

**SUMMIT HEALTHCARE ASSOCIATION  
MEDICAL STAFF BYLAWS**

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## **PREAMBLE**

The Medical Staff has overall responsibility for the quality of medical care and other professional services rendered at Summit Healthcare Association (“Summit Healthcare”) by individuals with clinical privileges. The Medical Staff is also responsible for accounting to the Governing Board, of the Summit Healthcare Association, Inc., concerning the quality of medical care and other professional services provided at the Medical Center. Furthermore, these Medical Staff Bylaws will provide a mechanism to assure that all individuals with clinical privileges at Summit Healthcare Association provide services within the scope of the individual clinical privileges granted by the Medical Staff and the Governing Board. The Medical Staff recognizes that the best interests of the patient and the Medical Center are best protected by the concerted effort of the Medical Staff and the Governing Board. Therefore, the Medical Staff at Summit Healthcare Association hereby organizes itself in conformity with these bylaws, and the rules and regulations hereinafter set forth.

## **DEFINITIONS**

### **Allied Health Professional (AHP)**

An individual, other than a licensed physician, dentist, or podiatrist, who exercises independent judgment within the areas of their professional competence and the limits established by the Medical Staff, the Board of Directors, and the applicable Arizona Practice Acts; who is qualified to render direct or indirect medical or dental care under the supervision or direction of a Medical Staff member possessing privileges to provide such care in the medical center; and who may be eligible to exercise practice privileges and prerogatives in conformity with these bylaws, and rules and regulations adopted by the Medical Staff and the Board of Directors. AHP’s are not eligible for Medical Staff membership.

### **Bylaws**

Medical Staff Bylaws will consist of these bylaws and all related documents such as the Credentialing Procedures Manual.

### **Chief Executive Officer (C.E.O.)**

The individual appointed by the Board of Directors of the Summit Healthcare Association to act on its behalf in the overall management of the medical center.

### **Chief of Staff**

The chief administrative officer of the Medical Staff.

### **Clinical Privileges or Privileges**

The specific diagnostic, therapeutic, or medical services which may be performed by a member of the Medical Staff with the permission of the Medical Staff and the Governing Body.

### **Dentist**

A duly licensed practitioner of dentistry who has attained a D.D.S. or D.M.D. degree.

### **Executive Committee or Medical Executive Committee**

The executive body of the Medical Staff authorized to represent and act on behalf of the Medical Staff.

### **Governing Board**

The Board of Directors of Summit Healthcare Association.

### **Medical Center**

Summit Healthcare Association (“Summit Healthcare”) located at 2200 E. Show Low Lake Road, Show Low, Arizona, 85901.

### **Medical Staff or Staff**

The formal organization of all duly licensed practitioners including physicians, dentists, and podiatrists

who have been granted privileges to attend patients in the Medical Center

**Medical Staff Year**

June 1 to May 31 of the following year.

**Physician**

A duly licensed practitioner of medicine who has attained a M.D. or D.O. degree.

**Podiatrist**

A duly licensed practitioner of medicine who has attained a D.P.M. degree.

**Practice Privileges**

The permission granted by the Medical Staff and the Governing Board to an Allied Health Professional (AHP) to participate in the provision of certain patient care services in the Medical Center.

**Quality Medical Care**

Medical care that is consistent with high standards of medical practice, and which is attainable within the Medical Center's means and circumstances.

**CONSTRUCTION OF TERMS AND HEADINGS.**

Pronouns or words used in these bylaws will be read as the masculine or feminine gender or as the singular or plural as the context and circumstances require. Captions, article headings, section headings or the like used in these bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these bylaws.

## **ARTICLE I: PURPOSE**

- 1.1** The purpose of the Summit Healthcare Association's (Summit Healthcare's) Medical Staff Bylaws is to bring together physicians and other licensed independent practitioners who practice at Summit Healthcare into a cohesive, self-governing body to promote excellence in healthcare.

The bylaws will be used to screen applicants for medical staff membership, review privilege requests from all licensed, independent practitioners requesting to practice at Summit Healthcare, evaluate work done by the staff, and interact with the Medical Center's administration and Governing Board. The bylaws will provide a mechanism for accountability through a defined Medical Staff structure.

## **ARTICLE II: MEDICAL STAFF MEMBERSHIP (REV: 03/2008)**

### **2.1 MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES**

Qualifications and conditions for appointment to the Medical Staff are outlined in the Credentialing Procedures Manual.

### **2.2 RESPONSIBILITIES OF MEMBERSHIP**

Medical Staff appointees will fulfill all responsibilities outlined in these bylaws, the Credentialing Procedures Manual and the Medical Staff Rules and Regulations.

### **2.3 EFFECT OF OTHER AFFILIATIONS**

No practitioner will be automatically entitled to Medical Staff membership or to exercise clinical privileges at the Medical Center merely because he holds a certain degree, or he is licensed to practice in the State of Arizona or any other state, or he is a member of any professional organization or society, or he is certified by any clinical board, or he has had, or presently has, staff membership or privileges at the Medical Center or at any other health care facility.

### **2.4 NONDISCRIMINATION**

Medical Staff membership or clinical privileges will not be approved or denied on the basis of ancestry, race, sex, age, creed, color, or national origin, or handicap nor based on any other criteria not set forth in these bylaws or related documents, the Medical Staff Rules and Regulations or Medical Center policies, or other criteria which are unrelated to the delivery of quality patient care in the Medical Center.

### **2.5 TERMS OF APPOINTMENT, PROCEDURES FOR APPOINTMENT, REAPPOINTMENT, CONCLUDING THE PROVISIONAL PERIOD, DELINEATING CLINICAL PRIVILEGES, TEMPORARY PRIVILEGES AND LEAVE OF ABSENCE**

The mechanisms for submitting, evaluating and making final decisions on applications for initial appointment, for conducting periodic reappraisals for reappointment to the Medical Staff, for delineating clinical privileges, for concluding or extending the provisional period, and for granting of temporary privileges or a leave of absence are outlined in the Credentialing Procedures Manual.

## 2.6 STAFF DUES

- 2.6.1 Annual medical staff dues will be governed by the most recent action which has been recommended by the Medical Executive Committee and adopted at a regular or special staff meeting. Medical Staff Services will notify each staff member in writing of any contemplated change in Medical Staff dues at least 21 days before the meeting at which voting on such proposed changes is to take place.
- 2.6.2 Medical Staff officers, Department Chairmen, honorary staff members and Allied Health Professionals will not be required to pay dues.
- 2.6.3 Dues will be due and payable upon request. Failure to pay dues will be construed as a voluntary resignation from the staff.

## 2.7 MEDICAL STAFF MEMBER RIGHTS

- 2.7.1 Each physician on the Medical Staff has the right to an audience with the Medical Executive Committee. Issues which can be addressed through this mechanism include, but are not limited to, discussion of any rule or policy established by the Medical Executive Committee, and actions taken by any Medical Staff committee.
- 2.7.2 Any practitioner has the right to initiate a recall election of a Medical Staff officer. A petition for such recall must be presented to the Medical Executive Committee, signed by at least 20% of the members of the active staff. Upon presentation of such valid petition, the Medical Executive Committee will schedule a special general staff meeting for purposes of discussing the issue, entertain a no confidence vote, if appropriate, and follow the removal from office process, if appropriate.
- 2.7.3 Any practitioner may call a general staff meeting upon presentation of a petition signed by 20% of the members of the active staff. The Medical Executive Committee will schedule a general staff meeting for the specific purpose addressed by the petitioners. No business other than that specified in the petition may be transacted.
- 2.7.4 Any member has a right to a hearing/appeal pursuant to the institution's Fair Hearing and Appeal Process in the event any of the following actions are taken or recommended:
1. Denial of membership status on the Medical Staff.
  2. Denial of Staff reappointment.
  3. Suspension of Staff membership until completion of specific conditions or requirements.
  4. Summary suspension of Staff membership during the pendency of corrective action and hearing and appeals procedures.
  5. Expulsion from Staff membership.
  6. Denial of requested privileges.
  7. Reduction of privileges.
  8. Suspension of privileges until completion of specific conditions or requirements.
  9. Summary suspension of privileges during the pendency of corrective action and hearing and appeals procedures.
  10. Termination of privileges.
  11. Requirement of consultation or supervision.

- 2.7.5 Any medical staff member may attend any scheduled meeting of any medical staff committee. However, only those designated as members of the committee may vote on action items, and the committee retains the right to Executive Session.

## 2.8 MEMBER'S ACCESS TO FILE

A Medical Staff member shall be granted access to his/her Medical Staff Credentials file subject to the following provisions:

- a) A request for access shall be made by the member to the Chief of Staff, or designee from the elected officers of the Medical Staff in writing at least forty-eight (48) hours prior to access;
- b) The member may review, and receive a copy of, documents provided by or addressed to the applicant in the Medical Staff Credentials file, the contents of which is defined by Medical Staff policy. Confidential and peer review letters of recommendation are not part of the Credentials file;
- c) The review by the member shall take place in Medical Staff Services, during normal working hours, in the presence of an elected officer or designee of the Medical Staff.

Revised 03/2008

## 2.9 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests, and other communications required or permitted to be served on or given to a party or parties by another, pursuant to these Bylaws, shall be in writing and shall be delivered personally or by United States Postal Service, first-class postage prepaid, certified or registered, return receipt requested. In the case of notice to Medical Center, Governing Body, Medical Staff or officers or committees thereof, the notice shall be addressed as follows:

(Name and proper title of addressee)  
Summit Healthcare Association  
2200 Show Low Lake Road  
Show Low, AZ 85901

In the case of a notice to a practitioner, AHP, or other party, the notice shall be addressed to the address as it appears in the records of the Medical Center. If personally delivered, such notice shall be effective upon delivery, and if mailed as provided for above, such notice shall be effective four (4) days after it is placed in the mail. Any party may change its address as indicated above, by giving written notice of such change to the other party in the manner as above indicated.

Revised 03/2008

## **ARTICLE III: CATEGORIES OF MEMBERSHIP (Rev 03/2008)**

### **3.1 CATEGORIES**

The categories of membership of the Medical Staff will include the following: Active, Consulting, Affiliate, Telemedicine and Honorary.

### **3.2 ACTIVE MEDICAL STAFF**

3.2.1 **Qualifications.** The Active Medical Staff will consist of practitioners who meet all of the following conditions:

3.2.1.1 Meet all of the qualifications set forth in the Credentialing Procedures Manual.

3.2.1.2 Regularly admit patients to, or otherwise regularly provide professional services in the Medical Center.

3.2.1.3 Maintain a residence and a professional practice within the primary service area of the Medical Center and are able to provide timely and appropriate care for Medical Center patients.

3.2.1.4 Have satisfactorily completed their provisional membership status for at least one year.

3.2.2 **Prerogatives.** The prerogatives of an Active Medical Staff member will be to:

3.2.2.1 Admit patients consistent with the scope of his privileges, unless otherwise provided for in the Medical Staff Bylaws or Medical Staff Rules and Regulations.

3.2.2.2 Exercise such clinical privileges as are granted to him pursuant to the Credentialing Procedures Manual.

3.2.2.3 Hold office in the Medical Center and serve on Medical Staff committees, unless otherwise provided for in the Medical Staff Bylaws.

3.2.2.5 Vote for Medical Staff officers, for amendments to these bylaws and related documents or the Rules and Regulations, and on other matters presented at general and special meetings of the Medical Staff or committees of which he is a member, unless otherwise provided for in the Medical Staff Bylaws.

3.2.3 **Responsibilities.** Each Active Medical Staff Member will:

3.2.3.1 Meet the basic responsibilities set forth in the Credentialing Procedures Manual.

3.2.3.2 Actively participate in and regularly assist the Medical Center in fulfilling its obligations related to patient care within the areas of his professional competence, including, but not limited to: consultation assignments; service on the emergency call roster except as exempt by policy; patient care evaluation; peer review; utilization review; quality assurance evaluation; and related monitoring activities required of the Medical Staff in supervising and monitoring Provisional Members and Allied Health Professionals; and discharging such other functions as he may be called upon to perform from time to time.

3.2.3.3 Be assigned to a Medical Staff Department, based on his clinical specialty.

3.2.3.4 Pay any dues or assessments as specified by the Medical Executive Committee.

### 3.3 CONSULTING MEDICAL STAFF

3.3.1 **Qualifications.** The Consulting Medical Staff will consist of practitioners who:

3.3.1.1 Meet the basic qualifications set forth in the Credentialing Procedures Manual.

3.3.1.2 Possess clinical expertise or are recognized specialists and who come to the medical center when scheduled or when called to render a clinical opinion within their competence.

3.3.1.3 Are members in good standing of the Active Medical Staff of an accredited medical center, although exceptions to this requirement may be made by the Medical Executive Committee for good cause.

3.3.1.4 Have satisfactorily completed provisional status for at least one year.

3.3.2 **Prerogatives.** The prerogatives of a Consulting Medical Staff member will be to:

3.3.2.1 Exercise such clinical privileges as are granted to him pursuant to the Credentialing Procedures Manual.

3.3.2.2 Admit patients to the Medical Center for up to 24 hours provided the consulting physician is locally available for patient management through discharge. Stays longer than 24 hours will require transfer of care to an appropriate member of the Active Medical Staff or to another facility if necessary.

