



PHOENIX CHILDREN'S *Hospital*

PHOENIX CHILDREN'S HOSPITAL
MEDICAL STAFF BYLAWS

M A Y, 2 0 0 8
(Revision Date)

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MISSION STATEMENT

Phoenix Children's Hospital is an independent health care services provider dedicated to excellence in the delivery of health care for infants, children and adolescents. Our mission is to provide hope, healing, and the best care for children and families.

VISION STATEMENTS

Phoenix Children's Hospital is the leading provider of children's health care in the Southwest through:

- * Developing programs that satisfy patients, families, and physicians, while meeting our strategic and financial goals
- * Offering superior patient care
- * Alleviating the suffering and pain of children
- * Providing education and clinical research opportunities
- * Successfully participating in a managed care environment

We will continue the unique partnership we have structured among the Hospital, the general pediatric community and the pediatric subspecialty community as advocates for children's health.

DELEGATION OF AUTHORITY

The Board of Directors of Phoenix Children's Hospital delegates to the Medical Staff the authority necessary to assure that the professional duties and responsibilities of the Medical Staff are fulfilled and the highest standards of medical care are maintained in accordance with these Bylaws. The organized Medical Staff is directly accountable to the Board of Directors in providing oversight for quality of care, treatment, and services provided by practitioners with clinical privileges, and for providing for a uniform quality of patient care.

VALUE STATEMENTS

The fulfillment of Phoenix Children's Hospital's Mission and Vision embodies the following set of values:

THE SUPPORT AND SATISFACTION OF PATIENTS AND THEIR FAMILIES.

We value the relationships we build with patients and families over time, because it is a measure of how successfully we fulfill our Mission.

FAMILY-CENTERED CARE.

We recognize the importance of incorporating the needs of patients and their families into a flexible, accessible and responsive hospital.

THE CULTURAL DIVERSITY OF OUR COMMUNITY.

We will continue to be responsive to the multilingual, multicultural values and beliefs that are important to patient care.

THE ETHICAL ROLE TO PROVIDE CHARITY CARE TO CHILDREN IN ARIZONA AND THE PLEDGE TO DO SO TO THE MAXIMUM EXTENT OUR RESOURCES ALLOW.

We recognize our commitment to provide specialized care to children regardless of ability to pay in areas where we provide unique tertiary care.

THE DEDICATION OF OUR VOLUNTEERS.

We enjoy tremendous support from this ever-growing circle of caring people who give so generously of both their time and talents.

THE SUPPORT OF THE COMMUNITY PHYSICIANS.

Our success is greatly dependent upon the care these physicians provide to patients, the confidence in the Hospital they show by referring their patients and their support for the Hospital in the community.

THE CONTRIBUTION OF OUR FULL TIME PHYSICIAN STAFF.

Our distinction as a unique facility is largely because of the dedication of these physicians.

EMPLOYEE SATISFACTION.

We promote respect for employees' skills and provide a safe and congenial working environment, as well as opportunities for professional and personal growth.

THE LEADERSHIP OUR PHYSICIANS AND EMPLOYEES PROVIDE.

As the children's hospital in Arizona, our physicians and employees have a unique responsibility and opportunity to provide leadership in children's health issues. We will continue to take the lead in advocating for public policy that ensures the well being of children, and in providing or supporting programs and services that improve children's health.

THE IMPORTANCE OF A STRONG FINANCIAL POSITION WHICH WILL ENSURE THE CONTINUED SUCCESS OF THE HOSPITAL.

Our financial well-being will be based on a variety of sources, including patient revenues, philanthropy, grants and endowments.

DEFINITIONS:

1. Allied Health Professionals: Individuals authorized to render medical care under the supervision of a member of the medical staff.
2. Attending physician: The physician who has primary responsibility for the patient
3. Available: ability to be contacted by any means possible such as by telephone or pager
4. Board of Directors: The governing body of the Hospital
5. Chief Executive Officer: The individual designated by the Board of Directors to administer the Hospital
6. Clinical privileges: in accordance with Medical Staff Bylaws, authorization granted by the Board of Directors to a medical staff member or other licensed practitioner to provide specific medical services in the hospital
7. Consultation: an evaluation of a patient requested by a medical staff member
8. Current: up-to-date and extending to the present time
9. Discharge Planning: a process of establishing goals and objectives for an inpatient in preparation for the inpatient's discharge.
10. Documentation: information in written, photographic, electronic, or other permanent form.
11. General Staff Meetings: Quarterly and annual meetings of the Medical Staff
12. Hospital: a health care institution that provides, through an organized medical staff, inpatient beds, medical services, and continuous nursing services for the diagnosis and treatment of patients
13. House Staff and Fellows: Practitioners who serve Phoenix Children's Hospital in a postgraduate training program.
14. Inpatient: an individual who a) is admitted to the hospital; or b) receives hospital services for 24 consecutive hours or more
15. Interval note: documentation updating a patient's medical condition after a medical history and physical examination are performed
16. Medical Executive Committee: The governing committee of the Medical Staff
17. Medical history: part of a patient's medical record consisting of an account of the patient's health, including past and present illnesses or diseases.
18. Medical Staff: The organization of practitioners who are privileged to attend patients in the Hospital
19. Medical Staff Bylaws: standards, approved by the Medical Staff and Board of Directors, providing the framework for the organization, responsibilities and self governance of the medical staff
20. Medical Staff Rules and Regulations: standards, approved by the Medical Staff, that govern the day-to-day activities and conduct of medical staff members
21. On call: a time during which an individual is available and required to come to a hospital when requested by the hospital
22. Organized service: specific medical services, such as surgical services or emergency services, provided in an area of a hospital designated for the provision of those medical services
23. Outpatient: an individual who a) is not admitted to a hospital; or b) receives hospital services for less than 24 consecutive hours
24. Pathology: an examination of human tissue for the purpose of diagnosis or treatment of an illness or disease
25. Patient: an individual receiving hospital services
26. Phoenix Children's Medical Group (PCMG): Phoenix Children's Hospital employed physicians (formerly referred to in these Bylaws as "faculty").

27. Physical examination: to observe, test, or inspect an individual's body to evaluate health or determine cause of illness or disease
28. Practitioner: An appropriately licensed physician or other qualified individual who is granted privileges to practice in Phoenix Children's Hospital
29. Specialty: a specific area of medicine practiced by a licensed individual who has obtained education or qualifications in the specific area in addition to the education or qualifications required for the individual's license
30. Special Notice: Notice by certified mail
31. Surgical services: medical services involving the excision or incision of a patient's body for the a) correction of a deformity or a defect; b) repair of an injury; or c) diagnosis, amelioration, or cure of disease
32. Telemedicine: The use of electronic communication or other communication technologies to provide or support clinical care at a distance.
33. Treatment: a procedure or method to cure, improve, or palliate an injury, an illness, or a disease
34. Unit: a designated area of an organized service
35. Verification: a documented telephone call, observation or confirmation of a fact including the information obtained, the date, and the name of the documenting individual

Pronouns: For purposes of simplification, the use of the male pronoun (he/his/him) throughout these Bylaws is applicable to either male or female, and the term "CHAIRMAN" is applicable to males or females who occupy that role.

ARTICLE I: NAME AND PURPOSE

The name of this organization shall be the Medical Staff of Phoenix Children's Hospital. The Medical Staff is a self-governing body, organized to continually seek to achieve excellence in patient care for all patients admitted to or treated in the Hospital and PCH ambulatory clinics, to provide a leadership role in hospital performance improvement activities to improve the quality of care, treatment and services and patient safety, and to make recommendations to the Board of Directors regarding the evaluation and monitoring of clinical performance.

ARTICLE II: MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff is a privilege granted only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws, the Medical Staff Rules and Regulations, and applicable policies.

2.1 MEMBERSHIP RESPONSIBILITIES

Each member of the Medical Staff shall, upon application for staff membership, agree to:

- a) Immediately inform the Hospital CEO of:
 - (i) Challenges to, or voluntary or involuntary, loss of licensure or registration;
 - (ii) Voluntary or involuntary changes in staff membership or privileges at another healthcare facility
 - (iii) Involvement in professional liability actions, at a minimum final judgments or settlements
 - (iv) Health status changes which would affect the practitioner's ability to exercise the privileges requested
 - (v) Expiration, reduction, suspension, relinquishment, termination or any other limitation of DEA registration
 - (vi) Any revocation or cancellation of professional liability insurance occurring at any time during Medical Staff membership
 - (vii) Medicare/Medicaid sanctions, including both current and pending investigations and challenges
 - (viii) Removal from a managed care organization's panel for quality of care reasons or unprofessional conduct.
- b) Members must strictly abide by these Bylaws, Medical Staff Rules and Regulations, and policies of the Hospital.
- c) Medical Staff Members, through its committees, are responsible for assuring the delivery of patient care of the highest quality for the pediatric population it serves, and will oversee the quality of care, treatment and services provided by practitioners privileged through the medical staff process.
- d) Members of the Medical Staff coordinate care by interacting with other professional staff within the organization, patients, and families.
- e) Members provide patient care within the parameters of their professional competence, as reflected in the scope of their clinical privileges.
- f) Members provide continuous care and supervision of patients.

- g) Members participate in ongoing measurement, assessment, and improvement of both clinical and non-clinical processes and the resulting patient outcomes in accordance with the Performance Improvement Plan and Peer Review Policy adopted by the Medical Staff and the Board. Discretionary corrective action may result if these policies are not adhered to by members of the Medical Staff.
- h) Members of the Medical and Allied Health Staffs participate in continuing medical education.
- i) Members must maintain current records with the Hospital so they can be reached at all times by the Hospital and by the Medical Staff office.
- j) Members of the Medical Staff and Allied Health Staff are required to treat patients, their families, hospital staff, and colleagues in a respectful and professional manner at all times. Each member is expected to comply with the Medical Staff Conduct Policy appended to the Medical Staff General Rules and Regulations.

2.2 **BASIC QUALIFICATIONS FOR MEMBERSHIP**

- a) Professional licensure in the State of Arizona.
- b) Graduation from a school of medicine accredited by the Liaison Committee on Medical Education, a school of osteopathic medicine accredited by the American Osteopathic Association, or, in the case of a non-physician, from a school with comparable recognition and accreditation in the respective professional field.
- c) Completion of one (1) or more years of postgraduate education, in accordance with the requirements of the clinical department to which assigned, in a program or programs accredited by the Accreditation Council for Graduate Medical Education.
- d) In the case of foreign medical graduates, fulfillment of the graduate and post-graduate requirements prescribed by the Arizona Medical Board.
- e) All applicants for initial appointment to the Medical Staff whose applications are submitted after June 1, 2008, must meet the following requirements, as applicable:
 - 1) Shall be certified or qualified to sit for the certifying examination administered by a specialty board approved by the American Board of Medical Specialties (ABMS) or by the American Osteopathic Association (AOA) and are required to be board certified by an ABMS or AOA specialty within six (6) years of completion of training.
 - 2) An applicant for podiatric appointment and privileges shall be certified or qualified to sit for the certifying examination administered by the American Podiatric Medical Specialties Board or the American Board of Podiatric Surgery and are expected to be board certified by one of these boards within six (6) years of completion of training.
 - 3) A DDS or DMD applicant for oral surgery appointment and privileges shall be certified or qualified to sit for the certifying examination administered by the American Board of Oral and Maxillofacial Surgery as recognized by the American Dental Association and are expected to be board certified within six (6) years of completion of training.

- 4) For physicians trained outside of the US and Canada, the requirements as described above for board certification in section 2.2 e) 1), shall apply. Rare exceptions may be made if the candidate can prove equivalency of training and board certification in the country of their post-graduate training. The documentation proving equivalency must be verifiable and specific. Evaluation of equivalency of training and board certification would be reviewed and determined by the Section and Department Chair and is subject to approval by the MEC. Any such denial shall not be subject to the provisions of Article VII of the Medical Staff Bylaws. Exceptional circumstances documented and verified based on experience in lieu of training that do not meet the above criteria, may be considered at the sole discretion of the Medical Executive Committee.
- f) Practitioners on the Medical Staff granted initial Medical Staff membership and clinical privileges after June 1, 2008 must meet the following Board recertification requirements when requesting reappointment to the Medical Staff. (Applicants for reappointment on the Medical Staff who apply for initial Medical Staff membership on or before June 1, 2008, shall not be subject to these requirements.)
 - 1) Current board certification or continued qualifications to sit for an examination by an American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) approved board.
 - 2) Applicants for reappointment in podiatry and oral surgery shall maintain board certification by their specialty boards as set forth in Section 2.2 e), 2 and 3 above.
 - 3) The applicant must maintain current certification/recertification in their primary specialty. If they are a subspecialist, they must maintain certification in their subspecialty but not in their primary specialty to maintain subspecialty privileges.
- g) Additional qualifications may be required for training and board certification by the specific Departments and/or Sections of the Medical Staff.
- h) Professional competence, ethical conduct, worthiness of character and evidence of health status.
- i) Willingness to comply with these Bylaws and support the Mission of PCH.
- j) Applicants/Reapplicants must provide all the information and supporting documentation requested in the medical staff application/reapplication forms, and must inform the Hospital CEO of any circumstances identified in Article 2.1(a).

