

**BYLAWS
AND
RULES & REGULATIONS
OF THE
MEDICAL STAFF**

REVISED AND RESTATED

January 27, 2011



BYLAWS OF THE MEDICAL STAFF OF
UNIVERSITY MEDICAL CENTER

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BYLAWS OF THE MEDICAL STAFF OF
UNIVERSITY MEDICAL CENTER

PREAMBLE

These Medical Staff Bylaws, and Rules and Regulations are adopted to provide for the organization of the Medical Staff of University Medical Center (UMC) and to provide a framework for self-governance to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors, and relations with applicants to and members of the Medical Staff. In the event that the law or regulatory requirements change, such changes will govern these Bylaws as legally required, by operation of law.

PREROGATIVES AND PURPOSE

The prerogatives and purpose of the Medical Staff shall be to maintain the highest possible standards of medical practice in the diagnosis and treatment of patients at UMC; to provide an optimum environment for the education of physicians, biomedical scientists, and other health care professionals; and to stimulate and promote research in problems of human health and disease. In furtherance of these goals, the Medical Staff shall work:

1. To assure that all patients admitted and/or treated at UMC receive care at a level of quality and efficiency consistent with generally accepted standards attainable within UMC's means and circumstances.
2. To provide for a level of professional performance that is consistent with generally accepted standards attainable within UMC's means and circumstances, and to strive to be a center of excellence in health care delivery.
3. To organize and support professional/health education and support services.
4. To initiate and maintain Bylaws, and Rules and Regulations for the Medical Staff to carry out its responsibilities for the professional work performed at UMC, pursuant to the authority delegated by the Board of Directors.
5. To provide an effective means of communication between the UMC Medical Staff, Board of Directors and Administration to discuss problems of a medico-administrative nature and to work collaboratively to enhance the quality and safety of patient care, treatment and services.
6. To provide for accountability of the Medical Staff to the Board of Directors.
7. To support the mission and vision of UMC.
8. To determine the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent clinical privileges.
9. To determine the mechanism for establishing and enforcing criteria and standards for Medical Staff membership.

10. To determine the mechanism for establishing and maintaining patient care standards, including procedures for credentialing and delineating clinical privileges.
11. To measure, assess and improve processes that primarily depend on the activities of one or more licensed independent practitioners, and other practitioners credentialed and privileged through the Medical Staff process, including use of medications, use of blood and blood components, operative and other procedures, appropriateness of clinical practice patterns, and significant departures from established patterns of clinical care.
12. To foster education and research programs of the Arizona Health Sciences Center, University of Arizona College of Medicine in an integrated manner with the clinical programs of UMC.

The Medical Staff operates within the legal structure of UMC, as set forth in the statutory provisions enabling UMC to operate and as provided for in UMC Corporation's Corporate Bylaws, as Amended and Restated. Specifically, Arizona Revised Statutes Section 15-1637(K)(3)(d) states:

The board of directors of the nonprofit corporation may adopt nondiscriminatory rules and regulations providing for the use of the university [sic] of Arizona hospital by and staff privileges for, any persons licensed under title 32, chapter 7, 13 or 17, whether or not such persons have a faculty teaching appointment with the school of medicine, providing, however, that such rules and regulations shall contain requirements sufficient to protect the educational and research purposes and goals of the university of Arizona hospital.

DEFINITIONS

1. ALLIED HEALTH PRACTITIONER (AHP) means a licensed health care practitioner, other than a physician, dentist, podiatrist, clinical psychologist, or nurse midwife, who has been granted clinical privileges pursuant to these Bylaws.
2. BOARD OF DIRECTORS (Board) means the governing body of UMC.
3. CHIEF EXECUTIVE OFFICER (CEO) means the person appointed by the Board of Directors to serve in an administrative capacity as the chief executive of UMC.
4. CHIEF MEDICAL OFFICER means a practitioner appointed by the UMC Chief Executive Officer to work with the Board, Administration and Staff to promote delivery of high quality care.
5. CHIEF OF CLINICAL SERVICE, SERVICE CHIEF or CHIEF OF SERVICE means the individual who is responsible for administration and oversight of his or her respective clinical service at UMC pursuant to the provisions of Article X of these Bylaws.
6. CHIEF OF STAFF means the current chief officer of the Medical Staff as elected by members of the Medical Staff eligible to vote.
7. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a practitioner by the Board to render specific patient services.
8. DAY when used in connection with a deadline imposed by these Bylaws means a business day, *i.e.* Monday through Friday and excluding holidays.
9. EX OFFICIO means membership by virtue of an office or position held.
10. HOUSE STAFF PHYSICIAN means a post-medical graduate and/or clinical fellow who is pursuing a defined course of study at the University of Arizona under the supervision of faculty at the University of Arizona College of Medicine.
11. MEDICAL EXECUTIVE COMMITTEE (MEC) means the executive committee of the Medical Staff, which shall constitute the governing body of the Medical Staff pursuant to the terms of these Bylaws.
12. MEDICAL STAFF or STAFF means those physicians (M.D. or D.O), dentists, podiatrists, clinical psychologists and nurse midwives who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.
13. MEDICAL STAFF YEAR means the period from January 1 through December 31.
14. MEMBER means, unless otherwise expressly limited, any physician (M.D. or D.O.), dentist, podiatrist, clinical psychologist or nurse midwife holding a current license to practice within the scope of his or her license who has been appointed to the Medical Staff, pursuant to the terms of these Bylaws.
15. PREROGATIVE means a right, granted to a practitioner by virtue of staff category or otherwise, exercisable subject to the conditions and limitations imposed in these Bylaws.

16. SPECIAL NOTICE means written notification given personally or sent by certified or electronic mail with return receipt requested. An alternate Mechanism may be used if it is reliable, expeditious, and if evidence of delivery to the named individual is obtained.
17. UMC means University Medical Center in Tucson, Arizona, including all of its medical offices, facilities, and clinics.

ARTICLE I

NAME

The name of this organization is the Medical Staff of University Medical Center, hereinafter referred to as the Medical Staff.

ARTICLE II

MEDICAL STAFF MEMBERSHIP

2.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the UMC Medical Staff shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws, Rules and Regulations, and applicable UMC policies. A Medical Staff Member may provide medical services at UMC only to the extent he or she has been granted clinical privileges by the Board in accordance with these Bylaws. Individuals in administrative positions who desire Medical Staff membership are subject to the same procedures as all other applicants for membership.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2.1 GENERAL QUALIFICATIONS

Members of the Medical Staff must:

- 2.2.1.1 Hold a current active license to practice medicine, dentistry, podiatry, clinical psychology or nurse midwifery in the State of Arizona;
- 2.2.1.2 Possess a Federal DEA number if prescribing controlled substances;
- 2.2.1.3 Be determined to adhere to the lawful ethics of his or her profession; be able to work cooperatively with others so as not to adversely affect patient care; and be willing to participate in and properly discharge Medical Staff responsibilities;
- 2.2.1.4 Meet health screening requirements as may be required by UMC and submit any reasonable evidence of current health status that may be requested; and
- 2.2.1.5 Maintain professional liability insurance at the level determined by the Board of Directors.

2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership on the Medical Staff merely by virtue of licensure to practice, membership in any professional organization, certification by any clinical board, or staff membership at any other health care facility.

2.4 NONDISCRIMINATION

Medical Staff membership or particular clinical privileges shall not be denied on the basis of gender, race, age, creed, color, religion, national origin, sexual orientation, marital status, or on the basis of any other criterion unrelated to the quality of patient care or to professional ability and judgment, or to community needs or based on any physical or mental impairment if, after any necessary reasonable accommodation, the applicant

agrees to comply with the Bylaws, Rules and Regulations, the Medical Staff Code of Conduct and UMC policies and procedures

2.5 GENERAL RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Each Medical Staff Member, and each practitioner in a category permitted to exercise clinical privileges without membership, shall continuously meet all of the responsibilities set forth below, as applicable:

- 2.5.1 Provide his or her patients with the quality of care meeting the professional standards of the Medical Staff of UMC, according to the principles established in these Bylaws, and Rules and Regulations;
- 2.5.2 Accept, understand and agree to be bound by these Bylaws, and Rules and Regulations;
- 2.5.3 Comply with all applicable federal, state and local laws, regulations and accreditation requirements, e.g. The Joint Commission's requirements for accreditation of health care organizations;
- 2.5.4 Discharge such Medical Staff, service, section, and committee functions for which he or she is responsible by appointment, election or otherwise;
- 2.5.5 Prepare and complete in a timely manner the medical records for all patients to whom the practitioner in any way provides services at UMC;
- 2.5.6 Abide by the ethical principles of the Member's profession;
- 2.5.7 Refrain from unlawful fee splitting or unlawful inducement relating to patient referral;
- 2.5.8 Refrain from delegating the responsibility for diagnosis or care of patients to an individual who is not qualified to undertake this responsibility or who is not adequately supervised;
- 2.5.9 Seek consultation whenever warranted by the patient's condition or when required by these Bylaws, the Rules and Regulations or UMC policy;
- 2.5.10 Work cooperatively with Medical Staff members, nurses, UMC administrative staff, and others so as not to adversely affect patient care;
- 2.5.11 Make appropriate arrangements for patient coverage as determined by guidelines approved by the MEC;
- 2.5.12 Actively participate in and regularly cooperate with other members of the Medical Staff and practitioners in discussion and decision making related to patient care, including but not limited to, peer review, utilization management, budgetary priorities, quality assessment and improvement and related monitoring activities, and in discharging such other functions as may be required by the Medical Executive Committee from time to time;

- 2.5.13 Upon request, provide information from his or her office records or from outside sources as necessary to facilitate the care, or to review the care, of specific patients;
- 2.5.14 Accept responsibility for participating in Medical Staff precepting and proctoring;
- 2.5.15 Complete continuing education that meets all applicable licensing requirements and is appropriate to the practitioner's specialty;
- 2.5.16 Participate in emergency and call coverage as may be determined by the Medical Staff leadership;
- 2.5.17 Report final malpractice judgments and settlements to the Medical Staff Services Office promptly;
- 2.5.18 Report immediately to the Chief of Staff any revocation, suspension, surrender or restriction of licensure or other legal credential authorizing practice in any state; any stipulations or conditions of probation imposed by any state's licensing or certifying authority; any revocation, limitation, surrender or suspension of Drug Enforcement Administration Controlled Substance Registration Permit; and/or any exclusion or notice of intent to exclude the Member or practitioner issued by any state or federal healthcare program;
- 2.5.19 Declare any financial conflict of interest, should one exist, in accordance with procedures established by UMC, when making a recommendation regarding patient care or that UMC purchase a particular product, drug or equipment;
- 2.5.20 Report to the Chief of Staff any physician (including House Staff), other health care provider or UMC employee who has contact with UMC patients who is or may be mentally or physically unable to safely interact with patients due to substance abuse problems, conduct issues or practices which are or may be harmful or dangerous to the health of patients or in any way may impair safe and effective performance of clinical duties;
- 2.5.21 Be willing and qualified to participate in and support the teaching and research missions of UMC and the Arizona Health Sciences Center;
- 2.5.22 Discharge such other Medical Staff obligations as may be lawfully established from time to time by the Medical Staff or MEC; and
- 2.5.23 At all times behave in a professional and cooperative manner while at UMC, treating all individuals associated with UMC with courtesy, respect and dignity in accordance with the Medical Staff Code of Conduct.

ARTICLE III

CATEGORIES OF MEMBERSHIP

3.1 ACTIVE STAFF

3.1.1 QUALIFICATIONS

The Active Staff shall consist of members who:

- 3.1.1.1 Meet the general qualifications for membership set forth in Article II of these Bylaws; and
- 3.1.1.2 Participate in the care at UMC of a minimum of fifty patients annually, or are voting faculty of the clinical departments of the University of Arizona College of Medicine whose clinical activities are primarily at Arizona Health Sciences Center.

3.1.2 PREROGATIVES

Appointees to the Active Staff may:

- 3.1.2.1 Exercise all clinical privileges granted by the Board;
- 3.1.2.2 Attend and vote on matters presented at general and special meetings of the Medical Staff and of the service, section and committees to which they are duly appointed or elected by the Medical Staff or duly authorized representatives thereof; and
- 3.1.2.3 Hold Medical Staff service or section office.

3.1.3 RESPONSIBILITIES

Appointees to the Active Staff shall:

- 3.1.3.1 Contribute to the governance and functioning of the Medical Staff;
- 3.1.3.2 Participate in Focused Professional Practice Review (FPPE) in accordance with the requirements of the Joint Commission and UMC policy; and
- 3.1.3.3 Act consistently with the educational and research purposes and goals of the Arizona Health Science Center and UMC.

3.2 ASSOCIATE STAFF

3.2.1 QUALIFICATIONS

The Associate Staff shall consist of members who:

- 3.2.1.1 Meet the general qualifications for membership set forth in Article II of these Bylaws; and
- 3.2.1.2 Do not meet the qualifications for Active Staff membership as set forth in Section 3.1, but participate in patient care at UMC or anticipate such activity.

3.2.2 PREROGATIVES

Appointees to the Associate Staff may:

- 3.2.2.1 Exercise all clinical privileges granted by the Board; and
- 3.2.2.2 Attend general and special meetings of the Medical Staff and of the service section of which he or she is a Member, including open committee meetings and educational programs, but shall have no right to vote in such meetings.

3.2.3 RESPONSIBILITIES

Appointees to the Associate Staff shall:

- 3.2.3.1 Be required to discharge staff responsibilities as determined by the Medical Staff;
- 3.2.3.2 Participate in Focused Professional Practice Review (FPPE) in accordance with the requirements of the Joint Commission and UMC policy; and
- 3.2.3.3 Act consistently with the educational and research purposes and goals of the Arizona Health Sciences Center and UMC.

3.3 ADMINISTRATIVE MEDICAL STAFF

3.3.1 QUALIFICATIONS

The Administrative Medical Staff shall consist of members who:

The general qualifications for membership set forth in Article II of these Bylaws shall apply to those practitioners who apply for or hold Administrative Membership, except that the applicant or Member need not demonstrate qualifications for clinical privileges under Article VI of these Bylaws. The Administrative Medical Staff shall consist of members who:

- 3.3.1.1 Meet the general qualifications for membership set forth in Article II of these Bylaws;
- 3.3.1.2 Do not demonstrate qualifications for clinical privileges under Article V of these Bylaws; and
- 3.3.1.3 Qualify for Administrative Medical Staff membership in one of the following categories:

- a. The academic leadership of the University of Arizona (Deans, Assistant Deans and the Vice President of the Arizona Health Sciences Center);
- b. Physicians asked by UMC to serve in leadership positions requiring Medical Staff membership, such as Medical Director or Committee Chair;
- c. Mentors in the University of Arizona College of Medicine Societies Program;
- d. Physicians on staff at Rehabilitative Services who are required to maintain Medical Staff membership at UMC; and
- e. Directors of Residency Programs at the University of Arizona College of Medicine who are required to maintain Medical Staff membership at UMC.

3.3.2 PREROGATIVES

Appointees to the Administrative Medical Staff may:

- 3.3.2.1 Attend general and special meetings of the Medical Staff and of the service and section to which they belong, including open committee meetings and educational programs, but may not vote in such meetings, unless they are the chair; and
- 3.3.2.2 In the case of mentors with the Societies Program and Directors of Residency Programs, teach at the bedside after obtaining appropriate consent of patients for such teaching activities, but may not exercise any clinical privileges while doing so.

3.3.3 RESPONSIBILITIES

Appointees to the Administrative Medical Staff shall:

- 3.3.3.1 Act consistently with the educational and research purposes and goals of the Arizona Health Sciences Center and UMC.

3.4 REFERRING STAFF

3.4.1 QUALIFICATIONS

The Referring Staff shall consist of members who:

- 3.4.1.1 Meet the general qualifications for medical staff membership as set forth in Article II of these Bylaws;
- 3.4.1.2 Do not hold clinical privileges at UMC;

3.4.1.3 Meet the qualifications for clinical privileges in their service area, except that they need not demonstrate current competence to exercise clinical privileges; and

3.4.1.4 Do not demonstrate the qualifications for Active, Associate or Administrative membership.

3.4.2 PREROGATIVES

Appointees to the Referring Staff may:

3.4.2.1 Review their patients' medical records and have access to results of tests and procedures performed at UMC;

3.4.2.2 Visit their patients at UMC, but may not document in the medical record or write orders; and

3.4.2.3 Attend general meetings of the Medical Staff, and of the Service and Section to which they belong, including non-confidential committee proceedings and educational programs.

3.4.3 RESPONSIBILITIES

Appointees to the Referring Staff shall:

3.4.3.1 Act consistently with the educational and research purposes and goals of the Arizona Health Sciences Center and UMC; and

3.4.3.2 Not be required to plan coverage for their patients.

3.5 TELEMEDICINE STAFF

Practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes at UMC. The Medical Staff recommends the clinical services to be provided by practitioners through a telemedical link at their respective sites.

3.6 MODIFICATION OF MEMBERSHIP CATEGORY

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a Staff Member, the MEC may recommend a change in the Medical Staff category of a Medical or Allied Health Staff Member consistent with the requirements of these Bylaws.

ARTICLE IV
INITIAL APPOINTMENT

4.1 APPLICATION FOR INITIAL APPOINTMENT

Each application for initial appointment to the Medical Staff shall be submitted on a form approved by the Credentials Committee and the MEC.

4.2 CONTENT OF APPLICATION

A separate credentials file shall be maintained for each applicant for Medical Staff membership and/or clinical privileges. Each applicant must furnish such information as required by the application form, including but not limited to complete information concerning the following:

- 4.2.1 Personal information, including social security number, national practitioner identification number, date of birth, home and office addresses and telephone numbers, and a photograph;
- 4.2.2 Educational background, internship, residency, and/or fellowship training, including degrees granted, programs attended, and names of individuals able to verify and comment on the applicant's performance during professional education and training;
- 4.2.3 Activities, including time frames, from date of medical school graduation to the present;
- 4.2.4 Employed faculty positions and academic affiliations;
- 4.2.5 Current Medical Staff memberships;
- 4.2.6 Peer references familiar with the applicant's professional competence;
- 4.2.7 Professional licensure and certifications, and Drug Enforcement Administration Controlled Substance Registration Permits as applicable, with the issuance date and number of each;
- 4.2.8 Publications and professional activities;
- 4.2.9 Military service;
- 4.2.10 Any physical or mental health conditions that affect or are likely to affect the applicant's ability to perform professional or Medical Staff duties;
- 4.2.11 Any history of alcohol or drug dependency;
- 4.2.12 Conviction of a crime (other than minor traffic violations);
- 4.2.13 Any challenges to licensure or registration, or voluntary or involuntary surrender of such license or registration;

- 4.2.14 Any voluntary or involuntary limitation, reduction or revocation of clinical privileges, prerogatives or contractual ability to care for patients at another hospital, health care facility or health plan;
- 4.2.15 Any denial of membership by any medical staff, medical society or professional society;
- 4.2.16 Any voluntary or involuntary termination of any medical staff membership;
- 4.2.17 Any suspension, sanction or other restriction from participation in private, federal or state health insurance programs, or any investigation concerning participation; and
- 4.2.18 Any claims, suits, settlements, or arbitration proceedings (past or pending) involving the applicant's professional practice.

4.3 EFFECT OF APPLICATION

By completing and signing an application form for membership on the UMC Medical Staff or Allied Health Staff, the applicant:

- 4.3.1 Attests to the correctness and completeness of all information;
- 4.3.2 Signifies his or her willingness to appear for interviews in regard to the application;
- 4.3.3 Agrees to comply with Medical Staff and UMC health screening requirements;
- 4.3.4 Authorizes consultation with others who have been associated with him or her who may have information bearing on his or her competence, qualifications and performance, and authorizes such individuals and organizations to release such information;
- 4.3.5 Authorizes a criminal background check;
- 4.3.6 Consents to inspection of records and documents that may be material to an evaluation of his or her qualifications and ability to perform the clinical privileges, if any, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- 4.3.7 Releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;
- 4.3.8 Releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
- 4.3.9 Acknowledges responsibility for timely payment of Medical Staff dues, as applicable;
- 4.3.10 Pledges to provide for continuous quality care for his or her patients;
- 4.3.11 Pledges to maintain an ethical practice;

4.3.12 Consents to the provisions set forth in Article XV of the Bylaws, including but not limited to those permitting third party disclosures, and releases the Medical Staff and UMC from liability for so doing to the fullest extent permitted by the law; and

4.3.13 Agrees to be bound by the Medical Staff Bylaws, and Rules and Regulations, the Medical Staff Code of Conduct and applicable UMC policies and procedures.

4.4 APPLICANT'S BURDEN

The applicant has the burden of producing adequate information for a proper evaluation of his or her character, judgment, experience, training, current clinical competence, and health status, and resolving any doubts about these or any of the qualifications required for Medical Staff membership, or clinical privileges, of satisfying any reasonable requests for information, clarification or physical or behavioral health examinations made by the Medical Staff and of assuring that his or her application is complete. Neither the Medical Staff nor the Board shall have any obligation to review or consider any application until it is complete, as defined in these Bylaws. The applicant shall be responsible for resolving any doubts regarding the application. The Credentials Committee, Chief of Staff and/or the Board may request that an applicant appear for an interview with regard to his or her application.

4.5 VERIFICATION OF APPLICATION

4.5.1 Upon receipt of an application form containing responses to all questions on the form, the data provided will be verified, the National Practitioner Data Bank and the federal programs sanctions websites will be queried, and a criminal background check will be ordered.

4.5.2 Personnel in the Medical Staff Services Office shall review the verified data and documentation for completeness. Information provided will be compared with the standards for clinical privileges of the applicant's clinical service and clinical competence will be verified with appropriate institutions and individuals.

4.5.3 Upon securing verification of clinical competence, the Medical Staff Services Office shall deliver the application and documentation, together with all supporting documentation and completed delineation of clinical privileges form, to the appropriate clinical section and/or service chief for review and recommendation.

4.5.4 The Medical Staff Services Office will take reasonable steps to ensure that the individual requesting Medical Staff membership and/or clinical privileges is the same individual identified in the credentialing documents.

4.6 SECTION AND SERVICE ACTION

When evaluating an applicant for Medical Staff membership, the clinical section chief and/or clinical service chief may seek supplementary information, if necessary, in order to make a recommendation regarding appointment to the Medical Staff and/or approval of requested clinical privileges.

4.6.1 The clinical section chief and/or a service chief, or his or her designee, may request additional information from the applicant. Such information may include,

but is not limited to, additional documentation of training and experience, and documentation of clinical competence. The burden of producing such information shall be upon the applicant.

