the distant site is a Joint Commission-accredited organization and if the application from the distant site meets quality standards as determined by the Medical Staff. Under this option, Medical Center may obtain and utilize the distant site’s primary source verified information including, but not limited to, licensure, education, training, the ability to perform privileges requested, and health status. Medical Center will re-verify licensure over 180 days old, and perform a query of the National Practitioner Data Bank. The information will be used for decision making in regard to granting of telemedicine privileges. The application approval process outlined in the Credentialing Procedures Manual, Section 1.6, will apply.

5.5-3 EVALUATION

The Medical Executive Committee shall evaluate the hospital’s ability to provide these services safely, and must evaluate the performance of the services by practitioners.

5.5-4 RIGHTS OF THE PRACTITIONER

Physicians seeking or who have been granted remote privileges are not entitled to due process rights under the Fair Hearing Plan if remote privileges are denied or terminated

unless such action is reportable to the National Practitioner Data Bank or the Arizona Medical Board. A physician who believes he or she was wrongly denied remote privileges or whose remote privileges were terminated or limited may submit information to the Medical Executive Committee demonstrating why the denial, limitation or termination was unwarranted. The Medical Executive Committee, in its sole discretion, shall decide whether to review the submission. The physician has no appeal or other rights in connection with the Executive Committee's decision.

5.6 PROCEDURE FOR DELINEATING PRIVILEGES

5.6-1 REQUESTS

Each application for appointment and reappointment must contain a request for the specific clinical privileges desired by the practitioner. In some instances, staff membership may be granted to a practitioner who desires not to request clinical privileges. Specific requests must also be submitted for modifications of privileges in the interim between reappointment periods. All requests for clinical privileges will be processed in accordance with the procedures set forth in the Credentialing Manual.

5.6-2 SUPERVISION

Whenever a practitioner requests clinical privileges not previously granted to the practitioner by the Board, the practitioner must arrange for the number and types of cases, if any, to be reviewed or observed as required in the department rules and regulations and privilege criteria, unless a waiver of supervision has been recommended by the department and the Medical Executive Committee subject to ratification by the Board. After the completion of such supervision, the practitioner may be granted unsupervised privileges.

5.7 BASIS FOR PRIVILEGES DETERMINATIONS

Clinical privileges shall be granted in accordance with education and training, experience, utilization practice patterns, current health status, and demonstrated competence and judgment to provide quality and appropriate patient care in an efficient manner as documented and verified in each practitioner's credentials file. Additional factors that may be used in determining privileges include those qualifications set forth in Section 3.1. Where appropriate, review of the records of patients treated in other hospitals or practice settings may also serve as the basis for privileges determination(s). In reappointment determinations, results of quality and performance improvement and utilization review, peer review, supervised cases (if applicable), and where appropriate, practice at other hospitals will also be considered. In review of requests for additional privileges, evidence of appropriate training and experience and current clinical competence must be documented.

5.8 PRIVILEGE DECISION NOTIFICATION

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

5.9 PRIVILEGES FOR NEW PROCEDURES

Departments will consider new technologies and procedures to determine whether the privilege to use such technologies or perform such procedures is subsumed under existing core or other privileges or requires additional education and training, experience and demonstrated competence and/or new staff competencies. Physicians desiring to utilize new technologies or perform new procedures may do so once the Medical 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 Medical Executive Committee's determination is subject to ratification by the Banner Board.

5.10 ESTABLISHMENT OF PRIVILEGES FOR INTERDISCIPLINARY PROCEDURES

5.10-1 REQUEST FOR PRIVILEGES

As a result of emerging technology, practitioners in different specialties may be qualified by training, demonstrated competence and judgment to perform procedures traditionally under the jurisdiction of one department. In the event that a practitioner requests privileges to perform a procedure not currently within the jurisdiction of his or her department, the practitioner will notify the Chief of Staff in writing. The notice must contain basis for such practitioner's determination that he or she is qualified for the requested privileges, including proof of training and number of procedures performed.

5.10-2 DETERMINATION OF APPROPRIATENESS

The Chief of Staff, with the approval of the Medical Executive Committee, will establish an interdisciplinary Ad Hoc Committee or request the Professional Review Committee to evaluate the request. The chairman of the Committee shall be a disinterested party currently not performing these procedures. The Committee shall give the affected practitioner and other interested persons an opportunity for an interview. After receipt of the Committee's report, the Medical Executive Committee will recommend to the Board whether interdisciplinary privileges are appropriate and, if applicable, the criteria and process for granting such privileges.

5.11 PRECEPTORSHIP PROGRAMS

5.11-1 STRUCTURE AND APPROVAL OF PROGRAMS

Preceptorship programs to train Medical Staff and Allied Health Staff members to qualify for privileges must be reviewed and approved by the Medical Executive Committee before being instituted. The Credentials Committee and Medical Executive Committee must review the content and number of cases to be observed and performed under supervision. The program must meet the education and training requirements for the privilege as stated in the Department's rules and regulations/privilege checklist.

5.11-2 PRECEPTORS

Preceptors must have been granted the appropriate privileges and have completed any required proctoring to be eligible to serve as a preceptor. Preceptors shall provide written, signed evaluations of each procedure supervised as part of a preceptorship program.

5.11-3 ADDITION OF CLINICAL PRIVILEGES

Upon receipt of documentation that the practitioner has satisfactorily completed the preceptorship program, including the supervision requirements for the privilege or procedure, the practitioner must submit a request for additional clinical privileges to the Medical Staff Services Office. Such request will be considered and acted upon in accordance with the Credentialing Manual. Such privileges will become effective once granted by the Board.

5.12 SPECIAL CONDITIONS

5.12-1 ORAL SURGEONS, DENTISTS AND PODIATRISTS

Surgical procedures performed by dentists and oral surgeons are under the overall supervision of the Clinical Service Chief of the Department of Surgery. Surgical

procedures performed by podiatrists are under the overall supervision of the Clinical Service Chiefs of the Department of Orthopedic Surgery. An oral surgeon or podiatrist who meets the requisite qualifications may be granted the privilege of performing a history and physical examination and assessing the medical risks of the proposed procedure to the patient but only in those instances where the patient has no known current unrelated medical problems. Where any medical problems exist, a physician member of the Medical Staff must perform a basic medical appraisal on such patient, must determine the risk and effect of any proposed surgical or special procedure, and must be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization. When significant medical abnormality is present, the final decision whether to proceed must be agreed upon by the oral surgeon, dentist or podiatrist and the physician consultant. The Clinical Service Chief will decide the issue in case of dispute. Where the patient is an inpatient, the oral surgeon, dentist or podiatrist must arrange for a physician member of the Medical Staff to be an attending physician.

5.13 TEMPORARY PRIVILEGES

5.13-1 CONDITIONS

Temporary privileges may be granted only in the circumstances and under the conditions described below, only to an appropriately licensed practitioner, only when the information available substantially supports a favorable determination regarding the requesting practitioner's qualifications, and only after the practitioner has satisfied the professional liability insurance requirement of these Bylaws. Special requirements of supervision and reporting may be imposed by the Chief of Staff or department Clinical Service Chief. Under all circumstances, the practitioner requesting temporary privileges must agree to abide by these Bylaws and the policies of the Medical Staff and Medical Center. Temporary privileges may be granted to an applicant for an initial 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. Any such renewal shall be made by the department Clinical Service Chief when the information available continues to support a favorable determination regarding the practitioner's application for membership and privileges.

5.13-2 CIRCUMSTANCES

Upon the recommendation of the Chief of Staff, department Clinical Service Chief or designee and Credentials Committee chairman or their respective designees, the CEO or designee may grant temporary privileges in the following circumstances:

(a) Pendency of Application: Temporary privileges may be granted to an applicant with a completed application that qualifies as a clean file (see §2.1 of the Credentials Manual). Temporary privileges may be granted to an applicant whose file has been approved by the Credentials Committee and is awaiting approval of the Medical Executive Committee and the Board. Under no circumstances may such privileges be granted or renewed if the application is still pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

(b) Care of Specific Patient: Temporary privileges may be granted to a practitioner for the care of a specific patient but only after receipt of a request for the specific privileges desired and confirmation of appropriate licensure, adequate professional liability insurance coverage and favorable results of the National Practitioner Data Bank query. Such temporary privileges may not be granted in more than (3) three instances in any 12 month period after which the practitioner must apply for staff

appointment, and are restricted to the care of specific patients for which they are granted.

(c) Coverage of Services: Where a service is not adequately covered to meet important 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 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.

(d) Teaching: Temporary teaching privileges may be granted for no more than five (5) days for each approved activity upon the recommendation of the Department Chair or Chief of Staff upon receipt of the following information: an Arizona license or Education Teaching license; documentation of the College of Medicine Dean's approval and invitation to demonstrate and perform medical procedures and surgical techniques; evidence of professional liability insurance in the amount required by the Board; documentation of compliance with health screening requirements; and a statement signed by the practitioner agreeing to comply with the Bylaws, the Code of Conduct and Banner policies and procedures, accepting responsibility and liability for all patient care activities performed and agreeing to abide by limitations placed on his/her activities.

