MEDICAL STAFF BYLAWS

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BYLAWS OF THE MEDICAL STAFF
OF CAPITAL MEDICAL CENTER

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PREAMBLE

These Bylaws are adopted to provide for the organization of the Medical Staff of Capital Medical Center, and supersede, as of the date of adoption, all previous versions. Additional policies and procedures with respect to credentialing, rules and regulations, behavior, and quality review are made a part of these Bylaws. Please see respective Medical Staff Credentialing Manual and the Rules and Regulation Manual. All of these components function as one. Maintaining separate integrity is essential to more efficient revision as outlined in these documents. Terms used in these Bylaws and aforementioned Manuals shall have the same meaning, unless the context clearly indicates otherwise. The provisions of these Bylaws shall apply equally to all Practitioners with privileges at the Hospital unless the context clearly indicates otherwise."

DEFINITIONS

1. HOSPITAL means Capital Medical Center.
2. BOARD and BOARD OF TRUSTEES (TRUSTEES) mean the local Advisory Board of Capital Medical Center.
3. ADMINISTRATOR or CHIEF EXECUTIVE OFFICER (CEO) means the person appointed by the Board of Trustees to act on its behalf in the overall management of the Hospital.
4. MEDICAL STAFF or STAFF means those Physicians and Dentists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.
5. MEDICAL EXECUTIVE COMMITTEE (MEC) means the Executive Committee of the Medical Staff of Capital Medical Center.
6. PRACTITIONER means any Physician, Dentist, or Allied Health Professional (AHP) applying for or exercising Clinical Privileges at Capital Medical Center.
7. DENTIST means an individual with a DDS or DMD degree who is properly licensed to provide dental medicine services in the state of Washington.
8. PHYSICIAN means an individual with an MD, DO, DPM degree who is properly licensed to practice medicine in the State of Washington.
9. ALLIED HEALTH PROFESSIONAL (AHP) means a Licensed Independent Practitioner (LIP), other than a licensed Physician (e.g., Clinical Psychologist, PA, CRNA, RNFA or ARNP) whose patient care activities require that his/her authority to perform specified services be processed through the usual Medical Staff channels delineating his/her qualifications, status, Clinical Privileges and responsibilities.
10. MEDICAL ASSISTANT refers to an individual who is not licensed to practice independently, who assists another Practitioner in the performance of patient care at the Hospital as an employee or independent contractor of that Practitioner.
11. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a Practitioner to render specific patient services.
12. CHIEF OF MEDICAL STAFF means the President of the Medical Staff elected by members of the Medical Staff.
13. LEAVE OF ABSENCE means a voluntary leave approved by the Board of Trustees after consideration of a recommendation from the MEC. Said leave shall be for a minimum of 30 days to a maximum of one year.
14. MEDICAL STAFF YEAR means the Medical Staff Year will commence on January 1, and end on December 31.

ARTICLE I
MEMBERSHIP

1.1 NATURE OF MEMBERSHIP

Medical Staff membership shall be extended only to Physicians and Dentists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and in the Rules and Regulations of the Medical Staff.

1.2 QUALIFICATIONS FOR MEMBERSHIP

1.2(a) General Qualifications

Physicians and Dentists are eligible for Medical Staff membership only upon approved documentation of the following to the reasonable satisfaction of the Hospital:

(1) Current unrestricted licensure in the applicable discipline issued by the State of Washington;

(2) Adequate experience, education and training; including an applicable degree from an accredited educational institution(s);

(3) Maintenance of professional liability insurance in an amount not less than one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) in the aggregate. Such insurance shall be with a carrier reasonably acceptable to the Hospital, and if on a claims made basis, the Practitioner agrees to obtain tail coverage covering his/her practice at the Hospital upon termination of such insurance. Each Practitioner shall provide a certificate of coverage reflecting the details of such coverage annually at the time of renewal of such insurance. He/She shall also be responsible for advising the MEC and the CEO of any change in such professional liability coverage.

(4) Certification in a board recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Association of Dental Boards (AADB), or the American Podiatry Medical Association (APMA); or proof of progression in the board exam process for a period not to exceed five (5) years or demonstration to the satisfaction of the Medical Executive Committee (MEC) and the Board of Trustees, competency and training equal or equivalent to that required for board certification (members of the CMC Medical Staff prior to 01/01/07 will be exempted from this requirement);

(5) Current professional competence;

(6) Good judgment;

(7) Adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent, and that patients treated by them can reasonably expect to receive quality medical care;
(8) Continuous compliance with federal, state and local requirements, if any, applicable to their medical practice(s);
(9) If Member has privileges/membership at another institution, continuous maintenance of such privileges/membership, absent good cause shown;
(10) Adherence to the ethics of their respective professions;
(11) Ability to work harmoniously with other Physicians, Hospital Medical Staff and patients, and to exercise professional conduct when engaged in Medical Staff or patient care activities; and
(12) Willingness to participate in and properly discharge those responsibilities determined by the Medical Staff.

1.2(b) Particular Qualifications

A Practitioner seeking Medical Staff Membership or Clinical Privileges, or renewal of the same, shall provide such additional evidence of his/her qualifications, credentials and competence as the Medical Staff may request.

1.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the Medical Staff merely because he or she holds a certain degree, is licensed to practice in this or in any other State, is a member of any professional organization, is certified by any medical board, or because such person had, or presently has, Medical Staff membership or Privileges at another health care facility.

1.4 NONDISCRIMINATION

No aspect of Medical Staff membership or particular Clinical Privileges shall be denied on the basis of sex, race, age, creed, color, national origin or disability except to the extent such disability prevents the Practitioner from fulfilling the essential functions of his/her Medical Staff Membership, Clinical Privileges or duties under the Bylaws and Rules and Regulations.

1.5 PURPOSES / RESPONSIBILITIES OF THE MEDICAL STAFF

The purposes and responsibilities of the Medical Staff include:

(1) Developing and adopting Bylaws and Rules and Regulations that create an atmosphere and framework within which each Medical Staff member can act with a reasonable degree of freedom and confidence. The Medical Staff shall regulate itself by these Bylaws and Rules and Regulations, which shall reflect current Medical Staff practices and shall be enforced;
(2) Assuring that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital should receive the quality of patient care that is achievable commensurate with community resources available;
(3) Serving as a primary means for accountability to the Board of Trustees in order to promote an optimal level of professional performance of all Practitioners authorized to practice in the Hospital through the appropriate delineation of the Clinical Privileges, and through an ongoing review and evaluation of each Practitioner's performance in the Hospital;
(4) Implementing and carrying out quality assurance activities as determined by the Medical Staff and consistent with the Hospital Quality Improvement Plan to promote optimal patient safety and maintenance of patient satisfaction;
(5) Providing an appropriate educational setting that will assist in maintaining patient care standards and that will lead to a continuous advancement in professional knowledge and skill;
(6) Providing a means whereby issues concerning the Medical Staff and Hospital may be discussed by the Medical Staff with the Board of Trustees and the CEO;
(7) Fostering cooperation with Administration and the Board of Trustees while allowing Medical Staff members to function with relative freedom in the care and treatment of their patients;
(8) Assisting the Board of Board of Trustees in identifying changing community health needs and preferences and to implement programs to meet those needs and preferences;
(9) Maintaining confidentiality with respect to the records and affairs of the Hospital, except as disclosure is authorized by the Board of Trustees or required by law;
(10) Assisting the Board of Trustees in maintaining the accreditation status of the Hospital;
(11) Implementing a Utilization Review Program, based on the guidelines of the Hospital's Utilization Review Plan;
(12) Initiating and pursuing action(s) to restrict Medical Staff Membership or Clinical Privileges of Practitioners, when warranted;
(13) Reviewing and evaluating the quality of patient care through a valid and reliable patient care monitoring procedure, including identification and resolution of important problems in patient care and treatment;
(14) Implementing a process to identify and manage matters of individual Physician health that is separate from the Medical Staff disciplinary function in accordance with the Practitioner Health Policy (Attachment A); and
(15) Performing other functions as described in Article 8.4.

1.6 BASIC RESPONSIBILITIES OF INDIVIDUAL MEDICAL STAFF MEMBERSHIP

Except for the Honorary and Retired Medical Staff, the responsibilities of each member of the Medical Staff include:

(1) Providing patients with continuous quality of care meeting the professional standards of the Medical Staff of this Hospital;
(2) Abiding by the Medical Staff Bylaws and Rules and Regulations, and Medical Staff policies;
(3) Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership;

(4) Preparing and completing in a timely fashion medical records for all the patients to whom the Member provides care in this Hospital;
(5) Abiding by the lawful, ethical principles of the Washington State Medical Association and the American Medical Association;
(6) Participating in such emergency service coverage as may be required;
(7) Attesting that he/she does not suffer from health problems which could affect ability to perform the functions of Medical Staff Membership and exercise the Clinical Privileges requested.
(8) Refusing to engage in improper inducements for patient referral;
(9) Informing any patient referred to the Hospital, in writing, of his/her ownership and/or investment interest(s), if any, in the Hospital.
(10) Notifying the CEO, Medical Staff Services Director, and/or the Chief of Staff immediately if:
    i. His/Her professional licensure in any state is suspended or revoked;
    ii. His/Her professional liability insurance is modified or terminated;
    iii. He/She is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;
    iv. He/She has been excluded from any federal or state health program, including Medicare and Medicaid;
    v. He/She is currently either voluntarily or involuntarily participating in any rehabilitation or impairment program; has previously participated in such a program; or has ceased participating in such a program without successful completion; or
    vi. There is any change in his/her health status that could or will affect his/her ability to perform the functions of Medical Staff Membership or the exercise of Clinical Privileges.
(11) Complying with the following requirements concerning history and physical examinations:
    i. Each patient shall have a History and Physical examination performed no more than thirty (30 days prior to, or within, twenty-four (24) hours of admission or registration (including outpatient), and prior to any procedure(s) requiring anesthesia;
    ii. For an H&P that was completed within 30 days prior to registration (including outpatient) or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or procedures requiring anesthesia services. Updates to outpatient H&Ps must occur the day of the procedure. The H&P may be transcribed or written, but must be legible.
    iii. The H&P may be performed by a qualified Physician or other Licensed Independent Practitioner (LIP) who has been credentialed and granted Privileges to perform a history and physical examination, including Podiatrists and Oral-Maxillofacial Surgeons. If the H&P is performed by a non-physician LIP, the findings, conclusions, and assessment of risk must be endorsed by a qualified Physician prior to surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia, or other major high risk procedure(s). H&Ps provided by non-members of the CMC Medical Staff or written in other facilities are not acceptable;
    iv. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the H&P shall specifically document the circumstances surrounding the need for additional acute care. ED Physicians may provide the H&P in this case, which includes the necessary elements as listed in the Rules and Regulations Article 5.4, and will be made available to the Admitting Physician;
    v. In an emergent need for an operative or invasive procedure the Physician will, as much as is possible, assess the patient and document the history of present illness, the current medications, any allergies, and the results of diagnostic testing. A complete H&P shall be completed within twenty-four (24) hours after the procedure;
    vi. Should the Physician fail to dictate the patient's H&P within twenty-four (24) hours after admission, the record shall be considered delinquent and the procedure outlined in the Delinquent Medical Records Policy (Attachment B) shall be in effect.