- 4.6.2 The clinical section chief and/or clinical service chief, or his or her designee, may require the applicant to participate in a personal interview.
- 4.6.3 When necessary, the clinical service chief shall attempt to resolve any disagreements that may arise with the applicant regarding requested clinical privileges.
- 4.6.4 The clinical service chief shall provide a recommendation to the Medical Staff whether to grant appointment and approve the requested clinical privileges. When making a recommendation to deny appointment or requested clinical privileges, the clinical service chief shall state in writing the specific reason(s) for the adverse recommendation. The clinical service chief's recommendation and written reasons for such an adverse recommendation shall be transmitted to the Credential Committee.

4.7 CREDENTIALS COMMITTEE REVIEW

Following the opportunity for review by the clinical section chief and/or clinical service chief, or his or her designee, the Credentials Committee shall consider the application and privileges requested. In cases in which the clinical section chief or service chief fails to act on an application within a reasonable time, the Credentials Committee may act on the application without such recommendation. The Credentials Committee may request supplementary information, if necessary, on which to base a recommendation. If no supplementary information is needed, the Credentials Committee shall prepare a recommendation to the MEC regarding appointment and requested clinical privileges.

4.8 ACTION OF THE MEDICAL EXECUTIVE COMMITTEE

The MEC shall consider the recommendation of the Credentials Committee regarding appointment and requested clinical privileges. The MEC may accept the recommendation of the Credentials Committee, refer the matter back to the Credentials Committee for further consideration or make its own recommendation to the Board.

- 4.8.1 When the recommendation of the MEC is to grant the application and requested clinical privileges, it shall be promptly forwarded, together with supporting documents, to the Board.
- 4.8.2 When the recommendation of the MEC is adverse to the applicant, either in whole or in any significant part, the applicant shall then be entitled to the procedural rights set forth in Article VIII of these Bylaws. The applicant shall be promptly informed by Special Notice, which shall comply with Section 8.1.7 of these Bylaws.

4.9 FINAL ACTION

The Board takes final action on each application for membership and requested clinical privileges either at its next regularly scheduled meeting or via a sub-group of the Board, which shall consist of at least two Board members. The Board may accept, reject or modify the MEC's recommendation or may refer the matter back to the MEC for further

consideration, stating in writing the reasons for such referral. The following procedures shall apply with respect to Board action on an application.

4.9.1 If the MEC issues a favorable recommendation and

4.9.1.1 the Board concurs in that recommendation, the decision of the Board shall be deemed final action.

4.9.1.2 the Board's tentative recommendation is unfavorable:

- a. A hearing shall be held before the Board, or a duly authorized committee or other designee the Board may appoint, unless the applicant has already received a hearing before the Hearing Committee of the Medical Staff pursuant to Article VIII of these Bylaws. When a hearing before the Board is held, insofar as practicable the procedures described in Article VIII shall apply, except as they may be expressly modified by rules, policies or procedures established by the Board.
- b. Following a Board hearing, if the proposed or tentative recommendation of the Board is still unfavorable to the applicant, the matter shall be referred to the Joint Conference Committee for consideration. The Joint Conference Committee shall have access to all records from the Board hearing. The Joint Conference Committee shall submit its written recommendation and all materials it considered to the Board within thirty days of receipt of the matter unless the Joint Conference Committee extends the date in its discretion.
- c. After reviewing the Joint Conference Committee's recommendation, the Board shall issue its decision, which shall constitute final action on the matter when the Board's decision is adverse to the applicant. The applicant shall be notified by Special Notice.

4.9.2 If the recommendation of the MEC, or any significant part of it, is unfavorable to the applicant, the procedural rights set forth in Article VIII of these Bylaws shall apply, and the applicant shall be informed of his or her right to a hearing under Article VII. If the applicant does not request a hearing, the recommendation of the MEC shall be transmitted to the Board for final decision.

4.9.2.1 if the recommendation of a hearing committee is unfavorable to the applicant, and the Board concurs in the unfavorable recommendation following an appeal (if one is requested pursuant to Article VIII), the decision of the Board shall be deemed the final action.

4.9.2.2 if the recommendation of a hearing committee is unfavorable to the applicant, and the tentative action of the Board following appeal is favorable to the applicant:

- a. Within fifteen days after the Board's tentative action, the matter shall be referred to the Joint Conference Committee for consideration. The Joint Conference Committee shall have access to all records from the hearing and appeal.

- b. The Joint Conference Committee shall submit its written recommendation and all materials it considered to the Board within thirty days of receipt of the matter, unless the Joint Conference Committee extends the date in its discretion.
- c. After reviewing the Joint Conference Committee's recommendation, the Board shall issue its decision, which shall constitute final action on the matter.

4.9.2.3 if a hearing is requested and the recommendation of a hearing committee is favorable to the applicant and if the Board concurs in the MEC's unfavorable recommendation following an appeal, if requested, the decision of the Board shall be deemed the final action. However, if the tentative action of the Board is favorable to the applicant, the matter shall be referred to the Joint Conference Committee for consideration and resolution as described in subsection 4.9.2.2 above.

4.10 NOTIFICATION OF FINAL ACTION

4.10.1 The applicant shall be informed promptly by Special Notice of the final action regarding his or her application and requested clinical privileges. A copy of the letter shall be placed in the applicant's Credentials file.

4.10.2 In cases where the final action is adverse to the applicant, either in whole or in part, the Medical Staff Services Office shall report the final action to the appropriate licensing board, the National Practitioner Data Bank, and/or to other government agencies as required by law.

4.11 REAPPLICATION AFTER ADVERSE ACTION

An applicant who has received a final action on appointment that is adverse shall not be eligible to reapply to the Medical Staff for a period of two years following the date upon which the prior adverse action. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

4.12 TIME PERIODS FOR PROCESSING

Applications for Medical Staff appointment and requests for clinical privileges shall be considered in a timely manner by all persons and committees required by these Bylaws to act. To warrant exceptions, the following time periods provide a guideline for routine processing of applications:

4.12.1 Review and recommendation by Credentials Committee: Next regular meeting after the applicant's credentials file is deemed complete, usually no more than sixty days after receipt of all necessary documentation;

4.12.2 Review and recommendation by MEC: Next regular meeting after action by the Credentials Committee, usually no more than sixty days after review and recommendation by Credentials Committee; and

4.12.3 Review by Board: Next regular meeting after the MEC acts, or via Board sub-group review, usually no more than sixty days after review and recommendation by MEC.

4.13 TERM OF INITIAL APPOINTMENT

Appointment to the Medical Staff is usually granted for a period of not more than two years. In the first year of an initial appointment, the appointment shall be deemed provisional. During the provisional period, the Medical Staff shall evaluate the competence of the new appointee. By accepting an initial appointment to the Medical Staff, the new appointee agrees to the following requirements, which, in addition to any other requirements that shall apply, are:

4.13.1 To consult with the Physician Well Being Committee at specified intervals if required by the MEC;

4.13.2 To comply with requirements for ongoing and focused professional practice evaluations (OPPE and FPPE), proctoring and/or consultation imposed by the MEC and/or the Board; and

4.13.3 To comply with such other conditions that the MEC and/or Board may deem appropriate under the circumstances.

If a new appointee resigns from the Medical Staff during the provisional term of his or her appointment, or otherwise opts to decline to meet requirements as set forth above, such action shall be deemed a voluntary resignation and shall not trigger the procedural rights under Article VIII.

ARTICLE V

CLINICAL PRIVILEGES

5.1 STANDARDS FOR CLINICAL PRIVILEGES

Each clinical service, and section within a clinical service, shall develop standards for clinical privileges which outline eligibility, training, experience, proctoring, and reappointment requirements, and shall prepare a delineation of clinical privileges form based upon those standards, and consistent with these Bylaws, and Rules and Regulations. Proposed standards and revisions to existing standards shall be reviewed by the Credentials Committee to ensure compliance with regulatory requirements and provision of one level of care throughout UMC, and thereafter must be approved by the MEC and the Board before they may be applied.

5.2 EXERCISE OF CLINICAL PRIVILEGES

Except as otherwise provided in these Bylaws, a practitioner providing clinical services at UMC shall be entitled to exercise only those clinical privileges specifically granted, including the privilege to serve as the attending practitioner for inpatients. Medical Staff membership does not confer any clinical privileges. Clinical privileges must be applied for and granted, must be setting specific, within the scope of the practitioner's license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the standards for clinical privileges of the clinical service and the authority of the applicable clinical service chief and the Board. The care of newborns, infants and children admitted to intensive care units must be managed by a neonatologist or pediatric intensivist. Other practitioners may manage the care of adult patients in an intensive care setting within the scope of clinical privileges granted. In cases where a practitioner exercises clinical privileges in two or more service areas, the practitioner's core clinical privileges in one service area will supersede the requirements for obtaining similar special clinical privileges in another service area.

5.3 DELINEATION OF CLINICAL PRIVILEGES DETERMINATION

5.3.1 REQUESTS FOR CLINICAL PRIVILEGES

Each application for clinical privileges must contain a request for the specific clinical privileges desired by the applicant. A request for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. If a practitioner requesting a modification of clinical privileges fails to timely furnish the information necessary to evaluate the request, the request shall be considered incomplete and automatically lapse, resulting in denial of the request without right to hearing to contest the denial.

5.3.2 BASIS FOR CLINICAL PRIVILEGES DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of education, training, experience, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care assessment and other quality review monitoring which the Medical Staff deems appropriate. Privilege

determinations may also be based on pertinent information concerning clinical performance obtained from other sources; especially other institutions and health care settings where a Member exercises or has recently exercised clinical privileges.

5.4 TEMPORARY PRACTICE PRIVILEGES

5.4.1 CATEGORIES OF TEMPORARY PRACTICE PRIVILEGES

The CEO or his or her designee may grant temporary practice privileges in exceptional circumstances and upon recommendation of the appropriate clinical service chief or the Chief of Staff:

- 5.4.1.1 In cases in which an applicant has a complete, clean application, before MEC and/or Board review and approval, when it is deemed necessary to expedite the granting of privileges (“expedited” temporary privileges); and
- 5.4.1.2 In cases in which the applicant does not have a complete, clean application, but can demonstrate to the satisfaction of the CEO or designee that privileges should be granted to fulfill an urgent patient care need, usually for a one-time incident (i.e. to perform a single procedure or follow a single patient) and/or for a limited duration (“urgent” temporary privileges).

5.4.2 APPLICATION REQUIREMENTS

Applicants for temporary practice privileges must satisfy the following requirements before the temporary practice privileges request may be granted:

- 5.4.2.1 Documentation of a full, active and unrestricted Arizona license to practice medicine, dentistry, podiatry, clinical psychology, nurse midwifery, or one of the allied health professions approved by the Board as set forth in Article II, XIII or XIV of these Bylaws;
- 5.4.2.2 Affirmation that the applicant is immune to measles, varicella and rubella, is negative for tuberculosis, has received infection control education and is otherwise in compliance with UMC policies regarding health screening;
- 5.4.2.3 Evidence of professional liability insurance in the amount deemed by the Board to be sufficient to cover the applicant’s activities at UMC; and
- 5.4.2.4 Verification of current clinical competence to exercise the privileges requested.

5.4.3 APPROVED TEMPORARY PRACTICE PRIVILEGES

- 5.4.3.1 An applicant granted temporary practice privileges shall be assigned to a service and shall act under the supervision of the clinical service chief of the service to which he or she has been assigned.
- 5.4.3.2 An applicant granted temporary practice privileges may be subject to proctoring requirements imposed at the discretion of the clinical service

chief and/or the Chief of Staff as may be deemed appropriate under the circumstances.

5.4.4 LIMITED DURATION OF TEMPORARY PRACTICE PRIVILEGES

- 5.4.4.1 Temporary practice privileges will be granted for a period not to exceed 120 days.
- 5.4.4.2 Temporary practice privileges may be summarily terminated or suspended by the Chief of Staff with the concurrence of the clinical service chief, or his or her designee, and subject to prompt review by the MEC. In such cases, the clinical service chief, or in the clinical service chief's absence, the Chief of Staff, shall assign an individual to assume responsibility for the care of the affected practitioner's patient(s). The wishes of the patient shall be considered in the choice of a replacement.
- 5.4.4.3 A person shall not be entitled to the procedural rights afforded by Article VIII when a request for temporary practice privileges is refused or because all or any portion of temporary practice privileges are terminated or suspended.
- 5.4.4.4 All persons requesting or receiving temporary practice privileges shall be bound by the Medical Staff Bylaws, Rules and Regulations and Code of Conduct, and UMC policies and procedures.

5.5 LOCUM TENENS PRIVILEGES

The Chief of Staff, with concurrence of the applicable clinical service chief, may grant locum tenens privileges upon the written request of a Medical Staff or Allied Health Staff member after certain requirements are met.

5.5.1 APPLICATION REQUIREMENTS

- 5.5.1.1 The applicant for locum tenens privileges shall submit:
 - a. a completed application;
 - b. a personal photograph;
 - c. proof of malpractice insurance as required by the Board for Medical or Allied Health Staff members, as applicable;
 - d. the consent and releases required by these Bylaws; and
 - e. copies of the practitioner's Arizona professional license and DEA certificate.
- 5.5.1.2 The Medical Staff Office shall query the National Practitioner Data Bank, review available online information from the applicant's licensing board and confirm the applicant's status and privileges in his or her primary hospital, when applicable.

- 5.5.1.3 When the application is complete, the Clinical service chief and Chief of Staff shall review the application and decide whether to grant the request. The decision whether to grant or deny locum tenens privileges shall be provided to the requesting Member and locum tenens applicant by Special Notice.
- 5.5.1.4 Practitioners exercising locum tenens privileges at UMC must agree to comply with all applicable legal requirements, including billing and reimbursement requirements, and must abide by these Bylaws, Medical Staff Rules and Regulations, the Medical Staff Code of Conduct and UMC policies and procedures.

5.5.2 EXTENT, DURATION AND LIMITATIONS

- 5.5.2.1 Members seeking to provide coverage through locum tenens practitioners shall, where possible, advise the UMC Medical Staff Services Office at least thirty (30) days in advance, of the identity of the locum tenens and the dates during which the locum tenens services will be utilized. Failure to do so may delay a decision as to the locum tenens application.
- 5.5.2.2 Upon approving an application for locum tenens privileges, the Medical Staff Services Office shall send a letter to the Member and/or the locum tenens practitioner identifying the time frame and specific privileges granted.
- 5.5.2.3 An initial grant of locum tenens privileges shall not exceed thirty days. Such privileges may be renewed for successive consecutive periods not to exceed thirty (30) days, but in no event shall a practitioner be granted locum tenens privileges for more than one hundred and twenty (120) days within a calendar year.
- 5.5.2.4 The procedural rights afforded by Articles VIII and XIII of these Bylaws shall not be available to any applicant for or holder of locum tenens privileges either because a request for locum tenens privileges is refused or because all or any portion of locum tenens privileges are terminated or suspended.

5.6 EMERGENCY PRIVILEGES AND DISASTER PRIVILEGES

In an emergency, any Member of the Medical Staff who has clinical privileges, to the degree permitted by his or her license and regardless of clinical service, Medical Staff status or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. A Medical Staff member exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up care.

Practitioners who do not possess clinical privileges at UMC may be granted temporary disaster privileges by the Chief of Staff or his or her designee, on a case-by-case basis, at his or her discretion, when the emergency management plan has been activated and UMC is unable to handle immediate patient needs. Privileges may be granted upon presentation of a valid government-issued photo identification issued by a state or federal agency and at least one of the following:

- 5.6.1 A current picture hospital ID card that clearly identifies professional designation;
- 5.6.2 Evidence of a current unrestricted license to practice in the specified designation;
- 5.6.3 Identification indicating that the individual is a member of a disaster medical assistance team (DMAT), or MCR, ESAR-VHP, or other recognized state or federal organizations;
- 5.6.4 Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances, such authority having been granted by a federal, state, or municipal entity; or
- 5.6.5 Identification by a current UMC Staff Member or Medical Staff Member with personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.

Primary source verification of licensure begins as soon as the immediate disaster or emergency situation is under control, and in any event should be completed within 72 hours from the time the volunteer practitioner offers services.

The practitioner will be issued an ID badge, paired with a Medical Staff Member and should act only under his or her supervision, as feasible depending on the disaster or emergency. A practitioner's disaster or emergency privileges will automatically be cancelled at the end of needed services.

5.7 TEACHING PRIVILEGES

In accordance with Arizona law, UMC may grant teaching privileges to two categories of physicians who do not hold active licenses to practice medicine in Arizona: those holding teaching licenses and those holding education teaching permits.

5.7.1 TEACHING LICENSEE PRIVILEGES

- 5.7.1.1 Teaching licensee privileges may be granted under this section to a physician who does not hold an Arizona license to practice medicine and, through the Arizona Health Sciences Center, seeks to provide and promote professional education through lectures, clinics or demonstrations at UMC.
- 5.7.1.2 Upon recommendation of the appropriate clinical service chief, the Chief of Staff may grant teaching licensee privileges to a physician whose professional board has granted him or her a teaching license under Arizona law. To qualify for teaching licensee privileges, applicants must meet the following requirements:
 - a. Documentation of a valid license to practice medicine in any state of the United States or another country;
 - b. Evidence of a current teaching license granted by the applicable Arizona professional board;

- c. Submission of all documents offered by the University of Arizona College of Medicine or anyone else to the applicable Arizona professional board supporting the granting of the teaching license;
- d. Documentation of the request by the Dean of the University of Arizona College of Medicine or his or her designee for issuance of the applicant's teaching license, including the description of the nature and purpose of the teaching program in which the teaching licensee will participate and the name of the Member who has agreed to serve as the licensee's attending physician and to provide for the licensee's appropriate supervision;
- e. A statement signed by the applicant that he or she accepts all responsibility and liability for the patient care activities he or she performs and that he or she will abide by the limitations placed on those activities, whether by the MEC, the applicable Arizona professional board and/or the University of Arizona College of Medicine;
- f. Evidence of professional liability insurance in the amount required by the UMC Board or these Bylaws that covers all of his or her activities at UMC; and
- g. Documentation of compliance with UMC's health screening requirements.

5.7.1.3 EXTENT, DURATION AND LIMITATIONS FOR TEACHING LICENSEES

- a. Teaching licensee privileges may be granted for no longer than the duration of the applicant's teaching license;
- b. Privileges shall be limited to the procedures necessary for the program in which the teaching licensee intends to participate;
- c. The Chief of Staff may terminate or suspend teaching licensee privileges in whole or in part at any time;
- d. The procedural rights afforded by Article VIII of these Bylaws shall not be available to any applicant or holder of teaching licensee privileges either because a request for teaching licensee privileges is refused or because all or any portion of teaching licensee privileges are terminated or suspended; and
- e. All persons requesting or receiving teaching licensee privileges shall be bound by the Medical Staff Bylaws, Rules and Regulations and Code of Conduct and UMC policies and procedures.

5.7.2 TEACHING PERMITTEE PRIVILEGES

- 5.7.2.1 Teaching permittee privileges may be granted under this section to a physician who does not hold an Arizona license and, on a short-term basis, seeks to demonstrate and perform medical procedures and

surgical techniques at UMC for the sole purpose of promoting professional education for students, interns, residents, fellows or physicians.

- 5.7.2.2 The Chief of Staff or his or her designee may grant teaching permittee privileges to a physician who has been granted an education teaching permit under Arizona law. Applicants for teaching permittee privileges must meet the following requirements:
- a. Documentation of a valid license to practice medicine in any state of the United States or another country;
 - b. Evidence of a current education teaching permit issued by the applicable Arizona professional board;
 - c. Submission of a letter from the Dean of the University of Arizona College of Medicine or his or her designee attesting to the clinics, procedures, techniques and/or demonstrations that the physician will perform and the dates this activity will occur;
 - d. Documentation that the applicant understands he or she may serve as a member of an organized medical team but shall not practice medicine independently;
 - e. Evidence of professional liability insurance in the amount required by the Board and these Bylaws, that covers his or her activities at UMC; and
 - f. Documentation of compliance with UMC's health screening requirements.

5.7.2.3 EXTENT, DURATION AND LIMITATIONS FOR TEACHING PERMITTEES

- a. Teaching permittee privileges may be granted for no more than five days for each approved activity.
- b. The Chief of Staff may deny or terminate teaching permittee privileges in whole or in part at any time.
- c. The procedural rights afforded by Article VIII shall not be available to any applicant or holder of teaching permittee privileges either because a request for teaching permittee privileges is refused or because all or any portion of the privileges are terminated or suspended, in whole or in part.
- d. All persons requesting or receiving teaching permittee privileges shall be bound by the Medical Staff Bylaws, Rules and Regulations and Code of Conduct, and UMC policies and procedures.

5.8 PRIVILEGES FOR TRAINING PERMITTEES

- 5.8.1 The Chief of Staff may grant training permittee privileges to a physician who does not hold an Arizona medical license and who seeks to participate in a short-term training program of four months or less for the purpose of continuing medical education at UMC through the Arizona Health Sciences Center.
- 5.8.2 Upon the recommendation of the appropriate clinical service chief, the Chief of Staff may grant training permittee privileges to a physician who has been granted a training permit under Arizona law. Applicants for training permittee privileges must meet the following requirements:
 - 5.8.2.1 Documentation of an active valid license to practice medicine in any state of the United States or another country;
 - 5.8.2.2 Evidence of a current physician training permit issued under Arizona law; and
 - 5.8.2.3 Documentation of the request by the Dean of the University of Arizona College of Medicine or his or her designee for issuance of the applicant's training permit, including the description of the nature and purpose of the training program in which the trainee will participate, and the name of the Member who has agreed to serve as the trainee's attending physician and to provide for the trainee's appropriate supervision while at UMC.
- 5.8.3 Evidence of professional liability insurance, in the amount required by the Board and these Bylaws that covers his or her activities at UMC;
- 5.8.4 Documentation that the applicant understands he or she may serve as a member of an organized medical team but shall not practice medicine independently; and
- 5.8.5 Documentation of compliance with UMC's health screening requirements.
- 5.8.6 EXTENT, DURATION AND LIMITATIONS FOR TRAINING PERMITTEES
 - 5.8.6.1 Training permittee privileges may be granted for no longer than the duration of the applicant's training permit.
 - 5.8.6.2 Privileges shall be limited to the procedures necessary for the training program in which the applicant intends to participate.
 - 5.8.6.3 The Chief of Staff may deny or terminate training permittee privileges in whole or in part at any time.
 - 5.8.6.4 The procedural rights afforded by Article VIII of these Bylaws shall not be available to any applicant or holder of training permittee privileges either because a request for training permittee privileges is denied or because all or any portion of training permittee privileges are terminated or suspended.

- 5.8.6.5 All persons requesting or receiving training permittee privileges shall be bound by the Medical Staff Bylaws, Rules and Regulations and Code of Conduct and UMC policies and procedures.