2.3 **NON-DISCRIMINATION**

Medical Staff Membership shall not be denied on the basis of sex, race, age, creed, color or national origin.

2.4 **MEDICAL ADMINISTRATIVE OFFICER**

A Medical Administrative Officer with responsibilities for patient care in Phoenix Children's Hospital must be a member of the Medical Staff and be granted privileges in accordance with the procedures in these Bylaws. Medical Staff Membership and clinical privileges of a Medical

Administrative Officer shall not necessarily terminate upon termination of the administrative appointment unless otherwise provided by the Officer's employment contract or agreement.

2.5 DURATION OF APPOINTMENT

Appointment and Reappointment to the Medical Staff shall be for no more than two (2) years. The Medical Staff member's birth month shall be used to determine the month in which he/she is eligible to be reappointed.

2.6 SUPERVISION

Supervision may be required at the discretion of the Departmental Committee for privileges requested. Supervised cases or retrospective review of cases shall be completed in accordance with the Proctoring Policy for Medical Staff.

2.7 LEAVE OF ABSENCE

- a) A request for leave of absence from the Medical Staff shall be submitted in writing to the Chief Executive Officer and state the reason and duration of leave requested. The request will be forwarded to the appropriate Department Committee and the Executive Committee for recommendation and to the Board of Directors for final action.
- b) A Department Committee may recommend leave of absence for a member of the Medical Staff who is under medical care.
- c) The following are examples of other situations necessitating a Medical Staff leave of absence: government or military service, continuing medical education, prolonged illness, or maternity leave. Leave of absence status is not available to a practitioner while under investigative or corrective action.
- d) A Medical Staff member on leave of absence cannot admit or treat patients and shall be excused from all General Staff and Committee meetings and payment of Staff Dues during the leave.
- e) If such leave extends beyond the practitioner's current appointment term, his membership will lapse and be deemed a voluntary resignation.
- f) A Medical Staff member who wishes to return to previous status from a leave of absence shall submit a written request for reinstatement, pursuant to Article IV, Section 4.6, to the Chief Executive Officer with a summary of relevant activities during the leave. A Medical Staff member returning from military leave of absence must submit discharge status. A Medical Staff member returning from medical leave of absence may be required to submit a physician's report. A Medical Staff member returning from academic leave of absence who requests a change of clinical privileges will be required to submit evidence of completed training. The request will be submitted to the Executive Committee for recommendations and to the Board for final action.
- g) Failure without good cause to request reinstatement or to provide upon request a summary of activities as provided above shall result in automatic termination of Medical Staff Membership and Privileges. A Medical Staff member so terminated shall be entitled to the procedural rights provided in Article VII for the sole purpose of determining the issue of good cause.

2.8 RESIGNATIONS AND TERMINATIONS

- a) A resignation from the Medical Staff should be submitted in writing to the Chief Executive Officer. The resignation will be forwarded to the appropriate Department Committee and the

Executive Committee for recommendation and to the Board of Directors for final action. The Chief Executive Officer will notify the resigning practitioner and all appropriate Hospital personnel upon acceptance of the resignation.

- b) A Medical Staff Member, who moves from the area without submitting a forwarding address or resignation from the Medical Staff, may be terminated from the Medical Staff upon recommendation by the appropriate Department Committee, the Executive Committee and approval by the Board of Directors. If a forwarding address is known, the Medical Staff member will be queried about Medical Staff Membership. If there is no response within thirty (30) days, the matter will be submitted to the appropriate Department Committee and the Executive Committee for recommendation and to the Board of Directors for final action. The Chief Executive Officer will send the Medical Staff member written notice of the termination.
- c) Failure to return a complete reappointment application in a timely manner will result in expiration of Medical Staff Membership at the end of the current term and deemed a voluntary relinquishment of clinical privileges.

2.9 **REINSTATEMENT OF APPOINTMENT AFTER RESIGNATION, EXPIRATION OF MEMBERSHIP OR LEAVE OF ABSENCE**

When a practitioner resigns from the Medical Staff as specified in Article II, Section 2.8, and subsequently submits a written request for reinstatement, the request will be handled as specified in Article IV or as determined by the Executive Committee.

**ARTICLE III
CATEGORIES OF THE MEDICAL STAFF**

The Medical Staff shall include the categories of Honorary, Active, Associate, Courtesy, Consulting, Affiliate and Senior.

3.1 **THE HONORARY STAFF**

- a) The Honorary Staff shall consist of those physicians who have rendered distinguished service to the Hospital and continue to exercise clinical privileges. A member of the Active Medical Staff may request appointment to the Honorary Staff and their application will be subject to approval by their department, the MEC and the Board of Directors.
- b) Members of the Honorary Staff are eligible to vote and serve on Committees, may hold Elected Office, are not required to attend General Staff meetings, pay Staff Dues and are not required to serve in the Emergency Center or Clinic.

3.2 **THE ACTIVE STAFF**

- a) The Active Staff shall consist of physicians and dental practitioners in active practice who have a major interest, special expertise and dedication to the care of children, who maintain a high level of professional and ethical conduct, who actively support the Mission of Phoenix Children's Hospital; and who provide the necessary leadership to fulfill the purposes of the organized Medical Staff.
- b) Active Staff members are eligible to vote and hold Elected Office unless otherwise provided in these Bylaws; shall pay Staff Dues as required; serve on Medical Staff Committees; serve in the Emergency Center; agree to attend clinic patients, patients who have no physician, and patients

for which consultation is required by the Medical Staff Rules and Regulations; and shall attend General Staff meetings and Department and Section meetings, as appointed.

- c) To be eligible for appointment to the Active Staff, a physician must demonstrate a high level of interest and activity at Phoenix Children's Hospital; must be a member of the Courtesy Staff for at least two (2) years, and must meet the utilization requirements for Active Staff category (minimum of ten (10) patient activities within a two (2)-year period, to include admissions, consultations, procedures, assisting in surgery, etc.). Upon the recommendation of the Executive Committee, this requirement may be waived by the Board of Directors.

3.3 **THE COURTESY STAFF**

- a) The Courtesy Staff shall consist of physicians and dental practitioners in active practice who have a major interest, special expertise and dedication to the care of children, who maintain a high level of professional and ethical conduct, who actively support the Mission of Phoenix Children's Hospital and who provide the necessary leadership to fulfill the purposes of the organized Medical Staff but do not qualify for Active Staff membership.
- b) Courtesy Staff members are not eligible to vote in regular or special elections or hold Elected Office; shall pay staff dues as required; serve on Medical Staff Committees; serve in the Emergency Center; agree to attend clinic patients, patients who have no physicians, and patients for which consultation is required by the Medical Staff Rules and Regulations; and shall attend General Staff meetings and Department and Section meetings, as appointed. A Courtesy Staff member may vote on matters presented at meetings of their Department or Section and Committees of which they are a member.

3.4 **THE CONSULTING STAFF**

- a) The Consulting Staff shall consist of physicians with privileges limited to providing consultation on patients in the Hospital. Consulting Staff may not admit patients to the hospital or perform invasive procedures.
- b) Consulting Staff members are not eligible to vote in regular or special elections, or hold Elected Office; shall pay staff dues as required; serve on Medical Staff Committees; may consult on patients in the Emergency Center; agree to attend clinic patients, patients who have no physician, and patients for which consultation is required by the Medical Staff Rules and Regulations; and shall attend General Staff meetings and Department and Section meetings, as appointed. A Consulting Staff member may vote on matters presented at meetings of their Department or Section and Committees of which they are a member.

3.5 **THE REFERRING CATEGORY**

- a) The Referring Staff is for those physicians who support the mission and philosophy of Phoenix Children's Hospital but have elected to utilize the service of a "hospitalist" group to care for their inpatients. The Referring Staff shall consist of physicians and dental practitioners in active practice that have a major interest, special expertise and dedication to the care of children, who maintain a high level of professional and ethical conduct, and who practice medicine in the state of Arizona. A Referring Staff member may not be the attending physician for patients in the hospital, write orders for hospitalized patients, perform or be the assistant for surgical or invasive procedures and do not have clinical privileges at the Hospital but are able to visit their patients in the hospital and review the medical record.

- b) Referring Staff members may apply for Courtesy or Active Staff appointment and clinical privileges through the Medical Staff office by completing the necessary application and documenting eligibility as defined in the Medical Staff bylaws and Rules and Regulations.
- c) Referring Staff members shall pay dues as required; may serve on Medical Staff Committees; may attend General Staff meetings and Department and Section meetings, as appointed. A Referring Staff member may vote on matters presented at meetings of their Department or Section and Committees of which they are a member.
- d) Referring Category – Eligibility to vote. Referring members are eligible to vote in regular and special elections and hold Elected Office if they meet 1. and 2. below and either 3. or 4. below:
 - 1. Have been a member of the Active, Courtesy or Referring Staff for at least two (2) years, and
 - 2. Have referred at least ten (10) patients to Phoenix Children’s Hospital for admission, subspecialist referrals or hospital services in the previous two (2) year period.
 - 3. Been active in House Staff education as demonstrated by their practice providing a resident continuity clinic experience for the previous two (2) year period,
 - or
 - 4. Have actively participated in Medical Staff affairs by attendance and participation on a Medical Staff committee, General Staff meeting or Grand Rounds. Active participation is defined as attending at least 50% of the scheduled committee meetings.

3.6 **THE AFFILIATE STAFF**

- a) The Affiliate Staff shall consist of non-physician healthcare practitioners, other than dental practitioners, who may provide professional services to Hospital patients, i.e., psychologists.
- b) Appointment and delineation of privileges of Affiliate Staff members will be made by the Board of Directors upon recommendation by the appropriate Department Committee and the Executive Committee, in accordance with specific protocols established by the Board of Directors.
- c) Affiliate Staff members may not vote in regular or special elections or hold Elected Office; may perform their services only pursuant to specific protocols established by the appropriate Departments and Committees; shall pay Staff Dues, and may attend General Staff meetings. An Affiliate Staff member may vote on matters presented at meetings of his Department or Section and Committees of which he is a member.

3.7 **EMERITUS ROSTER**

- a) The Emeritus Roster shall consist of physicians who are no longer members of the Medical Staff but have rendered distinguished service to the Hospital.
- b) Members of the Emeritus Roster are invited to attend General Staff meetings and shall receive appropriate Medical Staff mailings.
- c) Members of the Emeritus Roster are not members of the Medical Staff, may not attend patients, may not serve on Committees, are not eligible to vote and are not required to pay Staff Dues.

- d) Assignment to the Emeritus Roster will occur upon recommendation of the Executive Committee and approval by the Board of Directors.
- e) Physicians who were members of the Honorary Staff shall be placed on the Emeritus Roster with the designation of "Honorary" affixed to their name.
- f) Emeritus-Honorary members may serve on committees (with a vote) if appointed by the Medical Executive Committee, and are eligible to vote in general elections of the Medical Staff.

3.8 **RETIRED ROSTER**

- a) The Retired Roster shall consist of physicians who were members of the Medical Staff in good standing but who have retired from the practice of medicine.
- b) Members of the Retired Roster will receive appropriate Medical Staff mailings.
- c) Members of the Retired Roster are not members of the Medical Staff, may not attend patients, may not serve on Committees, are not eligible to vote and are not required to pay Staff Dues.
- d) Assignment to the Retired Roster will occur after a request by the retiring physician to be placed on Retired Roster has been received and upon recommendation of the Executive Committee and approval by the Board of Directors.

3.9 **HOUSE STAFF**

- a) The House Staff shall consist of practitioners in residency or fellowship training positions, who serve Phoenix Children's Hospital in a postgraduate training program.
- b) Application for appointment to Residency Training or Fellowship positions will be forwarded to the Director of Medical Education. Upon approval by the Director of Medical Education and the Residency Training Program Director, applicants will receive appropriate identification badge.
- c) Residents and Fellows rotating through Phoenix Children's Hospital from other institutions or training programs will require approval as above.
- d) Residents and Fellows shall function in the Hospital under an approved job description and must be supervised by the attending and teaching staffs of the corresponding Departments. They shall be governed by and through the Department of Medical Education. House Staff are not entitled to any of the rights outlined in Article VII of these Bylaws.
- e) Residents and Fellows may not admit patients, hold elected office or vote. They are not required to pay staff dues, however, they may attend meetings, serve on committees and may vote on matters presented to a committee of which he is a member.

**ARTICLE IV
PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT**

4.1 **GENERAL**

The Medical Staff will consider each application for appointment and reappointment to the Medical Staff and each request for modification of Medical Staff Membership status or privileges in accordance with procedures outlined in these Bylaws and prescribed by the Board of Directors.

(See the Medical Staff Rules and Regulations for the Mechanism for Appointment and Reappointment of Medical Staff Members and the Granting and Renewal or Revision of Clinical Privileges.)

The time periods specified in this Article are to assist in the processing of applications in a timely and good faith manner. They may be waived for good cause and shall not be deemed to give any applicant a right to have an application processed within those time periods.

An applicant whose initial application is withdrawn or placed into inactive status, more than twice, may not reapply for a period of three years.

As noted in Article II, Section 2.6 of these Bylaws, the requirements for Provisional status shall apply to all initial Medical Staff appointments. This Article shall not apply to House Staff.

