MultiCare Health System
Good Samaritan Hospital

Bylaws, Rules and Regulations Of the Medical Staff

Effective: June 21, 2011

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Medical Executive Committee
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BYLAWS, RULES AND REGULATIONS OF THE MEDICAL STAFF
MULTICARE GOOD SAMARITAN HOSPITAL
401 - 15th Avenue SE, Puyallup, WA

PREAMBLE

Recognizing that the Medical Staff membership is an entity of MultiCare Good Samaritan Hospital appointed by the Governing Body and is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility subject to the ultimate authority of the Governing Body and that the best interests of the patient are protected by concentrated effort and cooperation on the part of the Medical Staff, President of the Hospital, and the Governing Body, the physicians practicing at MultiCare Good Samaritan Hospital hereby organize themselves in conformity with these Bylaws, Rules and Regulations.

DEFINITIONS

1. **ALLIED HEALTH PROFESSIONAL** or AHP means an individual, other than a licensed physician, dentist, oral surgeon or podiatrist, who exercised independent judgment within the areas of his or her professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable State licensing laws, who is qualified to render direct or indirect medical, dental or podiatric care, independently or under the direction of supervision of a Medical Staff Member possessing privileges to provide such care in the Hospital, and who may be eligible to exercise privileges in conformity with the rules adopted by the Governing Body, these Bylaws, and the Rules and Regulations. AHPs are not eligible for Medical Staff membership.

2. **EX-OFFICIO** means service by virtue of office or position held. An Ex Officio appointment is without vote unless specified otherwise.

3. The term **GOVERNING BODY** means the Board of Directors of MultiCare Health System. As appropriate to the context and consistent with the Governing Body's Bylaws, it may also mean any Governing Body committee, such as the MultiCare Good Samaritan Regional Oversight Board, Quality Committee, or individual authorized to act on behalf of the Governing Body.

4. "Hospital" means the inpatient facilities of Good Samaritan Hospital owned and operated by MultiCare Health System. Throughout these Bylaws, references to "Hospital" shall also include Good Samaritan day surgery and other outpatient facilities that operate under the Good Samaritan Hospital license.

5. The term **MEDICAL EXECUTIVE COMMITTEE** (**MEC**) means the Medical Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Governing Body.

6. The term **MEDICAL STAFF** means the organizational component of the Hospital that includes all physicians (M.D. or D.O.), dentists, oral surgeons, and podiatrists who have been granted recognition as Members pursuant to these Bylaws.

7. **MEDICAL STAFF YEAR** is October through September.

8. **MEMBER** means any Practitioner who has been appointed to the Medical Staff

8. **NOTICE** means a written communication delivered personally to the addressee or sent by United States mail, first-class postage, prepaid, addressed to the addressee at the last

address as it appears in the official records of the Medical Staff or the Hospital. (See also, definition of "Special Notice" below.)

9. **PHYSICIAN** means an individual with an M.D. or D.O. Degree who is currently licensed to practice medicine.

10. The term **PRACTITIONER** means, unl**ess** otherwise expressly limited, currently licensed medical physician (M.D. or D.O.), dentist, oral surgeon or podiatrist.

11. The term **PRESIDENT OF THE HOSPITAL**" means the individual appointed by the Governing Body to act on its behalf in the overall management of the Hospital.

12. The term **PRIVILEGES** or **CLINICAL PRIVILEGES** means the permission granted to a Medical Staff Member or Allied Health Professional to render specific clinical services.

13. For the purpose of these Bylaws, the terms **DEPARTMENT** and **SERVICE** are interchangeable.

14. **RESIDENT MEDICAL STAFF** shall consist of residents enrolled in an accredited residency **p**rogram for post-graduate medical education. Residents are not eligible for membership.

15. **SPECIAL NOTICE** means a Notice sent by certified or registered mail, return receipt requested. (See also, definition of "Notice" above.)

ARTICLE I
NAME and PURPOSE

The name of this organization shall be "Medical Staff of MultiCare Good Samaritan Hospital."

The purpose of this organization shall be:

1. To ensure that all the patients treated in the Hospital receive quality care appropriate to their condition.

2. To provide a high level of professional performance and behavior of all Practitioners authorized to practice in the Hospital. To delineate Clinical Privileges that each Practitioner may exercise, and review and evaluate each Practitioner's performance in the Hospital.

3. To provide a means whereby the Medical Staff, the Governing Body and the President of the Hospital may discuss such things as Hospital mission, planning issues and other matters of mutual importance.

4. To initiate and maintain rules and regulations for governance of the Medical Staff.

5. To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill.

ARTICLE II
MEDICAL STAFF MEMBERSHIP

Nature of Medical Staff Membership: Membership on the Medical Staff may be extended to and maintained by only those professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws, Rules and Regulations. A Practitioner, including one who has a contract with the Hospital to provide medical-administrative services, may admit or provide services to patients in the Hospital only if the Practitioner is a Member of the Medical Staff or has been granted Temporary Privileges in accordance with these Bylaws, Rules and Regulations. Appointment to the Medical Staff shall confer only such Privileges as have been granted by the Governing Body in accordance with these bylaws. A Member is neither an employee nor an independent contractor of the Hospital, unless such a relationship is separately established between the Hospital and the Member.

Section 1 Qualifications

2.1-1 **General Qualifications**

Only physicians currently licensed to practice medicine, podiatry, dentistry or oral surgery in the State of Washington who can document their background, experience, training and demonstrate current professional competence, their adherence to the ethics of their profession and their good reputation, with sufficient adequacy to assure the Medical Staff and Governing Body that any patient treated by them in the Hospital will be given a high quality of medical care shall be qualified for membership on the Medical Staff.

Physicians must also have a demonstrated ability to work with others sufficient to assist the hospital to fulfill its responsibility without undue disruption. No applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible or qualified for Medical Staff membership.

2.1-2 **Basic Qualifications**

a. Board Certification, residency training:

i. Completion of an approved residency program American College of Graduate Medical Education (ACGME) that provided complete training in the specialty or subspecialty that the Practitioner will practice at the Hospital, and subsequent compliance with 2.1-2(ii) within five (5) years of completion of said training program, and

ii. Certification by a Board recognized by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), the American Board of Podiatric Surgery (ABPS), the American Board of Orthopedic Podiatric Medicine (APMA), or a board or association with equivalent requirements approved by the Governing Body; such certification shall be in the specialty that the Practitioner will practice at the hospital.

iii. Oral and Maxillofacial Surgeons must demonstrate completion of an approved residency program AND evidence of current board certification applicable to the type of practice.

b. The residency and Board Certification requirements do not apply to physicians on staff before January 1, 1999 and who have continued to maintain their member status through consecutive, uninterrupted reappointments to the Medical Staff, or Dental specialists other than oral and maxillofacial surgeons.

c. No Practitioner shall be entitled to Medical Staff membership merely because he/she is duly licensed or certified in this or any other state or that he/she is a member of any professional organization or that has had past or presently has such privileges at another hospital.

d. Gender, race, color, creed and national origin are not considered as part of the decision to grant or deny Medical Staff membership, appointments or Clinical Privileges.