5.9 PRECEPTORSHIP PROGRAMS

Clinical services may develop preceptorship programs to train Medical Staff or Allied Health Staff members, individuals with clinical privileges, or Administrative Staff members, so that they may then qualify for certain privileges. In order for such a program to qualify for approval as a preceptorship program, the program must fulfill the education and training requirements for that privilege as stated in the Medical Staff's approved standards and criteria for privilege review. Only individuals who have been granted the requested privilege and completed any required proctoring period shall be eligible to serve as preceptors. Preceptorship programs must be approved by the MEC prior to initiation. A practitioner who completes an approved preceptorship program may not begin to exercise the additional privilege independently until the privilege is formally granted by the Board.

5.9.1 STRUCTURE AND APPROVAL OF PROGRAM

Before instituting a preceptorship program, the MEC shall review and approve a proposed outline of the preceptorship program, including content and number of cases which must be observed and performed under supervision.

5.9.2 DOCUMENTATION

A preceptor shall provide a written, signed evaluation of each procedure he or she supervises as part of a preceptorship program. Upon satisfactory completion of the program, the preceptor shall provide a letter to the practitioner confirming that he or she has satisfied the supervision criteria for the privilege or procedure.

5.9.3 FORMAL PRIVILEGE REQUEST

When a practitioner has met the requirements of a preceptorship program, he or she may complete and submit a request for additional clinical privileges form, with the preceptor's letter, to the clinical service chief, and thereafter forwarded to the Medical Staff Services Office for review by the Credentials Committee. The Credentials Committee's recommendation will be forwarded to the MEC for its consideration. The MEC's recommendation will be forwarded to the Board, which considers the request and preceptor's letter and all other materials and may grant, deny or modify the request. No procedural rights in accordance with Article VIII of these Bylaws arise from the Board's denial or modification of a request for clinical privileges based on a preceptor program.

5.10 ADDITION OR MODIFICATION OF CLINICAL PRIVILEGES

The Board has final authority, upon recommendation of the Credentials Committee and the MEC, to grant or deny a request for additional privileges, or to modify clinical privileges, of a member of the Medical Staff or Allied Health Staff. The MEC may recommend that granting of additional or modified privileges be conditioned on successful completion of a preceptorship program, or otherwise subject to additional monitoring or proctoring.

5.11 LEAVE OF ABSENCE

A Member may request a leave of absence for any leave that the Member anticipates will exceed six (6) months. To request a leave of absence, a Member must make a written request to his or her service chief. The request for a leave of absence must state the reason and specific period of time for the leave, which may not exceed two (2) years. The service chief makes a recommendation and forwards it to the MEC for approval or denial.

5.11.1 During the period of leave, the Member shall not exercise privileges at UMC, and membership rights and responsibilities shall be deemed to be in an inactive status. The time period for consideration of reappointment shall be stayed during the leave of absence.

5.11.2 At least 30 days prior to termination of an approved leave of absence, or at any earlier time, the Member may request reinstatement of his or her Medical Staff clinical privileges by submitting a written request to the service chief, who shall promptly forward the request to the Credentials Committee via the Medical Staff Services Department for consideration. With the request for reinstatement, the Member shall submit a written summary of his or her activities during the leave. The Credentials Committee shall make a recommendation to the MEC whether to approve the request for reinstatement. The MEC shall consider the Credentials Committee's recommendation and recommend to the Board whether to approve the request for reinstatement. The Board will have final decision-making authority as to the request for reinstatement.

5.11.3 If the Board denies reinstatement after a leave of absence, the fair hearing provisions in Article VIII shall apply.

5.12 MEDICAL HISTORIES AND PHYSICAL EXAMINATIONS

All Medical Staff members and Allied Health staff with privileges to perform medical histories and physical examinations shall document evidence that a physical examination, including a health history, has been performed no more than seven days prior to admission or within 24 hours after admission and prior to surgery. This includes admission to observation status, ambulatory surgery status and invasive outpatient procedures where moderate sedation is used. In emergency situations, a brief note, including the preoperative diagnosis, shall be recorded before surgery. The Medical Staff Rules and Regulations contain additional detail regarding these requirements.

ARTICLE VI

PROCEDURES FOR REAPPOINTMENT AND RENEWAL OF CLINICAL PRIVILEGES

6.1 TIME PERIOD FOR APPLICATION FOR REAPPOINTMENT

Reappointment is performed based on the Member's birth month. Each application for reappointment shall be submitted on an approved form.

6.2 CONTENT OF APPLICATION

Each Member applying for reappointment shall furnish such information as required by the application form, including but not limited to, the following:

6.2.1 Employment history;

6.2.2 Staff memberships;

6.2.3 Peer references familiar with the Member's current professional competence, *i.e.*, within the previous two years;

6.2.4 Professional licensure and certifications;

6.2.5 Military service, if any;

6.2.6 Any physical or mental health conditions that affect or are likely to affect the Member's ability to perform professional or Medical Staff duties;

6.2.7 Any history of alcohol and/or drug dependency;

6.2.8 Any conviction of a crime, other than minor traffic violations;

6.2.9 Any challenges to licensure or registration, or voluntary or involuntary surrender of such license or registration;

6.2.10 Any voluntary or involuntary limitation, reduction, or revocation of clinical privileges, prerogatives or contractual ability to care for patients at another hospital, health care facility or health plan;

6.2.11 Any claims, suits, settlements or proceedings, past or pending, involving applicant's professional practice;

6.2.12 Other hospital or health care entity affiliations and any change in such affiliations;

6.2.13 Information required to update the Member's file as to the items listed in Article IV of these Bylaws;

6.2.14 Evidence of current competence to perform the clinical privileges requested;

6.2.15 Continuing training and education during the preceding period;

6.2.16 Specific request for clinical privileges with any basis for change; and

6.2.17 Any suspension, sanctions or other restrictions from participation in private, federal or state health insurance programs, or any including investigation concerning participation.

Failure to provide this information in sufficient time to process the reappointment application may be deemed a voluntary resignation by the Member from the Medical Staff and/or surrender of clinical privileges. The provisions set forth in Article VIII of these Bylaws shall not apply.

6.3 EFFECT OF APPLICATION

By completing and signing an application for reappointment to the UMC Medical Staff or Allied Health Staff, the Member agrees to the provisions specified in Articles IV and XV of these Bylaws.

6.4 VERIFICATION OF INFORMATION

The Medical Staff Services Office requests information on the Member's current status from the appropriate licensing authority and queries the National Practitioner Data Bank. Upon receipt of each application and supporting documentation, the information and peer evaluation and affiliation verification letters are sent. If an application for reappointment and renewal of clinical privileges is not received by the date set by the Medical Staff Services Office, written notice shall be promptly sent to the Member advising that the application has not been received.

6.5 INTERNAL REVIEW

Relevant information is collected regarding the Member's professional activities, performance, judgment, clinical and technical skills and conduct during his or her tenure at UMC. Such information includes, without limitation: patterns of care as demonstrated in UMC and Medical Staff quality assessment activities, and record of compliance with Medical Staff Bylaws, Rules and Regulations and Code of Conduct.

6.6 ACTION ON APPLICATION

Action on an application for reappointment and/or renewal of clinical privileges shall be the same as set forth in Article IV of these Bylaws.

6.7 FAILURE TO FILE COMPLETE APPLICATION

Failure to timely file a completed application for reappointment and/or renewal of clinical privileges shall result in the expiration of the individual's Medical Staff membership and clinical privileges at the end of his or her current Staff appointment or renewal period. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VIII of these Bylaws shall not apply.

ARTICLE VII

PEER REVIEW, PROFESSIONAL PRACTICE EVALUATION AND CORRECTIVE ACTION

7.1 FOCUSED PROFESSIONAL PRACTICE EVALUATION

Focused Professional Practice Evaluation (FPPE) shall be conducted in accordance with Joint Commission requirements and MEC and Board approved policy.

7.2 ONGOING PROFESSIONAL PRACTICE EVALUATION

7.2.1 UMC conducts ongoing evaluation of each practitioner's professional performance (OPPE) through Quality Review and other methods. Individual departments will monitor and review trends and outliers through the Quality Review process and through information provided through the Patient Safety Network. The OPPE allows UMC to identify professional practice trends that impact on quality of care and patient safety.

The MEC is responsible for evaluating reports regarding any Member's conduct, performance or competence. Any person may provide information to the MEC about the conduct, performance or competence of a Member. When reliable information indicates a Member may have exhibited acts, demeanor, or conduct, either within or outside UMC, which are or are reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within UMC; (2) unethical; (3) contrary to the Medical Staff Bylaws, the Code of Conduct and/or Rules and Regulations or to UMC policies and procedures; or (4) below applicable professional standards, the MEC may direct that certain actions be taken or recommendations made. All such actions or recommendations shall be made:

7.2.1.1 In the reasonable belief that the action or recommendation is warranted by the facts and circumstances, and is in furtherance of quality health care; and

7.2.1.2 After a reasonable effort to obtain the facts of the matter, including informing the Member involved, if practicable, and soliciting relevant information from that Member or after such other procedures as are fair to the Member under the circumstances.

7.3 MEC EVALUATION OF REPORTS

A request for an investigation or corrective action and any report referenced in this Article must be submitted to the MEC in writing supported by reference to specific activities or conduct.

7.3.1 If the MEC decides no investigation is warranted based upon its evaluation of the information received, the Chief of Staff shall so inform the reporting party in writing.

7.3.2 The MEC may request that the Quality Review Committee (QRC) initiate a focused review of the Member's performance in order to determine whether any basis

exists to request corrective action or initiate an investigation of the Member. Focused review shall not be construed to constitute an investigation.

7.3.3 The MEC may, in its sole discretion, give Special Notice to the Member that it requests an interview for the purpose of discussing the circumstances reported and, if possible and appropriate, resolving the matter without further MEC action.

7.3.3.1 The MEC may conduct the interview or may delegate that duty to an individual or standing or ad hoc committee. If the Member fails to respond to the Special Notice of interview or declines to participate in the interview, the matter shall be referred back to the MEC for consideration or initiation of an investigation. The interview provided for in this section is not a procedural right of any Member and will not be conducted according to the procedural requirements of Article VIII.

7.3.4 If the MEC decides the information merits the initiation of an investigation, it shall make a record of its reasons. The MEC shall appoint a committee or individual to carry out the investigation, or may delegate that appointment to the Chief of Staff, and shall proceed as described below.

7.3.5 The MEC may take other actions in response to a report about a Member as it deems appropriate and in the furtherance of quality health care, including but not limited to requesting more information before making a decision or requesting that the clinical service chief or one or more members of the MEC meet informally with the Member to coach, counsel and report back.

7.4 PRE-INVESTIGATION FOCUSED REVIEW OF MEMBER'S PERFORMANCE

The QRC may initiate a pre-investigation focused review (focused review) on its own or at the request of the MEC in order to attempt to resolve any concern regarding a Member's performance in a professional, helpful and non-adversarial manner. Focused review is conducted with a positive "performance improvement" philosophy, and efforts will be made to motivate, educate and help a Member whose performance requires improvement. A focused review is not an investigation, although it may be conducted in order to determine whether an investigation is necessary.

7.4.1 Focused review will be used only in circumstances where questions have been raised about a Member's performance, and in the judgment of the QRC or MEC, a focused review, rather than an investigation, may be productive and is safe for patients.

7.4.2 Once it has been decided to implement a focused review, the QRC shall appoint a committee of one or more persons who are members of the Medical Staff or one or more external reviewers to conduct the focused review. The committee shall be referred to as the "Focused Review Committee".

7.4.3 The QRC may direct that the focused review be conducted, in whole or in part, by one or more external reviewers in circumstances where there are few specialists on staff with sufficient knowledge of the area being reviewed or other circumstances dictate, in the judgment of the QRC or Focused Review Committee, that the assistance of an external reviewer would be advantageous to the focused review process.

- 7.4.4 The Chair of the QRC shall notify the Member that a focused review will be conducted of his or her performance. The Member shall have the right to participate in the review process. The Focused Review Committee performing the focused review shall determine whether the Member's participation will be written, through personal meetings, or any other form appropriate to the circumstance.
- 7.4.5 The focused review shall be completed within 45 days of the appointment of the Focused Review Committee. That time may be extended for good cause by the Chair of the QRC upon the request of the Focused Review Committee.
- 7.4.6 Focused review necessarily requires the cooperation of the Member. Whenever the Focused Review Committee finds the Member uncooperative, it may report back to the QRC and request termination of the focused review. In such an instance, the QRC shall notify the MEC, which thereafter will determine whether to initiate an investigation.
- 7.4.7 Upon concluding its focused review, the Focused Review Committee shall make a written report to the QRC, and to the Member by Special Notice. The report will include the Focused Review Committee's recommendations, which may include, but are not limited to, a recommendation for monitoring, proctoring, periodic meetings with a clinical section or service chief, referral to the Physician Well Being Committee, or that the MEC proceed with a formal investigation and consider corrective action. The report also will include a summary of the reasons for the Focused Review Committee's recommendations. The Member may, within five days of receiving a copy of the recommendation, provide his or her input to the QRC for its consideration.
- 7.4.8 The QRC shall consider the report of the Focused Review Committee and any material submitted by the Member and shall make its recommendation to the MEC based upon the facts found and in the furtherance of quality health care.

7.5 ADMINISTRATIVE RESTRICTION OR SUSPENSION

The MEC or Chief of Staff may impose an administrative restriction or suspension of any or all of the Member's clinical privileges in order to allow time to determine whether focused review, investigation or other action should be undertaken, for a period not to exceed fourteen days. An administrative restriction or suspension does not imply any finding on the merits of any issue. The Chief of Staff shall promptly notify the Member and the clinical service chief in the service in which the Member has clinical privileges of any restriction or suspension.

7.6 INVESTIGATING BODY

The MEC or Chief of Staff may conduct any investigation initiated under this Article, or may assign the task to an appropriate Medical Staff member, Medical Staff service member, standing or ad hoc committee of the Medical Staff, or outside reviewer(s). The Chief of Staff shall ensure that no individuals conducting the investigation are in direct economic competition with the Member under investigation.

7.7 NOTIFICATION OF MEMBER

The Member shall be notified promptly by Special Notice that an investigation is being conducted and will be given an opportunity to provide information.

7.8 INVESTIGATION PROCESS

The investigating body may, but is not obligated to, conduct interviews with persons involved in the underlying subject matter. The investigation shall not constitute a “hearing” as that term is used in Article VIII, nor shall the procedural rules with respect to hearings or appeals apply. The investigating body shall provide a written report of its investigation to the MEC as soon as practicable. The report may include recommendations for appropriate corrective action.

7.9 MEDICAL EXECUTIVE COMMITTEE AUTHORITY DURING INVESTIGATION

Regardless of the status of any investigation, the MEC shall retain authority and discretion at all times to take whatever action may be warranted by the circumstances, including administrative restriction or suspension, summary suspension, termination of the investigation process, or other appropriate action.

7.10 MEDICAL EXECUTIVE COMMITTEE ACTION OR RECOMMENDATION

As soon as practicable after the conclusion of an investigation, the MEC shall take action or make recommendations, which may include without limitation:

7.10.1 Determining no corrective action is appropriate, and, if the MEC determines there was no credible evidence for the complaint in the first instance, removing any adverse information related to the complaint from the Member’s file;

7.10.2 Deferring action for a reasonable time where circumstances warrant;

7.10.3 Issuing letters of admonition, censure, reprimand, or warning. In the event such letters are issued, the affected Member may make a written response which shall be placed in the Member’s Credentials file. Nothing herein shall be deemed to preclude service chiefs from issuing informal written or oral warnings outside of the mechanism for corrective action;

7.10.4 Recommending the imposition of terms of probation or a special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions; mandatory consultation, or monitoring;

7.10.5 Recommending reduction, modification, suspension or revocation of clinical privileges;

7.10.6 Recommending reduction of membership status or limitation of any prerogatives directly related to the Member’s delivery of patient care;

7.10.7 Recommending suspension, revocation or probation of Medical Staff membership; and

7.10.8 Taking other actions deemed appropriate under the circumstances.

7.11 PROVISIONAL IMPOSITION OF RESTRICTION

When the MEC recommends action that would have the effect of restricting a Member's clinical privileges, the MEC shall decide whether to impose such restriction immediately, pending the Member's request for hearing, pursuant to Article VIII of these Bylaws.

7.12 SUBSEQUENT ACTION ON MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION

The Chief of Staff shall promptly provide Special Notice to a Member who has been the subject of an investigation of any action or recommendation by the MEC pursuant to this Article, in accordance with Section 8.1.7. The Chief of Staff shall also inform the Board of its action or recommendation. If the action or recommendation is of a nature described in Section 8.1.4 of these Bylaws and if the Member fails to request a hearing under Article VIII in a timely manner, the recommendation of the MEC shall become a final recommendation, and the Chief of Staff shall so inform the Board. Otherwise, the provisions of Article VIII shall apply.

7.13 SUMMARY RESTRICTION OR SUSPENSION

7.13.1 CRITERIA FOR IMPOSITION

The Chief of Staff, the MEC, or the chief of the clinical service in which the Member holds clinical privileges, may summarily restrict or suspend the Medical Staff membership or clinical privileges of any Member without prior notice or hearing when he or she concludes such suspension or restriction is needed to protect the life or well being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition.

7.13.2 NOTICE

The person or body responsible for the summary restriction or suspension shall promptly give Special Notice to the Member, the Board, and the MEC.

7.13.3 DURATION

Subject to Article VIII of these Bylaws, the summary restriction or suspension shall remain in effect for the period stated or, if none stated, until the Board takes final action or the MEC rescinds or terminates the restriction or suspension.

7.13.4 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as possible and no longer than seven days after such summary restriction or suspension has been imposed, the MEC shall meet:

7.13.4.1 To determine whether a formal investigation should be initiated (if not previously initiated);

- 7.13.4.2 To determine whether the restriction or suspension should be rescinded, terminated, modified, or should remain in place;
- 7.13.4.3 To consider, as applicable, the Member's request or the MEC's request that the Member shall attend an MEC meeting and make a statement concerning the issues under investigation on such terms and conditions as the MEC may impose. In no event shall any such meeting of the MEC, with or without the Member, constitute a "hearing" within the meaning of Article VIII, nor shall any procedural rules apply. A request from the MEC to a Member to attend a meeting under this section shall include notice to the Member that failure to attend shall constitute a waiver of his or her rights under Article VIII of these Bylaws;
- 7.13.4.4 In cases where a Member has been requested by MEC to attend an MEC meeting pursuant to Section 7.13.4.3, but has failed to do so, to consider whether the Member had good cause for failing to attend. If no good cause is shown, failure to attend an MEC meeting upon request after appropriate notice shall constitute a waiver of his or her rights under Article VIII of these Bylaws; and
- 7.13.4.5 The MEC shall provide Special Notice, in compliance with Section 8.1.7 of these Bylaws, of its decision as to the restriction or suspension to the Member and the Board.

7.13.5 MEMBER'S PROCEDURAL RIGHTS

The Member shall be entitled to the procedural rights afforded by Article VIII of these Bylaws unless the MEC terminates the summary restriction or suspension or the Member waives his or her procedural rights.

7.14 AUTOMATIC REVOCATION OR RESTRICTION

In the following instances, the Member's clinical privileges or membership will be automatically revoked or restricted as described, which action shall be final without a right to hearing or further review under Article VIII of these Bylaws, except where a bona fide dispute exists as to whether the precipitating event has occurred. This section does not preclude the MEC from initiating another corrective action, as appropriate.

7.14.1 LICENSURE ACTIONS

- 7.14.1.1 Revocation, Surrender and Expiration: Whenever a Member's license or other legal credential authorizing practice in this state is restricted, revoked, suspended, surrendered or expired, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action became effective.
- 7.14.1.2 Restriction: Whenever a Member's license or other legal credential authorizing practice in this state is restricted, any clinical privileges which the Member has been granted at UMC which are within the scope of the restriction shall be automatically restricted to the same extent, as of the date such action became effective and throughout its term.

7.14.1.3 Probation: Whenever terms of probation are imposed on a Member's license or other legal credential authorizing practice in this state, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action became effective and throughout its term.

7.14.2 CONTROLLED SUBSTANCE

Whenever a Member's Drug Enforcement Administration Controlled Substance Registration Permit is restricted, revoked, suspended or expired, the Member shall automatically and correspondingly be divested of the right to prescribe medications covered by the permit, as of the date such action became effective and throughout its term.

7.14.3 PROBATION

Whenever a Member's Drug Enforcement Administration Permit is subject to probation, the Member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action became effective and throughout its term.

7.14.4 EXCLUSION FROM PARTICIPATION IN MEDICARE OR OTHER FEDERAL OR STATE HEALTHCARE PROGRAMS

Whenever a Member is notified by Medicare or any other federal or state health care program of the program's exclusion of the Member from any such program, the Member's Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action became effective.

7.14.5 FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

A Member who fails without good cause to appear and satisfy the Special Appearance requirements of Section 12.7 of these Bylaws shall be automatically suspended from exercising all clinical privileges.

7.14.6 MEDICAL RECORDS

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the MEC. A limited suspension in the form of withdrawal of, or limitation on, admitting and other related privileges until medical records are completed, shall be imposed by the Chief of Staff, or his or her designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this article, the term "related privileges" means on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on UMC cases, and providing professional services within UMC for future patients. Bona fide vacation or illness may constitute an excuse. Members whose clinical privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the Chief of Staff or his or her designee.

7.14.7 PROFESSIONAL LIABILITY INSURANCE

Whenever a Member fails to maintain the required professional liability insurance, the Member's Medical Staff membership and clinical privileges shall be automatically suspended as of the date the Member's insurance coverage lapsed or expired. If, within ninety days after a written warning of delinquency, the Member does not provide evidence of required professional liability insurance, the Member's membership and clinical privileges shall be automatically revoked.

7.14.8 NONPAYMENT OF MEDICAL STAFF DUES, REAPPOINTMENT FEE OR DELINQUENT DOSIMETER FEE

Whenever a Medical Staff Member does not pay Medical Staff dues, reappointment fee (if assessed) or has a delinquent dosimeter fee two weeks after receipt of a second notice (which will be sent by Special Notice), the Member's Medical Staff membership and clinical privileges shall be automatically revoked.

7.14.9 Annual Health Screening

Whenever a Medical Staff Member fails to demonstrate compliance with annual health screening requirements, the Member's Medical Staff membership and clinical privileges shall be automatically suspended. The suspension shall continue until compliance is demonstrated.

7.14.10 ANNUAL TRAINING / RADIATION / RADIOACTIVE MATERIALS

Whenever a Medical Staff Member who uses radiation or radioactive materials in his or her practice fails to complete the required annual training, the Member's ability to use radiation or radioactive materials shall be automatically suspended. The suspension shall continue until compliance is demonstrated.

