

John C. Lincoln Deer Valley Hospital
 Medical Staff Bylaws
 Table of Contents

Defined Terms		1
Article 1	NAME	3
Article 2	PURPOSE AND RESPONSIBILITIES OF THE MEDICAL STAFF	3
	2.1 Purpose	3
	2.2 Responsibilities	3
Article 3	APPOINTMENT TO STAFF	4
	3.1 Classification	4
	3.2 General Qualifications	5
	3.2-1 Professional Education and Training	5
	3.2-2 Licensure	6
	3.2-3 Clinical Performance	6
	3.2-4 Professional Behavior	6
	3.2-5 Satisfaction of Membership Obligations	7
	3.2-6 Satisfaction of Criteria for Privileges	7
	3.2-7 Professional Ethics and Conduct	7
	3.2-8 Health	7
	3.2-9 Verbal and Written Communication Skills	8
	3.2-10 Effects of Other Affiliations	8
	3.2-11 Professional Liability Insurance	8
	3.2-12 Non-Discrimination	8
	3.3 Basic Obligations of Individual Staff Membership	8
	3.4 Term of Appointment	9
	3.4-3 Expiration	10
	3.5 Practitioners Providing Contractual Professional Services By Contract of Employment	10
	3.5-1 Qualifications and Selection	10
	3.6 Exhaustion of Administrative Remedies	10
Article 4	QUALIFICATIONS FOR CATEGORIES OF STAFF APPOINTMENT	
	4.1 Active Staff	10
	4.2 Associate Staff	11
	4.3 Courtesy Staff	11
	4.4 House Staff	11
	4.5 Honorary Staff	11
	4.6 Provisional/Associate	11
	4.7 Ancillary Staff	12
	4.8 Emeritus Staff	12
	4.9 Affiliate Staff	12
Article 5	DELINEATION OF PRACTICE PRIVILEGES	13
	5.1 In General	13
	5.1-2 Experimental Procedures	13

John C. Lincoln Deer Valley Hospital
 Medical Staff Bylaws
 Table of Contents

5.2	Basis for Privileges Determinations	13
5.3	Privileges in Emergency Situations	13
5.4	Oral/Maxillofacial Surgeons/Dentists	13
5.5	Podiatrists	14
5.6	Temporary Privileges	14
5.6-1	Circumstances	14
5.6-2	Termination	15
5.6-3	Rights of the Practitioner	15
Article 6	ACTIONS CONCERNING MEDICAL STAFF MEMBERS	16
6.1	Definitions	16
6.1-1	Corrective Action Process	16
6.1-2	Informal Activity Assessments	16
6.1-3	Peer Review Process	16
6.1-4	Tools	16
6.1-5	PRC	17
6.2	Informal Activity Assessments	17
6.3	Corrective Action Process	18
6.3-1	Formal Initiation of Corrective Action	18
6.3-2	Notification of Chief Executive Officer	19
6.3-3	Appointment of An Ad Hoc Committee	18
6.3-4	Investigational Interview	18
6.3-5	Written Investigational Report	19
6.3-6	Executive Committee Action	19
6.3-7	Procedural Rights and Notification	20
6.4	Summary Suspension of Clinical Privileges	21
6.4-1	Grounds for Summary Suspension	21
6.4-2	Executive Committee Procedure	21
6.5	Automatic Revocation and Suspension	21
6.5-1	Revocation	21
6.5-2	Felony Conviction	22
6.5-4	Controlled Substances	23
6.5-5	Evidence from Infectious Tuberculosis	23
6.5-6	Exclusion from Medicare/State Programs	23
6.5-7	Failure to Become Board Certified	23
6.5-8	Automatic Corrective Action	23
Article 7	GENERAL STAFF OFFICERS	24
7.1	Identification	24
7.2	Qualifications	24
7.3	Term of Office	24
7.4	Eligibility for Re-Election	24
7.5	Nominations	24
7.6	Elections, Vacancies and Removals	25
7.6-1	Election process	25
7.6-2	Vacancies in Elected Offices	25
7.6-3	Resignations and Removal from Office	25
7.7	Responsibilities of Officers	26
7.7-1	Chief of Staff	26
7.7-2	Vice Chief of Staff	27

John C. Lincoln Deer Valley Hospital
 Medical Staff Bylaws
 Table of Contents

	7.7-3 Secretary/Treasurer	27
	7.7-4 Immediate Past Chief of Staff	27
Article 8	CLINICAL DEPARTMENTS	27
	8.1 Current Clinical Department	28
	8.2 Assignment to Departments	28
	8.3 Organization of Departments	28
	8.4 Function of Departments	28
	8.4-1 Tumor Evaluation	29
	8.4-2 Specialty Practice	29
	8.5 Department Officers	30
	8.5-1 Qualifications	30
	8.5-2 Election	30
	8.5-3 Term of Office	30
	8.5-4 Removal	30
	8.5-5 Vacancy	30
	8.5-6 Responsibilities	31
Article 9	COMMITTEES	32
	9.1 General	32
	9.1-1 Removal and Vacancies	32
	9.2 Provisions	33
	9.2-1 Ex-officio Members	33
	9.2-2 Hospital Personnel	33
	9.3 Executive Committee	33
	9.3-1 Composition	33
	9.3-2 Responsibilities	34
	9.3-3 Meetings	35
	9.4 Standing Committees	36
	9.4-1 Credentials Committee	36
	9.4-1.1 Composition	36
	9.4-1.2 Duties	36
	9.4-1.3 Meetings	36
	9.4-2 Hospital Services Committee	36
	9.4-2.1 Composition	36
	9.4-2.2 Duties	36
	9.4-2.3 Meetings	37
	9.4-3 Osteopathic Methods and Concepts Committee	37
	9.4-3.1 Composition	37
	9.4-3.2 Duties	37
	9.4-3.3 Meetings	37
	9.4-4 Pharmacy & Therapeutics Committee	38
	9.4-4.1 Composition	38
	9.4-4.2 Duties	38
	9.4-4.3 Meetings	38
	9.4-5 Bylaws Committee	38
	9.4-5.1 Composition	38
	9.4-5.2 Duties	38
	9.4-5.3 Meetings	38

John C. Lincoln Deer Valley Hospital
 Medical Staff Bylaws
 Table of Contents

	9.4-6 Utilization Review Committee	39
	9.4-6.1 Composition	39
	9.4-6.2 Duties	39
	9.4-6.3 Meetings	39
9.5	Ad Hoc Committees	39
	9.5-1 Tumor Evaluation Committee	39
9.6	Network Committees	39
	9.6-1 Organization	40
	9.6-1.1 Bioethics Committee	40
	9.6-1.1.1 Composition	40
	9.6-1.1.2 Duties	40
	9.6-1.1.3 Meetings	40
	9.6-1.2 Medical Education Committee	40
	9.6-1.2.1 Composition	40
	9.6-1.2.2 Duties	40
	9.6-1.2.3 Meetings	41
	9.6-2 Continuing Medical Education Committee	41
	9.6-1.2.1 Composition	41
	9.6-1.2.3 Meetings	41
	9.6-3 Joint Conference Committee	41
	9.6-3.1 Composition	41
	9.6-3.2 Duties	42
	9.6-3.3 Meetings	42
9.7	Professional Review Committee	42
	9.7-1 Composition and Authority	42
	9.7-2 Membership Selection Process	42
	9.7-3 Qualifications	42
	9.7-4 Duties	43
	9.7-5 Miscellaneous Provisions	43
Article 10	MEETINGS	43
	10.1 Medical Staff Meetings	44
	10.1-1 Regular Meetings	44
	10.1-2 Special Meetings	44
	10.1-3 Quorum & Voting	44
	10.1-4 Minutes	44
	10.1-5 Attendance at Staff Meetings	44
	10.1-6 Executive Session	44
	10.2 Peer Review	44
	10.2-1 Sentinel Event	45
	10.2-2 External Peer Review	45
	10.3 Peer Review Appearance	45
	10.4 Peer Review Communication	45
Article 11	CONFIDENTIALITY, IMMUNITY AND RELEASES	46
	11.1 Authorization and Releases	46
	11.2 Confidentiality of Information	46
	11.3 Activities Covered	47
	11.4 Releases	47

John C. Lincoln Deer Valley Hospital
 Medical Staff Bylaws
 Table of Contents

	11.5	Cumulative Effect	47
Article 12		GENERAL PROVISIONS	48
	12.1	Medical Staff Rules and Regulations	48
	12.2	Credentialing Procedures Manual	48
	12.3	Fair Hearing Plan	48
	12.4	Staff Dues	48
	12.5	Special Notices	49
	12.6	Construction of Terms and Headings	49
	12.7	Parliamentary Procedure	49
Article 13		ALLIED HEALTH PROFESSIONALS	49
	13.1	Allied Health Professionals Defined	49
	13.2	Categories of AHP's Currently Authorized to Function in the Hospital	49
	13.3	Qualifications of Allied Health Professionals	49
	13.4	Prerogatives of Allied Health Professionals	50
	13.5	Obligations of Allied Health Professionals	50
	13.6	Definition of Scope of Service	50
	13.7	Procedure for Credentialing	51
	13.8	Withdrawal of Practice Prerogatives	51
Article 14		RESIDENTS, FELLOWS, MEDICAL STUDENTS	51
	14.1	Physicians-in-Training	51
		14.1-1 Supervision	51
		14.1-2 Purpose	51
		14.1-3 Family Medicine Residency Program	52
Article 15		ADOPTION AND AMENDMENT	52
	15.1	Procedure for Amendment	52
	15.2	Medical Staff Action	52
	15.3	Board of Directors Action	52
	15.4	Technical and Editorial Amendments	53
	15.5	Approval of the Board	53
	15.6	Adoption and Approval	53

01/04, 10/04, 4/06, 2/07,9/07/12/07

Medical Staff Bylaws

1. Allied Health Professionals (AHP's) - Individuals, other than those defined below under "Practitioner" and podiatrists and other than Hospital employees, who provide defined direct patient care services in the Hospital under supervision, exercising judgment within the areas of their documented professional competence and consistent with these Bylaws and the Medical Staff Rules and Regulations and applicable law. They are further addressed in Article 13.
2. Ancillary Staff- Psychologists and other professionals qualified to render medical care within the Hospital within the legal definitions of their discipline.
3. Board of Directors - The governing board of John C. Lincoln Health Network as appointed pursuant to the corporate bylaws.
4. Bylaws - Refers to these Medical Staff Bylaws unless otherwise specified.
5. Chief Executive Officer (CEO) - The individual appointed by the Board to act on its behalf in the overall management of the Hospital.
6. Completed Application - An application for appointment or reappointment to the Medical Staff in such form as the Board may require.
7. Credentialing Agent - Agent commissioned by the Hospital to provide verification service of an applicant's credentials at the time of appointment and reappointment to the medical staff.
8. Days - Calendar days, unless otherwise noted.
9. Dentist - An individual, who has received a doctor of dental surgery or a doctor of dental medicine degree and has a current, unrestricted license to practice dentistry in Arizona.
10. Executive Committee - The Executive Committee of the Medical Staff, unless otherwise specified.
11. Ex-officio - A member of a group or entity by virtue of an office or position held.
12. Hospital - John C. Lincoln Deer Valley Hospital.
13. Observation - Retrospective or concurrent scrutiny during the provisional review process, or any other time required by a clinical department, the Executive Committee or the Board of Directors.
14. Patient Contact - Admissions, inpatient or outpatient consultations, or procedures done as a measurement of activity at the Hospital by members of the Medical Staff.
15. Physician - An individual who is appropriately trained and licensed in the state as a doctor or osteopathy or a medical doctor.
16. Practitioner - An osteopathic, allopathic or podiatric physician or surgeon or dentist or dental surgeon with a current, unrestricted license issued by the State of Arizona.

Medical Staff Bylaws

17. Prerogative - A participatory right granted by virtue of staff category or otherwise to a Staff appointee, which is exercisable subject to the conditions imposed in these Bylaws and applicable department rules and regulations.

18. Privileges or clinical privileges - The permission granted to a practitioner to render specific diagnostic, therapeutic, medical, dental, podiatric or surgical services.

19. Provisional - An initial and probationary appointment to the Associate Staff for a period of one year.

Medical Staff Bylaws

The Staff of John C. Lincoln Deer Valley Hospital (the "Staff") adopts these Bylaws to promote quality patient care, to establish just regulations for the orderly medical management of John C. Lincoln Deer Valley Hospital ("Hospital"), and to establish liaison between the Staff, the Board of Directors and the Hospital Administration.