2.1-3 **Waiver of Qualifications**

Insofar as is consistent with applicable laws, the Governing Body has the discretion to deem a Practitioner to have satisfied a qualification, with approval of the Medical Executive Committee, if it determines that the Practitioner has demonstrated he or she has substantially comparable qualifications, and that this waiver is necessary in order to serve the best interests of the patients and the Hospital. There is no obligation to grant any such waiver, and Practitioners do not have the right to a waiver. A Practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws.

Section 2 Terms of Appointment

2.2-1 Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body of the Hospital. Terms of appointment will be in two year increments terminating in the birth month of the applicant.

2.2-2 The Governing Body shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws. (Except in the event of unwarranted delay on the part of the Medical Staff, the Governing Body may act without such recommendation on the basis of appropriate documentation.)

2.2-3 Appointment to the Medical Staff shall confer on the appointee only such Clinical Privileges as have been granted by the Governing Body in accordance with these Bylaws.

2.2-4 Each application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligations to provide continuous care and supervision of his/her patients. The applicant acknowledges that he/she has read the current Bylaws, Rules and Regulations of the Medical Staff, as well as the pertinent current Bylaws of the Hospital, and that he/she agrees to be bound by the terms thereof if he/she is granted membership and/or Clinical Privileges, and that he/she agrees to accept committee and consultation assignments.

2.2-5 Each applicant must accept responsibility for participating in Medical Staff proctoring in accordance with the GSH Medical Staff Policy and Procedures.

2.2-6 All individuals with privileges to treat patients are required to carry a minimum of malpractice insurance as determined by the MEC and the Governing Board.

2.2-7 At all times, Medical Staff members and the Allied Health Staff agree to immediately (by the conclusion of the next business day) notify the Medical Staff President or Vice President of Medical Affairs or President of the Hospital, or their designee, of any of the following voluntary or involuntary events: suspension, modification or termination of his or her license to practice in Washington or any other state; change in status of his or her Drug Enforcement Administration (DEA) or other controlled substance registration; change in professional liability insurance coverage; suspension, restriction, modification or termination of his or her medical staff membership or Clinical Privileges at any other health care facility; the status of any professional liability settlements or judgments made regarding the Practitioner, and any restriction or exclusion from participation in the Medicare, Medicaid or any other federal or state health care program.

ARTICLE III
CATEGORIES OF THE MEDICAL STAFF

Section 1 The Medical Staff

The Medical Staff shall be divided into honorary, active, active affiliate, courtesy, administrative, and locum tenens categories.

Section 2 The Honorary Medical Staff

The Honorary Medical Staff shall consist of practitioners who are not active in the Hospital and who are honored by emeritus positions. They may be (1) practitioners who have retired from active hospital service or (2) practitioners of outstanding reputation not necessarily residents of the community. They should have demonstrated exceptional service to the Medical Staff, hospital and community. Honorary staff members are not eligible to vote or hold office, ordinarily do not admit patients, and shall have no assigned duties.

Section 3 The Active Medical Staff

3.3-1 The Active Medical Staff shall consist of practitioners who choose to affiliate with MultiCare Good Samaritan Hospital as the primary treatment facility for their patients. Active staff members are eligible to vote.

3.3-2 Obligations of Active status require that the individual: Contribute to the organizational and administrative activities of the Medical Staff, including quality and performance improvement, professional liability prevention, utilization management, and serving on Medical Staff committees.

3.3-3 Participate equitably in the discharge of staff functions by: Participating in the MultiCare Good Samaritan Hospital's training, research and continuing education programs, serving on the on-call roster as determined by Medical Executive Committee, providing consultation to other staff members consistent with specialty, and reviewing the performance of Practitioners when necessary.

3.3-4 Less than one patient contact per 2 year reappointment period is deemed a voluntary resignation from the Active staff.

3.3-5 Dues may be assessed as determined by the Medical Executive Committee.

3.3-6 Affiliate Medical Staff are Active Medical Staff who do not admit or provide professional services in the hospital. They may round and perform social visits (and may document these in the medical record) while their patients are inpatients.

a. Affiliate staff members are eligible to vote
b. Dues may be assessed as determined by the Medical Executive Committee

Section 4 The Courtesy Medical Staff

3.4-1 The Courtesy Medical Staff shall consist of physicians qualified for membership who average no fewer than one and no more than 24 patient contacts per two-year appointment period. Failure to maintain the minimum number of contacts is deemed a voluntary

resignation from the staff. Exceeding the maximum requires automatic transfer to active staff status, except where it can be demonstrated that the excess occurred because of a unique set of circumstances unlikely to occur again. No minimum or maximum applies to the circumstances where the sole purpose of Courtesy Staff membership is to permit coverage of patients by a partner or group member. In this circumstance, the Courtesy Staff covering the Practitioner may not make any elective admissions or perform any significant elective procedures, must have been granted the requisite clinical privileges to care for the patient, and must transfer the care of the patient to an active status partner or group member at the earliest possible time.

3.4-2 Courtesy Staff members must demonstrate active participation on the Active Staff (or equivalent) at another licensed hospital, or agree to participate in the quality review, professional liability prevention and utilization management activities of this Medical Staff, and to fulfill other obligations of Active Staff status as outlined in Article III, Section 3. Courtesy Staff members shall not be eligible to vote or hold offices in this Medical Staff organization.

3.4-3 Courtesy staff members shall at each reappointment time, provide evidence of clinical performance at their primary treatment facility in such form as may be required by the applicable staff and governing authorities in order to allow an appropriate judgment to be made with respect to their ability to exercise the clinical privileges requested.

3.4-4 Courtesy staff members shall have no voting privileges.

3.4-5 Dues may be assessed as determined by the Medical Executive Committee.

Section 5 The Administrative Medical Staff

3.5-1 The Administrative Medical Staff (eg., Vice President of Medical Affairs***)*** consists of practitioner(s) who have professional administrative positions at Good Samaritan Hospital.

3.5-2 Administrative Medical Staff must meet all credentials criteria for Medical Staff membership (as defined in Article II of the Bylaws).

3.5-3 Administrative Medical Staff may not vote and may not hold a position as an officer of the Medical Staff.

3.5-4 Administrative Medical Staff are eligible to serve on Medical Staff service committees in an ex-officio capacity.

3.5-5 Dues may be assessed as determined by the Medical Executive Committee.

Section 6 *Locum Tenens*

3.6-1 A *locum tenens* is a practitioner who is appointed to assist or temporarily fulfill the responsibilities of an active member of the medical staff within the same specialty.