5.13-3 **ADDITIONAL PROCEDURES**

Temporary privileges to obtain additional specific procedures approved to be performed at the Medical Center may be granted by the Department chair, subject to approval by the Medical Executive Committee and ratification by the Board, but only after the member has applied for the privileges and has provided documentation of appropriate training and recent experience as required by approved criteria.

5.13-4 **TERMINATION**

The CEO, Chief of Staff, department Clinical Service Chief, credentials chairman or Chief Medical Officer may terminate any or all of a practitioner's temporary privileges on the discovery of any information or the occurrence of any event of a nature that raises a question about a practitioner's professional qualifications. In the event of such termination, the practitioner's patients then in the Medical Center will be assigned to another practitioner. The wishes of the patient will be considered, where feasible, in choosing a substitute practitioner

5.13-5 **RIGHTS OF THE PRACTITIONER**

A practitioner is not entitled to the procedural rights afforded by these Bylaws because a request for temporary privileges is refused in whole or in part or because all or any portion of the temporary privileges are terminated, not renewed, restricted, suspended, or limited in any way. A physician who believes his or her temporary privileges were wrongly terminated may submit information to the Medical Executive Committee demonstrating why the termination was unwarranted. The Medical Executive Committee, in its sole discretion, shall decide whether to review the submission.

5.14 **DISASTER PRIVILEGES**

5.14-1 In the event of an officially declared emergency or disaster, any physician, dentist, nurse practitioner, or physician assistant may be granted temporary disaster privileges upon recommendation of the CEO, Chief Medical Officer, Chief of Staff or incident commander handling the disaster or their respective designee provided that the care, treatment, and services provided are within the scope of the individual's license. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:

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

Where the practitioner is not a member of an Arizona hospital's Medical Staff, a current Hospital employee or Medical Staff member must recommend the granting of such privileges. Such privileges expire within thirty (30) days or upon the termination of the disaster or completion of inpatient care, whichever occurs first, and may be terminated in accordance with Section 5.12-4**.** A practitioner is not entitled the procedural rights afforded by these Bylaws because a request for disaster privileges is refused or because such privileges are terminated or otherwise limited.

5.14-2 Primary source verification of licensure will begin as soon as the immediate situation is under control, and must be completed within 72 hours (or as soon as possible) from the time the volunteer begins working at the hospital. If not verified within 72 hours, the reason must be documented.

5.14-3 Oversight of the professional performance of volunteer practitioners who receive disaster privileges (e.g. direct observation, mentoring, clinical record review) will be the responsibility of the Chief of Staff, appropriate Department Clinical Service Chief, or other designee.

5.14-4 The CEO or designee will decide within 72 hours whether continuation or renewal of the disaster privileges is indicated. This decision is based upon information regarding the professional practice of the volunteer. The CEO, CMO or Chief of Staff may terminate any or all of a practitioner's disaster privileges on the discovery of any information or the occurrence of any event of a nature that raises a question about a practitioner's professional qualifications. In the event of such termination, the practitioner's patients then in the Hospital will be assigned to another practitioner.

5.14-5 Volunteer practitioners functioning under disaster privileges will be identified as such by wearing an identification badge provided upon the granting of privileges.

ARTICLE 6: PROFESSIONAL PRACTICE EVALUATION AND CORRECTIVE ACTION

6.1 PROFESSIONAL PRACTICE EVALUATION

The Medical Staff conducts Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) in accordance with Joint Commission requirements and Banner policy.

6.2 CRITERIA FOR INITIATING CORRECTIVE ACTION

Corrective action may be initiated against a practitioner if it appears that the practitioner does not meet the standards required by these Bylaws or any applicable Medical Staff policies, or if the practitioner is or may be engaged in a course of conduct, either within or outside the Medical Center, that is detrimental to patient care or lower than the standards or aims of the Medical Staff.

6.3 PROCEDURES FOR INITIATING FPPE OR AN INVESTIGATION LEADING TO POSSIBLE CORRECTIVE ACTION

(a) A request for an investigation and/or corrective action may be submitted to the Chief of Staff by any member of the Medical Staff, the CEO, or the Board. The request must be in writing and must be supported by reference to the specific activities or conduct forming the basis for the request.

(b) The Professional Review Committee or subcommittee thereof ("Professional Review Committee") shall consider the request and determine if an investigation is warranted or if a focused review should be conducted and recommended to the Medical Executive Committee. The Professional Review Committee may use one or more "evaluation tools" described below as part of FPPE or to determine if an investigation is warranted or, where an investigation is found to be warranted, to determine whether corrective action is necessary. Evaluation tools include but are not limited to an interview with the practitioner, concurrent or retrospective chart review, concurrent observation and/or consultation requirements. A practitioner's refusal to cooperate in an evaluation constitutes grounds for automatic suspension pursuant to Section 6.7-8 of these Bylaws. The practitioner has the right to an interview if he/she believes the Professional Review Committee should reconsider the use of any such evaluation tool. However, the practitioner is not entitled to the procedural rights afforded by these Bylaws because of the use of such tools. The Medical Executive Committee will be kept informed of the status of such investigations.

(c) Certain matters that may lead to FPPE or corrective action are routinely considered by each Medical Staff department and/or the Professional Review Committee as a part of their ongoing quality and performance improvement, clinical, administrative, and educational functions. When, as a result of fulfilling these functions, information comes to the attention of the department or the Professional Review Committee, the Professional Review Committee shall conduct a review as set forth herein, and no request for an investigation and/or corrective action is required.

6.4 PROCEDURE FOR PROFESSIONAL REVIEW

(a) Within 60 days of the determination by the Professional Review Committee that an investigation or corrective action may be warranted, the Professional Review Committee shall conclude an investigation and document its findings. If the findings warrant that corrective action be taken, the affected practitioner shall have an opportunity for an interview with the Professional Review Committee. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws shall apply thereto, including the right to be accompanied by counsel. A record of such interview shall be made and included with its report. In certain instances, the Professional Review Committee investigation may not be concluded within 60 days. In such instances, the investigation shall be concluded as soon as reasonably practical. The affected practitioner shall have no procedural rights arising out of such delay. After its deliberations, the Professional Review

Committee will make its recommendation, and if adverse, shall forward it to the Medical Executive Committee.

(b) If the Professional Review Committee recommends that corrective action be taken, the Medical Executive Committee shall review the recommendation to determine whether it is supported by substantial evidence and whether the Bylaws were followed. Prior to recommending reviewable corrective action, the Medical Executive Committee shall give the affected practitioner an opportunity for an interview. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws shall apply thereto, including the right to be accompanied by counsel. If the Medical Executive Committee recommends corrective action that is reviewable, the affected practitioner shall be given notice and a right to a hearing as set forth in these Bylaws.

6.5 SUMMARY SUPERVISION

6.5-1 INITIATION

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

(a) Chief of Staff or designee, acting as a member of and on behalf of the Medical Executive Committee;
(b) Chief Medical Officer;
(c) Member of the Professional Review Committee, acting on behalf of the Professional Review Committee;
(d) Applicable department Clinical Service Chief or designee, acting as a member of and on behalf of the applicable department committee;
(e) Chief Executive Officer or designee;
(f) Medical Executive Committee member, acting as a member of and on behalf of the Medical Executive Committee;
(g) The Professional Review Committee;
(h) Chairman of the Banner Board of Directors

6.5-2 REVIEW BY THE PROFESSIONAL REVIEW COMMITTEE

A practitioner whose clinical privileges have been placed under summary supervision by any two individuals identified in Section 6.4-1 (and not by the Professional Review Committee pursuant to Section 6.3) shall be entitled to request a review of the summary supervision by the Professional Review Committee or subcommittee thereof, having no less than three (3) members. The review must be requested, if at all, within 10 business days of the practitioner's receipt of notice of the supervision. Such review shall take place within 10 days of the request for review. Upon deliberation, the Professional Review Committee or subcommittee thereof may direct that summary supervision be terminated or continued.

6.6 SUMMARY SUSPENSION

6.6-1 INITIATION

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

(a) Chief of Staff or designee, acting as a member of and on behalf of the Medical Executive Committee;
(b) Chief Medical Officer;

(c) Member of the Professional Review Committee, acting on behalf of the Professional Review Committee;
(d) Applicable department Clinical Service Chief or designee, acting as a member of and on behalf of the applicable department committee;
(e) Chief Executive Officer or designee;
(f) Medical Executive Committee member, acting as a member of and on behalf of the Medical Executive Committee;
(g) The Professional Review Committee;
(h) Chairman of the Banner Board of Directors

A summary suspension is effective immediately upon imposition and until such time as a final decision is made regarding the practitioner's privileges. Summary suspension shall be followed promptly by special notice to the affected practitioner.

6.6-2 **REVIEW BY THE PROFESSIONAL REVIEW COMMITTEE AND MEDICAL EXECUTIVE COMMITTEE**

A practitioner whose clinical privileges have been summarily suspended shall be entitled to request a review of the summary suspension by the Professional Review Committee or a subcommittee thereof having no less than three (3) members. The review must be requested within 10 business days of the practitioner's receipt of notice of the suspension. Such review shall take place within 10 business days of the request for review, unless the Professional Review Committee has met with the practitioner. Upon deliberation, the Professional Review Committee or subcommittee thereof may direct that summary suspension be terminated or continued. Where the suspension is continued, the affected practitioner shall be entitled to request a review of the summary suspension by the Medical Executive Committee or a subcommittee thereof having no less than three (3) members. The review must be requested within 10 business days of the practitioner's receipt of notice of the Professional Review Committee's decision. Such review shall take place within 10 business days of the request for review.