1.7 INDEMNIFICATION

The Hospital shall indemnify any Indemnified Party (as hereinafter defined) against actual and necessary expenses, costs, and liabilities (including settlements approved by the Corporation) incurred by him or her in connection with the defense of any pending or threatened action, suit, or proceeding to which he is made a party by reason of his acting or having acted in an official capacity on behalf of the Hospital. As used herein the term "Indemnified Party" shall mean a present or former Practitioner acting in good faith on behalf of the Hospital through committee or other service. Such indemnification shall not be exclusive of any other rights of indemnity to which the Indemnified party may be entitled. Notwithstanding any other provision hereof to the contrary, no person shall be entitled to indemnity hereunder if the acts giving rise to the liability constituted willful misconduct, breach of fiduciary duty, self-dealing, and/or bad faith.

ARTICLE II
CATEGORIES OF MEMBERSHIP

2.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Courtesy, Affiliate, Honorary, and Retired. Initial appointees to the Active, Courtesy and Affiliate membership categories shall not exceed a period of twenty-four (24) months, and will receive a Focused Professional Practice Evaluation (FPPE) per Medical Staff Policy (Attachment C).

2.2 ACTIVE MEDICAL STAFF

2.2(a) Qualifications

The Active Medical Staff shall consist of Physicians who:

(1) Meet the basic qualifications as set forth in these Bylaws;

(2) Have an office and/or residence located within thirty (30) minutes response time of the Hospital in order to be available for emergency provision of care to his/her patients; and

(3) Regularly admit to, or are otherwise regularly involved in the care of at least 26 or more patients in the Hospital in a calendar year. For purposes of determining whether a Practitioner is "regularly involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include any of the following:

i. Admission;
ii. Consultation with active participation in the patient's care;
iii. Provision of direct patient care or intervention in the Hospital setting;
iv. Performance of any outpatient or inpatient surgical or diagnostic procedure;
v. Performance or interpretation of more than one procedure or diagnostic test during a single hospital visit/stay shall count as one patient contact.

2.2(b) Prerogatives

(1) To admit patients without limitation, unless otherwise provided in the Medical Staff Bylaws and Rules and Regulations;
(2) To exercise such Clinical Privileges as are granted to him/her;
(3) To vote on all matters presented at general and special meetings of the Medical Staff;
(4) To vote and hold office in the Medical Staff organization and on committees to which he/she is appointed; and
(5) To vote in all Medical Staff elections.

2.2(c) Responsibilities

(1) Meet the basic responsibilities set forth in these Bylaws;

(2) Retain responsibility, within his/her area of professional competence, for the continuous care and supervision of each patient in the Hospital for whom he/she is providing service, or arrange a suitable alternative for such care and supervision, and provide consultation within his/her specialty for patients of other Practitioners where applicable; and

(3) Actively participate in:

i. The Performance Improvement Program and other patient care evaluation and monitoring activities required of the Medical Staff and possess the requisite skill and training for the oversight of care, treatment and services in the Hospital;
ii. Supervision of other appointees where appropriate;
iii. The Emergency Department On-Call Rotation, as more specifically described in the Medical Staff Rules and Regulations, including personal appearance to assess patients in the Emergency Department when deemed appropriate by the Emergency Department Physician;
iv. Promoting effective utilization of resources consistent with delivery of quality patient care; and
v. Discharging such other Medical Staff functions as may be required from time-to-time.

2.3 COURTESY MEDICAL STAFF

2.3(a) Qualifications

The Courtesy Medical Staff shall consist of Physicians otherwise qualified for Active Medical Staff membership, but who regularly participate in the care of six (6) to 25 patients in a calendar year (the limitation on patient contacts shall not apply to contracted Emergency Department Physicians);

2.3(b) Prerogatives

(1) Admit patients to the Hospital within the limitations provided in this Section;
(2) Exercise such Clinical Privileges as are granted to him/her;
(3) Attend meetings of the Medical Staff and any education programs offered, and
(4) Serve on a standing committee as a voting member on matters of policies and procedure, except that he/she shall not be entitled to vote as a member of the General Medical Staff or for any elected officer positions.

2.3(c) Responsibilities

(1) Discharge the basic responsibilities specified in these Bylaws; and
(2) Retain 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 service.

2.4 AFFILIATE MEDICAL STAFF

2.4(a) Qualifications

The Affiliate Medical Staff shall consist of Physicians otherwise qualified for Courtesy Medical Staff membership, but who admit, consult and/or treat patients in the Hospital less than five (5) times in a calendar year. Advancement to Courtesy Medical Staff may be considered if the number of admissions or treatments exceeds five (5) in a calendar year.

2.4(b) Prerogatives

(1) May exercise any clinical privileges granted to him/her with the requirement to consult with a Hospitalist or another Active Medical Staff Member prior to the exercising of any clinical privileges, including admission;
(2) Attend meetings of the Medical Staff and any education programs offered, and
(3) Serve on a standing committee but may not serve as chair or have any voting privileges.

2.4(c) Responsibilities

(1) Discharge the basic responsibilities specified in these Bylaws; and
(2) Retain 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 service.

2.5 HONORARY MEDICAL STAFF

The Honorary Medical Staff shall consist of those who do not admit, consult, or treat patients in the Hospital and who are honored by emeritus positions. Honorary Medical Staff members are those deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or because of their previous long-standing service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct. Honorary Medical Staff members are eligible to attend meetings but are not eligible to vote or hold office. No Clinical Privileges are afforded to members of the Honorary Medical Staff, nor are they required to apply for reappointment.

2.6 RETIRED MEDICAL STAFF

The Retired Medical Staff shall consist of those who do not admit, consult, or treat patients in the Hospital. Retired Medical Staff members are those deemed deserving of membership by virtue of their previous service to the Hospital. Retired Medical Staff members are eligible to attend meetings, but are not eligible to vote or hold office. No Clinical Privileges are afforded to members of the Retired Medical Staff, nor are they required to apply for reappointment.

ARTICLE III
ALLIED HEALTH PROFESSIONALS

3.1 ELIGIBILITY OF ALLIED HEALTH PROFESSIONALS

The Medical Staff determines the classifications of, and the need for, Allied Health Professionals (AHP) at the Hospital based upon patient care services provided, strategic plans, and long-range goals, with approval of the Board of Trustees. Policies and procedures related to AHPs are also determined by the Medical Staff. AHPs are eligible to apply for clinical privileges at Capital Medical Center, but may not hold membership in the Medical Staff. AHPs shall provide service only within the scope of their license, registration, certification, special training, and approved privileges at the Hospital.

Both independent and dependent Allied Health Professionals must be sponsored by an acceptable Active Medical Staff Member. Independent AHPs are Advance Registered Nurse Practitioners (ARNP); and others as designated by the Board of Trustees. Dependent AHPs include Physician Assistants (PA), Certified Registered Nurse Anesthetists (CRNA), Registered Nurse First Assistants (RNFA), and others as designated by the Board of Trustees. AHP's will be subject to the same credentialing and privileging mechanisms as required of members of the Medical Staff.

3.2 AHP PREROGATIVES

Upon establishing experience, training and current competence, AHPs, as identified herein, shall have the following prerogatives:

(1) To exercise clinical judgment within his/her area of competence, providing that an Active Physician member of the Medical Staff has the ultimate responsibility for patient care;
(2) To participate directly, including recording in the medical record and writing orders to the extent permitted by Law and Privileges, in the management of patients under the supervision or direction of an Active Physician member of the Medical Staff; and
(3) To participate, as appropriate, in patient care evaluation and other quality assessment and monitoring activities required of the AHP Medical Staff, and to discharge such other AHP Medical Staff functions as may be required from time-to-time.
(4) May serve on a standing committee by invitation as a voting committee member on matters of policy and procedures, but may not serve as Chair or be entitled to vote as a member of the General Medical Staff.

3.3 AHP RESPONSIBILITIES

(1) Provide his/her patients with continuous care at the industry standard professional level of quality;
(2) Abide by the Medical Staff Bylaws and other lawful standards, policies, and Rules and Regulations of the Medical Staff, and personnel policies of the Hospital, if applicable;
(3) Discharge any committee functions for which he/she is responsible;
(4) Cooperate with members of the Medical Staff, Administration, the Board of Trustees and employees of the Hospital;
(5) Adequately prepare and complete in a timely fashion the medical records and other required records for which he/she is responsible;
(6) Participate in performance improvement activities and in continuing professional education;

(7) Abide by the ethical principles of his/her profession and specialty;
(8) Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended and its associate regulations, and execute a health information confidentiality agreement with the Hospital.
(9) Notify the CEO, Medical Staff Services Director, or the Chief of Medical Staff immediately if:
    i. His/Her professional license is suspended or revoked in any state;
    ii. His/Her professional liability insurance is modified or terminated;
    iii. He/She is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud; or
    iv. He/She ceases to meet any of the standards or requirements set forth herein for continued AHP appointment and/or Clinical Privileges.

3.4 AHP PHYSICIAN SPONSOR RESPONSIBILITIES

(1) Assume full responsibility and be fully accountable for the performance of the AHP within the Hospital;
(2) Furnish evidence of professional liability insurance coverage in accordance with the requirements of these Bylaws;
(3) Acquaint the AHP with the applicable rules and regulations of the Medical Staff and the Hospital;
(4) Verify and approve clinical privileges requested and performed by the AHP;
(5) Inform patients of the AHP's participation in their care and ensures that the AHP is clearly identified by Hospital badge;
(6) Notifies the Medical Staff office of any change in the AHP's status which would affect his/her ability to function in the privileges requested;
(7) Notified the Medical Staff office of any change in his/her status to continue to function as the Physician Sponsor (e.g., resignation/revocation/suspension of membership or privileges, status change to other than Active, inability to oversee activities of AHP for any reason); and
(8) If the supervising practitioner employs or directly contracts with the AHP for services, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP, negligence of such AHP, the failure of such AHP to satisfy the standards of proper care of patients, or any action by such AHP beyond the scope of his/her license or clinical privileges.

    If the supervising practitioner does not employ or directly contract with the AHP, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, causes of action, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP by the practitioner in question.