3.3.2.3 Consulting Medical Staff members who are employed by federally or state-operated health care institutions located within seventy-five (75) miles of the Medical Center, with the approval of the Medical Executive Committee and the Governing Board, may receive extended clinical privileges to provide clinical or surgical care at the Medical Center which is not available at such federally or state-operated health care institutions, but which can be provided at the Medical Center. Patients of these Consulting Medical Staff members may admit patients for these clinical or surgical procedures for periods of up to 96 hours provided the consulting physician is locally available for patient management through discharge. Patient stays longer than 96 hours will require transfer of care to an appropriate member of the Active Medical Staff or to another facility if necessary. (Rev 3/05)

3.3.2.4 Consulting Medical Staff are not eligible to vote or hold office, but may serve on committees of the Medical Staff as a non voting member.

3.3.3 **Responsibilities:** Each Consulting Medical Staff member will:

3.3.3.1 Meet the basic responsibilities set forth in the Credentialing Procedures Manual.

3.3.3.2 Pay any dues or assessments as specified by the Medical Executive Committee.

### 3.4 AFFILIATE MEDICAL STAFF (Rev 03/2008)

3.4.1 **Qualifications:** The Affiliate Medical Staff will consist of practitioners who:

3.4.1.1 Meet the basic qualifications set forth in the Credentialing Procedures Manual.

- 3.4.1.2 Possess clinical expertise or are recognized specialists in their field of medical practice.
- 3.4.1.3 Agree to refrain from participating in any activities within the Medical Center that require Clinical Privileges.
- 3.4.1.4 Be recommended for appointment or reappointment to the Affiliate Staff by the Credentials Committee and by the Medical Executive Committee.
- 3.4.1.5 Have completed, in a timely manner as described in the Credentialing Procedures Manual, an application for reappointment.

Failure to continue to meet any of these qualifications will be adequate grounds to deny reappointment.

**3.4.2 Prerogatives:** The prerogatives of an Affiliate Medical Staff member will be to:

- 3.4.2.1 Visit patients, review medical records and discuss care with the attending physician;
- 3.4.2.2 Order tests and procedures on an outpatient basis
- 3.4.2.3 Contribute to the organizational, quality improvement and administrative affairs of the medical staff
- 3.4.2.4 Attend medical staff and department meetings (in a non-voting capacity) and continuing education

**3.4.3 Responsibilities:** Each Affiliate Medical Staff member will:

- 3.4.3.1 Meet the basic responsibilities set forth in the Credentialing Procedures Manual;
- 3.4.3.2 Be cognizant of the needs of the hospital by responding in a timely manner regarding requests for pertinent information on the history, medications and allergies when his/her patient is admitted to the hospital;
- 3.4.3.3 Pay all dues, initial appointment and reappointment fees specific or appropriate to this medical staff category and comply with standardized credentialing processes for medical staff membership, initial appointment and reappointment
- 3.4.3.4 If a patient of a member of the Affiliate Staff requires care by the Medical Center, the Affiliate Staff member shall relinquish all responsibility for the patient to a Medical Staff member with the appropriate clinical privileges.

**3.4.4 Limitations**

Medical Staff members in the Affiliate category may not:

- a) Vote or hold office in the Medical Staff or Clinical Department
- b) Be a member of any Medical Staff Committee

- c) Admit patients, consult, actively participate in the direct provision of patient care, write orders, or perform surgery

### 3.4.5 Care of Patients

Should a member of the Affiliate Staff wish to provide clinical care for a patient in the Medical Center, the Affiliate Staff member must obtain Temporary Privileges as outlined in the Credentialing Procedures Manual. If the Affiliate Staff member wishes to obtain clinical privileges in the Medical Center, that member must apply for Modification of Medical Staff membership and clinical privileges as described in the Credentialing Procedures Manual Section 9.3.

REVISED 03/2008

## 3.5 HONORARY MEDICAL STAFF

- 3.5.1 **Qualifications.** The Honorary Medical Staff will consist of former Active or former Consulting Medical Staff Members or other practitioners recognized for outstanding reputation, noteworthy contribution to the medical and health sciences, or previous service to the Medical Center. Such recognition will be bestowed by the Medical Executive Committee.

Appointment to the Honorary Staff will be permanent, without any scheduled reappointments required.

- 3.5.2 **Prerogatives.** Honorary Medical Staff Members are not eligible to admit patients to the Medical Center or to exercise clinical privileges in the Medical Center. An Honorary Medical Staff Member may attend Medical Staff meetings, and Medical Staff or Medical Center educational seminars; but he is not eligible to vote or to hold office. He may serve on committees of the Medical Staff as a consultant or nonvoting member.
- 3.5.3 **Responsibilities.** Each Honorary Staff Member will meet the responsibilities specified in the Credentialing Procedures Manual. Honorary Staff Members will not be required to pay dues or assessments.

## 3.6 TELEMEDICINE MEDICAL STAFF (REV 03/2008)

- 3.6.1 **Qualifications.** The Telemedicine staff will consist of physicians who diagnose or treat patients via telemedicine link.

- 3.6.1.1 Meet the basic qualifications set forth in the Credentialing Procedures Manual.

- 3.6.1.2 Possess clinical expertise or are recognized specialists in their field of medical practice.

- 3.6.1.3 Have completed the provisional period for one (1) year.

- 3.6.1.4 Active or Consulting Medical Staff appointment and clinical privileges in good standing at another accredited hospital.

- 3.6.2 **Prerogatives.** The prerogatives of a Telemedicine Medical Staff member will be to:

- 3.6.2.1 Exercise such clinical privileges as are granted to him/her pursuant to the Credentialing Procedures Manual

3.6.3 **Responsibilities.** Each Telemedicine Medical Staff member will:

- 3.6.3.1 Meet the basic responsibilities set forth in the Credentialing Procedures Manual
- 3.6.3.2 Be cognizant of the needs of the hospital by responding in a timely manner regarding request for diagnosis, prescriptions, or other clinical treatment to a Medical Center patient through any electronic or telemedicine technology.
- 3.6.3.3 Pay all dues, initial appointment and reappointment fees specific or appropriate to this medical staff category and comply with standardized credentialing processes for medical staff membership, initial appointment and reappointment

3.6.4 **Limitations.** Telemedicine Medical Staff members may not:

- a) Vote or hold office in the Medical Staff or Clinical Department
- b) Be a member of any Medical Staff Committee
- c) Admit patients, consult, actively participate in the direct provision of patient care, write orders, or perform surgery.

The Medical Staff shall recommend the types of clinical services to be provided by Telemedicine Physicians. To the extent a Physician is licensed outside the State of Arizona, such Physician will satisfy the Arizona Board of Medical Examiners requirement for a Special Purpose License for practice of medicine across state lines.

REVISED 03/2008

### 3.7 ASSOCIATE MEDICAL STAFF

3.7.1 **Qualifications.** The Associate Medical Staff will consist of practitioners who:

- 3.7.1.1 Meet the basic qualifications set forth in the Credentialing Procedures Manual.
- 3.7.1.2 Have an active employment agreement or contract agreement with Summit Healthcare and/or it's subsidiary, in good standing.
- 3.7.1.3 Have satisfactorily completed provisional status for at least one year.
- 3.7.1.4 Maintain a residence and a professional practice through a Summit Healthcare Outpatient Clinic, and are able to provide timely and appropriate care for Summit Healthcare Outpatient Clinic patients.
- 3.7.1.5 Possess clinical expertise or are recognized specialists in their field of medical practice.

3.7.2 **Prerogatives.** The prerogatives of an Associate Medical Staff member will be to:

- 3.7.2.1 Exercise such outpatient clinical privileges as are granted to him pursuant to the Credentialing Procedures Manual.
- 3.7.2.2 Associate Medical Staff members are not eligible to hold office, but may serve on committees of the Medical Staff.
- 3.7.2.3 Vote on matters presented at general and special meetings of the Medical Staff or committees of which he is a member, unless otherwise provided for in the Medical Staff Bylaws.

3.7.3 **Responsibilities.** Each Associate Medical Staff member will:

- 3.7.3.1 Meet the basic responsibilities set forth in the Credentialing Procedures Manual.
- 3.7.3.2 Pay any dues or assessments as specified by the Medical Executive Committee.
- 3.7.3.3 Be assigned to a Medical Staff Department, based on his clinical specialty.
- 3.7.3.4 Visit patients, review medical records and discuss care with the attending physician for his patients admitted to the Medical Center.

3.7.3.5 Order tests and procedures on an outpatient basis.

3.7.3.6 Contribute to the organizational, quality improvement and administrative affairs of the medical staff.

3.7.4 **Limitations.** Medical Staff members in the Associate category may not:

3.7.4.1 Admit patients, consult, actively participate in the direct provision of inpatient care, write inpatient orders, or perform surgery.

ADDED (02/2014)

## **ARTICLE IV: MEDICAL STAFF OFFICERS**

### **4.1 OFFICERS OF THE MEDICAL STAFF**

4.1.1 The elected Officers of the Medical Staff are:

- Chief of Staff
- Vice Chief of Staff
- Treasurer

4.1.2 In addition to the election of Medical Staff Officers, two (2) Members-at-Large shall be elected to the MEC.

### **4.2 QUALIFICATIONS OF OFFICERS**

Officers of the Medical Staff must be members of the Active Medical Staff in good standing at the time of nomination, election and service. Failure to maintain such status will immediately create a vacancy in the office involved.

### **4.3 TERM OF OFFICE**

4.3.1 All Officers shall serve a two (2) year and four (4) month term from the date of their election, which may be coincidental with the Medical Staff Year. Officers shall serve until a successor is elected, unless removed as set forth in Section 4.5 below in which case the officer will leave office on the date when the removal procedure is concluded.

4.3.2 The elected Officers shall serve in an “elect” position for four (4) months prior to taking office.

4.3.3 All Officers may serve a maximum of two (2) consecutive terms.

4.3.4 The MEC Member-at-Large shall serve a two (2) year non-renewable term.

### **4.4 NOMINATION AND ELECTION OF MEDICAL STAFF OFFICERS**

4.4.1 Prior to the end of the term of office for the officers of the Medical Staff, or upon acceptance of a tender of resignation by an officer of the Medical Staff, a Nomination Committee shall be formed consisting of the current Chief of Staff and two Past Chiefs of Staff, who are members of the Active Medical Staff, to propose two candidates for each vacant office (Vice Chief of Staff and Treasurer). These nominations shall be promptly made known by notice in writing to all of the Active Medical Staff. Members of the Nomination Committee cannot request to run in a current election. Members of the Active Medical Staff who are not initially chosen by the Nomination Committee and wishing to have their names included on the election ballot must submit five (5) signatures of the Active Medical Staff at least 7 days prior to the balloting process.

4.4.2 A vote by secret ballot shall be conducted among the Active Medical Staff acting as a whole. Write-in candidates shall be permitted. Officers shall be selected by majority of the votes cast, or in the case of three or more candidates, a plurality (as defined by Robert’s Rules of Order) of the votes cast at the election.

4.4.3 In any election, if there are three or more candidates for an office and no candidate receives the majority, there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until one candidate obtains a majority.

- 4.4.4 In the event of a tie, the MEC shall make the final decision.
- 4.4.5 Two members of the Medical Executive Committee (MEC) who are not subjects of the election shall count the ballots.

#### 4.5 **NOMINATION AND ELECTION OF MEMBERS-AT-LARGE**

- 4.5.1 Nomination and election of Members-at-Large shall follow the procedures set forth in section 4.4, **except** the Active Medical Staff acting as a whole shall nominate candidates for the Member-at-Large office, when a vacancy presents itself.

#### 4.6 **REMOVAL OF ELECTED OFFICERS**

The Medical Staff may remove an elected officer by Medical Executive Committee (MEC) action or upon the written request of twenty percent (20%) of the Active Medical Staff and a subsequent two-thirds affirmative votes cast by ballot of the Active Staff.

#### 4.7 **DUTIES OF OFFICERS**

- 4.6.1 **Chief of Staff.** The Chief of Staff will serve as the Chief Administrative Officer of the Medical Staff and will:

- 4.6.1.1 Preside at Medical Staff meetings and functions.

- 4.6.1.2 Enforce these bylaws, and the Medical Staff Rules and Regulations.

- 4.6.1.3 Represent the Medical Staff in presenting its views, policies, needs and grievances to the Medical Center Administrator, the Governing Board and the Joint Conference Committee.

- 4.6.1.4 Act as the spokesman for the Medical Staff in professional and public relations outside the Medical Center.

- 4.6.1.5 Serve as the Chairman of the Executive Committee.

- 4.6.1.6 Serve as an ex-officio member of all other Medical Staff Committees.

- 4.6.1.7 Serve as the responsible representative of the Medical Staff to receive, understand and interpret the policies of the Governing Board to the Medical Staff.

- 4.6.1.8 Represent the Medical Staff on the Board of Directors of Summit Healthcare Association.

- 4.6.1.9 Perform such other functions as may be assigned to him by these bylaws, by the membership, by the Executive Committee, or by the Governing Board.

- 4.6.1.10 Assume the position of the Immediate Past Chief of Staff on the completion of the preceding Immediate Past Chief of Staff's term.

- 4.6.2 **Vice Chief of Staff.** The Vice Chief of Staff:

- 4.6.2.1 In the absence of the Chief of Staff, assume all duties and authority of the Chief of Staff.

- 4.6.2.2 Shall be a member of the MEC.