6.6-3 **EXPEDITED HEARING RIGHTS**

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

6.6-4 **ALTERNATIVE COVERAGE**

Immediately upon imposition of summary suspension, the Chief of Staff, Chief Medical Officer, CEO, department Clinical Service Chief or their respective designees shall have the authority to arrange or provide for alternative medical coverage for the patients of the suspended practitioner who remain in the Medical Center. Patients' wishes shall be considered in the selection of an alternative practitioner.

6.7 **AUTOMATIC SUSPENSION OR LIMITATION**

When grounds exist for automatic suspension, the privileges of the practitioner will be automatically suspended without prior action by the Medical Executive Committee or the Board. Alternative medical coverage will be provided for patients as set forth in Section 6.5-4. The Chief of Staff will notify the practitioner of the suspension. In addition, further corrective action may be recommended in accordance with the provisions contained within these Bylaws whenever any of the following actions occur:

6.7-1 **LICENSE**

a. Revocation: Whenever a practitioner's license to practice in this State is revoked, Medical Staff appointment and clinical privileges are immediately and automatically revoked.

b. Restriction: Whenever a practitioner's license is limited or restricted in any way, those clinical privileges that are within the scope of the limitation or restriction are similarly immediately and automatically restricted.

c. Suspension: Whenever a practitioner's license is suspended, Medical Staff appointment and clinical privileges are automatically suspended for the term of the licensure suspension.

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

e. Expiration: Whenever a practitioner's license expire, Medical Staff appointment and clinical privileges are immediately and automatically suspended.

6.7-2 **DEA REGISTRATION**

Whenever a practitioner's DEA registration is revoked, restricted, suspended, or has expired**,** the practitioner's right to prescribe medications covered by the registration is similarly revoked, restricted, or suspended. Where the practitioner's practice necessitates the prescription of medications, the practitioner must arrange with other practitioner(s) to prescribe medications, as appropriate, for practitioner's patients.

6.7-3 **MEDICAL RECORDS**

A temporary suspension of privileges to admit patients or to schedule new procedures shall be imposed for failure to complete medical records within the time periods established by the Medical Executive Committee and designated in the Medical Staff Rules and Regulations. Such suspension shall not apply to patients admitted or already scheduled at the time of the suspension, to emergency patients, or to imminent deliveries. Hospitalists and Emergency Medical Physicians will not be scheduled for shifts if suspended. Temporary suspension shall be lifted upon completion of the delinquent records. Temporary suspension shall become automatic permanent suspension for failure to complete delinquent records within 60 cumulative days per calendar year. Affected practitioners may request reinstatement during a period of 30 calendar days following permanent suspension if the delinquent records have been completed. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

6.7-4 **PROFESSIONAL LIABILITY INSURANCE**

A practitioner's Medical Staff appointment and clinical privileges shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required under Section 3.112 of these Bylaws. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension, upon presentation of proof of adequate insurance. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

6.7-5 **FREEDOM FROM INFECTIOUS TUBERCULOSIS**

A practitioner's Medical Staff appointment and clinical privileges shall be immediately suspended for failure to provide evidence of freedom from infectious tuberculosis whenever such evidence is requested. Affected practitioners may request reinstatement during a period of 90 calendar days following suspension upon presentation of evidence

of freedom from TB. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for staff membership and privileges.

6.7-6 **FAILURE TO BE VACCINATED OR TO OBTAIN EXEMPTION**

A practitioner's Medical Staff clinical privileges shall be immediately suspended for failure to provide evidence of flu vaccination or an approved exemption granted by Banner or, where granted an exemption, for failure to wear a mask as required by Banner policy. Privileges will be reinstated when evidence of vaccination or an approved exemption is provided or at the end of flu season, whichever occurs first.

6.7-7 **EXCLUSION FROM MEDICARE/STATE PROGRAMS**

The CEO with notice to the Chief of Staff will immediately and automatically terminate the Medical Staff privileges of an Excluded Practitioner. An "Excluded Practitioner" is a practitioner whose name is listed on the then current "list of Excluded Individuals/Entities" maintained by the Office of Inspector General, Department of Health and Human Services or who has been barred from participation in any Medicare/State Program. A "Medicare/State Program" is any federal or state program, including Medicare, Medicaid, AHCCCS, Indian Health Service, or Tricare (formerly CHAMPUS) program.

6.7-8 **FAILURE TO PARTICIPATE IN AN INVESTIGATION OR FPPE.**

A practitioner who refuses or fails to cooperate in an evaluation or FPPE conducted pursuant to Section 6.3 shall be automatically suspended from exercising all clinical privileges with the exception of emergencies and imminent deliveries. Failure to appear within 3 months of the request to appear shall result in revocation of staff membership and privileges. Thereafter, the affected practitioner must reapply for staff membership and privileges.

6.7-9 **FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT**

A practitioner who fails without good cause to appear at a meeting where his or her special appearance is required, in accordance with Section 10.33, shall automatically be suspended from exercising all clinical privileges with the exception of emergencies and imminent deliveries. Failure to appear within 3 months of the request to appear shall result in revocation of staff membership and privileges. Thereafter, the affected practitioner must reapply for staff membership and privileges.

6.7-10 **FAILURE TO PAY STAFF DUES**

A practitioner who fails to pay staff dues as set forth in Section 12.3 shall automatically be suspended from the Medical Staff. If the dues are paid within 30 calendar days of notification of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.7-11 **FAILURE TO COMPLETE CPOE TRAINING OR ORIENTATION**

Failure to complete CPOE training and/or orientation will result in automatic suspension of privileges. Failure to complete such training and orientation within six (6) months of appointment to the Medical or Allied Health (if applicable) Staff will result in an automatic relinquishment of membership and privileges.

6.7-12 **FAILURE TO EXECUTE RELEASES AND/OR PROVIDE DOCUMENTS**

A practitioner who fails to execute a general or specific release and/or provide documents, as set forth in Section 11.4, during a term of appointment when requested by the Chief of Staff, department Clinical Service Chief or designee shall automatically be

suspended. If the release is executed and/or documents provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.7-13 **FAILURE TO PARTICIPATE IN AN EVALUATION**

A practitioner who fails to participate in an evaluation of his/her qualifications for Medical Staff membership and/or privileges shall automatically be suspended. If, within 30 days of the suspension, the practitioner agrees in writing to participate in the evaluation and does participate constructively, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.7-14 **FAILURE TO COMPLETE ASSESSMENTS AND PROVIDE RESULTS**

A practitioner who fails to complete a required educational assessment and/or training program and/or health (including psychiatric/psychological health) assessment and follow-up treatment or to provide a report of such findings shall automatically be suspended. If the report is provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.7-15 **FAILURE TO COMPLETE HEALTH SCREENING AND/OR OBTAIN FLU VACCINATION OR EXEMPTION**

A practitioner who fails to demonstrate compliance with health screening examinations or compliance with flu vaccination requirements shall be automatically be suspended. For failure to comply with flu vaccination requirements, the suspension will last until compliance is demonstrated or the flu season ends, whichever occurs first. If documentation of compliance with health screening examinations is provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

6.7-16 **FAILURE TO OBTAIN COVID-19 VACCINATION OR EXEMPTION**

As required by Banner policy, a practitioner's Medical Staff clinical privileges and membership will be automatically suspended for failure to provide evidence of Covid-19 vaccination, or an approved exemption granted by Banner Health. After 30 days, privileges will be deemed voluntarily resigned if documentation of Covid-19 vaccination or an approved exemption is not received.

6.7-17 **FAILURE TO COMPLETE ANNUAL TRAINING FOR USE OF RADIOACTIVE MATERIALS**

The failure of a practitioner who uses radiation or radioactive materials to complete the required annual training shall result in the automatic suspension of such practitioner's ability to use radiation or radioactive materials. Suspension shall continue until compliance is demonstrated.

6.7-18 **FAILURE TO BECOME/REMAIN BOARD CERTIFIED**

Whenever a practitioner's time period in which to become/remain board certified expires, the practitioner is deemed to have immediately and voluntarily relinquished his/her Medical Staff appointment and clinical privileges unless an exception exists as provided in these Bylaws or department rules and regulations.

6.7-19 **REMOVAL FROM CALL FOR FINANCIAL CONFLICTS**

A practitioner who transfers patients for medical care to any diagnostic or treatment facility in which the practitioner, his/her group, or his/her employer has a direct financial interest despite available services located on the hospital's campus may be removed from Emergency Room call by the CEO, the Chief Medical Officer or the Board absent evidence that the transfer request was initiated by the patient or by the patient's insurance carrier. Removal from call under this section does not preclude the imposition of other corrective action as a result of inappropriate transfers.