3.5 AHP APPLICATION FOR PRIVILEGES

The applicant Allied Health Professional at Capital Medical Center must:

(1) Provide a service that is required by Hospital patients and that can be supported by the resources of the Hospital;
(2) Provide a completed Washington Practitioner Application, Releases, and other documents required by the Board of Trustees for the process of credentialing;
(3) Provide the name and signed acknowledgment of an Active Physician member of the Medical Staff who assumes responsibility for the acts and omissions of the AHP and responsibility for directing and supervising the AHP;
(4) Document his/her professional experience, background, education, training, demonstrated ability, current competence, and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board of Trustees that any patient treated by them will receive quality care and that they are qualified to the Privileges sought;
(5) Establish, on the basis of documented references, that they adhere strictly to the ethics of their respective provisions, work cooperatively with others and are willing to participate in the discharge of AHP Medical Staff responsibilities; and
(6) Have professional liability insurance in the amount required by these Bylaws.

3.6 AHP APPOINTMENT, RIGHTS, AND TERMINATION

The AHP application and reapplication will be processed per the Medical Staff credentialing procedures. Appointment and Privileges are approved by the Board of Trustees for a period up to twenty-four (24) months and will be subject to professional practice evaluations.

AHP appointment and/or privileges may be terminated by the Board of Trustees or the CEO. Any restriction or termination of AHP Privileges for a period of thirty (30) days or more that is based on the competence or professional conduct of the AHP shall be subject to review by the Credentials Committee and the Board of Trustees as described below:

(1) Adverse actions or recommendations affecting AHP Privileges shall not be covered by the provisions of the Fair Hearing Plan. However, the AHP shall have the right to request to be heard before the Credentials Committee with an opportunity to rebut the basis for termination:
    i. Upon receipt of a written request, the Credentials Committee shall afford the AHP to be heard by the Committee concerning the AHP's grievance;
    ii. Before the appearance, the AHP shall be informed of the general nature and circumstance giving rise to the action, and the AHP may present information relevant thereto;

iii. A record of the appearance shall be made; or
iv. The Credentials Committee shall, after conclusion of the investigation, submit a written decision simultaneously to the MEC and to the AHP.

(2) The AHP shall have a right to appeal to the Board of Trustees any decision rendered by the Credentials Committee. Any request for appeal shall be required to be made within 15 days after the date of the receipt of the Credentials Committee decision.
i. The written request shall be delivered to the Chief of Medical Staff and shall include a brief statement of the reason(s) for the appeal.
ii. If appellate review is not requested within such period, the AHP shall be deemed to have accepted the action involved which shall thereupon become final and effective immediately upon affirmation by the MEC and the Board of Trustees.
iii. If appellate review is requested, the Board of Trustees shall, within 15 days after the receipt of such an appeal notice, schedule and arrange for appellate review. The Board of Trustees shall give the AHP notice of the time, place and date of the appellate review, which shall not be less than 15 days nor more than 90 days from the date of the request for the appellate review.
iv. The appeal shall be in writing only, and the AHP's written statement must be submitted at least five (5) days before the review. New evidence and oral testimony shall not be permitted.
v. The Board of Trustees shall thereafter decide the matter by a majority vote of those Board of Trustees members present during the appellate proceedings.
vi. A record of the appellate proceedings shall be maintained.

(3) Any corrective behavior, problem-solving, or grievance issues of Hospital-employed AHPs will be handled through the Hospital's Human Resources Department.

(4) Automatic termination of the AHP's Privileges is required if the AHP's Physician Sponsor's privileges or membership are terminated/revoked/suspended for any reason unless another qualified Physician indicates his/her willingness to supervise the AHP and complies with all requirements hereunder for undertaking such supervision. In the event that an AHP's supervising Physician member's Privileges are significantly reduced or restricted, the AHP's Privileges shall be reviewed and modified by the Board of Trustees upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan.

(5) Automatic termination of the AHP's privileges is required due to failure to timely complete and return the required reappointment application and/or clinical privileges documentation.

ARTICLE IV
MEDICAL ASSISTANTS

4.1 ELIGIBILITY OF MEDICAL ASSISTANTS

Medical Assistants who, by virtue of their employment or as independent contractors, render service to a Physician are eligible for Clinical Privileges as a Medical Assistant to provide clinical services within the Hospital. Medical Assistants are not eligible for Medical Staff Membership. The Medical Staff determines the classifications of, and the need for, Medical Assistants at the Hospital based upon patient care services provided, strategic plans, and long-range goals. Policies and procedures related to Medical Assistants are approved by the Board of Trustees. Medical Assistants shall provide service only within the scope of their license, registration, certification, special training, and approved privileges at the Hospital.

4.2 SUPERVISION OF MEDICAL ASSISTANTS

A Medical Assistant exercising Privileges within the Hospital shall be under the direct and immediate supervision of the Sponsoring Physician, who shall be an Active member of the Medical Staff and is responsible for the conduct and acts, errors and omissions of the Medical Assistant at the Hospital.

4.3 APPLICATION OF MEDICAL ASSISTANTS

(1) Medical Assistants possessing a current Washington license or certificate in good standing as required by Washington State law and who regularly render services to a Practitioner may apply for Privileges with the following requirements:
(2) Provide a service that is required by Hospital patients and that can be supported by the resources of the Hospital;
(3) Provide a completed Washington Practitioner Application, Releases, and other documents required by the Board of Trustees for the process of credentialing;
(4) Provide the name and signed acknowledgment of an Active Physician member of the Medical Staff who assumes responsibility for the acts and omissions of the AHP and responsibility for directing and supervising the AHP;
(5) Medical Assistants' applications will be subject to the same credentialing and privileging mechanisms as required of members of the Medical Staff and Allied Health Professionals.
(6) The Board of Trustees shall decide whether to grant Privileges to the applicant and shall specify the scope of such Privileges and approve the specific sponsoring Practitioner(s) under whose supervision the Medical Assistant applicant may exercise Privileges in the Hospital.
(7) In the event of an adverse decision, and to ensure due process, the Medical Assistant applicant may request a meeting with the MEC to seek reconsideration of the decision by the Board of Trustees.

4.4 TERMINATION OF MEDICAL ASSISTANT PRIVILEGES

In the event that the Medical Assistant ceases to be employed by or contracted with the Sponsoring Practitioner, or in the event that the Sponsoring Practitioner's Privileges at the Hospital are terminated for any reason, the Privileges of the Medical Assistant shall be automatically terminated.

The Privileges of a Medical Assistant may be suspended, revoked or limited at any time by the Board of Trustees upon their own motion or following receipt of a recommendation from the MEC. In the event of an adverse decision, and to ensure due process, the Medical Assistant shall be entitled to the same grievance process as outlined for AHPs herein.

ARTICLE V
APPOINTMENT AND REAPPOINTMENT

The policies and procedures for the evaluation of an appointment or reappointment to the Medical Staff are defined in the Credentialing Manual and the Credentials Policies and Procedures, attached to these Bylaws, and which are adopted pursuant to the Medical Staff Bylaws and are made a part thereof.

ARTICLE VI
ORGANIZATION OF SERVICES

6.1 DESIGNATION OF CURRENT SERVICES

The Medical Staff shall be organized into Clinical Services. Each Medical Staff Member shall be assigned to the Clinical Service appropriate to the Practitioner's specialty, as defined by the Credentials Committee. Clinical Services shall be Medicine, Surgery, and Emergency. Additional Services may be established or existing Services may be consolidated or eliminated by the Medical Executive Committee, subject to Board of Trustees approval.

6.2 FUNCTION OF SERVICES

Each Service shall:

(1) Recommend to the MEC criteria for the granting of Clinical Privileges for members within that Service;
(2) Conduct appropriate patient care reviews and Quality Improvement studies;
(3) Be allowed to form subcommittees. The subcommittees shall report at the general Service meeting;
(4) Monitor the compliance of its members with these Bylaws, and the Rules and Regulations, Policies, Procedures and other standards of the Hospital;
(5) Monitor the compliance of its members with applicable professional Standards;
(6) Coordinate the patient care provided within the Service with nursing, administrative, and other non-Medical Staff Hospital services;
(7) Make recommendations to the MEC, subject to Board of Trustees approval, of the kinds, types, and amounts of data to be collected and evaluated to allow the Medical Staff to conduct an evidence-based analysis of the quality of professional practice of its members; and
(8) Submit written or verbal reports to the MEC on a regular basis concerning:
    i. Findings of the Service's review and evaluation activities, actions taken thereon, and the results thereof;
    ii. Recommendations for maintaining and improving the quality of care provided in the Service and in the Hospital; and
    iii. Such other matters as may be requested from time to time by the MEC.

ARTICLE VII
OFFICERS

7.1 OFFICERS OF THE MEDICAL STAFF

7.1(a) Identification

The officers of the Medical Staff shall be the Chief of Medical Staff, Vice Chief of Medical Staff, Immediate Past Chief of Medical Staff and the Service Chiefs.

7.1(b) Qualifications

Officers must be members of the Active Medical Staff at the time of their nominations and election, and must remain members in good standing during their term of office. All officers must be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process at the time of their election. Failure to maintain such status shall create a vacancy in the office involved. No Medical Staff member actively practicing in the Hospital is ineligible for membership on the executive committee solely because of his/her specialty or professional discipline.

7.1(c) Nominations

The Nominating Committee shall consist of the voting members of the MEC. The Nominating Committee shall nominate one or more nominees for each office to be filled. The nominations of the Committee shall be reported to the MEC at least 45 days prior to the

election. The list of nominations shall be made available to the voting members of the Medical Staff at least one month (30 days) prior to the election.

7.1(d) Elections

Officers shall be elected to open positions either at the annual meeting of the General Medical Staff each year; or by a mail-in ballot procedure where a written ballot will be delivered by mail, electronically, or in person and will be returned by mail, in person or by electronic means within ten (10) days. Open positions for the Service Chiefs shall also be voted upon during this annual election, but shall only be voted upon by the Active members of the particular Service for which they are being nominated. Only Active Medical Staff members shall be eligible to vote. Voting by proxy shall not be permitted.

A nominee shall be elected upon receiving a majority of the valid votes cast. In the event of a tie vote, a repeat mail-in ballot procedure shall be performed as outlined above, and shall be returned within ten (10) days. The results of such election will become final and published upon ratification by the Board of Trustees.

7.1(e) Term of Elected Office

Each officer shall serve a two (2) year term, commencing on the first day of January following his or her election. Each officer shall serve in his/her office until the end of his/her term, or until a successor is elected, unless he shall sooner resign or be removed from office.

At the end of the Chief of Medical Staff's elected term, he/she shall automatically assume the office of Immediate Past Chief of Medical Staff and the Vice Chief of Medical Staff shall automatically assume the office of Chief of Medical Staff.

7.1(f) Resignation, Removal, and Recall from Office

(1) Resignation: Any Medical Staff Officer may resign at any time by giving written notice to the Medical Executive Committee and the acceptance of such resignation shall not be necessary to make it effective.