4.2 **CONSIDERATIONS IN EVALUATING APPLICATIONS**

An applicant may be denied Medical Staff Membership, department affiliation, staff category assignment or clinical privileges for findings related to quality of patient care, unprofessional conduct, failure to demonstrate relevant training, experience, current licensure, current competence, or ability to perform the privileges requested.

An applicant may be denied specific privileges due to the Hospital's inability to provide adequate facilities or support services required by the privilege.

4.3 **PROCESSING OF APPLICATIONS**

4.3-1 Each application for appointment to the Medical Staff shall be submitted on the form prescribed by the Board of Directors and shall clearly provide all information required. The completed application shall be submitted to the Chief Executive Officer, or designee, who shall verify the required information provided by the applicant and obtain necessary additional information. Within sixty (60) days after receiving a completed application, the Chief Executive Officer shall transmit the application and all verified documents to the Credentials Committee.

4.3-2 The Credentials Committee shall examine the application and related materials and determine whether the applicant has fulfilled the qualifications for Medical Staff Membership set forth in Article II, Section 2.2. Within thirty (30) days after receiving the application, the Credentials Committee shall transmit the application and related materials, together with its report, to the Clinical Department(s) in which privileges are sought.

4.3-3 The Clinical Department(s) in which privileges are sought shall consider the application and related materials, together with the report of the Credentials Committee, and shall make recommendations pertaining to appointment to the Medical Staff and delineation of privileges. Within thirty (30) days after receiving the application, the Clinical Department(s) shall transmit the file, including its recommendations, to the Medical Executive Committee.

Fast Tracking - In between meetings of the Credentials Committee and the Medical Staff Department meetings and prior to the Medical Executive Committee meeting, new applicant files which meet Fast Tracking applications Category I criteria may be forwarded to the Credentials Committee Chairman (or designee) and Clinical Department Chairman (or designee) for recommendations on behalf of the Committee/Department in accordance with the Fast Tracking Credentials File Policy and Procedure.

- 4.3-4 The Medical Executive Committee shall consider the application at its regular meeting after receipt of the completed application and all related reports and recommendations. If the Executive Committee concludes that the applicant should be granted Medical Staff membership as requested, it shall recommend approval of the application by the Board of Directors. If the Executive Committee concludes that an application should be denied Medical Staff Membership, department affiliation, staff category assignment or specific clinical privileges, it shall appoint an Investigative Committee consisting of three practitioners to review the application more fully.
- 4.3-5 The Investigative Committee shall promptly give the applicant written notice of the investigation and shall follow the Fair Hearing provisions of Article VII, Section 7.1. Within sixty (60) days after its appointment, the Investigative Committee shall complete its review and submit to the Executive Committee a written report, including a recommendation for action on the application. A copy of the report shall be provided to the practitioner, the Chief Executive Officer and the President of the Medical Staff.
- 4.3-6 At its next regular meeting after submission of the report, the Executive Committee shall vote on the application. It shall vote to recommend granting approval of the application as requested, denial of the application in full, or granting of Medical Staff privileges subject to change in department affiliation, staff category assignment or particular clinical privileges from those requested. A representative of the Investigative Committee and the applicant or his designee may make oral presentations at the meeting. The Executive Committee shall notify the applicant and the Board of Directors of its recommendation in writing. It shall simultaneously forward the report of the Investigative Committee and any other relevant material to the Board of Directors. If its recommendation is adverse to the applicant, it shall explain the reasons for that recommendation in writing.
- 4.3-7 The Board of Directors shall act upon a recommendation of the Executive Committee regarding an application for Medical Staff privileges within sixty (60) days after receiving the recommendation. If it wishes to reverse or modify a favorable recommendation by the Executive Committee pursuant to Section 4.3-4, it shall first remand the application to the Executive Committee which shall appoint a Committee consisting of three (3) practitioners to investigate the application. Thereafter, the provision of Section 4.3-5 and 6 shall govern.
- 4.3-8 If, after considering the recommendation of the Executive Committee and the report of the investigative committee, the Board of Directors is inclined to reach a decision different from the recommendation of the Executive Committee, the Board of Directors shall submit the matter for consideration by a Joint Conference Committee prior to making its final decision. This Committee shall consist of two (2) members of the Board of Directors nominated by the Chairman, two members of the Executive Committee nominated by the President of the Medical Staff and the Chief Executive Officer. Upon making its final decision, the Board of Directors shall give written notice to the applicant, the Chief Executive Officer and the

President of the Medical Staff of the decision and the reason (s) thereof. The decision of the Board of Directors shall be final unless the applicant makes a timely request for a Hearing pursuant to Section 4.3-9.

- 4.3-9 The applicant shall have the right to a Hearing before the Board of Directors. This right shall be exercised by delivering a written request for such a hearing to the Chief Executive Officer in person or by certified mail within ten (10) days after the applicant has received notice of the Board of Directors' decision. The Hearing shall be conducted in accordance with the Fair Hearing procedures of Section 7.2. Within sixty (60) days after the Hearing, the Board of Directors shall issue its decision in writing, including the reasons for that decision. The decision of the Board of Directors shall be transmitted to the applicant, the Chief Executive Officer, the President of the Medical Staff and shall be final.

4.4 **REAPPOINTMENT PROCESS**

4.4-1 **APPLICATION**

The Chief Executive Officer, or designee, shall at least ninety (90) days prior to the expiration of the present Medical Staff appointment of each Medical Staff member, provide the member with an application for reappointment. Applications for reappointment must be submitted to the Chief Executive Officer no later than sixty (60) days prior to the expiration date. Each application for reappointment to the Medical Staff shall be submitted on a form prescribed by the Board of Directors. Failure without good cause to return the form will result in expiration of the member's current term. (See Section 2.8).

4.4-2 **CONSIDERATIONS IN EVALUATING APPLICATIONS**

Renewal of clinical privileges is based on a reappraisal of the Medical Staff member at the time of reappointment.

- a) The reappraisal includes confirmation of adherence to medical staff membership requirements stated in these bylaws, medical staff rules and regulations, and policies. Relevant practitioner-specific data are compared to aggregate data, when available, for comparative purposes in evaluating professional performance, judgment, and clinical or technical skills. Results of peer review of the individual's clinical performance and results of ongoing practitioner-specific professional practice evaluations are included in this review. Peer recommendations are used to recommend individuals for the renewal of clinical privileges when insufficient peer review data are available.
- b) Other reasonable indicators of continuing qualifications, in addition to the requirements for staff membership, include: evidence of continuing medical education relevant to the privileges requested, evidence of current competence as demonstrated by case lists, professional references, and evidence of the ability to provide quality care, treatment, and services for the privileges requested.

4.4-3 **PROCESSING THE APPLICATION**

- a) The completed application for reappointment will be submitted to the Chief Executive Officer, or designee, who will verify its contents and obtain necessary additional information for the Medical Staff member's file.

- b) The Chief Executive Officer, or designee, will then transmit the Medical Staff member's file to the appropriate Clinical Department.

4.4-4 DEPARTMENT ACTION

The Department Committee shall review the Medical Staff member's file and shall forward one of the following recommendations to the Medical Executive Committee:

- a) Approval for reappointment
- b) Approval for reappointment with one or more of the following modification(s):
 - 1. Change in staff category
 - 2. Change in department affiliation
 - 3. Change in clinical privileges (specify)
- c) Non-renewal due to incomplete application
- d) Non-approval of reappointment

Thereafter, the provisions of Sections 4.3-4 through 4.3-9 shall govern.

4.5 REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

A Medical Staff member may at any time request modification of his staff category, department assignment or clinical privileges by submitting a written request to the Chief Executive Officer or designee. Such application shall be processed in the same manner as provided in Section 4.4 for reappointment. The applicant must meet eligibility requirements for privileges as defined in 5.1.1 and 5.1.2.

4.6 REQUESTS FOR REINSTATEMENT OF MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES

- a) If a request for reinstatement is requested within six (6) months after voluntary resignation or expiration of the appointment term, the practitioner may complete a reappointment application through the Medical Staff Services Office.
- b) If a reinstatement is requested more than six (6) months after the voluntary resignation or expiration of appointment, the practitioner must complete an initial application for membership and privileges, and pay the initial processing fee.
- c) A second consecutive reinstatement will require the applicant to meet whatever credentialing criteria are in place at the time of the second reinstatement application.

4.7 EXPEDITED APPROVAL

In the event the Board of Directors meeting is delayed or canceled, and following a positive recommendation from the Medical Executive Committee on an application, the Board Executive Committee may render decisions regarding initial appointment, granting of privileges, reappointment, and renewal or modification of clinical privileges. The Board Executive Committee, with authority delegated by the Board, may reach consensus via mail, telephone, fax, or email. The full governing body must consider and ratify all positive committee decisions at its next regularly scheduled meeting. If the board committee's decision is adverse to an applicant, the matter is referred back to the Medical Executive Committee for further evaluation. An applicant is considered ineligible for this expedited process if any of the following has occurred:

- a) The applicant submits an incomplete application;
- b) The Medical Executive Committee makes a final recommendation that is adverse or has limitations;
- c) There is a current challenge or a previously successful challenge to licensure or registration;

- d) The applicant has received an involuntary termination of medical staff membership at another organization;
- e) The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges; or
- f) The applicant has had an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
- g) Other significant concerns within an application.

ARTICLE V MEDICAL STAFF PRIVILEGES

5.1 DELINEATION OF PRIVILEGES

5.1-1 Each application for appointment and reappointment to the Medical Staff must contain a request, on a form(s) prescribed by the Board of Directors, for the specific clinical privileges desired by the applicant. A request by a Medical Staff member pursuant to Section 4.5 for additional privileges must be supported by evidence of relevant training and/or experience.

5.1-2 Clinical privileges shall be granted by the Board of Directors, as recommended by the appropriate Section, Department and Medical Executive Committee, on the basis of current licensure and/or certification, specific relevant training, evidence of physical ability to perform the requested privilege, data from professional practice review from an organization where the applicant currently has the requested privilege(s), peer and or faculty recommendation. When the applicant is applying for renewal of clinical privileges, review of the practitioner's performance within the hospital is also considered.

5.1-2.1 Ongoing practitioner evaluation information is factored into the decision to maintain an existing privilege, to revise an existing privilege, or to revoke an existing privilege prior to or at the time of renewal. Practitioner-specific evaluation reports shall be completed by the Chairman (or designee) annually and shall be maintained in the physician's activity profile. Any evaluation referencing significant variances from acceptable rates as determined by the Medical Staff shall be submitted to the practitioner's Department at their next meeting, however the Chairman (or designee) shall, at any time, immediately act upon any reported concern regarding a privileged practitioner's clinical practice and/or competence. The Department Committee will address issues to determine the cause for the variance and resolve variances in accordance with the Medical Staff bylaws.

Factors to be Considered

- a) concurrent review of the practitioner's assessment and treatment of patients;
- b) review of invasive and non-invasive clinical procedures performed and their outcomes;
- c) blood utilization, medication management, and morbidity and mortality data;
- d) requests for tests and procedures; use of consultants; medical records compliance;
- e) and other relevant criteria as directed within these Bylaws and/or by the MEC.

The Evaluation Process

Information used in this evaluation may be obtained through, but is not limited to, the following:

- a) concurrent and/or targeted medical record review;
- b) direct observation;
- c) monitoring/proctoring;
- d) discussion with other practitioner's involved in the care of specific patients;
- e) data collected and assessed through the hospital quality improvement indicators;
- f) sentinel event data;
- g) and any applicable peer review data.

5.1-3 In the event there is a privilege request for which there are no approved criteria, the Board must determine whether it will allow any practitioner to perform the specific procedures or provide the specified clinical service. Such requests will be processed using the general criteria of adequate education, training, clinical experience, and professional references demonstrating current clinical competence. If the Board, upon recommendation of the Medical Executive Committee, allows the privilege, criteria will be developed in accordance with medical staff guidelines for developing privilege criteria for new procedures/techniques or utilizing new technology for diagnosis and/or treatment.

5.1-4 Prior to the consideration or granting of any privilege not currently delineated on any clinical privilege delineation form, it shall be determined by the appropriate Department Chairman (or designee), Medical Director if applicable (or designee) and President & CEO (or designee) whether or not the hospital has the necessary resources currently available to support the requested privilege or if the resources can be available within a specified time frame.

5.1-4 Specific, detailed privilege eligibility criteria are outlined in the Clinical Privilege Manual that is an appendage to these bylaws. The eligibility criteria include any and all requirements the applicant must meet in order to be eligible to apply for the specific privilege. The clinical privilege delineation forms include the scope of privileges for each specialty and category of practitioner. Meeting privilege eligibility criteria alone does not guarantee a practitioner will be granted the privilege(s). Clinical Privilege Delineation Forms are maintained in the Clinical Privilege Manual and include a list of specific privileges or limitations for each category of practitioner. The Clinical Privilege Manual is reviewed at least bi-annually. Proposed revisions to the Clinical Privilege Manual do not require a ballot by vote by the Active and Honorary Medical Staff. The applicable Medical Staff Department or the Credentials Committee can recommend revisions to the Medical Executive Committee who will forward their recommendations to the Board of Directors.