6.7-20 **FAILURE TO OBTAIN NPI AND ENROLL IN PECOS/OPT OUT OF MEDICARE**

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

6.8 HEARING AND APPEAL RIGHTS

6.8-1 **HEARINGS AND APPEALS**

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

6.8-2 **FAIR HEARING PLAN**

When hearing rights are triggered, the practitioner is notified of the grounds for the adverse action or recommendation and his/her right to request a hearing by submitting a written request to the CEO within 30 days.

6.8-3 **HEARING PANEL**

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

6.8-4 **SCHEDULING THE HEARING**

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

6.8-5 **HEARING PROCESS**

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

6.8-6 **SCHEDULING THE APPEAL**

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

6.8-7 **APPEAL PROCESS**

The practitioner has the burden of demonstrating, by preponderance of the evidence, that the hearing was not in substantial compliance with the procedures required by the Medical Staff Bylaws, or applicable law, and created demonstrable prejudice; or the adverse recommendation or action was arbitrary, capricious, or not supported by substantial evidence based upon the Hearing Record. Thereafter, the Medical Executive Committee may present evidence in support of the reconsidered recommendation or action.

6.9 **NONREVIEWABLE ACTION**

Not every action entitles the practitioner to rights pursuant to the Fair Hearing Plan. Those types of corrective action giving rise to automatic suspension as set forth in Section 6.7 are not reviewable under the Fair Hearing Plan. In addition, the following occurrences are also nonreviewable under the Fair Hearing Plan:

(a) Imposition of supervision pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.
(b) Issuance of a warning or a letter of admonition or reprimand.
(c) Imposition of monitoring of professional practices, other than direct supervision, for a period of 6 months or less.
(d) Termination or limitation of temporary privileges or disaster privileges.
(e) Supervision and other requirements imposed as a condition of granting privileges.
(f) Termination of any contract with or employment by the Medical Center(s) or Banner.
(g) Any recommendation voluntarily imposed or accepted by a practitioner.
(h) Denial of membership and privileges for failure to complete an application for membership or privileges.
(i) Denial or termination of community-based affiliation.
(j) Removal of membership and privileges for failure to complete supervision within the time period granted by these Bylaws.
(k) Removal of membership and privileges for failure to become or remain board certified as required by these Bylaws.
(l) Removal of membership and privileges for failure to submit an application for reappointment within the allowable time period.
(m) Reduction or change in staff category.
(n) Refusal of the credentials committee, department, or Medical Executive Committee to consider a request for appointment, reappointment, staff category, department assignment, or privileges within two years of a final adverse decision regarding such request.
(o) Removal or limitation of Emergency Department call obligations.
(p) Any requirement to complete an educational assessment or training program.
(q) Imposition of a consultation requirement pending completion of an investigation to determine if corrective action is warranted or pending exhaustion of due process rights.
(r) Any requirement to complete a health and/or psychiatric/psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.

(s) Retrospective chart review.
(t) Denial, removal or limitation of membership and/or privileges as a result of (1) the decision of the CEO to enter into, terminate or modify an exclusive contract for certain clinical services; or (2) the termination or modification of the practitioner's relationship with the exclusive provider.
(u) Grant of conditional appointment/reappointment or appointment/reappointment for a limited duration.
(v) Termination or limitation of membership or privileges based upon a limitation in the type or extent of clinical services which may be provided to Medical Center inpatients from a remote location.
(w) Denial or termination of appointment to the Faculty.

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

ARTICLE SEVEN: GENERAL STAFF OFFICERS

7.1 GENERAL OFFICERS OF THE STAFF

7.1-1 IDENTIFICATION

The general officers of the staff are:
(a) Chief of Staff
(b) Chief of Staff Elect
(c) Immediate Past Chief of Staff (ex officio)
(d) Secretary/Treasurer

7.1-2 QUALIFICATIONS

(a) Each general officer must:
   a. Be a member of the active staff at the time of nomination and election and remain a member in good standing during his or her term of office.
   b. Have demonstrated ability through experience and prior participation in staff activities and be recognized for a high level of clinical competence.
   c. Have demonstrated a high degree of interest in and support of the Medical Staff and the Medical Center.
   d. Be able and willing to fully discharge the duties and exercise the authority of the office held and work with the other general and department officers of the Medical Staff, the CEO, and the Board.
   e. Not have a disabling conflict of interest with the Medical Staff or Medical Center as determined by the Medical Executive Committee.
(b) A practitioner may not hold simultaneously two or more general staff offices.
(c) The provisions of this Article relating to qualifications, nomination, election and term of office do not apply to the initial general staff officers.

7.2 TERM OF OFFICE

The term of office of general staff officers is two years. Officers shall assume office on the first day of January following their election, except that an officer appointed to fill a vacancy assumes office immediately upon appointment and serves for the remainder of the unexpired term. Each

officer serves until the end of his or her term and until a successor is elected, unless such officer sooner resigns or is removed from office.

7.3 ELIGIBILITY FOR REELECTION

A general staff officer is eligible for nomination and reelection in succeeding terms, not to exceed a total of two successive two-year terms.

7.4 NOMINATIONS

7.4-1 NOMINATING COMMITTEE

The General Officers of the Staff and department chairs shall serve as the nominating committee. The Nominating Committee will develop a slate of nominees, which shall include at least one candidate for each office. Nominees for the Chief Elect must have served on a medical staff committee for at least one year. Nominees must disclose interests that potentially compete with the interests of the Medical Staff and/or the Medical Center, including ownership and financial interests in competing facilities or employment or contractual relationships with the Medical Center or with competing facilities. At the July meeting of the Medical Executive Committee, the Nominating Committee shall present for information the list of nominations to the Medical Executive Committee and the CEO. The Secretary shall give written notice of the nominations to all active staff members of the Medical Staff.

7.4.2 NOMINATION BY MEDICAL STAFF

Nominations may also be made before the July Medical Executive Committee meeting by any voting member of the Medical Staff if evidence is presented that the potential nominee meets the qualifications for office and consents to the nomination. Such nominees must also disclose potential conflicts of interest.

7.5 ELECTIONS, VACANCIES, AND REMOVALS

7.5-1 ELECTION PROCESS

The Medical Executive Committee shall conduct all elections, both regular and special, and shall be in charge of all matters pertaining thereto. The candidate receiving the highest number of votes via electronic and/or mail ballot vote of members of the Active Staff is elected. In the case of a tie, a majority vote of the Medical Executive Committee shall decide the election.

7.5-2 VACANCIES IN ELECTED OFFICES

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

7.5-3 RESIGNATIONS AND REMOVAL FROM OFFICE

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

(b) Removals: removal from office may be initiated only by the Medical Executive Committee or by petition signed by at least one-third of the active staff members, for failure to maintain qualifications of the office as outlined in Bylaws Section 7.1-2 and/or uphold the duties of the office as outlined in Bylaws Section 7.6 or for any other reason. Such removal shall be considered at a meeting of the Medical Executive Committee if initiated by the Medical Executive Committee. If initiated by petition, such removal shall be considered at a special meeting of the Medical Staff as provided in Section 10.12, for the purpose of considering and acting upon the

request for removal. Removal shall require a two-thirds vote of the voting members present at the special meeting and shall be effective immediately upon tabulation of the vote by the Secretary or his/her designee.

7.6 DUTIES OF OFFICERS

7.6-1 CHIEF OF STAFF

The chief of staff shall serve as the highest elected officer of the Medical Staff to:

(a) enforce the Bylaws and implement sanctions where indicated;
(b) call, preside at, and be responsible for the agenda of all general staff meetings, meetings of the Medical Executive Committee;
(c) serve as an ex officio member of all other staff committees without vote. If membership in a particular committee is specified by these Bylaws, he or she shall have a vote;
(d) appoint, with the consultation of the Medical Executive Committee, members for all standing and special Medical Staff or multidisciplinary committees, and designate the chairman of these committees;
(e) interact with the CEO and Chief Medical Officer in all matters of mutual concern within the Medical Center;
(f) represent the views and policies of the Medical Staff to the CEO;
(g) be a spokesman for the Medical Staff in external professional affairs;
(h) perform such other functions as may be assigned to him or her by these Bylaws, by the Medical Staff, or by the Medical Executive Committee;
(i) receive and act upon requests of the Board to the Medical Staff; and
(j) report to the Board on the performance and maintenance of quality with respect to the Medical Staff's delegated functions to promote quality patient care;
(k) serve on the Banner Peer Review Council;
(l) meet and discuss with the Board Subcommittee any matters of concern to the Medical Staff.

7.6-2 CHIEF OF STAFF-ELECT

The Chief Elect shall assume all duties and authority of the Chief of Staff in his or her absence or in the event of a conflict. The Chief Elect shall be a member of the Medical Executive Committee or a member of the medical staff with established leadership experience as determined by the Medical Executive Committee and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the Medical Executive Committee.

7.6-3 IMMEDIATE PAST CHIEF OF STAFF

The immediate past chief of staff shall be an ex officio member of the Medical Executive Committee and shall perform such duties as may be assigned by the Chief of Staff or delegated by these Bylaws or by the Medical Executive Committee.