- 4.6.2.3 Shall serve as an ex-officio member of the Credentials Committee and present the Credentials Committee recommendations to the MEC.
- 4.6.2.4 Shall assume the position of Chief of Staff on the completion of the preceding Chief of Staff's term, by confirmation of the majority of votes cast by the Active Medical Staff.
- 4.6.3 **Immediate Past Chief of Staff.** The Immediate Past Chief of Staff:
- 4.6.3.1 Shall act as an advisor to the Chief of Staff, as needed.
- 4.6.3.2 Perform such other supervisory duties and functions as the Chief of Staff may assign, or as may be delegated by these bylaws or by the membership.
- 4.6.4 **Treasurer.** The Treasurer will:
- 4.6.4.1 Be a member of the Executive Committee and the Joint Conference Committee.
- 4.6.4.2 Oversee the use of Medical Staff funds, and provide an updated report at least yearly
- 4.6.4.3 Shall serve as an ex-officio member of the Peer Review Committee.
- 4.6.5 **“Elect-“Officers.** The “Elect” Officers shall participate in the duties and functions of his/her respective position for four (4) months before assuming his/her position. This “elect” timeframe is to learn and understand the duties and functions of the position.

#### 4.7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon death or disability incapacitating offer's ability to perform duties, resignation, failure to maintain good standing on the Active Medical Staff, or removal of the officer as set forth in Section 4.5 above.

- 4.7.1 **Chief of Staff Vacancy:** If there is a vacancy in the office of the Chief of Staff, the Vice Chief shall succeed to that office until the position is confirmed by majority of votes cast by the Active Medical Staff at a Special Election.
- 4.7.2 **Vice Chief of Staff Vacancy:** If there is a vacancy in the office of the Vice Chief of Staff, the Treasurer shall fill that office until the position is filled by majority of votes cast by the Active Medical Staff at a Special Election.
- 4.7.3 **Treasurer Vacancy:** If there is a vacancy in the office of the Treasurer, the position will be filled by majority of votes cast by the Active Medical Staff at a Special Election.
- 4.7.4 Special Elections may be held via mail and/or electronic communications.
- 4.7.5 **Member-at-Large:** The Member-at-Large shall:
- 4.7.5.1 Serve as a voting member of the Medical Executive Committee
- 4.7.5.2 Perform such other duties as may be assigned by the Chief of Staff or the Medical Executive Committee

## **ARTICLE V: COMMITTEES, MEETINGS AND FUNCTIONS**

The required functions of the Medical Staff are as specified and described below. They will be accomplished as indicated in these bylaws through assignment to the staff as a whole, to staff committees, to staff officers or other individual staff members, or to interdisciplinary Medical Center committees with participation of Medical Staff members.

### **5.1 CLINICAL PERFORMANCE IMPROVEMENT FUNCTIONS**

The Medical Staff will provide a leadership role in the performance improvement function for all clinical processes and will provide a participative role in the non-clinical processes. When the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges, the Medical Staff will provide leadership for the process measurement, assessment and improvement. These processes will include, but not be limited to:

- Medical assessment and treatment of patients,
- Use of medications,
- Use of blood and blood components,
- Use of operative and other procedures,
- Efficiency of clinical practice patterns,
- Significant departures from established patterns of practice, and
- Surveillance over the medical center's infection control program, including assistance in developing preventive and corrective programs to minimize infection hazards.

### **5.2 PATIENT CARE PROCESS IMPROVEMENT FUNCTIONS**

The Medical Staff will participate in the measurement, assessment and improvement of other patient care processes. The processes will include, but not be limited to:

- Education of patients and families,
- Coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient, and
- Accurate, timely and legible completion of patients' medical records.

### **5.3 GOVERNANCE, DIRECTION, COORDINATION, COMMUNICATION AND ACTION**

The Medical Staff will:

- Receive, coordinate and act upon the reports and recommendations from committees, groups and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities,
- Coordinate the activities of and policies adopted by the staff, and committees,
- Account to the Governing Board and Medical Center Administration and to the staff by written reports, meetings, mailings and attendance at meetings on the overall quality and efficiency of patient care in the medical center as documented in the findings and actions from the Medical Staff's quality assessment and performance improvement activities,
- Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of staff members, including initiating investigations and initiating and pursuing corrective action, when warranted,
- Make recommendations on medico-administrative and Medical Center deliberations affecting the Medical Staff's discharge of responsibilities,
- Inform the Medical Staff and Governing Board of the accreditation program and the

- accreditation status of the medical center,
- Act on all matters of Medical Staff business, subject to such limitations as may be imposed by the staff, and
- Fulfill reporting requirements established by state or federal regulation.

#### **5.4 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT ACTIVITIES**

The Medical Staff will participate in the following quality assessment and performance improvement activities:

- Adopt, modify and supervise, subject to the approval of the MEC and the Governing Board, the conduct of specific programs and procedures for assessing, maintaining and improving the quality and efficiency of medical care provided in the Medical Center;
- Implement the procedures required by defining important aspects of care and developing indicators and criteria to measure them, by assessing and evaluating the processes and outcome of care, by identifying opportunities to improve care, by identifying patterns of performance within or outside of the acceptable range, by receiving and evaluating explanations for patterns significantly different from the norm and by reporting these findings and explanations,
- Formulate and act upon specific recommendations to correct identified improvable situations, follow up on action taken, determine the use of any assessment process relevant to an individual's performance and determine its use in peer review or the ongoing evaluation of competence, in accordance with the credentialing procedures,
- Provide reports to the organizational entities to which they are responsible on the results and progress of the quality/performance improvement activities, and
- Participate in evaluating the overall quality assessment and performance improvement activities for their comprehensiveness, integration, effectiveness and cost efficiency.

#### **5.5 CONTINUING EDUCATION**

The Medical Staff will participate in continuing medical education relevant to the type and nature of care offered by the Medical Center, current clinical practice and clinical privileges requested. The education will be designed to keep the Medical Staff informed of pertinent new developments in the diagnostic and therapeutic aspects of patient care and to update them in various aspects of appropriate patient care. The programs will be related, in part, to the findings of quality assessment/performance improvement activities performed in the Medical Center. Documentation of participation in continuing medical education will be maintained and considered at the time of reappointment to the Medical Staff.

#### **5.6 PLANNING**

The Medical Staff will participate in the evaluation of existing programs, services and facilities of the Medical Center and the Medical Staff and recommend continuation, expansion, abridgement or termination of each.

#### **5.7 BYLAWS REVIEW AND REVISION**

The Medical Staff will conduct a review of the bylaws and related manuals at least every two years.

#### **5.8 PRINCIPLES GOVERNING COMMITTEES**

The principles concerning the manner of appointment of committee members, terms and composition, functions, reporting and meeting requirements of Medical Staff committees are set forth below. Any committee, whether Medical Staff wide or specialty related, standing or special, that is carrying out all or any portion of a function or activity required by these bylaws and the

related manuals pertaining to quality, utilization or risk management, assessment, review or performance improvement, practitioner credentialing or otherwise to the maintenance or improvement of the quality, appropriateness or efficiency of patient care in the medical center is deemed a duly authorized Medical Peer Review Committee of the Medical Staff and Medical Center.

## 5.9 STANDING COMMITTEES

There will be a Medical Executive Committee (MEC) and the following standing committees responsible to the MEC: Credentials, and Medical Staff Department Committees.

## 5.10 OPERATIONAL MATTERS RELATING TO COMMITTEES

Staff leadership and participation in performance improvement activities and staff functions and responsibilities relating to liaison with the Governing Board and Medical Center administration, accreditation/licensure/certification, disaster planning, facility and services planning, financial management and functional and physical plant safety (which require participation of, rather than direct monitoring by the staff,) will be discharged in part by various Medical Staff officers and Medical Staff committees and by Medical Staff representation on Medical Center committees established to perform such functions. The medical staff, through the general staff or through its committees, will participate in all medical center deliberations affecting patient care, the medical staff or the discharge of medical staff responsibilities.

**5.10.1 Action Through Subcommittees.** Any committee may elect to perform any of its specifically designated functions by constituting a subcommittee for that purpose, reporting such action to the MEC.

**5.10.2 Composition and Voting Rights.** A Medical Staff committee established to perform functions required by the Bylaws will be composed of members of the Active Staff, and may include, where appropriate and at the discretion of the Active Staff members any of the following: Consulting Staff members, Allied health Professionals, and representatives from Administration, the Governing Board, Nursing, Medical Records, Quality Management, or others, as are necessary to the functions to be discharged. Only Active Staff members shall vote on committee business, with each such member participating with a vote, including committee chairpersons. Vote by written ballot may be requested by any voting member. All other participants shall be non-voting.

**5.10.3 Term, Removal And Vacancies.** Each elected committee member serves a two (2) year term, unless he sooner resigns or is removed from the committee. Committee members may be reelected without limitation. To facilitate continuity of function, terms of committee members may be staggered so that complete turnover in membership does not occur at any given point in time.

A Medical Staff member serving on a committee, except one serving ex officio, may be removed from the committee for failure to maintain himself in good standing as a staff member, failure to fulfill his committee responsibilities, including attending meetings, or by action of the MEC. Any ex officio member of a staff committee ceases to be such if he ceases to hold a designated position, which is the basis of ex officio membership. A vacancy in any committee is filled for the unexpired portion of the term in the same manner in which original election is made.

**5.10.4 Compensation.** In recognition of the time commitment required of the members of the Medical Executive Committee, the Credentials Committee, and the Department Chairmen, a stipend may be provided, to be determined by the Medical Executive Committee, and approved by a simple majority of the Medical Staff. The stipend may, at least in part, be

derived from medical staff dues (section 2.6)

## 5.11 MEDICAL EXECUTIVE COMMITTEE

5.11.1 **Membership.** The Medical Executive Committee will consist of the Medical Staff officers and the Medical Staff Department Chairmen.

5.11.2 **Meetings.** The Medical Executive Committee will meet at least monthly and will make recommendations directly to the Governing Board as necessary or required under these bylaws and related manuals, or the Medical Staff Rules and Regulations.

5.11.3 **Duties.** The duties of the Medical Executive Committee will be to:

5.11.3.1 Represent and act on behalf of the Medical Staff.

5.11.3.2 Coordinate and implement the activities and general policies of the Medical Staff not otherwise established as the responsibility of committees.

5.11.3.3 Receive, review and act upon reports/recommendations of Medical Staff committees and other assigned activity groups;

5.11.3.4 Present Medical Staff recommendations to the Governing Board concerning the:

- medical staff's structure,
- mechanism used to review credentials and to delineate individual clinical privileges,
- individuals recommended for Medical Staff membership,
- individuals recommended for delineated clinical privileges,
- Medical Staff's participation in organizational performance improvement activities,
- mechanism by which Medical Staff membership may be terminated, and the
- mechanism for fair hearing procedures.

5.11.3.5 Provide a liaison relationship amongst the Medical Staff, the Chief Executive Officer and the Governing Board,

5.11.3.6 Recommend actions to the Chief Executive Officer on medico-administrative matters,

5.11.3.7 Make recommendations to the Governing Board through the Chief of Staff,

5.11.3.8 Organize the Medical Staff's leadership role in performance improvement activities and establish a mechanism designed to conduct, evaluate and revise such activities as well as provide oversight to any delegated responsibilities,

5.11.3.9 Encourage Medical Staff participation in the Medical Center's accreditation process and communicate the status of the accreditation program and licensure of the Medical Center to the Medical Staff,

5.11.3.10 Take reasonable steps to assure professionally ethical conduct and competent clinical performance of all members of the Medical Staff and AHPs, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted,

5.11.3.11 Report at each general Medical Staff meeting,

- 5.11.3.12 Receive and review reports of the Medical Center's Safety Committee in accordance with the current requirements of the Joint Commission on Accreditation of Health Care Organizations,
  - 5.11.3.13 Review reports of overall Medical Staff timeliness and pertinence of medical record documentation and take or recommend action to appropriate committee(s) as necessary,
  - 5.11.3.14 Monitor utilization review activities, review reports and assure appropriate utilization of Medical Center resources specified in the medical center's Utilization Review Plan,
  - 5.11.3.15 Perform other such functions as may be assigned to it by these bylaws, by the Medical Staff, or by the Governing Board.
- 5.11.4 **Notice of Meeting.** All Medical Executive Committee members shall be provided at least five (5) days advance written or electronic notice of the time, date, and place of each regular meeting, and reasonable notice, oral or written, of each emergency meeting. Personal attendance at any meeting will constitute a waiver of notice of such meeting.
- 5.11.5 **Attendance.** Committee members will be required to attend at least 2/3rds of the scheduled committee meetings. Unexcused absence for three (3) consecutive meetings will result in automatic termination of committee membership and/or elected office.
- 5.11.5.1 At the discretion of the chairman or presiding officer, when a provider's practice or conduct is scheduled for discussion at a regular committee meeting, the member may be requested to attend.
- If a suspected deviation from standard practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and general indication of the issue involved. At the discretion of the chair or presiding officer, the discussion will be postponed for failure of a member to appear at any meeting to which notice was given, and excused upon a showing of good cause. In no case shall postponement be granted for a period longer than that which will elapse until the next regular meeting.
- 5.11.6 **Quorum.** The quorum required to transact business will be 50% of the total number of voting members.
- 5.11.7 **Confidentiality.** The Medical Executive Committee will function as a peer review committee consistent with Arizona State Law §36-445 and 36-445.01-02. All members of the Medical Executive Committee will, consistent with Medical Staff and Medical Center confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee. Members of the above noted committee will be able to obtain certain minutes and information to review before each regularly scheduled meeting. Such materials are confidential and must be returned at the relevant meeting.

## 5.12 CREDENTIALS COMMITTEE

- 5.12.1 **Membership.** Committee membership will consist of one representative from each Medical Staff Department, and Members-At-Large as nominated by and approved by the

Medical Executive Committee. Each department will elect its own representative from among its membership.