5.2 **EMERGENCY PRIVILEGES**

5.2-1 For the purposes of this Section, an "emergency" is defined as a condition in which serious or permanent harm to a patient may result or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

5.2-2 In the case of an emergency, any practitioner who has been granted clinical privileges shall be permitted to do everything possible to save the life of a patient or to save a patient from

serious harm regardless of Staff status or clinical privileges, provided that the care provided is within the scope of the individual's license. When the emergency is concluded, a practitioner exercising emergency privileges shall obtain appropriate consultation and provide for appropriate follow-up care. In addition, such emergency care may be provided by properly supervised members of the House Staff. In a disaster situation, Section 5.4 of the Bylaws "Disaster Privileges" will be followed.

5.3 **TEMPORARY PRIVILEGES**

- 5.3-1 A licensed physician or other qualified individual may be granted temporary privileges upon a finding by the Chief Executive Officer or designee, the President of the Medical Staff, and the appropriate Department Chairman or designee (i.e. Vice Chairman or Section Chief), that the applicant is an appropriately licensed practitioner competent to exercise the privileges requested. Temporary privileges may be terminated by the Chief Executive Officer or President of the Medical Staff at any time and shall not extend beyond a decision by the Board of Directors on whether to grant Medical Staff membership and clinical privileges. In exercising temporary privileges, the applicant shall act under the supervision of an unsupervised member of the Medical Staff holding the same privileges, or the appropriate Department Chairman, and is subject to any conditions that the Chief Executive Officer or President of the Medical Staff may impose.
- 5.3-2 Temporary privileges requested by a physician not applying to the Medical Staff may only be granted on two (2) occasions during a one (1)-year period and must be for purposes of fulfilling a specific patient care need. Temporary privileges pertain to a specific patient and time frame specified on the temporary privilege form but are not exceed 120 days.
- 5.3-3 Physicians who have been approved for Medical Staff membership by the Credentials Committee and the appropriate Department Committee may request temporary privileges pending Board of Directors approval, but for no longer than thirty (30) days.
- 5.3-4 At a minimum, verification of current Arizona licensure, DEA registration and proof of insurance must be obtained by the Hospital. In addition, information regarding education, training and board certification status should be submitted by the applicant. Verification that the applicant has unsupervised privileges in the area requested at a JCAHO-accredited hospital must be obtained. If the applicant does not hold membership on another Medical Staff, verification of current competency to perform the privileges requested must be obtained from a licensed individual who can attest to the applicant's clinical judgment and technical skills in treating pediatric patients.

5.4 **DISASTER PRIVILEGES**

Disaster privileges may be granted when the emergency management plan has been activated and the hospital is unable to handle immediate patient needs. In a disaster situation, a physician or practitioner, who is not a member of the Medical or Allied Health Staff, should be granted privileges in order to provide patient care within Phoenix Children's Hospital. Privileges shall be granted by the Chief Executive Officer (or designee handling the disaster), or the Medical Staff President (or designee), upon presentation of any of the following forms of identification:

1. A current picture hospital ID Card or critical access hospital ID card that clearly identifies professional designation.
2. A current license to practice and a valid picture ID issued by a state, federal or regulatory agency.

3. Primary source verification of the license.
4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), MRC, ESAR-VHP or other recognized state or federal organization or group.
5. Identification indicating that the individual has been granted authority to render patient care in emergency (disaster) circumstances by a federal, state or municipal entity.
6. Presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity.

The physician or practitioner who is granted disaster privileges will be issued a temporary identification badge and should be paired with or act under the supervision of a member of the Medical Staff.

As soon as the immediate situation is under control and when possible within 72 hours, the following information will be verified by Medical Staff Services:

1. Current, valid professional license to practice in the state of Arizona
2. Current, valid DEA registration
3. Certificate of malpractice insurance in the amount required by the hospital
4. Name of JCAHO-accredited hospital where the practitioner has unsupervised privileges
5. Information regarding education, training and board certification status
6. National Practitioner Data Bank and OIG query

A record of this information will be maintained in the Medical Staff Office.

Such privileges shall terminate once the disaster situation no longer exists or if any information received through the verification process suggests the person is not qualified to render services in an emergency.

5.5 **TELEMEDICINE PRIVILEGES**

5.5-1 Practitioners who prescribe, render a diagnosis, or provide clinical treatment to patients of Phoenix Children's Hospital by telemedicine link are subject to the credentialing and privileging processes set forth in Articles IV and V of these Bylaws. The provisions in Article V, Section 5.3-2, Temporary Privileges, may apply to practitioners requesting such privileges for purposes of fulfilling a specific patient care need.

5.5-2 The medical staffs at both the originating and distant sites recommend the clinical services to be provided by licensed independent practitioners through a telemedical link at their respective sites, according to commonly accepted quality standards, and with consideration of appropriate telemedicine equipment to be utilized.

5.6 **TRAINING PRIVILEGES**

5.6-1 A licensed physician or other qualified individual may be granted training privileges upon a finding by the Chief Executive Officer or designee, the President of the Medical Staff or designee, the appropriate Chairman or designee, the appropriate Section Chief or designee and the Chairman of the Credentials Committee that the applicant is an appropriately licensed practitioner competent to participate in the training program as approved by the Medical Education Committee, practitioners may be granted training privileges to update or enhance their pediatric skills. The training privileges are subject to any conditions or limitations imposed by the Chief Executive Officer or the Medical Staff.

- 5.6-2 Training privileges requested by a physician or other qualified practitioner may not exceed 120 days. Training privileges may only be granted one (1) time during a one (1) year period.
- 5.6-3 At a minimum, verification of education, post graduate training, current Arizona licensure, DEA registration, proof of insurance and claims history, health status, peer references, staff status at the applicant's primary hospital OIG and NPDB report will be obtained, reviewed and determined sufficient to qualify the applicant for training privileges.
- 5.6-4 Training privileges may be terminated at the discretion of the President and CEO or the President of the Medical Staff without affording the practitioner the right to a hearing or due process.

ARTICLE VI CORRECTIVE ACTION

6.1 MANDATORY CORRECTIVE ACTION

- 6.1-1 A practitioner's Medical Staff privileges shall automatically be revoked, suspended or restricted in accordance with any revocation, suspension or restriction of the practitioner's license by the appropriate state licensing agency.
- 6.1-2 A practitioner's Medical Staff privileges shall be suspended for failure to maintain the minimum amount of professional liability insurance that may be required by the Hospital, provided that suspension shall not occur if the practitioner cures the failure within ten (10) days after receiving written notice thereof. The suspension shall be lifted when the practitioner cures the failure.
- 6.1-3 A practitioner's Medical Staff privileges shall be suspended for failure to make timely payment of Staff Dues if the practitioner has received written notice of the failure from the President of the Medical Staff and has not remedied such failure within the time specified in the notice. The suspension shall be lifted when the practitioner pays the required medical staff dues plus a reinstatement fee established by the Medical Executive Committee.
- 6.1-4 Upon recommendation from the Medical Executive Committee a practitioner's Medical Staff privileges shall be suspended for failure to prepare or complete medical records in a timely and professional manner, provided that such suspension shall not occur unless the practitioner has received written notice of the failure from the President of the Medical Staff and has not remedied such failure within the time specified in the notice. The suspension shall be lifted when the medical records are completed to the satisfaction of the President of the Medical Staff.
- 6.1-5 A practitioner's right to prescribe medications shall be revoked, suspended or restricted in accordance with any revocation, suspension or restriction of the practitioner's prescribing authority by the Drug Enforcement Administration.

6.2 SUMMARY SUSPENSION AND SUMMARY SUPERVISION

- 6.2-1 Whenever corrective action must be taken immediately to protect and assure patient care and safety in the Hospital, the following individuals or bodies shall be authorized to summarily suspend or place under supervision all or any portion of the clinical privileges of a practitioner: The President of the Medical Staff, Vice President of the Medical Staff, Department Chairman, the Chief Executive Officer or designee, the Executive Committee of

the Medical Staff or the Executive Committee of the Board of Directors. Summary suspension or supervision is effective immediately upon imposition.

- 6.2-2 When summary suspension/supervision has been imposed, the Chief Executive Officer shall be notified verbally and in writing as soon as reasonably possible and the President of the Medical Staff shall implement corrective action procedures in accordance with Article VI, Section 6.3 of these Bylaws.

6.3 **DISCRETIONARY CORRECTIVE ACTION**

- 6.3-1 Corrective action procedures shall be initiated when either the Chief Executive Officer or the President of the Medical Staff has received written notice that a practitioner:

6.3-1.1.1 is or may be engaged in conduct that is contrary to good patient care, prevailing ethical standards or sound administration; or

6.3-1.1.2 has had Medical Staff privileges at another health care institution revoked, suspended or restricted for reasons relating to quality of patient care.

- 6.3-2 Upon receipt of such notice, the President of the Medical Staff or his designee shall conduct a preliminary investigation to determine whether the charges against the practitioner have any basis. The practitioner shall be notified in writing that a preliminary investigation is underway and shall be given an opportunity to discuss the charges with the President of the Medical Staff or his designee. The preliminary investigation shall be completed within thirty (30) days after receipt of the notice by the President of the Medical Staff.

- 6.3-3 Upon completion of the preliminary investigation, the President of the Medical Staff or his designee shall convene the Executive Committee and report his findings. If the Executive Committee concludes that the charges have no basis, no further action shall be taken. If the Executive Committee concludes that the charges may have a basis, it shall appoint a Committee consisting of three practitioners, who are impartial peers of the individual under review, to investigate the charges more fully. In addition, the Executive Committee may take such temporary corrective action, as it deems necessary to safeguard the health of patients. Such action may consist of suspension or restriction of the practitioner's privileges or placement of the practitioner on supervised status. It shall become effective immediately and shall remain in effect until the Executive Committee takes action pursuant to Section 6.3-5.

- 6.3-4 The Committee appointed to investigate charges against a practitioner shall promptly give the practitioner written notice of the investigation and shall follow the fair hearing provision of Section 7.1. Within sixty (60) days after its appointment, the Committee shall complete its investigation and submit to the Executive Committee a written report, including recommendation for corrective action, if any. A copy of the report shall be provided to the practitioner, the Chief Executive Officer and the President of the Medical Staff.

- 6.3-5 Upon filing of the report, the Executive Committee shall promptly be convened to determine what, if any, corrective action should be taken. Such action may consist of termination of medical staff membership, revocation, suspension or restriction of the practitioner's privileges, placement of the practitioner on supervised status, or such other action as the Executive Committee deems appropriate in order to safeguard the welfare of patients. At the meeting, a representative of the investigative committee and the practitioner or his designee may make an oral presentation. Any action by the Executive Committee shall become

effective immediately and shall remain in effect unless altered by the Executive Committee or by the Board of Directors.

- 6.3-6 Section 6.3 shall not apply to House Staff. Discretionary corrective action for House Staff rests with the appropriate Chief and the Director of Medical Education.

6.4 **FURTHER PROCEDURES**

6.4-1 A practitioner who is the subject of corrective action by the Medical Executive Committee pursuant to Section 6.2-6.5 shall have the right to a hearing before the Board of Directors. This right shall be exercised by delivering a written request for such a Hearing to the Chief Executive Officer in person or by certified mail within thirty (30) days after the practitioner has received notice of the corrective action. The Hearing shall be conducted in accordance with the Fair Hearing procedures of Section 7.2.

6.4-2 If the Board of Directors is inclined to reach a decision different from the mandatory corrective action or the corrective action taken by the Medical Executive Committee, the Board of Directors shall submit the matter for consideration by a Joint Conference Committee prior to making its final decision. This committee shall consist of two (2) members of the Board of Directors nominated by the Chairman, two (2) members of the Medical Executive Committee, who are impartial peers of the practitioner under review, nominated by the President of the Medical Staff and the Chief Executive Officer.

6.4-3 Within sixty (60) days after the Hearing, the Board of Directors shall give written notice to the practitioner, the Chief Executive Officer and the President of the Medical Staff of its final decision and the reasons for that decision. The decision of the Board of Directors shall be final and are effective immediately.

6.5 **MISCELLANEOUS**

6.5-1 All decisions relating to corrective action shall be made in order to further patient care and sound administration. Accordingly, any suspension pursuant to Sections 6.1-2 or 6.1-3 shall not affect the practitioner's right to treat patients in the Hospital at the time of the suspension. With respect to revocation or suspension of privileges pursuant to 6.1-1, 6.1-4 or 6.2, responsibility for the practitioner's patients in the Hospital at the time of corrective action shall be assigned to another practitioner by the appropriate Department Chairman and the President of the Medical Staff. Whenever possible, the wishes of the patient or the patient's family shall be considered in selecting a substitute practitioner.

6.5-2 Corrective action with respect to a practitioner for reasons unrelated to professional clinical capability, exercise of clinical privileges or other reasons set forth in Section 6.1 shall be accomplished in accordance with the applicable hospital policies or the terms of the practitioner's employment agreement or other arrangement, if any, with the Hospital, or the provisions of the Medical Staff Rules and Regulations, if applicable.

6.5-3 The time periods specified in this Article are to assist in the orderly administration of the Hospital in the interests of patient care. They may be waived for good cause and shall not be deemed to give any practitioner a right to insist upon adherence to those time periods.

ARTICLE VII

FAIR HEARING AND APPEAL PROCESS

The organized medical staff provides the following mechanism for addressing adverse decisions regarding appointment, reappointment, denial, reduction, suspension, or revocation of privileges that may relate to quality of care, treatment, and services issues.