7.6-4 SECRETARY/TREASURER

The secretary/treasurer shall be a member of the Medical Executive Committee. As secretary, he/she shall determine that accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings are maintained. As treasurer, he/she shall safeguard all funds of the Medical Staff. The secretary/treasurer shall perform all such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or the Medical Executive Committee.

ARTICLE EIGHT: CLINICAL DEPARTMENTS

8.1 CURRENT CLINICAL DEPARTMENTS

The Medical Staff shall be divided into fifteen clinical departments: the Departments of Anesthesiology, Emergency Medicine, Family Medicine, Medicine, Neurology, OB/GYN, Ophthalmology, Orthopedic Surgery, Otolaryngology, Pathology, Pediatrics, Psychiatry, Radiation Oncology, Radiology, and Surgery. Each department shall be organized as a separate component of the Medical Staff and shall have a chairman entrusted with the authority, duties, and responsibilities as specified in this Article. A department may be further divided into Sections that shall be directly responsible to the department within which they function, and that shall have a Section chief appointed by the Department Clinical Service Chief and entrusted with the authority, duties, and responsibilities specified in this Article. When appropriate, the Medical Executive Committee may recommend the creation, elimination, modification, or combination of departments or sections. Such recommendation shall become effective upon Board approval and shall not require formal amendment of these Bylaws.

8.2 ASSIGNMENT TO DEPARTMENTS

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

8.3 FUNCTIONS OF DEPARTMENTS

Departments shall continually seek to improve quality of care for all patients through an effective peer review process as defined by Medical Staff policy. Each department shall:

(a) develop, approve and review annually clinically relevant quality and appropriateness parameters and criteria/indicators including medication use, blood use, operative/invasive review, unexpected deaths and identification of known or potential problems that have an adverse effect on patient care and recommend appropriate action to the Medical Executive Committee.

(b) develop recommendations for the qualifications and credentialing criteria appropriate to obtain and maintain clinical privileges in the department and its sections.

(c) establish and implement clinical policies and procedures, and monitor its members' adherence to them.

(d) identify and engage in opportunities for education and process improvement.

(e) participate in Banner clinical initiatives and assist with the adoption of appropriate clinical standards to facilitate improved aggregated clinical outcomes and patient safety as determined by the Medical Staff and Banner;

(f) adopt rules and regulations to clarify or expand these Bylaws to meet the needs of its particular area of practice. Department rules and regulations shall not conflict with these Bylaws and shall be subject to approval by the Medical Executive Committee and the Board. Any rule, regulation or policy that may be temporarily adopted on an emergency basis shall be approved by the Chief of Staff prior to communication or enforcement.

(g) meet at least quarterly to consider the results of the aggregated quality/appropriateness review and any other review and evaluation activities, make recommendations relating thereto and to provide a forum for discussion of matters of concern to its members.

(h) work with the Medical Executive Committee and CEO to assure adequate on-call coverage for emergency patients consistent with the physician resources available within the department.

(i) be responsible for the conducting of continuing education within the department.

(j) coordinate the professional services of its members with those of other departments and with Medical Center nursing and support services.

(k) participate in budgetary planning pertaining to department activities including but not limited to space and resources with Medical Center administration, including the review of new technologies.
(l) support the utilization management program by conducting reviews for appropriateness of admissions, level of care, continued stays, procedures, testing and treatment, discharges and transfers.
(m) establish a department committee and any subcommittees as are necessary to perform functions required of it. The composition and method of selection of the department committee and subcommittee members shall be defined within the department rules and regulations.

8.4 DEPARTMENT OFFICERS

8.4-1 QUALIFICATIONS

Each department shall have a Clinical Service Chief who is head of the College of Medicine department or his/her designee. Each Clinical Service Chief shall be and remain, during his or her term, a member in good standing of the active Medical Staff and board certified by an appropriate specialty board or must demonstrate comparable competence. Each Clinical Service Chief shall demonstrate a high degree of interest in and support of the Medical Staff and Medical Center.

Departments will also have a vice Clinical Service Chief who is appointed by the Department Clinical Service Chief. Departments may also have sections. Section chiefs are appointed by the Clinical Service Chief.

8.4-2 TERM OF OFFICE

The term of the department chairmen shall be co-terminus with their term as head of the College of Medicine department. The term of the department vice chair and section chiefs shall continue until removed by the department Clinical Service Chief.

8.4-3 REMOVAL

The department chairmen may be removed by the Dean of the College of Medicine. Where the College of Medicine department Clinical Service Chief appoints a designee, such designee may be removed the College of Medicine department chairman.

8.4-4 DUTIES OF CLINICAL SERVICE CHIEF

Each Clinical Service Chief shall have the authority, duties, and responsibilities listed below:

(a) Act as presiding officer at department meetings;
(b) Be a member of the Medical Executive Committee and account to the Medical Executive Committee for all administrative and clinically related activities within the department;
(c) Monitor and evaluate the quality and appropriateness of patient care and professional performance rendered by practitioners with clinical privileges in the department;
(d) Recommend to the Medical Executive Committee and implement department rules and regulations, criteria for credentials review and privileges delineation, programs for orientation and continuing medical education, and improvement in quality of care, treatment, services and utilization management;
(e) Provide guidance on overall medical policies of the Medical Center, and make specific recommendations regarding the department;
(f) Recommend the clinical privileges and staff category of practitioners who are members of or applying to the department;

(g) Refer to the Professional Review Committee issues relating to professional conduct and the quality and appropriateness of patient care and professional performance.
(h) Enforce the Bylaws, rules and regulations, and policies of the department and the Medical Center;
(i) Implement, within the department, actions directed by the Medical Executive Committee or the Board;
(j) Participate in every phase of administration of the department, including cooperation with the nursing service and Medical Center administration;
(k) Appoint such committees as are necessary to conduct the functions of the department;
(l) Appoint such chairmen or committee members as required by these Bylaws and department rules and regulations;
(m) Perform such other duties as may be reasonably requested by the Chief of Staff or the Medical Executive Committee;
(n) Assess and recommend to the Medical Executive Committee and the CEO off-site sources for needed patient care, treatment, and services not provided by the department or the Medical Center;
(o) Assess and recommend to the Medical Executive Committee and the CEO a sufficient number of qualified and competent persons to provide care, treatment, and service; and
(p) Ascertain the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

8.4-5 **DUTIES OF SECTION CHIEFS**

Each section chief shall have the authority, duties, and responsibilities listed below:
(a) Act as presiding officer at section meetings;
(b) Implement and supervise, in cooperation with the Department chair and other appropriate Medical Center and Banner staff, quality management functions assigned to the section;
(c) Maintain continuing review of patient care, professional performance and conduct of practitioners with clinical privileges in the section;
(d) Recommend criteria for privileges in the section;
(e) Make recommendations regarding appointment, reappointment and clinical privileges for practitioners seeking privileges within the section;
(f) Ascertain the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services in the section;
(g) Perform such other duties as may be reasonably requested by the Chief of Staff or the Medical Executive Committee.

ARTICLE NINE: COMMITTEES

9.1 **DESIGNATION**

The committees described in this Article or in the Medical Staff Rules and Regulations shall be the standing committees of the Medical Staff. The Chief of Staff may appoint other standing committees for specific purposes, the descriptions of which will be contained in the Medical Staff Rules and Regulations. When appropriate, the Medical Executive Committee may recommend the creation, elimination, modification, or combination of committees. Such recommendation shall become effective upon Board approval and shall not require formal amendment of these Bylaws.

In addition, special or ad hoc committees may be appointed for specific purposes by the Chief of Staff; such appointment will cease upon the accomplishment of the purpose of the committee. Such special or ad hoc committees shall report to the Medical Executive Committee. The Medical Executive Committee may waive minimum composition requirements for the first year of operation.

9.2 GENERAL PROVISIONS

9.2-1 EX OFFICIO MEMBERS

The Chief of Staff, Chief Medical Officer, the CEO or their respective designees and Medical Directors as consistent with their contract duties are ex officio members of all standing and special committees of the Medical Staff. Professional Review Committee members may serve as ex-officio appointee(s) with vote on committees of the Medical Staff if and as requested by the Chief of Staff, CMO or CEO. Residents will be appointed to standing and special committees as appropriate without vote.

9.2-2 SUBCOMMITTEES

Any standing committee may elect to perform any of its specifically designated functions by appointing a subcommittee which reports its recommendations to the parent committee. Any such subcommittee may include individuals appointed by the committee chairman who are not members of the standing committee.

9.2-3 SPECIAL OR STANDING INTERDISCIPLINARY COMMITTEES

When a procedure or group of procedures is performed on a regular basis by members of more than one clinical department, the Medical Executive Committee may create a committee to recommend privileges and develop regulations in regard to the performance of those procedures. The formed committee may carry out peer review and make recommendations to the Professional Review Committee.

9.2-4 APPOINTMENT OF MEMBERS AND CHAIRMEN

Except as otherwise provided, the Chief of Staff shall appoint, in consultation with the Medical Executive Committee, the members and chairman of any Medical Staff committee formed to accomplish Medical Staff functions. The chairmen of all committees shall be members of the Active Staff.

9.2-5 TERM, REMOVAL, AND VACANCIES

(a) Except as otherwise provided, committee members and chairmen shall be appointed by the Chief of Staff for a term of two years or until the member's successor is appointed, unless such member or chairman sooner resigns or is removed from the committee.