ARTICLE ONE: NAME

- 1.1 Name -The organizational component of John C. Lincoln Deer Valley Hospital to which these Bylaws are addressed, is called "The Medical Staff of John C. Lincoln Deer Valley Hospital.

ARTICLE TWO - PURPOSE AND RESPONSIBILITIES OF MEDICAL STAFF

- 2.1 Purposes - The purposes of this Medical Staff are:

- 2.1-1 To continually seek to improve the quality of care for all patients admitted to, or treated in, any facility, department, or service of John C. Lincoln Deer Valley Hospital and related elements of the John C. Lincoln Health Network.
- 2.1-2 To provide a mechanism for reporting to the Board, through defined organizational structures, for the review of the appropriateness of patient care services, and professional and ethical conduct of each practitioner appointed to the Medical Staff, so that patient care provided at the Hospital's facilities is maintained at that level of quality and efficiency consistent with generally recognized standards of care.
- 2.1-3 To provide an appropriate educational setting and to maintain high educational standards for graduate and continuing medical education programs for residents and members of the Medical Staff.
- 2.1-4 To serve as the organization through which individual practitioners may obtain prerogatives and clinical privileges at the Hospital and through which they fulfill the obligations of staff appointment.
- 2.1-5 To provide an orderly and systematic means by which staff members can give input to the Board and Chief Executive Officer on Hospital policy making and planning processes.

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

- 2.2-1 To participate in performance improvement programs by conducting all activities necessary for assessing, maintaining and improving the quality and efficiency of care provided in the Hospital, including:
 - (a) Evaluating practitioners and institutional performance through measurement systems based on objective, clinically sound criteria;

Medical Staff Bylaws

- (b) Engaging in the ongoing monitoring and evaluation 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 Hospital resources.
- 2.2-2 To make recommendations to the Board concerning appointments and reappointments to the Medical Staff, including category, department, clinical privileges and corrective action.
- 2.2-3 To participate in the development, conduct and monitoring of medical education programs.
- 2.2-4 To develop and maintain Bylaws and policies that are consistent with sound professional practices. Policies of the Medical Staff are to be supportive and congruent with the Bylaws, rules and regulations.
- 2.2-5 To participate in the Hospital's long-range planning activities, to assist in identifying community health needs, and to participate in developing and implementing appropriate institutional policies and programs to meet those needs.
- 2.2-6 To exercise through its officers, committees 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 of Directors.

ARTICLE THREE: APPOINTMENT TO STAFF

- 3.1 Classification - The Staff shall include all practitioners whose appointment grants them the privilege of using the facilities and attending patients at the Hospital. The Staff shall be classified as follows:
- 3.1-1 Active
 - 3.1-2 Associate
 - 3.1-3 Courtesy
 - 3.1-4 Honorary
 - 3.1-5 Ancillary
 - 3.1-6 Affiliate
- 3.1-7 Provisional/Associate (Network Pediatric Department only)
- 3.2 General Qualifications - Every practitioner who seeks or enjoys staff membership must, at the time of application and continuously thereafter, demonstrate to the

Medical Staff Bylaws

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, the Medical Staff Rules and Regulations, and/or in the respective Department Rules and Regulations.

3.2-1 Professional Education and Training - Appointees to the Active Staff, Associate Staff and Courtesy Staff shall meet the following requirements:

3.2-1.1 Graduation from an approved osteopathic or allopathic medical school or dental or podiatric school or attainment of a doctorate level degree in a psychological and/or behavioral health field from an accredited university or graduate school; or certification by the Education Council for Foreign Medical Graduates; or Fifth Pathway certification and successful completion of the Foreign Medical Graduate Examination in the Medical Sciences. For the 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 American Osteopathic Association, Accreditation Council for Graduate Medical Education, 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 by an accrediting agency on file with the U.S. Secretary of Education.

3.2-1.2 Board Certified or currently Board admissible for examination by the American Board of Medical Specialists, the American Osteopathic Association, or by a board determined by the clinical department to be equivalent. For purposes of this section, "Board Admissible" means the applicant has applied for and been accepted to become an active candidate for certification as determined by the applicable board. All applicants who initially apply to staff after 7/1/2007 must become board certified within the time frame specified by the Board or 5 years from completion of residency if no time limit is defined. If the applicable Board requires a period of practice prior to submitting an application for certification, the applicant will be deemed "admissible" during the time period if the director of his training program certifies that he has met all training requirements for qualification by the applicable board. Failure to obtain certification within this time period will result in the automatic loss of membership and clinical privileges, without the procedural rights afforded by the Fair Hearing Plan.

Exceptions may be granted for an applicant, whose privileges are limited to surgical assisting only.

3.2-2 Licensure - Appointees must provide evidence of a currently valid license issued by the State of Arizona to practice either medicine, osteopathy, dentistry, podiatry or psychology. No practitioner shall be entitled to appointment merely by virtue of being licensed to practice in this or any

Medical Staff Bylaws

other state, being a member of any professional organization, or having had privileges at this or another hospital.

- 3.2-3 Clinical Performance - Current experience, clinical results, and utilization patterns, demonstrating a continuing ability to provide patient care services at an acceptable level of quality and efficiency. Each clinical department is responsible for developing and describing in its Rules and Regulations the process for the delineation of clinical privileges and its evaluation of current clinical competency to individual practitioners.
- 3.2-4 Professional Behavior - Demonstrated ability 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.
- (a) Avoid conduct which reflects adversely on the practitioner's professional fitness;
 - (b) Cooperate in any review of a practitioner's (including one's own), credentials, qualifications or compliance with these bylaws, and refrain from directly or indirectly interfering, obstructing, or hindering any such review, whether by threat of harm or liability, by withholding information, by refusing to serve or participate in assigned responsibilities, or otherwise;
 - (c) Comply with requests from any two (2) of the following: the Chief Executive Officer, Chief of Staff, Department Chairmen or their respective designees to confirm their current physical and mental capacity to practice medicine and their freedom from, or adequate control of, any medicine and their freedom from, or adequate control of, any physical, mental or behavioral impairment, including substance abuse;
 - (d) Demonstrate the ability to work cooperatively and professionally with the Hospital, its staff and the Medical Staff. To that end, all shall refrain from disruptive behavior or any behavior that could be construed as causing a hostile work environment or a situation which has interfered or could interfere with patient care or the operation of the Hospital and its Medical.
 - (e) Demonstrate the ability to adequately communicate with patients, families, staff and peers.
- 3.2-5 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.

Medical Staff Bylaws

- 3.2-6 Satisfaction of Criteria for Privileges - Evidence of satisfaction of the criteria for the granting of clinical privileges in at least one (1) department.
- 3.2-7 Professional Ethics and Conduct - Members are required to:
- (a) Demonstrate 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 to treatments.
 - (b) Maintain the confidentiality of peer review activities of the Medical Staff by not disclosing of such information except to those persons authorized to receive it in the conduct of Medical Staff activities.
 - (c) When a special notice is required, the Hospital shall send such notice by hand delivery, courier, or certified mail, return receipt requested, to the address provided by the practitioner. Acceptance of certified mail shall be a condition of continuing staff membership, and if the Post Office indicates that a certified letter has been refused, such notice shall be deemed to be delivered on the date delivery was first attempted. Such refusal shall be regarded as unprofessional conduct, and may be grounds for the denial of appointment or reappointment.
- 3.2.8 Health - Each applicant and medical staff member shall document his or her good physical and mental health. He/she shall be free from or have adequate control over any physical or mental condition, and/or chemical or substance impairment that may interfere with the ability to perform the privileges requested, and provide safe and quality patient care.
- 3.2-9 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.
- 3.2-10 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;

Medical Staff Bylaws

- (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 this Hospital.

3.2-11 Professional Liability Insurance - Evidence of professional liability insurance coverage of a kind and in an amount satisfactory to the Board.

3.2-12 Non-Discrimination - No aspect of Medical Staff appointment or particular clinical privileges shall be denied on the basis of age, sex, race, creed, color, national origin, a handicap unrelated to the ability to fulfill patient care and required staff obligations, or any other criterion unrelated to the delivery of quality and efficient patient care in the Hospital, to professional qualifications, to the Hospital's purposes, needs and capabilities, or to community need.

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:

- 3.3-1 Provide patients with continuous care at the level of quality and efficiency generally recognized as appropriate. Osteopathic physicians shall subscribe to and utilize the distinctive osteopathic approach in the provision of patient care, to include a musculoskeletal examination as part of the history & physical on all admitted patients, unless contraindicated. The reason for omitting the musculoskeletal examination shall be documented where this exam is contraindicated.
- 3.3-2 Abide by the Corporate Bylaws, these Bylaws, Medical Staff and department Rules and Regulations, and all other standards and policies of the Medical Staff and Hospital;
- 3.3-3 Abide by the Corporate and Hospital Plan and policies for Legal and Regulatory Compliance;
- 3.3-4 Discharge such staff, committee, department and Hospital functions for which he or she is responsible;
- 3.3-5 Prepare and complete in timely fashion, according to these Bylaws and to Hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the Hospital, or within its facilities, services, or departments;

Medical Staff Bylaws

- 3.3-6 Arrange for appropriate and timely medical coverage and care for patients for whom he or she is responsible and to obtain consultation when necessary for the safety of those patients;
 - 3.3-7 Treat as confidential any information discussed in a Medical Staff or Hospital committee in executive session;
 - 3.3-8 Participate in continuing education programs as determined by the Medical Staff, the State of Arizona for Licensure and/or the respective professional associations, boards and societies;
 - 3.3-9 Immediately notify the Chief Executive Officer and Chief of Staff of the voluntary or involuntary revocation or suspension of his or her professional license; the imposition of terms of probation or limitation of his or her practice by any state licensing agency, including any stipulation; the cancellation or restriction of his or her professional liability coverage; or the revocation, suspension or voluntary relinquishment of his or her DEA certificate; and
 - 3.3-10 Promptly notify the Chief Executive Officer and Chief of Staff of any health status change which would significantly affect his or her ability to practice; his or her voluntary or involuntary loss of staff membership or loss, curtailment, or restriction of privileges at any hospital or other healthcare institution; or an adverse determination by a peer review organization concerning his or her quality of care; the commencement of formal investigation or the filing of charges by the Department of Health and Human Services; the exclusion as a provider by the Office of Inspector General of any Medicare/Medicaid programs; or any law enforcement agency or health regulatory agency of the United States or the State of Arizona, or any other state.
- 3.4 Term Of Appointment - Appointments to the Medical Staff and grants of clinical privileges are for a period of two (2) years, except that:
- 3.4-1 New members of the Medical Staff are subject to an initial provisional period as required under Section 4.2 and upon satisfactory conclusion of that period are placed in the appropriate reappointment cycle as determined by the Hospital's system of staggered reappointments; and
 - 3.4-2 The Board, after considering the recommendations of the Executive Committee, may set a more frequent reappraisal period for the exercise of particular privileges in general or for a staff member who has an identified impairing disability or has been the subject of disciplinary or corrective action.
 - 3.4-3 Expiration - The appointment of each staff member shall expire every two (2) years on the last day of the month in which the Board granted membership.
- 3.5 Practitioners Providing Professional Services By Contract or Employment.

Medical Staff Bylaws

- 3.5-1 Qualifications and Selection - A practitioner who is or who will be providing specified professional services pursuant to employment or by a contract with the Hospital 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.
- 3.5-2 Practitioners rendering professional services pursuant to employment by or contracts with the Hospital shall be required to maintain Medical Staff membership and privileges.
- 3.5-3 Unless otherwise provided in the terms of employment or the contract for professional services, termination of such employment or contracts shall not result in automatic termination of Medical Staff membership.
- 3.6 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 the Executive Committee, the effect of which is to deny, revoke, or otherwise limit privileges or membership of the applicant or staff member, such applicant or member shall exhaust the administrative remedies afforded in the Bylaws prior to initiating litigation.