7.15 ALTERNATIVE MEDICAL COVERAGE

Unless otherwise indicated by the terms of the restriction or suspension, and in all cases of automatic termination, the appropriate clinical service chief or, in his absence, the Chief of Staff, shall make arrangements for alternative medical coverage for the affected Member's patients still at UMC at the time of such suspension or termination. The wishes of such patients shall be followed, to the extent possible, when electing alternative medical coverage.

7.16 PEER REVIEW PROTECTIONS

All activities set forth in this Article and all the work performed and materials gathered or generated to support such activities, including but not limited to OPPE, FPPE, focused review, investigations, corrective action and any other actions or activities under this Article are peer review activities protected by A.R.S. Sections 36-445.01 and 36-445.02 and the Health Care Quality Improvement Act. As such, the Medical Staff intends them to be confidential and subject to all the immunities and protections provided by state and federal law and regulation.

ARTICLE VIII

HEARINGS AND APPELLATE REVIEWS

8.1 GENERAL PROVISIONS

8.1.1 APPLICABILITY

Under these Bylaws, circumstances may arise in which an initial hearing is provided by the Board. In such cases, the procedures set forth herein for hearings before the Hearing Committee generally shall apply to hearings before the Board, except as reasonably modified by the Board. Circumstances also may arise when an appeal is to the Joint Conference Committee, in which case the procedures applicable to appeals to the Board shall apply, except as reasonably modified by the Joint Conference Committee. All activities related to a hearing or appellate review procedure are confidential peer review activities.

8.1.2 REFERENCE TO MEMBERS

Reference in this Article to the term "members" shall include not only members of the Medical Staff but also applicants for Medical Staff membership.

8.1.3 RIGHT TO ONE HEARING

A Member shall be entitled to only one evidentiary hearing and one appellate review on any adverse action or recommendation.

8.1.4 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing;

8.1.4.1 Denial of Medical Staff membership;

8.1.4.2 Denial of Medical Staff reappointment;

8.1.4.3 Denial of requested privilege(s);

8.1.4.4 Any action of a nature described in Sections 7.10.4 through 7.10.7 of these Bylaws;

8.1.4.5 Involuntary imposition of other significant adverse or burdensome requirements excluding monitoring incidental to Articles IV, VI and VII of these Bylaws; and

8.1.4.6 Summary restriction or suspension pursuant to Section 7.13 of these Bylaws in effect for more than fourteen days.

8.1.5 An action or recommendation listed in this Article does not entitle the Member to a hearing when it is voluntarily imposed or accepted by the Member.

- 8.1.6 Initiation of a focused review of a Member's performance does not constitute an adverse action, and no hearing rights pertain to such initiation.
- 8.1.7 Notice of Action or Proposed Action: In all cases involving an action or recommendation listed in Section 8.1.4 of these Bylaws, the person or body taking or recommending the action shall give the Member prompt Special Notice of the recommendation or action, including;
 - 8.1.7.1 A description of the action that has been taken or recommended;
 - 8.1.7.2 Reasons for the action or recommendation;
 - 8.1.7.3 Notice that the Member has the right to request a hearing on the action or recommendation and has thirty days to request such a hearing; and
 - 8.1.7.4 A copy of these Bylaws.

8.2 HEARINGS

8.2.1 REQUEST FOR HEARING:

A Member shall have thirty days following receipt of Special Notice of an action or recommendation to request a hearing. The request shall be in writing, addressed to the Chief of Staff, and delivered by hand or sent by electronic or certified mail with proof of receipt requested. In the event the Member does not request a hearing within the time and in the manner described, the Member shall be deemed to have waived any right to a hearing and accepted the action or recommendation.

8.2.2 NOTICE OF DATE, TIME AND PLACE FOR HEARING

Upon receipt of a timely request for hearing, the MEC shall promptly schedule a hearing and give notice to the Member of the hearing. The date of commencement of the hearing shall be no fewer than thirty days following the notice of the hearing to the Member, nor more than sixty days, unless the date is extended by agreement between the affected Member and the MEC or order of the Hearing Committee. The notice shall include a list of the affected Member's hearing rights as set forth in Section 8.2.4 and a list of the witnesses, if any, the MEC expects to call at the hearing.

8.2.3 HEARING COMMITTEE

Hearings are held before the elected Hearing Committee described in Section 11.17, whose members shall not have actively participated in the consideration of the matter leading to the recommendation or action and excluding any member who is in direct competition with the Member involved. Knowledge of the matter shall not preclude a Member of the Medical Staff from serving as a Member of the Hearing Committee.

- 8.2.3.1 The affected Member shall have the right to submit a challenge to the service of any Member of the Hearing Committee in writing to the Chief of Staff. The Chief of Staff in his or her sole discretion will decide whether to

allow the Hearing Committee Member to serve. If the Chief of Staff determines not to allow the challenged Hearing Committee Member to serve, then he or she will appoint a replacement.

- 8.2.3.2 The Chief of Staff may appoint a hearing officer to preside in matters leading up to and during the hearing, make evidentiary decisions, if needed, impose reasonable time limitations, keep order and take such steps as may be necessary to make the hearing go forward fairly and efficiently. If no hearing officer is appointed, the Chair of the Hearing Committee shall undertake these tasks.

8.2.4 HEARING RIGHTS

An affected Member and the MEC each shall have the following rights in connection with a hearing, all or any of which the Member or MEC may waive, in writing, prior to the time of the hearing:

- 8.2.4.1 The right to be present at all hearings; in the case of the MEC, the right to have a representative present;
- 8.2.4.2 The right to be accompanied by and represented by an attorney or other person of his or her choice, including a Member of the Medical Staff, in good standing, or by a member of his or her local professional society;
- 8.2.4.3 The right to have a stenographic record made of all the proceedings, copies of which may be obtained by the MEC and/or the Member upon payment of any reasonable charges associated with their preparation;
- 8.2.4.4 The right to call, examine and cross-examine witnesses and to present evidence determined by the Hearing Committee to be relevant, regardless of its admissibility in a court of law;
- 8.2.4.5 The right to submit a written statement prior to and at the close of the hearing;
- 8.2.4.6 The right to testify in his, her or its own behalf; but even if the Member does not elect to do so, he or she may be called by the Hearing Committee and examined as if under cross-examination; and
- 8.2.4.7 The right to receive the Hearing Committee's written findings of fact and a recommendation based upon the hearing record.

8.2.5 HEARING PROCEDURE

The MEC and the Member shall exchange their final lists of hearing witnesses and exhibits no later than one week prior to the hearing. The Hearing Committee shall not be bound in such hearings to the rules of evidence applicable in courts of law but shall, instead, receive and consider any evidence which, in its judgment, would be considered by reasonable and prudent persons in the management of their own affairs. A majority of the Hearing Committee must be present at all times during the hearing; otherwise the hearing shall be postponed. At the hearing, unless otherwise determined for good cause, the MEC shall have the initial duty to present

evidence in support of its action or recommendation. The Member shall have the opportunity to present evidence in response. Throughout the hearing, the MEC shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that its action or recommendation was a reasonable and warranted one. The MEC does not have the burden to prove that its recommendation or action was the only recommendation or action that could have been warranted.

A stenographic record of the hearing proceedings may be made upon request of either the Member or the MEC.

8.2.6 HEARING COMMITTEE REPORT

The Hearing Committee will submit a written report, including findings of fact and recommendations, to the MEC and the affected Member within fifteen days after the completion of the hearing.

8.2.7 MEMBER'S FAILURE TO APPEAR OR PROCEED

An affected Member's failure without good cause to be in attendance throughout a hearing and proceed during the hearing in an efficient and orderly manner shall constitute a waiver of the Member's right to a hearing and a voluntary acceptance of the recommendations or actions involved. Good cause shall be determined by the hearing officer, if any, or the Chair of the Hearing Committee.

8.3 APPEAL

8.3.1 REQUEST FOR APPEAL

Within ten days after receipt of the report of the Hearing Committee, either the Member or the MEC may request an appeal. A written request for appeal shall be delivered by hand or by electronic or certified mail, proof of receipt requested, to the Chief of Staff, the CEO, the Board Chair, and the other party in the hearing. If an appeal is not properly requested within the stated period, the Hearing Committee's recommendation shall be submitted to the Board for final action.

8.3.2 GROUNDS FOR APPEAL

The grounds for appeal from the hearing shall be limited to:

8.3.2.1 Substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; and/or

8.3.2.2 the decision was not supported by substantial evidence based upon the hearing record.

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal.

8.3.3 NOTICE OF TIME AND PLACE

If an appeal review is requested timely, a Medical Staff Appeals Committee (Appeals Committee) shall be formed in accordance with Section 11.16. The Appeals Committee shall schedule a review date and notify the Member, the MEC and the CEO of the time and place of the appeal. The date of the appeal shall not be less than thirty days nor more than sixty days from the date of such notice; provided, however, that when a request for an appeal concerns a Member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen days from the date of the notice. The time for an appeal may be extended by the Appeals Committee for good cause if agreed to by both parties.

8.3.4 APPEALS COMMITTEE

The Appeals Committee, as described in Section 11.16, shall consist of one Member of the active Medical Staff from each of the clinical services. No Member of the MEC may serve on the Appeals Committee. Each clinical service shall elect its representative and an alternate to the Appeals Committee annually. The committee may not convene to consider an appeal with fewer than one-half of its members present; no substitution of members may occur while a particular case is in progress.

8.3.4.1 The affected Member shall have the right to submit a challenge to the service of any Member of the Appeals Committee in writing to the Board Chair. The Board Chair in his or her sole discretion will decide whether to allow the Appeals Committee Member to serve. If the Board Chair determines not to allow the challenged Appeals Committee Member to serve, then he or she will appoint a replacement if the removal of the Appeals Committee Member reduces the number of committee members below half its membership.

8.3.5 APPEAL PROCEDURES

8.3.5.1 The Appeals Committee shall conduct its appellate review based solely upon the record of the hearing before the Hearing Committee, except that the Appeals Committee may accept additional oral or written evidence if the party offering the evidence shows that it could not have been made available to the Hearing Committee in the exercise of reasonable diligence. If additional evidence is accepted, the other party shall have the right to respond to it with evidence and argument. Alternatively, the Appeals Committee may remand the matter to the Hearing Committee for the taking of further evidence and for decision, to be completed within thirty days of the remand date. Each party shall have the right to be represented by legal counsel in connection with the appeal and to present a written statement in support of their positions on appeal. The Appeals Committee in its sole discretion may conduct deliberations outside the presence of the parties and their representatives at a time convenient to itself. Within fifteen days after its deliberations conclude, the Appeals Committee shall present to the Board its written recommendations as to whether the Board should affirm, modify, or reverse the Hearing

Committee decision or should remand the matter to the Hearing Committee for further review and decision.

8.3.5.2 Except as otherwise provided herein, within thirty days after the Board receives the recommendation of the Appeals Committee, the Board shall render a decision in writing and shall forward copies thereof to the Member and the MEC. The Board may affirm, modify, or reverse the decision of the Hearing Committee or may remand the matter to the Hearing Committee for further review and recommendation. If the matter is remanded to the Hearing Committee, that committee shall promptly conduct its review and make its recommendations to the Board within thirty days. This time may be extended upon agreement of the parties or for good cause as jointly determined by the Board Chair and the Hearing Committee.

8.3.6 SUBMISSION TO JOINT CONFERENCE COMMITTEE

In the event the decision of the Board follows the recommendations of the MEC, that decision shall become final. In the event the Board decision is contrary in whole or in part to the MEC recommendation, the Board's action shall also be final unless the MEC elects within thirty days to submit the matter to the Joint Conference Committee described in Section 11.15. The Joint Conference Committee shall have access to the records from the hearing and appeal. The Joint Conference Committee's recommendation shall be made in writing within thirty days of receipt of the matter unless extended for good cause. This recommendation shall be forwarded to the Board which shall then take final action and shall notify the Member and the MEC by Special Notice of its action.

8.4 EXCEPTIONS TO HEARING RIGHTS

8.4.1 MEDICAL-ADMINISTRATIVE OFFICERS AND CONTRACT PHYSICIANS

Members who are directly under contract with UMC in a medical-administrative capacity or members whose Staff membership is contingent upon a faculty appointment shall have the procedural rights specified in this Article related solely to their status as Members of the Medical Staff. Contractual issues and issues related to faculty appointments shall not be the subject of hearings under this Article.

8.4.2 AUTOMATIC SUSPENSION OR LIMITATION OF PRACTICE

No hearing is required when a Member's license or other legal credential to practice has been revoked, suspended or otherwise restricted as set forth in Article VII of these Bylaws. In cases of automatic suspension, revocation or restriction under Article VII, the only issues which may be considered at any hearing shall be whether the Member may continue to practice at UMC with those limitations imposed.

8.5 PEER REVIEW CONFIDENTIALITY

All activities set forth in this Article, and all the work performed and materials gathered or generated to support such activities, are peer review activities protected by A.R.S.

Sections 36-445.01 and 36-445.02 and the Health Care Quality Improvement Act. As such, the Medical Staff intends them to be confidential and subject to all the immunities provided by state and federal law and regulation.

ARTICLE IX

ELECTED MEDICAL STAFF POSITIONS

9.1 OFFICERS OF THE MEDICAL STAFF

- 9.1.1 Chief of Staff;
- 9.1.2 Chief of Staff-Elect;
- 9.1.3 Immediate Past Chief of Staff; and
- 9.1.4 Secretary-Treasurer.

9.2 ELECTED MEDICAL STAFF POSITIONS

Additional elected positions of the Medical Staff shall be:

- 9.2.1 Four at-large members of the MEC;
- 9.2.2 Credentials Committee chair;
- 9.2.3 Eleven Credentials Committee members (no more than two members from a clinical service);
- 9.2.4 A Member of the Board, subject to acceptance by the Arizona Board of Regents;
- 9.2.5 Seven members of the Medical Staff Hearing Committee. Members of the Hearing Committee shall not be members of the MEC or the Appeals Committee;
- 9.2.6 A Member and alternate Member of the Medical Staff Appeals Committee elected by each clinical service;
- 9.2.7 Two members of the Nominating Committee; and
- 9.2.8 A primary and alternate representative to the Arizona Hospital and Healthcare Association and the American Medical Association-Organized Medical Staff Section.

9.3 QUALIFICATIONS

Candidates for elected positions must be Active Medical Staff members at the time of their nomination and election, and must remain Active Staff members in good standing during their term. Failure to maintain such status shall constitute a voluntary resignation from the office or position and create a vacancy in the office or position.

9.4 NOMINATIONS

Medical Staff elections shall be held biennially during each even year. The Nominating Committee shall meet prior to the annual staff meeting to be held during the election year

or prior to any special election. The nominations of the committee shall be delivered or mailed to the Medical Staff at least sixty days prior to an election. The Nominating Committee shall offer one or more nominees for the following positions:

- 9.4.1 Chief of Staff-Elect;
- 9.4.2 Secretary-Treasurer;
- 9.4.3 Credentials Committee chair and eleven members;
- 9.4.4 Four at-large members of the MEC;
- 9.4.5 A Member of the Board, subject to acceptance by the Arizona Board of Regents;
- 9.4.6 A primary and alternate representative to the Arizona Hospital and Healthcare Association and the American Medical Association-Organized Medical Staff Section;
- 9.4.7 Seven members of the Medical Staff Hearing Committee; and
- 9.4.8 Two members of the Nominating Committee.

Further nominations may be made for any office by any Member of the Medical Staff eligible to vote, provided that the name of the candidate is submitted in writing to the chair of the Nominating Committee, is endorsed by the signature of at least ten percent of other members who are eligible to vote, and bears the candidate's written consent. These nominations shall be delivered to the chair of the Nominating Committee as soon as reasonably practicable, but at least thirty days prior to the date of the election. If any nominations are made according to these requirements, the nominees' names shall be placed on the written ballot.

9.5 ELECTION

Ballots listing the nominated candidates for the biennial election shall be mailed or delivered not less than twenty days prior to the date scheduled for the annual meeting to those members who are entitled to vote. Ballots must be returned to the Medical Staff Service Office at UMC within fifteen days of the date the ballots are mailed or delivered. All ballots received after that time shall be ineligible for consideration. The results of the election shall be determined by the majority of those ballots properly returned. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held. In the case of a tie on the second ballot, the majority vote of the MEC shall decide election by secret written ballot at its next meeting.

9.6 TERM OF ELECTED OFFICE OR POSITION

Each officer or other elected official shall serve a two-year term, commencing on the first day of the Medical Staff Year following his or her election. The Board Member's term shall commence in accordance with the provisions of the UMC Corporation Bylaws. At the end of his or her term, the Chief of Staff shall automatically assume the office of Immediate Past Chief of Staff, and the Chief of Staff-Elect shall automatically assume the office of the Chief of Staff.

9.7 RECALL

An individual in an elected position may be subject to recall based on his or her failure to perform the duties of the office or otherwise fail to perform satisfactorily. Recall may be initiated by the MEC or by a petition specifying the charges against the individual and signed by at least one-third of the members of the Medical Staff eligible to vote. Recall shall be considered at a special meeting of the MEC called for that purpose. A person holding an elected position shall be recalled upon the vote of two-thirds of the Medical Staff members eligible to vote who return ballots within the time specified on the ballot, provided that at least 50% of the members eligible to vote return ballots.

A non-elected MEC member may be recalled under the procedures set forth in Section 11.8.3.

9.8 VACANCIES IN ELECTED POSITIONS

Vacancies in elected positions shall be filled as follows:

9.8.1 The Chief of Staff-Elect shall fill a vacancy in the Chief of Staff position by assuming the office of Chief of Staff;

9.8.2 A vacancy in the Chief of Staff-Elect or Board Member position shall be filled by a special election following the process outlined in Section 9.5 of these Bylaws;

9.8.3 A vacancy in the position of Immediate Past Chief of Staff shall not be filled;

9.8.4 A vacancy in the position of Secretary-Treasurer, at-large Member of the MEC, representative to the Arizona Hospital and Healthcare Association, representative to the American Medical Association-Organized Medical Staff Section, or chair or member of the Medical Staff Hearing Committee or Credentials Committee, shall be filled by appointment by the Chief of Staff until the next regular election; and

9.8.5 A vacancy in the membership of the Medical Staff Appeals Committee shall be filled through election by the Clinical Service affected, following the process outlined in Section 9.5, except that ballots shall be mailed or delivered only to Active members of the Clinical service.

9.9 RESPONSIBILITIES AND AUTHORITY OF OFFICERS AND OTHER ELECTED MEDICAL STAFF MEMBERS

9.9.1 RESPONSIBILITIES AND AUTHORITY OF THE CHIEF OF STAFF

The Chief of Staff serves as the chief administrative officer of the Medical Staff with the following responsibilities and authority:

9.9.1.1 Transmitting the views and recommendations of the Medical Staff and the MEC to the Board and to the CEO on matters of UMC policy, planning, operations, governance, credentialing and relationships with external entities, and transmitting the views and decisions of the Board and CEO to the MEC and the Medical Staff membership;

- 9.9.1.2 Communicating the opinions of the Medical Staff and individual members on organizational and individual staff matters affecting UMC operations to the Board and the CEO;
- 9.9.1.3 Overseeing compliance of the Medical Staff with the procedural safeguards and rights of individual staff members in all stages of the credentialing process;
- 9.9.1.4 Directing the operation of the Medical Staff organization;
- 9.9.1.5 Assisting the CEO in coordinating Medical Staff functions and responsibilities with UMC administration, nursing, and other support staff;
- 9.9.1.6 Enforcing compliance with the provisions of the Bylaws, Rules and Regulations and Code of Conduct and UMC policies and procedures;
- 9.9.1.7 Presiding over all general and special meetings of the Medical Staff and of the MEC including responsibility for the agenda;
- 9.9.1.8 Appointing Medical Staff members to chair and serve on Medical Staff committees;
- 9.9.1.9 Serving as chair of the MEC, alternating annually with the chair of the Board as chair of the Joint Conference Committee; and serving as an Ex Officio Member without vote on all other standing Medical Staff committees, unless otherwise provided by the UMC or Medical Staff Bylaws.
- 9.9.1.10 Reviewing and enforcing compliance with standards of ethical conduct and professional demeanor by the Medical Staff in their relations with each other, the Board, UMC administration, support staff, and the community UMC serves;
- 9.9.1.11 Directing the development and implementation of the Medical Staff components of the performance improvement programs and overseeing processes consistent with accrediting agency requirements;
- 9.9.1.12 Appointing Medical Staff members to chair and serve on committees formed to accomplish Medical Staff performance improvement and monitoring functions, unless otherwise provided in the Medical Staff Bylaws; and
- 9.9.1.13 Performing such additional duties as may be assigned by the MEC or the Board.

9.9.2 RESPONSIBILITIES AND AUTHORITY OF THE CHIEF OF STAFF-ELECT

The Chief of Staff-Elect shall serve as Chair of the Quality Review Committee and as a voting Member of the MEC. The Chief of Staff-Elect will exercise all of the responsibilities and authority of the Chief of Staff in his or her absence.

9.9.3 RESPONSIBILITIES AND AUTHORITY OF THE IMMEDIATE PAST CHIEF OF STAFF

The Immediate Past Chief of Staff shall serve as acting Chief of Staff in the absence of the Chief of Staff and Chief of Staff-Elect.

9.9.4 RESPONSIBILITIES AND AUTHORITY OF THE SECRETARY-TREASURER

The Secretary-Treasurer shall have overall responsibility for funds collected from Medical Staff members in accordance with approved guidelines, and serve as a voting Member of the MEC. The Secretary-Treasurer shall serve as acting Chief of Staff in the absence of the Chief of Staff, Chief of Staff-Elect, and Immediate Past Chief of Staff.

ARTICLE X

CLINICAL SERVICES AND SECTIONS

10.1 ORGANIZATION OF CLINICAL SERVICES AND SECTIONS

The Medical Staff shall be divided into clinical services. Each clinical service shall be organized as a separate component of the Medical Staff and shall have as clinical service chief the head of the corresponding University of Arizona College of Medicine department or his or her designee. The clinical service chief shall be certified by an appropriate specialty board or comparable competence established through the credentialing process. Clinical service chiefs shall be members of the Active Medical Staff. A clinical service may be further divided, as appropriate, into sections which shall be responsible to the clinical service within which it functions, and which shall have a section chief selected by the clinical service chief. Section chiefs shall be members of the active Medical Staff and members of the sections, which they head, and shall be qualified by training, experience, and demonstrated current competence in the clinical area covered by the section. The specific responsibilities and authority of clinical service chiefs and section chiefs are detailed in this Article. When appropriate, the MEC shall recommend to the Medical Staff the creation, elimination, modification, or combination of clinical services or sections.

