

JOHN C. LINCOLN NORTH MOUNTAIN HOSPITAL
Phoenix, Arizona
2008 Medical Staff Bylaws

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DEFINED TERMS:

1. Allied Health Professional (AHP's) - Individuals, other than those defined below under "Practitioner, "Ancillary Staff" and "Dentist" 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 defined in Article 13.
2. Ancillary Staff - Psychologists, podiatrists and other professionals qualified to render medical care within the Hospital within the legal definitions of their discipline.
3. Board of Directors or Board - 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 this state.
10. Executive Committee - The Executive Committee of the Medical Staff, unless otherwise specified.
11. Ex-officio - A member of a body by virtue of an office or position held.
12. Hospital - John C. Lincoln North Mountain Hospital
13. Medical Staff - Practitioners who are formally appointed by the Board as members of the Medical Staff of the Hospital.

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14. Observation - Retrospective or concurrent scrutiny during the provisional review process, or any other time required by a clinical department.
15. Patient Contact - Admission, inpatient or outpatient consultation, or procedures.
16. Physician - An individual who is appropriately trained and licensed in this state as an M.D. or D.O.
17. Practitioner - A physician or dentist with a current, unrestricted license issued by the state.
18. Privileges or Clinical Privileges - The permission granted to a physician, podiatrist, clinical psychologist or dentist to a physician, podiatrist, clinical psychologist or dentist to render specific diagnostic, therapeutic, medical, dental, podiatric, psychological or surgical services.
19. 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 & regulations.

ARTICLE ONE: NAME

The organizational component of John C. Lincoln North Mountain Hospital, to which these Bylaws are addressed is called "The Medical Staff of John C. Lincoln North Mountain Hospital"

ARTICLE TWO: PURPOSE AND RESPONSIBILITIES OF THE 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 the Hospital.
- 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

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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;
- 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, or monitoring of medical education programs.

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- 2.2-4 To develop and maintain Bylaws and policies that are consistent with sound professional practices.
- 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: MEMBERSHIP

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 Courtesy
- 3.1-3 Emeritus
- 3.1-4 Affiliate
- 3.1-5 Honorary
- 3.1-6 Ancillary

3.2 GENERAL QUALIFICATIONS - Every practitioner who seeks or enjoys staff membership must, at the time of application and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board the following qualifications and any additional qualifications and procedural requirements as are set forth in these Bylaws or in Department Rules and Regulations.

3.2.1 LICENSURE - Evidence of a currently valid license issued by the State of Arizona to practice either medicine, osteopathy, dentistry, podiatry, or psychology.

3.2.2 Office of Inspector General - In accordance with the Network Compliance Program for Business Practices, any provider on the Office of Inspector General's Exclusion List will be ineligible for appointment to the Medical Staff.

3.2.3 PROFESSIONAL EDUCATION AND TRAINING

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- a) Graduation from an approved medical, osteopathic, dental or podiatric school or attainment of a doctorate level degree in a psychological and/or behavioral health field from an accredited university 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 Accreditation Council for Graduate Medical Education (or its predecessor, the Liaison Committee on Graduate Medical Education, by the American Osteopathic Association, by the Commission of Dental Accreditation, 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.

- b) Satisfactory completion of approved post-graduate training as specified in the Rules and Regulations of the Department.

3.2.4 BOARD CERTIFICATION – Be currently Board Certified or Admissible by a board approved by the American Board of Medical Specialists or the American Osteopathic Association or by a board determined by the clinical department to be equivalent, as may be required by the appropriate Department.

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

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

All applicants who initially apply to staff after June 1, 2006 must become board certified within the time frame specified by the board or within 5 years from residency if no time limit is defined. Where the 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/her training program certifies that he/she has met all training requirements necessary to become board certified by the appropriate board. Failure to become board certified within this time period will result in loss of membership and privileges without the procedural rights afforded by the Fair Hearing Plan.

3.2-5 CLINICAL PERFORMANCE - Current experience, clinical results, and utilization patterns, demonstrating a continuing ability to perform privileges being requested in order 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 & Regulations the process for the delineation of clinical privileges and its evaluation of current clinical competency for individual practitioners.

3.2-6 PROFESSIONAL BEHAVIOR - Demonstrated ability to work with and relate to others with courtesy and dignity in a cooperative, professional manner that is essential for maintaining an environment appropriate to quality and efficient patient care.

- a) Avoid conduct that 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 two (2) of the following: the Chief Executive Officer, Chief of Staff, Department

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Chairmen or their respective designees to confirm their current physical and mental capacity to practice medicine and their freedom from, or adequate control of, any physical, mental or behavioral impairment, including substance abuse;

- 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 Staff. If a practitioner fails to conduct himself/herself appropriately, corrective action, including summary suspension, may result.
- e) Demonstrate the ability to adequately communicate with patients, families, staff, and peers.

3.2-7 SATISFACTION OF MEMBERSHIP OBLIGATIONS -

Satisfactory compliance with the basic obligations accompanying appointment to the staff and equitable participation, as determined by Medical Staff and Board authorities, in the discharge of staff obligations specific to staff category.

3.2-8 SATISFACTION OF CRITERIA FOR PRIVILEGES -

Evidence of satisfaction of the criteria for the granting of clinical privileges in at least one (1) department.

3.2-9 PROFESSIONAL ETHICS AND CONDUCT

- 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.

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- 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 hand delivered and/or 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 have been delivered on the date delivery was first attempted. Such refusal shall be regarded as unprofessional conduct, and may be grounds for denial of appointment or reappointment. 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/her. If such attempt is unsuccessful, notice shall be deemed to be delivered on the date delivery was first attempted.

3.2-10 HEALTH - Each applicant and Medical Staff member shall document his or her good physical and mental health. He/she shall be free from any physical or mental condition, and/or chemical or substance impairment that interferes with his/her ability to perform the privileges requested, and to provide safe and quality patient care.

3.2-11 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.

3.2-12 PROFESSIONAL LIABILITY INSURANCE - Evidence of professional liability insurance coverage of a kind, in an amount, satisfactory to the Board.