ARTICLE FOUR: QUALIFICATIONS FOR CATEGORIES OF STAFF APPOINTMENT

- 4.1 Active Staff - The Active Staff shall be appointed from osteopathic, allopathic and podiatric physicians and surgeons and dentists and oral surgeons whose post-doctoral training is approved by the appropriate national educational and accrediting authorities. Staff members who have held an appointment for one (1) year shall be eligible to request promotion to the Active Staff in the appropriate department. Active staff appointees shall reside within a reasonable distance and/or travel time to the hospital in order to provide continuous care to their patients. Members of the Active Staff must be (i) regularly involved in caring for patients or (ii) demonstrate by way of other substantial involvement in Medical Staff or hospital activities, a genuine interest in the Hospital. Regular involvement in patient care shall mean admitting, referring or consulting on at least 10 patients annually for all practitioners, except Dermatologists, Psychiatrists and Rheumatologists, who must be involved in at least 5 cases in a two-year period. Members of the Active Staff shall be encouraged to regularly attend general staff and applicable department and/or committee meetings. Active Staff members shall be entitled to vote and provide service as a Staff Officer, Department or Section leader, serve on Medical Staff committees and as Chairman of such committee(s).
- 4.2 Associate Staff - The Associate staff shall be appointed from osteopathic, allopathic and podiatric physicians and surgeons and dentists and oral surgeons who are new appointees to the Staff. Appointees to the Associate Staff are provisional for at least one year and shall not exceed two (2) years. An Associate Staff member's subsequent reappointment date shall coincide with the

Medical Staff Bylaws

cycle that has been established by the Hospital's system for staggered reappointments. Observation requirements may be required at the time of initial appointment and failure to comply with the observation requirements, as required by the practitioner's respective department, may result in voluntary relinquishment of his or her staff appointment and privileges.

Associate Staff appointees may be appointed to serve on Committees of the Staff. Associate Staff appointees shall not vote or hold Staff office, except that, when serving as a member of a committee, they may vote in that capacity.

- 4.3 Courtesy Staff - Courtesy Staff shall be appointed from osteopathic, allopathic and podiatric physicians and surgeons and dentists and oral surgeons who are otherwise qualified and eligible for Active Staff appointment. Courtesy Staff appointees may be appointed to serve on Committees of the Staff. Courtesy Staff appointees shall not vote or hold Staff office, except that, when serving as a member of a committee, they may vote in that capacity.
- 4.4 House Staff - House Staff are residents and interns who shall be supervised by the attending and teaching staffs and shall be governed by and through the Medical Education Committee. House Staff are not entitled to any procedural rights as defined under Article VI or the Fair Hearing Plan.
- 4.5 Honorary Staff - Honorary Staff appointees shall be osteopathic, allopathic or podiatric physicians or surgeons or dentists or oral surgeons who are retired from active practice and of outstanding reputation or persons who have performed outstanding service to the Hospital or to their respective profession. They shall not admit vote, hold office or pay dues.
- 4.6 Provisional/Associate – The Provisional Associate staff shall include all physicians assigned to the Network Pediatric Department. They shall be appointed from osteopathic and allopathic physicians who are new appointees to the Staff of John C. Lincoln Hospitals – Deer Valley and North Mountain. Appointees to this category are provisional for at least one year and shall not exceed two (2) years. A staff member's subsequent reappointment date shall coincide with the cycle that has been established by the Hospital's system for staggered reappointments. Observation requirements may be required at the time of initial appointment and failure to comply with the observation requirements, as required by the department, may result in voluntary relinquishment of his/her staff appointment and privileges.

Provisional/Associate staff appointees may be appointed to serve on Committees of the Staff. They shall not vote or hold Staff office, except that, when serving as a member of a committee, they may vote in that capacity.

- 4.7 Ancillary Staff - The Ancillary Staff shall include psychologists and other professionals qualified to render medical care within legal definitions of their discipline and must meet standards as established by the Medical Staff. Upon the recommendation of the Executive Committee, they shall be assigned to a specific clinical department. Their work within the Hospital shall be under the observation of the clinical department to which they are assigned. They shall be

Medical Staff Bylaws

requests for changes in privileges, evidence of appropriate training and experience and current clinical competence must be documented.

- 5.3 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, when better alternative sources of care are not available within the necessary time frame, to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license but 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 Oral/Maxillofacial Surgeons/Dentists - Surgical procedures performed by Oral/Maxillofacial surgeons and dentists are under the overall observation of the Department of Surgery. An oral surgeon who meets the prerequisite 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. Dentists are responsible for the part of their patients' history and physical examination that relates to dentistry. 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/Maxillofacial surgeon or dentist and the physician consultant. The Department of Surgery will decide the issue in the case of dispute.
- 5.5 Podiatrists - Privileges granted to podiatrists shall be based on their training, experience and demonstrated current competence and judgment. Surgical procedures performed by a podiatrist are under the overall observation of the Department of Surgery. A podiatrist who meets the prerequisite qualifications may be granted the privilege of performing a history and physical examination and assessing the medical risks of the proposed procedure of the patient. Should a medical problem arise at the time of admission or during hospitalization, a physician member of the Medical Staff must perform a medical appraisal on such patient, must determine the risk and effect of any proposed surgical or special procedure, and be responsible for the care of any medical problem that may be present. When significant medical abnormality is present the final decision whether to proceed must be agreed upon by the podiatrist and the physician consultant. The Department of Surgery will decide the issue in the case of dispute.
- 5.6 Temporary Privileges - 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

Medical Staff Bylaws

professional liability requirement. Special requirements of observation and reporting may be imposed by the Chief of Staff or Department Chairman. Under all circumstances, the practitioner requesting temporary privileges must agree to abide by these Bylaws and the Rules and Regulations of the Medical Staff and the Hospital.

5.6-1 Circumstances - Upon the recommendation of the Chief of Staff or Department Chairman, the Chief Executive Officer may grant temporary privileges in the following circumstances:

- (a) Pending of Application -To an applicant for staff membership who has requested temporary privileges but only upon verification of such information contained in the completed application. Temporary privileges may be granted to an applicant for an initial period of ninety (90) days, with subsequent renewals not to exceed the pendency of the application. The Department Chairman shall make any such renewal only when the information available continues to support a favorable determination regarding the practitioner's application for membership and privileges. 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 - To a practitioner for the care of a specific patient but only after receipt of a request for the specific privileges desired and telephone confirmation (or receipt of copy) of both appropriate licensure and adequate professional liability insurance coverage. Such temporary privileges may not be granted in more than two (2) instances in any calendar year, after which the practitioner must apply for staff appointment, and temporary privileges are restricted to the care of specific patients for which they are granted.
- (c) Locum Tenens - To a practitioner who will be serving as a locum tenens for a staff member but only after receipt of a complete application for appointment as a locum tenens, including a request for specific privileges; confirmation of appropriate licensure; DEA/controlled substances registration, and adequate professional liability insurance coverage; and a complete, written reference specific to the requested privileges from one or more members of the Medical Staff. The privileges for locum tenens last for up to sixty 90 days in length and may be renewed for one (1) additional sixty-day 90 period upon approval of the Department Chairman. Temporary Privileges may not be granted to a physician serving as a locum tenens again for one (1) year from the first day of the previous locum tenens. The practitioner must be registered and authorized to provide locum tenens medical services with the appropriate licensing board.

Medical Staff Bylaws

(d) Emergency or mass casualty disaster situation - To a practitioner responding to the Hospital at the time of an emergency or mass casualty disaster situation.

5.6-2 Termination - The Chief Executive Officer, Chief of Staff, or Department Chairman, 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 or clinical competency. In the event of such termination, the practitioner's patients then in the Hospital will be assigned to another practitioner by the Department Chairman. The wishes of the patient will be considered, where feasible, in choosing a substitute practitioner.

5.6-3 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. No such adverse action taken with respect to a practitioner's temporary privileges shall be reported to the affected practitioner's licensing board or under the Health Care Quality Improvement Act of 1986, unless such reporting is required by law.

ARTICLE SIX: ACTIONS CONCERNING MEDICAL STAFF MEMBERS

6.1 Definitions – The following definitions apply to this Article Six involving actions concerning Medical Staff members:

6.1-1 **Corrective Action Process** – the process involving a formal investigation of a matter involving a physician or another practitioner having privileges to practice at the Hospital which may lead to an adverse action affecting the practitioner's membership on the Medical Staff and/or privileges to practice at the Hospital. The Corrective Action Process shall be conducted in accordance with Section 6.3 of these Bylaws.

6.1-2 Informal Activity Assessments – the initial steps taken by either the Chairman of a clinical Department or the Professional Review Committee ("PRC") including using one or more Tools, following a matter which may merit investigation being brought to their attention. Informal Activity Assessments are conducted prior to conducting a formal investigation or initiating corrective action and generally will be conducted in connection with matters other than those addressed under the Peer Review Process.

6.1-3 Peer Review Process – the process by which medical decision making and other medical activities of physicians and other practitioners are reviewed and assessed by the Medical Staff in accordance with applicable policies and procedures and rules and regulations. The Peer Review Process is intended to be an intra-professional process designed for the purpose of reducing morbidity and mortality and for improving patient care provided in the Hospital. The Peer Review Process includes reviewing and analyzing the nature, quality and necessity of the care

Medical Staff Bylaws

provided and the preventability of complications and adverse patient outcomes occurring in the Hospital.

6.1-4 Tools – “tools” means the various non-disciplinary steps available to Department chairmen and the PRC for use in connection with the Peer Review Process and conducting Informal Activity Assessments. Tools are generally intended to be used prior to the initiation of the Corrective Action Process as an intra-professional means of assessing practitioners’ clinical competence and improving patient care provided in the Hospital. Tools include, but are not limited to,

- a) collegial intervention with the practitioner by an appropriate representative of the Medical Staff including a Department Chairman, the PRC or its designee, or the Medical Director of the Hospital;
- b) reviewing a practitioner’s prior and/or current medical records;
- c) referring a practitioner from an outside practice evaluation/assessment;
- d) recommending that a practitioner obtain additional training and/or education;
- e) referring a practitioner to a professional for a medical and/or psychological evaluation and, if necessary, treatment;
- f) one on one mentoring of a practitioner;
- g) having a practitioner’s cases reviewed by another qualified physician who is either on or off the Hospital’s Medical Staff;
- h) recommending that a practitioner refrain from practice in the Hospital, either generally or with respect to certain specified privileges, pending the practitioner’s obtaining additional education and/or training; or
- i) issuing letter of guidance.

6.1-5 PRC – the Professional Review Committee of the Medical Staff as described in Section 9.11 of these Bylaws.

6.2

INFORMAL ACTIVITY ASSESSMENT - Whenever a matter which may merit investigation, other than a matter involving the Peer Review Process, unless such matter is referred pursuant to Section 6.3-1, comes to the attention of the Chief Executive Officer or his or her designee, the Chief of Staff, the Executive Committee, a clinical department, the Chairman of a clinical department or any committee of the Medical Staff, the matter may be referred to the Chairman of the clinical department wherein the affected practitioner has privileges or to the PRC for an Informal Activity Assessment. If the matter is referred directly to the PRC, the Chairman of the Department must be notified. This Assessment may take whatever form and may include the use of any of the Tools that the Department Chairman or the PRC deems appropriate, but shall include notification of and opportunity to respond in the Assessment by the affected practitioner. If the matter is referred to the Chairman of the clinical Department,

Medical Staff Bylaws

he/she may refer the matter to the PRC for its review and recommendations. Based upon his/her/its conclusions following his/her/its assessment, the Chairman or the PRC, as applicable, may either dismiss the matter with no further action or request corrective action as provided in these Bylaws. If the Chairman or PRC, as applicable, determines that this matter be dismissed, this will be documented for the Executive Committee.

However, initiation of corrective action will not be precluded if an unacceptable pattern of care and/or disruptive behavior by a practitioner occurs following the dismissal of a previously conducted Informal Activity Assessment.

6.3 CORRECTIVE ACTION PROCESS

6.3-1 Formal Initiation of Corrective Action - Whenever, during the term of his or her appointment to the Medical Staff, a practitioner fails to comply with the Bylaws, policies and directives of the Hospital involving the Medical Staff, the Bylaws or Rules and Regulations of the Medical Staff or respective clinical department pertaining to his or her activities or professional conduct, or whenever his or her activities or professional conduct are considered to fall below the standards of the Hospital or to be disruptive to the operations of the Hospital, the Chief of Staff, the Chairman of any clinical department, the PRC, the Chairman of any standing committee of the Medical Staff or the Chief Executive Officer may, as he/she/it deems appropriate, either refer the matter for an Informal Activity Assessment in accordance with 6.2 of these Bylaws or request that corrective action be taken. All requests for such action shall be in writing, shall be made to the Executive Committee and shall be supported by reference to the specific activity or conduct which constitutes the grounds for the request.

6.3-2 Notification Of Chief Executive Officer - The Executive Committee shall promptly notify the Chief Executive Officer, in writing, of all requests for corrective action received by the Executive Committee and shall continue to keep him/her fully informed of all action taken in conjunction therewith.