10.2 CLINICAL SERVICES AND SECTIONS

10.2.1 Anesthesiology

10.2.2 Emergency Medicine

Emergency Medicine
Clinical Toxicology

10.2.3 Family Practice

10.2.4 Medicine

Cardiology
Critical Care
Dermatology
Endocrinology
Gastroenterology
General Medicine
Geriatrics
Hematology/Oncology
Infectious Diseases
Inpatient Integrative Medicine
Nephrology
Physical Medicine and Rehabilitation
Pulmonology Rheumatology

10.2.5 Neurology

10.2.6 Obstetrics and Gynecology

General Obstetrics and General and Benign Gynecology
Gynecologic Oncology
Maternal and Fetal Medicine
Reproductive/Endocrine/Infertility

10.2.7 Ophthalmology

10.2.8 Orthopedic Surgery

Orthopedic Surgery
Podiatry

10.2.9 Pathology

Anatomic Pathology
Blood Banking
Chemical Pathology
Clinical Pathology
Cytogenetics
Dermatopathology
Hematology
Medical Microbiology
Neuropathology
Ob/Gyn Pathology
Surgical Pathology

10.2.10 Pediatrics

Allergy and Immunology
Cardiology
Critical Care Medicine
Dermatology
Endocrinology
Gastroenterology
General Pediatrics
Genetics
Hematology/Oncology
Infectious Diseases
Neonatology
Nephrology
Neurology
Pulmonary Medicine
Rheumatology

10.2.11 Psychiatry

Psychology

10.2.12 Radiation Oncology

10.2.13 Radiology

Diagnostic Radiology
Nuclear Medicine

10.2.14 Surgery

Abdominal Transplant
Cardiothoracic Surgery
General Dentistry
General Surgery
Neurosurgery
Oral Surgery
Otolaryngology
Pediatric Surgery
Plastic Surgery
Surgical Oncology
Trauma/Plastics
Urology
Vascular Surgery

10.3 ASSIGNMENT TO CLINICAL SERVICES AND SECTIONS

Each clinical service and section is a component of the Medical Staff and every Medical Staff Member shall have a primary affiliation with, and membership in, the clinical service and section (if applicable) in his or her main area of clinical practice at UMC. A Medical Staff Member may be granted additional clinical privileges in another service and section, as applicable, when the clinical privileges granted are under the jurisdiction of that service. Medical Staff members will be subject to the rules and regulations of the service in which they hold membership and all services where they hold clinical privileges.

10.4 RESPONSIBILITIES AND AUTHORITY OF CLINICAL SERVICE CHIEFS

Each clinical service chief is responsible for the following:

- 10.4.1 All clinically related activities of the service;
- 10.4.2 All administratively related activities of the service, unless otherwise provided for by UMC;
- 10.4.3 The continuous assessment and improvement of the quality of care, treatment, and services;
- 10.4.4 The maintenance of quality control programs in the service, as appropriate;
- 10.4.5 Continuing surveillance and review of the professional performance of all individuals who have delineated clinical privileges in the service and of all House Staff Physicians assigned to the service through morbidity and mortality conferences or through any other Mechanism deemed effective by the clinical service chief to reduce morbidity and mortality and to improve the care of patients provided at UMC through the service;

- 10.4.6 Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided;
- 10.4.7 Recommending clinical privileges for each applicant for Medical Staff membership and/or clinical privileges in the service;
- 10.4.8 Assessing and recommending to the relevant UMC authority off-site sources for needed patient care, treatment, and services not provided by the service or at UMC;
- 10.4.9 Participating in planning with respect to the service's equipment, facilities, and services;
- 10.4.10 The integration of the service into the primary functions of the organization;
- 10.4.11 The coordination and integration of the services within the clinical service and with other clinical services;
- 10.4.12 The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;
- 10.4.13 The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;
- 10.4.14 The determination of the qualifications and competence of service personnel who are not independent licensed practitioners and who provide patient care, treatment, and services;
- 10.4.15 The orientation and continuing education of all persons in the clinical service; and
- 10.4.16 The performance of such other duties as may be reasonably requested by the Chief of Staff, the MEC or the Board.

10.5 RESPONSIBILITIES AND AUTHORITY OF CLINICAL SECTION CHIEFS

Each clinical section chief is responsible for the following:

- 10.5.1 Implementing and supervising, in cooperation with the clinical service chief and other appropriate officials of the Medical Staff and UMC, systems to carry out the quality management functions assigned to the section;
- 10.5.2 Participating in planning with respect to equipment, facilities, and service for the section;
- 10.5.3 Maintaining continuing review of patient care and of the professional performance of practitioners with clinical privileges in the section, as well as of the professional performance of all House Staff Physicians who rotate through the section through morbidity and mortality conferences or through any other Mechanism deemed effective by the section chief to reduce morbidity and mortality and to improve the care of patients provided in UMC through the section;

10.5.4 Submitting assessments of clinical competency, as required by Articles IV, V and VI, to the clinical service chief and the Credentials Committee regarding appointment, reappointment, and delineation of clinical privileges with respect to practitioners holding membership or providing services in or applying to the section; and

10.5.5 Performing such other duties commensurate with the office as may be reasonably requested by the Chief of Staff, the clinical service chief, the MEC, or the Board.

10.6 PEER REVIEW CONFIDENTIALITY

All activities set forth in this Article and all the work performed and materials gathered or generated to support such activities, are peer review activities protected by A.R.S. Sections 36-445.01 and 36-445.02 and the Health Care Quality Improvement Act. As such, the Medical Staff intends them to be confidential and subject to all the immunities provided by state and federal law and regulation.

ARTICLE XI

FUNCTIONS, COMMITTEES, AND RELATIONSHIPS

11.1 MEDICAL STAFF FUNCTIONS

The Medical Staff shall have overall responsibility for the quality of the professional services provided by individuals with clinical privileges and for accounting therefore to the Board. These functions are as described in this article and shall include such other functions as the MEC or the Board shall reasonably require.

The required functions of the Medical Staff shall be accomplished through assignment to the Medical Staff as a whole, to clinical services or sections, to Medical Staff committees, to Medical Staff officers or other individual Medical Staff members, or to interdisciplinary UMC committees with participation of Medical Staff members.

The Medical Staff shall:

- 11.1.1 Govern, direct and coordinate the Medical Staff organization and its functions, including delegating authority to the MEC and other Medical Staff committees;
- 11.1.2 Plan, conduct coordinate and evaluate the Medical Staff components of UMC's performance improvement program;
- 11.1.3 Participate in and evaluate the effectiveness of patient care monitoring and utilization management activities;
- 11.1.4 Direct, coordinate, and oversee the credentialing process for Medical Staff clinical privileges;
- 11.1.5 Maintain surveillance over the completeness, timeliness and clinical pertinence of patient medical records;
- 11.1.6 Monitor UMC's infection control program;
- 11.1.7 Maintain surveillance over drug utilization policies and procedures;
- 11.1.8 Participate in planning for response to fire and other disasters;
- 11.1.9 Participate in planning for UMC growth and development, and for the provision of services required to meet community needs;
- 11.1.10 Participate in maintenance of UMC accreditation; and
- 11.1.11 Support the missions of University Medical Center and the Arizona Health Sciences Center.

11.2 DESIGNATION OF COMMITTEES

There shall be a Medical Executive Committee (MEC), a Joint Conference Committee, and the following standing committees responsible to the MEC: Bioethics; Blood Utilization;

Bylaws; Code Blue; Credentials; Infection Prevention; Medical Staff Appeals; Medical Staff Hearing; Nominating; Perioperative Services; Pharmacy and Therapeutics; Physician Well-Being and Quality Review. Special or ad hoc committees may be established from time to time as determined by the MEC.

Each Medical Staff committee described below which reviews professional practices at UMC, including but not limited to those committees which review the qualifications of Medical Staff members and applicants, for the purposes of reducing morbidity and mortality and for improving the quality of care of UMC patients, is engaged in a quality review function required by Arizona law pursuant to A.R.S. Sections 36-445.01 and 36-445.02. The proceedings, deliberations, records and materials prepared in connection with all such reviews shall be confidential and shall be protected from discovery and disclosure, pursuant to Arizona law. All members of such committees and all individuals who make decisions or recommendations in connection with such reviews, or who furnish records, information or assistance to such committees, shall be immune from civil damages or legal actions, as provided by Arizona and federal law. Confidentiality and immunity shall be afforded these processes to the fullest extent of the law.

11.3 COMMITTEE COMPOSITION

The composition of all standing committees is set forth in this Article. The CEO or his or her designee may attend any committee meeting without vote.

11.4 SUBCOMMITTEES AND AD HOC COMMITTEES

Any standing committee may elect to perform any of its designated functions by constituting any of its members as a subcommittee for that purpose, reporting such action to the MEC in writing. Any such subcommittee may include individuals in addition to members of the standing committee. Special ad hoc committees may be appointed by the Chief of Staff to perform specific tasks.

11.5 APPOINTMENT AND TERM

Unless otherwise provided in these Bylaws, the chair, co-chair, or vice chair, and members of all committees shall be appointed by, and may be removed by, the Chief of Staff subject to approval by the MEC. Unless otherwise specified, committee members shall be appointed for a term of two Medical Staff Years and shall serve until the end of this period or until the Member's successor is appointed, whichever is longer, unless the Member shall resign or be removed from the committee.

11.6 REPRESENTATION ON UMC COMMITTEES

Staff functions and responsibilities which require participation of the Medical Staff may be discharged by various officers and organizational components of the Medical Staff as described in these Bylaws and/or by Medical Staff representation on UMC committees established to perform such functions.

11.7 VOTING

Except as otherwise specified, appointees to a committee shall have voting rights.

11.8 MEDICAL EXECUTIVE COMMITTEE

11.8.1 PURPOSE AND MEETINGS

The Medical Staff delegates authority to the MEC to act for the Medical Staff and to coordinate all activities and policies of the Medical Staff, its clinical services and committees. The MEC reviews professional practices within UMC for the purpose of reducing morbidity and mortality and for the improvement of care of patients provided in the institution. The proceedings, records and materials of the MEC are confidential pursuant to A.R.S. Sections 36-445.01 and 36-445.02. It shall meet at least monthly and communicate to the clinical services and chiefs and/or Medical Staff members as appropriate.

With assistance from the Chief of Staff, the Medical Executive Committee shall:

11.8.1.1 Supervise the performance of all Medical Staff functions, which shall include:

- (1) Requiring regular reports and recommendations from the Medical Staff Officers, UMC Administrators, Clinical Services and Committees concerning discharge of assigned functions;
- (2) Issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and follow up to assure implementation of all directives;
- (3) Coordinating the activities of the Committees and Clinical Services;
- (4) Based upon input from the Clinical Service and Credentials Committee after their review and comment of delineated clinical privileges for each eligible applicant, making recommendations regarding all applications for Medical Staff or AHP appointment, reappointment and clinical privileges;
- (5) When indicated, initiating and/or pursuing disciplinary or corrective actions affecting Medical Staff members or AHPs.
- (6) With the Clinical Services, establishing, maintaining, and enforcing professional standards for the continuing improvement of the quality of care provided, and assisting in the development of programs to achieve these objectives within UMC.
- (7) Regularly reporting to the Board through the Chief of Staff and the UMC CEO on at least the following:
 - (a) The outcomes of quality improvement programs with sufficient background and detail to assure the Board that quality of care is consistent with professional standards; and
 - (b) The general status of any Medical Staff or AHP disciplinary or corrective actions in progress.

- (8) Acting on behalf of the Medical Staff in the intervals between medical meetings; and
- (9) Making recommendations to the Board regarding structure of the Medical Staff, the mechanism used to review credentials and to delineate individual clinical privileges, the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities, the mechanism by which membership on the Medical Staff may be terminated, and the mechanism for hearing procedures. (This responsibility may be satisfied by way of Medical Staff Bylaws, and Rules and Regulations addressing these issues.)

11.8.2 ADDITIONAL MEC RESPONSIBILITIES

11.8.2.1 With the assistance of the Chief of Staff, the MEC supervises the Medical Staff's compliance with:

- a. The Medical Staff Bylaws, Rules and Regulations, Code of Conduct, and policies;
- b. UMC's Bylaws, Rules and Regulations, and policies and procedures;
- c. State and Federal laws and regulations; and
- d. Joint Commission accreditation requirements.

11.8.2.2 The MEC oversees the development of Medical Staff Rules and Regulations, communicating such new or amended rules and regulations to the Medical Staff prior to approving them, approving or amending all such Rules and Regulations, and overseeing the implementation of all such Rules and Regulations.

11.8.2.3 When a documented need exists for an urgent amendment to Rules and Regulations to comply with law or regulation, the MEC may provisionally adopt an urgent amendment without prior notification of the Medical Staff and send such urgent amendment to the Board for provisional approval. The MEC shall notify the Medical Staff immediately after provisional approval and afford the Medical Staff an opportunity for retrospective review and comment on the provisional amendment.

11.8.2.4 The MEC oversees the development of any Medical Staff policies, approves or amends all such policies and oversees the implementation of all such policies.

11.8.2.5 The MEC implements, as it relates to the Medical Staff, the approved Rules and Regulations.

11.8.3 COMPOSITION

The MEC shall consist of: The Chief of Staff, the Chief of Staff-Elect, the Immediate Past Chief of Staff, the Secretary-Treasurer, the Chair of the Credentials Committee, the chiefs of each of the clinical services, and four at large members of the Medical Staff. The MEC is chaired by the Chief of Staff, who may invite other Medical Staff members and members of UMC's administrative, nursing or other staff to attend meetings or otherwise assist with carrying out the functions of the committee. The Medical Staff may, by Bylaws amendment, authorize the Chief of Staff to appoint physicians or other practitioners and any other individuals to the MEC.

11.8.4 RECALL OF MEC MEMBERS

11.8.4.1 Any Member of the MEC may be subject to recall based on his or her failure to perform the duties of the office or failure to perform satisfactorily. The procedures for recall of elected MEC members are outlined in Section 9.7.

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

11.8.5 CONFLICT RESOLUTION

11.8.5.1 Any Member of the Medical Staff may challenge a rule, regulation, policy or action of the MEC by submitting to the Chief of Staff written notification of the challenge, with a petition signed by one-third of the members of the Medical Staff and stating the basis for the challenge, including any recommended changes.

11.8.5.2 The MEC will consider the challenge at its next meeting and may determine what changes, if any, will be made to the rule, regulation, policy or action. The MEC may allow the Medical Staff Member or members who initiated the challenge to speak at the meeting. Alternatively, the MEC may appoint an ad hoc committee to review the challenge and recommend potential changes to address the concerns. If the MEC appoints an ad hoc committee, it will review the ad hoc committee's recommendations and take final action on the rule, regulation, policy or action, subject to Board oversight. The MEC will communicate to the Medical Staff any changes made in response to the challenge.

11.9 BIOETHICS COMMITTEE

11.9.1 PURPOSE AND MEETINGS

The Bioethics Committee participates in the development of guidelines for consideration of cases having bioethical implications; development and

implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment of such cases; retrospective review of cases for the evaluation of bioethics policies; consultation with concerned parties to facilitate communication and aid conflict resolution; and education of UMC staff on bioethical matters. the Committee shall also serve as the Infant Care Review Committee (ICRC) under A.R.S. Section 36-2284. the Bioethics Committee meets as often as necessary and reports to the MEC.

11.9.2 COMPOSITION

The Bioethics Committee is an interdisciplinary committee of representatives of UPH Hospital and UMC Hospital. The Bioethics Committee shall include physicians and such other staff members from or affiliated with UPH Hospital and UMC as each hospital may deem appropriate. The Bioethics Committee may include lay representatives, nurses, social workers, clergy, ethicists, attorneys, administrators and representatives from the board of each hospital.

11.10 BLOOD UTILIZATION

11.10.1 PURPOSE AND MEETINGS

The Blood Utilization Committee reviews and evaluates cases in which patients were administered transfusions (including the use of whole blood components) for the purpose of reducing morbidity and mortality and improving the care of patients receiving transfusions. The blood utilization committee develops and approves policies and procedures relating to the distribution, handling, use and administration of blood and blood components; services and the ordering practices for blood products. The Committee shall meet at least quarterly and report to the MEC in accordance with a biennial blood plan and the blood peer review flow chart.

11.10.2 COMPOSITION

The Blood Utilization Committee shall consist of Medical Staff members from oncology, cardiothoracic surgery, emergency medicine, orthopedic surgery, gynecology; and the medical director of the blood bank. A representative from UMC administration and a representative from the Department of Quality and Outcomes Management shall be designated to assist the Blood Utilization Committee in carrying out its functions.

11.11 BYLAWS COMMITTEE

11.11.1 PURPOSE AND MEETINGS

The Bylaws Committee reviews the UMC Medical Staff Bylaws and may recommend Bylaws amendments to the MEC for consideration in accordance with Article XVI of these Bylaws. The Bylaws Committee shall meet at least once annually.

11.11.2 COMPOSITION

The Bylaws Committee shall consist of the Chief of Staff, the Immediate Past Chief of Staff, the Chair of the Credentials Committee or his or her designee, who also must be a Member of the Credentials Committee, the Chief Medical Officer and at least one other Member, chosen by the Chief of Staff, who has been a Member of the Active Staff for at least four consecutive years.

11.12 CODE BLUE COMMITTEE

11.12.1 PURPOSE AND MEETINGS

The Code Blue Committee is responsible for monitoring and evaluating the effectiveness of the Code Blue Response Team. The Committee meets at least quarterly and reports to the MEC.

11.12.2 COMPOSITION

The Code Blue Committee shall consist of Medical Staff members as well as representatives from Pharmacy Services, Information Systems Services, Patient Care Services, and Respiratory Services.

11.13 CREDENTIALS COMMITTEE

11.13.1 PURPOSE AND MEETINGS

The Credentials Committee reviews and evaluates each practitioner's Medical Staff appointment, reappointment, or clinical privileges, and makes recommendations to the MEC regarding acceptance, denial, modification or other action. In addition, the committee reviews forms and recommends protocol for the credentialing process, reviews proposed standards for clinical privileges to ensure one level of care at UMC, and serves as an impartial body to resolve interdisciplinary credentialing issues. Credentials Committee meetings are scheduled on a monthly basis and cancelled when there is no business to conduct.

11.13.2 COMPOSITION

The Credentials Committee shall consist of twelve members elected by the Medical Staff, one of whom shall represent the Outpatient Clinics. There shall be no more than two representatives from any clinical service. Clinical service chiefs shall be ineligible to serve on this committee. The chair shall be elected by the Medical Staff and a vice chair will be appointed by the Chief of Staff. The chair shall be a Member of the MEC.

11.14 INFECTION PREVENTION COMMITTEE

11.14.1 PURPOSE AND MEETINGS

The Infection Prevention Committee shall meet at least bi-monthly. In recognition of the importance of infection control to the reduction of morbidity and mortality at UMC, the duties of the Infection Prevention Committee shall include:

- 11.14.1.1 Developing a UMC-wide infection control program and maintaining surveillance over the program;
- 11.14.1.2 Developing a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;
- 11.14.1.3 Developing and implementing a preventive and corrective program designed to minimize infection control hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;
- 11.14.1.4 Developing written policies defining special indications for isolation requirements;
- 11.14.1.5 Coordinating action on findings from the Medical Staff's review of the clinical use of antibiotics;
- 11.14.1.6 Acting upon recommendations related to infection control received from the Chief of Staff, the MEC, clinical services and other committees;
- 11.14.1.7 Reviewing sensitivities of organisms specific to the facility; and
- 11.14.1.8 In situations where there is reasonably felt to exist an infectious hazard for patients or personnel, the committee, through its chairman or physician members, has the authority to institute any control measures, consultations, or studies appropriate to the circumstance.

11.14.2 COMPOSITION

The Infection Prevention Committee shall consist of at least five members including medical staff representatives from Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, and Pathology. Representatives from patient care services, and UMC Administration, and an individual employed in a surveillance or epidemiological capacity shall be designated to assist the Infection Prevention Committee in carrying out its functions. The committee chair may call upon consultants in microbiology and representatives from relevant UMC departments to assist the committee.

11.15 JOINT CONFERENCE COMMITTEE

11.15.1 PURPOSE AND MEETINGS

The Joint Conference Committee shall constitute a forum for collaboration on matters referred by the MEC or by the Board and exercise other responsibilities set forth in these Bylaws. The committee shall meet at the request of the Chief of Staff or chairman of the Board, and shall transmit written reports of its activities to the MEC and the Board.

11.15.2 COMPOSITION

The Joint Conference Committee shall consist of four members of the Board appointed by the Board Chair, the Chief of Staff, the Chief of Staff-Elect, the Immediate Past Chief of Staff, and one other Member of the MEC appointed by the Chief of Staff. The CEO shall be a non-voting, Ex Officio Member. The chairmanship of the committee shall alternate annually between the Board and the Medical Staff.

11.16 MEDICAL STAFF APPEALS COMMITTEE

11.16.1 PURPOSE AND MEETINGS

The Medical Staff Appeals Committee hears appeals by any Member of the Medical Staff who has completed a hearing in accordance with the procedures set forth in Article VIII of these Bylaws. The first meeting of the committee shall be called by the Chief of Staff and the committee shall elect a chair and vice-chair. The committee may not convene to consider an appeal with fewer than one-half of the members present and no substitution of members may occur while a case is in progress. No committee Member shall participate in an appeal if he or she is in direct economic competition with the affected Medical Staff Member or if he or she has participated in any proceedings in the matter prior to the appeal.

11.16.2 COMPOSITION

The Medical Staff Appeals Committee shall consist of a Member of the active Medical Staff from each of the clinical services. No Member of the MEC may serve on the Medical Staff Appeals Committee. Each clinical service shall elect a representative and an alternate.

11.17 MEDICAL STAFF HEARING COMMITTEE

11.17.1 PURPOSE AND MEETINGS

The Medical Staff Hearing Committee shall be convened as set forth in Article VIII of these Bylaws to hear Medical Staff Member challenges to adverse actions taken or recommended against them by the MEC or the Board. The first meeting of the committee shall be called by the Chief of Staff and the committee shall elect a chair. No committee Member shall participate in a hearing if he or she is in direct economic competition with the affected Medical Staff Member or if he or she has participated in any proceedings leading up to the appeal.

11.17.2 COMPOSITION

The Medical Staff Hearing Committee shall consist of seven members of the active Staff who shall be elected by the Medical Staff. Members of the Medical Staff Hearing Committees shall be impartial peers and shall not be members of the MEC or the Medical Staff Appeals Committee.

11.18 MEDICAL STAFF NOMINATING COMMITTEE

11.18.1 PURPOSE AND MEETINGS

The Medical Staff Nominating Committee selects the most qualified Medical Staff members to serve in elected Medical Staff leadership positions. The Committee meets during each election year and prior to any special election to prepare a slate of nominees.