3.2-13 EFFECTS OF OTHER AFFILIATIONS - No practitioner shall be entitled to appointment, reappointment, or the exercise of particular clinical privileges merely because of:

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- a) Licensure to practice;
- b) Completion of a postgraduate training program;
- 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.

3.2-14 LOCALITY REQUIREMENT - Each staff member must maintain an active practice in Maricopa County, Arizona in the specialty for which he/she has requested or been granted privileges at the Hospital, excluding members of the Emeritus or Honorary Staff, and those approved for a Leave of Absence.

3.2-15 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 continuous care to patients at the level of quality and efficiency generally recognized as appropriate;
- 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

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- required records for all patients to whom the practitioner provides care in the Hospital, or within its facilities, services, or Departments;
- 3.3-6 Arrange for appropriate and timely medical coverage and continuous care for patients for whom he or she is responsible and 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 and the State of Arizona;
- 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 insurance coverage; the revocation, suspension or voluntary relinquishment of his or her DEA certificate;
- 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 health care 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 or by any law enforcement agency or health regulatory agency of the United States or the State of Arizona, or any other State.

Failure to meet these obligations may result in non-reappointment or the imposition of corrective action as provided in these Bylaws or the exclusion as a provider in any Medicare/Medicaid programs.

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:

- a) New members of the Medical Staff are subject to an initial provisional period as required under Section 4.1-6 and upon

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satisfactory conclusion of that period are placed in the appropriate reappointment cycle as determined by the Hospital's system of staggered reappointment; and

- b) 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.

3.4-1 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

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.

- a) Practitioners rendering professional services pursuant to employment by or contracts with the Hospital shall be required to maintain Medical Staff membership and privileges.
- b) Unless otherwise provided in the terms of employment or the contract for professional services, termination of such employment or contract shall not result in automatic termination of Medical Staff membership.

3.5-2 OBSERVATION – The practitioner must complete the observation requirements as set forth in the Department Rules and Regulations unless a waiver of observation has specifically been recommended by the Executive Committee and approved by the Board. Failure to comply with the observation requirements, as required in the practitioner's respective Department, will result in voluntary relinquishment of his or her staff appointment and privileges.

3.6 EXHAUSTION OF ADMINISTRATIVE REMEDIES - Every applicant to and member of the Medical Staff agrees that when corrective action is

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initiated or taken or when a recommendation is made by the Executive Committee, the effect of which is to deny, revoke, or otherwise limit the privileges or membership of the applicant or staff member, such applicant or member shall exhaust the administrative remedies afforded in these Bylaws prior to initiating litigation.

ARTICLE FOUR: CATEGORY AND CONDITIONS OF APPOINTMENT

4.1 IN GENERAL – All appointments to the Medical Staff shall be made by the Board of Directors upon recommendation of the Executive Committee; and shall be in one (1) of the following categories:

4.1-1 ACTIVE STAFF - 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. Each applicant for promotion shall be a person whose work is limited to his or her particular specialty or specialties. Staff members who have held an appointment for one (1) year and can demonstrate their interest and involvement as described in this Section shall be eligible to request promotion to the Active Staff in the appropriate department. Staff members 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 (i) be 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 Allergists, Dermatologists, Psychiatrists, and Rheumatologists, who must be involved in at least 5 cases in a two year period. Active Staff members 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 committees.

At the age of 65, Active Staff members will be exempt from the payment of dues.

4.1-2 COURTESY STAFF - Courtesy staff members shall be physicians and dentists of demonstrated competence qualified for staff membership. Members shall remain in this category for a minimum of (1) year prior to being eligible for promotion to the Active Staff.

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They shall not be entitled to vote on general Medical Staff issues or hold office but may serve on Medical Staff committees and may attend Medical Staff meetings. At the age of 65, Courtesy Staff members will be exempt from the payment of dues.

4.1-3 AFFILIATE STAFF – Affiliate staff members shall consist of physicians who do not admit or manage patients in the Hospital but who diagnose or treat patients who use the Hospital. These members shall participate in recognized functions of staff appointment, including participation in quality assessment and other monitoring functions that may be required from time to time.

Physicians appointed to this category **may**:

- a) order tests and procedures at the hospital to be done on an outpatient basis;
- b) attend medical staff, clinical departmental meetings and continuing education meetings;
- c) be invited to serve as members of standing and/or departmental committees; and
- d) pay all staff dues and assessments as determined by the Medical Staff Executive Committee.

Physicians appointed to this category **may not**:

- a) admit patients, do consults, write orders or progress notes, participate in surgery, or actively participate in patient care;
- b) vote on general staff matters.

4.1-4 EMERITUS STAFF - At the age of 65, or upon retirement from active practice, members of the Medical Staff who have served the Hospital shall be eligible for membership on the Emeritus Staff. Such physicians and dentists shall not have admitting privileges. They shall not be eligible for elective office or have the right to vote. They shall be exempt from payment of Medical Staff dues and shall be excused from required attendance at Medical Staff meetings.

4.1-5 HONORARY STAFF - Physicians or dentists may be appointed to the Honorary Staff on the recommendation of the appropriate clinical Department and the Executive Committee. These will be physicians or dentists whom the Medical Staff wishes to honor in recognition of their achievements in the local, national, or international communities. Such appointments shall not include admitting or clinical privileges and the members shall not be entitled to vote, hold office, or serve on staff committees. They

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shall be exempt from payment of staff dues and excused from required attendance at Medical Staff meetings.

4.1-6 ANCILLARY STAFF - The Ancillary Staff shall include psychologists, podiatrists 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 required to pay dues and shall be entitled to all procedural rights afforded by the Fair Hearing Plan.

4.1-7 PROVISIONAL PERIOD – All physicians are initially appointed to the Provisional Staff category for a minimum of twelve (12) months, and not to exceed twenty-four (24) months. At the conclusion of the initial 12-month provisional period, if all criteria for Active Staff status are satisfied, a physician may request elevation to the Active Staff category. A Provisional 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 any failure to comply, as required by the practitioner's respective Department, may result in voluntary relinquishment of his or her staff appointment and privileges.