7.1 PROCEDURE FOR INVESTIGATIVE COMMITTEES

- 7.1-1 Pursuant to Sections 4.3-5, 4.4-4 and 6.3-3, the Executive Committee shall appoint a committee to investigate: (a) any application for appointment or reappointment to the Medical Staff or (b) any corrective action. A Committee so appointed shall not include any practitioner who was directly involved in the subject of the investigation. The Executive Committee shall designate one of the members of the Investigative Committee to be Chairman.
- 7.1-2 The Chairman of the Investigative Committee shall promptly schedule the hearing. The Chairman shall send out a notice specifying the date, time and place of the hearing at least thirty (30) days prior to the hearing. The notice shall include a written statement of charges and, if applicable, a list of witnesses anticipated to participate in the hearing.
- 7.1-3 The practitioner shall have the right to determine whether or not the hearing will be open to members of the Medical Staff. The practitioner must be present at the hearing but may choose to be represented by legal counsel.
- 7.1-4 At the Hearing, both the Investigative Committee and the practitioner may call and examine witnesses, introduce exhibits and cross-examine any witness. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered. The practitioner may submit one written memorandum setting forth his position. The practitioner has the burden of proof to establish that adverse action should not be taken.
- 7.1-5 A record of the Hearing shall be kept by a verbatim transcript taken by a court reporter. The practitioner shall bear all the expenses incurred by him in connection with the hearing.
- 7.1-6 The Investigative Committee shall make a written report of its findings and conclusions. It shall designate one of its members to represent the Committee at subsequent deliberations of the Executive Committee.

7.2 PROCEDURE FOR BOARD OF DIRECTORS HEARINGS

- 7.2-1 Pursuant to Sections 4.3-9, 4.4-4 and 6.3-1, the Board of Directors shall hold a Hearing to consider adverse action regarding a practitioner. Any member of the Board of Directors who was directly involved in the subject of the Hearing shall not participate.
- 7.2-2 The Hearing before the Board of Directors shall be scheduled within sixty (60) after receipt by the Chief Executive Officer of a timely request for such Hearing. The practitioner shall be given written notice of the date, time and place of the Hearing.
- 7.2-3 The practitioner must be present at the Hearing but may choose to be represented by legal counsel. The practitioner or his counsel may make an oral presentation and may submit a

written memorandum but shall not be entitled to offer any evidence unless the Board of Directors permits.

- 7.2-4 A record of the Hearing shall be kept by a verbatim transcript taken by a court reporter. The practitioner shall bear all the expenses incurred by him in connection with the Hearing.

ARTICLE VIII MEDICAL STAFF DEPARTMENTS

8.1 DEPARTMENTS AND SECTIONS

- a) DEPARTMENT OF PEDIATRIC ANESTHESIA
Sections:
 - 1. Anesthesiology
 - 2. Pain Management

- b) DEPARTMENT OF PEDIATRIC MEDICINE
Sections:
 - 1. Adolescent
 - 2. Allergy & Immunology
 - 3. Ambulatory
 - 4. Behavioral Development (Psychiatry and Psychology)
 - 5. Cardiology
 - 6. Critical Care
 - 7. Dermatology
 - 8. Developmental
 - 9. Emergency Medicine
 - 10. Endocrinology & Diabetes
 - 11. Family Practice
 - 12. Forensic Medicine
 - 13. Gastroenterology
 - 14. General Pediatrics
 - 15. Genetics & Dysmorphology
 - 16. Hematology & Oncology
 - 17. Infectious Disease
 - 18. Medical Imaging/Radiology
 - 19. Neonatology
 - 20. Nephrology
 - 21. Neurology
 - 22. Physical Medicine & Rehabilitation
 - 23. Pulmonary
 - 24. Radiation Oncology
 - 25. Rheumatology

- c) DEPARTMENT OF PEDIATRIC SURGERY
Sections:
 - 1. Dentistry and Oral Surgery
 - 2. Pediatric Surgery
 - 3. Neurosurgery

4. Obstetrics/Gynecology
5. Ophthalmology
6. Orthopedic Surgery
7. Otorhinolaryngology
8. Pathology
9. Plastic Surgery
10. Thoracic & Cardiovascular Surgery
11. Transplant Surgery
12. Urology

8.2 ASSIGNMENTS TO DEPARTMENT AND SECTIONS

Each member of the staff shall be assigned membership in at least one Department and Section and shall be granted clinical privileges relevant to the care provided within that Department.

8.3 FUNCTIONS OF DEPARTMENTS

Each Department shall:

- a) Review patient care
- b) Establish procedure for delineating clinical privileges and evaluating the performance of services within the Department
- c) Recommend protocols for delineation of privileges for members of the Affiliate Staff and Allied Health Staff assigned to the Department.
- d) Submit recommendations required under Articles IV and V concerning the privileges of each member or applicant
- e) Facilitate continuing education programs
- f) Monitor the professional conduct of the Department members
- g) Coordinate Department functions with nursing, ancillary patient care services, and administrative support services
- h) Submit the following reports on a regular basis to Medical Executive Committee:
 1. A summary of Department activities
 2. Recommendations for maintaining and improving quality of care
 3. Other matters determined by the Department or upon request of the Executive Committee
- i) Meet monthly to conduct departmental business unless cancelled by the Chair.
- j) Fulfill all other departmental responsibilities.

8.4 FUNCTIONS OF CLINICAL SECTIONS

Each Section shall have a Chief appointed by the Department Chairman and perform the functions assigned to it by the Department Chairman and approved by the Executive Committee. The Section may meet as needed at the discretion of the Section Chief, and will report activities and recommendations directly to the appropriate Department Committee.

**ARTICLE IX
OFFICERS AND ELECTED OFFICIALS**

9.1 OFFICERS AND ELECTED OFFICIALS OF THE MEDICAL STAFF

- a) Officers:
 - President of the Medical Staff
 - Vice-President of the Medical Staff (President-Elect)
 - Secretary-Treasurer

- Immediate Past President of the Medical Staff
- b) Elected Officials:
 - Six (6) Members-at-Large of the Executive Committee. Two (2) must be office based General Pediatricians)
 - Chairman of the Department of Pediatric Anesthesia
 - Chairman of the Department of Pediatric Medicine
 - Chairman of the Department of Pediatric Surgery
 - Phoenix Children's Medical Group (PCMG) Representative

9.2 **QUALIFICATIONS**

- a) Officers and Elected Officials must be members of the Active, Honorary or Senior Medical Staff.
- b) All officers and elected officials including Department Chairs, appointed after January 1, 2008 shall be board certified by an appropriate American Board of Medical Specialties or American Board of Osteopathic Association specialty or subspecialty board.
- c) Candidates for Department Chairman must have served as a recent member of the respective Departmental Committee for a minimum of two (2) years with good attendance and active participation in PCH affairs.
- d) Candidates for Member-at-Large of the Executive Committee should have a minimum of two (2) years recent experience as a member of a Medical Staff Committee.

9.3 **NOMINATING COMMITTEE RESPONSIBILITIES**

- a) The Nominating Committee will prepare a slate of at least one (1) candidate for each office at least thirty (30) days prior to the Annual Medical Staff meeting.
- b) This slate shall be mailed to eligible voters at least thirty (30) days prior to the Annual Medical Staff meeting.
- c) Candidates for Department Chairman shall be nominated and elected by non-PCMG Active, Honorary and Senior members of their respective Departments. The elected PCMG member shall be nominated and elected by the Active, Honorary and Senior members of the Phoenix Children's Medical Group (PCMG). All other positions shall be nominated and elected by the Active, Honorary and Senior members of the Medical Staff.
- d) The proposed slate shall be presented at the Annual Medical Staff meeting. Additional nominations by eligible voters may be made from the floor. If the election is to occur to fill a vacated or new Officer position during a term, the ballot may be prepared and mailed directly to the voting members of the staff without presentation at the Annual Medical Staff meeting.
- e) A nomination shall not be accepted without permission of the nominee.

9.4 **ELECTION PROCEDURE**

The Secretary-Treasurer shall prepare the official ballot listing the candidates. No other ballot will be accepted. The Secretary-Treasurer shall mail one (1) official ballot and two (2) official envelopes, with instructions, to each eligible voter within fourteen (14) days after nominations are completed. A voting member must write his or her name on the official outside envelope and must return the same with the official inside envelope containing the ballot within fourteen (14) days after mailing of the ballots. The official outside envelope shall remain sealed until the voter's name has been checked off the list of eligible voters by the Secretary-Treasurer or designee. The official inside envelope containing the ballot shall remain sealed and be deposited in the official ballot box. The envelopes shall be opened and the ballots counted by the Executive Committee or a Committee of tellers authorized by the Executive Committee. At least one (1) member of the Executive Committee shall be present and supervise the counting of the ballots.

Both a majority and plurality of the votes cast on any ballot shall be necessary to elect. If there are more than two (2) nominees for a single office and no nominee is elected on the first ballot, all of the nominees except the two (2) who receive the highest number of votes on the first ballot shall be dropped and a second mail ballot shall be taken in the same manner as the first.

For the annual election of two (2) Members-at-Large of the Executive Committee, all nominees (minimum of four (4)) will be listed in alphabetical order for one-half of the ballots and reverse alphabetical order for one-half of the ballots. Voters will be required to vote for no more than two (2) nominees and cast no more than one (1) vote for a single nominee. Both a majority and plurality of the votes cast on any ballot shall be necessary to elect. If fewer than two (2) nominees are elected on the first ballot, those elected on the first ballot, if any, and the nominee who receives the least number of votes on the first ballot, shall have their names removed from the slate, and a second election from the remaining candidates shall be conducted in the same manner as the first. This process shall continue until four (4) Members-at-Large of the Executive Committee are elected. In the event two (2) or more candidates receive an equal number of votes, their names shall remain on the subsequent ballot if any. In case the only two (2) nominees for an office receive an equal number of votes, election shall be determined by lot in such manner as the Executive Committee may prescribe, and the person in whose favor it results shall be elected. The Secretary-Treasurer shall certify the results of the election.

9.5 **TERM OF ELECTED OFFICE**

All terms of office shall commence on January 1. The President and Vice President of the Medical Staff shall each serve a two (2)-year term and be limited to only one (1) term, and they cannot immediately succeed themselves. The Secretary-Treasurer shall serve a two (2)-year term and no more than two (2) consecutive terms. Department Chairmen shall each serve a two (2)-year term and no more than two (2) consecutive terms. Officers will be elected on years alternate to the election of Department Chairmen. Members-at-Large of the Executive Committee shall serve a two (2)-year term and no more than two (2) consecutive terms. Terms should be staggered among members-at-large to permit continuity. The Phoenix Children's Medical Group Representative shall serve a two (2)-year term and no more than two (2) consecutive terms. No one shall simultaneously occupy more than one (1) Elected Office.

9.6 **VACANCIES IN ELECTED OFFICE**

Vacancies in Elected Office, other than those of President of the Medical Staff and Vice President of the Medical Staff, shall be filled by action of the Executive Committee. If there is a vacancy in the office of President of the Medical Staff, the Vice President of the Medical Staff shall serve out the remaining term. A vacancy in the office of Vice President of the Medical

Staff shall be filled by a special election conducted as soon as reasonably possible after the vacancy occurs following the procedure outlined in Section 9.1-3.

9.7 REMOVAL OF ELECTED OFFICERS AND OFFICIALS

Upon receipt of a written petition for recall of an Elected Officer or Official signed by no fewer than one-third of the members of the Active, Honorary and Senior Staff, the Executive Committee shall submit the request to a written ballot of eligible voters. An affirmative vote of two-thirds of the members of the Active, Honorary and Senior Staff shall be necessary to recall the Officer or Official.

Elected Officers and Officials may be removed for non-performance of duties of the office held as defined in the Bylaws, or for reasons related to unethical conduct or non-performance of Medical Staff responsibilities as determined by the Medical Staff.

9.8 DUTIES OF ELECTED OFFICERS AND OFFICIALS

Leaders of the organized Medical Staff participate actively in performance improvement activities to improve quality of care, treatment, and services and patient safety.

9.8-1 PRESIDENT OF THE MEDICAL STAFF

The President of the Medical Staff is the principal Elected Officer of the Medical Staff and shall:

- a. Participate in interdisciplinary and interdepartmental performance improvement activities
- b. Assist in coordinating the activities of administration, nursing and other patient care services with those of the Medical Staff
- c. Represent the Medical Staff to the Chief Executive Officer, other Officials of the Medical Staff and the Board of Directors
- d. Enforce the Medical Staff Bylaws, Medical Staff Rules and Regulations and the Medical Staff's compliance with patient safety standards
- e. Call, preside over and prepare the agenda for all meetings of the General Medical Staff and Executive Committee.
- f. Approve additional attendees to Executive Committee meetings
- g. Serve as Chairman of the Executive Committee and as ex-officio member of all Medical Staff Committees, with vote
- h. Serve as an ex-officio member of the Board of Directors and the Executive Committee of the Board of Directors of Phoenix Children's Hospital, with vote
- i. Appoint, in accordance with the provisions in Article X, members of all standing, special and multidisciplinary Medical Staff Committees except the Executive and Department Committees
- j. Report to the Board of Directors on the quality of care and opportunities for continuous quality improvement in the Hospital as recommended by the Medical Staff
- k. Represent the Medical Staff in its professional and community relations.