3.6-2 A practitioner applying for privileges in a *locum tenens* capacity shall meet the same qualifications and follow the same procedure required for all new applicants. An appropriately licensed Practitioner of documented competence may be granted privileges for 12 months with limitation of no more than a total of 90 days (within the 12 month period.)

3.6-3 Dues may be assessed as determined by the Medical Executive Committee.

3.6-4 Locum Tenens members shall have no voting privileges

Section 7 Resident Medical Staff

3.7-1 The Resident Medical Staff shall consist of residents enrolled in East Pierce Family Medicine Residency (EPFMR) or from another accredited residency program for post-graduate medical education. If the Resident is from a program other than EPFMR, appointment to the Resident Medical Staff requires a letter of acceptance from the Residency Program Director, liability insurance coverage through the residency program and, when available, a valid limited or unrestricted medical license.

3.7-2 The Resident Medical Staff will work under the supervision of the medical director and faculty of the EPFMR or a member of the Medical Staff serving as faculty.

3.7-3 Clinical privileges are limited to the extent needed to fulfill the educational Requirements of the Residency Program and as permitted by these Bylaws and Rules and Regulations. These privileges require working under the supervision or an attending physician with the appropriate privileges.

3.7-4 Resident Medical Staff shall have no voting privileges and are not entitled to hearing and review procedures as outlined in the Medical Staff Bylaws.

ARTICLE IV
ALLIED HEALTH PROFESSIONALS

Section 1 Qualifications of Allied Health Professionals (AHP)

Qualified Allied Health Professionals, although not eligible for Medical Staff membership, with the concurrence of the Medical Staff and approved by the Hospital Governing Body, may participate in the care of a Medical Staff member's patient. Allied Health professionals must comply with credentialing and privilege delineation procedures as well as the Rules and Regulations of the Medical Staff and Hospital Policies and Procedures.

4.1-1 **Independent Allied Health Professionals** (Limited to Surgical First Assistants)

a. Any non-physician (Surgical First Assistant) who desires to provide services or treatment to patients within the hospital must apply for an appointment to the Allied Health Staff and privileges through the Medical Staff and the Hospital Governing Body. The applicant shall provide evidence of current licensure or certification, as appropriate, verification of education, training and experience, three professional references, as well as specify the exact proposed duties and responsibilities that they will perform in the Hospital. Further information required will be litigation experience, any restriction, denial, or suspension of privileges at any other hospitals and whether or not there are any physical/mental health problems which could interfere with carrying out the requested privileges. Independent allied health staff must also have a demonstrated ability to work with others sufficient to assist the hospital fulfill its responsibility without undue disruption.

b. As part of the person's application, the Hospital requires evidence that they are covered under a professional liability (malpractice) insurance policy and if there is any change in such coverage the professional person is required to promptly notify the President of the Hospital, or the Vice President of Medical Affairs, or the President of the Medical Staff, or their designee.

c. Gender, race, color, creed and national origin are not considered as part of the decision to grant or deny Allied Health Staff membership, appointments or Clinical privileges.

4.1-2 **Physician Sponsored Allied Health Professional**

a. Any physician or dentist who desires to train or use a professional person as his/her employee in the Hospital must apply for the privileges to the Medical Staff and the Hospital Governing Body. The physician shall provide all information requested concerning the professional person's education, training and experience, as well as specify the exact proposed duties and responsibilities that the person will perform in the Hospital.

b. As part of that application, the Hospital requires from the physician evidence that the person is covered under a professional liability insurance policy, and if there is any change in such coverage, the physician is required to promptly notify the President of the Hospital, or Vice President of Medical Affairs, or the President of the Medical Staff, or their designee. Approval of the training of personnel

within the Hospital, under the physician's supervision, shall be for two (2) years, subject to renewal after review.

c. Gender, race, color, creed and national origin are not considered as part of the decision to grant or deny Allied Health Staff membership, appointments or Clinical Privileges.

d. Matters of conflict regarding professional judgment or scope of duties should be promptly resolved by the employing physician and Hospital and/or Medical Staff representatives.

Section 2 Procedural Rights of Allied Health Professionals

4.2-1 Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an AHP to the procedural rights set forth in Article XIII and Article XIV.

4.2-2 An AHP shall have a right to informal hearing and appeal proceedings to challenge any action that would constitute grounds for a hearing under 14.1-3 of the Bylaws by filing a written grievance with the Medical Executive Committee within 30 days of notification of such action. Upon receipt of such a grievance, the Medical Executive Committee shall authorize the President of the Hospital or his or her designee to arrange an informal hearing to be conducted by one or more persons to be appointed by the President of the Hospital. The hearing committee may, but need not, to be comprised of AHPs or members of the Medical Staff; however, in cases involving clinical competency or clinical performance, and subject to feasibility, the President of the Hospital should attempt to include at least one individual who is a professional peer of the affected AHP. This informal hearing need not be conducted in accordance with the provisions of Article XIII and Article XIV, subject to the discretion of the President of the Hospital or designee. At a minimum, however, the following provisions shall apply:

The AHP shall be informed of the general nature and circumstances giving rise to the action and the AHP may present information relevant thereto at the informal hearing. Evidence in support of the adverse recommendation will be presented by an authorized representative of the Medical Executive Committee. The AHP shall have the burden to prove his or her competence and that the action leading to the hearing was arbitrary or capricious. A record of the proceeding shall be made. The resulting finding and recommendation shall be reported to the AHP and Medical Executive Committee, and shall be appealable to an appeal committee appointed by the Governing Body.

Appeals shall be based solely upon the record of the informal hearing maintained by the Medical Staff, plus such oral or written statements and/or new evidence as the appeal committee, in its sole discretion, may permit. The recommendation of the appeal committee shall be forwarded to the Governing Board (or authorized committee thereof) for final action.

The rights afforded by this Section shall not apply to any decision regarding whether a category of AHP shall or shall not be eligible for AHP Privileges and the terms or conditions of such decision.

ARTICLE V
PROCEDURES FOR APPOINTMENT/REAPPOINTMENT

Section 1 Procedure for Appointment

5.1-1 Applications for appointment to the Medical Staff by Practitioners or AHP shall be in writing signed by the applicant and submitted on a form prescribed by the Governing Body after consultation with the Medical Executive Committee. Such application shall state the qualifications and references of the applicant including the names of at least three peers (appropriate practitioners in the same professional discipline as the applicant who have personal knowledge of the applicant) who have had extensive experience observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence and ethical character. It shall include information as to whether the applicant's membership status and/or Clinical Privileges have ever been revoked, suspended, reduced or not renewed at any other hospital or institution, or his/her license to practice any profession in any jurisdiction has ever been suspended or terminated. This shall include voluntary as well as involuntary relinquishment or changes to license, registration, Clinical Privileges or membership. Every applicant must furnish complete documentation concerning at least the information listed in 5.1-2 through 5.1-9

5.1-2 Staff category and specific privileges requested, undergraduate, medical school, and postgraduate training, including the name of each institution attended, degrees granted, program completed, and dates attended. This information must be verified.