(b) A Medical Staff member serving on a committee, except one serving ex officio, may be removed by the Chief of Staff from the committee for failure to remain as a member of the staff in good standing, for failure to satisfy the attendance requirements specified in Section 10.3, or by action of the Medical Executive Committee. A committee member removed by the Chief of Staff or the Medical Executive Committee action shall have the right to an appearance before the Medical Executive Committee to request reconsideration of the removal.

(c) Recall of non-elected MEC members may be initiated by a petition, submitted to the Dean of the University of Arizona, College of Medicine, specifying the charges against the individual and signed by at least one-third of the members of the Medical Staff eligible to vote. The decision of the Dean shall be final. If the Dean approves the recall of a non-elected MEC Member, the Dean shall appoint a replacement.

(d) A vacancy in any committee may be filled for the unexpired portion of the term in the same manner in which the original appointment was made.

9.2-6 **VOTING RIGHTS**

Each Medical Staff committee member shall be entitled to one vote on committee matters unless disallowed by staff category. Medical Center personnel assisting the Medical Staff in performance of the functions of the committee shall have no voting rights.

9.3 **MEDICAL EXECUTIVE COMMITTEE**

The Medical Executive Committee acts as the organizational body which oversees the functions and duties of the Medical Staff. It is empowered by the organized medical staff to act for the Staff, to coordinate all activities and policies of the Staff, its Departments and Committees and is actively involved in ensuring excellent patient care.

9.3-1 **COMPOSITION**

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

(a) Chief of Staff, as chairman
(b) Vice-Chief of Staff
(c) Secretary/Treasurer
(d) Immediate Past Chief of Staff (ex officio, with vote)
(e) Department Clinical Service Chiefs or their designees
(f) Credentials Committee Chairman
(g) Two at-large members of the Medical Staff
(h) Hospitalists (ex officio with vote)
(i) Chief Medical Officer (ex officio with vote)
(j) Chief Executive Officer (ex officio without vote)
(k) Chief Nursing Officer (ex officio without vote)
(l) Other representation as necessary, may be appointed by the Chief of Staff and approved by majority vote of the Medical Executive Committee (ex officio, without vote)

Chairmen of standing committees may be invited to meetings of the Medical Executive Committee as appropriate (without vote).

9.3-2 **ELECTIONS, TERMS, VACANCIES, AND REMOVALS**

(a) **ELECTIONS**

The Medical Staff officers and Members at Large shall be elected in the manner prescribed in Section 7.5. Department chairmen shall be designated in the manner prescribed in Section 8.4.

(b) **TERMS OF OFFICE**

With the exception of ex officio members, all members of the Medical Executive Committee shall serve a two year term. General staff officers shall serve terms that terminate December 31 in odd-numbered years. Members serving on the Medical Executive Committee by virtue of appointment by the Chief of Staff shall serve two year terms that terminate on December 31 in odd-numbered years. The Chief of Staff may appoint these members to subsequent two-year terms with approval of the Medical Executive Committee, or appoint new members, with approval of the Medical Executive Committee.

(c) **REMOVALS AND VACANCIES**

Removals and vacancies of general staff officers, department chairmen, and other Medical Executive Committee members, will be handled in the manners prescribed in

Section 7.5, Section 8.4 and Section 9.2-5, respectively. Vacancies among at-large members may be filled by appointment by the Chief of Staff with approval of the Medical Executive Committee.

9.3-3 **DUTIES**

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

(a) Act on all matters of Medical Staff business, except for the election or removal of general staff officers and for the approval of Medical Staff Bylaws. The Medical Executive Committee may act on behalf of the Medical Staff between meetings of the Medical Staff within the scope of its authority as set forth herein;
(b) Receive and act upon reports and recommendations from Medical Staff departments and committees, and other assigned activity groups;
(c) Make recommendations to the Board of Directors regarding the organized medical staff structure, and the process used to review credentials and delineate privileges;
(d) Coordinate and implement the professional and organizational activities and policies of the Medical Staff, including but not limited to the review of department and committee policies and procedures, the review of department and committee reports, the determination of dues and assessments of members; responsibility for the investment and expenditure of Medical Staff funds which shall be exclusively for purposes permitted by the IRS and consistent with the responsibilities of the Medical Staff.
(e) Review aggregate quality performance data and make recommendations for quality improvement;
(f) Review quality parameters and indicators recommended by departments, Care Management and/or Banner;
(g) Account to the Board for the quality and efficiency of medical care provided to patients in the Medical Center, including a summary of specific findings, actions, and results and including an assessment of the quality of services rendered pursuant to contract; and for the other responsibilities delegated by the Board to the Staff;
(h) Represent the views of the Medical Staff to the Board and make recommendations to the CEO and to the Board on Medical Center medico-administrative matters;
(i) Review the qualifications, credentials, performance, delineation of privileges and professional competence and character of Medical Staff applicants and members and make recommendations to the Board regarding such matters;
(j) Review quality issues regarding contracted services and make recommendations to the CEO as necessary.
(k) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members;
(l) Designate such committees as may be appropriate to assist in carrying out the duties and responsibilities of the Medical Staff and provide consultation to the Chief of Staff in the appointment of members to such committees; and
(m) Assist in obtaining and maintaining regulatory compliance of the Medical Center.
(n) Review and act on information derived from Risk Management, incident reports, and trend analysis, concurrent and retrospective, to effectively maintain a safe patient environment and reduce liability;
(o) Make recommendations to the Medical Staff for the approval of, use of, and material changes in format of the medical record;
(p) Provide oversight for the Utilization Review process, including review and approval of the annual Utilization Review Plan.
(q) Act on behalf of the organized medical staff.

9.3-4 **MEETINGS**

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

9.3-5 **ATTENDANCE REQUIREMENTS**

All members of the Medical Executive Committee are required to attend. If any Department Chair is unable to attend, he/she shall arrange in advance for the attendance of the Vice-Clinical Service Chief of the Department or designee. When a member fails to attend or send a designee to three meetings consecutively or a minimum of 50% of the meetings, he/she will be contacted by the Chief of Staff who may appoint a representative for the Medical Executive Committee to replace that member.

9.4 PROFESSIONAL REVIEW COMMITTEE

9.4-1 COMPOSITION

The Professional Review Committee (PRC) shall consist of at least five members, including the Chief Medical Officer who shall serve as Chairman. The Chairman shall designate a member or members of the Committee as Vice-Chair(s). Members shall be members of the medical staff engaged to assist the Medical Staff in the performance of its functions and duties, including its peer review and quality improvement activities. The Chief of Staff and CEO shall serve as ex officio members of the PRC (the CEO without vote). Members shall be appointed for staggered terms of three years and may be appointed for successive terms. For the initial term, members may be appointed for a term less than three years.

9.4-2 QUALIFICATIONS

PRC members (except the Chief Medical Officer) must continuously satisfy the qualifications and complete the requirements set forth in Section 3.1. Such members must demonstrate leadership skills and may not have disabling conflicting interests.

9.4-3 SELECTION AND REVIEW PROCESS

The Chief of Staff and the CMO shall assemble a slate of nominees to serve on the PRC and present it to the Medical Executive Committee, which shall select the members. The Medical Executive Committee will periodically review the performance of PRC members and may remove any member for failure to maintain qualifications as outlined in Bylaws Section 9.4-2 and/or uphold the duties of the position as outlined in Bylaws Section 9.4-4 or for any other reason.

9.4-4 DUTIES

The duties of the Professional Review Committee are to:

(a) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members;
(b) Enforce the Bylaws, rules and regulations, and policies of the department and the Medical Center;
(c) Review sentinel events, near misses, and complex clinical issues;
(d) Review potential conflicts of interest and recommend actions to address actual conflicts;
(e) Investigate, review and resolve complaints of disruptive conduct by any of member of the Medical and Allied Health Professional Staff;
(f) Serve as a resource for moral and ethical issues;
(g) Monitor and evaluate the quality and appropriateness of patient care and professional performance and conduct and assign ratings based upon such evaluations;
(h) Seek peer review assistance from external sources if and when the PRC determines that such assistance is appropriate and/or necessary.

(i) Review aggregate quality performance data of individual physicians and make recommendations for quality improvement in the context of peer review;
(j) Share information with the Departments and Committees to provide opportunities for learning and process improvement;
(k) Review professional competence issues identified as part of its ongoing quality and performance improvement, clinical, administrative and educational functions as well as issues referred from a department chair, Medical Director or Chief Medical Officer;
(l) Implement investigative and precautionary tools as required, including requiring educational/health assessments, supervision, consultation and suspension as warranted
(m) Recommend to the Medical Executive Committee as required the limitation, revocation or termination of Medical Staff membership and/or privileges;
(n) Establish a subcommittee or subcommittees as are necessary to perform its duties. Members of subcommittees may include practitioners who are not members of the PRC and/or who are not members of the Medical Staff.
(o) Serve as ex officio appointee(s) with vote on committees of the Medical Staff if and as requested by the Chief of Staff or CEO.