9.8-2 VICE PRESIDENT OF THE MEDICAL STAFF

The Vice President of the Medical Staff shall:

- a. Participate in interdisciplinary and interdepartmental performance improvement activities
- b. Assume all responsibilities and authority of the President of the Medical Staff in his absence
- c. Serve as a voting member and Vice Chairman of the Executive Committee

- d. Serve as Chairman of the Quality Council
- e. Serve as the AMA Hospital Medical Staff Section (OMSS) representative
- f. Serve on the Hospital Board of Directors during the second year of the term of the President of the Medical Staff.
- g. Serve on the Strategic Planning Committee of the Board of Directors as an ex-officio member without vote during the first year of term, and shall become a voting member of the committee during the second year of term.
- h. Serve as President-Elect

9.8-3 SECRETARY-TREASURER

The Secretary-Treasurer shall:

- a. Participate in interdisciplinary and interdepartmental performance improvement activities
- b. Issue proper notice of all Staff meetings
- c. Serve as a voting member of the Executive Committee
- d. Supervise preparation of minutes for all Executive Committee meetings; record attendance and fulfill other secretarial duties
- e. Collect Staff Dues and prepare a financial report of the Medical Staff Accounts for the Executive Committee and the Medical Staff
- f. Maintain appropriate financial records of the Medical Staff Accounts
- g. Notify the President of the Medical Staff of members who fail to pay Staff Dues
- h. Upon temporary absence, the duties of the Secretary-Treasurer shall be assumed by a member of the Executive Committee designated by the President of the Medical Staff
- i. Upon premature vacancy of the office of Secretary-Treasurer, the Executive Committee will elect one of its members to complete the unexpired term
- j. Serve as Chairman of the Credentials Committee

9.8-4 IMMEDIATE PAST PRESIDENT OF THE MEDICAL STAFF

The Immediate Past President of the Medical Staff shall:

- a. Participate in interdisciplinary and interdepartmental performance improvement activities
- b. Serve as a voting member of the Executive Committee, and perform other duties assigned by the President of the Medical Staff, the Executive Committee or the Board of Directors
- c. During the first year of the term of the President of the Medical Staff, the Immediate Past President of the Medical Staff shall continue to serve on the Hospital Board of Directors.
- d. Serve as Chairman of the Nominating Committee

9.8-5 MEMBERS-AT-LARGE OF THE EXECUTIVE COMMITTEE

The Members-at-Large of the Executive Committee shall:

- a. Participate in interdisciplinary and interdepartmental performance improvement activities
- b. Serve as voting members of the Executive Committee, and perform other duties assigned by the President of the Medical Staff, the Executive Committee or the Board of Directors

9.8-6 CLINICAL DEPARTMENT CHAIRMEN

Each Chairman shall participate in interdisciplinary and interdepartmental performance improvement activities. In addition, each Chairman is responsible for:

- a. Clinically related activities of the department
- b. Administratively related activities of the department/service, unless otherwise provided by the hospital
- c. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges
- d. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department
- e. Recommending clinical privileges for each member of the department
- f. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization, to ensure provision of essential services in a timely manner; and to ensure services provided by consultation, contractual arrangements, or other agreements are provided safely and effectively.
- g. Participating, as needed, in administrative decisions regarding medical services provided by the hospital
- h. The integration of the department or service into the primary functions of the organization
- i. The coordination and integration of interdepartmental and intradepartmental services
- j. The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services
- k. The recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services
- l. The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services within the department
- m. The continuous assessment and improvement of the quality of care, treatment, and services provided
- n. The maintenance of quality control programs, as appropriate
- o. The orientation and continuing education of all persons in the department or service
- p. Recommendations for space and other resources needed by the department or service
- q. Enforcement of the Medical Staff Bylaws, Medical Staff Rules and Regulations and Department Rules and Regulations
- r. Keeping abreast of Hospital policies and procedures and all State and Federal regulations affecting departmental operations, as well as requirements of regulatory and accrediting agencies in which the Hospital is a participant, and taking all reasonable steps to conform therewith
- s. Responsibility for teaching, education and research within the department. These functions shall be accomplished through the coordinating efforts of the Chairman and/or his designee(s).

Specific credentialing and privileging, or peer review activities may be delegated to the appropriate Section Chief within the Department who has expertise in the specialty area.

The Department Chairman shall:

- a. Serve as a voting member of the Executive Committee
- b. Participate in the evaluation of practitioners within his/her department at the time privileges are granted and renewed

- c. Report to the Executive Committee regarding professional activities, quality, and performance improvement within the department, appointments, reappointments, delineation of clinical privileges and recommendations for corrective action within the Department
- d. Assist, as needed, in the development and implementation of departmental programs
- e. Appoint members of the Department Committee and a Chief for each Section of the Department, after consultation with the President of the Medical Staff and subject to approval by the Executive Committee
- f. Implement directives of the Executive Committee and Board of Directors
- g. Participate in administration of the department in cooperation with the nursing service and the hospital administration
- h. Assist in the preparation of annual reports and budget planning as requested by the Executive Committee, the Chief Executive Officer or the Board of Directors.

9.8-7 PCMG REPRESENTATIVE

The Phoenix Children's Medical Group (PCMG) Representative shall:

- a. Participate in interdisciplinary and interdepartmental performance improvement activities
- b. Serve as a member of the Executive Committee, with vote, and perform other duties assigned by the President of the Medical Staff, the Executive Committee or the Board of Directors.

**ARTICLE X
MEDICAL STAFF COMMITTEES**

The Medical Staff has organized Committees to review the professional practices of practitioners and others granted hospital privileges for the purposes of continuous quality improvement. Departments and Sections may organize into Committees to assess and formulate recommendations related to the nature, quality and necessity of care provided.

10.1 BOARD COMMITTEES

Members of the Medical Staff shall participate on Committees of the Board of Directors as assigned by the Chairman of the Board to provide a means of communication among members of the Medical Staff, Hospital Administration and the Board of Directors.

10.2 SPECIAL COMMITTEES

The President of the Medical Staff may appoint ad hoc committees as required to perform specific functions for the Medical Staff.

- a) Each ad hoc committee shall confine its work to its specific purpose and dissolve upon completion of assignment, or no longer than twenty-four (24) months, unless extended by the President of the Medical Staff.
- b) Each ad hoc committee reports to the Medical Executive Committee.

10.3 STANDING COMMITTEES

The President of the Medical Staff shall have authority to appoint all Standing Committees and their Chairmen, except the Department Committees and Executive Committee, subject to approval by the Executive Committee.

- a) Members shall serve a one (1)-year term and may be reappointed.
- b) A Standing Committee shall meet on call of the Chairman.
- c) The Chief Executive Officer or designee is an ex-officio member without vote of all standing committees.
- d) The President of the Medical Staff is an ex-officio member, with vote, of all standing committees.

10.4 **MEDICAL EXECUTIVE COMMITTEE**

- a) The Medical Executive Committee shall consist of fourteen (14) voting members. The composition of the committee is as follows:
 1. The President of the Medical Staff, Vice President of the Medical Staff, Secretary-Treasurer, Immediate Past President of the Medical Staff, six (6) Members-at-Large, two (2) of the six (6) Members-at-Large must be office based General Pediatricians), the Chairmen of the Departments of Pediatric Anesthesia, Medicine, and Surgery, and the Phoenix Children's Medical Group (PCMG) Representative. Voting members of the Executive Committee must be elected.
 2. The Chief Executive Officer of the hospital, or designee, shall attend Executive Committee meetings on an ex-officio basis, without vote. The Chairman of the Quality Council, if not a Medical Staff Officer or Department Chairman, shall be an ex-officio member without vote. The Physician-in-Chief shall be an ex-officio member without vote.
- b) At no time shall there be more than five (5) voting members of the Executive Committee who are salaried by the Hospital.
- c) The Executive Committee is the governing Committee of the Medical Staff to which other Medical Staff Committees report and which has the following duties and responsibilities:
 1. Enforce the Bylaws, Rules and Regulations of the Medical Staff.
 2. Ensure quality of professional services provided by individuals with clinical privileges
 3. Receive and act upon reports and recommendations from the Officers, Clinical Departments, Medical Staff Committees and assigned activity groups of the Medical Staff concerning: performance improvement evaluation and monitoring including sentinel events, patient safety and patient/family satisfaction initiatives, delegated administrative responsibilities, and practitioner-specific ongoing performance evaluations and shall recommend to the Board of Directors specific actions to implement these functions.
 4. Provide for effective communication among the Medical Staff, Hospital Administration and Board of Directors

5. Enforce policies adopted by the Medical Staff, Departments and Medical Staff Committees
 6. Recommend to the Board of Directors all matters relating to the Medical Staff's structure, the mechanism used to review credentials and to delineate individual clinical privileges; Medical Staff appointments, reappointments, category and department assignments, clinical privileges, corrective action and the mechanism for termination of Medical Staff Membership, and Fair Hearing procedures
 7. Account to the Board of Directors and to the Medical Staff for the overall quality, performance improvement and efficiency of patient care in the Hospital
 8. Take reasonable steps to ensure ethical and competent conduct by Medical Staff members
 9. Establish policies for corrective action for Medical Staff members who have failed to complete medical records within the prescribed time
 10. Inform the Medical Staff of the accreditation status of the Hospital
 11. Identify community health needs and Hospital goals
 12. Represent the Medical Staff, subject to these Bylaws, to act on behalf of the organized Medical Staff between General Medical Staff meetings
- d) The Medical Executive Committee shall meet monthly unless cancelled by the Chairman. Any voting member of the Executive Committee who is absent without cause from more than two (2) consecutive regular meetings may be removed from the Executive Committee by majority vote of the Executive Committee.

10.5 **DEPARTMENT OF ANESTHESIA COMMITTEE**

- a) The Committee shall consist of the Chairman and Vice Chairman of the Department, a representative from the Surgery Department Committee and Medical Staff members appointed by the Department Chairman, after consultation with the President of the Medical Staff and approved by the Executive Committee.
- b) Duties and responsibilities:
 1. Submit regular reports and recommendations to the Executive Committee.
 2. Monitor anesthesia, sedation and pain management practice in the Hospital.
 3. Formulate and implement rules and regulations necessary for optimal care of patients receiving anesthesia, sedation and pain management subject to approval of the Executive Committee.
 4. Perform other duties as assigned.
- c) The Committee shall meet monthly unless cancelled by the Chairman.

10.6 **DEPARTMENT OF MEDICINE COMMITTEE**

- a) The Committee shall consist of the Chairman and Vice Chairman of the Department, physician representatives from Pediatric Cardiology, Critical Care, Emergency Medicine, General Pediatrics, Neonatology, Radiology, and other Medical Staff members appointed by the

Department Chairman after consultation with the President of the Medical Staff and approved by the Executive Committee.

- b) Duties and responsibilities:
 - 1. Submit regular reports and recommendations to the Executive Committee.
 - 2. Monitor medical practice in the Hospital.
 - 3. Formulate and implement rules and regulations necessary for optimal medical care of patients, subject to approval of the Executive Committee.
 - 4. Perform other assigned duties.
- c) The Committee shall meet monthly unless cancelled by the Chairman.

10.7 **DEPARTMENT OF SURGERY COMMITTEE**

- a) The Committee shall consist of the Chairman and Vice Chairman of the Department, a representative from the Anesthesia Department Committee and Medical Staff members appointed by the Department Chairman after consultation with the President of the Medical Staff and approved by the Executive Committee.
- b) Duties and responsibilities:
 - 1. Submit regular reports and recommendations to the Executive Committee.
 - 2. Monitor surgical practice in the Hospital.
 - 3. Formulate and implement rules and regulations necessary for optimal surgical care of patients, subject to approval of the Executive Committee.
 - 4. Perform other assigned duties.
- c) The Committee shall meet monthly unless cancelled by the Chairman.

10.8 **BYLAWS COMMITTEE**

- a) The Committee shall consist of a Chairman and five (5) appointed Medical Staff members.
- b) Duties and responsibilities:
 - 1. Review recommendations for Bylaws submitted by members of the Active, Honorary or Senior Staff, Standing Committees and the Chief Executive Officer.
 - 2. Initiate, prepare and recommend Bylaws changes to the Active, Honorary and Senior Staff.
 - 3. Respond, via the Executive Committee, to requests for interpretation of the Bylaws.
- c) The Committee shall meet when convened by the Chairman.

10.9 **CANCER COMMITTEE**

- a) The Committee shall be interdisciplinary, representing physicians from the diagnostic and treatment specialties and non-physicians from administrative and supportive services.
- b) Duties and responsibilities: The Cancer Committee shall be responsible for:
 - 1. developing and evaluating annual goals;
 - 2. promoting a multidisciplinary approach to patient management;
 - 3. ensuring multidisciplinary cancer conference that provides a forum for patient consultation and contributes to physician education;
 - 4. ensuring an active support care system;
 - 5. monitoring quality management and improvement through studies;

6. promoting clinical research;
7. supervising cancer registry and ensuring timely abstracting;
8. performing quality control of registry data;
9. encouraging data usage and regular reporting;
10. upholding medical ethical standards; and
11. publishing an annual report of the cancer program that meets requirements of the Commission on Cancer Standards of the American College of Surgeons.

c) The Cancer Committee shall meet as often as necessary but at least four times per year.