5.1-3 Currently valid medical and other professional licenses or certifications, and Drug Enforcement Administration (DEA) controlled substances registration, with the date and number of each. A copy of the current Washington license and DEA controlled substances certificate must accompany the application.

5.1-4 Specialty or sub-specialty board certification, recertification, or current qualification status to sit for the examination.

5.1-5 Any previous or current health condition or disability (including alcohol or drug dependencies) that effects or that may progress within the next two year period to the point of affecting the applicant's ability in terms of skill, attitude or judgment to perform professional and Medical Staff duties fully; hospitalizations or other institutionalizations for any such health problem or disability during the past ten-year period; if any such health problem or disability is currently controlled by therapy or is resolved but may reoccur, date of last health examination with name and address of performing physician and findings related to that problem or disability.

5.1-6 Verification of professional liability insurance coverage and information on professional liability history and experience (formal claims other than suits made for compensation based on an injury suffered; and suits and settlements made, concluded and pending); including the names of present and past insurance carriers.

5.1-7 Any proceedings initiated, pending or completed involving allegations or findings of professional medical misconduct.

5.1-8 Any proceedings initiated, pending or completed or any action involving denial, revocation, suspension, reduction, limitation, probation or non-renewal of any of the following:

a. License or certificate to practice any profession in any state or country;

b. Drug Enforcement Administration or other controlled substances registration;

c. Membership or fellowship in local, state or national professional organizations;

d. Faculty membership at any medical or other professional school;

e. Appointment or employment status, prerogatives or Clinical Privileges at any other hospital, facility or organization.

5.1-9 Any instances in which the applicant did not renew, or terminated, restricted, limited, withdrew or failed to proceed with an application for any of the elements listed in (g) immediately above in order to foreclose or terminate actual or possible investigation or disciplinary or adverse action.

5.1-10 Any of the following actions pending or taken in connection with professional liability insurance: denial, non-renewal, cancellation, limitation in coverage, or application of a surcharge.

5.1-11 Location of offices; names and addresses of other Practitioners with whom the applicant is or was associated and inclusive dates of such association; names and locations of any hospital or facility where the applicant had or has any association, employment, privileges or practice with the inclusive dates of each affiliation, status held, and general scope of Clinical Privileges.

5.1-12 Any current felony criminal charges pending against the applicant and any past charges including their resolution.

5.1-13 The applicant has the burden of providing adequate information for a proper evaluation of his/her experience, training, current competence, utilization practice patterns, ability to work cooperatively with others, and health status, and of resolving any doubts about these or any of the qualifications required for staff appointment or the requested staff category, or Clinical Privileges and of satisfying any requests for information or clarification (including health examinations) made by appropriate staff or board authorities.

5.1-14 The hospital's authorized representative will query the National Practitioner Data Bank regarding the applicant and will submit any resulting information to the applicant's credentials file. A Washington State criminal and child/adult abuse background check will be requested on all applicants. A database search will be conducted through the Office of Inspector General (OIG). New applicants who are excluded will not be eligible for appointment.

5.1-15 By applying for appointment to the Medical Staff, each applicant thereby authorizes the Hospital to consult with members of Medical Staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on competence, character, and ethical qualifications, consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the Clinical Privileges he/she requests, as well as of his/her moral and ethical qualifications for staff membership.

5.1-16 The time period to process a completed application can take between 90 and 120 days. Once all the references and other pertinent materials have been verified, the application is forwarded to the Chair of the appropriate Service Committee and then to the Credentials Committee.

5.1-17 The Credentials Committee, with the assistance from the appropriate Service Committees, shall review the application, the supporting documentation and any other relevant information available to it. The Credentials Committee may conduct an interview with the applicant or designate two or more of its members to do so. If the Credentials Committee requires further information, it may defer transmitting its report but generally for not more than sixty (60) days except for good cause, and it must notify the applicant and the president of the staff in writing of the deferral and the grounds. If the applicant is to provide the additional information or a specific release/authorization to allow hospital representatives to obtain information, the notice to him must so state, must be a special notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application.

The Credentials Committee shall prepare its written report and recommendations and transmit them to the Medical Executive Committee.

5.1-18 The Medical Executive Committee, at its next regular meeting after receiving the report of the Credentials Committee, and with the assistance of the appropriate service committee and Credentials Committee Chair, shall investigate the character, qualifications and standing of the applicant and shall submit a report of the findings to the Governing Body along with supporting data through the President of the Medical Staff at its next regularly-scheduled monthly meeting. An exception to this will be instances in which negative or conflicting information is presented which requires additional research. In such cases the applicant will be notified of the reason for the delay. Such a report must include its recommendation that the Practitioner must be provisionally appointed to the Medical Staff, that he/she be rejected from Medical Staff membership, or that his/her application be deferred for further consideration. All recommendations to appoint must also specifically recommend the Clinical Privileges to be granted which may, where appropriate, be qualified by probationary conditions.

5.1-19 When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within sixty (60) days with a subsequent recommendation for provisional appointment with specified Clinical Privileges or for rejection of staff membership.

5.1-20 The recommendation of the Medical Executive Committee shall be transmitted to the Governing Body along with supporting data through the President of the Medical Staff at its next regularly scheduled monthly meeting.

5.1-21 After receipt of the favorable recommendation, the Governing Body shall act in the matter. The requesting practitioner will be notified within 30 days of the Governing Body's decision to grant, limit, or deny privileges. If its decision is adverse to the Practitioner (a decision based upon professional competence or conduct is adverse to the Practitioner if it reduces, restricts, suspends, revokes, denies or fails to renew Clinical Privileges or Medical Staff membership) in respect to either appointment or Clinical Privileges, the President of the Hospital shall promptly notify him of such adverse decision by certified mail, and state that the action, if adopted, will be reported to the National Practitioner Data Bank as required by state law and will state the text of the

proposed report. Except as provided for a precautionary or summary suspension under these Bylaws, Rules and Regulations, such adverse decision shall not become effective until the Practitioner has exercised or has been deemed to have waived his/her rights under 14.1- through 14.1-11 of these Bylaws and until there has been compliance with 5.1-26. The fact that the adverse decision does not take effect shall not be deemed to confer privileges where none existed before.

5.1-22 Reporting to the National Practitioner Data Bank will occur as required by the policies and rules of the Data Bank. Reporting will not occur until final action has been taken by the Governing Body, unless such recommendation or action affects the Clinical Privileges of a Practitioner for a period of longer than thirty (30) days.