4.1-8 ASSIGNMENT TO DEPARTMENT – Medical Staff members shall be assigned to a Department in which their performance shall be evaluated by the Department Chairman or his or her representative to determine the eligibility of members for reappointment and promotion and to recommend continuation, decrease, or increase of clinical privileges granted to them. (Reference Section 8.2)

4.1-9 RIGHTS AND RESPONSIBILITIES OF APPOINTEES – Appointments to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board of Directors under these Bylaws and shall require that each appointee assume such reasonable responsibilities as the Executive Committee shall require.

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ARTICLE FIVE: DELINEATION OF PRACTICE PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

5.1-1 IN GENERAL - Except in an emergency, a practitioner providing clinical services at the Hospital may exercise only those clinical privileges specifically granted.

5.1-2 EXPERIMENTAL PROCEDURES – Experimental drugs, procedures, or other therapies or tests (experimental procedures) may be performed only after approval of the pertinent protocols by the Institutional Review Board (IRB). Any experimental procedure may be performed only after the regular credentialing process has been completed, and the privilege to perform or use such procedure has been granted to the practitioner.

5.1-3 CONDITIONAL APPOINTMENT – An Executive Committee recommendation that is favorable to the applicant, but that is conditional, shall be forwarded to the Board. Where conditional appointment is recommended, the Executive Committee will specify the conditions of the conditional appointment and the consequences if those conditions are not met. A conditional appointment is not a reduction or limitation of membership or privileges, does not constitute an adverse recommendation or corrective action, and does not entitle the applicant to the procedural rights provided by the Bylaws and the Fair Hearing Plan.

5.2 BASIS FOR PRIVILEGES DETERMINATIONS - Clinical privileges shall be granted in accordance with education and training, experience, utilization practice patterns, current health status, and demonstrated current clinical competence and judgment to provide quality and appropriate patient care in an efficient manner as documented and verified in each practitioner's credentials file. Where appropriate, review of the records of patients treated in other hospitals or practice settings may also serve as the basis for privilege determinations.

In reappointment determinations, results of quality assessment and utilization review, demonstrated current competence, observed cases, and where appropriate, practice at other hospitals will also be considered. In review of requests for changes in privileges, evidence of appropriate training, experience and current clinical competence must be documented.

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- 5.3 SPECIAL CONDITION FOR 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. Where any medical problems exist, a physician member of the Medical Staff must perform a basic medical appraisal on such patient, must determine the risk and effect of any proposed surgical or special procedure, and must be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization. When significant medical abnormality is present the final decision whether to proceed must be agreed upon by the oral/maxillofacial surgeon or Dentist and the physician consultant. The Department of Surgery will decide the issue in the case of dispute.
- 5.4 SPECIAL CONDITIONS FOR 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 to the patient. 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.
- 5.5 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.

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5.6 TEMPORARY PRIVILEGES -

5.6-1 CONDITIONS - Temporary privileges may be granted only in the circumstances and under the conditions described below, only to an appropriately licensed practitioner, only when the information available substantially supports a favorable determination regarding the requesting practitioner's qualifications, and only after the practitioner has satisfied the professional liability insurance requirements. Special requirements for 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 Hospital.

5.6-2 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) To an applicant for staff membership who has requested temporary privileges 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. Any such renewal shall be made by the Department Chairman when the information available continues to support a favorable determination regarding the practitioner's application for membership and privileges. 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) 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 are restricted to the care of specific patients for which they are granted.

- c) 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

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privileges; confirmation of appropriate licensure; DEA/Controlled substances registration; and adequate professional liability coverage; and a complete, written reference specific to the requested privileges from a responsible Medical Staff authority. The temporary privileges granted to a locum tenens for a period of up to 60 days in length may be renewed for one (1) additional sixty-day (60) period upon approval of the Department Chairman. Temporary privileges may not be granted to a locum tenens again for one (1) year from the last day of the previous period for which temporary privileges were granted to the locum tenens. The practitioner must be registered and authorized to provide locum tenens medical services with the Arizona Medical Board or the Arizona Osteopathic Board of Medicine.

d) To a practitioner responding to the Hospital at the time of an emergent or mass casualty disaster situation.

5.6-3 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 competence. 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.

5.6-4 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

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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 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 for 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;

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- 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 9.12 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, the Chief of Staff, the Executive Committee, a clinical Department, the Chairman of a clinical Department, any other committee of the Medical Staff, or the PRC, the matter may be referred to either 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, 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 Department 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 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

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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 Section 6.2 of these Bylaws or request that corrective action be taken. All requests for corrective action shall be in writing, shall be made to the Executive Committee and shall be supported by reference to the specific activity or conduct that 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 for corrective action, 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 participated 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 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 Sections 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

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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 conclusions 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 shall take action upon the request. 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 letter, 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 or under the Health Care Quality Improvement Act of 1986.)

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b) Impose terms of probation including, but not limited to, requiring the use of one or more Tools. (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

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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 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, 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 a 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 of the Medical Staff or the Board of Directors.

6.4-2 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

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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 on such suspension until they are discharged from the Hospital.

6.4-3 AUTOMATIC SUSPENSION

- a) Medical Staff membership and clinical privileges shall be automatically suspended, without any of the procedural rights provided in the Fair Hearing Plan, in any of the following events:
 - 1) Action by any State of Arizona licensing or certifying agency revoking, suspending the Medical Staff member's professional license to practice medicine in this State.
 - 2) Action by any State of Arizona licensing or certifying agency restricting the Medical Staff member's professional license to practice medicine in the State, shall automatically restrict the physician's privileges to the extent his/her license is restricted.
 - 3) Failure by the Medical Staff member to complete the required reappointment forms within thirty (30) days of the member's biennial expiration date.
 - 4) Failure by the Medical Staff member to pay his or her Medical Staff dues within thirty (30) days of certified receipt of invoice;
 - 5) 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) Failure to:
 - a) notify the Hospital of a lapse in professional liability insurance coverage; and/or

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- b) maintain professional liability insurance of a kind, in an amount and with a carrier satisfactory to the Board.

- b) Medical Staff membership and clinical privileges shall be automatically restricted, without the procedural rights provided in the Fair Hearing Plan in the following event:
 - 1) Action by any State of Arizona licensing or certifying agency restricting the medical Staff member's professional license to practice medicine in this State, shall automatically result in the restriction of the physician's privileges to the same extent his/her license is restricted.