(2) Removal: Any Medical Staff Officer may be removed from office for cause. Removal shall occur with the majority vote of the Medical Executive Committee as to whether there is sufficient evidence for grounds for removal from office for cause, with the majority vote of the Board of Trustees. Grounds for removal may include any one of the following causes, without limitations:
   i. Failure to perform the duties of office;
   ii. Failure to comply with or support the enforcement of the Medical Staff Bylaws, Rules and Regulations, or policies;
   iii. Failure to support the compliance of the Medical Staff to applicable Federal and State laws and regulations;
   iv. Failure to maintain qualifications for office, specifically, failure to maintain active Medical Staff status in good standing; and/or
   v. Failure to adhere to professional ethics or any action(s) deemed injurious to the reputation of, or inconsistent with, the best interests of the Hospital and Medical Staff.

(3) Recall: Any Medical Staff Officer may be recalled from office, with or without cause. Recall of a Medical Staff Officer may be initiated by a majority of members of the Medical Executive Committee or by a petition signed by at least one-third of the Medical Staff Members eligible to vote in Medical Staff elections. Recall shall be considered by the Medical Staff at a special meeting of the Medical Staff called for that purpose. A recall shall require two-thirds of the votes of the Medical Staff Members who are eligible to vote. Votes can be authenticated by direct ballot, fax ballot or mailed in ballot. The recall shall become effective upon approval of the Board of Trustees.

7.1(g) Vacancies in Elected Office

Vacancies in the offices of Service Chiefs during an ongoing term shall be filled by the MEC. If there is a vacancy in the office of Chief of Medical Staff, the Vice-Chief of Medical Staff shall serve out the remaining term. A vacancy in the office of Vice-Chief of Medical Staff shall be filled by a special election conducted within thirty (30) days after the vacancy occurs.

7.2 DUTIES OF OFFICERS

7.2(a) Chief of Staff

The Chief of Staff shall serve as the Chief Officer of the Medical Staff. The duties of the Chief of Staff shall include, but not be limited to:

(1) Enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
(2) Calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;
(3) Serving as Chair of the MEC;
(4) Serving as ex-officio member of all other Medical Staff committees without vote, unless his or her membership in a particular committee is required by these Bylaws and as a voting member of the Board of Trustees as a representative of the Medical Staff;
(5) Interacting with the Administrator and Board of Trustees in all matters of mutual concern within the Hospital;

(6) Appointing the Chair and members for standing and special committees, except where otherwise provided by these Bylaws, subject to confirmation by the MEC;
(7) Representing the views and policies of the Medical Staff to the Board of Trustees and to the Administrator;
(8) Being a spokesman for the Medical Staff in external professional and public relations;
(9) Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff, or by the MEC;
(10) Serving on liaison committees with the Board of Trustees and Administration, as well as outside licensing or accreditation agencies; and
(11) Serving as a member of the Joint Conference Committee;
(12) Appointing multi-disciplinary Medical Staff committees;
(13) Being responsible to the Board of Trustees, in conjunction with the MEC, for the quality and efficiency of clinical services and professional performance within the Hospital and for the effectiveness of patient care evaluations and maintenance functions delegated to the Medical Staff; work with the Board of Trustees in implementation of the Board of Trustees' quality, performance, efficiency and other standards;
(14) Aiding in coordinating the activities of the Hospital Administration and of nursing and other non-Physician patient care services with those of the Medical Staff;
(15) In concert with the MEC and Credentials Committee, developing and implementing methods for credentials review and for delineation of Privileges; along with the continuing medical education programs, utilization review, monitoring functions and patient care evaluation studies;
(16) Conferring with the CEO, CFO, CNO and Service Chief on at least a quarterly basis as to whether there exists sufficient space, equipment, Medical Staffing, and financial resources or that the same will be available within a reasonable time to support each privilege requested by applicants to the Medical Staff; and report on the same to the MEC and to the Board of Trustees; and
(17) Assisting the Service Chiefs as to the types and amounts of data to be collected and compared in determining and informing the Medical Staff of the professional practice of its members.

7.2(b) Vice Chief of Staff

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence, unavailability or disqualification of the Chief of Staff. The Vice Chief of Staff shall be a member of the MEC, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws, or by the MEC. The duties of Vice Chief of Staff shall also include those duties ordinarily pertaining to the office of Secretary-Treasurer.

7.2(c) Immediate Past Chief of Staff

The Immediate Past Chief of Staff shall be a member of the MEC and shall perform such other duties as may be assigned by the Chief of Staff or delegated by these Bylaws, or by the MEC. The Immediate Past Chief of Staff shall assume the duties and authority of the Chief of Staff when the Chief of Staff and Vice Chief of Staff are both absent, unavailable or disqualified from acting.

7.2(d) Service Chiefs

Each Clinical Service shall be chaired by a member of the Active Medical Staff.
Service Chiefs are responsible for:

(1) All clinically related activities of the Service;
(2) All administratively related activities of the Service, unless otherwise provided for by the Hospital;
(3) Continuing surveillance of the professional performance of all individuals in the Service who have Clinical Privileges;
(4) Recommending to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the Service;
(5) Recommending Clinical Privileges for each member of the Service;
(6) Recommending to the relevant Hospital authority off-site resources for needed patient care services not provided by the Service or the Hospital;
(7) The integration of the Service into the primary functions of the organization;
(8) The coordination and integration of Clinical Services throughout the Hospital;
(9) The development and implementation of policies and procedures that guide and support the provision of services;
(10) The recommendations for a sufficient number of qualified and competent persons to provide patient care;
(11) Recommendations concerning the qualifications and competence of Service personnel who are not Licensed Independent Practitioners and who provide patient care services;
(12) The continuous assessment and improvement of the quality of care and services provided;
(13) The maintenance of quality control programs as appropriate;
(14) The orientation and continuing education of all persons in the Service;
(15) Recommendations for space and other resources needed by the Service; and
(16) Promoting required performance improvement and quality control functions including surgical case review, blood usage review, drug usage evaluation, medical record review, pharmacy and therapeutics, risk management, safety, infection control and utilization review, are performed within the Service, and that findings from such activities are properly integrated with the primary functions of the Service level.

7.3 CONFLICT OF INTEREST

The best interest of the community, Medical Staff and the Hospital are served by Medical Staff Leaders (defined as any member of the Medical Executive Committee, officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Hospital's Board of Trustees) who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision-making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally bear on that member's opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationships of any Medical Staff Leader which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis. No Medical Staff Leader shall use his/her position to obtain or accrue any benefit.

Annually, on or before January 31, each Medical Staff Leader shall file with the MEC a signed Conflict of Interest statement with reasonable disclosure of each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Medical Staff Leader, and/or a member of the community, which may impact on the finances or operations of the Hospital or its Medical Staff, or the Hospital's relationship to the community, including but not limited to each of the following:

(1) Any leadership position on another Medical Staff or educational institution that creates a fiduciary obligation on behalf of the Practitioner, including, but not limited to member of the governing body, executive committee, or service or department chairmanship with an entity or facility that competes directly or indirectly with the Hospital;
(2) Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Hospital;
(3) Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Hospital; or
(4) Business practices that may adversely affect the Hospital or community.

A new Medical Staff Leader shall sign the Conflict of Interest statement immediately upon being elected or appointed to his/her leadership position. This disclosure requirement is to be construed broadly, and a Medical Staff Leader should determine the need for reasonable disclosures, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure procedure will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

Between annual disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The MEC Secretary will provide each MEC member with a copy of each member's written disclosure at the next MEC meeting following filing by the member for review and discussion by the MEC.

Medical Staff Leaders shall abstain from voting on any issue in which the Medical Staff Leader has an interest other than as a fiduciary of the Medical Staff. A breach of these provisions is deemed sufficient grounds for removal of a breaching member by the remaining members of the MEC or the Board of Trustees on majority vote.

ARTICLE VIII
COMMITTEES

8.1 DESIGNATION

All standing committees are created and defined in accordance with these Bylaws or applicable policies and procedures. Special or ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. Unless otherwise specified, the committee Chair shall be appointed by, and/or removed by, the Chief of Staff, subject to confirmation by the MEC. Medical Staff committees shall be responsible to the MEC. The CEO or his/her designee shall serve as an ex-officio member, without vote, of each standing and special Medical Staff committee.

8.2 GENERAL PROVISIONS

8.2(a) Terms of Committee Members

Unless otherwise specified, committee members shall be appointed for a term of at least one (1) year, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

8.2(b) Removal of Committee Members

If a member of a committee ceases to be a member in good standing of the Medical Staff, loses employment or a contract relationship with the Hospital, suffers a loss or significant limitation of practice Privileges, fails to attend a majority of scheduled committee meetings, or if any other good cause exists, that member may be removed by the MEC.

8.2(c) Vacancies

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the MEC.

8.3 MEDICAL EXECUTIVE COMMITTEE

8.3(a) MEC Composition

Note: No Medical Staff member, actively practicing in the Hospital, is ineligible for membership on the MEC solely because of his or her professional discipline or specialty. The MEC shall consist of the following persons:

(1) The Chief of Staff
(2) Vice Chief of Staff
(3) Immediate Past Chief of Staff
(4) Chiefs of Clinical Services
(5) Chair of Credentials Committee
(6) Chair of Quality Improvement Council
(7) The CEO and other administrative representatives, as requested by the MEC, shall be ex-officio members without voting rights.

8.3(b) MEC Duties and Authority

All Active Medical Staff members shall be eligible to serve on the MEC. The authority of the MEC is outlined in this Article and additional functions may be delegated or removed through amendment of this Article. The MEC shall meet monthly, at least ten (10) times per year, and shall maintain a record of its proceeding and actions. A quorum of fifty percent of the voting members shall be required for MEC meetings. The functions and responsibilities of the MEC shall include, but not be limited to the following:

(1) Representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;
(2) Coordinating and implementing the professional and organizational activities and policies of the Medical Staff;
(3) Receiving and acting upon reports and recommendations from Medical Staff services and/or the CEO;
(4) Making Medical Staff recommendations directly to the Board of Trustees for its approval pertaining to:
    i. The Medical Staff structure;
    ii. The mechanism used to review credentials and to delineate individual clinical Privileges;
    iii. Recommendations of individuals for Medical Staff Privileges;
    iv. Recommendations for delineated Clinical Privileges for each eligible individual;
    v. The participation of the Medical Staff in organization performance improvement activities;
    vi. The mechanism by which Medical Staff membership may be terminated; and
    vii. The mechanism for fair hearing procedures.
(5) Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in Medical Staff corrective or review measures when warranted;
(6) Taking reasonable steps to develop continuing education activities and programs for the Medical Staff;
(7) Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Medical Staff;
(8) Reporting to the Medical Staff at each regular Medical Staff meeting;
(9) Assisting in the obtaining and maintaining of accreditation;
(10) Assisting in the development and maintenance of methods for the protection and care of patients and others in the event of internal or external disaster;
(11) Appointing such special ad hoc committees as may seem necessary or appropriate to assist the MEC in carrying out its functions and those of the Medical Staff;
(12) Participating in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;
(13) Representing and acting on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;
(14) Requesting evaluation of Practitioners in instances where there is doubt about an applicant's ability to perform the Privileges requested. Initiating an investigation of any incident, course of conduct, or allegation indicating that a Practitioner to the Medical Staff may not be complying with the bylaws; may be rendering care below the standards established for Practitioners to the Medical Staff; or may otherwise not be qualified for continued Medical Staff Appointment or Clinical Privileges;
(15) Recommending action to the CEO on matters of a medico-administrative nature; and
(16) Assisting with annual evaluation of the effectiveness of the Hospital's performance improvement program is conducted.