5.12.1.1 **Chairman.** The Credentials Committee Chairman will be appointed by the Medical Executive Committee. The Credentials Committee Chairman must be a member of the Active Medical Staff in good standing at the time of the appointment, with a minimum of two (2) years experience on the Credentials Committee and have attended at least two (2) medical staff/credentialing conferences. The Credentials Chairman shall serve a two (2) year renewable term.

5.12.2 **Meetings.** This committee will meet as often as necessary, but no less than six times annually and report its actions and recommendations to the Medical Executive Committee.

5.12.3 **Duties.** The duties of the Credentials Committee will be to:

5.12.3.1 Review and recommend action on all initial applications and reapplications for membership and status on the Summit Healthcare Medical Staff.

5.12.3.2 Review and recommend action on all requests for privileges, changes in privileges and the number and types of requests for temporary privileges for practitioners applying at Summit Healthcare.

5.12.3.3 Recommend criteria for the granting of Medical Staff membership and clinical privileges at Summit Healthcare.

5.12.3.4 Review provisional staff appointments and evaluations and recommend action.

5.12.3.5 Develop, recommend, maintain and consistently implement contemporary policy and procedures for all credentialing activities at Summit Healthcare.

5.12.3.6 Conduct all interviews and investigate, as may be necessary, and provide a written report of its findings and recommendations to the Medical Executive Committee.

5.12.4 **Notice of Meeting.** All Credentials Committee members shall be provided at least five (5) days advance written or electronic notice of the time, date, and place of each regular meeting, and reasonable notice, oral or written, of each emergency meeting. Personal attendance at any meeting will constitute a waiver of notice of such meeting.

5.12.5 **Attendance.** Committee members will be required to attend at least 75% of the scheduled committee meetings. Unexcused absence for three (3) consecutive meetings will result in automatic termination of committee membership and/or elected office.

5.12.5.1 At the discretion of the chairman or presiding officer, when a provider's practice or conduct is scheduled for discussion at a regular committee meeting, the member may be requested to attend.

If a suspected deviation from standard practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and general indication of the issue involved. At the discretion of the chair or presiding officer, the discussion will be postponed for failure of a member to appear at any meeting to which notice was given, and excused upon a showing of good cause. In no case shall postponement be granted for a period longer than that which will elapse until the next regular meeting.

- 5.12.6 **Quorum.** The quorum required to transact business will be 50% of the total number of voting members.
- 5.12.7 **Confidentiality.** The Credentials Committee will function as a peer review committee consistent with Arizona State Law §36-445 and 36-445.01-02. All members of the Credentials Committee will, consistent with Medical Staff and Medical Center confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee. Members of the above noted committee will be able to obtain certain minutes and information to review before each regularly scheduled meeting. Such materials are confidential and must be returned at the relevant meeting.

### 5.13 MEDICAL STAFF DEPARTMENT COMMITTEES

REVISED (02/2014)

5.13.1 **Membership.** Committee membership for each department will consist of all Active Medical Staff members belonging to the medical specialties that have been assigned to that department (as per Section 6).

5.13.2 **Department Chair.**

5.13.2.1 **Qualifications.** The Chair of each department must be a member of the Active Medical Staff at the time of nomination, election, and service.

5.13.2.2 **Responsibilities.** Of Department Chair include but are not limited to the following:

- Serve as Chair of the Department Committee and as department representative to the Medical Executive Committee;
- Establishing, together with medical staff and Administration, the type and scope of services required to meet the needs of the patients and hospital;
- Developing and implementing policies and procedures that guide and support the provision of services in the department;
- Recommending to the Medical Staff the criteria for clinical privileges in the department;
- Recommending clinical privileges for each department member;
- Continuing surveillance of the professional performance of all individuals with clinical privileges in the department, and;
- Assessing and improving the quality of care and services provided in the department.

5.13.2.3 **Term** of Department Chair shall be two (2) years. Department Chair shall serve a maximum of 3 consecutive terms and must be off for a minimum of 1 term before serving again.

5.13.2.4 **Nomination, Election and Removal** of Department Chair shall proceed according to the general rules established for Medical Staff Officers in Sections 4.4 and 4.5, **except** that the acting body shall be the Active Medical Staff members of the specific department, rather than the medical staff as a whole.

**5.13.3 Department Vice Chair**

**5.13.3.1 Qualifications.** The Vice Chair of each Department must be a member of the Active Medical Staff in good standing.

**5.13.3.2 Responsibilities.** Responsibilities of the Department Vice Chair include but are not limited to the following:

- Assist the Department Chair to perform his or her duties.
- The Department Vice Chair shall perform the duties of the Department Chair (including but not limited to assuming the Department Chair's voting rights on all Medical Staff or Department Committees) if the Department Chair is absent or otherwise unavailable.
- Other duties as assigned by the Department Chair.

**5.13.3.3 Term** of Department Vice Chair shall be two (2) years. Department Vice Chair shall serve a maximum of 3 consecutive terms and must be off for a minimum of 1 term before serving again.

**5.14.3.4 Nomination and Election** of Department Vice Chair shall be conducted in the appropriate Department Committee. The acting body shall be the Active Medical Staff members of the specific department rather than the medical staff as a whole.

**5.13.4 Meetings.** Each Department Committee will meet as often as necessary, but no less than quarterly, and report its actions and recommendations to the Medical Executive Committee.

**5.13.5 General Duties.** The duties of each Department Committee will be to:

5.13.5.1 Develop protocols and standards of care.

5.13.5.2 Monitor the quality and appropriateness of care provided.

5.13.5.3. Provide leadership for the process measurement, assessment and improvement. These processes include, though are not limited to:

- Medical assessment and treatment of patients,
- Use of medications,
- Use of blood and blood components,
- Use of operative and other procedures;
- Efficiency of clinical practice patterns, and
- Significant departures from established patterns of clinical practice;
- Education of patients and families,
- Coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient;
- Accurate, timely and legible completion of patients' medical records, and
- Review of the findings of the assessment process to ensure that they are relevant to an individual's performance, the Medical Staff members of the committee who determine the use of the findings in peer review, or ongoing evaluations of a licensed independent practitioner's competence.

**5.13.6 Notice of Meetings.** Written and/or electronic notice stating the place, day and time of a meeting at least five (5) days in advance of the meeting. This requirement may be satisfied by providing to each member a written schedule of regular meetings on an annual or more frequent basis. Personal attendance at a meeting will constitute a waiver of notice of such meeting.

5.13.7 **Attendance.** Active Medical Staff members are urged to attend at least 50% of the scheduled committee meeting of the department to which they are assigned. Meeting attendance will be considered by the Credentials Committee in evaluation at the time of reappointment.

5.13.7.1 At the discretion of the chairman or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular committee meeting, the member may be requested to attend.

If a suspected deviation from standard practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and general indication of the issue involved. At the discretion of the chair or presiding officer, the discussion will be postponed for failure of a member to appear at any meeting to which notice was given, and excused upon a showing of good cause. In no case shall postponement be granted for a period longer than that which will elapse until the next regular meeting.

5.13.8 **Quorum.** A quorum required to transact business at Department meetings shall consist of those voting members present at the time of the meeting.

#### 5.14 SPECIAL COMMITTEES

Special Committees may be created by the Chief of Staff or the Executive Committee on an ad hoc basis to perform special tasks.

#### 5.15 JOINT CONFERENCE COMMITTEE

5.15.1 **Membership.** The Joint Conference Committee will consist of at least three officers of the Medical Staff and an equal number of representatives of the Governing Board as chosen by the Chairperson of the Governing Board, and the Medical Center Chief Executive Officer as a non voting member.

5.15.2 **Meetings.** This committee will meet as needed. The Committee shall submit reports of its meetings to both the Medical Staff and the Governing Board.

5.15.3 **Duties.** The duties of the Joint Conference Committee will be to:

5.15.3.1 Conduct itself as a forum for the discussion of matters concerning Medical Center policy and practice, especially those pertaining to effective and efficient patient care.

5.15.3.2 Provide a liaison role between the Medical Staff and the Governing Board offering conflict resolution concerning any matter in which the Governing Board determines a resolution contrary to the MEC's recommendations.

#### 5.16 PROFESSIONAL WELLNESS COMMITTEE (PWC)

5.16.1 **Membership.** The PWC will consist of the elected officers of the medical staff and the Medical Center Chief Executive Officer.

5.16.2 **Meetings & Duties.** The PWC will meet as needed, with duties as stated under Article VII in these Bylaws.

#### 5.17 PROFESSIONAL REVIEW COMMITTEE (PRC)

The Professional Review Committee reviews and evaluates complaints involving behavior of medical staff and allied health professional staff appointees, operating under the auspices of the

Medical Executive Committee (MEC). This committee reports pertinent findings and recommendations to the Medical Executive Committee.

- 5.17.1 **Membership.** The PRC will consist of the elected officers of the medical Staff, the Chief Medical Officer and/or the Medical Center Chief Executive Officer.
- 5.17.2 **Meetings & Duties.** The PRC will meet each month following the MEC meeting, if needed. Other duties as described in the Rules & Regulations.
- 5.17.3 **Duties.**
- a) Peer review of concerns referred to the committee primarily regarding medical staff and allied health professional member's behavior, professionalism, collegiality and relations with other physicians, clinical and administrative staff of Summit Healthcare and patients.
  - b) Cooperation and coordination with, and referral to, appropriate Department Chairs; it is explicitly acknowledged that concerns delineated in (a) above are inevitably intertwined with clinical judgment and quality medical care which are the primary peer review responsibility of the clinical departments. Concurrent evaluation with clinical departments and appropriate medical staff committees will frequently be appropriate.
  - c) Initial evaluation of concerns/complaints/occurrence reports to determine severity and appropriate time frame for PRC response.
  - d) As needed by determination of the PRC or as directed by the Medical Executive Committee (MEC), to investigate the circumstances of concerns/complaints/occurrence/Quantros reports by interview of principals, review of charts and, if needed, request MEC approval to obtain expert opinion.
  - e) To design and oversee the performance of a confidential, peer review protected data base, to allow monitoring of frequency, severity, unit of origin and recurrence of concerns/complaints/occurrence/Quantros Reports. Such data base to provide for quality assurance monitoring and action by the MEC and Board of Trustees of Summit Healthcare.
  - f) To perform, at the direction of the MEC, monitoring of continued physician compliance with conditions and/or recommendations of the MEC regarding behavior, professionalism, collegiality and appropriate relations with other medical staff members and hospital staff.
  - g) To perform peer review duties with respect for the privacy of all principles involved. To maintain strict confidentiality of all information obtained.
  - i) To actively pursue opportunities to enhance the skills of physicians and hospital staff to communicate and interact respectfully, productively and professionally.

## 5.18 PROFESSIONAL HEALTH COMMITTEE

ADDED (2/2014)

- 5.18.1 **Composition.** The Professional Health Committee shall consist of a chairman and four other members. When possible, the Committee shall include at least one member in recovery and one behavioral health professional as appointed by the Medical Staff Executive Committee.
- 5.18.2 **Duties.** The Professional Health Committee will:
- a) Provide ongoing education to the Medical Staff, Hospital Staff and

Administrative leadership regarding physician and AHP health, impairment recognition, types and levels of impairment, problems associated with impairment, resources available for the prevention, diagnosis, treatment and rehabilitation of impairment, and the process for referral to the committee, while maintaining informant confidentiality if requested and whenever possible;

- b) Evaluate the credibility of a complaint, allegation or concern;
- c) Maintain confidentiality of the practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened;
- d) Recommend available resources for diagnosis and/or treatment of physicians and allied health professionals experiencing possible illness and impairment issues;
- e) Serve as a resource for physicians and allied health professionals experiencing illness and impairment issues;
- f) Assist the Medical Staff in evaluating potential illness and impairment and in monitoring ongoing compliance with treatment recommendations which may include a signed monitoring agreement;
- g) Assist Medical Staff leadership with an intervention, when so requested by a department chairman or Chief of Staff/designee.

#### 5.18.3 Meeting with the Provider.

- 5.18.3.1 The provider whose health or behavior is in question shall be invited to meet with the committee. The provider shall be apprised of the nature of the meeting and of the opportunity to be accompanied by a physician who may be treating the condition at issue.
- 5.18.3.2 The purpose of this Committee and this meeting is to discuss what, if any, problems exist and to work mutually towards a solution that is in the best interest of not only the provider's health but also patient care. As this meeting does not represent a formal investigation or proceeding, legal representation is not required.
- 5.18.3.3 The purpose of this meeting is to discuss the nature of the problem, and modifications of the individual's practice that may be appropriate and what accommodations, if any, can be made to enable the provider to continue clinical practice. If accommodations or modifications to the individual's practice are agreed upon, these accommodations or modifications shall be in writing, reported to the appropriate Department Chair and the Medical Executive Committee, and maintained in a confidential file in the Medical Staff Office, filed by a code number.
- 5.18.3.4 If the provider declines to meet with the committee, or if an appropriate course of action cannot be mutually agreed upon, and there continues to be a concern about the provider's health or ability to care for patients safely and competently, that question shall be forwarded to the appropriate Department Chair and the Medical Executive Committee for investigation in accordance with the Medical Staff Bylaws. If the provider declines such evaluation, the work of the Committee shall be concluded and it shall notify the appropriate Department Chair and the Medical Executive Committee for investigation.

#### 5.18.4 Confidentiality.

- 5.18.4.1 Throughout this process, all parties shall avoid speculation, premature conclusions, and any such discussion of the matter with anyone other than those individuals with a need for such information described in this policy.
- 5.18.4.2 A specific Release of Information from the provider will be required before responding to queries from other entities or organizations except as required by law.