- c) A practitioner who has been convicted of a felony may be suspended from practicing at the Hospital by the Chief Executive Officer 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.

- d) Failure by a practitioner to complete a medical record in accordance with applicable provisions as defined in Section 5.2 of the Medical Staff Rules & Regulations of these Bylaws shall result in the accumulation of delinquent days. A practitioner who exceeds a total of sixty (60) delinquent 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

- e) Controlled Substances Registration – Whenever a Medical Staff member's DEA certificate is revoked, limited or suspended, the member's right to prescribe medications shall automatically and correspondingly be revoked, limited or suspended, 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.

- f) Freedom From Infectious Tuberculosis - Failure to provide evidence of freedom from infectious tuberculosis as required

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by law and Hospital policy. Acceptable forms of evidence include:

- 1) Negative PPD test or
 - 2) Negative Chest X-Ray or
 - 3) Tuberculosis Questionnaire documenting no pulmonary symptoms. The Tuberculosis Questionnaire is acceptable only for providers with a history of a positive tuberculin skin test or an allergy to the PPD Vaccine
- g) Exclusion from Medicare/State Programs - The Chief Executive Officer, with notice to the Chief of Staff, will immediately and automatically suspend the Medical Staff privileges of an Excluded Practitioner.
- h) Failure to Become Board Certified
Whenever a practitioner's time period in which to become board certified expires without the practitioner becoming board certified, the practitioner shall be deemed to have immediately and voluntarily relinquished his/her Medical Staff membership and clinical privileges.

ARTICLE SEVEN: GENERAL STAFF OFFICERS

7.1 GENERAL OFFICERS OF THE STAFF

7.1-1 IDENTIFICATION - The general officers of the staff are:

- a) Chief of Staff;
- b) Vice Chief of Staff;
- c) Immediate Past Chief of Staff (ex-officio); and
- d) Secretary/Treasurer.

7.1-2 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;
- b) Be Board Certified or Board Qualified, 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 clinical competence;

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- 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 simultaneously hold two (2) or more general staff offices.

7.2 TERM OF OFFICE - The term of office of general staff officers is two (2) years. Officers shall assume office on the first day of January following their election, except that an officer appointed to fill a vacancy assumes office immediately upon appointment and serves for the remainder of the unexpired term. Each officer serves until the end of his or her term and until a successor is elected, unless such officer sooner resigns or is removed from office.

7.3 ELIGIBILITY FOR 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 as Immediate Past Chief of Staff. All other general staff officers are eligible for nomination and re-election in succeeding terms.

7.4 NOMINATIONS

7.4-1 NOMINATING COMMITTEE – Nominations for Medical Staff officers will be accomplished, as outlined in Section 9.9.

7.5 ELECTIONS, VACANCIES, AND REMOVALS

7.5-1 ELECTION PROCESS - The Executive Committee shall conduct all elections, both regular and special, and shall be in charge of all matters pertaining thereto.

- a) The Secretary 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

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after the designated date shall not be opened and shall not affect the outcome of the election.

- b) The Secretary 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.
- c) During the first elective process, any individual obtaining a majority of the votes cast on the first ballot for each office shall be elected. If no candidate receives a majority on the first ballot, the second mail election will be performed using a ballot that contains the names of one more candidate than the number of positions to be elected. The candidates receiving the highest number of votes on the first ballot will be on the second ballot. The winner(s) will be the candidate(s) with the most votes.
- d) In the case of a tie, a second election will be performed. If a tie occurs again, a majority vote of the Executive Committee shall decide the election.

7.5-2 VACANCIES IN ELECTED OFFICES - In the event of a vacancy in the office of Chief of Staff, the 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.

7.5-3 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 or at any later time specified in the notice.
- b) Removals: Failure of an officer to meet the qualifications as defined under Section 7.1.2 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 as provided in Section

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10.1-2, for the purpose of considering and acting upon the request for removal. Removal shall require a two-thirds vote of the voting members present at the special meeting and shall be effective immediately upon tabulation of the vote.

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, or policies.

7.6 RESPONSIBILITIES OF OFFICERS

7.6-1 CHIEF OF STAFF - The Chief of Staff shall serve as the highest elected officer of the Medical Staff and shall:

- a) Enforce the Bylaws, Rules and Regulations;
- b) Call, preside at, and be responsible for the agenda of all general staff meetings, and meetings of the Executive Committee;
- c) Serve as Chairman of the Executive Committee and ex-officio member of all other staff committees without vote; if membership in a particular committee is specified by these Bylaws, he or she shall have a vote;
- d) Appoint, with the consultation of the Executive Committee, members for all standing and special Medical Staff or multi-disciplinary committees, and designate the Chairman of these committees, except for Department Committee Chairmen, who shall be elected;
- e) Interact with the Chief Executive Officer and the Board in all matters of mutual concern within the Hospital;
- f) Represent the views and policies of the Medical Staff to the Board and to the Chief Executive Officer;
- g) Advise the Board of recommendations for credentialing and recredentialing of Medical Staff appointees.

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- h) Be a spokesman for the Medical Staff in external professional affairs; and
- i) Perform such other functions as may be assigned to him or her by these Bylaws, by the Medical Staff, or by the Executive Committee.

7.6-2 VICE CHIEF OF STAFF - The Vice Chief of Staff shall assume all responsibilities and authority of the Chief of Staff in his or her absence. The Vice Chief of Staff shall be a member of the Executive Committee, and perform such other responsibilities as the Chief of Staff may assign or as may be delegated by these Bylaws or the Executive Committee.

7.6-3 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.

7.6-4 SECRETARY-TREASURER - The secretary-treasurer shall be a member of the Executive Committee and as secretary shall determine that accurate and complete minutes of all Executive Committee and Medical Staff meetings are maintained; and as treasurer shall receive and safeguard all funds of the Medical Staff. The secretary-treasurer shall perform all such other responsibilities as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or 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 elected and entrusted with the authority, functions, and responsibilities as specified in this Article. When appropriate, the Executive Committee may recommend the creation, elimination, 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 Medicine, Obstetrics and Gynecology, Pediatrics which is a joint Department with the Pediatrics Department of John C. Lincoln Deer Valley Hospital and Surgery.