5.1-23 When the recommendation of the Medical Executive Committee is adverse to the Practitioner either in respect to appointment or Clinical Privileges, the President of the Hospital shall promptly so notify the Practitioner by certified mail, stating that the action, if adopted, based on competence or professional conduct, will be reported to the National Practitioner Data Bank and Department of Health as required by law. No such adverse recommendation shall be forwarded to the Governing Body until after the Practitioner has exercised or has been deemed to have waived his/her right to a hearing as provided in 14.1- through 14.1-11 of these Bylaws.

5.1-24 If, after the Medical Executive Committee has considered the report and the recommendation of the Hearing Committee, its recommendation continues to be adverse, the President of the Hospital shall also forward such recommendation and documentation to the Governing Body, but the Governing Body shall not take any action until after the Practitioner has exercised or has been deemed to have waived his/her right to an appellate review as provided 14.1- through 14.1-11, of these Bylaws.

5.1-25 Whenever the Governing Body's decision will be contrary to the recommendation of the Medical Executive Committee, the Governing Body shall submit the matter to the ad hoc joint review committee for review and recommendation within five (5) days and shall consider such before making its decision final. The ad hoc review committee of not less than three (3) members shall be composed of at least one member of the Governing Body and at least one member of the Active Medical Staff. Active staff member(s) will be appointed by the President of the Medical Staff.

5.1-26 When the Governing Body’s decision is final, it shall send notice of such decision through the President of the Hospital to the President of the Medical Staff, to the Chief of the Service concerned, and by certified mail to the Practitioner.

5.1-27 All decisions regarding the selection and employment of physicians or dentists in medico-administrative positions shall be made by the President of the Hospital after consultation with the Medical Executive Committee. A physician or dentist whose employment by the Hospital requires Medical Staff appointment shall not have his/her privileges terminated without the same due process provisions as detailed in 14.1 through 14.1-11 of these Bylaws unless otherwise stated by contract.

5.1-28 The Governing Body may reject or accept and process an application for initial appointment to the Medical Staff, or for renewal of appointment to the Medical Staff, or for Clinical Privileges related to facilities, equipment or services of the hospital which are covered by exclusive contracts, letters of agreement, or other documents. Any grant of appointments or privileges

related to facilities, equipment or services of the hospital which are covered by exclusive contracts, letters of agreement, or other documents will not be accepted by the Governing Body or processed, except when submitted in accordance with an existing exclusive contract, letter of agreement or other document with the Governing Body and endorsed by the exclusively contracting entity or group.

Section 2 Reappointment Process

5.2-1 The Medical Executive Committee, based on recommendations of the Credentials Committee, with the assistance of the appropriate service committee(s), shall review all pertinent information available to that Practitioner's reappointment. This will include any information obtained through an inquiry to the National Practitioner Data Bank and a database search will be conducted through the Office of Inspector General (OIG). It shall thereon determine its recommendations for reappointments to the Medical Staff and for the granting of Clinical Privileges for the ensuing period. These recommendations shall be transmitted in writing to the Governing Body. Where non-reappointment or change in Clinical Privileges is recommended, the reason for such recommendations shall be stated and documented. Recommendations for reappointments must be reviewed every two years.

5.2-2 Recommendations concerning appointment and Clinical Privileges shall be based upon evidence of current licensure, such member's professional competence and clinical judgment in the treatment of patients as evidenced by the results of Medical Staff quality assurance peer reviews and Ongoing Professional Practice Evaluation (OPPE), his/her mental and physical competence, his/her ethics and conduct, his/her compliance with the Hospital Bylaws and the Medical Staff Bylaws, Rules and Regulations, his/her cooperation with Hospital personnel, his/her use of the Hospital's facilities, his/her relationships with other Practitioners, and his/her behavior toward patients of the Hospital and the public.

5.2-3 With the exception of Peer References the procedure provided for in 5.1-1 through 5.1-28 relating to recommendations on applications for initial appointment shall be followed. At reappointment, only one peer reference is required.

5.2-4 The applicant for reappointment shall notify the Medical Staff of any voluntary or involuntary change in status, or proceedings toward a change in status related to professional license, registration, insurance, staff membership, Clinical Privileges, board certification or other changes pertinent to the applicant’s ability to practice within the scope of his/her existing or requested privileges. Notification shall occur immediately by the conclusion of the next business day.

5.2-5 At least 120 days prior to expiration of each Medical Staff member’s term of appointment, the Medical Staff Office shall provide the members with a reappointment application. Completed applications should be returned to the Medical Staff Office at least 90 days prior to the expiration date. If the Practitioner fails to submit a completed application for reappointment within the time specified and the application has not been fully processed before the appointment expires, the Practitioner shall be deemed to have resigned membership and privileges. In the event member and privileges terminates for the reasons set forth herein, the Practitioner shall not be entitled to any hearing or review.

ARTICLE VI
PRIVILEGES

Section 1 Clinical Privileges

6.1-1 Clinical Privileges:

a. Every Practitioner/AHP practicing in the Hospital by virtue of the Medical Staff membership or otherwise shall, in connection with such practice, be entitled to exercise only those Clinical Privileges specifically granted to him by the Governing Body except as provided for in 6.2-1 through 6.2-4 and 6.3-1.

b. Every initial application for staff appointment with privileges must contain a request for the specific Clinical Privileges desired by the applicant. The evaluation of such request shall be based on the same data as required in 5.1-1 through 5.1-28.

Clinical practice privileges shall be granted in accordance with prior education and training, prior and current experience, utilization practice patterns, current health status, and demonstrated current competence and judgment to provide quality and appropriate patient care in an efficient manner as documented and verified in each Practitioner/AHP's credentials file.

Additional factors that may be used in determining privileges are patient care needs and hospital capability to support the type of privileges being requested by the applicant, the geographic location of the Practitioner/AHP in terms of his/her personal availability to provide timely coverage for his/her patients, the availability of qualified medical coverage in his/her absence, and an adequate level of professional liability insurance. Where appropriate, review of the records of patients treated in other hospitals may also serve as the basis for privileges determinations.

Determination of any privileges for appointment, reappointment, provisional review period or any requested changes in privileges, will include observed clinical performance, documented results of quality review, utilization management and professional liability prevention program activities, and in the case of additional privileges requested, evidence of appropriate training and experience supportive of the request.

To renew or reinstate a privilege that has been voluntarily or involuntarily reduced will require completion of the privilege request and approval process for the specific privilege(s) to be renewed.

c. Privileges granted to dentists shall be based on their training, experience, and demonstrated competence and judgment. The scope of and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chief of Surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to their surgical services. The physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

d. Experimental drugs, procedures, or other therapies or tests may be administered or performed only after approval of the protocols involved by the Institutional Review Board. (This is intended to also include a review by the appropriate clinical service of any procedures a physician wishes to perform which were not included in his/her initial request for privileges or at his/her last reappointment.) Any experimental or other new, untried, or unproven procedure/treatment modality/instrumentation may be performed or used only after the regular credentialing process has been completed, and the privileges to perform or use said procedure/treatment modality/instrumentation has been granted to the individual Practitioner. For the purposes of this paragraph, a new, untried, or unproven procedure/treatment modality/instrumentation is one that is not generalizable from an established procedure/treatment modality/instrumentation in terms of involving the same or similar skills, the same or similar instrumentation and technique, the same or similar complications, the same or similar indications, or the same or similar expected physical outcome for the patient as the established procedure/treatment modality/instrumentation.

e. The Medical Staff Policy and Procedures outlines the process for all requests for new privileges, use of new techniques or equipment or non-FDA approved uses of equipment, techniques or drugs. [Note: the policies and procedure of the Institutional Review Board are still applicable when appropriate.]