## 5.19 MEDICAL STAFF MEETINGS

The Active Medical Staff will meet at least semi-annually, and more often as necessary. The primary purpose of each such meeting will be to receive reports on the quality and appropriateness of patient care. They will also consider the effectiveness of the mechanisms in place which assure the quality and appropriateness of patient care. Other business will include receipt and consideration of recommendations made by the standing committees, recommendations made by the Executive Committee to the Governing Board during the interim, and to conduct the business of the Active Medical Staff.

5.19.1 **Notice.** Written notice stating the place, day and time for a Medical Staff meeting not held pursuant to resolution, will be provided to each person entitled to be present not less than five (5) days nor more than thirty (30) days before the date of such meeting. Personal attendance at any meeting will constitute a waiver of notice of such meeting.

5.19.2 **Taking Action by Mail Vote.** In the event it is necessary for the Medical Staff to act on a question without being able to meet, the voting members of the Medical Staff may be presented with the question by mail or electronically. Such vote shall be valid so long as the voting members of the Medical Staff are given notice allowing them at least thirty (30) days to cast their vote. The notice will include the exact wording of the proposed change and the date ballots must be returned. An affirmative vote may be cast either by marking the ballot "yes" or by discarding the ballot. In order to act on a question presented, the affirmative vote of two-thirds (2/3) of the Active Medical Staff eligible to vote will be required.

5.19.3 **Attendance.** Active Medical Staff members are urged to attend at least fifty percent (50%) of the regularly scheduled general Medical Staff Meetings within any Medical Staff year.

5.19.4 **Quorum.** A quorum to transact business shall consist of those voting members present at the time of the meeting.

## 5.20 PEER REVIEW COMMITTEE

The Peer Review Committee membership, meetings, duties, attendance, quorum, and notice are outlined in the Peer Review Policy. The Peer Review Committee Chairman will be appointed by the Medical Executive Committee to serve a two (2) year renewable term.

## 5.21 SPECIAL MEETINGS

5.21.1 **Calling a Special Meeting.** Special meetings of the Medical Staff or Active Medical Staff may be called at any time by the Governing Board, Medical Executive Committee, the Chief of Staff, or on written request of 20% of the Active Medical Staff. The written request will specify the nature of the business that will be transacted at the special meeting. No other business will be transacted at that meeting except that stated in the notice calling the meeting.

5.21.2 **Scheduling.** Special meetings will be convened within thirty (30) days of the receipt of the written request for a special meeting, which will be delivered, to the Chief of Staff. Notice shall be given to the voting members at least ten (10) days prior to the meeting, and shall include the time, place and stated purpose of the meeting. Personal attendance at a meeting will constitute a waiver of notice of such meeting.

## 5.22 MINUTES

Minutes of each regular and special meeting of a committee or of the Medical Staff will be prepared and the minutes will include a record of the attendance of members, and the vote taken on each matter discussed. The presiding officer designates who will take the minutes, and will

sign the minutes, copies of which will be submitted to the Medical Executive Committee. A permanent file of the minutes of each meeting will be maintained.

**5.23 CONDUCT OF MEETING**

Unless otherwise specified, meetings will be conducted according to Robert's Rules of Order; however, failure to follow such rules will not invalidate any action taken at such a meeting. Meetings and action(s) may also be conducted utilizing electronic methods that permit for the interchange of information.

(SECTION REVISED 05/2009; 01/2015)

## **ARTICLE VI: MEDICAL STAFF DEPARTMENT STRUCTURE**

### **6.1 DEPARTMENTS**

- 6.1.1 Medical specialties, represented by Active Medical Staff members, will be assigned to specific Medical Staff Departments by the Medical Executive Committee, with such designation to be approved by a simple majority of the Active Medical Staff
- 6.1.2 Initial Department designation shall be the following: Emergency Medicine, Family Medicine, Medicine and Surgery.

### **6.2 DIVISIONS**

Division Subcommittees may form within a department when necessary or desire, upon the recommendation of the department and approval of the Medical Executive Committee. Divisions may apply to the Medical Executive Committee for Department status. To apply for Department status, the division must consist of a minimum of 10% of the Active Medical Staff and must demonstrate an indicated need for Department status to the Medical Executive Committee. Upon approval by the Medical Executive Committee, and if ratified by a simple majority vote of the Active Medical Staff by secret ballot, the Division will be granted Department status, with its own standing committee. (Section 5.14).

#### **6.2.1 Division Chairman.**

6.2.1.1 **Qualifications.** The Division Chairman must be a member of the Active Medical Staff in good standing at the time of nomination, election, and service.

6.2.1.2 **Term.** Of Division Chairman shall be two (2) years.

6.2.1.3 **Nomination, Election and Removal** of Division Chairman shall proceed according to the general rules established for Medical Staff Officers in Section 4.4 and 4.5, **except** that the acting body shall be the Active Medical Staff members of the specific department, rather than the medical staff as a whole.

6.2.2 **Meetings.** Each Division Committee will meet as often as necessary, and report its actions and recommendations to the respective Department Committee.

6.2.3 **Notice of Meetings.** Written and/or electronic notice stating the place, day and time of a meeting at least five (5) days in advance of the meeting. This requirement may be satisfied by providing to each member a written schedule of regular meetings on an annual or more frequent basis. Personal attendance at a meeting will constitute a waiver of notice of such meeting.

6.2.4 **Quorum.** A quorum required to transact business at Division meetings shall consist of those voting members present at the time of the meeting.

**ARTICLE VII: PROFESSIONAL STAFF WELLNESS**

REVISED (02/2014)

- 7.1 **Purpose.** To establish the steps to be taken in the event a Professional Staff member is suspected of having a drug, alcohol, psychological, medical or other impairment. This policy creates a process that allows Professional Staff impairment issues to be addressed quickly, appropriately and in a fashion consistent with the best interests of patient care, confidentiality and so as to qualify for peer review immunity under state and federal law.
- 7.2 **Definitions.**
- 7.2.1 “Professional Staff” shall mean a member of the Medical Staff or Allied Health Professional Staff.
- 7.2.2 “Impairment” shall mean the presence of a psychological or physical condition or the usage of drugs or alcohol in a fashion which interferes with a Professional Staff’s ability to render safe and appropriate medical care to Hospital patients. Impairment may include, but not limited to, drug or alcohol or use or addiction, erratic behavior, physical illness, aging issues and inappropriate workplace behavior.
- 7.3 **Process.**
- 7.3.1 Any individual working in the hospital who has a good faith belief that a Professional Staff member is treating Hospital patients while impaired shall immediately contact his or her supervisor. Patients and visitors may notify any employee, who will in turn contact their supervisor. Physicians should contact the unit supervisor.
- 7.3.2 If the supervisor concurs, the supervisor shall immediately contact the Chief of Staff (COS) or designee, and the Chief Executive Officer (CEO) or designee. Additionally, within twenty-four (24) hours of the incident, the person raising the concern and the involved supervisor will submit a written report to the CEO and the Chief of Staff, documenting the basis for the allegation, the facts and circumstances which led to the allegation, the names of persons who observed the incident and all other material facts.
- 7.3.3 The Chief of Staff (COS) or designee, and the Chief Executive Officer (CEO) or designee, will come to the Hospital to meet with the Professional Staff member. Pending their arrival, the supervisor will privately request the Professional Staff member refrain from treating Hospital patients. The Chief of Staff (COS) or designee, and the Chief Executive Officer (CEO) or designee will meet with the Professional Staff member privately to discuss the allegation and assess the Professional Staff’s condition.
- 7.3.4 The Chief of Staff (COS) or designee, and the Chief Executive Officer (CEO) or designee, may request the Professional Staff member submit to a blood test or urinalysis. The Professional Staff member’s refusal to comply with such request will be deemed grounds for immediate investigative suspension. They may also request that the Professional Staff member leave the premises, refrain from treating patients for up to forty eight (48) hours under a precautionary leave and the COS shall make appropriate coverage arrangements for the Professional Staff member’s Hospital patients as a result of such decision as necessary. The Chief of Staff (COS) or designee, and the Chief Executive Officer (CEO) or designee, will complete written reports within twenty-four (24) hours of the occurrence, including their observations, conclusions and the basis for their decision(s).
- 7.3.5 Where the Chief of Staff (COS) or designee, and the Chief Executive Officer (CEO) or designee, have a good faith basis to believe a Professional Staff member was in the Hospital, or otherwise treating Hospital patients, whole impaired, they shall immediately contact the chairperson of the Medical Staff Physician Wellness Committee (“PWC”).

- 7.3.6 The PWC will convene a meeting with the Professional Staff member. They will review the written occurrence reports and use best efforts to meet with the individuals who generated the reports. The purpose of this meeting shall be to conduct a good faith, reasonable investigation of the facts of the situation and to assess the need for referral of the Professional Staff member shall have the right to know the materials submitted to the MEC as read to him by the Chief of Staff or designee, as well as present additional information pertinent to the occurrence.
- 7.3.7 If in the reasonable belief of the PWC, the Professional Staff member requires a psychological, medical or other assessment, the following process will be implemented:
- 7.3.7.1 The Professional Staff member will be required to immediately contact the Arizona State Licensing Board or such other appropriate evaluation program as determined by the PWC for any appropriate evaluation(s) warranted by the circumstances (“Program”).
- 7.3.7.2 The Professional Staff member will agree to voluntarily refrain from exercising his or her clinical privileges pending enrollment in, cooperation with and completion of the Program evaluation process, completion of any indicated treatment, receipt of a release to return to practice by the Program and the PWC.
- 7.3.7.3 The Professional Staff member will execute a Professional Staff Support Agreement with the PWC in the same or similar format as that provided in Attachment “A”.
- 7.3.8 If the Professional Staff member refuses to cooperate and comply with these steps, the PWC may recommend to the MEC that the Professional Staff member be subject to corrective action, including summary suspension, which will entitle the Physician to the rights under the fair hearing plan.
- 7.3.9 The Program and the Professional Staff member will share all information from the Program, including the evaluation and treatment process, requests and recommendations with the PWC. The PWC will meet with the Professional Staff member to determine how any treatment prescriptions or recommendations issued by the Program will be implemented, supplemented and/or supported by the PWC. Before resumption of Hospital privileges, the Professional Staff member will execute a Professional Staff Assistance Agreement describing this implementation and the relative rights and responsibilities involved.
- 7.3.10 The Medical Staff shall not file a report with the National Practitioner Data Bank or State Medical Licensing Board regarding Professional Staff members with suspected impairment(s) who cooperate with the PWC and complete the steps outlined in this policy unless otherwise compelled to do so by applicable law.
- 7.3.11 Professional Staff impairment issues, including reports, PWC minutes, test results, Program and PWC documents, shall be treated as confidential and privileged matters, as required by applicable peer review laws.
- 7.3.12 The Hospital has a zero tolerance policy regarding Professional Staff retaliation against persons who reported suspected impairment or otherwise participated in the Professional Staff Wellness process as articulated herein. Professional Staff who retaliate against such persons may be subject to immediate corrective actions, including but not limited to investigative or summary suspension.

## **ARTICLE VIII: CONFIDENTIALITY, IMMUNITY AND RELEASES**

### **8.1 SPECIAL DEFINITIONS**

For purposes of this article only, the following definitions will apply:

**Information** means proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearing, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications, in whatever form, relating to any of the subject matter specified in section 8.5.

**Good Faith** means having an honest purpose or intent and being free from intention to defraud.

**Malice** means the dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.

**Practitioner** means a Medical Staff member, applicant or Health Professional affiliate staff member.

**Representative** means: the Governing Board of the Medical Center and any trustee or committee; the Medical Center Chief Executive Officer or his designees, registered nurses and other employees of the Medical Center; the Medical Staff and any member, office or committee; and any individual authorized by any of the above to perform specific information gathering, analysis, use or disseminating functions.

**Third Parties** means both individuals and organizations providing information to any representative.

### **8.2 CONFIDENTIALITY OF INFORMATION**

The health care setting allows Medical Staff, Allied Health Professional Staff, Hospital Administrative staff and hospital employees access or exposure to confidential and proprietary information that is not in the public domain concerning patient care, peer review, medical staff and hospital business. Information submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the following purposes, shall, to the fullest extent permitted by law be confidential:

- (a) assessing, reviewing, evaluating, monitoring or improving the quality and efficiency of health care provided;
- (b) reducing morbidity or mortality;
- (c) evaluating current clinical competence and qualifications for staff appointment/affiliation or clinical privileges or specified services;
- (d) contributing to teaching or clinical research;
- (e) determining that health care services were indicated or were performed in compliance with the applicable standard of care.

Said information will not be disseminated to anyone other than an authorized representative of the Medical Center or other health care facilities or organizations of health professionals engaged in an official, authorized activity for which the information is needed nor be used in any way except as provided here or except as otherwise required by law. Such confidentiality will also extend to information of like kind that may be provided by third parties. This information will not become part of any particular patient's record. It is expressly acknowledged by each practitioner or medical center representative that violation of the confidentiality provided here except in the course of normal duties may result in disciplinary action.

### **8.3 IMMUNITY FROM LIABILITY**

No representative will be liable to a practitioner for damages or other relief for any decision,

opinion, action, statement or recommendation made within the scope of his duties as a representative, and no representative or third party will be liable to a practitioner for damages or other relief by reason of providing information, opinion, counsel or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner, if such representative or third part acts:

- (a) in good faith and without malice;
- (b) in the reasonable belief that the decision, opinion, action, statement, recommendation, information, opinion, counsel or services were in furtherance of quality or efficient health care services and were warranted by the facts known;
- (c) after a reasonable effort to obtain the facts of the matter; and
- (d) in accordance with any applicable procedures specified in the Medical Staff Bylaws, Governing Board Bylaws, or other relevant manuals or policies.