11.18.2 COMPOSITION

The Medical Staff Nominating Committee shall consist of the current Chief of Staff, who shall serve as chair, the Immediate Past Chief of Staff, the Chief of Staff-Elect, and two members chosen by vote of the active Medical Staff. The members selected shall serve as the Medical Staff Nominating Committee for any election during their two-year tenure.

11.19 PERIOPERATIVE SERVICES COMMITTEE

11.19.1 PURPOSE AND MEETINGS

The duties of the Perioperative Services Committee shall include general oversight of the OR, including issues related to access to the OR; reviewing capital equipment requests; evaluating satisfaction of patients and providers; and reviewing care provided for the purpose of reducing morbidity and mortality and improving the quality of care in the OR. The committee meets as often as necessary, but at least quarterly.

11.19.2 COMPOSITION

The Perioperative Services Committee shall consist of the clinical service chief, Anesthesiology Service, or his or her designee; medical director of Perioperative Services; clinical service chief, Surgery Service; and ten additional Medical Staff members designated by the following services or sections: General Surgery, Cardiothoracic Surgery, Vascular Surgery, Orthopedic Surgery; Otolaryngology, Neurosurgery, Urology, Plastic Surgery, Obstetrics and Gynecology, and Organ Transplantation. The Operating Room nursing director and representatives from Patient Care Services, UMC administration and other areas of the UMC may assist the Perioperative Services Committee in carrying out its functions.

11.20 PHARMACY AND THERAPEUTICS COMMITTEE

11.20.1 PURPOSE AND MEETINGS

The Pharmacy and Therapeutics Committee shall review practices at UMC relating to the use of drugs and therapeutics, including:

11.20.1.1 Assisting in the formulation of professional practices and the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters at UMC, including antibiotic usage;

11.20.1.2 Advising the Medical Staff and Pharmacy Services on matters pertaining to the choice of available drugs;

- 11.20.1.3 Making recommendations concerning drugs to be stocked on the nursing unit floors and by other services in patient care areas;
- 11.20.1.4 Periodically developing and reviewing a formulary or drug list for use at UMC;
- 11.20.1.5 Evaluating clinical data concerning new drugs or preparations requested for use at UMC;
- 11.20.1.6 Reviewing non-formulary drug use;
- 11.20.1.7 Maintaining a record of all activities and therapeutics functions and submitting periodic reports and recommendations to the MEC concerning those activities;
- 11.20.1.8 Reviewing drug usage for patient safety, efficacy and cost effectiveness; and
- 11.20.1.9 Reviewing untoward drug reactions including adverse drug events and developing procedures for and content of drug-food counseling.

The committee meets as often as necessary but at least quarterly.

11.20.2 COMPOSITION

The Pharmacy and Therapeutics Committee shall consist of at least four representatives from the Medical Staff and one House Staff Physician. Representatives from Pharmacy Services, Patient Care Services and UMC administration shall be designated to assist the Pharmacy and Therapeutics Committee in carrying out its functions.

11.21 PHYSICIAN WELL-BEING COMMITTEE

11.21.1 PURPOSE AND MEETINGS

The Physician Well-Being Committee may receive reports from any source related to the health, well-being, or impairment of Medical Staff members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual Medical Staff members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. All such activities shall be confidential pursuant to A.R.S. Sections 36-445.01 and 36-445.02. In the event information received by the committee clearly demonstrates that a Medical Staff Member's condition has adversely or may adversely affect the safety of patients or quality of care delivered at UMC, that information shall be referred immediately to the MEC for corrective action. The committee shall also consider general matters related to the health and well-being of the Medical Staff and, with the approval of the MEC, develop educational programs and related activities.

The Committee shall comply with the requirements of A.R.S. Section 32-1451 to report certain information to the Arizona Medical Board. The committee is

empowered to co-opt such members as may be required to investigate individual incidents.

11.21.2 COMPOSITION

The Physician Well-Being Committee shall consist of no less than three members of the Medical Staff. Insofar as possible, members of the committee shall not serve as active participants on other peer review or quality assessment committees while serving on this committee.

11.22 QUALITY REVIEW COMMITTEE

11.22.1 PURPOSE AND MEETINGS

The purpose of the Quality Review Committee is to review professional practices in UMC for the purpose of reducing morbidity and mortality and improving the quality of care delivered at UMC. It evaluates the quality of patient care provided by individuals with clinical privileges following protocol approved by the MEC. The committee may review the professional practices of licensed professionals in addition to physicians, including nurses and allied health professionals. It works closely with other committees, clinical services and sections, unit medical directors, UMC departments to coordinate quality of care issues throughout UMC. It evaluates and attempts to find solutions to systems problems that cross UMC departments. Deliberations of the committee are confidential and protected from disclosure under A.R.S. Sections 36-445.01 and 36-445.02. The committee may recommend corrective action to the MEC and UMC. The committee reports to the MEC and aggregate reports are provided to the Quality and Safety Board and the Board.

11.22.2 COMPOSITION

The Quality Review Committee shall consist of the Chief of Staff, Chief of Staff-Elect, and at least four other Medical Staff members appointed by the Chief of Staff. The committee is chaired by the Chief of Staff-Elect who may invite other Medical Staff members and members of UMC's administrative, nursing or other staff to attend meetings or perform other tasks to assist with carrying out the functions of the committee.

11.23 SUPPORT/COOPERATIVE ACTIVITIES

The MEC and any standing or other committee of the Medical Staff may, in conjunction with, and as a part of its activities, enlist the assistance of UMC personnel and resources and may undertake the foregoing, as appropriate, as part of joint or cooperative undertaking with other individuals and parties.

11.24 MEDICAL STAFF RELATIONSHIPS

11.24.1 MEDICAL STAFF SERVICES OFFICE

The Chief of Staff shall have involvement in the hiring and evaluation of qualified medical staff services professionals who shall report to him or her in matters relating to medical staff responsibilities.

11.24.2 INSTITUTIONAL REVIEW BOARD

All investigational studies, research projects, or clinical trials conducted on patients must be approved by the Institutional Review Board of the University of Arizona, which serves as the institutional Review Board for UMC. The Institutional Review Board is responsible for ensuring that the rules and regulations of the federal office for protection from research related risk are followed.

11.24.3 GRADUATE MEDICAL EDUCATION OFFICE

The Graduate Medical Education Office of the Arizona Health Sciences Center is responsible for verifying the education, training, and professional liability insurance of house staff physicians in programs conducted by the University of Arizona College of Medicine; registering them with the Arizona Medical Board; ensuring that they meet the hospital's health screening requirements; and maintaining semi-annual house staff physician evaluations.

11.24.4 CONTINUING MEDICAL EDUCATION OFFICE

Support for the continuing professional development of physicians and other health professionals is provided by the Continuing Medical Education Office of the University of Arizona College of Medicine.

11.24.5 ARIZONA HEALTH SCIENCES CENTER LIBRARY

The Arizona Health Sciences Center Library serves as the medical library for UMC. It offers in-library and remote on-line search capabilities for library materials on several health-related databases. The Library is a participant in the National Library of Medicine's regional medical library system, supporting an extensive interlibrary loan and referral system. The Library is open twenty-four hours a day, seven days a week, and all Arizona physicians are eligible for borrowing privileges.

11.25 SUPPORT/COOPERATIVE ACTIVITIES

The MEC and any standing or other committee of the Medical Staff may, in conjunction with, and as a part of its activities, enlist the assistance of UMC personnel and resources and may undertake the foregoing, as appropriate, as part of joint or cooperative undertaking with other individuals and parties.

11.26 PEER REVIEW CONFIDENTIALITY

The Medical Staff intends that all activities performed by any committee set forth in this Article which fall within the scope of peer review protections under A.R.S. Sections 36-445.01 and 36-445.02 and the Health Care Quality Improvement Act are confidential and subject to all the immunities provided by state and federal law and regulation.

ARTICLE XII

MEETINGS

12.1 GENERAL MEDICAL STAFF MEETINGS

12.1.1 REGULAR MEETINGS

There shall be at least one meeting of the Medical Staff during each Medical Staff year. Three additional meetings shall be tentatively scheduled during the year and cancelled if there is no business to conduct. The date, place, and time of the meeting(s) shall be determined by the Chief of Staff, and adequate notice shall be given to the members. No business shall be transacted at any Medical Staff meeting except that stated in the notice calling the meeting.

12.1.2 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, the MEC, or upon the written request of ten percent of the active Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting will be scheduled by the MEC within thirty days after receipt of such request. No later than ten days prior to the meeting, notice shall be mailed or delivered to the members of the Staff which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.1.3 ORDER OF BUSINESS

At each general meeting, the Chief of Staff shall present a report on significant actions taken by the MEC during the time since the last Medical Staff meeting and on other matters believed to be of interest and value to the membership.

12.1.4 QUORUM

Unless otherwise specified in the Bylaws, twenty-five percent of the total qualified voting members of the active Medical Staff at any regular or special meeting in person or through written ballot shall constitute a quorum for the transaction of any business under these Bylaws.

12.2 COMMITTEE MEETINGS

12.2.1 Except as otherwise specified in these Bylaws, committees may establish the times for the holding of regular meetings.

12.2.2 A special meeting of any committee may be called by the chair or the MEC, the Chief of Staff, or by written request of twenty-five percent of the current members of the committee.

12.2.3 Chairs of committees shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

12.2.4 A quorum of fifty percent of the voting members shall be required for committee meetings, but in no event less than three voting members.

12.3 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present, shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws. Committee action may be conducted by telephone conference which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken which is signed by at least two-thirds of the members entitled to vote.

12.4 MINUTES

Minutes of meetings shall document conclusions, recommendations, actions, and follow-up. The minutes shall be signed by the presiding officer, and a permanent file maintained.

12.5 ATTENDANCE REQUIREMENTS

Medical Staff members are encouraged to attend Medical Staff and committee meetings.

12.6 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to the most recent edition of Sturgis' Code of Parliamentary Procedure; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

12.7 SPECIAL APPEARANCE

A committee, at its discretion, may require the appearance of a Member during a review of the clinical course of treatment regarding a patient. If possible, the chair of the meeting should give the Member at least ten days' advance notice of the time and place of the meeting. In addition, whenever an appearance is requested because of an apparent or suspected deviation from standard clinical practice, specific notice shall be given and shall include a statement of the issue involved and that the Member's appearance is mandatory.

ARTICLE XIII

CREDENTIALING OF ALLIED HEALTH PROFESSIONALS

13.1 DETERMINATION OF ALLIED HEALTH PROFESSIONAL STATUS

The Board shall determine the categories of allied health practitioners (AHPs) eligible to practice at UMC.

13.2 PROFESSIONAL LIABILITY INSURANCE

AHPs must maintain professional liability insurance of not less than \$1M/\$1M.

13.3 RESPONSIBILITIES

AHPs are not eligible for Medical Staff membership but as members of the Allied Health Staff are subject to the applicable provisions of the Bylaws, Rules and Regulations and Code of Conduct, and UMC's policies and procedures and performance improvement program.

13.4 ACTIVITIES CONCERNING ALLIED HEALTH PROFESSIONALS

Activities of UMC, the Board, any standing or ad hoc clinical services and sections, and those who may assist them or to whom they report, in connection with the review of AHP professional practices at UMC for the purposes of reducing morbidity and mortality and improving patient care are peer review activities within the scope and context of A.R.S. Sections 36-445.01 and 36-445.02 and the Health Care Quality Improvement Act.

13.5 CREDENTIALING/PRIVILEGING PROCESS

13.5.1 CATEGORIES

The following categories of AHPs shall be eligible for clinical privileges but subject to the supervision requirements as required by law and UMC policy. Employees of UMC and contract employees in these categories shall also be subject to this process.

Nurse Practitioners
Physician Assistants
Certified Registered Nurse Anesthetists

13.5.2 QUALIFICATIONS

Only an AHP holding a current active license, certificate or such other credentials as may be required by applicable state law and UMC policy is eligible to provide specified services. The Board may, in consultation with the MEC, establish additional qualifications for membership or any particular category of AHP.

13.5.3 CLINICAL PRIVILEGES

Written guidelines outlining clinical privileges appropriate for each category of AHP shall be developed by UMC and the MEC with input, where applicable, from the clinical service chief, section chief, or medical director of the clinical service or UMC department involved. AHPs shall be subject to the OPPE, FPPE and focused review provisions of Article VII.

13.5.4 INITIAL CREDENTIALING PROCESS

13.5.4.1 An AHP applying for clinical privileges shall complete an application approved by the MEC which contains the information in Section 4.2 of these Bylaws.

13.5.4.2 The applicant must sign the application and in so doing agrees to the provisions specified in Article IV of these Bylaws, as applicable.

13.5.4.3 The application will be reviewed for completeness and adequacy of information and the data verified.

13.5.4.4 Action on the application shall be the same as set forth in Article IV of these Bylaws, as applicable.

13.5.5 RENEWAL OF CLINICAL PRIVILEGES

The process for renewal of clinical privileges for AHPs shall be the same as set forth in Article VI of these Bylaws, as applicable.

13.6 OTHER ALLIED HEALTH PROFESSIONALS

Health care professionals other than those categories eligible for Medical Staff and Allied Health Staff membership shall be subject to job descriptions and shall be credentialed through the Human Resources Department in accordance with written policies and procedures approved by the Interdisciplinary Practice and Competency Committee (IPCC).

13.7 LIMITATION OR REVOCATION OF APPROVAL

13.7.1 APPEALABLE ACTION

The MEC shall receive and evaluate any reports regarding the clinical performance of an AHP. If the MEC concludes that the performance does not meet expected standards of care, poses a threat to patient well-being, exceeds the scope of the AHP's clinical privileges, impedes the operation of UMC or violates any rules, regulations, policies or procedures the AHP is bound to follow, the MEC may issue a reprimand or may limit, suspend or revoke the clinical privileges of the AHP. The clinical privileges of an AHP also may be revoked, suspended or limited by the Chief of Staff. The MEC shall provide Special Notice to an AHP of any such action. The AHP and his or her supervising or collaborating physician shall be given written notice of any adverse action taken under this section. Denial of clinical privileges or limitation, suspension or revocation of clinical privileges shall constitute appealable actions, and shall be effective immediately or as otherwise set forth in the written notice to the AHP, and may be appealed by the AHP as set forth in this Article. Any such appealable action, which is not appealed in a timely manner under this Article,

shall be final. The hearing and appeal provisions of Article VIII shall not apply to AHPs.

13.8 ACTION WITHOUT APPEAL

If an AHP's supervising or collaborating physician loses his or her clinical privileges pertaining to approved activities of the AHP, resigns his or her status as the supervising or collaborating physician of the AHP, or resigns from the Medical Staff, the AHP's authorization will terminate without right of appeal, unless and except to the extent that, prior to such loss or resignation, a qualified supervising or collaborating physician for such AHP replaces the supervising or collaborating physician who is the subject of the loss or resignation. If an AHP loses his or her license, the AHP's approved activities dependent upon such license will automatically terminate without right to appeal. If and while an AHP does not have professional liability insurance at the level required by Section 13.3, the AHP's clinical privileges shall be suspended automatically without appeal until the required coverage is replaced without interruption or gaps in coverage.

13.9 APPEAL PROCEDURE

13.9.1 NATURE OF APPEAL

An AHP with respect to whom an appealable action has been taken shall have fourteen calendar days from the date of written notice of the appealable action to the AHP to file a written notice of appeal with the Chief of Staff. Failure to file a timely written notice of appeal shall constitute a waiver and an acceptance of the appealable action. An appeal from an appealable action may be taken only by the AHP and may not be taken by his or her supervising or collaborating physician, employer or any other party.

13.9.2 AD HOC APPEAL COMMITTEE

When a timely appeal is filed, the Chief of Staff shall appoint a three-member ad hoc committee to investigate and decide the matter. Medical Staff members and AHPs are eligible to serve on an Ad Hoc Appeal Committee in the discretion of the Chief of Staff.

13.9.3 ACTION OF AD HOC COMMITTEE

Within thirty days after the Ad Hoc Appeal Committee has completed its deliberations in the matter, it shall forward its decision and a report on its investigation to the MEC. Prior to the issuance of the report, the AHP and his or her supervising or collaborating physician shall have an opportunity for an interview with the Ad Hoc Appeal Committee. At the interview, the AHP shall be invited to discuss, explain or refute the charges made. A record of the interview shall be made by the Ad Hoc Appeal Committee and included with its report to the MEC.

If, after conclusion of the appeal process, an AHP's clinical privileges are restricted, terminated or suspended, the AHP's licensing board will be notified by UMC pursuant to the licensing board's requirements. If an AHP waives his or her right to the appeal process, notification may be made at that time.

ARTICLE XIV

HOUSE STAFF PHYSICIANS

14.1 DEFINITION

A House Staff Physician is a resident or fellow who is enrolled in a training program affiliated with UMC. House Staff Physicians are not Medical or Allied Health Staff members and do not serve on Medical Staff committees or vote in Medical Staff elections.

14.2 QUALIFICATIONS

The House Staff Physician meets the qualifications for resident eligibility outlined in the Essentials of Accredited Residencies in Graduate Medical Education in the American Medical Association Graduate Medical Education Directory or the qualifications of other graduate medical education programs whose House Staff are covered by an affiliation agreement with UMC.

14.3 COMPETENCE

As the position of House Staff Physician involves a combination of supervised, progressively more complex and independent patient evaluation and management functions and formal education activities, the program evaluates on a regular basis the competence of House Staff Physicians. The program maintains a confidential record of each evaluation.

14.4 SUPERVISION

The position of House Staff Physician entails provision of care commensurate with the House Staff Physician's level of advancement and competence, under the general supervision of appropriately privileged Medical Staff members.

ARTICLE XV

CONFIDENTIALITY, IMMUNITY AND RELEASES

15.1 AUTHORIZATION AND CONSENT

By applying for membership, reappointment and/or clinical privileges within UMC, each applicant, Medical Staff Member and AHP agrees to the provisions of Section 4.3 and:

- 15.1.1 Authorizes representatives of UMC and the Medical Staff to request information reasonably believed to bear upon an applicant's, Medical Staff Member's or AHP's professional ability and qualifications, clinical abilities, judgment, character, physical or mental health, emotional stability, professional ethics or the applicant's, Member's or AHP's conduct at UMC;
- 15.1.2 Authorizes persons and organizations to provide information to the Medical Staff concerning such practitioner;
- 15.1.3 Agrees to be bound by these Bylaws and specifically by the provisions of this Article to waive all legal claims against any representative of the Medical Staff, its members and representatives and against UMC, its employees, agents, officers or directors, who act in accordance with the provisions of these Bylaws;
- 15.1.4 Acknowledges that the provisions of these Bylaws are express conditions to the application for Medical Staff membership or reappointment, the continuation of such membership, and to the exercise of clinical privileges at UMC;
- 15.1.5 Consents to participation in the ongoing peer review and quality assessment processes at UMC, and understands that an effective peer review and quality assessment process may necessitate consideration of confidential information pertaining to activities at other hospitals or health care entities; authorizes UMC to obtain or provide such information when appropriate; and agrees to hold other hospitals or health care entities, including their staff, employees and any representatives, harmless for providing, requesting or obtaining such information to the fullest extent of the law.

15.2 CONFIDENTIALITY OF INFORMATION

15.2.1 GENERAL

Medical Staff, service, section, and committee minutes, files, and records, including information regarding any Medical Staff member, applicant or AHP shall, to the fullest extent permitted by law, be confidential.

15.2.2 BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review, including consideration of the qualifications of Medical Staff members, AHPs and applicants to perform specific procedures, must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff services, sections, or committees, in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff and for AHPs and will be deemed

disruptive to the operations of UMC. If it is determined that such a breach has occurred, the MEC may undertake such corrective action as it deems appropriate.

15.3 IMMUNITY FROM LIABILITY

15.3.1 FOR ACTION TAKEN

By applying for membership or reappointment and/or exercising clinical privileges, each applicant, AHP and Member waives any claim against, and releases from all liability, each Member of the Medical Staff, all UMC employees, officers, directors and agents, to the fullest extent permitted by law, for damages or other relief for any action taken or statements or recommendations made within the scope of his or her duties as a Member or representative of the Medical Staff or UMC.

15.3.2 FOR PROVIDING INFORMATION

By applying for membership or reappointment and/or exercising clinical privileges, each applicant, AHP and Member of the Medical Staff agrees that all employees, officers, directors or agents of UMC and related third parties shall be exempt, to the fullest extent permitted by law, from damages or other relief by reason of providing information to a representative of the Medical Staff or UMC concerning such applicant, AHP or Member.

15.4 ACTIVITIES AND INFORMATION COVERED

15.4.1 ACTIVITIES

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations 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:

15.4.1.1 Applications for appointment, reappointment, or clinical privileges;

15.4.1.2 Investigation and corrective action;

15.4.1.3 Hearings and appellate reviews;

15.4.1.4 Focused and ongoing professional practice reviews;

15.4.1.5 Utilization reviews;

15.4.1.6 Peer review organizations, Board of Medical Examiners and similar reports;

15.4.1.7 Claims reviews;

15.4.1.8 Malpractice loss prevention; and

15.4.1.9 All other UMC, service, or section, committee, or Medical Staff activities related to activities undertaken for the purposes of reducing morbidity and mortality and improving patient care, including but not limited to monitoring

and maintaining or improving the quality of patient care and appropriate professional conduct.

15.4.2 THIRD PARTY INVOLVEMENT

The Medical Staff may, without breaching any obligations of confidentiality, enlist the assistance of third parties and may delegate to third parties all or any part of any one or more of the activities described in Article 10.4.1 and may enter into cooperative arrangements and share information with other hospitals or health care entities for that purpose.

15.5 RELEASES

Each applicant, AHP or Member shall, upon request of the Medical Staff or UMC, execute general and specific releases in accordance with the express provisions and general intent of this article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

15.6 CUMULATIVE EFFECT

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 law and not in limitation thereof.

ARTICLE XVI

AMENDMENT OF BYLAWS, AND RULES AND REGULATIONS

16.1 AMENDMENT

Upon the request of the Chief of Staff, the MEC, or upon timely written petition signed by at least ten percent of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, or repeal of these Bylaws, and Rules and Regulations. Proposed changes shall be presented for discussion at a meeting of the MEC and two regular or special meetings of the Medical Staff. Special Notice shall be sent to all voting members at least fourteen days prior to the meetings stating the exact wording of the existing language, if any, and the proposed change(s).

16.2 ACTION ON PROPOSED CHANGES

Voting on proposed Bylaws changes shall be conducted by electronic mail or regular mail. An affirmative vote of two-thirds of the members voting is required for approval.