Section 2 Temporary Privileges

6.2-1 Upon receipt of an application for Medical Staff membership and privileges for an appropriately licensed Practitioner/AHP, the President of the Hospital (acting for the Governing Body) and the President of the Medical Staff (acting for the Medical Executive Committee) or their designees may grant temporary appointment to the Medical Staff and Clinical Privileges in the following circumstances: (1) to fulfill an important patient care need when there is no other physician on the Medical Staff who can provide the special skills needed by the patient; or, (2) when a complete application meeting all the qualifications for membership on the Medical Staff is awaiting approval by the Medical Executive Committee and the Governing Body.

6.2-2 The President of the Hospital, Vice President of Medical Affairs, Medical Staff President or their designee may, after consultation with the chair of the applicable service committee(s) as appropriate, terminate any or all of a Practitioner/AHP's temporary privileges, provided that nothing herein shall be deemed to prevent any authority entitled to impose summary suspensions from doing so under the circumstances set forth within. In the event of any such termination, the Practitioner's patients then in the hospital will be assigned to another Practitioner/AHP by the head of the responsible service. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

6.2-3 A Practitioner/AHP is not entitled to the procedural rights afforded in 14.1 through 14.1-11, Appeals Procedure, when his/her request for temporary privileges is refused in whole or in part or when all or any portion of his/her temporary privileges are terminated, not reviewed, restricted, suspended, or limited in any way.

6.2-4 Temporary privileges are limited to not more than 60 days unless renewed (may be renewed one time.)

Section 3 Emergency Privileging

6.3-1 In the case of an emergency, any physician member of the Medical Staff, to the degree permitted by his/her license, and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such a physician or dentist must request the privileges necessary to continue to treat the patient. In the event such privileges are denied, or he/she does not desire to request them, the patient shall be assigned to an appropriate member of the Medical Staff. For the purposes of this section, an emergency is defined as a condition in which serious permanent harm would result to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

6.3-2 In accordance with the policy and procedure for emergency credentialing, a Practitioner (Physician or Allied Health Professional) who is not a member of the medical staff may be granted temporary emergency privileges by the Medical Staff President or Vice President of Medical Affairs or President of the Hospital, or their designee, as needed to assist in staffing for the emergency.

Section 4 Proctoring and Monitoring

6.4-1 Proctoring is a focused evaluation (FPPE) to confirm an individual Practitioner/AHP's current competence at the time when he or she requests new privileges, either at initial appointment or as a current member of the medical staff. In addition to specialty-specific issues, proctoring also will address the general competencies of physician performance as defined in Medical Staff Policy.

6.4-2 As outlined in the Medical Staff Policy and Procedures, proctoring applies to all new applicants, Practitioners/AHP's Requesting privileges for a procedure they have not yet performed, and Practitioners/AHP's where current competency is a concern either due to data from Ongoing Professional Practice Evaluation (OPPE) or because the Practitioner/AHP has not used the privilege for an extended period of time.

6.4-3 Practitioners requesting membership but no privileges do not need to be proctored.

ARTICLE VII
MEDICAL STAFF OFFICERS

Section 1 Officers of the Medical Staff

The Officers of the Medical Staff shall be:

1. President
2. President-Elect
3. Immediate Past President

Section 2 Chief of Staff

Every odd-numbered year, there shall be elected a President of the Medical Staff who shall also serve in the role of the Chief of Staff. This role shall include responsibility for the functioning of the clinical organization of the Hospital, and keeping or causing to be kept a careful supervision over the clinical work in all services

Section 3 Qualification of Officers

Membership in the Active Medical Staff, remaining in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Section 4 Election of Officers

7.4-1 A nominating committee shall consist of members of the Active Medical Staff appointed by the President. This committee shall offer one or more nominees for President-Elect.

7.4-2 Nominations may be submitted by petition. The petition must state the nominee and the office for which he/she is being nominated, be accompanied by the nominee's written statement of consent to serve if elected and bear the signature of at least ten(10) active Medical Staff members.

7.4-3 A ballot with nominated candidates will be sent to the active staff members for their approval. Ballots must be returned within 15 days from the date the ballots were distributed (this date will be indicated on the ballot.)

7.4-4 A count of ballots by the Medical Staff Office and results of the election will be forwarded to the President of the Medical Staff and Medical Executive Committee, as well as all members of the Medical Staff. In the event of a tie, the Nominating Committee will be responsible for resolving the selection.

Section 5 Vacancies in Office

Removal of an officer of the Medical Staff may be initiated by a request from the Medical Executive Committee or upon presentation to the President of the Staff of a petition signed by thirty percent (30%) of the Active Staff members. The petition will specify the reasons or causes for removal which may include but not be limited to: action by the State Board of the Medical Board of Examiners suspending license or placing him or her on probation; suspension by supportive grounds by the Pierce County Medical Society; activities or professional conduct which is deemed to be lower than the standards or aim

of the Medical Staff or to be detrimental and/or disruptive to the operations of the Hospital; negligence in the treatment of patients posing life threatening results, possibilities, and/or harm to the patient or the potential thereof.

The President will immediately notify the affected officer of this proposed action and a secret ballot vote will be conducted within twenty (20) days. An officer shall only be removed from office upon an affirmative vote of two-thirds of the Active Medical Staff membership.

Section 6 Duties of Officers

7.6-1 President--The President shall serve as the Chief Administrative Officer of the Medical Staff to:

a. Act in coordination and cooperation with the President of the Medical Staff in all matters of mutual concern.

b. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.

c. Serve as Chair of the Medical Executive Committee.

d. Serve as an ex-officio member of all other Medical Staff committees, without vote.

e. Be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, for implementation of the sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner.

f. Appoint committee members to all committees with the exception of the Medical Executive Committee.

g. Represent the views, policies, needs and grievances of the Medical Staff to the Governing Body and to the President of the Hospital**.**

h. Serve as an ex-officio member of the Governing Body and attend all Board meetings. Receive and interpret the policies of the Governing Body to the Medical Staff, and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff's responsibility to provide medical care.

i. Be responsible for the educational activities of the Medical Staff.

j. Be the spokesperson for the Medical Staff in its external, professional and public relations.