## 8.4 ACTIVITIES AND INFORMATION COVERED

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

- (a) applications for appointment/affiliation, clinical privileges or specified services;
- (b) periodic reappraisals for renewed appointment/affiliations, clinical privileges or specified services;
- (c) corrective or disciplinary actions;
- (d) hearings and appellate reviews;
- (e) quality assessment and performance improvement activities;
- (f) utilization review and improvement activities;
- (g) claims reviews;
- (h) risk management and liability prevention activities;
- (i) other Medical Center, committee, or Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

8.4.2 **Information:** The information referred to in this article may relate to a practitioner's professional licensure or certification, education, training, clinical ability, judgment, utilization practices, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect the quality, efficiency or appropriateness of patient care provided in the Medical Center.

## 8.5 RELEASES

Each practitioner will, upon request of the Medical Center, execute general and specific releases in accordance with the tenor and import of this article, subject to such requirements, including those of good faith and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under relevant Arizona law. Execution of such releases is not a prerequisite to the effectiveness of this article.

## 8.6 CUMULATIVE EFFECT AND SEVERABILITY

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

## **ARTICLE IX: CORRECTIVE ACTION**

### **9.1 CORRECTIVE ACTION**

- 9.1.1 **Initiation.** An investigation may be initiated by a written request from any two of the following: the Chief of Staff or his/her designee, the Chief Executive Officer or his/her designee, the Chair of a relevant peer review committee, the Medical Executive Committee or the Governing Board. Upon receiving a written complaint or a written request for an investigation, the Medical Executive Committee will conduct or direct an investigation be undertaken. The Chief of Staff will promptly notify the Chief Executive Officer and the Governing Board and the physician involved of the pendency of any such investigation, and of all corrective action taken in conjunction therewith.
- 9.1.2 **Preliminary Investigation:** When considering the initiation of corrective action or an investigation, the initiating person or committee must arrange for an informal interview with the practitioner, and notify that individual within ten (10) working days of receiving the complaint or request for an investigation. At the informal interview, the circumstances prompting the consideration of an investigation should be discussed with the practitioner, and the practitioner should be asked to present relevant and material information on the practitioner's own behalf. Some written record should be maintained reflecting the general substance of the informal interviews, with copies of the written record to be sent to the practitioner, the Chief of Staff, the Chief Executive Officer, the Medical Executive Committee and the Governing Board. If the practitioner fails to or declines to participate in the informal interview, an investigation in accordance with Section 9.1.3 shall be initiated
- 9.1.3 **Investigation.** An investigation may be initiated whenever a practitioner with clinical privileges engages in, makes, or exhibits acts, statements, demeanor or professional conduct, either within or without the Medical Center, and the same is, or is reasonably likely to be, detrimental to the quality of patient care or safety, disruptive to the Medical Center's operations, an impairment to the community's confidence in the Medical Center, contrary to these bylaws, contrary to Medical Center rules, regulations, policies or standards, or in violation of state, federal or local criminal statutes.
- 9.1.4 **Scope of Investigation.** The Medical Executive Committee or an ad hoc investigative committee appointed by the Medical Executive Committee shall investigate all written complaints or requests. The investigating committee shall afford the practitioner who is being investigated the opportunity to meet with the investigating committee to discuss, explain or refute the charges against him. The investigation should be fair and complete, and may include review of medical records, interviews with witnesses or a referral of the file to an independent health care provider for investigation or review. Either the Medical Executive Committee or any ad hoc committee appointed may seek referral of a complaint for investigation or an investigation file for review to an independent health care provider. This investigation shall not be deemed to be a "hearing" as that term is used in Article X, below. The Medical Executive Committee or the ad hoc committee appointed will prepare a written report of its investigation and forward it to the Medical Executive Committee as soon as practicable after completing the investigation. The Executive Committee may at any time request that the investigating committee terminate the investigative process and proceed with an action as provided in Section 9.1.6, below.
- 9.1.5 **Investigation Report.** If the investigation is accomplished by a group or individual other than the Medical Executive Committee, that group or individual will forward a written report of the investigation to the Medical Executive Committee as soon as practicable after the completion of the investigation.

- 9.1.6 **Medical Executive Committee Action.** As soon as practicable after the conclusion of an investigation, if any, but in any event within twenty-one (21) days after the conclusion of an investigation or after receipt of an Investigation Report, the Medical Executive Committee will act upon the results of such investigation. The Medical Executive Committee may at any time within its discretion terminate an investigation and proceed with action as provided below. The Medical Executive Committee action may include, without limitation, recommending:
- 9.1.6.1 No corrective action.
  - 9.1.6.2 Additional education, training, supervision or monitoring.
  - 9.1.6.3 Medical/Psychiatric assessment or treatment.
  - 9.1.6.4 Denial of Medical Staff appointment for reasons of quality of care or professional conduct.
  - 9.1.6.5 Denial of reappointment to the Medical Staff.
  - 9.1.6.6 Suspension of Medical Staff appointment.
  - 9.1.6.7 Revocation of Medical Staff appointment.
  - 9.1.6.8 Denial or restriction of requested clinical privileges.
  - 9.1.6.9 Modification, suspension, limitation or revocation of all or any portion of clinical privileges.
  - 9.1.6.10 Application of or modification of mandatory direct supervision, monitoring or concurrent consultation requirements.
  - 9.1.6.11 Issuance of a letter of reprimand.
- 9.1.7 **Recommendation.** Any Medical Executive Committee action shall be in the form of a recommendation to the Governing Board. The recommendation of the Medical Executive Committee will be delivered to the practitioner and the Chief Executive Officer as soon as practicable after the recommendation has been transmitted to the Governing Board.
- 9.1.8 **Extensions of Time.** If additional time is needed to complete its deliberations, the Medical Executive Committee may defer action on the investigation; however, the Medical Executive Committee must take action in accordance with Section 9.1.6, above, within sixty (60) days of the conclusion of an investigation or of its receipt of an Investigation Report.
- 9.1.9 **Governing Board Action.** The Governing Board will consider recommendations relating to corrective action from the Medical Executive Committee and may affirm, deny, or modify the recommendation, or it may remand the matter to the Medical Executive Committee for further investigation or other corrective action. The decision of the Governing Board will be delivered to the Medical Executive Committee, the Chief Executive Officer and the practitioner as soon as possible after the decision is reached.

## 9.2 SUMMARY SUSPENSION

9.2.1 **Criteria for Initiation:** Whenever a practitioner's action or conduct threatens a patient's life or impairs the health or safety of any patient or the public, prospective patient, employee, the practitioner, himself/herself, or any other person in the Medical Center, that practitioner's clinical privileges or medical staff membership status may be summarily suspended or modified. The two parties who must act together to suspend or modify the privileges or status of a practitioner are the Medical Staff, through action of either the Chief of Staff or the Medical Executive Committee, and the Medical Center, through action of either the Chief Executive Officer or the Governing Board.

Summary suspension shall become effective immediately upon notice to the practitioner; however, prompt notice shall also be given to the Chief of Staff, the Chief Executive Officer, to the Medical Executive Committee and the Governing Board. Such notice of a summary suspension, when given to the Medical Executive Committee, shall constitute a request for an investigation and the procedures set forth in Section 9.1.2, above. At any time after the receipt of a written complaint or a written request for an investigation as set forth in Section 9.1.1, 9.1.2, or 9.1.3 above, the Medical Executive Committee may, within its discretion, terminate the investigation and order summary suspension of the practitioner if the Medical Executive Committee believes that the practitioner presents a threat to the health or safety of any patient, the public, Medical Center employees or staff, or to the practitioner himself/herself.

## 9.3 AUTOMATIC SUSPENSION (REV 03/2008)

### 9.3.1 License to Practice Medicine

9.3.1.1 **License Termination, Revocation or Expiration:** Whenever a practitioner's license authorizing him to practice medicine in the State of Arizona is terminated, revoked or has expired, his Medical Staff membership, prerogatives, and clinical privileges shall immediately and automatically be terminated.

9.3.1.2 **Restriction or Suspension:** Whenever a practitioner's license is restricted or suspended, the practitioner's Medical Staff membership and clinical privileges automatically shall be restricted or suspended at least to the extent of, and for the duration of, the license restriction or suspension.

- a. A restriction or suspension imposed by the practitioner's licensing board also may trigger an investigation and disciplinary action under these Bylaws.
- b. The practitioner shall notify the hospital Medical Staff Office within 10 days after his or her license has been restricted or suspended.
- c. The practitioner shall notify the Chief of Staff within 10 days after each meeting with or further action by his or her licensing board until such time as the licensing board removes any restrictions from the practitioner's license.
- d. The restriction or suspension of a practitioner's privileges under this section will not trigger any hearing or appeal rights under these Bylaws.

### 9.3.2 Drug Enforcement Administration Certificate

9.3.2.1 **Drug Enforcement Administration Certificate:** Whenever a practitioner's Drug Enforcement Administration Certificate is revoked, suspended, expired, or placed on probation by the Drug Enforcement Administration, the practitioner's

right to prescribe medication covered by such certificate shall automatically be suspended for at least the term of the probation. In addition, the Medical Executive Committee shall initiate corrective action as set forth in Sections 9.1.4 through 9.1.9, above whenever a practitioner's right to prescribe medications has been restricted by the Drug Enforcement Administration, the Board of Medical Examiners or any other entity authorized to do so.

- 9.3.2.2 **Drug Enforcement Administration Restriction or Probation:** Whenever a practitioner's license authorizing medical practice in the State of Arizona is restricted or placed on probation, the practitioner's Medical Staff membership and clinical privileges shall be automatically suspended or restricted for at least the term of the probation, or in accordance with the restriction, until the practitioner's application for reinstatement of clinical privileges has been granted by the applicable licensing authority in accordance with the Medical Staff Bylaws. A restriction or probation imposed by the Drug Enforcement Administration may also trigger an investigation as set forth in Sections 9.1.2 or 9.1.3 above.
- 9.3.3 **Professional Liability Insurance:** A practitioner's Medical Staff appointment and clinical privileges will be immediately and automatically suspended for failure to maintain the specified minimum amount of professional liability insurance. In the event that a practitioner's professional liability insurance (malpractice insurance) is terminated or lapses for any reason, the practitioner shall immediately give written notification of such termination or lapse to the Chief Executive Officer and the Chief of Staff.
- 9.3.4 **Refusal to Provide Requested Information:** If at any time a practitioner fails to provide required information pursuant to a written request by the Credentials or Executive Committee or the Chief Executive Officer, the practitioner's clinical privileges will be automatically suspended until the required information is provided to the satisfaction of the requesting party. For purposes of this section "required information" will include, but not be limited to: (1) physical or mental examinations as specified elsewhere in these bylaws or the Credentialing Procedures Manual; (2) information necessary to explain an investigation, professional review action or resignation from another facility or agency; or (3) information pertaining to professional liability actions involving the practitioner. If a practitioner's Medical Staff membership is terminated or suspended pursuant to this paragraph, the practitioner must reapply for membership on the Medical Staff.
- 9.3.5 **Failure to Attend Special Conference:** Whenever there is an apparent or suspected deviation from standard clinical practice involving any practitioner, the Chief of Staff may notify the practitioner that he/she is required to attend a special conference to consider the matter. The conference will be held with certain individual Medical Staff leaders and/or with a committee of the Medical Staff. The notice to the practitioner regarding this conference will be provided by certified mail, return receipt requested, at least seven (7) days prior to the conference and will inform the practitioner that attendance at the conference is mandatory. Failure of the practitioner to attend the conference will be reported to the Credentials Committee. Unless excused by the Credentials Committee upon showing of good cause, such failure will constitute automatic suspension of all or such portion of the practitioner's clinical privileges as the Credential Committee may direct. Such suspension will remain in effect until the matter is resolved.
- 9.3.6 **Criminal Activity:** Any practitioner who has been convicted of any felony or of any misdemeanor involving violations of law pertaining to controlled substances, illegal drugs or Medicare, Medicaid or insurance fraud or abuse, or any practitioner who pleads

guilty or nolo contendere (“no contest”) to charges pertaining to the same, will be automatically suspended. The Executive Committee may consider a waiver of this provision in cases involving settlements with Medicare or Medicaid of matters related to inadvertent billing errors, upon request of an individual.

- 9.3.7 **Medicare and Medicaid Participation:** Any practitioner whose participation in the Medicare, Medicaid or ACCCHS programs is terminated by either or both of those programs, or who is otherwise excluded or precluded from participation in either or both of those programs, shall be automatically suspended as of the effective date of the termination, exclusion or preclusion. If the practitioner’s participation in those programs is not fully reinstated by the expiration of the practitioner’s then current appointment term, the practitioner will be deemed to have resigned from the Medical Staff at that time. It shall be the duty of all practitioners to promptly inform the Medical Center of any action taken by either such program in this regard.
- 9.3.8 **Failure to Complete Medical Records:** Failure to complete medical records within the time frames specified in the Rules and Regulations of the Medical Staff shall result in temporary suspension of clinical and surgical privileges. Temporary suspension will remain in effect until such time needed for the practitioner to complete all such delinquent medical records. Suspensions for incomplete medical records shall be reported to the Medical Executive Committee for corrective action as set forth in Section 9.1, Corrective Action, above.
- 9.3.9 **Failure to Comply with AZ Code R9-10-207 (B)(1) – Infectious Pulmonary Tuberculosis Clearance:** Failure to comply with AZ Code R9-10-207 (B)(1) within the time frame indicated (once every 24 months) shall result in temporary suspension of clinical and surgical privileges. Temporary suspension will remain in effect until such time as needed for the practitioner to provide evidence of freedom from infectious pulmonary tuberculosis. Acceptable evidence of freedom from infectious pulmonary tuberculosis are as follows:
- a. A report of a negative Mantoux skin test signed by a licensed healthcare worker;
  - b. Another physician’s formal written statement that the individual is free from infectious pulmonary tuberculosis (for practitioners with a positive Mantoux skin tests only); or
  - c. A report of a negative chest x-ray.