9.5 CREDENTIALS COMMITTEE

9.5-1 COMPOSITION

The Credentials Committee shall consist of at least three active staff members appointed by the Chief of Staff, one of whom shall be designated by the Chief of Staff as chairman, and a representative of Medical Center administration.

9.5-2 DUTIES

The duties of the Credentials Committee are to examine the qualifications of each applicant to determine whether all qualifications for staff membership have been met. It shall forward applications recommended for privileges to the clinical departments or sections in which privileges have been requested.

9.6 BYLAWS COMMITTEE

9.6-1 COMPOSITION

The Bylaws Committee shall consist of at least three members appointed by the Chief of Staff, one of whom shall be designated by the Chief of Staff as chairman. Committee will meet as necessary.

9.6-2 DUTIES

The duties of the Bylaws Committee are to:
(a) conduct a review of the Bylaws at least every two (2) years or more frequently when deemed necessary;
(b) submit to the Medical Executive Committee recommendations for changes in the Bylaws; and
(c) receive and evaluate, for recommendation to the Medical Executive Committee, suggestions for modifying the Bylaws.

9.7 PROFESSIONAL WELLNESS COMMITTEE

9.7-1 COMPOSITION

The Professional Wellness Committee is a multifacility committee which shall consist of a chairman or designee and at least two other members. When possible the Committee shall include at least one member in recovery and one behavioral health professional.

9.7-2 DUTIES

The duties of the Professional Wellness Committee are to:

(a) provide ongoing education to the Medical Staff, Hospital Staff and Administrative leaders regarding physician and AHP health, impairment recognition issues, types and levels of impairment, problems associated with impairment, resources available for the diagnosis, prevention, treatment and rehabilitation of impairment, and the process for referral to the committee, while maintaining informant confidentiality if requested and whenever possible;
(b) evaluate the credibility of a complaint, allegation, or concern;
(c) maintain confidentiality of the practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened;
(d) recommend available resources for diagnosis and/or treatment of physicians and AHP experiencing possible illness and impairment issues;
(e) serve as a resource for physicians and AHPs experiencing illness and impairment issues;
(f) assist the Medical Staff in evaluating potential illness and impairment and in monitoring ongoing compliance with treatment recommendations which may include a signed monitoring agreement;
(g) assist Medical Staff leadership with an intervention, when so requested by a department Clinical Service Chief or Chief of Staff/designee;
(h) recommend to the affected practitioner that either a psychological, psychiatric and/or physical examination is obtained;
(i) ensure the recommendations of the committee/subcommittee are followed;
(j) monitor the practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required;
(k) require the affected practitioner to obtain a report from his or her treating physician/psychologist stating the practitioner is able to engage safely in the practice of medicine and obtain subsequent periodic reports from his or her treating physician/psychologist for a period of time specified by the Professional Wellness Committee or appropriate department Clinical Service Chief; and
(l) advise the appropriate Department Clinical Service Chief /Medical Executive Committee of instances in which a practitioner is providing unsafe treatment or if an affected practitioner fails to adhere with the committee's recommendations.
(m) initiate appropriate actions when a practitioner fails to complete the required rehabilitation program.

9.8 INFECTION PREVENTION COMMITTEE

9.8-1 COMPOSITION

The Infection Prevention is a multidisciplinary committee which shall consist of a Chairman appointed by the Chief of Staff, with MEC approval, and at least three other members of the medical staff, and hospital representatives including an infection prevention representative and ad hoc members as necessary.

9.8-2 DUTIES

The duties of the Infection Prevention Committee are to:
(a) support and directing the Infection Prevention Program;
(b) review and analyzing findings from the Infection Prevention Plan indicators;
(c) implement measures to prevent infections and optimize care;
(d) assess current and future risks from infection;
(e) review and revise policies and procedures related to the Medical Center's Infection Prevention Program;
(f) implement plans to protect patients, visitors and staff;

(g) present recommendations to the appropriate medical staff committee and/or the Medical Executive Committee.

9.9 PHARMACY & THERAPEUTICS COMMITTEE

9.9-1 COMPOSITION

The Pharmacy & Therapeutics Committee is a multidisciplinary committee which shall consist of a Chairman appointed by the Chief of Staff, with MEC approval, and at least three other members of the medical staff, and hospital representatives from Pharmacy Services and Administration and ad hoc members as necessary.

9.9-2 DUTIES

The duties of the Pharmacy & Therapeutics Committee are to:

(a) recommend or assisting in the formulation of programs designed to meet the needs of the professional staff (physicians, licensed independent practitioners, nurses, pharmacists) for complete current information on matters related to medications and pharmaceutical care (i.e. Medication Use Evaluation and Improving Organizational Performance);
(b) serve in an advisory capacity to the Medical Staff and hospital administration in all matters pertaining to the safe use of medications;
(c) serve in an advisory capacity to the Medical Staff and Pharmacy Department in the selection or choice of medications which meet the most effective therapeutic quality standards;
(d) evaluate objectively the clinical data regarding new medications or agents proposed for use in the hospital;
(e) develop a formulary of accepted medications for use in the hospital and provide for continued review;
(f) participate in the formulation and analysis of Medication Use Evaluations;
(g) review and approving pharmacy policies and procedures;
(h) review adverse drug reactions reports and making appropriate recommendations;
(i) review medication occurrence reports and pharmacy intervention activities and making appropriate recommendations;
(j) present recommendations to the appropriate medical staff committee and/or the Medical Executive Committee.

9.10 ETHICS COMMITTEE

9.10-1 COMPOSITION

The Ethics Committee is a multifacility, interdisciplinary group composed of representatives from Banner hospitals. The Committee includes physicians, nurses, social workers, clergy and at least one lay representative and may include other members.

9.10-2 DUTIES

The Ethics Committee offers consultative services for ethical issues, questions or dilemmas related to patient care. The Committee is available to consult with families, patients, health care professionals and hospital employees desiring assistance with ethical decision making. The Committee shall also serve as the Infant Care Review Committee under A.R.S. §36-2284.

ARTICLE TEN: MEETINGS

10.1 MEDICAL STAFF MEETINGS

10.1-1 REGULAR MEETINGS

General staff meetings will be held at least annually.

10.1-2 SPECIAL MEETINGS

A special meeting of the Medical Staff may be called by the Chief of Staff, the Medical Executive Committee, or the Board. The Chief of Staff will call for such a meeting upon petition signed by 10% of the members of the active staff.

10.2 CLINICAL DEPARTMENT AND COMMITTEE MEETINGS

10.2-1 REGULAR MEETINGS

Clinical departments and committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution is required. A department must meet as often as necessary to conduct department business.

10.2-2 SPECIAL MEETINGS

A special meeting of any department or committee may be called by the chairman thereof, and must be called by the chairman at the written request of the Chief of Staff, or the Medical Executive Committee. A notice of such special meeting will be sent to all members of the department or committee. Advanced notice of at least two days of such special meeting will be given to all members of the department or committee except the Professional Wellness Committee, the Professional Review Committee and the Medical Executive Committee.

10.2-3 EXECUTIVE SESSION

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

10.2-4 CEO ATTENDANCE

The CEO or his/her administrative representative may attend all clinical department and committee meetings as well as meetings of the Medical Staff.

10.3 ATTENDANCE REQUIREMENTS

10.3-1 CHART REVIEW

A practitioner whose patient's clinical course of treatment is scheduled for case discussion as part of regular quality review activities may be required by the PRC to present the case. If the practitioner has been so notified, his or her attendance will be mandatory at the meeting at which the case is to be discussed. Absent good cause, failure to appear may result in automatic suspension under Section 6.7-3.

10.3-2 CLINICAL CONFERENCE

Whenever a department and/or the PRC perceives an education program or clinical conference is needed based on the findings of quality review, risk management, utilization management, or other monitoring activities, the practitioners whose patterns of performance prompted the program will be notified by the department Clinical Service Chief and/or PRC chairman of the time, date, place of the program, the subject matter to be covered, and its special applicability to their practice. Attendance is mandatory. Failure to attend may result in initiation of corrective action proceedings. Absent good cause, failure to attend may result in automatic suspension.

10.3-3 **SPECIAL APPEARANCE**

Whenever deviation from standard practice is identified or suspected with respect to a practitioner's performance or conduct, the Chief of Staff, or the applicable department Clinical Service Chief and/or PRC committee chairman may require the practitioner to confer with him or her or with the committee considering the matter. The practitioner will be notified of the date, time, and place of the conference, and the reasons therefore. Failure of a practitioner to appear at any such meeting may result in automatic suspension.

10.4 **QUORUM**

10.4-1 **GENERAL STAFF MEETINGS**

The presence of 15 of the voting members of the staff at any regular or special meeting shall constitute a quorum for the transaction of any business under these Bylaws.

10.4-2 **COMMITTEE MEETINGS**

The presence of 50% of the voting members shall constitute a quorum for committee meetings, but in no event less than two voting members.

10.4-3 **DEPARTMENT MEETINGS**

Two members of the department shall constitute a quorum for the transaction of business before the department as a whole unless the department establishes a higher quorum requirement in its rules and regulations.