6.3-3 Appointment Of An Ad Hoc Committee – The Executive Committee shall immediately forward the request for corrective action to the Chairman of the clinical Department wherein the affected practitioner has privileges. The Executive Committee shall not conduct its own investigation or evaluation of the matter giving rise to the request for corrective action until it has received the Department Chairman's recommendation and the ad hoc committee's (or the PRC's) report in accordance with Section 6.3-5. Upon receipt of the request, the Department Chairman shall immediately either appoint an Ad Hoc Committee of at least three peers to investigate the matter, or refer the matter to the PRC to investigate the matter. If appointed, the ad hoc committee shall not include in its membership either partners or associates of the affected practitioner or anyone who provided information or who participate in initiating the investigation or the request for corrective action.

In the event the affected practitioner is the Chairman of the Department, the Executive Committee shall refer the matter to the PRC to investigate the matter.

If corrective action is requested in connection with a matter the PRC has reviewed and assessed in accordance with the Peer Review Process or in connection with an

Medical Staff Bylaws

Informal Activity Assessment, which included an interview with the affected practitioner that substantially conforms with the requirements of Section 6.3-4, the provisions of Section 6.3-3 and 6.3-4 shall be waived. In such event, the PRC shall make a written report in accordance with Section 6.3-5.

6.3-4 Investigational Interview – Prior to the meeting with the ad hoc committee or the PRC, as applicable, the affected practitioner will be provided with a written description of the specific activity or conduct that constituted grounds for the request for corrective action.

The affected practitioner shall have an opportunity to meet with the ad hoc Committee or the PRC before it makes its report. At such interview, the specific nature of the evidence to support the action requested shall be discussed, explained or refuted. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in the Fair Hearing Plan with respect to hearings shall apply. A record of such interview shall be made by the ad hoc committee or the PRC and included with its report to the Chairman of the Department.

6.3-5 Written Investigational Report - The ad hoc committee or the PRC shall make a written report of its findings and recommendations to the Chairman of the department and the affected practitioner. Every effort shall be made to have the Ad Hoc Committee or the PRC complete its investigation and make its written report to the Chairman of the department and the affected practitioner within thirty (30) days, but in no case to exceed sixty (60) days after the department Chairman receives the request for corrective action from the Executive Committee. The written report shall set forth a summary of the facts and circumstances surrounding each activity or conduct of the affected practitioner that was the basis for the request for corrective action and the conclusion of the ad hoc committee or the PRC as to the extent to which the facts and circumstances support or fail to support the request for corrective action. Upon receipt of the ad hoc committee's or the PRC's report, the Chairman of the department shall forward such report, together with his or her own recommendations, to the Executive Committee.

6.3-6 Executive Committee Action - At its next regularly scheduled meeting following receipt of the department Chairman's recommendations and the ad hoc committee's or the PRC's report on a request for corrective action, the Executive Committee may request that the affected practitioner appear for an interview. The Executive Committee, when acting on a request for corrective action, may reject the request for corrective action or impose appropriate corrective action as follows:

- (a) Issue a warning, a letter of admonition or a letter of reprimand. (This action shall not entitle the affected practitioner to the procedural rights provided in the Fair Hearing Plan or be reported to the affected practitioner's licensing board under the Health Care Quality Improvement Act of 1986.)

Medical Staff Bylaws

- (b) Impose terms of probation, including, but not limited to requiring the use of one or more Tool. (This action shall not entitle the affected practitioner to the procedural rights provided in the Fair Hearing Plan or be reported to the affected practitioner's licensing board or under the Health Care Quality Improvement Act of 1986.)
- (c) Recommend to the Board that the affected practitioner's clinical privileges be reduced, limited, or put under supervision, or that the affected practitioner's clinical privileges and membership on the Medical Staff be suspended or revoked.

6.3-7 Procedural Rights and Notification

- (a) Any recommendation by the Executive Committee for the reduction, limitation or supervision of the affected practitioner's clinical privileges or the suspension or revocation of the affected practitioner's Medical Staff membership or clinical privileges shall entitle the affected practitioner to the procedural rights provided in the Fair Hearing Plan. In such event, the Chief Executive Officer shall promptly notify the affected practitioner, by hand delivery, courier, or certified mail, return receipt requested, of the Executive Committee's adverse recommendation. Such notice shall state that corrective action has been proposed to be taken against the affected practitioner, the reasons for the proposed action, that the affected practitioner has the right to request a hearing on the proposed action, that the affected practitioner has thirty (30) days from receipt of the written notice within which to request a hearing and set forth a summary of the affected practitioner's rights at the hearing. No such adverse recommendation need be forwarded to the Board until after the affected practitioner has exercised or has been deemed to have waived his or her rights to a hearing as provided in the Fair Hearing Plan.

No applicant or Medical Staff appointee shall be entitled to more than one (1) hearing and one (1) appeal on any matter which may be the subject of an appeal. If the Board determines to deny initial Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current appointee, that individual may not apply for staff appointment or for those clinical privileges for a period of two (2) years after the Board's decision is finalized unless the Board provides otherwise.

- (b) If the action of the Executive Committee is less severe than a reduction, limitation or supervision of clinical privileges or a suspension or revocation of the affected practitioner's Medical Staff membership or clinical privileges, it shall take effect immediately without action of the Board and the affected practitioner shall not be entitled to the procedural rights provided in the Fair Hearing Plan. However, a report of such lesser action

Medical Staff Bylaws

taken and the reasons therefore shall be submitted to the Board and to the affected practitioner.

6.4 Summary Suspension of Clinical Privileges

6.4-1 Grounds for Summary Suspension - Whenever a Medical Staff member willfully disregards or recklessly or wantonly violates any provision of the Medical Staff Bylaws, Medical Staff or clinical departmental Rules and Regulations, or the Hospital's bylaws, rules and regulations or policies, or whenever his or her conduct requires that immediate action be taken to protect the life of any patient or to reduce the substantial likelihood of immediate injury or threat to the health or safety of any patient, employee or other person present in the Hospital, or whenever the conduct of the Medical Staff member materially disrupts the operations of any department or unit of the Hospital, the Chief Executive Officer (or, in his or her absence, his or her designee or if no one has been designated, the Chairman, or in his or her absence, any Vice Chairman of the Board of Directors of the Hospital), and either the Chief of Staff or the Chairman of the respective clinical department shall have the authority to summarily suspend the staff appointment or all or any portion of the clinical privileges of a Medical Staff member; provided, that in the event such action is taken by the Chief Executive Officer and a Chairman of a clinical department, the Chief of Staff shall be notified as soon as practicable of such action and, if possible, the Chief of Staff shall be notified prior to such summary suspension becoming effective. Such summary suspension shall become effective immediately upon imposition, and the Chief Executive Officer shall promptly give notice of the suspension to the Medical Staff member, either personally or by certified mail, return receipt requested, with notice to the Executive Committee of such action. Such summary suspension shall remain in effect unless and until modified by the Executive Committee or the Board of Directors.

6.4-2 Executive Committee Procedure

- (a) An individual whose clinical privileges have been summarily suspended shall be entitled to request, in writing, that a hearing be held, as provided in the Fair Hearing Plan. If the individual timely requests a hearing, the hearing shall be held as soon as practical but, in no event, not more than fourteen (14) days from the date of receipt of the request for hearing. The summary suspension shall remain in effect pending a final decision by the Board of Directors.
- (b) Immediately upon the imposition of a summary suspension, the appropriate department Chairman, or, in his or her absence, his or her designee, or the Chief of Staff, shall, with the patient's consent, assign to a member of the Medical Staff responsibility for care of the suspended practitioner's patient(s) still in the Hospital at the time of such suspension until they are discharged from the Hospital.

6.5 Automatic Revocation and Suspension

Medical Staff Bylaws

6.5-1 Medical Staff member's membership shall be automatically revoked and his/her clinical privileges shall be automatically suspended, without any of the procedural rights provided in the Fair Hearing Plan, in any of the circumstances described in this Section 6.3. If and when the circumstances giving rise to this action have been rectified to the reasonable satisfaction of the Hospital, the Medical Staff member may request that his/her membership and clinical privileges be reinstated.

- (a) Action by any State of Arizona licensing or certifying agency revoking or suspending the Medical Staff member's professional license to practice medicine in this State;
- (b) Failure by the Medical Staff member to complete the required reappointment forms within no more than thirty (30) days of the member's biennial expiration date.
- (c) Failure by the Medical Staff member to pay his or her Medical Staff dues within thirty (30) days of certified receipt of invoice; or
- (d) Failure to notify the Hospital of a lapse in professional insurance of a kind, in an amount and with a carrier satisfactory to the Board.
- (e) Failure by the Medical Staff member to obtain photo identification within ninety (90) days of notification (or prior to practicing in the Hospital, whichever comes first).

6.5-2 Felony Conviction - A practitioner who has been convicted of a felony may be suspended from practicing at the Hospital by the Chief of Staff (or his designee) and the Chief Executive Officer (or his designee) without any of the procedural rights provided in the Fair Hearing Plan. The suspension shall remain in effect until the matter is resolved to the satisfaction of the Chief Executive Officer and the Medical Executive Committee.

6.5-3 Medical Records - Failure by a practitioner to complete a medical record in accordance with applicable provisions as defined in Section 4.0 of the Medical Staff Rules and Regulations of these Bylaws shall result in the accumulation of delinquent days. A physician who exceeds a total of sixty (60) days in a calendar year shall be automatically terminated from the Medical Staff without any of the procedural rights provided in the Fair Hearing Plan.

Medical Staff Bylaws

- 6.5-4 Controlled Substances - Whenever a Medical Staff member's DEA certificate is revoked, limited or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term. Whenever an appointee's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.
- 6.5-5 Failure to Provide Evidence Indicating Freedom from Infectious Tuberculosis – Failure to provide evidence of freedom from infectious tuberculosis as required by law and Hospital policy.
- 6.5-6 Exclusion From Medicare/State Programs – The Chief Executive Officer with notice to the Chief of Staff shall immediately and automatically suspend 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 the Medicare, Medicaid, AHCCCS, Indian Health or Tricare programs.
- 6.5-7 Failure to Become Board Certified – Whenever a Medical Staff member's time period in which to become board certified expires, the member shall be deemed to have immediately and voluntarily relinquished his/her Medical Staff appointment and clinical privileges.
- 6.5-8 Automatic Corrective Action – In the event corrective action is taken by John C. Lincoln North Mountain Hospital against a practitioner who is assigned to the Pediatric Department or who has applied for pediatric privileges, such corrective action will be deemed to have simultaneously been taken against the affected practitioner at this Hospital. In such event, the affected practitioner shall not be afforded any of the procedural rights otherwise available to him under these Bylaws or the Fair Hearing Plan as such practitioner's only procedural rights shall be those afforded to the practitioner under the Medical Staff Bylaws and Fair Hearing Plan at John C. Lincoln North Mountain Hospital.

ARTICLE SEVEN: GENERAL STAFF OFFICERS

- 7.1 Identification - The general officers of the Medical Staff are:

Medical Staff Bylaws

- 7.1-1 Chief of Staff;
- 7.1-2 Vice Chief of Staff; and
- 7.1-3 Secretary/Treasurer; and
- 7.1-4 Immediate Past Chief of Staff (ex-officio with vote);

7.2 Qualifications - 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. Failure to maintain such status shall immediately create a vacancy in the office involved.
- (b) Be board certified, eligible or an admissible candidate for certification, or have the training and experience to equate to board certification as determined by the Executive Committee.
- (c) Have demonstrated ability through experience and prior participation in staff activities and be recognized for a high level of competence.
- (d) Have demonstrated a high degree of interest in and support of the Medical Staff; and
- (e) Be able and willing to fully discharge the responsibilities and exercise the authority of the office held and work with the other general and department officers of the Medical Staff, the Chief Executive Officer, and the Board. A practitioner may not hold simultaneously two (2) or more general staff offices.

7.3 Term of office - The term of office of general staff officers is two (2) years. Officers shall assume office on January 1st of an election year. 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.

7.4 Eligibility for Re-Election - The Chief of Staff may not serve more than two (2) consecutive terms, nor hold any position on the Executive Committee by virtue of an elected office while serving in this capacity. All other general staff officers are eligible for nomination and re-election in succeeding terms.