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8.2 ASSIGNMENT TO DEPARTMENTS - For purposes of credentialing, each practitioner shall be assigned membership in one (1) Department. A practitioner may be granted clinical privileges in more than one (1) Department; the exercise of clinical privileges within the jurisdiction of any Department, is always subject to the Rules and Regulations of that Department. The Department of Medicine will have primary responsibility for Emergency Medicine physicians and Radiologists. The Department of Surgery will have primary responsibility for Anesthesiologists and Pathologists. Surgical assistants will be placed in the Department of which he or she received the majority of his/her training.

8.3 FUNCTIONS 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 to the Executive Committee regarding the initial appointment and biennial reappointment of all applicants and members.
- 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 provide a forum for discussion of matters of concern to its members.
- f) Be responsible for conducting and making recommendations regarding continuing education programs pertinent to departmental clinical practice;
- h) Coordinate the professional services of its members with those of other Departments and with the Hospital nursing and support services;

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- i) Report and make recommendations regarding clinical, quality review and administrative activities to the Executive Committee;
- j) Establish a Department committee and any subcommittees as are necessary to perform functions required of it. The composition and method of selection of the Department committee and subcommittees shall be defined within the Department Rules and Regulations.

8.4 DEPARTMENT OFFICERS

8.4-1 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. He or she must be Board Certified as required by his or her respective Department, unless this requirement is waived as recommended by the Executive Committee and approved by the Board of Directors. Departments will also have a Vice-Chairman or other officers as defined in the Department's Rules and Regulations. The Vice Chairman is responsible for the review of biennial reappointment applications and recommendation of continuing reappointment to the respective clinical Departments.

8.4-2 ELECTION - The Chairman and Vice-Chairman of each Department shall be elected by Active Staff members of that Department. In an election year, the Department Chairman shall appoint a Nominating Committee of three (3) Active Staff members of the Department who shall present a slate of nominees at a meeting preceding the a meeting preceding Fall General Staff General Staff meeting. Any voting member of the department may make additional nominations from the floor. A secret mail ballot shall be conducted following the Fall General Staff meeting even in situations where a. even in situations where candidate is running unopposed. Individuals for each office receiving a majority of votes cast shall be recommended to the recommended to the Executive Committee and Board of Directors for approval.

8.4-3 TERM OF OFFICE – Elected 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 by their respective Department Rules and Regulations.

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8.4-4 REMOVAL - Removal of an elected Department Officer may result from failure to conduct those responsibilities assigned within these Bylaws, 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 and the Board of Directors.

8.4-5 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 Departmental Vice-Chairman for the duration of the unexpired term subject to the approval of the Executive Committee and the Board subject to the approval of the Executive Committee and the Board. 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 and the Board of Directors, may appoint a member or members of the Department to carry out the functions of Chairman and Vice-Chairman for the duration of the unexpired terms or may convene a special election.

8.4-6 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. In the absence of the Chairman, the Vice-Chairman shall have the authority, functions, and responsibilities listed below.

- a) Act as presiding officer at Department meetings;
- b) Account 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; 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

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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 for 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 clinically related activities to include clinically related activities to include 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 with other Hospital quality assessment and improvement activities;
- e) Be a member of the Executive Committee where so designated in Section 9.8-1, give guidance on overall medical policies of the Hospital, and make specific recommendations regarding the Department;
- f) Transmit to the Executive 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, Rules & Regulations and policies of the Department and the Hospital;
- h) Implement within the Department actions directed by the Executive Committee 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.

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ARTICLE NINE: COMMITTEES OF THE MEDICAL STAFF

9.1 DESIGNATION

The committees described in this Article shall be the standing committees of the Medical Staff. In addition, special or ad hoc committees may be established for specific purposes by the Chief of Staff. Such Committees will dissolve upon the accomplishment of the purpose of the committee. Special or ad hoc Committees shall report to the Executive Committee. 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 Chairman and the members of the standing, special and ad hoc committees with the approval of the Executive Committee.

9.2 GENERAL PROVISIONS

9.2-1 Ex Officio Members

The Chief Executive Officer (or his/her respective designee) is an ex-officio member without vote 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 are not members of the committee.

9.2-2 Subcommittees

A standing committee may elect to perform any of its specifically designated functions by appointing a subcommittee that reports its recommendations to the parent committee. Individuals appointed by the standing committee Chairman shall serve as members.

9.3 APPOINTMENT

9.3-1 CHAIRMEN

- a) The Chief of Staff shall appoint committee Chairmen except the Chairman of the Executive Committee who is Chief of Staff, and the Chairman of each Clinical Department and the Nominating Committee, who will be elected by their respective members. The Chairman of each clinical Department shall be an Active Staff member; all other Chairmen shall be members of either the Active or Courtesy Staffs.
- b) The initial term of office of the Chairmen of Medical Staff committees shall be two (2) years which shall coincide with the

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term of the Chief of Staff or until the Chairman's successor is appointed The term of office of Chairmen of Clinical Departments is determined in accordance with Article 8.4-3.

9.3-2 MEMBERS –

Members of each committee, with the exception of the Executive Committee, shall be appointed yearly by the Chief of Staff not more than ten (10) days after the end of the Medical Staff year, with no limitation in the number of terms they may serve.

9.3-2.1 - Removal and Vacancies

A Medical Staff member serving as a Chairman or a member of 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 Medical 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.

9.3-2.2 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.

9.4 BYLAWS COMMITTEE

9.4-1 COMPOSITION - The Bylaws Committee shall consist of at least five (5) members of the Medical Staff of whom no more than two (2) may simultaneously serve as members of the Executive Committee.

9.4-2 RESPONSIBILITIES – The Bylaws committee shall be charged with periodically reviewing the Bylaws of the Medical Staff and evaluating any recommended amendments received from the Medical Staff. The Bylaws Committee will recommend, through the Executive Committee, any changes it deems necessary and the Executive Committee may offer a dissenting opinion to any recommended amendment to the Bylaws. Any dissenting opinion shall be reported to the Active Staff during the notification process of proposed amendments and at the General Staff Meeting when these amendments are discussed.