ARTICLE ELEVEN: CONFIDENTIALITY, IMMUNITY, RELEASES AND INDEMNIFICATION

11.1 **AUTHORIZATIONS AND RELEASES**

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

(a) authorizes Medical Center representatives to solicit, provide, and act upon information bearing on or reasonably believed to bear upon the practitioner's professional ability, utilization practices, and qualifications;

(b) agrees to be bound by these Bylaws regardless of whether membership or clinical privileges are granted or are subsequently limited;

(c) acknowledges that the provisions of this Article are express conditions to an application for, or acceptance of, staff membership, and the continuation of such membership and the exercise of clinical privileges or provision of specified patient care services at the Medical Center;

(d) agrees to release from legal liability and hold harmless the Medical Center, Medical Staff, members of the Medical Staff, Medical Staff committees and all persons engaged in peer review activities, which include but are not limited to those activities identified in Article 11.3 of these Bylaws as well as any other Medical Staff functions provided for, or permitted, in the Bylaws or any applicable federal or state statute or regulation; agrees that his/her sole remedy for any corrective action taken or recommended by the Medical Staff, for failure to comply with these Bylaws or the Fair Hearing Plan, or for any other peer review action shall be the right to seek injunctive relief pursuant to ARS 36-445 et seq.

(e) agrees to release from legal liability and hold harmless any individual who or entity which provides information regarding the practitioner to the Medical Center or its representatives; and

(f) authorizes the release of information about the practitioner in accordance with the Banner Sharing of Information Policy.

11.2 **CONFIDENTIALITY OF INFORMATION**

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

11.3 **ACTIVITIES COVERED**

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

(a) applications for appointments, clinical privileges, or specified services;
(b) periodic reappraisals for reappointment, clinical privileges, or specified services;
(c) corrective or disciplinary actions;
(d) hearings and appellate reviews;
(e) quality review program activities, including root cause analyses;
(f) utilization review and management activities;
(g) claims reviews;
(h) profiles and profile analysis;
(i) significant clinical event review;
(j) risk management activities; and
(k) other hospital, committee, department, section, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

11.4 **RELEASES AND DOCUMENTS**

Each practitioner shall, upon request of the Medical Center, execute general and specific releases and provide documents when requested by the Chief of Staff or Chairmen of Department or Committees or their respective designees. Execution of such releases is not a prerequisite to the effectiveness of this Article. Failure to execute such releases or provide requested documentation shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn, and it shall not be further processed. Failure to execute such releases or provide documents upon request during a term of appointment to the staff shall result in automatic suspension as provided in Section 6.7-12.

11.5 **CUMULATIVE EFFECT**

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

11.6 **INDEMNIFICATION**

Banner Health shall provide indemnification for Medical Staff activities pursuant to the policy adopted by the Board.

ARTICLE TWELVE: GENERAL PROVISIONS

12.1 MEDICAL STAFF RULES AND REGULATIONS

Subject to approval by the Board, the Medical Executive Committee shall adopt and amend such Medical Staff Rules and Regulations as may be necessary to implement the general principles found in these Bylaws; such rules and regulations shall be consistent with these Bylaws and Medical Center policies. The Medical Staff Rules and Regulations may not conflict with the Banner Health Bylaws.

12.2 DEPARTMENT RULES AND REGULATIONS

Each department and section will formulate written rules and regulations for the conduct of its affairs and the discharge of its responsibilities, all of which must be consistent with the Bylaws and Medical Center policies. These department rules and regulations must be reviewed and approved by the Medical Executive Committee and the Board as needed, but must be reviewed at least every two (2) years by the department. Any changes affecting qualifications, privileges, supervision, and call coverage must be approved by the Medical Executive Committee and the Board.

12.3 STAFF DUES

The Medical Executive Committee shall establish the amount of annual Medical Staff and Allied Health Professional dues. Notice of dues shall be given to the staff by written notice in January. Dues are payable on or before March 31 of each year. If dues are not paid by April 1, a special notice of delinquency shall be sent to the practitioner and an additional 30 days given in which to make payment. All new staff members shall be billed on a pro-rated basis and given 30 days in which to make payment for the current year upon their appointment to the staff. Failure to render payment shall result in automatic suspension as provided in Section 6.6-8. Special assessments may be levied by a majority vote of the active staff, and rules of payment similar to those described above in terms of time frame shall apply.

12.4 SPECIAL NOTICE

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

12.5 CONSTRUCTION OF TERMS AND HEADINGS

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

12.6 PARLIAMENTARY PROCEDURE

All committee meetings will be conducted with the intent of allowing interested parties an opportunity to provide their input and to achieve a fair resolution. Robert's Rules of Order, Newly Revised, shall provide general guidance for the conduct of meetings, but adherence to Robert's Rules of Order shall not be required, and technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

12.7 CONFLICT RESOLUTION

12.7-1 **STAFF MEMBER CHALLENGE**

Any member of the Medical Staff may challenge any rule or policy established by the Medical Executive Committee by submitting to the Chief of Staff written notification of the challenge, with a petition signed by one third members of the Medical Staff and the basis for the challenge, including any recommended changes to the rule or policy.

12.7-2 **MEDICAL EXECUTIVE COMMITTEE REVIEW**

The Medical Executive Committee will consider the challenge at its next meeting and will determine what changes will be made to the rule or policy or may, at its discretion, appoint a subcommittee to review the challenge and recommend potential changes to address the concerns. The Medical Executive Committee may use internal or external resources to assist in resolving the conflict. The Medical Executive Committee will review subcommittee recommendations and take final action on the rule or policy, subject to Board approval as required. The Medical Executive Committee will communicate all changes to the Medical Staff.

12.7-3 **CONFLICT RESOLUTION RESOURCES AND BOARD RESPONSIBILITY**

A recommendation to use either internal or external resources to resolve the conflict may be made by the Board, the CEO, the Executive Committee, or members of the Medical Staff. Any conflict regarding the use of such resources or the process to be followed will be decided by the Board through the Medical Staff Subcommittee. The Board has final authority to resolve differences between the Medical Staff and the Executive Committee.

12.8 **HISTORIES AND PHYSICALS**

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

ARTICLE THIRTEEN: ADOPTION AND AMENDMENT

13.1 **MEDICAL STAFF AUTHORITY AND RESPONSIBILITY**

The Medical Staff shall be responsible for the development, adoption, and periodic review of these Bylaws which must be consistent with Medical Center policies, Banner Bylaws, and applicable laws. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the CEO, the Board and the community. These Bylaws may not conflict with the Banner Health Bylaws. In the event that a law or regulatory requirement changes, such change will govern these Bylaws as legally required by operation of law.

13.2 **BYLAW REVIEWS**

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

13.3 MEDICAL EXECUTIVE PROCESS

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

13.4 MEDICAL STAFF PROCESS

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

13.5 BOARD OF DIRECTORS ACTION

13.5-1 WHEN FAVORABLE TO MEDICAL STAFF RECOMMENDATION

Medical Staff recommendations regarding proposed Bylaws or amendments thereto shall be effective upon the affirmative vote of the Board.

13.5-2 BOARD CONCERNS

In the event the Board has concerns regarding any provision or provisions of the proposed Bylaws or amendments thereto, the Board shall advise the Medical Staff of its concerns. The Medical Staff may request, and if so requested, the Board will establish, a joint conference committee comprised of three representatives of each body to resolve such concerns.

13.6 JOINT CONFERENCE COMMITTEE

The Medical Executive Committee may request a Joint Conference Committee to resolve concerns regarding Medical Staff Bylaws, credentialing recommendations, policies or other issues that the Medical Executive Committee has been unable to resolve through informal processes with Medical Center or Banner Health administration, management or Board of Directors. This committee shall consist of three representatives appointed by Banner and three members of the Medical Staff appointed by the Chief of Staff as specified in the Banner Health Bylaws.

13.7 TECHNICAL AND EDITORIAL AMENDMENTS

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

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

13.8 -1 PERIODIC REVIEW

The Credentials Procedure Manual, Fair Hearing Plan, Medical Staff Rules and Regulations, Allied Health Rules and Regulations shall be reviewed at least every two (2) years and shall be revised as needed. Reviews shall also be conducted upon request of the Board.

13.8 -2 COMMUNICATION TO THE MEDICAL STAFF

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

(b) Urgent matters. In cases of a documented need for urgent amendment, the Medical Executive Committee and Board may provisionally adopt an urgent amendment without prior notification of the Medical Staff. The Medical Executive Committee will immediately notify the Medical Staff of the amendment and provide an opportunity for comment. If concerns are not received within 10 days, the amendment stands. If there is a conflict and 40% of the Active Staff oppose the amendment, the Medical Executive Committee will utilize the conflict resolution process set forth in Section 12.3. If necessary, a revised amendment will be submitted to the Medical Staff, and if approved, to the Board for action.

13.8 -3 MEDICAL STAFF AMENDMENTS

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

ADOPTION AND APPROVAL

Approved by the Banner Health Board of Directors: January 8, 2015
Revised and approved by the Banner Health Board of Directors: December 10, 2015
Reviewed by Bylaws Committee on September 14, 2017
Revised and approved by the Banner Health Board of Directors: July 14, 2018
Revised and approved by the Banner Health Board of Directors: October 14, 2021