7.5 Nominations - the Nominating Committee shall consist of five (5) Active Staff members chosen by the Chief of Staff the summer prior to an election year. The committee will select its own Chairman. The Nominating Committee shall nominate one or more candidates for each office. A list of nominees shall be submitted to all Active Staff members at least two weeks before the Fall Medical Staff meeting. Active Staff members may also make nominations from the floor.

7.6 Elections, Vacancies and Removals

7.6-1 Election Process - The Executive Committee shall conduct all elections, both regular and special, and shall be in charge of all matters pertaining

Medical Staff Bylaws

to thereto. Only Active Staff members shall be eligible to vote and hold office. Written ballots shall be used whenever two or more candidates are presented for consideration.

7.6-1.1 The Secretary/Treasurer shall mail one official ballot and envelope, with instructions, to each Active Staff member of the Medical Staff within 14 days after nominations are completed.

The sealed ballot must be returned on or before the date specified in the instructions, which shall be no more than 14 days after the mailing of the ballots. Any ballot received after the designated date shall not be opened and shall not affect the outcome of the election.

7.6-1.2 The Secretary/Treasurer or his or her designee shall identify the ballot envelope as containing the vote of a qualified voter and shall deposit it into the ballot box. On the designated date, the ballot envelopes shall be opened and the ballots counted by two (2) designated Active Staff members.

7.6-1.3 A majority of the votes cast for any office shall be necessary to elect any officer. If more than two (2) nominees appear on the ballot and no nominee receives a majority of the votes cast, the second election ballot shall be conducted and shall contain the name of one more candidates than the number of positions to be elected. The name(s) receiving the highest number of votes on the first ballot will be on the second ballot. The winner(s) will be candidate(s) with the most votes.

7.6-2 Vacancies in Elected Offices - In the event of a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall assume the responsibilities of the Chief for the remainder of the term. A vacancy in any other general staff office shall be filled by appointment by the Chief of Staff with the approval of the Executive Committee.

7.6-3 Resignations and Removal From Office

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

(b) Removals: Failure of an officer to meet the qualifications as defined under Section 7.2 or the failure of an officer to competently perform his or her duties for medical, physical or other reasons may be grounds for removal from office. Removal from office may be initiated by the Executive Committee or by petition signed by at least one-third of the Active Staff members. Such removal shall be considered at a special meeting of the Medical Staff for the purpose of considering and acting upon the

Medical Staff Bylaws

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.

A Medical Staff officer may also be removed in accordance with these Bylaws if any of the following occurs:

- (1) revocation of professional license by the authorizing agency;
- (2) suspension of Medical Staff privileges or appointment;
- (3) failure to adhere to professional ethics;
- (4) failure to comply with or support enforcement of the Medical Staff Bylaws, Rules and Regulations, Hospital or Medical Staff policies, or departmental Rules and Regulations.

7.7 Responsibilities of Officers

7.7-1 Chief Of Staff - The Chief of Staff shall serve as the highest elected officer of the Medical Staff. The responsibilities of the Chief of Staff include:

- (a) Call and preside at all Staff meetings;
- (b) Serve as Chairman of the Executive Committee and as an ex-officio member without vote of all other committees. If membership in a particular committee is specified by these Bylaws, he or she shall have a vote;
- (c) He or she shall exercise general charge of Staff affairs, be responsible for the proper functioning of the Staff unless otherwise provided herein;
- (d) Interact with the Chief Executive Officer, the Chief Operating Officer, and the Board in all matters of mutual concern within the Hospital and the John C. Lincoln Health Network;
- (e) Represent the views and policies of the Medical Staff to the Board and to the Chief Executive Officer;
- (f) Advise the Board of recommendations for credentialing and recredentialing of Medical Staff appointees;
- (g) Be a spokesman for the Medical Staff in external professional affairs; and
- (h) Perform such other functions as may be assigned to him or her by these Bylaws, by the Medical Staff, or by the Executive Committee.
- (i) Enforce the Bylaws, Rules and Regulations.

Medical Staff Bylaws

- 7.7-2 Vice Chief Of Staff - The Vice Chief of Staff shall assume the duties of the Chief of Staff in his or her absence. He or she shall perform such duties as may be assigned to him or her by the Chief of Staff or as may be delegated by these Bylaws and the Executive Committee. The Vice Chief of Staff shall be a member of the Executive Committee.
- 7.7-3 Secretary/Treasurer - The Secretary/Treasurer shall keep or cause to be kept minutes of all meetings and shall keep the books of account as custodian of all Staff funds. Disbursement of funds from the Staff's checking account(s) shall only be made with the signature of the Treasurer, countersigned by the Chief of Staff or Vice Chief of Staff. The Treasurer shall post a fidelity bond in an amount fixed by the Executive Committee. Premiums thereon are to be paid from the Staff funds. The Secretary/Treasurer exclusively shall be responsible for (a) the collection of all dues and assessments and (b) ensuring that the Chief of Staff's stipend is paid timely, the amount of which is to be acted upon annually by the Executive Committee. The Secretary/Treasurer shall be a member of the Executive Committee.
- 7.7-4 Immediate Past Chief of Staff – The immediate past Chief of Staff shall be an ex-officio member with vote of the Executive Committee and shall perform such responsibilities as may be assigned by the Chief of Staff or delegated by these Bylaws or by the Executive Committee.

ARTICLE EIGHT: CLINICAL DEPARTMENTS

- 8.1 Current Clinical Departments -. Each department shall be organized as a separate component of the Medical Staff and shall have a Chairman selected and entrusted with the authority, functions and responsibilities as specified in this Article. When appropriate, the Executive Committee may recommend creation, elimination and modification or combination of departments. Such recommendation shall become effective upon Board approval and shall not require formal amendment of these Bylaws. The current clinical departments are: Emergency Medicine, Medicine, Pediatrics (which is a joint Department with the Pediatrics Department of John C. Lincoln North Mountain Hospital Mountain), Radiology and Surgery.
- 8.2 Assignment To Departments - At the time of initial application and from time to time thereafter, each Staff member shall apply for clinical privileges in one or more departments, designating one as his or her primary department. The right to vote on departmental matters shall be limited to the primary department. The Hospital Services Department will have primary responsibility for Emergency Medicine physicians and Radiologists. The Department of Surgery will have primary responsibility for Anesthesiologists and Pathologists. Each department shall review applications presented to it, and recommend to the Credentials Committee approval or denial of the application and the privileges, if any, to be granted in that department pursuant to Section 8.4 of these Bylaws. Each department shall recommend privileges on the basis of training, experience, demonstrated ability and current competence.

Medical Staff Bylaws

- 8.3 Organization of Departments - each department shall have no fewer than three (3) active staff members, and shall be headed by a chairman who shall be elected in accordance with, and perform functions designated in the Rules and Regulations of the department and whose appointment shall be approved by the Executive Committee. Organized departments will meet as specified in the Rules and Regulations of the department to present educational programs and conduct clinical review of practice within the Department.
- 8.4 Function of Departments - Each department shall:
- (a) Conduct reviews to monitor and evaluate the quality and appropriateness of care and treatment provided by practitioners with privileges in the department and make recommendations based on the results of these reviews;
 - (b) Develop recommendations for the qualifications appropriate to obtain and maintain clinical privileges in the department;
 - (c) Report and make recommendations regarding the applications for initial appointment and biennial reappointment of all members to the Executive Committee;
 - (d) Establish and implement clinical policies and procedures, and monitor its members' adherence to them;
 - (e) Adopt its own Rules and Regulations to clarify or expand these Bylaws to meet the needs of its particular area of practice. Department Rules and Regulations shall not conflict with these Bylaws and shall be subject to approval by the Executive Committee and the Board;
 - (f) Monitor and evaluate the results of the review for quality and appropriateness of patient care and any other review and evaluation activities, and to provide a forum for discussion of matters of concern to its members. Assist in establishing, with the approval of the Executive Committee, specific methods of patient care review which may include data displays of patient information; chart review of selected cases; consideration of deaths, extended morbidity, unimproved patients, patients with infections, complications, questionable diagnosis of treatment, inadequate consultations, tissue reports from Pathology, record quality, utilization of Hospital facilities including beds, diagnostic, nursing and therapeutic resources, and any other reports believed important for adequate patient care evaluation;
 - (g) Report and make recommendations regarding clinical, quality review and administrative activities to the Executive Committee;
 - (h) Be responsible for conducting and making recommendations regarding continuing medical education programs pertinent to departmental clinical practice;

Medical Staff Bylaws

- (l) Coordinate the professional services of its members with those of other departments and with the Hospital patient care and support services;
- (j) Adopt Rules and Regulations, subject to the approval of the Executive Committee and the Board of Directors, for the conduct and internal management of the department, which shall include the election of the Chairman and other officers, the establishment of any subcommittees as are necessary, establishment of categories of departmental membership and of procedures governing the calling and conduct of the department meetings and internal operation. If departmental Rules & Regulations conflict with these Bylaws, these Bylaws shall govern; and
- (k) Review, on a regular basis, the mortalities within the Hospital, considering from the records of each mortality whether the case had adequate diagnostic evaluation and adequate care and whether the attending and consulting physicians recognized the critical nature of the case and its complications. Written minutes of all meetings shall be maintained.

8.4-1 Tumor Evaluation - In addition to the duties listed above, the Department of Medicine together with a representative from Radiology, Pathology and the Surgery Department shall perform the function of a hospital tumor evaluation committee pursuant to Section 9.4-1.

8.4-2 Specialty Practice - Specialty or subspecialty practice shall require Board Certification or Board Eligibility or qualifications for Board Eligibility as established by the Advisory Board of Osteopathic Specialists, the American Board of Medical Specialists, the Royal College of Canada or as may be established by the appropriate department.

8.5 Department Officers

8.5-1 Qualifications - Each department shall have a Chairman who during his or her term shall be and remain a member in good standing of the Active Medical Staff; shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the Department; and shall demonstrate a high degree of interest in the a Vice-Chairman or other officers as defined in the Department's Rules & Regulations. The Chairman or his designee is responsible for the review of biennial reappointment applications and recommendations of continuing reappointment to the respective clinical departments.

8.5-2 Election - In an election year, the Department Chairman shall appoint a Nominating Committee of three (3) Staff members of the department who shall present a slate of nominees at the Fall General Staff meeting. Any Active member of the department may make additional nomination from the floor. A secret mail ballot shall be conducted following the Fall meeting unless a candidate is running unopposed. Individuals for each

Medical Staff Bylaws

office receiving a majority of votes cast shall be elected. The Executive Committee shall approve the Chairman and Vice-chairman of each department.

- 8.5-3 Term Of Office - Department Chairmen and other department officers, shall serve a two-year term terminating on December 31, or until their successors are chosen, unless such officer is filling a vacancy, in which one such officer shall serve for the remainder of the unexpired term. Department Officers shall be eligible to succeed themselves unless prohibited in their respective Department Rules & Regulations.
- 8.5-4 Removal - Removal of a Department Officer may result from failure to conduct those responsibilities assigned within these Bylaws, Medical Staff or department Rules and Regulations or other policies and procedures of the Medical Staff. Removal may be initiated by the Executive Committee or by petition signed by at least one-third of the Active Staff members of the department. Such vote shall occur by written ballot conducted in the same manner as that used in the election of department officers. Removal shall require two-thirds vote of the Active Staff members of the department who casts a vote, but no such removal shall be effective unless and until it has been approved by the Executive Committee.
- 8.5-5 Vacancy - If the office of Chairman becomes vacant for any reason, the Vice-Chairman shall succeed to the Chairmanship for the unexpired term. If the office of Vice-Chairman becomes vacant for any reason, the Chairman shall appoint a temporary departmental Vice-Chairman for the duration of the unexpired term. If both the Chairman and Vice Chairman's positions become vacant during the same term, the Chief of Staff, with the approval of the Executive Committee, may appoint a member or members of the department to carry out the functions of the Chairman and Vice Chairman for the duration of the unexpired term or may convene a special election.
- 8.5-6 Responsibilities - Each Chairman shall have the authority, functions, and responsibilities listed below. In the absence of the Chairman, the Vice Chairman shall have the authority, functions and responsibilities below.
- (a) Act as presiding officer at department meeting.
 - (b) Be responsible to the Executive Committee for all professional and administrative activities within the department including making recommendations as appropriate regarding the
 - (1) integration of the department into the primary functions of the hospital;
 - (2) coordination and integration of interdepartmental and intradepartmental services;

Medical Staff Bylaws

- (3) development and implementation of policies and procedures that guide and support the provision of care;
 - (4) recommendation for a sufficient number of qualified and competent persons to provide care and services;
 - (5) recommendations for space and other resources needed for functioning of the department;
 - (6) assessment and recommendation to the relevant hospital authority regarding off-site sources for needed patient care services not provided by the department or the Hospital; and
 - (7) implementation of department Rules and Regulations, criteria for privilege delineation, and programs for continuing medical education and improvement in the quality management program.
- (c) Monitor and evaluate the quality and appropriateness of patient care and professional competence rendered by practitioners with clinical privileges in the department;
 - (d) Develop a planned, on-going process to monitor and evaluate the quality of care and integration of this process and other hospital quality assessment and improvement activities;
 - (e) Be a member of the Executive Committee where so designated in Section 9.2-1, give guidance on overall medical policies of the Hospital, and make specific recommendations regarding the department;
 - (f) Transmit to the Credentials Committee the department's recommendations concerning the clinical privileges and staff category of practitioners who are members of or applying to the department, and corrective action specific to practitioners with privileges within the department.
 - (g) Enforce the Bylaws, Medical Staff and departmental Rules and Regulations and policies of the department and the Hospital;
 - (h) Implement within the department actions directed by the Executive Committee and/or the Board; and
 - (i) Perform such other functions as may from time to time be reasonably requested by the Chief of Staff or the Executive Committee.