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9.4-3 MEETINGS - The Bylaws Committee shall meet at least biennially for the required review of the Bylaws. Any additional meetings shall be called by a majority vote of the members or by the Chairman.

9.5 CREDENTIALS COMMITTEE

9.5-1 COMPOSITION - The Credentials Committee shall consist of at least seven (7) members of the Active Staff who are not currently serving as members of the Executive Committee, with the exception of the Chairman who may be a member of the Executive Committee.

9.5-2 RESPONSIBILITIES - 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 interview those practitioners whose credentials have been reviewed and classified as Category III for appointment and/or reappointment to the Medical Staff. It shall make a recommendation to the clinical Department in which privileges have been requested.
- c) The Credentials Committee shall meet as often as necessary to discharge its responsibilities and shall maintain a permanent record of its meetings.

9.6 CRITICAL CARE COMMITTEE

9.6-1 COMPOSITION - A multidisciplinary committee, reporting directly to the Medical Executive Committee, shall include a broad representation of Medical Staff members who care for patients in the Intensive Care Unit, and other support personnel as determined by the Chief of Staff. A quorum shall consist of the voting members present at any given meeting.

9.6-2 RESPONSIBILITIES - The responsibilities of the Critical Care Committee shall include:

- a) Review of policy/procedure/statistical issues regarding care of patients in the Intensive Care Unit;

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- b) Quality Management through specific indicator monitors, chart reviews and education;
- c) Forum for medical staff discussion/intervention of problem issues and concerns.
- d) Concerns regarding individual physician performance shall be deferred to the respective department for formal review.

9.6-3 MEETINGS - The Critical Care Committee shall meet as often as necessary to discharge its responsibilities and shall maintain a permanent record of its proceedings and actions and report to the Medical Executive Committee.

9.7 EMERGENCY MEDICINE COMMITTEE

9.7-1 COMPOSITION - The Emergency Medicine Committee members shall include at least three (3) Emergency Medicine physicians. Liaison representatives from clinical departments shall be invited when deemed appropriate for discussion of relevant issues.

9.7-2 RESPONSIBILITIES - The responsibilities of the Emergency Medicine Committee include:

- a) Review of all deaths in the Emergency Department (excluding Trauma);
- b) Review of any and all identified problems in the Emergency Department;
- c) Review of statistics/utilization of services in the Emergency Department;
- d) Establish and monitor policies and procedures related to the Emergency Department; and
- e) Monitor and evaluate patient care within the Emergency Department.

9.7-3 MEETINGS - The Emergency Medicine Committee shall meet no less than quarterly, maintain a permanent record of its findings, proceedings and actions, and report to the Executive Committee.

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9.8 EXECUTIVE COMMITTEE

9.8-1 COMPOSITION

- a) The Executive Committee shall consist of (the officers of the Medical Staff; the Chairmen of the clinical Departments; the immediate Past Chief of Staff; and two members-at-large, all of whom shall have a vote and shall be members of the Active Medical Staff. The Medical Director of Emergency Services, the Medical Director of Trauma Services, the Chairmen of the Credentials, Critical Care and the Pharmacy and Therapeutics Committees; the Program Director of the Family Medicine Residency Program, the Chief Executive Officer or his designee, and the Nurse Executive shall also serve as ex officio members of the Executive Committee, without vote. The officers and members-at-large shall be elected in accordance with Section 7.5 of these bylaws.

- b) The term of each at-large member shall be two (2) years. At-large members 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 General 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 7.5-2 of these Bylaws.

- c) Members of the Board of Directors may attend meetings of the Executive Committee.

- d) The Chief of Staff shall vote only in the event of a tie.

9.8-2 RESPONSIBILITIES - The responsibilities of the Executive Committee shall be:

- a) To represent and act on behalf of the Medical Staff and 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,

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appointment, reappointment, privileges, 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;
- d) To supervise, oversee, monitor and 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 in areas 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 a 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 for appointment and 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, make recommendations for reappointments and renewal of or changes in clinical privileges;

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- 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 Articles 4, 5 and 6; and

- 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 or in matters of general Medical Staff interest.

9.8-3 MEETINGS - The Executive Committee shall meet as often as necessary to transact pending business. The Chairman will maintain minutes of all meetings, which reports 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 to the Medical Staff Office. 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.

9.9 NOMINATING COMMITTEE

9.9-1 COMPOSITION - The Nominating Committee shall consist of five (5) Active Staff members, elected by the Active Staff by mail ballot following the March General Staff Meeting in election years. The members of the committee shall elect their own Chairman.

9.9-2 RESPONSIBILITIES - This committee shall present at the Fall General Staff meeting at least one (1) nominee for each office and two (2) nominees for each of the at-large-memberships on the Executive Committee. Nominations from the floor which have been

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duly seconded shall be accepted and voted upon in like manner as nominees proposed by the Nominating Committee.

9.9-3 MEETINGS - The Nominating Committee shall meet as often as necessary to accomplish its purpose.

9.10 PHARMACY & THERAPEUTICS

9.10-1 COMPOSITION – The Pharmacy & Therapeutics Committee shall be a multidisciplinary committee, reporting directly to the Medical Executive Committee, shall include a broad representation of Medical Staff members and consist of at least the following additional voting members: pharmacists, including the Director of Pharmacy, clinical directors, a representative from administration, quality management, and others as appropriate.

9.10-2 RESPONSIBILITIES – The responsibilities of the Pharmacy and Therapeutics Committee include:

- a) To serve in an evaluative, educational and advisory capacity to the medical staff and Hospital administration in all matters pertaining to the use of drugs.
- b) To develop a formulary of drugs accepted for use in the Hospital and provide for its constant revision.
- c) To establish programs and procedures that help ensure safe, effective and cost-effective drug therapy.
- d) To monitor and evaluate adverse drug reactions in the health-care setting and to make appropriate recommendations to prevent their occurrence.

9.11 NETWORK COMMITTEES

9.11-1 DEFINITION - Network committees are those whose members are comprised of representatives from the Hospital and from John C. Lincoln Deer Valley Hospital as well as other entities affiliated with 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 be appointed for a term of two years (2) and shall not hold office for more than four (4) years.