8.4 MEDICAL STAFF FUNCTIONS

The MEC shall designate appropriate Medical Staff committees to perform the functions of the Medical Staff. The functions of the Medical Staff are to:

(1) Monitor, evaluate and improve care provided in and develop clinical policy for all areas, including special care areas, such as intensive or coronary care unit; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, surgical, outpatient, home care and ambulatory care services;
(2) Conduct or coordinate appropriate performance improvement reviews, including review of invasive procedures, blood and blood component usage, drug usage, medical record and other appropriate Ongoing Professional Practice Evaluations (OPPE) reviews per the Medical Staff Policy (Attachment C);
(3) Conduct or coordinate utilization review activities;

(4) Assist the Hospital in providing continuing education opportunities responsive to performance improvement activities, new state-of-the-art developments, services provided within the Hospital and other perceived needs;
(5) Develop and maintain surveillance over drug utilization policies and practices;
(6) Investigate nosocomial infections and monitor the Hospital's infection control program;
(7) Plan for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community;
(8) Direct Medical Staff organizational activities, including Medical Staff bylaws, review and revision, Medical Staff officer and committee nominations, liaison with the Board of Trustees and Hospital Administration, and review and maintenance of Hospital accreditation;
(9) Provide for appropriate Practitioner involvement in, and approval of, the multi-disciplinary plan of care, and provide a mechanism to coordinate the care provided by members of the Medical Staff with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services;
(10) Adopt a Practitioner Health Policy, as part of the Hospital and Medical Staff's obligation to protect patients and others in the organization from harm. The purpose of this policy is to provide education about Practitioner health, address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment, and rehabilitation of Practitioners who suffer from a potentially impairing condition. The Practitioner Health Policy (Attachment A) affords resources separate from the corrective action process to address Physician health. The policy provides a confidential mechanism for addressing impairment of Medical Staff members and providing appropriate advice, counseling or referrals;
(11) Provide leadership in activities related to patient safety;
(12) Oversee that the Medical Staff provides leadership for process measurement, assessment and improvement for the following processes which are dependent on the activities of individuals with Clinical Privileges:
   i. Medical assessment and treatment of patients;
   ii. Use of medications, use of blood and blood components;
   iii. Use of operative and other procedure(s);
   iv. Efficiency of clinical practice patterns; and
   v. Significant departure from established patterns of clinical practice.
(13) Promote Medical Staff participation in the measurement, assessment and improvement of other patient care processes, including, but not limited to, those related to:
   i. Education of patients and families;
   ii. Coordination of care, treatment and services with other Practitioners and Hospital personnel, as relevant to the care of an individual patient;
   iii. Accurate, timely and legible completion of patients' medical records including history and physicals;
   iv. Patient satisfaction;
   v. Sentinel events; and
   vi. Patient safety.
(14) Recommend to the Board of Trustees policies and procedures that define the trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a Practitioner's performance and evaluation of a Practitioner's performance by peers. The process and procedure for focused professional review shall be substantially in accord with the Medical Staff Professional Practice Evaluation Policy (Attachment C). The information relied upon to investigate a Practitioner's professional conduct and practice may include (among other items or information), internal or external chart reviews, prospective, concurrent and/or retrospective monitoring of actual practice, monitoring of clinical practice patterns, proctoring, and consultations with other Physicians, assistants, nursing or Administrative personnel involved in the care of patients;
(15) Make recommendations to the Board of Trustees regarding the Medical Staff Bylaws, Rules & Regulations, and review same on a regular basis;
(16) Engage in other functions reasonably requested by the MEC and Board of Trustees or those which are outlined in the Medical Staff Rules & Regulations, or other policies of the Medical Staff;
(17) Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of Clinical Privileges;
(18) Review, on a periodic basis, applications for reappointment including information regarding the competence of Medical Staff members; and as a result of such reviews make recommendations for the granting of Privileges and reappointments;
(19) Investigate any breach of ethics that is reported to it;
(20) Review AHP appeals of adverse privilege determinations as provided herein; and
(21) To prepare and recommend a slate of nominees for the officers of the Medical Staff.

8.5 CONFLICT RESOLUTION COMMITTEE

For managing conflict among Leadership Groups that involve Practitioners, the Quality Improvement Committee (QIC) shall provide and implement an ongoing Conflict Resolution Committee in accordance with the Hospital's Managing Conflicts Policy. The QIC shall meet as needed, specifically when a conflict arises that, if not managed, could adversely affect patient safety or quality of care. When such a conflict arises, the Conflict Resolution Committee shall meet with the involved parties as early as possible to resolve the conflict; gather information regarding the conflict; work with the parties to manage and to resolve the conflict, when possible; and to protect the safety and quality of care.

When conflict arises between the Medical Staff and the MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, this process shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety.

An ad hoc committee selected by the Board of Trustees Chair shall meet, as needed, with leaders of the Medical Staff and MEC as early as possible to work with the parties to manage and, when possible, resolve the conflict. Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Board of Board of Trustees on a rule, regulation, or policy adopted by the Medical Staff or the MEC or to limit the Board of Trustees' final authority as to such issues.

The Board of Trustees shall have final authority regarding the adoption of any rule, regulation or policy or amendment thereto and (except in the case of a provisional adoption provided for in this Article) no such rule, regulation or policy or amendment thereto, shall be effective until approved by the Board of Trustees.

8.6 JOINT CONFERENCE COMMITTEE

A Joint Conference Committee shall be implemented as needed to mediate matters of conflict between the MEC and the Board of Trustees. The Joint Conference Committee shall meet as needed when a conflict arises that has not been resolved through prior discussion of the issue; and shall consist of an equal number of members of the MEC and Board of Trustees, including the Chief of Staff and/or Vice Chief of Staff and at least one Hospital Executive as a non-voting ex-officio member. This Committee shall gather information regarding the conflict; work together to resolve the conflict; and will transmit reports of its activities to both the MEC and the Board of Trustees.

ARTICLE IX
MEETINGS

9.1 GENERAL MEDICAL STAFF MEETINGS

The General Medical Staff (GMS) shall conduct regular meetings at least once a year, or more often as determined by the MEC. The date, place, and time of the regular meetings shall be determined by the MEC, and adequate notice shall be given to the members. The order of business at the GMS meetings shall be determined by the Chief of Staff.

9.2 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the MEC, or shall be called upon the written request of ten (10) percent of the members of the Active Medical Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the MEC within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the members of the Medical Staff which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting. A majority of those Active Medical Staff members must be present, or must respond to a mail/email vote, for any business transactions to be completed.

9.3 COMMITTEE AND SERVICE MEETINGS

9.3(a) Service Meetings

Services shall meet at least four (4) times per year or more often as necessary to conduct Service business and provide medical education to members. The Service Chief may call Service meetings more often as deemed necessary, giving reasonable notice to Service members.

9.3(b) Regular Meetings

Except as otherwise specified in these Bylaws, the Service Chief may establish the times for holding regular meetings. The Service Chief shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

9.3(c) Special Meetings

A special meeting of any Medical Staff Committee or Service may be called by the Service Chief thereof, the MEC, the Chief of Staff, or by written request of one-third of the current Committee or Service members eligible to vote.

9.3(d) Committee Quorum

A quorum for Committees and Services shall be defined as the presence of the majority of the committee voting members. If no such quorum exists, the meeting shall be rescheduled or all voting actions shall be tabled to a future meeting.

9.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the Medical Staff Members present and voting at a meeting at which a quorum is present shall be the action of the group. Valid action may be taken by a committee without a meeting if the action so taken is set forth in writing and signed by at least two-thirds of the committee members entitled to vote.

9.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, all items requiring action. A summary of the actions taken at each committee meeting will be provided to the MEC.

9.6 PARLIAMENTARY AUTHORITY

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order Newly Revised.

ARTICLE X
CORRECTIVE ACTION

10.1 CORRECTIVE ACTION

10.1(a) Criteria for Initiation

Any person may raise concerns about the qualifications, conduct, performance, or competence of a Practitioner by submitting such questions to the Chief of Staff, CEO, CQO, or Medical Director of Quality Improvement. A request for an investigation or action against such Practitioner may be initiated by the Chief of Staff, the QIC, the Credentials Committee, or the MEC when reliable information indicates a Practitioner may have exhibited acts, demeanor, or conduct reasonably likely to be:

(1) Detrimental to patient safety or to the delivery of quality patient care within the Hospital;
(2) Unethical;
(3) Contrary to the Medical Staff Bylaws and Medical Staff Rules and Regulations;
(4) Below applicable professional standards; or
(5) Disruptive to Hospital operations (Attachment D).

10.1(b) Initiation

All requests for corrective action shall be in writing, submitted to the MEC, and be supported by reference to the specific activities or conduct which constitute the grounds for the request.

10.1(c) Investigation

If the MEC concludes an investigation is warranted, it shall direct an investigation to be undertaken. The MEC may conduct the investigation itself, or may assign the task to an appropriate Medical Staff Officer, or a standing or ad hoc Committee of the Medical Staff.

If the investigation is delegated to an Officer or Committee other than the MEC, such Officer or Committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the MEC as soon as practicable. The report may include recommendations for appropriate corrective action. The Officer or Committee may contract with a professional peer review company outside the Hospital for review of investigative materials, if needed.

The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate.

The investigating Officer or Committee may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article XI, nor shall the procedural rules with respect to hearings or appeals apply.

10.1(d) Medical Executive Committee Action

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

(1) Recommending that no action be taken;
(2) Deferring action for a reasonable time where circumstances warrant, subject to Board of Trustees approval;
(3) Recommending the issuance of letters of admonition, censure, reprimand, or warning. In the event such letters are issued, the affected Practitioner may make a written response which shall be placed in the Practitioner's file;
(4) Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;
(5) Recommending reduction, modification, suspension, or revocation of Clinical Privileges;
(6) Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care; or
(7) Recommending suspension, revocation, or probation of Medical Staff membership.