7.6-2 President-Elect--In the absence of the President, he/she shall assume all the duties and have the authority of the President. He/she shall be a member of the Medical Executive Committee of the Medical Staff. He/she shall automatically succeed the President at the end of the President's term or if the President should fail to serve for any reason.

7.6-3 Immediate Past President--The duties of the Immediate Past President are, for the most part, advisory in nature. He/she is a member of the Medical Executive Committee.

ARTICLE VIII
MEDICAL STAFF COMMITTEES

Section 1 Committees

8.1 Medical Staff committees shall include Administrative, Service, Interdisciplinary, and Special committees:

a. Administrative Committees: The Administrative committees shall include Medical Executive Committee, Credentials Committee, Bylaws Committee, Peer Review Committee, and Physician Advocacy Committee

b. Service Committees: Service committees shall include Adult Medicine, Anesthesia, Cardiac Services, Emergency Services, Medical Imaging, Surgery (including Orthopedic Subcommittee), Pediatric, and Obstetrics/Gynecology.

c. Interdisciplinary Committees: Interdisciplinary committees shall include Cancer, Critical Care, Education, Ethics, Infection Control, Pharmacy and Therapeutics, Trauma.

d. Special Committees: Special committees shall be those appointed for special purposes.

8.1-2 Committee chairpersons and the majority of committee members shall be members of the active staff. All committee members shall be approved by the President.

8.1-3 Removal of Committee Members:

Any committee member who is appointed by the President of the Medical Staff may be removed by a majority vote of the Medical Executive Committee. Any committee member who is appointed by the service chair may be removed by a majority vote of his or her service committee or the Medical Executive Committee. The removal of any committee member who is automatically assigned to a committee because he or she is an officer shall be governed by the provisions pertaining to the recall of officers (Article VII, Section 5).

8.1-4 Medical Staff Committees may hold educational forums to discuss interesting cases. These cases are not part of peer review process and the identity of the patients shall be anonymous. There will be no minutes taken at these meetings.

Section 2 Administrative Committees

8.2-1 The Medical Executive Committee

a. The size and composition of the Medical Executive Committee shall include:

i. The officers of the Medical Staff: President, President-Elect, and the Immediate Past President.

~~ii.~~ The chair of all Administrative, Service, and Interdisciplinary committees

iii. President of the Hospital, Vice President of Medical Affairs, and Vice President Patient Care Services, GS as ex-officio members.

b. The duties of the Medical Executive Committee shall be:

i. To represent the Medical Staff and to act for the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by the Bylaws;

ii. To coordinate the activities and general policies of various services;

iii. To receive and act on committee reports;

iii. To implement policies of the Medical Staff not otherwise the responsibility of the services;

v. To review and approve the designation of the hospital's authorized representative for National Practitioner Data Bank purposes;

vi. To provide a liaison between Medical Staff and President of the Hospital and the Governing Body;

vii. To recommend action to the President of the Hospital on matters of a medical administrative nature;

viii. To make recommendations on Hospital management matters such as long-range planning to the Governing Body through the President of the Hospital;

ix. To fulfill Medical Staff accountability to the Governing Body for the overall quality of medical care rendered to patients in the Hospital;

x. To be responsible for the application of Joint Commission on Accreditation of Healthcare Organizations' standards relevant to the Medical Staff;

xi. To provide for the preparation of all meeting programs, either directly or through delegation to the Medical Education Committee;

xii. To review the credentials of all applicants as presented by the Credentialing Committee and to carry recommendations to the Governing Body for staff membership assignments to services and delineation of Clinical Privileges;

xiii. To review periodically all information available regarding the performance and clinical competence of staff members and other Practitioners with Clinical Privileges as raised through Medical Staff quality assessment and improvement reviews and as a result of such reviews, to make recommendations for reappointments and renewal or changes in Clinical Privileges;

xiv. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;

xv. To report at each general Medical Staff meeting.

c.. The Medical Executive Committee shall meet monthly unless otherwise specified by the President of the Medical Staff or a majority of the members of the Committee.

8.2-2 Credentials Committee

a. The Credentials Committee shall consist of a chairperson and at least two (2) members of the Active Medical Staff.

b. The duties of the Credentials Committee shall be:

i. To review the credentials of all applicants and to make recommendations for initial membership, reappointment and delineation of Clinical Privileges in compliance with 3.1-6, 2.1-2 and 4.1-2, and 9.1-7 of these Bylaws;

ii. To make a report to the Medical Executive Committee on each applicant for Medical Staff membership or Clinical Privileges, including recommendations for and any special limitations on reappointments and non-reappointment and Clinical Privileges. Special consideration will be given to the recommendations from the services in which each applicant for reappointment requests continuing privileges;

iii. To review reports that are referred by the Medical Executive Committee, Quality Improvement Committee and other committees and by the President of the Medical Staff.

8.2-3 Bylaws Committee

This Committee shall consist of at least three members of the Medical Staff appointed by the President. The Committee will meet at least biennially and as often as indicated, for review and recommendation.

8.2-4 Peer Review Committee

Medical Staff Peer Review is considered part of the Quality Improvement program of MultiCare Good Samaritan Hospital. The Medical Staff Peer Review Committee provides a review framework to be utilized by the medical staff to assess the performance of individuals granted Clinical Privileges using the results to improve care, monitor and comply with regulatory requirements, and regularly provide feedback to Practitioners while assuring the system s be fair and enforced consistently among all medical staff.

A consistent peer review process utilizes all types of indicators including Type I – Rules, Type II – Significant events, and Type III – Rates. Hospital-wide indicators will be used as well as Service specific indicators and will be selected based on volume, problem prone, high-risk factors identified as pertinent to each service or the organization as a whole. Service specific indicators will be initiated by the appropriate Service Committee and approved by the Peer Review Committee. Periodically all indicators used Quality Management for case identification and screening will be presented to the Peer Review committee for review, revisions and approval. Cases may be referred as appropriate from the Peer Review Committee to the Service Committees for information and/or educational purposes. In addition,

the MEC or Quality Improvement Committee may direct specific reviews consistent with the Performance Improvement Program and Patient Safety Program. The Peer Review Committee may also receive referrals from Service and Interdisciplinary Committees or their chairpersons for review. No physician shall have primary review responsibility for any cases in which he/she was professionally involved. However, all reviews will encourage the active participation by the attending physician.

This Committee shall consist of 12 active staff physicians appointed by the Chair. Stability and consistency of the Committee will be assured through staggered terms. Four members will serve a three-year term; four members will serve a two-year term; and four members will serve a one-year term. The position of Chair will be for a period of one year and be elected by the members of the Committee.

8.2-5 Physician Advocacy Committee

The Physician Advocacy Committee shall be composed of Practitioners and others as appointed by the Chair. The Chair shall report to the President of the Medical Staff.