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9.11-2 BIOETHICS COMMITTEE

9.11-2.1 COMPOSITION - The Bioethics Committee shall consist of the following: one-third Medical Staff members, one-third Hospital staff personnel, and one-third other representation from the community, including clergy and lawyers.

9.11-2.2 RESPONSIBILITIES - The responsibilities of the Bioethics Committee shall include education and development purposes of education, development and revision of policies and procedures relating to issues of an ethical nature, and providing case consultations.

9.11-2.3 MEETINGS - The Bioethics Committee shall meet at least quarterly and maintain a permanent record of its proceedings and actions and report its recommendations to the Executive Committees of both Hospitals.

9.11-3 CONTINUING MEDICAL EDUCATION COMMITTEE

9.11-3.2 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.

9.11-3.3 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.

9.11-3.4 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 Committees of both Hospitals.

9.11-4 JOINT CONFERENCE COMMITTEE

9.11-4.1 COMPOSITION - The Joint Conference Committee shall include three (3) elected members of the Board of Directors, three (3) members of the Active Medical Staff of John C. Lincoln Deer Valley Hospital and three (3) members of

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the Active Medical Staff of this Hospital selected by the Executive Committee of the respective Medical Staffs, and the President/Chief Executive Officer.

9.11-4.2 RESPONSIBILITIES - The Joint Conference Committee shall conduct itself as a forum for the discussion of matters of Hospital policy and practice and matters of a medical administrative nature requiring agreement among the Board of Directors, Medical Staff and Administration.

9.11-4.3 MEETINGS – The Joint Conference Committee shall meet when requested by the Board of Directors or the Executive Committee of either Hospital to accomplish its purpose.

9.11-5 SPECIAL COMMITTEES - In addition, special 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, and shall stand discharged after their purpose for appointment has been satisfied.

SECTION 9.12

9.12 PROFESSIONAL REVIEW COMMITTEE

9.12-1 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 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 Review Committee of John C. Lincoln North Mountain Hospital shall be entitled to designate one of its members to serve as an ex officio member of the PRC without vote.

The PRC will not have authority to take disciplinary action against any member of the Medical 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.

9.12-2 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

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Committee shall nominate an additional two (2) or more candidates and present the slate of candidates to the General Staff for consideration at 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 (2) of the initial members shall be for one (1) year) and members may be appointed for successive terms.

9.12-3 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.

9.12-4 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.

9.12-5 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 A.R.S. 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.

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- 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.

ARTICLE TEN: MEETINGS

10.1 MEDICAL STAFF MEETINGS

10.1-1 GENERAL STAFF MEETINGS - General Staff meetings will be held in the Spring and Fall each year. During an election year, an additional meeting of the General Staff may be held in December.

10.1-2 SPECIAL MEETINGS - A special meeting of the Medical Staff may be called by the Chief of Staff or the Executive Committee. The Chief of Staff will call for such a meeting upon petition signed by not less than twenty-five percent (25%) of the Active Staff.

10.2 CLINICAL DEPARTMENT AND COMMITTEE MEETINGS

10.2-1 REGULAR MEETINGS - All clinical Departments or their Committees, individually or in combination, must meet at least quarterly.

10.2-2 SPECIAL MEETINGS - A special meeting of any Department or committee may be called by the Chairman thereof, and must be called by the Chairman at the written request of the Chief of Staff or the Executive Committee. A notice of such special meeting will be sent to all members of the Department or committee.

10.2-3 EXECUTIVE SESSION - Any Department or committee may call itself into Executive Session at any time during a regular or

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special meeting at the discretion of the Chairman. Attendance at Executive Sessions is restricted to members of the Department or committee and individuals with a legitimate reason to be present may remain during such session; this is to be determined by the Chairman. Separate minutes must be kept of any executive session.

10.3 ATTENDANCE REQUIREMENTS

10.3-1 IN GENERAL - In addition to satisfying the peer review appearance or communication requirements of Section 10.3-2, each member of the Active Staff is encouraged to attend each committee or Department meeting, as assigned. If a physician does not have any committee assignments, he or she is encouraged to attend at least one (1) General Staff meeting per year, unless a more stringent meeting attendance requirement has been established by the clinical Department. Committee meeting attendance may be considered for maintaining Active Staff status and in committee assignments.

10.3-2 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.

Whenever a practitioner's clinical course of treatment is identified as being outside the normal range of established criteria, the process defined within Section 7.0 of the Medical Staff Rules & Regulations shall be followed.

10.3-2.1 Sentinel Event - Upon determination that a case 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.

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10.3-2.2 External Peer Review - The Chairman of the Clinical Department (or his designee), or Chief of Staff (or his designee), or the Chief Executive Officer (or his designee) subject to the approval of the Executive Committee, may at any time 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 these Bylaws and the Fair Hearing Plan.

10.3-3 PEER REVIEW APPEARANCE

- a) 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.
- b) 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.

10.3-4 PEER REVIEW COMMUNICATION

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

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- b) Failure to Respond (Second Occurrence and Thereafter): If a practitioner fails to respond subsequent to a first occurrence, immediate suspension of privileges will be recommended for a period of thirty (30) days without the granting of a thirty-day (30) grace period.

10.4 QUORUM

10.4-1 GENERAL STAFF MEETINGS - Those members present and qualified to vote at a duly called regular or special meeting shall constitute a quorum for the transaction of any business under these Bylaws. In the event that a non-posted issue is called for a vote, the Chief of Staff or his/her designee shall have the power to delay such vote and the balance of discussion until proper notice has been given.

10.4-2 COMMITTEE MEETINGS - The presence of fifty percent (50%) of the members of the Executive Committee shall constitute a quorum. Those present and qualified to vote shall constitute a quorum at any other committee meeting.

10.4-3 DEPARTMENT MEETINGS - Each department shall establish what constitutes a quorum for the transaction of business before the Department as a whole.

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, qualifications and current clinical competence;
- 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

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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, the Rules & Regulations, the Credentials Procedures Manual or the Fair Hearing Plan;
- 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; and
- f) Agrees to release from legal liability and hold harmless any individual who or entity which provides information regarding the practitioner to the Hospital and/or the Medical Staff or their representatives.