10.1(e) Rights

Any action by the MEC that materially restricts a Practitioner's exercise of Privileges shall entitle the Practitioner to the procedural rights as specified in the Fair Hearing Plan (Article XI). The Board of Trustees may be informed of the recommendation, but shall take no action until the member has either waived his/her right to a hearing or completed the hearing.

If the MEC's recommended action does not materially restrict a Practitioner's exercise of Privileges, such recommendation, together with all supporting documentation, shall be transmitted to the Board of Trustees. The Fair Hearing Plan shall not apply to such actions.

When routine corrective action is initiated by the Board of Trustees, the functions assigned to the MEC under this Section shall be performed by the Board of Trustees, and shall entitle the Practitioner to the procedural rights as specified in the Fair Hearing Plan.

10.2 SUMMARY RESTRICTION OR SUSPENSION

10.2(a) Criteria for Initiation

Whenever a Practitioner's conduct may require that immediate action be taken to protect the life of any patient/s or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee, or other person present in the Hospital, the Chief of Medical Staff and CEO or their designees may summarily restrict or suspend the Medical Staff Membership or Clinical Privileges of such member. Unless otherwise stated, such Summary Restriction or Suspension shall become effective immediately upon imposition. Prompt written notice shall be given to the member, the MEC, and the Board of Trustees.

The Summary Restriction or Suspension may be limited in duration and shall remain in effect for the period stated or, if none, until modified or subject to a final determination as set forth herein.

Unless otherwise indicated by the terms of the Summary Restriction or Suspension, the Member's patients shall be promptly assigned to another Member by the Service Chief or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute Physician.

10.2(b) Medical Executive Committee Action

Within seventy-two (72) hours after such Summary Suspension, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may recommend modification, ratification, or termination of the Summary Suspension. Such recommended action shall be effective immediately and shall remain effective pending a final decision of the Board of Trustees, unless modified by the MEC. The Practitioner shall receive prompt written notice of the recommendation of the MEC.

Further, the MEC shall initiate an investigation into the matter that prompted the Suspension unless it finds no basis for such an investigation, in which event the matter shall be closed. If the Suspension is terminated, any investigation shall continue under the same procedures and time frames as for a routine investigation. If the Suspension is not terminated, the MEC shall meet to select an investigating committee as soon as reasonably possible, but no later than fourteen (14) days following the imposition of Summary Suspension. If the MEC cannot meet within that deadline, the Chairperson of the MEC shall appoint the investigating committee.
If, during the course of the investigation, it becomes clear that no imminent danger to any individual in fact exists, the MEC may modify or revoke the Summary Suspension, such that any or all of the appointee's privileges and staff appointment are reinstated. Such reinstatement shall not constitute a termination of the investigation or a determination that there is no basis for action against the Practitioner. The MEC shall immediately provide notice of such action to the CEO and to the affected Practitioner.

10.2(c) Procedural Rights

If the Summary Suspension is continued for purposes of further investigation the MEC shall reconvene within fourteen (14) days of the original imposition of the Summary Suspension and shall modify, ratify or terminate the Summary Suspension. If the Summary Suspension is terminated or modified such that the Practitioner's privileges are not materially restricted within fourteen (14) days of the original imposition of the Summary Suspension, the Practitioner shall not be entitled to the procedures delineated in the Fair Hearing Plan. If the Summary Suspension is continued beyond fourteen (14) days, the affected Practitioner shall be entitled to Fair Hearing rights pursuant to the Fair Hearing Plan.

10.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership may be suspended or limited as described, which action shall be final without a right to hearing or further review:

10.3(a) Licensure

(1) Revocation and Suspension: Whenever a member's license or other legal credential authorizing practice in this state is revoked or suspended, Medical Staff membership and Clinical Privileges shall be automatically revoked as of the date such action becomes effective.

(2) Restriction: Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical Privileges which the member has been granted at the Hospital, which are within the scope of said limitation or restriction, shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(3) Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and Clinical Privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

10.3(b) Federal Programs

If a Practitioner becomes excluded, sanctioned or restricted from participation in any federal healthcare program, his/her Medical Staff Privileges and membership shall be automatically suspended until such time as written proof of lifting of said sanction is received from the federal entity imposing the sanction. It is the Practitioner's responsibility to notify the Hospital if any such sanction is imposed.

10.3(c) Controlled Substances

(1) Revocation and Suspension: Whenever a member's DEA certificate is revoked, limited, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

(2) Probation: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

10.3(d) Malpractice Insurance Coverage

Any Practitioner unable to provide proof of current medical malpractice coverage in the amounts prescribed in these bylaws will be automatically suspended until proof of such coverage is provided to the MEC and CEO.

10.3(e) Medical Records

Automatic suspension of a Practitioner's Privileges shall be imposed for failure to complete medical records as required by the Medical Staff Bylaws and Rules & Regulations and the Delinquent Medical Records Policy (Attachment B). The suspension shall continue until such records are completed unless the Practitioner satisfies the Chief of Medical Staff that he/she has a justifiable excuse for such omissions.

10.3(f) Executive Committee Deliberation

As soon as practicable after action is taken or warranted as described in this Article, the MEC shall convene to review and consider the facts, and may recommend such further action as it may deem appropriate. If the MEC determines that action will be taken, then the steps generally set forth in Article 11 shall be followed.

10.4 COLLEGIAL INTERVENTION

10.4(a) Purposes of Collegial Intervention

In addition to any other action described in these Bylaws, Medical Staff leaders may utilize collegial and educational efforts to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education. All Collegial Intervention efforts by Medical Staff leaders are part of the Medical Staff's performance improvement and professional and peer review activities.

10.4(b) Documentation of Collegial Intervention

The relevant Medical Staff leader shall determine whether it is appropriate to include documentation of Collegial Intervention in an individual's confidential file. If documentation is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response shall be maintained in the individual's confidential file along with the original documentation.

10.4(c) Utilization of Collegial Intervention

Collegial Intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders. Neither Collegial Intervention nor a Practitioner's voluntary responsive actions following a Collegial Intervention shall be deemed a professional review Action or grounds for a Fair Hearing.

The Chief of Staff, and the CEO as indicated, shall also consider whether the matter leading to a Collegial Intervention should be handled in accordance with another policy, such as the Practitioner Health policy, or directed to the MEC for further discussion.

ARTICLE XI
HEARINGS AND APPELLATE REVIEWS

11.1 GENERAL PROVISIONS

11.1(a) Exhaustion of Remedies

If adverse action described in this Article is taken or recommended, the Medical Staff Applicant or Member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

11.1(b) Application of Article

For purposes of this Article, the term "member" or "petitioner" may include a Medical Staff Member or an Applicant to the Medical Staff.

11.2 GROUNDS FOR HEARING

11.2(a) Actions Entitling Medical Staff Member to Hearing

Except as otherwise specified in these Bylaws, any one or more of the following shall constitute grounds for a hearing if recommended or taken by the MEC, or taken by the Board of Trustees, based upon a Member's competence or professional conduct:

(1) Demotion to lower Medical Staff category or membership status that restricts the Member's exercise of clinical privileges;
(2) Summary Suspension of privileges for a period in excess of fourteen (14) days;
(3) Denial of Medical Staff membership;
(4) Denial of Medical Staff reappointment;
(5) Revocation of Medical Staff membership;
(6) Denial of requested Clinical Privileges (excluding Temporary Privileges);
(7) Involuntary reduction of current Clinical Privileges (excluding Temporary Privileges);
(8) Suspension of Clinical Privileges (excluding Temporary Privileges);
(9) Termination of Clinical Privileges (excluding Temporary Privileges); or
(10) Terms of probation or conditions on practice, if such terms of probation materially restrict the Member's exercise of Privileges (e.g., imposition of a mandatory concurrent consulting requirement).

11.2(b) Actions Not Entitling Medical Staff Member to Hearing

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his/her file:

(1) Issuance of a letter of guidance, warning, reprimand or other Collegial action;
(2) Imposition of conditions, monitoring, or a general consultation requirement that do not adversely affect the exercise of privileges (e.g., the individual must obtain a consult but need not obtain prior approval for the treatment);
(3) Termination of Temporary Privileges;
(4) Automatic relinquishment of appointment of privileges;
(5) Requirement for additional training or continuing education;
(6) Denial of a request for leave of absence, or for an extension of a leave;
(7) Determination that an application is incomplete;
(8) Determination that an application will not be processed due to a misstatement or omission; or
(9) Determination of ineligibility based on a failure to meet threshold criteria, a lack of need or resources, or because of an existing exclusive contract.

11.3 REQUEST FOR HEARING

11.3(a) Notice of Action or Recommendation

In all cases in which action has been taken or recommended as set forth in Article 11.2(a), said person or body shall give the Medical Staff Member prompt written notice of the recommendation or action set forth in this section, and notice of the right to request a hearing pursuant to Article 11.3(b). Such notice shall:

(1) Advise the Member of the action or recommendation, the grounds upon which the action or recommendation is based and his/her right to a hearing pursuant to the provisions of these Medical Staff Bylaws;
(2) Specify that Member has thirty (30) days following the date of receipt of notice within which a request for a hearing must be submitted;
(3) State that failure to request a hearing within the specified time period shall constitute a waiver of rights to a hearing and to an appeal of the matter;
(4) State that upon receipt of this hearing request, the Member will be notified of the date, time and place of the hearing, the grounds upon which the adverse action is based, and a list of the witnesses expected to testify in support of the adverse action;
(5) Provide a summary of the Member's rights at the hearing; and
(6) Include a copy of this Article.

11.3(b) Request for Hearing

The Medical Staff Member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Medical Executive Committee with a copy to the CEO. In the event the Member does not request a hearing within the time and in the manner described, the Member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

11.3(c) Hearing Panel and Hearing Officer; Notice and Objection

When a hearing is requested, the MEC shall appoint a Hearing Panel composed of not less than three (3) Medical Staff Members ~~of~~ who have not have actively participated in the consideration of the matter leading to the hearing, and who are not in direct economic

competition with the individual who requested the Fair Hearing ("the Petitioner"). Mere knowledge of the matter leading to the hearing shall not preclude a Medical Staff Member from serving on the Hearing Panel One of the Hearing Panel Participants ("Panel Participants") must have the same healing arts licensure as the Petitioner. All other Panel Participants shall hold MD or DO degrees. If the MEC determines that it is not feasible to appoint three (3) qualified Medical Staff Members to the Hearing Panel, it may appoint Physicians who do not hold privileges at the Hospital as it deems necessary, provided that such other Physicians meet all other qualifications set forth in this section.

The MEC shall designate one of the Panel Participants as Chair of the Hearing Panel. The MEC also may appoint a Hearing Officer, who shall be an attorney or other individual familiar with the conduct of quasi-judicial or administrative proceedings. The Hearing Officer may advise the Hearing Panel regarding the procedure for the hearing and subsequent deliberations but shall not participate in such deliberations. The Hearing Officer shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure and the admissibility of evidence.