10.10 **CARDIOVASCULAR COMMITTEE**

a) The Committee shall be multidisciplinary and shall consist of a Chairman, who is a member of the Medical Staff, and other appointed members including representatives from Cardiovascular Surgery, Cardiology, Radiology, Anesthesia and Critical Care.

b) Duties and responsibilities:

1. Submit regular reports, recommendations and peer review summaries to the Medical Executive Committee and the Department of Surgery, Medicine or Anesthesia when applicable.
2. Supervise and review all cardiovascular surgery, invasive and diagnostic cardiology procedures. Formulate and implement necessary rules and regulations, performance improvement initiatives and practice protocols and guidelines subject to approval of the Medical Executive Committee.
3. The Committee shall meet when convened by the Chairman.

10.11 **CREDENTIALS COMMITTEE**

a) The Committee shall consist of the Secretary-Treasurer of the Medical Staff, who shall be the Chairman, a representative from each clinical Department, and other appointed Medical Staff members.

b) Duties and responsibilities:

1. Review the qualifications of each Medical Staff applicant for initial appointment.
2. Submit reports to Clinical Department Committees, in accordance with Articles IV and V, on each applicant for Medical Staff Membership.

c) The Committee shall meet monthly unless cancelled by the Chairman.

10.12 **CRITICAL CARE COMMITTEE**

a) The Committee shall consist of the Chairman, appointed Medical Staff members, and designated representatives from Nursing.

b) Duties and responsibilities:

1. Submit regular reports and recommendations to the Department of Pediatric Medicine and Executive Committees.
2. Supervise and review all pediatric critical care activities and formulate and implement necessary rules and regulations subject to the approval of the Executive Committee.

c) The Committee shall meet when convened by the Chairman.

10.13 HEALTH INFORMATION COMMITTEE

- a) The Committee shall be multidisciplinary and shall consist of a Chairman and appointed Medical Staff members. Other appointed members may include representatives from Pharmacy, Radiology, Laboratory, Nursing, Health Information Management, Information Technology, Quality Management, and Administration.
- b) Duties and responsibilities:
 - 1. Submit pertinent reports and recommendations to the Department Committees and/or the Medical Executive Committee.
 - 2. Establish and enforce policies pertaining to health information.
 - 3. Review privacy and confidential health information issues as reported by the Privacy Compliance Committee/Privacy Officer.
 - 4. Act upon recommendations from the Executive Committee, Department Committees and other Medical Staff Committees.
- c) The Committee shall meet when convened by the Chairman.

10.14 INFECTION CONTROL COMMITTEE

- a) The Committee shall be multidisciplinary and shall consist of a Chairman, who is a member of the Medical Staff, and other appointed members including Infection Control Practitioner and representation from laboratory services, administration, nursing and other personnel as required.
- b) The Infection Control Committee or its appropriate members have delegated authority from hospital administration to institute Infection Control measures, studies, and policy enforcement, and act upon a suspected or defined problem when indicated by findings or through surveillance, to protect patients and personnel.
- c) Duties and responsibilities:
 - 1. Submit pertinent reports and recommendations to Departmental Committees and/or the Medical Executive Committee.
 - 2. Recommend and implement programs to prevent infection in hospitalized patients and hospital personnel.
 - 3. Establish effective isolation practices.
 - 4. Establish a system of infection reporting, surveillance and investigation.
 - 5. Establish and maintain an Infection Control Manual for the organization.
- d) The Committee shall meet quarterly and when convened by the Chairman.

10.15 JOINT CONFERENCE COMMITTEE

- a) The Committee shall consist of at least two (2) representatives each from the Board of Directors, Medical Staff and Administration. The Medical Staff representatives shall include the President of the Medical Staff and Vice President of the Medical Staff.
- b) Duties and responsibilities:
 - 1. Serve as a liaison between the Board of Directors, Medical Staff and Administration.
- c) The Committee shall meet at the request of either the Board of Directors, President of the Medical Staff or Chief Executive Officer.

10.16 GRADUATE MEDICAL EDUCATION COMMITTEE

- a) The Committee shall consist of a Chairman and appointed Medical Staff members.
- b) Duties and responsibilities:
 - i. Submit pertinent reports and recommendations to the department committees, the Medical Executive Committee, and the Board of Directors.
 - ii. Serve as an Advisory Committee to the Director of Medical Education
 - iii. Establish policies for Graduate Medical Education (GME) and Continuing Medical Education (CME).
 - iv. Maintain the GME and CME programs, and formulate House Staff rules and regulations and job descriptions.

2. ADMISSIONS POLICIES

- a) The authority for admission of patients to the Hospital has been vested in the Chief Executive Officer by the Board of Directors. Requests for admission are made by the physician staff member, but the final approval rests with the Chief Executive Officer or designee. The Hospital shall admit patients, provided that facilities are available for care of the patient and protection of Hospital personnel. Only physicians who are members of the Honorary, Active, , or Courtesy Medical Staff shall have privileges to admit patients to the hospital.
- b) Management of a patient's general medical condition is the responsibility of a qualified physician member of the medical staff, who has been granted the appropriate clinical privileges. The initial visit is to occur within four (4) hours of admission by a practitioner who can write orders and initiate the patient's plan of care. The Attending physician must see the patient within twenty fours (24) hour or sooner if warranted by the patient's condition. .
- c) A CME Subcommittee, will be given the responsibility of developing and supporting the CME program at Phoenix Children's Hospital. Duties and responsibilities of the Subcommittee will include the establishment of a Mission Statement and policies and procedures of the CME program. Meetings shall convene as necessary.
- d) A GME Committee of the Pediatric Residency Program will meet monthly and as needed. This Committee will be given the responsibility of administering the GME program at Phoenix Children's Hospital and its integrated institutions. Membership shall consist of Program Directors, other Faculty, residents and at least one accountable management official. This Committee should conform to the responsibilities listed in the current publication of "Essentials of Accredited Residencies in Graduate Medical Education, Part 1, Institutional Requirements."
- e) Regulation and discipline of the House Staff shall be the responsibility of the Program Director, GME Committee and Director of Medical Education in accordance with established policies.
- f) The Committee shall meet when convened by the Chairman.

10.17 MEDICAL ENDOSCOPY COMMITTEE

- a) The Committee shall consist of the Chairman and other appointed Medical Staff members.

Duties and responsibilities:

1. Submit regular reports and recommendations to the Department of Pediatric Medicine and Executive Committees.
2. Supervise and review all endoscopic patient care activities; formulate and implement necessary rules and regulations, performance improvement initiatives and practice protocols and guidelines subject to the approval of the Executive Committee.

b) The Committee shall meet when convened by the Chairman.

10.18 NEONATAL PATIENT CARE COMMITTEE

a) The Committee shall consist of the Chairman, appointed Medical Staff members, and designated representatives from Nursing.

b) Duties and responsibilities:

1. Submit regular reports and recommendations to the Department of Pediatric Medicine and Executive Committees.
2. Supervise and review all neonatal patient care activities; formulate and implement necessary rules and regulations subject to the approval of the Executive Committee.

c) The Committee shall meet when convened by the Chairman.

10.19 NOMINATING COMMITTEE

a) The Committee shall consist of the Immediate Past President of the Medical Staff, who shall be the Chairman, and two (2) Active Staff members from each Department appointed by the President of the Medical Staff in consultation with the Department Chairmen and subject to approval by the Executive Committee. If the Immediate Past President of the Medical Staff is unable to serve, a member and Chairman shall be appointed by the President of the Medical Staff.

b) The Committee's duties and responsibilities are outlined in Section 9.1-3.

c) The Committee shall meet when convened by the Chairman.

10.20 PEER REVIEW COMMITTEE

a) The Committee shall be multidisciplinary and shall consist of all Department Chairs and Vice Chairs, the Immediate Past President for a minimum of one year and other appointed, assigned or invited members of the Medical Staff including, a representative for Emergency Medicine, Pediatric General Surgery, Neuro-surgery, Orthopedics, Anesthesia, Critical Care and Radiology. Appointed members shall serve for a minimum of two years.

Duties and responsibilities:

2. Assure timely completion of the peer review process (within 45 days of being notified of the event) by facilitating an interdisciplinary review of cases involving multiple departments or sub-specialties in accordance with the Peer Review Policy and Procedure.
3. Provide oversight of all peer review activities and case rating assignments for consistency across Sections, Departments and Committees.

4. Provide oversight of cases which are determined appropriate and are not referred to committee for review (rating of care appropriate).
4. Submit reports semi annually of number of cases reviewed, final case ratings and any recommendations or actions to the Medical Executive Committee.

b) Meet as convened by the Chairman.

10.21 **PHARMACY AND THERAPEUTICS COMMITTEE**
(Refer to Pharmacy & Therapeutics Committee Rules and Regulations.)

10.22 **QUALITY COUNCIL**

a) This council shall be multidisciplinary, with all members having a vote. Physician membership will include the Vice President of the Medical Staff, the Vice Chairmen for the Departments of Anesthesia, Medicine, and Surgery, Physician-In-Chief, and Medical Directors for Lab, Radiology, Emergency Department, Perioperative Services, General Pediatrics, PICU, and NICU. Non-Physician members will include a representative from the Patient Care/Quality Enhancement Committee of the Board, Administration/CNE, Quality Director, Clinical Director of Outpatient Services, Safety Officer, Patient Safety Committee representative and three appointed Clinical Director representatives. At the discretion of the Chairman, team members from other hospital departments and ancillary areas will participate as needed. The President of the Medical Staff and the Hospital President/CEO are ex-officio members. Staff support will be provided by Quality Management and Medical Staff Services.

b) Duties and responsibilities:

- 1) Receive and act on recommendations or reports from other medical staff committees related to quality and performance improvement initiatives.
- 2) Submit regular reports and recommendations to Departmental committees as appropriate, Medical Executive Committee, and Quality Committee of the Board.
- 3) Enhance internal operations throughout PCH and improve the processes of services impacting patient care.
- 4) Ensure comprehensive, high quality, cost effective care and services that are responsive to the needs of children, families, physicians and other constituents.

c) The Committee shall meet at least quarterly and when convened by the Chairman.

10.23 **SCIENTIFIC REVIEW COMMITTEE**

a) The Committee shall consist of a Chairman and other appointed Medical Staff members and other designated members including hospital personnel as appointed by the Chairman.

b) Duties and responsibilities:

1. Submit regular reports and recommendations to the Executive Committee.
2. Monitor and administer research functions in accordance with policies approved by the Executive Committee.
3. Review all research proposals including investigational medications, investigational procedures, use of Hospital records and original research by a Medical Staff member and make recommendations to the Executive Committee for approval or denial.

c) The Committee shall meet when convened by the Chairman.

**ARTICLE XI
ALLIED HEALTH STAFF**

11.1 MEMBERSHIP RESPONSIBILITIES

Each Allied Health Professional shall:

- a) Provide patients with care at the level of quality and efficiency generally recognized appropriate at facilities such as the Hospital.
- b) Participate, when appropriate, in quality review program activities and in discharging such other functions as may be required.
- c) Meet those responsibilities required by the Medical Staff Bylaws, Medical Staff Rules and Regulations, the Hospital Bylaws, and all other standards, policies, and rules of the Medical Staff and Hospital.
- d) Prepare and complete in a timely fashion those portions of patients' medical records documenting services provided and any other required records.
- e) Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the hospital for who he/she is providing services.
- f) Notify the Medical Staff Services Department immediately if there is a change in my employer/sponsoring physician or contact information (ie. address, telephone number).
- g) Function under the supervision and/or direction of a physician on the Medical Staff who has been approved for privileges.

11.2 BASIC QUALIFICATIONS

Allied Health Professionals ("AHPs") holding a license, certificate or such other legal credentials, as required by Arizona law, which authorize AHPs to provide certain professional services, are not eligible for Medical Staff membership. AHPs are eligible for practice privileges in this Hospital only if they:

- a) Hold a license, certificate or other legal credential in a category of AHPs which the Board of Directors has approved, and
- b) Document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the Hospital, and that they are qualified to exercise/practice privileges within the Hospital; and
- c) Are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others in the Hospital setting; and to be willing to commit to and regularly assist the Hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and approved scope of practice and;

- d) Function under the supervision and/or direction of a physician on the Medical Staff who has been approved for privileges as defined below; and

Definition of Supervision: The Nurse Practitioner will consult with the sponsoring physician regarding the treatment plan at least every twenty-four (24) hours. The supervising physician is to countersign the NP progress notes or write a progress note personally at least every twenty-four (24) hours.

Definition of Direct Supervision: The supervising physician must be immediately, and locally available by electronic communication or on hospital premises for consultation/direction of the PA. All entries in the medical record are to be countersigned by the/a sponsoring physician or the patient's attending physician within 24 hours. For the first three months the supervising physician must immediately co-sign orders. The Physician Assistant will consult with the attending physician regarding the treatment plan at least every twenty-four (24) hours and document that the consultation/discussion occurred in the medical record. The date and time of the consultation/ discussion is to be included in the documentation.