ARTICLE NINE: COMMITTEES

Medical Staff Bylaws

- 9.1 General - All committees of the Medical Staff, other than the Executive Committee, shall be either standing or called as ad hoc committees. Standing committees shall meet regularly and special committees shall meet according to need, unless otherwise provided. Written records of attendance at meetings and minutes describing business conducted shall be maintained of all meetings. Except as otherwise provided, the Chief of Staff shall appoint the Chairmen and the members of the standing and special committees with the approval of the Executive Committee. The Chairmen shall be members of either the Active or Courtesy Staffs. The initial term of office of Chairmen of Medical Staff Committees shall be one (1) year.

Members of all committees shall be encouraged to attend no less than fifty percent of all meetings held in a calendar year. Failure to maintain attendance would be considered a failure to perform duties duly assigned.

9.1-1 Removals and Vacancies

A medical staff member serving as Chairman or a member on a committee may be removed by the Chief of Staff from the Committee for failure to remain a member of the Medical Staff in good standing, or by action of the Executive Committee. A committee member removed by Executive Committee action shall have the right to an appearance before the Executive Committee to request reconsideration of the removal but shall not be entitled to the procedural rights contained in the Fair Hearing Plan.

- 9.1-2 A vacancy in any committee shall be filled for the unexpired portion of the term in the same manner in which the original appointment was made.

9.2 Provisions

9.2-1 Ex Officio Members

The Chief of Staff and the Chief Executive Officer or their respective designees are ex-officio members of all committees of the Medical Staff.

- 9.2-1.1 Hospital personnel assisting the Medical Staff in the performance of the functions of the committee shall have no voting rights.

9.3 Executive Committee

9.3-1 Composition

- (a) The Executive Committee shall be a standing committee and shall consist of fourteen (13) voting members. Active medical staff members who are elected to serve shall include:

- (1) The Chief of Staff,
- (2) Vice Chief of Staff,
- (3) Secretary/Treasurer;
- (4) Immediate Past Chief of Staff;
- (5) Two Members-at-Large,

Medical Staff Bylaws

- (6) The Chairmen of the Departments of Emergency Medicine, Medicine; Pediatrics; Radiology and Surgery.
- (b) The Chairmen of Standing Committees - Bylaws, Credentials; Medical Education and Osteopathic Methods and Concepts shall be appointed by the Chief of Staff and may be members of the Courtesy Staff.
- (c) The Chief Executive Officer and/or his or her designee, the Nurse Executive, the Program Director of the Family Medicine Residency Program, the Hospital Medical Director and the Director of Medical Education shall also serve on the Executive Committee, without vote. The officers and members-at-large are elected pursuant to Section 7.6 of these Bylaws.

Note: Members of the Board of Directors may attend meetings of the Executive Committee.

- (d) Election of Member-at-Large positions shall take place pursuant to Section 7.6-1 of these Bylaws. The term of each member-at-large shall be two (2) years. Members at-large shall be eligible for re-election in that capacity but they shall not serve more than two (2) consecutive terms. If a member-at-large vacates his or her office for any reason with more than six (6) months of his or her term remaining, a replacement election shall be held at the next Quarterly Staff meeting. If less than six (6) months of the term remains, a member at-large replacement shall be appointed within thirty (30) days by the Chief of Staff from candidates proposed by the members of the Executive Committee. A vacancy in a General Officer position will be filled in accordance with Section 7.6-2 of these Bylaws.
- (d) The Chief of Staff shall vote only in the event of a tie.

9.3-2 Responsibilities - The duties and responsibilities of the Executive Committee shall be:

- (a) To represent and to act on behalf of the Medical Staff and to make recommendations to the Board of Directors regarding Medical Staff structure, mechanisms used to review credentials and to delineate individual clinical privileges, mechanisms for termination of appointments and/or clinical privileges, and mechanisms for fair hearing proceedings, appointment, reappointment, departmental assignments, medical staff status and other issues involving credentialing;
- (b) To coordinate the activities and general policies of the various departments;
- (c) To receive and act upon committee reports, and to make recommendations concerning them to the Chief Executive Officer and the Board of Directors;

Medical Staff Bylaws

- (d) To supervise, oversee, monitor, establish guidelines, and make recommendations to the Board of Directors for the participation of the Medical Staff in organizational performance improvement activities;
- (e) To implement policies of the Medical Staff which are not the responsibility of the departments;
- (f) To provide liaison between the Medical Staff, the Chief Executive Officer, and the Board of Directors;
- (g) To participate in hospital planning efforts and to recommend action to the Chief Executive Officer on matters of medico-administrative and hospital management nature;
- (h) To discharge the Medical Staff's accountability to the Board of Directors for the medical care rendered to patients in the hospital;
- (i) To ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the hospital;
- (j) To review the credentials of all applicants and to make recommendations for staff membership assignment to departments and delineation of clinical privileges;
- (k) To review periodically all information available regarding the performance and clinical competence of staff members and as a result of such review to make recommendation for reappointments and renewal of or changes in clinical privileges; and
- (l) To promote professional and ethical conduct and competent clinical performance of the Medical Staff including recommendations to the Board of Directors on actions described in Article 11.1.
- (m) To secure, as needed, legal consultation and representation for the Medical Staff as a group. The Executive Committee may select such legal representation or consultation and pay for legal services it obtains from Medical Staff funds. When necessary, the Executive Committee may impose a special assessment upon Medical Staff members. Such legal representation is considered appropriate on an ad hoc basis in matters of general Medical Staff interest.

9.3-3 Meetings - The Executive Committee shall meet as often as necessary, but no less than quarterly, to transact business. The Chairman will maintain a permanent record of its proceedings and actions, which

Medical Staff Bylaws

records shall include the minutes of the various committees and departments of the staff.

Whenever action on credentialing reports and other routine items are required, and the Executive Committee is not scheduled to convene a timely meeting, a Consent Agenda may be used to transact business. Each member of the Executive committee shall be provided with appropriate documentation pertaining to each item on the Consent Agenda to review and approve by returning a signed authorization of the Consent Agenda. An affirmative response from a majority of the members of the Executive committee shall constitute approval on the required action items. A written report summarizing all matters approved by the use of a Consent Agenda shall be signed by the Chief of Staff attesting to the approval of such matters by a majority of the members of the Executive Committee and forwarded to the Board of Directors.

9.4 Standing Committees

9.4-1 Credentials Committee

9.4-1.1 Composition - The Credentials Committee shall consist of a Chairman and six members from a variety of specialties. Appointments to the Committee shall be approved by the Executive Committee.

9.4-1.2 Duties - The responsibilities of the Credentials Committee shall be to:

- (a) examine the qualifications of each applicant to determine whether all qualifications for staff membership have been fulfilled;
- (b) investigate and confirm the credentials of all reapplicants for medical staff membership at least every two years;
- (c) Recommend expansion or limitation of privileges of staff members based on a thorough review of credentials;
- (d) Maintain minutes of each meeting and submit a report to the Executive Committee that shall contain recommendations for appointments and biannual reappointments.

9.4-1.3 Meetings - The Credentials Committee shall meet monthly or as necessary to discharge its responsibilities.

9.4-2 Hospital Services Committee

9.4-2.1 Composition – The committee shall consist of:

Medical Staff Bylaws

- Committee Chairman
- Radiology Department Chairman
- Emergency Medicine Department Chairman
- Pathology Medical Director
- Hospital Medical Director
- Medical Staff Members from radiology, emergency services, cardiology, orthopedics, surgery, family practice, adult and pediatric hospitalists and internal medicine.
- Nursing representative
- Laboratory representative
- Administrative Representative

9.4-2.2 Duties – The Hospital Services Committee is the oversight committee for the departments of Radiology & Emergency Medicine. The duties of the committee include the following:
(a) Measuring, assessing and improving the medical assessment and treatment of patients via interdisciplinary interaction. Ensure communication of findings, conclusions, recommendations and actions taken to improve organization performance.
(b) The Department Chairman is responsible for the professional function, duties and responsibilities within the department as outlined in Article 8 of the Medical Staff Bylaws.

9.4-2.3 Meetings - The Hospital Services Committee shall meet quarterly to discharge its responsibilities.

9.4-3 Osteopathic Methods and Concepts Committee

9.4-3.1 Composition - The committee shall consist of a Chairman and representatives from each of the clinical departments.

9.4-3.2 Duties - The Osteopathic Principles and Methods Committee shall:

- (a) Keep minutes of each meeting and report to the Executive Committee and the Staff;
- (b) Promote the most effective methods for osteopathic diagnosis and treatment for comprehensive patient care;
- (c) Improve recording of osteopathic musculoskeletal findings, diagnosis and management on patient charts;
- (d) Provide for ongoing continuing education in osteopathic principles and practice;
- (e) Provide a clinical environment for osteopathic diagnosis and treatment to promote quality patient care;

Medical Staff Bylaws

- (f) Establish and conduct retrospective and concurrent audits of patient charts relating to the application of osteopathic principles and practice to patient diagnosis and treatment; and
- (g) Inform Staff appointees of the committee's evaluation of patient charts and recommendations to improve utilization of osteopathic principles and practices.

9.4-3.3 Meetings - The Osteopathic Principles and Methods Committee shall meet as often as necessary.

9.4-4 Pharmacy & Therapeutics Committee

9.4-4.1 Composition – The Pharmacy & Therapeutics Committee shall consist of a Chairman, at least one member of the medical staff, the Hospital Pharmacist, representatives from nursing, pharmacy and nutrition services.

9.4-4.2 Duties

- (a) Assume responsibility for development and supervision of the Hospital Formulary. The committee as needed shall amend the formulary.
- (b) Formulate drug policies and establish pharmacy procedures, which include minimization of drug errors. Formulate regulations concerning administration of drugs in order to safeguard patients and improve their care.
- (c) Suggest means to economize on the cost of drugs to the patient.
- (d) Discuss pertinent matters with regard to the Pharmacy
- (e) Look at antibiograms and ways to educate physicians and nursing staff on use of antibiograms.
- (f) Be the mainstream as to what is going on with susceptibility patterns.
- (g) Address issues of resistance within various groups of microorganisms. Make recommendations of handling resistance in the future.
- (h) Shall recommend drugs, which should be stocked on nursing units.
- (i) Shall evaluate clinical data concerning new drugs requested for use in the hospital.
- (j) Shall help formulate broad policies on evaluation, selection, procurement, distribution and use of drugs.
- (k) Shall advise the professional staff and the pharmacist on the choice and use of drugs.
- (l) Shall formulate procedures for reporting adverse drug reactions and errors in administration of drugs.
- (m) Serve as a liaison with the professional staff.

Medical Staff Bylaws

9.4-4.3 Meetings - The P&T Committee shall meet as often as necessary to conduct business.

9.4-5 Bylaws Committee

9.4-5.1 Composition - The Bylaws Committee shall consist of a Chairman and a representative from each of the clinical departments.

9.4-5.2 Duties - The committee shall be charged with the biennial review of the Medical Staff Bylaws. Any changes recommended in the Bylaws shall be submitted to the Bylaws Committee for review and recommendation to the Executive Committee and Medical Staff for adoption.

9.4-5.3 Meetings - The Bylaws Committee shall meet at least biennially for the required review of the Bylaws. Any additional meetings shall be by majority vote of the members or as called by the Chairman.