16.3 APPROVAL

Changes in the Medical Staff Bylaws, and Rules and Regulations adopted by the Medical Staff shall become effective following approval by the Board, which approval shall not be withheld unreasonably. Neither the Board of Directors nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.

16.4 MEDICAL STAFF RULES & REGULATIONS

The Medical Staff Rules and Regulations shall implement more specifically the general principles found within these Bylaws with regard to both the Medical Staff and the Allied Health Staff. The Medical Staff Rules and Regulations may be revised and amended by approval of the MEC and the Board. Revisions to these documents do not require a vote of the active Medical Staff.

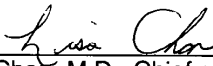
16.5 EXCLUSIVITY

The mechanism described herein shall be the sole method for the amendment or repeal of the Medical Staff Bylaws, and Rules and Regulations.

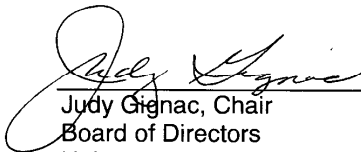
16.6 FREQUENCY OF REVIEW

The Medical Staff Bylaws, and Rules and Regulations shall be reviewed at least annually and revised as necessary.

Bylaws revised and restated January 27, 2011.



Lisa Chan, M.D., Chief of Staff
University Medical Center Corporation



Judy Gignac, Chair
Board of Directors
University Medical Center Corporation

RULES AND REGULATIONS OF THE MEDICAL STAFF
OF UNIVERSITY MEDICAL CENTER

SECTION ONE

ADMISSION, DISCHARGE AND TRANSFER;
HISTORY AND PHYSICAL EXAMINATIONS

1.1 ATTENDING PHYSICIAN

Each inpatient shall have an attending who is either a physician Member of the Medical Staff or a certified nurse midwife with appropriate inpatient attending Privileges. The attending shall remain the attending unless and until a written order is entered on the chart transferring the patient to another physician Member or certified nurse midwife who has appropriate inpatient attending Privileges and has agreed to assume responsibility for the patient.

The attending physician or certified nurse midwife may be assisted by Housestaff Physicians in caring for a patient, but the attending physician or certified nurse midwife shall be responsible for the care of the patient.

A patient admitted for inpatient care shall have a medical history taken and an appropriate physical examination performed by a qualified physician or other independent practitioner who has been granted such privileges. Podiatrists or dentists arranging an admission shall be responsible for documenting an assessment of the reason for admission from the perspective of his or her professional discipline and for management of the admitting problem(s) and clinical activity shall be restricted thereto. The podiatrist or dentist shall arrange for a history and physical to be performed by a practitioner eligible to do so. Qualified oral surgeons who have been granted the Privilege may perform histories and physical examinations on their own patients to include assessing medical, surgical and anesthetic risks of the proposed operation or other procedure. A Staff physician shall be responsible for the management of the medical problem not within the Clinical Privileges of the podiatrist, oral surgeon, or certified nurse midwife. Podiatrists, dentists and certified nurse midwives must have a qualified physician endorse their findings, conclusions, and assessments prior to high-risk procedures. A high-risk procedure is one that is experimental or highly specialized in which there is a significant possibility of loss of limb, organ or life.

1.2 REQUIRED INFORMATION

The admitting physician will provide any available information necessary to protect other patients and staff.

1.3 ADMISSION AND DISCHARGE TIMES

1.3.1 Patients scheduled for admission to the Hospital should be requested to report to the admitting area on the day of their admission.

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1.3.2 Same day surgery patients should report directly to the Ambulatory Surgery Department.

- 1.3.3 All emergency direct admissions will be registered as they occur.
- 1.3.4 All discharges should be scheduled to occur prior to 11:00 a.m.
- 1.3.5 When adherence to these times is not appropriate for medical reasons, registration will be notified and take appropriate action concerning additional room charges.

1.4 CONTROL OF ADMISSION, DISCHARGE AND TRANSFER

The policies and procedures governing admission, discharge, transfer, and triage shall be followed. Members who want to transfer a patient for admission to the Hospital must ensure that a bed is available to accommodate the patient and there is an accepting attending physician before the transfer is accepted. For non-emergency patients only, a financial clearance must be completed.

SECTION TWO

MEDICAL RECORD

"Medical Records" means all communications that are recorded in any form or medium and that are maintained for purposes of patient treatment, including reports, notes and orders, test results, diagnoses, treatments, photographs, videotapes, x-rays, billing records and the results of independent medical examinations that describe patient care. Medical records include psychological records and all medical records held by a health care provider, including medical records that are prepared by other providers. Medical records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities, including records that a health care provider prepares pursuant to Section 36-441, 36-445, or 36-2402 of the Arizona Revised Statutes. Medical records do not include recorded telephone and radio calls to and from a publicly operated emergency dispatch office relating to requests for emergency services or reports of suspected criminal activity, but shall include communications between emergency medical personnel and medical personnel concerning the treatment of a person.

2.1 PURPOSES OF THE MEDICAL RECORD

- 2.1.1 To serve as a basis for planning patient care and for continuity in the patient's condition and treatment;
- 2.1.2 To provide documentation of the course of the patient's medical evaluation, treatment, patient's response to treatment, and change in condition during the Hospital stay, or during ambulatory care or an emergency visit to the Hospital;
- 2.1.3 To document communication between the responsible practitioner and any other health professional contributing to the patient's care;
- 2.1.4 To provide sufficient detail to allow another practitioner to assume the care of the patient at any time;
- 2.1.5 To assist in protecting the legal interest of the patient, the Hospital, and the responsible practitioner;
- 2.1.6 To provide data for use in continuing education and research;

- 2.1.7 To supply pertinent information required for utilization review and quality assessment activities; and
- 2.1.8 To serve as an information base for developing and substantiating the billing and claim for payment of charges, either on a prospective or retrospective basis.

2.2 CUSTODY OF MEDICAL RECORD

The medical record, paper based or electronic, is the property of the Hospital and is maintained by Health Information Management and Information Systems Services, respectively, for the benefit of the patient, the Medical Staff, the Hospital and pursuant to contract and an organized health care arrangement (OHCA), to University Physicians Healthcare, Inc. and the Board of Regents on behalf of the University of Arizona College of Medicine. The medical record may be removed from the Hospital's premises only in accordance with a valid court order, subpoena or statute. All subpoenas issued to University Medical Center must be referred to Health Information Management for response.

2.3 CONTENT OF MEDICAL RECORD

2.3.1 All inpatient medical records shall contain the following:

2.3.1.1 Patient identification data and registration documents

2.3.1.2 Medical history of the patient including medication, food and environmental allergies:

2.3.1.2.1 Chief complaint;

2.3.1.2.2 Details of present illness;

2.3.1.2.3 Relevant past, social and family histories; and

2.3.1.2.4 An inventory by body system.

2.3.1.3 Initial assessment:

2.3.1.3.1 Physical examination;

2.3.1.3.2 Psychological status;

2.3.1.3.3 Social status; and

2.3.1.3.4 Learning needs related to diagnosis and treatment.

2.3.1.4 Assessments for specific patient populations:

2.3.1.4.1 Infants, children and adolescents;

- a. Developmental age, length or height, head circumference, and weight (as appropriate);

- b. Consideration of educational needs and daily activities as appropriate to age and length of stay;
 - c. Immunization status; and family/ guardian
 - d. Expectations for and involvement in the assessment, initial treatment, and continuing care.
- 2.3.1.4.2 Victims of alleged or suspected abuse or neglect, including domestic violence:
 - a. Assessment is conducted with consent of patient or legal guardian, or as otherwise provided by law, and
 - b. In accordance with the Hospital's responsibility for the collection, retention, and safeguarding of evidentiary material released by the patient and includes as legally required, the notification and release of information to the proper authorities.
- 2.3.1.5 Conclusions/impressions from the admission history and physical;
- 2.3.1.6 Goals of treatment and the treatment plan;
- 2.3.1.7 Diagnostic and therapeutic orders;
- 2.3.1.7 Evidence of informing the patient of advance directives and whether the patient has one and provided it to the Hospital;
- 2.3.1.8 Evidence of appropriate informed consent, with required signatures;
- 2.3.1.9 Reports of procedures, tests and their results, with required signatures
- 2.3.1.10 Operative reports of patients undergoing operative or other anesthesia shall include the findings, the technical procedures used, estimated blood loss, the specimen(s) removed and disposition of each specimen, the postoperative diagnosis, and the name of the primary surgeon and any assistants.
- 2.3.1.11 Clinical observations (including results of therapy):
- 2.3.1.12 Consultation reports, if applicable;
- 2.3.1.13 Progress notes;
- 2.3.1.14 Discharge/death summary
 - 2.3.1.14.1 The discharge summary shall be dictated or written on an approved form on the day of discharge and signed by the attending physician.
 - 2.3.1.14.2 The discharge summary shall include

- a. The reason for hospitalization;
- b. Significant findings;
- c. Procedures performed and treatment rendered;
- d. Condition at discharge; and
- e. Discharge instructions.

2.3.2 Emergency Care

2.3.2.1 The medical record of a patient receiving emergency, urgent or immediate care notes the conclusions at termination of treatment, including final disposition, condition at discharge, and instructions for follow-up care.

2.3.2.2 The medical record notes when a patient receiving emergency, urgent, or immediate care left against medical advice.

2.3.3 Hospital Based Ambulatory Surgery and Other Ambulatory Procedure Records

2.3.3.1 Records for ambulatory surgery and other ambulatory procedures (endoscopy, interventional radiology, cardiac catheterization and other invasive procedures) shall contain the following:

2.3.3.1.1 Documentation of chief complaint and details of present illness;

2.3.3.1.2 Relevant past history (personal, family or social);

2.3.3.1.3 Inventory by body system;

2.3.3.1.4 Physical exam;

2.3.3.1.5 Psychosocial status and social status; pain assessment;

2.3.3.1.6 Assessments for pediatric patients, including developmental age, length or height, head circumference and weight (as appropriate); consideration of educational activities as appropriate to age; immunization status; and family/guardian expectations for involvement in the assessment, initial treatment and continuing care;

2.3.3.1.7 Conclusions/impressions from medical history and physical exam;

2.3.3.1.8 Goals of treatment and treatment plan or diagnostic workup;

2.3.3.1.9 Evidence of appropriate informed consent;

2.3.3.1.10 Report of procedure describing the pre-operative diagnosis, technical procedures used, findings, specimens removed, postoperative diagnosis and the name of the primary surgeon and any assistants; and

2.3.3.1.11 Condition of patient at discharge.

2.3.4 Ambulatory Care Services (Medical Offices)

2.3.4.1 For patients receiving continuing ambulatory care services, the medical record contains a summary list of known significant diagnoses, conditions, procedures, drug allergies, and medications. The list is initiated for each patient by the third visit and maintained thereafter.

2.3.4.2 All medical office records shall include:

2.3.4.2.1 An appropriate data base when care is established and when condition changes;

2.3.4.2.2 Documentation of each visit describing the reason for the visit and treatment plan, completed on the date of service or within a specified time frame;

2.3.4.2.3 Reassessment occurring during follow-up appointments should document patient status, including any unresolved health issues, and effectiveness of any medications; if appropriate;

2.3.4.2.4 Assessments for pediatric patients, including developmental age, length or height, head circumference and weight (as appropriate); consideration of educational needs and daily activities as appropriate for age; immunization status; and family/guardian expectations for and involvement in the assessment, initial treatment and continuing care;

2.3.4.2.5 Evidence of appropriate informed consent for procedures; and

2.3.4.2.6 Documentation of procedures performed including, as applicable, findings, techniques, and specimen removed.

2.4 DOCUMENTATION IN THE MEDICAL RECORD

All medical record documentation shall be dated, timed, recorded via black or dark blue pen, or machine printed and signed by the author; or entered electronically in compliance with UMC's policies on electronic systems. The signature of every Medical Staff Member, Housestaff Physician and AHP shall be accompanied by a unique number to be valid unless the name is machine printed. Use of a signature stamp is not permitted; however, a stamp with a printed name may be used to supplement a signature.

2.4.1 Individuals Authorized to Document in the Medical Record

- 2.4.1.1 Members of the UMC Medical Staff as designated in the Medical Staff Bylaws;
- 2.4.1.2 Members of physician training programs;
- 2.4.1.3 University of Arizona medical, nursing and pharmacy students when on approved rotations;
- 2.4.1.4 Health professional and technical staff licensed or registered by the State of Arizona (employed or approved through a credentialing process);
- 2.4.1.5 Health professional and technical students participating in approved on-site training programs; and
- 2.4.1.6 Members of the UMC pastoral care staff.

Other individuals having a need to communicate with the above-authorized caregivers may do so by phone or by placing a note with patient name and UMC medical record number on their agency's letterhead or form. Such information will be filed with referral data.

2.4.2 Progress Notes

Progress notes shall document the management plan for the patient, give a pertinent chronological report of the patient's course in the Hospital, ambulatory care service or physician office, reflect any change in condition and the results of treatment, and include a discharge plan when appropriate. There shall be a signed note by the attending physician within 24 hours of admission and daily thereafter.

2.4.3 Supervision of Housestaff Physicians, Allied Health Professionals, and Other Authorized Health Professionals

History and physical examinations performed by Housestaff Physicians or AHPs (with the exception of certified nurse midwives) shall be countersigned by an attending physician or the medical record shall contain a progress note by an attending physician which comments on the history and physical within 24 hours of admission.

Progress notes shall reflect collaboration between the supervising physician and Housestaff Physicians, AHPs, and other authorized health professionals as appropriate. Dictated operative and invasive procedure notes and dictated or handwritten discharge summaries shall be signed by the responsible attending physician.

2.5 REPORTS OF PROCEDURES, TESTS AND THE RESULTS

- 2.5.1 All diagnostic and therapeutic procedures shall be recorded and authenticated in the medical record. This may also include any reports from facilities outside of the hospital, in which case the source facility shall be identified in the report.

- 2.5.2 The attending physician shall record or authenticate a preoperative diagnosis, a plan for the procedure, and a plan for the postoperative level of care, prior to surgery.
- 2.5.3 Immediately following surgery, and prior to a change in the level of care, a handwritten procedure note will be documented in the progress notes and an operative report dictated.
- 2.5.4 An operative report shall be completed within 24 hours after the procedure and signed by the attending physician.
- 2.5.5 All tissues, implants, medical devices and other foreign objects removed during operations shall be sent to the Hospital pathologist who shall make such examinations as he may consider necessary to arrive at a diagnosis. All reports shall be signed by the pathologist.
- 2.5.6 Reports of pathology and clinical laboratory examinations, anesthesia records, and any other diagnostic or therapeutic procedures shall be completed promptly and filed in the record within 24 hours of completion if possible.
- 2.5.7 When an organ is obtained from a live donor for transplantation purposes, the medical record of the donor and recipient shall fulfill the requirements for any surgical inpatient medical record. When the donor organ is obtained from a patient who is dead by brain criteria (where legally permissible) the medical record of the donor shall include the date and time of death, documentation by and identification of the physician who determined the death, the method of transfer and machine maintenance of the patient for organ donation, as well as an operative report. When a cadaver organ is removed for purposes of donation, there shall be an autopsy report that includes a description of the technique used to remove and preserve the donated organ.

2.6 CONCLUSIONS AND REPORTS AT TERMINATION OF HOSPITALIZATION OR EVALUATION/TREATMENT

- 2.6.1 The discharge summary shall be dictated the day of discharge.
- 2.6.2 The discharge summary shall be signed by the attending physician.
- 2.6.3 The dictated discharge summary shall include:
 - 2.6.3.1 The principal diagnosis; i.e. the diagnosis of the condition established after study to be chiefly responsible for occasioning the admission of the patient to the Hospital for care;
 - 2.6.3.2 All other diagnoses and complications/comorbid conditions established and/or treated by the time of discharge;
 - 2.6.3.3 The principal and other procedures/operations performed;
 - 2.6.3.4 The clinical course of treatment and diagnostic/consultative results;

2.6.3.5 The condition of the patients on discharge and stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague, nonspecific, and relative terminology such as “improved”; and

2.6.3.6 Instructions relating to physical activity, medication, diet, and follow-up care.

2.6.4 A copy of the form “PATIENT DISCHARGE INSTRUCTION AND PLAN” shall be given to each discharged patient or significant other, or legal guardian. Additionally, a copy of the dictated discharge summary and/or other pertinent information may be provided to any known medical practitioner or medical facility responsible for subsequent medical care of the patient.

2.6.5 Authorization to release discharge information shall be by virtue of the signed “CONDITIONS OF TREATMENT” agreement, or by the dictated discharge summary or completed “PATIENT DISCHARGE INSTRUCTION AND PLAN” either of which shall specify the responsible follow-up physician or facility.

2.6.6 A dictated discharge summary is required on all discharges except:

2.6.6.1 Newborns who stay three days or less, or other healthy newborns with longer length of stay attributed to the mother’s inpatient stay, and

2.6.6.2 Certain short stay cases of less than 48 hours where the patient is discharged alive and has not been in an ICU or operating rooms. In such cases a short stay summary will suffice.

2.7 RESPONSIBILITY FOR TIMELY COMPLETION OF THE MEDICAL RECORD

The timely completion of the medical record shall be the responsibility of the attending physician.

2.8 TIMELY COMPLETION OF THE MEDICAL RECORD: EFFECTIVE FOR ADMISSIONS PRIOR TO JANUARY 26, 2006

2.8.1 All medical records must document evidence of a physical examination, including a health history, performed no more than seven days prior to admission or within 24 hours of admission and prior to surgery. This includes admission to observation status, and ambulatory surgery status; and invasive outpatient procedures where moderate sedation is used. In emergency situations, a brief note, including the preoperative diagnosis, shall be recorded before surgery.

2.8.1.1 An admission history and physical will meet the seven day requirement if:
The history and physical was performed within thirty days prior to the Hospital admission; and

An appropriate assessment, which should include a physical examination of the patient to update any components of the patient’s current medical status that may have changed since the prior history and physical or to address any areas where more current data is needed, was completed

seven days prior to admission or 24 hours after admission confirming that the necessity for the procedure or care is still present and the history and physical is still current; and

The physician or other individual qualified to perform the history and physical writes an update note addressing the patient's current status and/or any changes in the patient's status, within seven days prior to, or within 24 hours after admission. The update note must be on or attached to the history and physical; and

The history and physical, including all updates and assessments, must be included within 24 hours after admission in the patient's medical record for this admission.

- 2.8.1.2 An outpatient surgery history and physical will meet the seven day requirement if:

The history and physical was performed within thirty days prior to the outpatient surgery; and

An appropriate assessment, which should include a physical examination of the patient to update any components of the patient's current medical status that may have changed since the prior history and physical or completed within seven days prior to outpatient surgery confirming that the necessity for the procedure is still present and that the history and physical is still current; and

The physician or other individual qualified to perform the history and physical writes an update note addressing the patient's current status and/or any changes in the patient's status, regardless of whether there were any changes in the patient's status, within 24 hours prior to the outpatient surgery. The update note must be on or attached to the history and physical; and

The history and physical, including all updates and assessments, must be included in the patient's medical record, except in emergency situations, prior to surgery.

2.8 TIMELY COMPLETION OF THE MEDICAL RECORD: EFFECTIVE AFTER JAN. 26, 2007

- 2.8.1 All medical records must document evidence of a physical examination, including a health history, performed no more than thirty days prior to admission or within 24 hours of admission and prior to surgery. This includes admission to observation status, and ambulatory surgery status; and invasive outpatient procedures where moderate sedation is used. In emergency situations, a brief note including the preoperative diagnosis, shall be recorded before surgery.

When a medical history and physical examination is completed within the thirty days before admission, an updated medical record entry documenting an examination for any changes in the patient's condition must be completed. This updated examination must be completed and documented in the patient's medical record within 24 hours after admission.

SECTION THREE

CORRECTIVE ACTION – INCOMPLETE RECORDS Reference: Medical Staff Bylaws, 5.3.5, Medical Records

Members of the Medical Staff are required to sign verbal/telephone orders within 48 hours and complete medical records within thirty days from discharge. A limited suspension in the form of withdrawal of certain Privileges, until verbal/telephone orders are signed or medical records are completed, shall be imposed by the Chief of Staff, or his or her designee, after notice of delinquency for failure to complete verbal orders or medical records within such period. (See 3.3). Bona fide vacation, travel, or illness may constitute an excuse. The suspension shall continue until lifted by the Chief of Staff or his or her designee.

3.1 UNDICTATED OPERATIVE REPORTS

Operative reports which are not dictated within 24 hours of surgery shall be called to the attention of the attending surgeon via a telephone call and a warning letter. Operative dictation must be completed within two days from the date of the warning.

Failure to dictate the operative report by the specified date will result in automatic suspension of Privileges.

3.2 INCOMPLETE MEDICAL RECORDS OF DISCHARGED PATIENTS

Incomplete medical records of discharged patients are reported to physicians each Monday in a report entitled "Deficiencies by Attending". Anesthesia records will be considered deficient if they are not signed by the attending anesthesiologist in the space attesting to his/her personal participation in the procedure. Deficient anesthesia records will be included in the "Deficiencies by Attending" Report. The clock for incomplete medical records of discharged patients (exclusive of undictated operative reports) and deficient anesthesia records begins running on the day of discharge.

3.2.1 REMINDER

A physician who has not responded to the initial notice within one week will receive an automatic reminder. The reminder will state that medical records must be completed within one week; i.e. by the third week from discharge.

3.2.2 WARNING

Failure to respond by the third week will result in a warning. This warning will allow two working days for completion of the records. The specific due date will be inserted and will allow for mail receipt by the physician. The warning will inform the physician that if records are not completed by the specified date, Privileges will be suspended.

3.3 SUSPENSION OF PRIVILEGES

Failure to respond to the warning results in a suspension of Privileges letter from the Chief of Staff with copies to the chief of the physician's clinical service, the director of the admitting

office, the director of the operating room, the O.R. scheduling desk, and the Director of Health Information Management. Suspended Privileges are as follows:

- 3.3.1 No admitting Privileges except (a) life-threatening emergencies and (b) admission of patients previously scheduled to be admitted for elective surgical or other elective indications. All admissions by suspended physicians will be reviewed for appropriateness.
- 3.3.2 Cancellation of Privileges to use or schedule patients for the operating room, delivery room and any other procedural privileges, except (a) emergencies and (b) elective surgical procedures or other elective procedures scheduled prior to the suspension. All emergency procedures by suspended physicians will be reviewed for appropriateness.
- 3.3.3 If, after 48 hours following institution of suspension, the delinquent records have not been completed, the following additional Privileges will be suspended: Privileges to use the operating room, delivery room, and other procedural Privileges, including previously scheduled elective admissions and procedures; consulting on Hospital cases; assisting at surgery; and providing any professional service within the Hospital except for acute management of life-threatening emergencies. All emergency procedures by suspended physicians will be reviewed for appropriateness.
- 3.3.4 When the appropriate medical records are completed, Health Information Management will notify the director of the operating room and the operating room scheduling desk by telephone. The Office of Chief of Staff, the chief of the physician's clinical service, and the director of Health Information Management will be notified via a copy of the suspension notice, which will include date and time that the suspension was lifted.