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 herein or except as otherwise specifically authorized by law. Such confidentiality shall also extend to information provided by third parties.

If it is 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, 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 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;

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- 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 of information, and immunity 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 provision of these bylaws is not enforceable shall not affect the legality or enforceability of the remainder of these Bylaws or any other provision hereof.

ARTICLE TWELVE - GENERAL PROVISIONS

12.1 DEPARTMENT RULES AND REGULATIONS - Each Department will formulate written Rules and Regulations for the conduct of its affairs and the discharge of its responsibilities, all or which must be consistent with the Bylaws and Hospital policies. These Department Rules and Regulations must be reviewed and approved by the Executive Committee and the Board, biennially. Any changes must be approved by the Executive Committee and the Board.

12.2 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 30 days given in which to make payment. All new staff members shall be billed and given 90 days in which to make payment for the current year upon their appointment to the staff. Failure to render timely 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.

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12.2-1 CHARITABLE CONTRIBUTIONS – Single charitable contributions from the Medical Staff Treasury proposed by the Executive Committee which are in excess of \$15,000 must be ratified by the Active Staff by mail ballot following discussion at a regularly scheduled or special General Staff meeting.

12.3 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.

12.4 PARLIAMENTARY PROCEDURE - The rules contained in the current edition of Roberts Rules of Order shall govern the Medical Staff in all cases to which they are 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 (AHPs) 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 practitioners who have agreed to work in collaboration with or be responsible for such AHPs.

13.2 CATEGORIES OF ALLIED HEALTH PROFESSIONALS CURRENTLY AUTHORIZED TO FUNCTION IN THE HOSPITAL - Included but not limited to the following are categories of AHPs currently authorized to provide services the Hospital: Clinical perfusionists, physicians assistants, nurse practitioners, non-physician first assistants and scrub technicians. The Executive Committee may recommend for Board approval other categories of AHPs to be given authorization to provide services in the Hospital. If an AHP does not have a practitioner employer or other sponsor who is a member of the Medical Staff and 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

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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 practitioner on the Medical Staff of the Hospital with appropriate privileges.

13.3 QUALIFICATIONS OF ALLIED HEALTH PROFESSIONALS - A practice guidelines/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. Each statement must be:

- a) Developed with input, as applicable, from the physician director of the clinical unit or service involved, the practitioner 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 of the type, in the amounts with a carrier, and with such other provisions as required for Medical Staff Members. 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 AHPs 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 AHPs in general or to a specific category of AHPs.

13.5 OBLIGATIONS OF ALLIED HEALTH PROFESSIONALS – Each AHP shall:

- a) Meet the basic responsibilities required by Section 3.2 for Medical Staff members;

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- 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 category of AHPs 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, procedures, 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 practitioner and any limitations thereon, including the degree of practitioner observation required.

13.7 PROCEDURE FOR CREDENTIALING - The procedure for processing individual applications from AHPs, for reviewing performance during the probationary period, for periodic reappraisal and assessment of clinical competence, and for disciplinary action shall be established by the Allied Health Committee, the Credentials Committee, the respective Clinical Department, the Executive Committee, and the Board of Directors.

- a) 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.

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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 regarding Allied Health Professionals.

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.

a) Supervision

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

b) Purpose

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

c) Family Medicine Residency Program

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.
2. The Medical Education Committee shall provide a comprehensive report to the Board of Directors annually about the educational needs and performance of residents.
3. A resident or fellow must seek appointment to the Medical Staff at such time as he or she intends to function as a member of the Medical Staff and is duly licensed and trained, and meets the qualifications of membership in accordance with Article 3 of these Bylaws.

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ARTICLE FIFTEEN: RULES AND REGULATIONS, CREDENTIALING PROCEDURES MANUAL AND FAIR HEARING PLAN

15.1 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 Executive Committee which is recommended to and adopted by the Board.

15.2 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 Executive Committee which is recommended to and adopted by the Board.

15.3 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 whom corrective action has been requested or taken, including the procedures for requesting and conducting hearings 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 Executive Committee which is recommended to and adopted by the Board.

ARTICLE SIXTEEN - ADOPTION AND AMENDMENT

16.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY - Proposed amendments to the Bylaws can be initiated in writing to either the Bylaws Committee or through a special meeting of the Medical Staff as referenced in section 10.1-2.

The Medical Staff shall be responsible for the development, adoption, and biennial review of these Bylaws, consistent with the Hospital's Bylaws, policies, and applicable laws. Except as provided in Section 16.3-3, the amendment of these Bylaws shall require Medical Staff action specified below.

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16.2 MEDICAL STAFF ACTION - The Bylaws Committee will distribute proposed changes to the Active Staff along with its recommendations regarding the changes to the Active Staff along with its recommendations regarding the changes at least 14 days prior to a regular or special staff meeting. Within 14 days after the meeting, a ballot will be mailed to all Active Staff members. A favorable vote of two-thirds of those voting is required on each proposed amendment. The ballots must be returned within twenty-one (21) days after their mailing at which time they will be tallied. Any ballots received after the designated date shall not be opened and shall not affect the outcome of the election.

16.3 BOARD OF DIRECTORS ACTION WHEN FAVORABLE TO MEDICAL STAFF

16.3-1 RECOMMENDATION – Medical Staff recommendations regarding proposed Bylaws or amendments thereto shall be effective upon the affirmative vote of the Board.

16.3-2 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 refer the matter to the Joint Conference Committee comprised of three (3) representatives of each body to resolve such concerns.

16.3-3 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.

16.4 ADOPTION AND APPROVAL

Adopted by the Medical Staff on October 26, 1995.

George Schade, M.D.
Chief of Staff

Upon recommendation of the Medical Staff, approved by John C. Lincoln Hospital Board of Directors on November 2, 1995.

Joel Kramer
Board of Directors

Revised:

November 26, 1997, Medical Staff Executive Committee
December 4, 1997, Board of Directors
March 26, 1998, Medical Staff Executive Committee

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May 7, 1998, Board of Directors
May 25, 2000, Medical Staff Executive Committee
June 1, 2000 Board of Directors
December 2001
September 2002
January 2005
January 2007
January 2008