The Petitioner shall be notified of the appointment of the Hearing Panel and Hearing Officer, and shall have ten (10) days after the date of such notice to object and identify, in writing, any conflict of interest that the Petitioner believes should disqualify the Panel Participant or Hearing Officer from service. The failure of the Petitioner to object and identify any conflict of interest as stated above shall constitute a waiver of any such right. Notice of such objection and alleged conflict shall be provided to the MEC and the CEO. Within seven (7) days of the receipt of the objections, the CEO shall determine whether such grounds asserted by the affected individual are sufficient for disqualification. If a determination is made that a disqualification is appropriate, the MEC shall appoint a replacement within seven (7) days of the determination. The Chief of Staff shall advise the Petitioner of the new appointment.

11.3(d) Time and Place for Hearing

Upon receipt of a request for hearing, the MEC shall schedule a hearing and, at least thirty (30) days prior to the hearing, give notice to the Petitioner of the time, place, and date of the hearing.

Such notice shall be in writing, delivered to the home or office of the Petitioner in person, via generally-recognized express mail service or via certified mail, return receipt requested. Notice shall be deemed to be given to the Petitioner on the earlier of the date that it is delivered in person, actually received by mail or three business day after it is deposited in the U.S. mail. The notice of hearing shall also contain a list of witnesses (if any) expected to testify in support of the recommendation or action and a brief summary of their anticipated testimony. The notice of hearing shall include a written notice of charges that states concisely the reasons for the adverse recommendation or action, including the acts or omissions with which the Petitioner is charged and a list of any charts involved.

11.3(e) Response and Access to Information

Within ten (10) days of receipt of the notice of hearing, the Petitioner shall deliver, by special notice, a list of witnesses expected to testify on his/her behalf at the hearing with a brief summary of their anticipated testimony, and a list of documents the Petitioner expects to rely upon at the hearing in addition to those identified by the MEC.

The Petitioner may examine any documents to be introduced in support of the adverse recommendation or action. Copies of such documents, including any patient charts, shall be made available to the Petitioner, at his/her expense, within a reasonable time after a request is made for same. The body recommending or taking the adverse action shall be entitled to examine all documents expected to be produced by the Petitioner at the hearing and to obtain copies of such documents at its expense. The parties shall exchange documents at a mutually agreeable time at least ten (10) days prior to the hearing.

11.4 CONDUCT OF HEARING

The hearing shall be conducted in the presence of the entire Hearing Panel, the Hearing Officer, the Petitioner, and/or his or her designated representative. Unless both the Petitioner and the Chair of the Hearing Panel agree otherwise, a record of the hearing shall be made by a court reporter or by an electronic recording unit. The cost of recording the hearing shall be borne by the Hospital, and the Petitioner shall be entitled to a copy thereof upon the payment of a reasonable charge.

11.4(a) Failure to Appear

If a Petitioner fails without good cause to appear and/or proceed at the hearing, that Petitioner shall be deemed to have waived his/her right to a Fair Hearing and to have voluntarily accepted the recommendations or actions involved.

11.4(b) Postponement

The Hearing Panel Chairperson may, at his/her discretion, postpone commencement of the hearing beyond the time set therefore; provided, however, that no such postponement shall cause a hearing to commence more than forty-five (45) days after the MEC's receipt of the request for a hearing, unless otherwise agreed by the parties.

11.4(c) Representation and Examination

The Petitioner may be accompanied and represented at the hearing by an attorney or by another representative of the Petitioner's choice. The Board of Trustees or MEC shall also be entitled to representation by an attorney and may appoint one of its members or

some other Medical Staff Member to represent it at the hearing, to present the facts in support of its recommendation, and to examine the witnesses.

Each party shall have the right to: present written evidence; to call, examine, and cross-examine witnesses; and to refute evidence introduced by the other. If the Petitioner does not testify on his/her own behalf, the Petitioner may be called and examined as though under cross-examination.

11.4(d) Proceedings, Evidence and Burden of Proof

The hearing shall be conducted in as informal a manner as possible. The hearing need not be conducted according to rules of law relating to the examination of witnesses or the presentation and exclusion of evidence. The Hearing Officer shall permit any relevant evidence upon which responsible persons would customarily rely in the conduct of serious affairs to be considered.

The hearing shall be limited to the action and reasons for it stated in the notice of adverse action, unless the Petitioner was given notice of any new reasons at least thirty (30) days prior to the hearing.

Prior to, during, or at the close of the hearing, each party shall have the right to submit a memorandum concerning any relevant issue or issues. The Hearing Panel may request memoranda from the parties on any issue. Such memoranda shall become a part of the hearing record.

The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support thereof; but the practitioner thereafter shall be responsible for supporting his/her challenge to the adverse recommendation or action by a preponderance of the evidence that the grounds therefore lack factual basis or that the action is arbitrary, capricious, or impermissibly discriminatory.

The standard of proof set forth herein shall apply and be binding upon the Hearing Panel and on any subsequent review or appeal.

11.4(e) Hearing Recess and Deliberations

The Hearing Panel may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence, or of consultation; provided, however, that no such recess or combination of recesses shall exceed ten (10) days, excluding Sundays, in length unless the Petitioner expressly so consents in writing. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Panel shall thereupon conduct its deliberations outside the presence of the parties and shall determine all issues by majority vote.

11.4(f) Decision of the Hearing Panel

Within twenty-one (21) days after final adjournment of the hearing, the Hearing Panel shall make a written report including its recommendation, and shall forward the same, together with the hearing record and all other documentation, to the MEC, the Administrator, and to the Board of Trustees. A copy of the report shall be sent to the Petitioner by delivery in person, or by certified mail, return-receipt requested. The report may recommend confirmation, modification, or withdrawal of the action recommended or of the action taken.

11.4(g) Action on Report

If the MEC initiated the action, and the Hearing Panel's report alters, amends or modifies the MEC's recommendation, the MEC shall take action on the Hearing Panel's report no later than twenty-eight (28) days after receipt of same, and prior to any appeal by the Petitioner. If the Board of Trustees initiated the action, and the Hearing Panel recommendation is favorable to the Petitioner, the Board of Trustees shall take action on the Hearing Panel's report no later than twenty-eight (28) days from receipt of same.

If the MEC initiated the action and the Hearing Panel has not altered, amended or modified the MEC's recommendation, or the Board of Trustees action remains adverse to the Petitioner as described in Article 11.2, the Petitioner shall be given notice of the right to appeal prior to final action by the Board of Trustees.

11.4(h) Extension of Time Period

Any time period set forth herein may be extended by mutual agreement of the parties or by the Hearing Panel Chairperson upon good cause shown.

11.5 APPEAL OF THE HEARING PANEL DECISION

11.5(a) Time for Appeal

Within ten (10) days after receipt of the decision of the Hearing Panel the Petitioner or the Medical Executive Committee or Board of Trustees may request an appellate review. A written request for such review shall be delivered to the Chief of Medical Staff, the Administrator, and the other party in the hearing. If a request for appellate review is not requested within such period, the right to appeal shall be deemed waived.

11.5(b) Grounds for Appeal

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

(1) Substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice; or

(2) The decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Article 11.5(e).

11.5(c) Appeal Board

The Board of Trustees may sit as the Appeal Board, or it may appoint an Appeal Board, which shall be composed of not less than three (3) members of the Board of Trustees. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board. The Appeal Board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote in respect to the appeal.

The Chairperson of the Appellate Review Body shall be the Presiding Officer. He/She shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

11.5(d) Appeal Time, Place, and Notice

If an appellate review is to be conducted, the Appeal Board shall within fifteen (15) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place, and date of the appellate review. The date of appellate review shall not be less than thirty (30) or more than sixty (60) days from the date of such notice, provided, however, that when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen (15) days from the date of the notice. The time for appellate review may be extended by the Appeal Board for good cause.

11.5(e) Appeal Procedure

The proceeding by the Appeal Board shall be in the nature of an appellate hearing based upon the record of the hearing before the Hearing Panel, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Hearing Panel in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Hearing Panel; or the Appeal Board may remand the matter to the Hearing Panel for the taking of further evidence and for decision.

Each party shall have the right to be represented by legal counsel in connection with the appeal, to present a written statement in support of his or her position on appeal and, in its sole discretion, the Appeal Board may allow each party or representative to personally appear and make oral argument.

The Appeal Board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The Appeal Board shall present to the Board of Trustees its written recommendations as to whether the Board of Trustees should affirm, modify, or reverse the Hearing Panel decision, or remand the matter to the Hearing Panel for further review and decision.

11.5(f) Decision

Except as otherwise provided herein, within thirty (30) days after the conclusion of the appellate review proceeding the Board of Trustees shall render a decision in writing and shall forward copies thereof to each side involved in the hearing. Such decision shall constitute a final action.

The Board of Trustees may affirm, modify, or reverse the decision of the Hearing Panel or remand the matter to the Hearing Panel for reconsideration.

If the matter is remanded to the Hearing Panel for further review and recommendation, said Panel shall promptly conduct its review and make its recommendations to the Board of Trustees. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the Chairpersons of the Board of Trustees and the Hearing Panel.

11.5(g) Right To One Hearing

No Medical Staff Member shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any matter which shall have been the subject of adverse action or recommendation.

ARTICLE XII
CONFIDENTIALITY, IMMUNITY, AND RELEASES

12.1 ASSESSMENT OF PRACTITIONER'S ABILITY & QUALIFICATIONS

By applying for, or exercising, Clinical Privileges within this Hospital:

(1) The Hospital will obtain and review all information needed to assess Practitioner's (Applicant, Member, AHP) professional ability and qualifications to perform Clinical Privileges requested;
(2) The Practitioner authorizes representatives of the Hospital, including the Medical Staff, to solicit, provide, and act upon information bearing on, or reasonably believed to bear on, the Practitioner's professional ability and qualifications;
(3) The Practitioner authorizes persons and organizations to provide information concerning such Practitioner to the Hospital, including the Medical Staff;
(4) The Practitioner agrees to be bound by the provisions of this Article and waive all legal claims against any representative of the Medical Staff or the Hospital or other persons who act in accordance with the provisions of this Article;
(5) The Practitioner acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of Clinical Privileges at this Hospital; and
(6) The Hospital adopts and references the Practitioner Health Policy, the Professional Practice Evaluation Policy, and the Unprofessional Conduct Policy for use in these reviews (as Attachments to these Bylaws).