Tuberculosis screening can be done at Summit Healthcare Employee Health free of charge.

Revised 03/2008

## 9.4 TRANSFER/ASSIGNMENT OF PATIENTS

- 9.4.1 **Transfer/Assignment of Patients:** When a practitioner has been suspended or summarily suspended, patients being treated by such practitioner may be assigned to another practitioner by the Chief of Staff with notice to the Chief Executive Officer. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.
- 9.4.2 **Notice of Automatic Suspension; Transfer of Patients:** Whenever a practitioner's privileges are automatically suspended in whole or in part, notice of such suspension shall be given to the practitioner, the Medical Executive Committee, the Chief Executive Officer and the Governing Board as soon as practicable. The giving of such notice will not, however, be required before the suspension becomes effective. In the event of any such suspension, patients being treated by such practitioner whose treatment is no longer

appropriately provided by such practitioner will be assigned to another practitioner by the Chief of Staff with notice to the Chief Executive Officer. The wishes of the patient will be considered, where feasible, in choosing a substitute practitioner.

## **9.5 MEDICAL RECORDS PREPARATION**

9.5.1 **Medical Records Preparation and Completion:** The rules for medical records preparation and completion are outlined in Medical Staff Rules and Regulations.

9.5.2 **Restriction/Suspension:** The failure to prepare and/or to complete medical records in a timely fashion may result in limitation, restriction or automatic suspension of some or all of a practitioner's prerogatives and clinical privileges.

## **9.6 VOLUNTARY RESIGNATION**

9.6.1 Six (6) suspensions within any twelve (12) month period for failure to complete or prepare records will be deemed a voluntary resignation from the staff. Practitioners who so resign may submit a formal application for appointment.

## **9.7 PROCEDURAL RIGHTS; HEARINGS AND APPEALS**

9.7.1 **Procedural Rights:** A recommendation made by the Medical Executive Committee and decisions of the Governing Board pursuant to this Article IX shall constitute an "Adverse Action or Recommendation" as defined in Section 10.2.1.1, below which may trigger a practitioner's request for a hearing pursuant to Article X.

## **ARTICLE X: FAIR HEARING AND APPEAL PROCESS**

### **10.1 PURPOSE**

10.1.1 The purpose of this article is to provide a fair hearing to review any adverse action or recommendation taken against an applicant for Medical Staff privileges or a member of the Medical Staff whether such action or recommendation be automatic or with notice to the practitioner. It is recognized that the Governing Board and the Medical Staff have both the right and the duty to maintain control over the Medical Staff to ensure the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. The substantive rules and regulations governing the conduct of Medical Staff members shall be applied as set forth in these bylaws and the Medical Staff Rules and Regulations and policies of the Medical Center. Furthermore, it is intended that these bylaws, the Medical Staff Rules and Regulations and the policies of the Medical Center will be applied equally and fairly to all members of the Medical Staff. The hearings and reviews provided for in this article shall be open and available to any applicant for Medical Staff privileges as well as any member of the Medical Staff who has suffered an adverse action or recommendation with respect to Medical Staff membership, Medical Staff status, committee membership or status, or clinical privileges. This article shall not apply to Medical Center employees who are not also members of the Medical Staff, etc.

### **10.2 SPECIAL DEFINITIONS**

10.2.1 The following definitions will apply to the terms used in this article:

10.2.1.1 **Adverse Action or Recommendation** means one or more of the following actions or recommendations or any other professional review action as defined by the "Health Care Quality Improvement Act of 1986," as amended, taken either by the Medical Executive Committee or the Governing Board (see Section 10.3, below).

10.2.1.1.1 Denial of membership status on the Medical Staff.

10.2.1.1.2 Denial of Staff reappointment.

10.2.1.1.3 Suspension of Staff membership until completion specific conditions or requirements.

10.2.1.1.4 Summary suspension of Staff membership during the pendency of corrective action and hearing and appeals procedures.

10.2.1.1.5 Expulsion from Staff membership.

10.2.1.1.6 Denial of requested privileges.

10.2.1.1.7 Reduction of privileges.

10.2.1.1.8 Suspension of privileges until completion of specific conditions or requirements.

10.2.1.1.9 Summary suspension of privileges during the pendency of corrective action and hearing and appeals procedures.

10.2.1.1.10 Termination of privileges.

## 10.2.1.1.11 Requirement of consultation or supervision.

- 10.2.1.2 **Appeals Board** means the group of persons designated by this article to conduct an appeal. Appeals Board members will not be in direct economic competition with the practitioner who is involved in the appeal.
- 10.2.1.3 **Hearing Committee** means a group of at least three (3) physicians who are licensed to practice in the State of Arizona, appointed by the Chief of Staff to hold a hearing and take evidence following the filing of a petition or grievance by a member of the Medical Staff. Hearing Committee members will not be in direct economic competition with the practitioner who requests a hearing. Hearing Committee members need not be members of the Medical Staff.
- 10.2.1.4 **Hearing Officer** means a physician licensed to practice in the State of Arizona, appointed by the Chief of Staff to hold a hearing and take evidence following the filing of a petition or grievance by a member of the Medical Staff. Hearing Officers will not be in direct economic competition with the practitioner who requests a hearing. A Hearing Officer need not be a member of the Medical Staff.
- 10.2.1.5 **Notice** means a written communication delivered personally, or mailed by United States Mail, certified or registered mail, return receipt requested, addressed to the practitioner or the Medical Center Chief Executive Officer at his or its address, as it appears in the Medical Center's records. Notices will be deemed to have been received on the date it was personally delivered, or if delivered by mail, the Notice will be deemed received three (3) days after being deposited, postage pre-paid, in the United States Mail.
- 10.2.1.6 **Parties** means the practitioner and the Governing Board or other Medical Center body or committee upon whose adverse action or recommendation triggers the right to a hearing or appellate review.
- 10.2.1.7 **Practitioner** means a Medical Staff member or an applicant for Medical Staff privileges who has requested a hearing pursuant to this article.

### 10.3 INITIATION OF HEARING

- 10.3.1 **Initiation:** An action or recommendation will not be subject to hearing or appeal until such adverse action/recommendation has been either:
- 10.3.1.1 Recommended by the Medical Executive Committee to the Governing Board;  
or
- 10.3.1.2 The Governing Board has taken action
- 10.3.2 **Notice.** Promptly and no less than ten (10) days after the Medical Executive Committee or Governing Board takes action with respect to a practitioner's status or privileges, written notice shall:
- 10.3.2.1 Advise the practitioner of the action or recommendation and of the practitioner's right to request a hearing or appeal pursuant to this Article and the "Health Care Quality Improvement Act of 1986," as amended.
- 10.3.2.2 Notify the practitioner that he/she has thirty (30) days from the date of the notice to request the hearing and that the request for the hearing must be in

writing.

- 10.3.2.3 Notify the practitioner that the hearing shall be held before a Hearing Committee or Hearing Officer appointed by the Chief of Staff. Where a single Hearing Officer has been appointed, either party may request a change from a Hearing Officer to a Hearing Committee which shall be comprised of at least three (3) physicians. See Section 10.2.1.3
- 10.3.2.4 Notify the practitioner of his/her right to:
  - 10.3.2.4.1 Be represented by an attorney or other person of the practitioner's choice.
  - 10.3.2.4.2 Request that a record be made of the proceedings.
  - 10.3.2.4.3 Call, examine and cross-examine witnesses.
  - 10.3.2.4.4 Present other evidence determined to be relevant by the Hearing Committee or Hearing Officer, regardless of its admissibility in a court of law.
  - 10.3.2.4.5 Submit a written statement to the Hearing Committee or Hearing Officer at the close of the hearing.
  - 10.3.2.4.6 Receive the written recommendation of the Hearing Committee, Hearing Officer or Appeal Board which shall include the basis for the recommendation or decision.
  - 10.3.2.4.7 Receive the written decision of the Governing Board after all hearings and appeals have been conducted.
- 10.3.2.5 State that if the practitioner wishes to be represented by an attorney, that he/she must make that known within ten (10) days of the practitioner's request for a hearing, and the attorney shall enter an appearance in writing at least fifteen (15) days prior to the date set for the hearing.

- 10.3.3 **Notice of Adverse Action/Recommendation.** Within fifteen (15) days of the delivery of a notice to the practitioner of any adverse action/recommendation by the Medical Executive Committee or Governing Board, the practitioner shall be advised in writing of the charges against him/her or the factual basis upon which the adverse action/recommendation was taken. In addition, witnesses and exhibits then known to the Medical Executive Committee or Governing Board and which are intended to be used at the hearing, should be disclosed to the practitioner. These documents may accompany the notice of adverse action/recommendation as provided in Section 10.3.2, above.

## 10.4 THE HEARING

- 10.4.1 **Request for Hearing.** The petitioner will have thirty (30) days following the date of receipt of notice of an adverse action to request a hearing by a Hearing Officer or Hearing Committee. All such requests will be by written notice to the Chief of Staff with a copy to the Medical Center Chief Executive Officer. In the event the petitioner does not request a hearing within the time allowed or in the manner set forth herein, he will be deemed to have accepted the adverse action which action will thereupon become the final action of the Medical Staff. Such final action will be transmitted to the Governing Board

forthwith and the Governing Board shall take final action, with or without a hearing, within forty-five (45) days.

- 10.4.2 **Time and Place for Hearing.** The hearing shall take place not less than thirty (30) days nor more than ninety (90) days from the date of the receipt of a practitioner's request for hearing, unless the chairperson of the Hearing Committee or the Hearing Officer grants a continuance or extension of time, for good cause shown. In the event that the adverse action terminates clinical privileges or membership on the active or consulting Medical Staff, the hearing shall be held as soon as practicable, but no more than forty-five (45) days from the date the request for hearing is received, unless a continuance or extension of time is granted as set forth in this paragraph.
- 10.4.3 **Stay of Enforcement.** On written request, the Hearing Committee chairperson or the Hearing Officer with the approval of the Governing Board may stay the enforcement of the adverse action upon adequate showing by clear and convincing evidence that the Medical Center and the public is adequately protected. Hearings will take place at the Medical Center or at such other places as may be set from time-to-time by the Hearing Committee or Hearing Officer.
- 10.4.4 **Exchanging Witnesses and Exhibits.** The parties will exchange the names and address of witnesses and a list of exhibits which they intend to introduce at the hearing at least twenty-one (21) days prior to the date of the scheduled hearing. In exceptional circumstances, the Hearing Committee or Hearing Officer may allow a later disclosure of witnesses or exhibits upon a showing of good cause. However, in all cases, the names and addresses of witnesses and a list of exhibits will be exchanged at least ten (10) days before the scheduled hearing. Any witnesses or exhibits not so disclosed shall not be allowed to testify or be introduced at the hearing. The relevancy of testimony and the content of exhibits shall be determined by the Hearing Committee or Hearing Officer.
- 10.4.5 **Notice of Charges.** Prior to beginning the hearing, the Hearing Committee or Hearing Officer shall read a list of the charges against the practitioner or the factual basis for the adverse action, unless waived by the parties.
- 10.4.6 **Failure to Appear.** If either party fails to appear for the hearing without good cause, such absence shall be deemed to constitute a voluntary absence from the proceeding. The Hearing Committee or Hearing Officer may proceed with the hearing or take such other action as they/he/she believes is fair under the circumstances, including dismissal of the request for hearing or transmittal of a recommendation to the Governing Board for final action.
- 10.4.7 **Continuances and Extensions of Time.** Continuances and extensions of time may be requested by either party, in writing, which request will state the reasons for the request. Continuances and extensions of time may be granted by the Hearing Committee chairman or Hearing Officer only upon a showing of good cause.
- 10.4.8 **Record of Proceedings.** A record of the hearing will ordinarily be made by a certified transcriptionist or reporter. However, upon motion of either party with good cause shown, the Hearing Committee chairperson or Hearing Officer may authorize the record of the hearing be made by audio visual recording, or other reliable methods to be determined.
- 10.4.9 **Hearing Committee/Officer Participation.** Hearing Committee members or the Hearing Officer may participate in hearings by asking questions of the parties, witnesses, or by requesting additional testimony from witnesses appointed by the Hearing Committee or Hearing Officer. In addition, the Hearing Committee or Hearing Officer may request the submission of other documentary evidence by the parties, if the Hearing

Committee or Hearing Officer determines that it would be helpful in resolving the issues or matters presented.