9.4-6 Utilization Review Committee

9.4-6.1 Composition - The Utilization Review Committee shall consist of a Chairman, two or more practitioners, other professional personnel, the medical records administrator (as an advisor to the committee) and an administrator or designee.

9.4-6.2 Duties - The committee shall provide for review for Medicare and Medicaid patients with respect to the necessity of: (a) admissions to the institution; (b) the duration of stays; and (c) professional services furnished, including drugs and biologicals. UR activities are kept as peer review and confidential.
Members of the committee may not review their own charts.

The Utilization Review Committee shall report its findings to the Medical Executive Committee.

9.4-6.3 Meetings - The Utilization Review Committee shall meet as necessary to perform the required functions.

9.5 Ad Hoc Committees - Ad Hoc Committees shall be appointed by the Chief of Staff, as they are required. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Executive Committee. An Ad Hoc committee shall limit its activities to the accomplishment of the task for which it is appointed and shall be discharged after their purpose for appointment has been satisfied. The Chairman of each Committee shall serve until completion of the assignment given the Committee. Duties of each Committee shall be specified by the Chief of Staff.

Medical Staff Bylaws

9.5-1 Tumor Evaluation Committee - The functions of the tumor evaluation committee shall be performed by the members of the Department of Medicine to include representation from Pathology and Radiology.

9.6 Network Committees

9.6-1 Organization - Network committees are those whose members are comprised of representatives from the Hospital and from John C. Lincoln Hospital - North Mountain as well as other entities of the John C. Lincoln Health Network. The Chairman of a Network Committee shall be appointed mutually by the Chiefs of the Medical Staffs on a rotating basis between the two hospitals. A chairman shall preside for a minimum of two (2) years and not to exceed a total of four (4) years.

9.6-1.1 Bioethics Committee

9.6-1.1.1 Composition - The Bioethics Committee shall consist of the following: one-third medical staff members, one-third hospital staff personnel, and one-third other representation of at least, but not limited to clergy, legal, administration and the community.

9.6-1.1.2 Duties - The Bioethics Committee shall exist for purposes of education, development and revision of policies and procedures relating to issues of an ethical nature, and for the purpose of providing case consultations.

9.6-1.1.3 Meetings - The Bioethics Committee shall meet quarterly and/or on demand and maintain a permanent record of its proceedings and actions, and report dually and jointly to the Executive Committee's of both medical staffs.

9.6-1.2 Medical Education Committee

9.6-1.2.1 Composition - The Medical Education Committee shall consist of a Chairman and eight members. The Director of Medical Education shall be an ex-officio member and shall serve as secretary of the Committee. The Chairman shall be appointed for a term of one year and shall be an ex-officio member of all subcommittees. The subcommittees shall include the Intern Training Subcommittee, the Resident Training Subcommittee and the Library Subcommittee.

9.6-1.2.2 Duties - The responsibilities of the Medical Education Committee shall include:

Medical Staff Bylaws

- (a) formulate the educational policies of the Medical Staff and coordinate interdepartmental involvement in education in the following areas:
 - (i) clinical clerkships and externships;
 - (ii) internships and residencies;
 - (iii) staff continuing medical education; and
 - (iv) the Medical Library.
- (b) assist the Director of Medical Education in the organization, coordination and supervision of the educational training program for interns, residents, externs and clinical clerks equal to or superior in quality to that required for AOA hospitals approved to provide medical education;
- (c) review and approve the selection of interns, externs, and residents;
- (d) maintain detailed minutes of each meeting and submit a report no less than quarterly to the Executive Committee.
- (e) provide necessary oversight and advice to the Medical Librarian regarding decisions when necessary.

9.6-1.2.3 Meetings - The Medical Education Committee shall meet as often as is necessary to discharge its responsibilities but no less than quarterly.

9.6-2 Continuing Medical Education Committee

9.6-2.1 Composition – The Continuing Medical Education Committee shall consist of a minimum of five (5) Medical Staff members who are representative of each clinical Department at both Hospitals.

9.6-2.2 Responsibilities - The responsibilities of the Continuing Medical Education Committee shall be to ensure that a quality continuing medical education program is offered for members of the Medical Staffs. The Program should be oriented toward assisting practitioners in maintaining a high standard of practice.

9.6-2.3 Meetings - The Continuing Medical Education Committee shall meet as often as necessary to discharge its responsibilities. It shall maintain a permanent record of its findings, proceedings and actions, and shall report to the Executive Committee of both Hospitals.

9.6-3 Joint Conference Committee

Medical Staff Bylaws

9.6-3.1 Composition - The Joint Conference Committee shall include three (3) elected members of the Board of Directors, three (3) members of the active Medical Staff from the Hospital and (3) members of the active Medical Staff of John C. Lincoln Hospital - North Mountain selected by the Executive Committee of the respective medical staffs, and the President Chief Executive Officer.

9.6-3.2 Duties - The Joint Conference Committee shall conduct itself as a forum for the discussion of matters of hospital policy and practice on matters of a medical administrative nature requiring agreement among the Board of Directors, Medical Staff and Administration.

9.6-3.3 Meetings - The Joint Conference Committee shall meet when necessary.

9.7 Professional Review Committee

9.7-1 **Composition and Authority** – The Professional Review Committee (PRC) shall consist of five (5) voting members, including the chairman, all of whom shall be on the Active Staff and willing to serve on a consistent basis. The Medical Director of the Hospital, the Chief of Staff and the Chief Executive Officer (or his/her designee) shall serve as ex-officio members of the PRC without vote. In addition, the Professional Committee of John C. Lincoln North Mountain Hospital shall be entitled to designate one of its members to serve as an ex officio members of the PRC without vote.

The PRC will not have authority to take disciplinary action against any member or AHP Staff. Rather, the PRC will have authority to evaluate and/or investigate matters brought to its attention and report and make recommendations in accordance with the Peer Review Process or Article 6 of these Bylaws, as applicable.

9.7-2 **Membership Selection Process** – The PRC shall have a chairman appointed by the Chief of Staff with approval by the Medical Executive Committee and a vice chairman elected by the PRC from the remaining four (4) voting members of the PRC. The Executive Committee shall appoint two (2) members of the PRC. The Executive Committee shall nominate an additional two (2) or more candidate and present the slate of candidates to the General Staff for consideration as a meeting. Further nominations may be made from the floor at such meeting. Following the General Staff meeting, two (2) members of the PRC shall be elected by mail ballot in accordance with Section 7.5-1 of these Bylaws. However, if no further nominations are made from the floor, the two candidates nominated by the Executive Committee will be considered elected. Members shall be appointed/elected for staggered terms of two (2) years each (except the initial terms of two of the initial

Medical Staff Bylaws

members shall be for one year and members may be appointed for successive terms.

9.7-3 **Qualifications** – PRC members must continuously satisfy the qualifications and complete the requirements set forth in Section 3.2. PRC members must demonstrate leadership skills and must disclose any conflicting interests they may have with the Hospital or the Medical Staff prior to being appointed/elected.

9.7-4 **Duties** – The Professional Review Committee shall:

- a) Participate in the Peer Review Process in accordance with these Bylaws and applicable policies and procedures and rules and regulations.
- b) Perform Informal Activity Assessments, conduct investigations and make reports and recommendations in accordance with Article 6 of these Bylaws.
- c) Periodically evaluate the Peer Review, Informal Activity Assessments and Corrective Action processes being performed at the Hospital and report to the Medical Executive Committee with any recommendations the PRC may have for improvements and/or modifications of such processes.
- d) Perform any other activities or functions as may be referred to the PRC by the Medical Executive Committee.

9.7-5 Miscellaneous Provisions

- a) The PRC shall meet as frequently as necessary to conduct its business. The meetings shall be conducted in executive session and the minutes shall be recorded as privileged and confidential pursuant to applicable state law including ARS 36-445 et seq.
- b) PRC members shall be entitled to be compensated in the manner and in the amount as determined from time to time by the Medical Executive Committee. Such compensation shall be paid in equal amounts by the Medical Staff and the Hospital.
- c) The confidentiality of the PRC records will be strictly maintained.
- d) The following attendance requirements apply to PRC members –
 - (1) voting members are required to attend 75% of all meetings;
 - (2) compliance with this requirement shall be reviewed every six (6) months; and
 - (3) any member not meeting this requirement shall be automatically removed and the Medical Executive Committee will appoint a replacement.
- e) A quorum shall consist of three (3) of the five (5) voting members.
- f) When appropriate, the PRC Chairman may appoint qualified professionals to review specific matters pending before the PRC and provide input to the PRC Committee and shall be supported by reference to the specific activity or conduct that constitutes the grounds for the request.

ARTICLE TEN: MEETINGS

10.1 Medical Staff Meetings

Medical Staff Bylaws

- 10.1-1 Regular Meetings - Meetings of the General Medical Staff shall be held as necessary to conduct medical staff business or to approve proposed amendments to the Bylaws. A written record of attendance shall be kept for all Staff and departmental meetings.
- 10.1-2 Special Meetings - Special meetings of the Staff may be called by the Chief of Staff or on request of a majority of Staff officers or on written request of at least ten Active Staff members. Written notice of special meetings shall be mailed to each Staff member at least seventy-two hours before such special meeting.
- 10.1-3 Quorum and Voting - Any action taken at a quarterly staff meeting of the Staff requires the presence of a quorum which shall consist of one-fourth of the Active Staff members or committee members entitled to vote at a meeting.
- 10.1-4 Minutes - Minutes of each regular and special meeting of a committee, department or General Staff shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be sent to the Executive Committee. A permanent file of the minutes of each meeting shall be maintained in the Medical Staff Office.
- 10.1-5 Attendance at Staff Meetings - In addition to satisfying the peer review appearance or communication requirements of Section 10.3, members of the Active staff are expected to attend general staff, department, section and/or committee meetings. Staff membership, with resulting privileging carries obligations to reasonably participate in Medical Staff self-governance. All other categories of membership are encouraged to attend general staff, department, section and/or committee meetings.
- 10.1-6 Executive Session - Any department or committee may call itself into executive session at any time during a regular or special meeting at the discretion of the Chairman. Attendance at executive session shall be restricted to members of the department or committee and individuals with a legitimate reason to be present as determined by the Chairman. Separate minutes must be kept of any executive session.
- 10.2 Peer Review
Peer review is a process of evaluating practitioners by independent practitioners who have knowledge and experience in the specialty or area under review. Peer review is the responsibility of all Medical Staff members and provides an opportunity for changing practices and improving overall patient care. The type and extent of the review is dependent upon the reason for the review. Failure to participate in the peer review process in a timely manner may be cause for corrective action. Peer review shall be focused on patterns and trends using defined criteria established and approved by the individual clinical Departments with its primary focus being for educational purposes.

Medical Staff Bylaws

Whenever a practitioner's clinical course of treatment is identified as being outside the normal range of established criteria, the process defined within Section 6.0 of the Medical Staff Rules and Regulations shall be followed.

10.2-1 Sentinel Event

Upon determination that a cause may possibly involve a sentinel event as defined within the Hospital's Sentinel Event policy, the Chief of Staff and the Chief Executive Officer shall be informed of the case and a process of root cause analysis and peer review shall be immediately initiated.

10.2-2 External Peer Review

The Chairman of the Clinical Department (or his designee) may at any time, with approval from the Chief of Staff and the Chief Executive Officer, arrange for the assistance of one or more practitioners who are not members of the Medical Staff to serve as consultants with respect to peer review, applications for appointment or reappointment to the Medical Staff. If a consultant is used, he or she shall ordinarily file a written report. The report shall be made available to the affected practitioner upon request. The report may serve as the basis for action to be taken. If action to terminate or limit a Medical Staff member's appointment or privileges is based upon a consultant's report, all due process rights shall be afforded the affected practitioner pursuant to the Medical Staff Bylaws and the Fair Hearing Plan.

10.3 Peer Review Appearance

10.3-1 A practitioner whose patient's clinical course of treatment is scheduled for case discussion as part of regular peer review activities, may be required by the department or committee to present the case. If the practitioner has been so notified, his or her attendance will be mandatory at the meeting at which the case is to be discussed. Failure to attend may result in initiation of corrective action proceedings.

10.3-2 Whenever deviation from standard practice is identified or suspected with respect to a practitioner's performance, the Chief of Staff or applicable Department 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 therefor. Failure of a practitioner to appear at any such meeting may result in initiation of corrective action proceedings.