12.2 REVIEW OF ADVERSE INFORMATION

The following applies to the review of adverse information in any individual Practitioner's file:

(1) Prior to recommendation on reappointment, the Medical Staff Credentials Committee, as part of its reappraisal function, shall review any adverse information in any individual Practitioner's file pertaining to a member.
(2) Following this review, the Medical Staff Credentials Committee shall determine whether documentation in the file warrants further action.
(3) With respect to such adverse information, if it does not appear that an investigation and/or adverse action on reappointment is/are warranted, the Medical Staff Credentials Committee shall so inform the MEC.
(4) However, if an investigation and/or adverse action on reappointment is/are warranted, the Medical Staff Credentials Committee shall so inform the MEC.
(5) No later than 60 days following final action on reappointment, the MEC shall initiate a request for corrective action, based on such adverse information and on the Medical Staff Credentials Committee's recommendation relating thereto.
(6) The member shall have the right to respond thereto in writing, and the MEC may elect to remove such adverse information on the basis of such response.

12.3 CONFIDENTIALITY / DISCLOSURE OF INDIVIDUAL MEDICAL STAFF FILES

Medical Staff Services committee minutes, files, and records, and other information created for, by, or on behalf of any Hospital committee for purposes of peer review, quality improvement or risk management, including information regarding any member or applicant to this Medical Staff shall, to the fullest extent permitted by law, be confidential. Each Practitioner agrees, by the acceptance of Medical Staff Membership or Privileges, to maintain the confidentiality of such information. Dissemination of such information and records shall only be made where expressly required by law or pursuant to officially adopted policies of the Medical Staff. Where no officially adopted policy exists, dissemination of the information and records shall be made only with the express approval of the Medical Executive Committee or its designee and the affected Practitioner.

The following applies to records of the Medical Staff and its committees responsible for the evaluation and improvement of patient care:

(1) The records of the Medical Staff and its committees responsible for the evaluation and improvement of the quality of patient care rendered in the Hospital shall be maintained as confidential.
(2) Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.
(3) Information which is disclosed to the Board of Trustees of the Hospital or its appointed representatives, in order that the Board of Trustees may discharge its lawful obligations and responsibilities, shall be maintained by that body as confidential.
(4) Information contained in any individual Practitioner's file may be disclosed with the member's consent, or as otherwise specified in these Bylaws, or as required by law. However, any disclosure outside of the Medical Staff not consented to by the member shall require the authorization of the MEC and the CEO and notice to the member.
(5) A Medical Staff member shall be granted access to his/her own individual Practitioner file, subject to the following provisions:
    i. A minimum of twenty-four (24) hours notice of such shall be made by the member to the Chief of Staff or his designee.
    ii. All third party information contained in the file shall be removed and summarized prior to review by the Practitioner in order to maintain confidentiality.
    iii. The review by the member shall take place in the Medical Staff Office, during normal working hours, with an officer or designee of the Medical Staff present.

12.4 BREACH OF CONFIDENTIALITY

Any breach of confidentiality of the discussions or deliberations of the Medical Staff or committee meetings except in conjunction with other Hospitals, professional society, or licensing authority is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the MEC may undertake such corrective action as it deems appropriate.

12.5 IMMUNITY FROM LIABILITY

12.5(a) For Action Taken

No representative of the Medical Staff or Hospital shall be liable to a Practitioner for damages or other relief from any decision, opinion, action, statement or recommendation made within the scope of his duties as a representative, if such representative acts:

(1) In substantial good faith and without malice within the scope of his/her function;
(2) In the reasonable belief that the action is in furtherance of quality or efficient health care;
(3) After a reasonable effort to obtain the facts of the matter;
(4) In accordance with the procedures specified in the Hospital and Medical Staff Bylaws or other relevant manuals or policies; and
(5) In the reasonable belief that the action was warranted by the facts known.

12.5(b) For Providing Information

No representative and no third party shall be liable to a Practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any other health care facility or organization of health professionals concerning said Practitioner or to any agency to whom reports must be made as required by law, provided that such representative or third party acts in substantial good faith or unless such information is false and such representative or third party knew it was false.

12.6 ACTIVITIES AND INFORMATION COVERED

The information referred to in this Article may relate to a Practitioner's professional licensure or certification, education, training, clinical ability, judgment, utilization practices, character, physical or mental health, professional ethics, or any other matter that might directly or indirectly affect the quality or efficiency of patient care provided in the Hospital.

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

(1) Applications for appointment or Clinical Privileges;
(2) Periodic reappraisals for reappointment or Clinical Privileges;
(3) Corrective or disciplinary actions;
(4) Hearings and appellate reviews;
(5) Quality assurance reviews;
(6) Utilization review and management activities;
(7) Claims reviews;
(8) Profiles and profile analysis;
(9) Professional liability prevention program activities;
(10) Other Hospital, committee, clinical unit, or Medical Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

12.7 RELEASES

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

ARTICLE XIII
GENERAL PROVISIONS

13.1 MANDATORY REPORTING REQUIREMENTS

The Medical Staff will observe the mandatory reporting requirements of the Washington State Department of Health (DOH) RCW 18.130.70, RCW 70.41.210, and WAC 246-16-220.

13.2 DUES OR ASSESSMENTS

The MEC shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership, subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds received.

13.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. These Bylaws apply with equal force to both sexes wherever either term is used.

13.4 AUTHORITY TO ACT

Any member(s) who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as specified in Article X, entitled "Corrective Action".

13.5 MEDICAL STAFF REPRESENTATIVE APPOINTMENTS

Candidates for positions as Medical Staff representatives to local, state, and national Hospital Medical Staff offices should be filled by such selection process as the Medical Staff may determine. Nominations for such positions shall be made by a nominating committee appointed by the MEC.

ARTICLE XIV
ADOPTION AND AMENDMENT

14.1 RULES & REGULATIONS, CREDENTIALS MANUAL, AND POLICIES

The Credentials Manual shall be considered a part of these Bylaws and shall be reviewed as necessary to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to the Medical Staff organization and functions. The Credentials Manual may be adopted, amended or repealed pursuant to the same amendment and adoption process for the Medical Staff Bylaws as outlined herein.

Subject to approval by the Board, the Medical Staff hereby delegates authority to the MEC to adopt Rules and Regulations and Policies as necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each staff member or affiliate in the Hospital. The Rules and Regulations shall be considered a part of these Bylaws, except that they may be amended or repealed at any regular MEC meeting at which a quorum is present and without previous notice, or at any special MEC meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board.

Where the voting members of the Medical Staff propose to adopt a rule, regulation or policy, or an amendment thereto, they must first communicate the proposal to the MEC. Where the MEC proposes to adopt a rule or regulation, or an amendment thereto, it must first communicate the proposal to the Medical Staff. The MEC is not, however, required to communicate adoption of a policy or an amendment thereto prior to adoption. In such circumstances, the MEC must promptly thereafter communicate such action to the Medical Staff.

In cases of a documented need for urgent amendment to Rules and Regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board of Trustees may provisionally approve, an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff shall be immediately notified by the MEC. The Medical Staff shall have the opportunity for retrospective review of, and comment on, the provisional amendment. If there is not conflict between the Medical Staff and the MEC, the provisional amendment shall stand. If there is conflict over the provisional amendment, the process described below shall be implemented.

When conflict arises between the Medical Staff and the MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy, or an amendment thereto, this process shall serve as means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety. An ad hoc committee selected by the Board of Trustees Chair shall meet, as needed, with leaders of the Medical Staff and the MEC as early as possible to work with the parties to manage and, when possible, resolve the conflict.

Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Board of Trustees on a rule, regulation, or policy adopted by the Medical Staff or the MEC, or to limit the Board of Trustees' final authority as to such issues. The Board of Trustees shall have final authority regarding the adoption of any rule, regulation, or policy, or amendment thereto, and no such rule, regulation, policy, or amendment thereto, shall be effective until approved by the Board of Trustees.

14.2 REVIEW OF BYLAWS

The Bylaws shall be reviewed at least every three (3) years and a report of such review submitted to the Medical Executive Committee.

14.3 AMENDMENT OF BYLAWS

Upon the request of the Chief of Staff, the MEC, the Bylaws Committee, or upon timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws.

14.4 PROCEDURE FOR AMENDMENT OF BYLAWS

The procedure for amendment of the Bylaws will be as follows:

(1) Written notice (via postal mail or electronic mail) of the proposed change will be sent to all Active Medical Staff members at least twenty-eight (28) days in advance of a vote for the members' review.
(2) The notice shall include the exact wording of the existing Bylaw language, if any, and the proposed change(s).

(3) A meeting of the General Medical Staff may be held for discussion during this 28 day period, if requested. The proposal may be modified at the meeting by a majority vote of the Active Medical Staff in attendance, provided the amendment(s) to the proposal substantially cover the same topic.
(4) Near the end of the 28 day review period, a ballot will be sent to the Active Medical Staff members (via postal mail or electronic mail), to be voted and returned within ten (10) days to the Medical Staff Office. The ballot may be returned via postal mail, electronic mail, or hand delivery.
(5) Approval of the proposed change shall require a vote response of at least 50% of Active Medical Staff, and with an affirmative vote of 2/3 of those responses.
(6) At the end of the 10 day voting period, the ballots will be tallied and the results provided to the MEC at their next regular meeting for review and ratification.

14.5 APPROVAL OF BYLAWS

After ratification (adoption) by the MEC, the results shall become effective following approval by the Board of Trustees. After approval of the Bylaws amendment(s) by the Board of Trustees, communication of the approved change(s) will be provided to the Medical Staff via general or special meeting, postal mail, electronic mail, or fax.

If the Board of Trustees does not approve Bylaw changes, a Joint Conference Committee will be convened consisting of three (3) members from the Medical Executive Committee and three (3) members from the Board of Trustees. The Joint Conference Committee is charged with resolution of differences that exist between the Medical Staff and Board of Trustees regarding Bylaw changes. The Joint Conference Committee shall present a recommendation to the Medical Executive Committee and the Board of Trustees to resolve these differences.

14.6 URGENT AMENDMENT OF BYLAWS

Under normal circumstances, neither the organized Medical Staff nor the Governing Body (Board of Trustees) may unilaterally amend the Medical Staff Bylaws. If the Medical Staff fails to act in a timely manner on accreditation and/or federal requirements necessary to maintain Joint Commission accreditation status and to ensure compliance with CMC Conditions of Participation, the Board of Trustees may resort to its own initiative in formulating or amending Medical Staff Bylaws as necessary to comply with accreditation standards or applicable law. Should the Board of Trustees act as such, it shall consult with the Medical Staff at the next regular medical staff meeting (or at a special meeting called for as provided in these Bylaws) and shall advise the Medical Staff of the basis for the unilateral action. If there is a conflict over the amendment(s) made by the Board of Trustees, the process for the Joint Conference Committee between the organized Medical Staff and the Board of Trustees will be implemented.

14.7 EXCLUSIVITY

The mechanisms described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

14.8 SEVERABILITY

The invalidity or unenforceability of any provision or article of these Medical Staff Bylaws shall not affect the validity or enforceability of any other provision or article.