- 10.4.10 **Written Statements.** Each party will have the right to submit a written statement in support of its position at the close of the hearing. In addition, the Hearing Committee or Hearing Officer may request written statements from the parties to be submitted either before or after the hearing.
- 10.4.11 **Burden of Proof.** The burden of proof in all hearings, except for a stay of enforcement (See Section 10.4.3), will be a preponderance of the evidence. The party that has the burden of proof must persuade the Hearing Committee or Hearing Officer by the evidence that his/her claim is more probably true than not more likely than not. In other words, the evidence supporting the propositions or elements which a party has the burden of proving must outweigh the evidence opposed to it. In determining whether a party has met this burden of proof, all of the evidence will be considered, no matter which party introduces it.
- 10.4.12 **Adjournment.** Following the hearing, the Hearing Committee or Hearing Officer will conclude the hearing.
- 10.4.13 **Deliberations.** Following the conclusion of the hearing, the Hearing Committee or Hearing Officer shall, outside the presence of any other persons, conduct deliberations and render a written decision. The written decision will state the reasons for the decision. The decision will be based on the evidence produced at the hearing, although the Hearing Committee or Hearing Officer may consider the evidence in light of their training and experience.
- 10.4.14 **Written Decision.** Within ten (10) days after the conclusion of the hearing and the submission of any written statements by the parties, the Hearing Committee or Hearing Officer will render a written decision which will include the factual basis for the decision. The decision will be mailed or delivered forthwith to the Governing Board, the Chief of Staff, the Medical Center Chief Executive Officer and the practitioner. The Governing Board will not take final action on a Hearing Committee/Hearing Officer decision until after the time for appeal has run.

## 10.5 APPEALS

- 10.5.1 **Appeal Board.** When an appeal is requested, the Governing Board may sit as the Appeal Board or it may appoint an Appeal Board composed of at least three (3) members of the Governing Board. The Appeal Board may also request legal counsel to give it advice at appeal hearings, during deliberations, and in the preparation of the Appeal decision.
- 10.5.2 **Reasons for Appeal.** The only reasons which may be raised for an appeal from a Hearing Committee or Hearing Officer decision are:
- 10.5.2.1 The discovery of new evidence which could not have reasonably been discovered prior to the hearing.
- 10.5.2.2 That the Hearing Committee acted arbitrarily or capriciously.
- 10.5.2.3 That the hearing procedures did not comply with the procedures set forth in these Bylaws, so as to deny practitioner a fair hearing.
- 10.5.2.4 That these Bylaws, the Medical Staff Rules and Regulations or the policies of the Medical Center which formed the basis of the adverse ruling or decision by,

the Hearing Committee/Hearing Officer is invalid.

10.5.2.5 That there was fraud, misrepresentation, or other misconduct of an adverse party which denied practitioner a fair hearing.

- 10.5.3 **Time for Appeal.** Within ten (10) days after the receipt of the decision of the Hearing Committee or Hearing Officer, either party may file a written request for appeal with the Chief of Staff and copy made to the Medical Center Chief Executive Officer stating the reasons for the appeal. A copy of the request for appeal will be delivered to the other party within two (2) days of such filing. If no appeal is requested the Hearing Committee's or Hearing Officer's recommendation or decision will be forwarded to the Governing Board for final action.
- 10.5.4 **Record on Appeal.** The record on appeal will consist of three (3) copies of a complete, typewritten transcript of the proceedings before the Hearing Committee or Hearing Officer, along with three (3) copies of any exhibits, documents or written statements received and considered by the Hearing Committee or Hearing Officer. Costs of providing transcripts and other documents will be borne by the party requesting the appeal, although the other party will be entitled to receive a copy of the record on appeal by paying reasonable charges for copies.
- 10.5.5 **Time and Place of Appeal Hearing.** The Appeal Board will schedule the Appeal Hearing within forty (45) days after the receipt of a request for appeal. The hearing will take place at the Medical Center or at such other place as the Appeal Board will designate.
- 10.5.6 **Appeal Hearing Procedure and Decision.** The proceedings before the Appeal Board shall be to review the record on appeal and to give the parties an opportunity to present additional oral or written arguments. No new evidence will be received by the Appeal Board; however, in the event that the Appeal Board believes that new or other evidence should be considered before a final decision is rendered, the Appeal Board may refer the matter back to the Hearing Committee or Hearing Officer for further limited proceedings as may be designated by the Appeal Board. Each party shall have the right to present a written statement in support of its position on appeal in accordance with a submission schedule to be determined by the Appeal Board. After the submission of the written statements and/or the conclusion of oral argument, the Appeal Board will conduct deliberations outside the presence of all other persons and render a written decision within fifteen (15) days after the conclusion of the appeal hearing. The written decision of the Appeal Board shall then be promptly submitted to the parties and to the Governing Board, to the Chief of Staff and the Chief Executive Officer and the practitioner.
- 10.5.7 **Stay of Enforcement.** On written request, the Hearing Committee chairperson or the Hearing Officer, with the approval of the Appeal Board, may stay the enforcement of the adverse action upon adequate showing by clear and convincing evidence that the Medical Center and the public are adequately protected. Hearings will take place at the Medical Center or at such other places as may be set from time-to-time by the Hearing Committee or Hearing Officer.
- 10.5.8 **Standard of Review on Appeal.** The Appeal Board will determine whether substantial evidence supports the decision of the Hearing Committee or Hearing Officer. On appeal, the Appeal Board will review the record to see whether it supports the factual findings of the Hearing Committee or Hearing Officer. If substantial evidence supports the findings of fact of the Hearing Committee or Hearing Officer, and the decision or recommendation was not arbitrary, capricious or an abuse of discretion, the Appeal Board should not overturn or discard the factual findings. A decision or recommendation is not

arbitrary or capricious if it is exercised honestly upon due consideration of the facts and circumstances, even though there may be other opinions or inferences which may be drawn from the facts. If the Appeal Board determines that there is not substantial evidence to support the charges giving rise to the action taken, it must reject or modify the action or recommendation.

## **10.6 GOVERNING BOARD ACTION**

10.6.1 Within thirty (30) days after the time for appeal from the decision of a Hearing Committee or Hearing Officer, if no request for appeal has been filed, or within thirty (30) days after the receipt of a final decision of the Appeal Board; the Governing Board shall take final action on the action, recommendation or decision. However, the Appeal Board shall have the power to accept, reject or modify any action or recommendation consistent with the Governing Board's duty to protect both the Medical Center and the public from unlawful, incompetent, unqualified, impaired or unprofessional practitioners. The standard of review used by the Governing Board shall be to determine what is in the best interests of the Medical Center and the public.

## **10.7 FURTHER REVIEW**

10.7.1 Except in the instance where the Governing Board remands matters to the Medical Executive Committee or to the Hearing Committee, Hearing Officer or Appeal Board for further action, the decision of the Governing Board will be final and immediately effective and shall not be subject to further administrative review.

## **10.8 EXHAUSTION OF REMEDIES**

10.8.1 If an adverse ruling is made with respect to a practitioner's Medical Staff membership or status, or with respect to his clinical privileges at any time, regardless of whether he is an applicant or a Medical Staff Member; the practitioner must first exhaust the remedies afforded by these bylaws before filing or otherwise pursuing any formal legal action in state or federal court challenging the adverse ruling, the procedures used to arrive at the ruling, challenging the legality of these bylaws or the Medical Staff Rules and Regulations or policies of the Medical Center, or asserting any claim against the Medical Center, members of the Medical Staff, the Governing Board or any other persons who participated in the decision process which led to the adverse action. In no event shall a practitioner seek judicial review of an adverse action until the hearing and appeals procedure pursuant to this Article has been completed.

## **10.9 JUDICIAL REVIEW**

10.9.1 A judicial review will not be *de novo*, but will only be a review of the record. The court shall not weigh the evidence, but shall only determine whether the action taken against the practitioner was illegal, arbitrary or capricious, or whether there was an abuse of discretion.

10.9.2 In the event the practitioner pursues judicial review in the State or Federal Courts of the matter, the Governing Board shall have the sole authority and discretion to stay the proceedings against the practitioner pending judicial review. A stay of the action, recommendation, decision or proceedings shall occur only upon consideration by the Governing Board after written request by the practitioner and response by the Body whose decision prompted the hearing. In the event the Governing Board determines that a stay of the proceedings is appropriate pending judicial review, it shall notify the parties in writing of its decision within five (5) days of its consideration of practitioner's request and the response.

**10.10 RIGHT TO HEARING/APPEAL**

10.10.1 Notwithstanding any other provision of this Article or these Bylaws, no practitioner will be entitled as a matter of right to more than one (1) hearing before a Hearing Committee or Hearing Officer (evidentiary hearing), and one (1) appeal before an Appeal Board on any adverse action or recommendation.

**10.11 EXCEPTIONS TO HEARING AND APPEAL RIGHTS**

10.11.1 **Medical Center Employees:** The hearing and appeal rights set forth in this article do not apply to Medical Center employees or any persons other than persons seeking admission to the Medical Staff or members of the Medical Staff. Medical Center employees will be governed by Medical Center policies. Likewise, the provisions of this article and these bylaws do not apply to the Chief Executive Officer or other quasi-employees, consultants or persons not governed by the Medical Staff Bylaws or this policy.

10.11.2 **Allied Health Professionals :** The hearing and appeal rights set forth in this article do not apply to Allied Health Professionals. An Allied Health Professional's privileges shall automatically terminate in the event:

10.11.2.1 The Medical Staff membership of the Supervising Physician is terminated for any reason.

10.11.2.2 The Supervising Physician no longer agrees to act as the Supervising Physician, or the relationship between the Allied Health Professional and the Supervising Physician is terminated for any reason.

10.11.2.3 The Allied Health Professional's certification expires, or is suspended or revoked by any competent authority.

10.11.2.4 Nothing contained in these Bylaws will be interpreted to entitle an Allied Health Professional to the hearing or appeal rights set forth in these Bylaws.

## **ARTICLE XI: MEDICAL STAFF RULES AND REGULATIONS**

### **11.1 ADOPTION**

Committee will adopt such rules and regulations as may be necessary to implement more specifically the general principles stated in these bylaws. The rules and regulations will be subject to the approval of the Governing Board, which approval will not be unreasonably withheld. Rules and regulations adopted by the Medical Executive Committee and approved by the Governing Board will have the same force and effect as the bylaws.

### **11.2 REVIEW PERIOD**

The Medical Executive Committee will review the Medical Staff Rules and Regulations every two years and make changes as necessary. The Medical Staff Rules & Regulations are to be reviewed and approved by the Departments every two years.

### **11.3 AMENDMENTS**

Amendments to the Medical Staff Rules and Regulations will be made when necessary to effectuate the purposes of these bylaws and the rules and regulations. Amendments will be made upon recommendation of the Medical Executive Committee, or a Medical Staff subcommittee with the concurrence of the Medical Executive Committee. Amendments will become effective only after approval by the Governing Board.

### **11.4 HISTORY AND PHYSICALS**

A member of the Medical Staff must complete a History and Physical within the first 24 hours of admission. Information to be included in the History and Physical is delineated in the Medical Staff Rules and Regulations. The History and Physical is the responsibility of the attending physician.

## **ARTICLE XII: REVIEW AND AMENDMENTS TO BYLAWS**

### **12.1 REVIEW**

The Medical Staff will review the Medical Staff Bylaws every two years and make changes as necessary.

### **12.2 AMENDMENTS TO BYLAWS**

12.2.1 All proposed amendments, whether originated by a standing committee or by a member of the active staff, must be reviewed, discussed and recommended by the Medical Executive Committee prior to a vote by the Medical Staff. Amendments may then be adopted, amended or repealed by ballot (mail or electronic) provided that notice of such changes is delivered to all Active members of the Medical Staff at least thirty (30) days prior to balloting. The notice will include the exact wording of the proposed change and the date ballots must be returned. In order to enact an amendment, (i) the amendment must be voted on by at least 20% of the Active Medical Staff, and (ii) an amendment must receive a majority of the votes cast. Following the required vote of the Active Medical Staff, the amendments will be submitted to the Governing Board for approval.

12.2.2 The Medical Executive Committee will have the power to adopt such amendments to these bylaws that are needed because of reorganization, renumbering, punctuation, spelling or other errors of grammar of expression. Such amendments will be effective when approved by the Governing Board.

12.2.3 All amendments will be effective on the date of approval by the Governing Board. Neither the Medical Staff nor the Governing Board may unilaterally amend these bylaws.

12.2.4. All members of the Medical Staff will be notified of amendments made to these bylaws and related manuals once approved by the Governing Board.

12.2.5 In cases of a documented need for urgent amendment to the bylaws and/or related manuals necessary to comply with law or regulation, the medical executive committee may provisionally adopt and the Governing Board may provisionally approve an urgent amendment without prior notification to the medical staff. In such cases, the medical staff will be immediately notified by the medical executive committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment as identified in 12.2.1.

### **12.3 RELATED PROTOCOLS AND MANUALS**

12.3.1 The Medical Executive Committee will recommend to the Governing Board a Credentialing Procedure Manual, an Allied Health Professional Procedures Manual, rules and regulations, and other such documents as are necessary to further define the general policies contained in these bylaws. Upon adoption by the Governing Board, these manuals and rules/regulations will be incorporated by reference and become part of these bylaws.

12.3.2 If the medical executive committee proposes to adopt a rule or regulation or, an amendment thereto, it first communicates the proposal to the medical staff and allows for an opportunity for comment prior to the Governing Board's final approval.

### **12.4 CHOICE OF LAW**

These bylaws and the Medical Staff Rules and Regulations will be construed in accordance with the laws of the State of Arizona. Persons or other entities agree that jurisdiction and venue for any proceedings or challenges arising out of these bylaws or the Medical Staff Rules and Regulations will lie only in the Superior Court of Arizona, in and for Navajo County.

**ADOPTION**

These Bylaws are adopted and made effective upon approval of the Governing Board, superseding and replacing any and all other Medical Staff bylaws, rules, regulations, policies, manuals or Medical Center policies pertaining the subject matter thereof.

Adopted by the Medical Staff on:           *January 20, 2015*            
Date

Approved by the Governing Board on:           *January 22, 2015*            
Date