3.4 VERIFICATION OF ABSENCE

Verification that a physician is not on vacation, sabbatical or extended medical leave will be performed by Health Information Management before the suspension of Privileges letter is sent by the Chief of Staff.

- 3.4.1 If the responsible physician is on vacation, out of town, or on short-term medical leave of less than six weeks, delinquent medical records must be completed within five days of expected date of return. In these cases the letter of suspension of Privileges will state that suspension will commence five days after the physician's return.
- 3.4.2 If the physician is on sabbatical, extended Medical leave greater than six weeks, deceased, or no longer on Staff, the clinical service chief or his or her designee will appoint a physician alternate who is acquainted with the physician's practice and the patient to complete the record.
 - 3.4.2.1 The appointed physician will be immediately notified by a phone call to his or her office and receive a letter from Health Information Management indicating that his or her clinical service chief has made the appointment.

- 3.4.2.2 The appointed physician alternate must complete the record within the time frame specified in Section 3.2 with the time starting when the physician alternate is first notified via the Health Information Management print-out notice of incomplete records.
- 3.4.2.3 Failure to complete the medical record will result in the alternate being suspended. Failure of the chief of the clinical service or his or her designee to respond to the request for an alternate within five days mandates automatic suspension of the clinical service chief or designee's Privileges.
- 3.4.2.4 If there is no physician alternate who is familiar with the physician's practice and the patient, specific reports/records may be declared complete for filing purposes only. In such instances, specific reports are annotated with the reason and signature of the clinical service chief.

3.5 INTENT TO REVOKE MEDICAL STAFF APPOINTMENT

Failure to complete medical records within two weeks of the suspension of Privileges letter will result in notice of intent to revoke Medical Staff appointment. This notice will come from the Chief of Staff and will indicate that Medical Staff appointment revocation will be recommended to the Board if medical records are not completed within two weeks. Copies of this notice will be distributed to the clinical service chief and the MEC.

3.6 REVOCATION OF MEDICAL STAFF APPOINTMENT

Failure to complete medical records within two weeks of the notice of intent to revoke will result in revocation. The revocation letter to the physician will come from the Board and will include the reasons for revocation, i.e. failure to comply with bylaws regarding medical record completion after four notifications. Copies of the revocation of Medical Staff appointment will be distributed to the clinical service chief, the MEC, and the Board of Medical Examiners.

3.6.1 Prior to revocation of Medical staff appointment, the Chief of Staff will:

- 3.6.1.1 Ensure that all four notices (first warning, second warning, suspension of Privileges, and intent to revoke Medical Staff appointment) have been sent;
- 3.6.1.2 Ensure that the physician was not on extended medical leave or sabbatical; and
- 3.6.1.3 Contact the physician by special notice.

3.6.2 Reinstatement of appointment to the Medical Staff is by making full application for membership after correction of the deficient medical records.

SECTION FOUR

ORDERS

UMC requires the presence of a written or electronically completed order for admission, transfer, and discharge, including when a patient is discharged AMA (Against Medical Advice) and for all services

rendered. Services will not be provided in the absence of an order. Staff responsible for writing orders will use the electronic order entry system as directed after completion of training. A requisition may be required in addition to an order for some services.

4.1 DIAGNOSTIC AND THERAPEUTIC ORDERS

Diagnostic and therapeutic orders shall include those written by Members of the Medical Staff, Housestaff Physicians, and AHPs within the scope of their licensure and Clinical Privileges. Orders written by a medical student must be co-signed (paper based order) or verified (electronic orders) by the attending or Housestaff Physician before they are carried out.

One or more chief complaints or diagnosis codes must be documented on the order to justify the service. The chief complaint must describe the patient's condition to the highest degree of specificity known at the time the order is written. In the absence of a definitive diagnosis, patient signs or symptoms should be used. All physician orders must be complete and include all of the elements listed below. All diagnostic and therapeutic orders must be complete and writing must be legible. To be considered a complete physician order, the following information is required.

- 4.1.1 All orders must include both the date and time they were written;
- 4.1.2 Patient name;
- 4.1.3 Medical record number, date of birth and visit number or other unique identifier specific to research patients;
- 4.1.4 Diagnosis, chief complaint and/or reason for service;
- 4.1.5 Test or service ordered;
- 4.1.6 Printed name of both the attending and ordering physician;
- 4.1.7 Signature of ordering physician accompanied by title and unique identifier, except when using the electronic order entry system, which has the unique identifier embedded in the system;
- 4.1.8 Location should be identified at the top of the order. This is the location where the order was originated and helps ensure test results getting to the correct provider at the correct location in a timely manner. (Note: Some laboratory order forms are location specific; e.g., Emergency Room and North Hills Clinic).
- 4.1.9 Radiology procedures requiring the use of contrast material must include known allergies and weight; and
- 4.1.10 Laboratory standing orders are valid for one year from the date of the order and require a start date, stop date and frequency.
- 4.1.11 Allow Natural Death orders and/or orders to limit medical treatment must be handwritten by an attending physician or a resident physician acting in consultation with the attending physician. The attending physician must authenticate any "Limitation of Medical Treatment Order" written by a resident within 24 hours of the

order. The authentication should include verifying the accuracy of the order with the patient or the patient's surrogate decision-maker as appropriate. In addition, the attending physician must sign the order within 24 hours of the order if the order was completed by a resident. Telephone orders are accepted provided that two registered nurses witness the phone call. "Limitation of Medical Treatment Orders" of inpatients shall be renewed every seven days.

- 4.1.12 All existing orders for patients are cancelled and must be rewritten when the patient is transferred from a general nursing unit to an ICU, from an ICU to a general nursing unit, from an ICU unit to another ICU with service change, the operating room, delivery room, labor room, or to another service, except when intermediate care status is discontinued and there is no change of service, and for "Allow Natural Death" and "Limitation of Medical Treatment" orders when the attending physician remains the same.
- 4.1.13 All paper-based orders for medications entered into on-line computer systems by other than authorized practitioners shall also contain a unique identifier for the entry person and shall be considered inactive until activated by the pharmacist following review of an original or direct copy of the order.

4.2 ORDERS FOR PHARMACY SERVICES

Pharmacy orders must be legible and complete. Orders may not contain prohibited abbreviations as defined in UMC policy. To be considered a complete physician order for Pharmacy Services, the following information is required.

- 4.2.1 All orders must include both the date and time they were written;
- 4.2.2 Patient name;
- 4.2.3 Medical record number and visit number;
- 4.2.4 Patient location;
- 4.2.5 Patient allergies (at least for the initial orders) and weight;
- 4.2.6 Drug name, strength/dose, route of administration, frequency or time of administration;
- 4.2.7 There is a documented diagnosis, condition or indication-for-use for each Medication ordered;
- 4.2.8 Printed name of ordering physician is optional;
- 4.2.9 Signature of ordering physician;
- 4.2.10 Unique identifier except when using the electronic order entry system, which has the unique identifier embedded in the system;
- 4.2.11 Prescription orders written for patients to have filled and to take at home must meet the regulatory requirements of the Arizona State Board of Pharmacy.

4.3 PREPRINTED ORDER SETS

Categories of preprinted order sets are formulated and approved by the Medical Staff in consultation with Hospital administration. All orders are reviewed upon reorder with the appropriate physicians. No category of order sets shall replace or override those orders written for the specific patient.

4.4 VERBAL ORDERS

Verbal/telephone patient care orders for laboratory tests, medications, and other diagnostic tests and services are discouraged due to increased potential for errors. Verbal/telephone orders are accepted only in instances when appropriate patient care would otherwise be delayed and/or it is not possible for the prescriber to go immediately to the patient's bedside, or have access to an order entry device.

During a code arrest procedure or other bona fide emergency in which the provider is present at the patient's bedside but for reasons of maintaining constant patient contact cannot place orders directly, verbal orders may be given to authorized persons as described.

If the physician is off-site and does not have access to an order entry device, telephone orders are appropriate.

Verbal/telephone orders may not be utilized for cytotoxic drugs.

If the RN contacts the physician for a new order or an order change, the RN will enter the order as a telephone order.

Verbal/telephone orders must be signed by the prescribing physician within 48 hours to ensure that the order is correctly communicated and implemented. If the prescribing physician is unavailable it is acceptable for a covering physician to co-sign the verbal order of the ordering physician. The signature indicates that the covering physician assumes responsibility for his/her colleague's order as being complete, accurate and final. Telephone orders for DNAR orders and/or orders to limit medical treatment are acceptable provided that two registered nurses witness the phone call. Verbal orders in the outpatient setting will be signed by the end of the next business day after the order is issued.

Verbal/telephone patient care orders may be dictated by physicians or AHPs within the scope of their licensure and Clinical Privileges to authorized practitioners. Practitioners authorized to transcribe orders are:

- 4.4.1 A registered nurse;
- 4.4.2 A licensed practical nurse when reviewed and countersigned by a registered nurse prior to implementation;
- 4.4.3 A certified transplant coordinator;
- 4.4.4 A registered pharmacist;
- 4.4.5 A licensed respiratory care practitioner (for medication orders and procedures pertinent to respiratory care only);

- 4.4.6 A registered dietician (for orders related to nutrition support only); or
- 4.4.7 A certified or licensed technologist in Radiology, Pathology, Radiation Oncology, Neuro-Sleep, or Rehabilitation Services, or their support staff responsible for orders related to their area.

The order will be written down and read back to the prescriber giving the verbal/ telephone order to confirm the accuracy of the order.

SECTION FIVE

PHARMACEUTICAL RELATED MATTERS

5.1 CONTROL AND HANDLING OF DRUGS

Control and handling of drugs shall be in accordance with the policies and procedures of the Pharmacy and Therapeutics Committee.

5.2 FORMULARY

Drugs ordered shall be limited to those listed in the formulary except that restricted drugs may be used with specific prior approval of the Pharmacy and Therapeutics Committee. Non-formulary drugs may be dispensed upon special request of the attending physician. Investigational drugs require prior approval of the Human Subjects Committee of the University of Arizona.

5.3 MEDICATIONS BROUGHT TO THE HOSPITAL BY THE PATIENT

Generally, medications brought to the Hospital by a patient will not be administered. Such medication will be handled and stored as patient valuables. If the physician desires to continue a patient on medication, an order for the drug must be written and it will be supplied by the Department of Pharmacy Services. In unusual circumstances, it may be desirable for a patient to take the drugs the patient has brought into the Hospital. In such cases, the identity of the drugs must be verified by a pharmacist or credentialed prescriber. The physician must specifically order each drug by the name on the label and note that the patient may use his or her own supply.

SECTION SIX

CONSULTATIONS

Consultations shall be required to admit, treat, or manage a patient whose needs exceed the Privileges granted to the attending physician, or when indicated for optimal patient care.

6.1 POLICIES AND PROCEDURES

- 6.1.1 Each consultation report shall contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient, review of the patient's medical record, and signature of the consultant.

- 6.1.2 When a consultation is necessary for evaluation of a patient prior to the performance of a procedure, the consultant, except in an emergency, shall complete the written consultation before the procedure is done. A second concurring opinion must be documented in the medical record, in writing, before any non-standard procedure is done.
- 6.1.3 The physician may proceed without consultation in emergencies when delay in surgery or treatment in order to obtain consultation would endanger the life of the patient. In these situations, the responsible physician shall note in the patient's medical record both indications for the operation and the nature of the emergency.
- 6.1.4 In those emergency situations in which the surgery or treatment involves the termination of a known or suspected pregnancy, the attending physician will be responsible for informing the clinical service chief, or his or her designee, of the situation and the treatment or surgery contemplated, prior to carrying out the surgery or treatment. The physician so informed will be responsible for confirming such notification at the earliest opportunity by means of a note in the patient's medical record.
- 6.1.5 On petition to commit psychiatric patients, arrangements for petition and transfer will be the responsibility of the service from which the patient is being committed. Members of the service shall obtain the assistance of a psychiatric consultant as to the proper method of procedure. The psychiatric consultant shall act as one signatory on the commitment papers.
- 6.1.6 A consultation from a Member of the Psychiatry Service shall be requested on all patients registered in the Emergency Department or admitted to the Hospital when mental disorder as manifested by suicide attempt or other self-destructive behavior is exhibited.

SECTION SEVEN

CONSENTS

7.1 POLICIES AND PROCEDURES

- 7.1.1 Hospital policies and procedures on informed consent shall be adopted by the Medical Staff and shall be consistent with any legal requirements. The medical record shall contain evidence of informed consent for procedures and treatments for which it is required by these policies.

The special consent forms "CONSENT TO OPERATION, SPECIAL THERAPEUTIC PROCEDURES INCLUDING MODERATE SEDATION" and "TRANSFUSION OF BLOOD AND BLOOD PRODUCTS CONSENT" shall be used to supplement the general medical and surgical consent portion of the "CONDITIONS OF TREATMENT" Agreement. These forms (where indicated) are to be completed prior to performing the procedure for the purpose of consenting to the physician's exercise of professional judgment in prescribing treatment or diagnosis when the patient is to submit to a procedure which involves more than negligible risk of injury to the patient.

Informed consent is obtained for research participants with a description given of the benefits, risks, alternatives, procedures to be allowed and the participant's right to refuse without compromising their access to services. It also addresses the participant's right to privacy, confidentiality and safety.

- 7.1.2 The medical record shall contain evidence that the patient was provided information relative to an alternative means of therapy.
- 7.1.3 Consent for operations shall be signed by the individual patient, or the patient's surrogate decision maker when the patient does not have the mental capacity to consent, the signature of the professional person witnessing the consent, and the name and signature of the person who explained the procedure to the patient or legal guardian. In cases where an emergency exists and where there is no express refusal by a competent patient and where consent cannot be obtained from others, the physician can provide treatment to the patient without obtaining an informed consent. At least one, and preferably two, physicians should document in the patient's medical record that the situation was a medical emergency if the following three conditions are present:
 - 7.1.3.1 The patient needs immediate medical attention.
 - 7.1.3.2 An attempt to secure express consent would delay treatment. The patient must be unable to give express consent (by reason of legal incompetence or a prohibiting mental or physical condition), and there must be no one else immediately available who is entitled by law to consent for the patient, such as a surrogate decision maker.
 - 7.1.3.3 Delay of treatment would increase the risk to the patient's life or health. An emergency may exist even though the patient's life is not in danger. If the health of the patient may be substantially worsened by delay, the patient's condition is sufficiently serious.
- 7.1.4 When a patient or his surrogate decision maker refuses to consent to Medical or drug therapy, surgical or other procedure, blood transfusion or safety measures, the physician shall explain to the patient or his or her representative the nature of the treatment, the reason it is urged, and the probable medical consequences if refused. If the patient or his or her surrogate decision maker persists in the refusal, a full statement shall be made in the medical record and a "Refusal to Consent" form shall be completed and placed in the medical record.

SECTION EIGHT

AUTOPSIES

8.1 POLICY

Criteria identifying deaths in which an autopsy should be performed are outlined in the policies and procedures of the Pathology Service. Every Member of the Medical Staff shall actively participate in securing autopsies. No autopsy shall be performed without valid consent as provided in Hospital policy. All autopsies shall be performed by the Hospital

pathologist or a delegated representative except in cases where the coroner or medical examiner has jurisdiction.

SECTION NINE

MEDICAL STAFF DISASTER ASSIGNMENTS

9.1 POLICY

All Members of the Medical Staff shall be familiar with the Hospital disaster plan. Normal Hospital procedures shall be superseded by the provisions of the Hospital disaster plan.

SECTION TEN

CARE IN THE EMERGENCY DEPARTMENT

10.1 POLICIES AND PROCEDURES

All persons presenting to the Emergency Department shall receive, within the capabilities of University Medical Center's staff and facilities, a medical screening exam conducted by a physician or qualified nurse practitioner, necessary treatment to stabilize the emergency medical condition (including treatment for an unborn child), and, if necessary, an appropriate transfer to another facility. These services will be provided regardless of whether the person can pay for the services, has medical insurance, or participates in Medicare or Medicaid. The order in which persons receive a medical screening exam shall be determined by the Emergency Department Triage Nurse. The minimum requirements for the Triage Nurse position are an R.N. designation plus one-year emergency department experience.

10.1.1 Patients are automatically the responsibility of the Emergency Services attending physician(s) or qualified nurse practitioner on duty, unless prior arrangement have been made for their care by a physician from another service.

10.1.1.1 Patients may be seen by the Emergency Services attending physician, a Housestaff Physician, or a qualified nurse practitioner assigned to Emergency Services. All patients seen by the Emergency Services Housestaff remain the responsibility of the Emergency Services attending physician, who also retains responsibility for supervising the Housestaff Physician.

10.1.1.2 Physicians having Privileges at University Medical Center may choose to assume responsibility for the care of one of their patients in the Emergency Department. In such cases arrangements must be made by communicating with the Emergency Department. The Emergency Services physician will not have responsibility for the patient unless requested by the attending physician.

10.1.1.3 Emergency physicians will not accept patients previously evaluated at other health care facilities who will be admitted to a clinical service unless specifically permitted by the service or required for compliance with legal or contractual obligations.

- 10.1.1.4 Members who want to transfer a patient to the Emergency Department must contact the Emergency Department attending and ensure that adequate resources are available to accommodate the patient. The Emergency Department attending will work collaboratively with Members to ensure high quality care for all patients.
- 10.2 Follow-up care, specialty care, and consultation will be arranged, as appropriate by the physician responsible for the patient's Emergency Department care.
 - 10.2.1 Whenever possible and appropriate:
 - 10.2.1.1 The physician or physician group requested by the patient will be utilized.
 - 10.2.1.2 A physician with whom the patient has established a relationship through prior episode(s) of care will be utilized.
 - 10.2.1.3 Patients enrolled in managed care organizations will have care arranged within that managed care system.
 - 10.2.1.4 The physician "on call" for the appropriate clinical service will be used for consultation/referral in the absence of specific patient preference.
- 10.3 Each clinical service is responsible for developing an "on call" list for consultation/referral for the Hospital. It is recognized that many clinical services may designate a Housestaff Physician as the first person "on call" for the clinical service. An attending physician in the appropriate specialty must be designated and available. While each clinical service will determine the manner in which their Housestaff is supervised, the consulting attending physician is responsible for all decisions made by their Housestaff Physicians regardless of whether the physician sees the patient.
 - 10.3.1 Clinical services will ensure that the patient is evaluated by their service in a timely manner. If there is no response, the clinical service attending, the clinical service chief or the medical director may be called to facilitate the consultation and care of the patient.
 - 10.3.2 Physicians who are on call for Emergency Department patients have the responsibility to provide timely and appropriate care for patients. Refusal by an "on call" physician to see and evaluate the patient will be referred to the clinical service chief and Chief of Staff for review and appropriate action.
 - 10.3.3 Members who are "on call" to the Emergency Department for primary care or specialties must see and provide appropriate follow-up care to patients seen in the Emergency Department within a reasonable time period designated by the emergency physician. A copy of the Emergency Department record will be forwarded to the referral physician. The referral physician must see the patient, regardless of their ability to pay, and provide care as necessary for the specific illness or condition that the patient was seen for in the Hospital. Refusal to see the patient in follow up or placing financial barriers to care is inappropriate and will be referred to the clinical service chief and Chief of Staff for review and appropriate action. (Refer to 10.2.1.2.)

- 10.3.4 Any physician listed as “on call” may arrange for a qualified colleague to cover this duty. It is, however, the responsibility of that individual to make the arrangement and notify the Hospital and the Emergency Department.
- 10.4 The decision to admit the patient to the Hospital from the Emergency Department is made by the consulting clinical service. Each clinical service determines how the decision is made and Housestaff are supervised. The attending physician responsible for the consulting service is responsible for decisions made by the Housestaff on the service including the decision to admit or discharge a patient to the Hospital regardless of whether the physician sees the patient.
- 10.4.1 Care of patients admitted from the Emergency Department is transferred to the appropriate clinical service attending when the decision to admit the patient is made by the clinical service. The admitting clinical service attending remains responsible for the patient’s medical care in the Emergency Department and for expediting transfer to another location.

SECTION ELEVEN
AVAILABILITY OF ATTENDING SURGEON

- 11.1 POLICY
- 11.1.1 The attending surgeon must be present in the operating room for the key portions of the operation.
- 11.1.2 On elective cases, the attending surgeon must be in the Hospital prior to the Housestaff Physician starting a case in the operating room.
- 11.1.3 In life-threatening cases, the Housestaff Physician may start a case with the attending surgeon on the way into the Hospital.
- 11.1.4 The attending surgeon must remain in the Arizona Health Sciences Center until the patient is stable out of the operating room, or until the responsibility for the patient has been assumed by another attending physician.

Changes adopted 11/20/2008 include:

1. Preamble – further defines responsibilities of the Medical Staff
2. ARTICLE II, MEMBERSHIP, 2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP, 2.5.24, requires professional and cooperative conduct.
3. ARTICLE II, MEMBERSHIP, 2.6 TERM OF APPOINTMENT allows for a professional period during which to evaluate the practitioner.
4. ARTICLE IV, CLINICAL PRIVILEGES, 4.3 DELINEATION OF PRIVILEGES DETERMINATION, 4.3.2 BASIS FOR PRIVILEGE DETERMINATION allows for a one-year provisional period during which to evaluate practitioner’s competency.
5. ARTICLE IV, CLINICAL PRIVILEGES, 4.3 TEMPORARY PRIVILEGES denotes the CEO or his/her designee shall grant temporary privileges.
6. ARTICLE IV, CLINICAL PRIVILEGES, 4.9.1 MODIFICATION OF CLINICAL PRIVILEGES denotes the Board of Directors shall have final authority for granting additional privileges.
7. ARTICLE IX, FUNCTIONS, COMMITTEES AND RELATIONSHIPS, 9.2 DESIGNATION OF COMMITTEES, allows the CEO or his/her designee to attend each Medical Staff Meeting without vote.
8. ARTICLE IX, FUNCTIONS, COMMITTEES AND RELATIONSHIPS, 9.7 further defines the duties of the Medical Executive Committee.
9. AMENDMENT OF BYLAWS, AND RULES AND REGULATIONS, 11.3 APPROVAL indicates neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations.
10. RULES & REGULATIONS, SECTION TEN, CARE IN THE EMERGENCY DEPARTMENT, 10.1 POLICIES AND PROCEDURES allows a qualified nurse practitioner to perform a medical screening exam.