10.4 Peer Review Communication

10.4-1 Failure to Respond (First Occurrence): If a physician fails to respond to an initial request for clarification and/or information regarding peer review issues, a certified letter will be sent informing the physician he or she has thirty (30) days in which to respond or privileges will automatically be suspended pending receipt of a response.

10.4-2 Failure to Respond (Second Occurrence and Thereafter): If a physician fails to respond subsequent to a first time occurrence, suspension of

Medical Staff Bylaws

privileges will be recommended for a period of thirty (30) days without the granting of a thirty-day (30) grace period.

ARTICLE ELEVEN: CONFIDENTIALITY, IMMUNITY AND RELEASES

- 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 Hospital, a practitioner:
- (a) Authorizes Medical Staff 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 Hospital;
 - (d) Agrees to release from legal liability and hold harmless any representative who acts in accordance with these Bylaws;
 - (e) Agrees to release from legal liability and hold harmless any representative who provides information regarding such practitioner pursuant to his or her direct or indirect authorization or pursuant to law;
 - (f) Agrees to release from legal liability and hold harmless any individual who or entity which provides information regarding the practitioner to the Hospital or its representatives; and
 - (g) Agrees that information involving a practitioner's membership, clinical privileges, competence, character, health status and ethical qualifications, including privileged and confidential peer review information will be shared by and between the John C. Lincoln Health Network hospitals during the appointment and reappointment process and at any time thereafter including immediately upon the imposition of a summary suspension.
- 11.2 Confidentiality Of Information - Information obtained or prepared by any representative for the purpose of monitoring and 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.

Medical Staff Bylaws

If it has determined that a breach of confidentiality has occurred, the Executive Committee may undertake corrective action as is deemed appropriate.

- 11.3 Activities Covered - All Medical Staff members and applicants for membership on the Medical Staff acknowledge that, by applying for and/or accepting membership on the Medical Staff, that they agree to respect and maintain the confidentiality of all discussions, deliberations, proceedings and activities of the Medical Staff. Therefore, 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 organizations' activities concerning, but not limited to: 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 action or disciplinary actions;
 - (d) Hearings and appellate reviews;
 - (e) Quality management activities;
 - (f) Claims reviews;
 - (g) Profiles and profile analysis; and
 - (h) Other hospital, committee, department, or staff activities related to monitoring and evaluating of quality and efficient patient care and appropriate professional conduct.
- 11.4 Releases - Each practitioner shall, upon the request of the Medical Staff, execute general and specific releases in accordance with the tenor and import of this Article. Execution of such releases is not a prerequisite to the effectiveness of this Article. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn, and it shall not be further processed.
- 11.5 Cumulative Effect - Provisions in these Bylaws and in application and reapplication forms relating to authorization, confidentiality or information, and immunities from liability are in addition to other protections provided by relevant Arizona and federal law and not in limitation thereof. A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provision or any other provision.

ARTICLE TWELVE: GENERAL PROVISIONS

Medical Staff Bylaws

- 12.1 Medical Staff Rules and Regulations – The Medical Staff has adopted Rules and Regulations which are hereby incorporated into these Bylaws and which are intended to provide guidance for practitioners providing medical treatment at the Hospital. The Rules and Regulations of the Medical Staff may be amended or repealed, in whole or in part, by resolution of the Medical Staff Executive Committee which is recommended to and adopted by the Board.
- 12.2 Credentialing Procedures Manual – The Medical Staff has adopted a Credentialing Procedures Manual which is hereby incorporated into these Bylaws and which sets forth the procedures for applying for and being granted privileges to practice at the Hospital and membership on the Medical Staff, including procedures pertaining to leaves of absence. The Credentialing Procedures Manual may be amended or repealed, in whole or in part, by resolution of the Medical Staff Executive Committee which is recommended and adopted by the Board.
- 12.3 Fair Hearing Plan – The Medical Staff has adopted a Fair Hearing Plan which is hereby incorporated into these Bylaws and which sets forth the rights available to a practitioner against who corrective action has been requested or taken, including the procedures for requesting and conducting hearing and appellate reviews in connection with such corrective action. The Fair Hearing Plan may be amended or repealed, in whole or in part, by resolution of the Medical Staff Executive Committee which is recommended to and adopted by the Board.
- 12.4 Staff Dues - The Executive Committee shall establish the amount of annual Medical Staff dues. Notice of dues shall be given to the staff by written notice in December. 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 thirty (30) days given in which to make payment. All new staff members shall be billed and given ninety (90) 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 6.2-3. 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.
- 12.5 Special Notices - When special notice is required, the Hospital shall send such notice by certified mail, return receipt requested to the address provided by the practitioner. If the post office indicates that the letter had 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 Services Department 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.
- 12.6 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 of effect of any provision of these Bylaws.
- 12.7 Parliamentary Procedure - The rules contained in the current edition of Robert's Rules of Order, shall govern the Medical Staff in all cases to which they are

Medical Staff Bylaws

applicable and in which they are not inconsistent with these Bylaws and any special rules of order the Medical Staff may adopt.

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order. Departures from such rules shall not invalidate action taken at such a meeting.

ARTICLE THIRTEEN - ALLIED HEALTH PROFESSIONALS

13.1 Allied Health Professionals Defined - Allied Health Professionals (AHP's) are individuals who:

- (a) Are qualified by training, experience and current competence in a discipline permitted to practice in the Hospital; and
- (b) Function in a medical support role to physicians who have agreed to work in collaboration with or be responsible for such AHP's.

13.2 Categories of AHP's Currently Authorized To Function In The Hospital - Included but not limited to the following are categories of AHP's currently authorized to provide services in the Hospital: Physician Assistants, Certified Nurse anesthetists, nurse practitioners, non-physician first assistants, scrub technicians, perfusionists and certified nurse midwives. The Executive Committee may recommend for Board approval other categories of AHP's to be given authorization to provide services in the Hospital. If an AHP does not have a physician employer or other sponsor who has signed an AHP sponsorship agreement for all of the AHP's services in the Hospital, the AHP, if approved to perform activities in the Hospital, must sign an agreement evidencing the AHP's responsibilities and also that the AHP will not perform any activity or assist with any procedure in the Hospital, except with medical supervision or direction for that particular activity or procedure by a physician on the Medical Staff of the Hospital with appropriate privileges

13.3 Qualifications Of Allied Health Professionals - A practice guideline (Scope of Service) position summary of qualifications for each category of Allied Health Professionals shall be developed by the department to which the AHP supervising physician is assigned, subject to approval by the Executive Committee and the Board of Directors. Each statement must be:

- (a) Developed with input, as applicable, from the physician director of the clinical unit or service involved, the physician observer/sponsor of the AHP, and other representatives of the Medical Staff, Hospital management, and other professional staff;
- (b) Require the individual AHP to hold a current license, certificate or such other credential, if any, as may be required by state law; and
- (c) Appropriate professional liability insurance coverage in an amount, and with such other provisions, as required for Medical Staff members.

Medical Staff Bylaws

Failure of an AHP to obtain or maintain current insurance will result in the automatic termination of permitted activities without a right of appeal.

13.4 Prerogatives of Allied Health Professionals - The prerogatives of an AHP are to:

- (a) Provide such specifically designated patient care services as are granted by the Board upon recommendation of the Executive Committee and consistent with any limitations stated in the Bylaws, the policies governing the AHP's practice in the Hospital, and other applicable Medical Staff or Hospital policies; and
- (b) Exercise such other prerogatives as the Executive Committee with the approval of the Board may accord AHP's in general or to a specific category of AHP's.

13.5 Obligations of Allied Health Professionals - Each AHP shall:

- (a) Meet the basic responsibilities required by Section 3.3 (1-10) for Medical Staff members;
- (b) Retain appropriate responsibilities within his or her area of professional competence for the care and observation of each patient in the Hospital for whom services are provided.
- (c) Participate when requested in quality management activities and in discharging such other functions as may be required from time to time;
- (d) When requested, attend meetings of the staff and/or the department; and
- (e) Refrain from any conduct or act that could be reasonably interpreted as being beyond the scope of practice authorized by the Board.

13.6 Definition Of Scope Of Service - The scope of service that may be provided by any group of AHP's shall be developed by the appropriate department and representatives of management, if applicable, and subject to the recommendation of the Executive Committee and the approval of the Board. For each group, practice guidelines/position summary must include at least:

- (a) A description of the services to be provided and procedures to be performed, including any special equipment, procedure, or protocols that specific tasks may involve, and responsibility for documenting the services provided in the medical record, if applicable; and
- (b) A description of the scope of assistance that may be provided to a physician and any limitations thereon, including the degree of physician observation required.

13.7 Procedure for Credentialing - The procedure for processing individual applications for AHP's, for reviewing performance during the probationary period, for periodic reappraisal and assessment of clinical competence, and for

Medical Staff Bylaws

disciplinary action shall be established by the respective Clinical Department, the Credentials Committee, the Staff Executive Committee and the Board of Directors.

13.7-1 The Hospital shall establish the requirements and procedures applicable to AHP's who are Hospital employees. Pursuant to Article 13-6, the scope of service and all requests for privileges to perform invasive procedures by employed AHP's shall be subject to the recommendation of the Executive Committee and approval by the Board of Directors. The Medical Staff shall be responsible for the evaluation of continuing competency and qualifications of an employed AHP on a biennial basis.

13.8 Withdrawal Of Practice Prerogatives - It is the intent of these Bylaws that persons who have the Practice Prerogatives allowing participation in patient care activities as AHP's not be deemed members of the Medical Staff, and shall not have any rights under the Fair Hearing Plan; provided, however, that they shall be given a course of due process in accordance with Medical Staff Services policy.

ARTICLE FOURTEEN: RESIDENTS, FELLOWS, MEDICAL STUDENTS

14.1 Physicians-in-Training - A resident, fellow or medical student is a physician-in-training who works under the supervision of a Medical Staff member.

14.1.1 Supervision

Licensed, independent practitioners with appropriate clinical privileges shall supervise a physician in his/her patient care responsibilities.

14.1-2 Purpose

Supervision of physicians-in-training is to safeguard patient care and enhance graduate medical education by setting appropriate standards for evaluation and supervision.

14.1-3 Family Medicine Residency Program

14.1-3.1 The Medical Education Committee, through its Program Director for the Family Medicine Residency Program shall regularly communicate and report at least annually to the Medical Staff Executive Committee regarding the safety and quality of patient care provided by the resident staff and their related educational and supervisory needs.

14.1-3.2 The Medical Education Committee shall provide a comprehensive report to the Board of Directors annually about the educational needs and performance of residents.

ARTICLE FIFTEEN ADOPTION AND AMENDMENT

Medical Staff Bylaws

15.1 Procedure for Amendment

Medical Staff Bylaws 15.1.1 A proposed amendment shall be initiated either in writing to the Bylaws Committee or through a special meeting of the Medical Staff as referenced in 10.1-2.

The Medical Staff shall be responsible for the development, adoption and biennial review of these Bylaws, consistent with the Hospital's policies, John C. Lincoln Health Network Bylaws and applicable laws. Except as provided in Section 15.4, the amendment of these Bylaws shall require Medical Staff action specified below.

15.2.1 Medical Staff Action – Amendments to these Bylaws may be adopted upon approval by the Executive Committee and by the Active Staff members who shall vote by ballot. Ballots shall be sent to each Active Staff member, accompanied by a copy of the proposed amendments and a summary thereof. The ballots must be returned within twenty-one (21) days after their mailing at which time they will be tallied. A favorable vote by two-thirds of those voting is required to approve each proposed amendment. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the election.

15.3 Board of Directors Action

15.3-1 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.

15.3-2 Board Concerns

In the event the Board has concerns regarding any provision or provisions of the proposed Bylaws or amendments thereto, the Board and Medical Staff shall utilize the Joint Conference Committee to resolve such concerns.

15.4 Technical and Editorial Amendments

Upon recommendation of the Bylaws Committee, the 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.

15.5 Approval of the Board - Amendments made pursuant to the provisions of this Article shall become effective upon the affirmative vote by the Board.

15.6 Adoption And Approval - Adopted by the Medical Staff on August 9, 2007.

Upon recommendation of the Medical Staff, approved by the John C. Lincoln Health Network Board of Directors on September 6, 2007.

John C. Lincoln Deer Valley Hospital
Phoenix, Arizona

Medical Staff Bylaws

Richard Wright, III, D.O., Chief of Staff

Joel Kramer, Secretary, Board of Directors

Rev. 10/98, Rev. 09/99, Rev. 03/01, 11/01, 01/04, 10/04, 4/06, 2/07,9/07