Definition of Collaborating Physician: Collaborating Physician is one or more physician(s) with which the NP has a formal sponsorship agreement with on record in the Medical Staff Services Department. The collaborating physician(s) must be a member of the PCH Medical Staff in good standing. The collaborating physician must be available on an as-needed basis to consult with the NP. Direct/on-site supervision of the NP activities is not required.

- e) Maintain adequate professional liability insurance coverage required by the Hospital.

11.3 **REQUEST FOR MODIFICATION OF CLINICAL PRIVILEGES OR SPONSORING PHYSICIAN**

An Allied Health Staff member may at any time request modification of his/her staff clinical privileges by submitting a written application to the Chief Executive Officer on the prescribed form. Such application shall be processed in the same manner as provided above for reappointment.

An Allied Health Staff member may at any time request modification of his/her Sponsoring physician. This request will require completion of the Sponsoring Physician Statement and the Sponsoring Physician's Explanation of AH Duties/Competency Attestation Form by the Applicant's Sponsoring Physician. If a modification of privileges shall occur at this time, the applicant's privilege modification will require for review and approval as stated above for reappointment.

11.4 **REQUEST FOR REINSTATEMENT OF ALLIED HEALTH STAFF MEMBERSHIP AND CLINICAL PRIVILEGES**

If a request for reinstatement is requested within six (6) months after voluntary resignation or expiration of the appointment term, the practitioner may complete a reappointment application through the Medical Staff Services Office. If a reinstatement is requested more than six (6) months after the voluntary resignation or expiration of appointment, the practitioner must complete an initial application for membership and privileges, and pay the processing fee.

11.5 **TERMINATION**

Any one of the following may summarily suspend the Practice Privileges of any AHP: the President of the Medical Staff; the chairman of the clinical department; the CEO; the Executive Committee; or the Board. Summary suspension may be imposed by said individuals or groups at any time, when

immediate action is reasonably deemed necessary or advisable, in the judgment of the person or persons invoking summary suspension, in order to safeguard adequate patient care.

11.6 APPEALS PROCESS

If the Medical Executive Committee recommends that Practice Privileges of an AHP be denied, reduced, terminated, or revoked on a non-summary basis, the Allied Health Practitioner is afforded the right to an informal/appeal with the MEC. After the informal interview with the MEC, the MEC will reconsider the matter based on any additional information provided by the AHP and forward a final recommendation to the Board of Directors. If the AHP waives the right to meet with the MEC, the MEC will be notified of the AHP's decision and will forward the final recommendation to the Board of Directors. The Board of Directors shall be informed of any action taken by the Medical Staff Executive Committee to deny the application of an AHP to perform activities in the Hospital or with respect to termination or modification of permitted activities, as well as any written communication from the AHP pertaining to the matter. The Board may take such action, if any, as it deems appropriate in its discretion. Unless the Board takes action, the decision of the Medical Staff Executive Committee shall be deemed final.

**ARTICLE XII
MEDICAL STAFF MEETINGS**

12.1 GENERAL STAFF MEETINGS

a) REGULAR MEETINGS

Quarterly General Staff meetings and an Annual General Staff meeting shall be held each year when convened by the President of the Medical Staff. The Medical Staff business year shall begin January 1 and end December 31.

b) ORDER OF BUSINESS AND AGENDA

The order of business at general staff meetings shall be determined by the President of the Medical Staff.

c) SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time upon fourteen (14) days notice by the President of the Medical Staff, the Executive Committee or not less than twenty percent (20%) of the members of the Active, Honorary and Senior Staff, and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting other than that stated in the meeting notice.

12.2 COMMITTEE AND DEPARTMENT MEETINGS

a) REGULAR MEETINGS

Committees and Departments may determine the time for holding regular meetings and no other notice shall be required.

b) SPECIAL MEETINGS

A special meeting of any Committee or Department may be called by the Chairman, the President of the Medical Staff or twenty percent (20%) of the group's current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

12.3 ATTENDANCE AT MEETINGS

Members of the Medical Staff are expected to attend regular and special meetings of the Medical Staff, and regular and special meetings of the Department and Committees to which they are elected or appointed. Attendance at meetings will be considered an important indication of interest and participation in Phoenix Children's Hospital. Fifty percent (50%) attendance of meetings will be considered an acceptable level of participation.

12.4 **NOTICE OF MEETINGS**

Written or printed notice stating the day, hour and place of any General Staff meeting, of any special meeting, or of any regular Committee or Department meeting not held pursuant to resolution, shall be delivered either personally or by mail to each person entitled to be present not less than five (5) days nor more than fourteen (14) days before the date of such meeting. Notice of Committee or Department meetings may be given verbally. If mailed, the notice of the meeting shall be deemed delivered seventy-two (72) hours after deposited, postage prepaid, in the United States mail addressed to each person entitled to such notice at his or her address as it appears on the records of the Hospital. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

12.5 **QUORUM**

a) **MEDICAL EXECUTIVE COMMITTEE**

A majority of the Membership shall constitute a quorum of the Medical Executive Committee. In the event a regular meeting of the MEC is cancelled, not less than two (2) members shall constitute a quorum to take action on individual applications for appointment or reappointment. Such actions will be ratified by the full membership of the MEC at its next regularly scheduled meeting.

b) **DEPARTMENT AND COMMITTEE MEETINGS**

Thirty-three percent (33%) of the voting members of a Committee or Department, but not less than two (2) members, shall constitute a quorum.

12.6 **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. Action may be taken without a meeting by setting forth the action to be taken and as approved by a majority of members entitled to vote at a meeting.

12.7 **MINUTES**

Minutes of all meetings shall be prepared by the secretary of the meeting and shall include a record of attendance and the results of each vote taken on each matter. Copies of such minutes shall be made available to the Medical Staff. A permanent file of the minutes of each meeting shall be maintained.

**ARTICLE XIII
CONFIDENTIALITY, IMMUNITY AND RELEASES**

13.1 **SPECIAL DEFINITIONS**

For the purpose of this Article, the following definitions shall apply:

- a) **INFORMATION:** The record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 12.4.
- b) **PRACTITIONER:** A Medical Staff member, Allied Health Staff member, or applicant.
- c) **THIRD PARTY:** An individual or organization providing information to any representative.

13.2 AUTHORIZATIONS AND CONDITIONS

A practitioner authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon information bearing on professional ability and qualifications.

A practitioner acknowledges that the provisions of this Article are conditions for application to, or acceptance of, Medical Staff Membership and the continuation of such Membership or the exercise of clinical privileges.

13.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner which is submitted, collected or prepared by any representative of this or any other health care facility or organization or Medical Staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative of this or other Hospitals nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file.

13.4 ACTIVITIES AND INFORMATION COVERED

a) **ACTIVITIES**

Confidentiality and immunity provided by law 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:

1. Applications for appointment, clinical privileges or specified services
2. Periodic appraisals for reappointment, clinical privileges or specified services
3. Corrective action, including summary suspension and/or supervision
4. Hearings and appellate reviews
5. Medical care evaluations
6. Utilization reviews
7. Other Hospital, Departmental, Committee or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct

b) **INFORMATION**

The acts, communications, reports, recommendations, disclosures and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or any other matter that might directly or indirectly affect patient care.

13.5 MEDICAL STAFF CREDENTIAL FILES

Medical Staff credential files shall be maintained as confidential. Access shall be limited to duly appointed Officers and Committees of the Medical Staff and the Board of Directors for the sole purpose of discharging their respective responsibilities and subject to the requirement that confidentiality be maintained. Information contained in the credential file of any member may be disclosed with the member's consent to any professional licensing board and as otherwise required by law.

A Medical Staff member shall be granted access to his own credential file, subject to the following provisions: 1) Timely prior notice of such access shall be made by the member to the President of the Medical Staff or his designee; 2) The member may review and receive a copy of only those documents provided by or addressed personally to the member. A summary of all other information may be provided to the member, as determined by the President of the Medical Staff, but such summary shall disclose only the substance, and not the source, of the information summarized; 3) The review by the member shall take place in the Medical Staff Services Office, during normal working hours, with an Officer or designee of the Medical Staff present.

13.6 NOTIFICATION OF BOARD ACTIONS

Practitioners are notified of Board of Directors actions pertaining to granting, limiting, or denying initial requests or an existing privilege request for renewal within seven (7) days of the Board of Directors action and always before the date the appointment or privilege is to be in effect. If a request for appointment or clinical privileges is denied, the practitioner will be notified in accordance with the fair hearing process. Applicable hospital departments are notified in the time-frame established and through the mechanism determined as outlined in hospital policies.

13.7 RELEASES

Each practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the significance of this Article, subject to such requirements, including those of good faith and absence of malice as may be applicable under the law of this state.

**ARTICLE XIV
GENERAL PROVISIONS**

14.1 MEDICAL STAFF RULES AND REGULATIONS

The Medical Executive Committee shall adopt such Medical Staff Rules and Regulations as may be necessary to implement more specifically the general principles found in these Bylaws. These shall relate to the proper administration of Medical Staff organizational activities as well as represent the level of practice that is required of each practitioner in the Hospital. They may be amended or replaced at any regular meeting of the Executive Committee at which a quorum is present and without previous notice, or at any special General Staff meeting on notice, by a majority vote of those present and eligible to vote. Amendments to the Medical Staff Rules and Regulations shall be forwarded to the Board of Directors for approval.

14.2 DEPARTMENT RULES AND REGULATIONS

Subject to the approval of the Executive Committee, each Department shall formulate its own Rules and Regulations for the conduct of its affairs and the discharge of its responsibilities. Such Department Rules and Regulations shall not be inconsistent with these Bylaws, the Medical Staff Rules and Regulations or other policies of the Hospital.

14.3 CONSTRUCTION OF TERMS AND HEADINGS

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these Bylaws are for convenience and are not intended to limit or define the scope of effect of any provision of these Bylaws.

14.4 PARLIAMENTARY PROCEDURE

The rules contained in the latest revised edition of Robert's Rules of Order shall govern the staff in all cases to which they are applicable and in which they are not inconsistent with these Bylaws and any special rules of order the Medical Staff may adopt.

14.5 STAFF DUES AND SPECIAL ASSESSMENTS

Staff Dues and Special Assessments for all categories of Medical Staff Membership of Phoenix Children's Hospital will be determined by the Executive Committee on an annual basis at its November meeting.

If the need should arise for a Special Assessment, this will be recommended by the Executive Committee and must be approved by a majority vote of the members of the Active, Honorary and Senior Staff present and voting at any regular or special General Staff meeting.

Notification of Staff Dues will be mailed before January of each year. If response is not received by March 31 of that year, notification by certified letter will be sent to the Medical Staff member. If response is not received after thirty-one (31) days from the time of mailing, the Medical Staff member will be suspended.

**ARTICLE XV
ADOPTION, AMENDMENT, ANNUAL REVIEW OF BYLAWS**

The Medical Staff Bylaws and Medical Staff Rules and Regulations are reviewed on an annual basis. When necessary, the Medical Staff Bylaws and Medical Staff Rules and Regulations and policies are revised to reflect the hospital's current practices with respect to Medical Staff organization and functions.

Proposed amendments to the Bylaws may be made by individual members of the Active, Honorary or Senior Staff or by any standing Medical Staff Committee by submission to the Bylaws Committee. When a General Staff meeting is to occur within thirty (30) days, the Bylaws Committee will present the proposed changes with their recommendations to the Active, Honorary and Senior Staff fourteen (14) days prior to the regular or special General Staff meetings, at which time the Bylaws changes will be discussed. Within fourteen (14) days of this meeting, a ballot for vote on each proposed amendment will be mailed to all members of the Active, Honorary and Senior Staff. A two-thirds majority of the Active, Honorary and Senior Staff members voting is required for approval.

The returned ballots will be counted twenty-one (21) calendar days after the day of mailing. Amendments so made shall become effective when approved by the Board of Directors at a meeting within sixty (60) days. Should the Board of Directors not approve any amendment, notification to the Active, Honorary and Senior Staff should be sent of such action with the reasons for this action.

In the event a General Staff meeting isn't scheduled to occur within the next thirty (30) days, the proposed revision(s) ballot can be mailed to the Active, Honorary and Senior Staff for vote. The members will be provided with a written explanation of the reason(s) for the proposed revision and will be given twenty-one (21) calendar days after date of mailing to return the ballot. Amendments so made shall become effective when approved by the Board of Directors at a meeting within sixty (60) days. Should the Board of Directors not approve any amendment, notification to the Active, Honorary and Senior Staff should be sent of such action with the reasons for the action.

If significant changes are made to the Medical Staff Bylaws and Medical Staff Rules and Regulations, or policies, Medical Staff members and individuals who have delineated clinical privileges will be informed of the revisions.

Approved by the Phoenix Children's Hospital
Medical Staff on _____

Approved by Phoenix Children's Hospital
Board of Directors on _____

President of the Medical Staff

President and Chief Executive Officer

Revisions Approved:	June 1985	March 1996
	May 1986	December 1997
	December 1986	April 1999
	March 1987	March 2000
	April 1988	May 2001
	March 1989	January 2004
	March 1990	June 2004
	October 1991	April 2005
	June 1992	April 2006
	June 1993	June 2006
	April 1994	August 2006
	November 1994	September 2006
	October 1995	January 2007
		April 2007
		Nov. 2007
		May, 2008