The primary responsibility of this committee is to help create a healthy work environment. This may be accomplished as follows:

a. Education of Medical Staff/Allied Health Professionals about impairment and manifestations and recognition of impairment. This shall be accomplished through CME programming, presentations by a recognized third party specializing in physician health and assessment program, and other activities.

b. Opportunities for self-referral to appropriate professional recovery programs for diagnosis and treatment and/or mandatory referral by the organization or Medical Staff;

c. Maintenance and confidentiality of quarterly compliance reports;

d. Monitoring of the safety of patients until the rehabilitation and/or any disciplinary process is complete;

e. Develop mechanisms to recognize “good behavior”; and

f. The President of the Medical Staff will be responsible for reporting the following items to the Medical Executive Committee:
    i. The topic and date for a planned CME;

    ii. An update on those physicians currently being monitored; and

    iii. Report on any Practitioner providing unsafe treatment.

Meetings will be scheduled quarterly or more often as needed.

Section 3 Service Committees

8.3-1 There should be committees appointed representing each of these services: Adult Medicine, Anesthesia, Cardiac Services, Emergency Services, Medical Imaging, Surgery, Pediatric(s), and Obstetrics/Gynecology.

Each Service is responsible for the quality of clinical activities performed by Practitioners with delineated Clinical Privileges within each service. Service committees are responsible for developing monitors and methods to evaluate patient care.

The Peer Review Committee is responsible for Peer Review; and, the results from records reviewed in the Peer Review Committee shall be used in implementing appropriate corrective or educational responses and assessing the effectiveness of such responses. The Peer Review Committee may refer issues or cases to the appropriate Service Committee for additional review and/or consultation. For informational purposes, the results of the reviews by the Peer Review Committee will be forwarded to the respective Service Committee Chair.

No physician shall have primary review responsibility for any cases in which he/she was professionally involved. However, all reviews will encourage the active participation by the attending physician.

Reviews by the committee may include a consideration of deaths; of patients with nosocomial infections, complications, errors of diagnosis and treatment; (of patients currently in the Hospital with unsolved clinical problems;) of proper utilization of Hospital services and facilities; and other patient care matters.

Each Service Committee shall participate in the review of privilege delineation requests for new appointment and reappointment, and shall forward their recommendations to the Credentials Committee.

8.3-2 The review of surgical matters shall include a tissue review for justification of surgeries performed, whether tissue was removed or not, to determine the following: that surgery performed was justified and of high quality; that any discrepancies between pre-operative diagnoses, pathological diagnoses and post-operative results are appropriately analyzed; and that screening mechanisms are developed using indicators to help identify cases needing more extensive analyses as well as those that may be excluded from review in the future. An exception to the requirement that all cases receive a surgical review will allow sample cases as representative examples if repeated reviews have justified the procedures employed.

8.3-3 The physicians practicing in Pathology and Laboratory Medicine are under the direction of the Surgery Committee.

8.3-4 Each committee will have the responsibility for assuring that medical records within that service jurisdiction are satisfactory in every respect. This will include ongoing review of current records to assure that they properly describe condition and progress of the patient, therapy provided, results thereof, and the identification of responsibility for all action taken. Records should be sufficiently complete at all times so as to meet the criteria of medical comprehension of a case in the advent of the transfer of physician responsibility for patient care.

8.3-5 Each committee shall keep permanent minutes to be made available to all Medical Executive Committee members. An oral report by the Chair of each committee shall be presented at the Medical Executive Committee.

Section 4 Interdisciplinary Committees

8.4-1 Cancer Committee

This Committee shall consist of Medical Staff representatives (from surgeon caring for oncology patients, medical oncology, radiation oncology, diagnostic radiology, pathology and others as appropriate), hospital administrator, oncology nursing manager, Social Work, Pharmacy, Cancer Registry, and Quality Management. Duties of the Committee shall include planning, initiating, stimulating, and assessing the results of cancer activities, to facilitate patient access to consultative services in appropriate disciplines, evaluating, recommending and presenting educational programs and conferences and when appropriate, performing studies and reviews of the quality of care provided to Hospital cancer patients. It shall meet at least quarterly.

8.4-2 Critical Care

This Committee will consist of representatives from the Medical Staff, the Anesthesia Department, the Respiratory Therapy Department, the Pharmacy Department, Nursing Service (including Critical Care Nursing staff) and Administration. Specific duties of the Committee include the review of equipment purchase proposed for the Critical Care Unit, the establishment and review of protocols, policies and procedures relating to the provision of care to patients in the Unit, review of the quality of care and the monitoring of education programs intended to assure proper utilization of the Critical Care Unit and the provision of a high level of patient care.

8.4-3 Education Committee

This Committee will consist of Medical Staff members, a hospital Education Administrator and a pharmacy representative who indicate interest in the continuing education structure of the staff. Duties of the Committee shall include responsibility of setting up continuing education programs that are of current interest to the medical staff and hospital clinical personnel. Continuing education programs may include matters that result from quality and performance improvement activities and utilization review done by other committees when appropriate.

8.4-4 Ethics Committee

This committee shall consist of members representing a wide spectrum of professions and involved in hospital operations and community activities. Representation includes but is not limited to: Physicians, Nursing Services, Pastoral Care, Home Health/Hospice, community members, other clinical disciplines, hospital administration, and the Governing Body. The Ethics Committee's objectives include education, consultation, and policy development in relation to biomedical ethics and ethical dilemmas. In addressing ethical dilemmas, the "Ethical Framework" is utilized as a guide in the decision-making process. Quality measurement of the committee's effectiveness occurs through focused case review and compliance with ethics policies. Ethics Committee consultation and services are available to patients/families, physicians, and staff. The committee meets at least every other month and for emergency sessions as necessary.

8.4-5 Infection Control

A committee composed of appropriate key Hospital personnel, including at least but not limited to, the following staff (or designee): Physicians, Director of Environmental Services, Director of Central Service and Supplies, Vice President of Patient Care Services-GS**,** Director of the Operating Room, and Infection Control Coordinator. It will be responsible for the following: will review and analyze actual infections, promote preventive and corrective programs designed to minimize infection hazards, and will supervise infection control in all phases of the Hospital activities including operating rooms, delivery room, recovery rooms, and special care units; sterilization procedures by chemicals or otherwise; isolation procedures; prevention of cross infection by anesthesia apparatus or inhalation therapy equipment; testing of Hospital personnel for carrier status; disposal of infectious material; and other situations as requested by a service or Medical Executive Committee.

8.4-6 Pharmacy and Therapeutics Committee

This Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimal clinical results and a minimal potential for hazard. The majority of the voting members will be active staff. The Director of Pharmacy, the Vice President of Patient Care Services-GS (or designee), and the Vice President of Medical Affairs (or designee) will be ex-officio members of this Committee. The Committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use and safety procedures, and all other matters relating to drugs in the Hospital. It shall also perform the following specific functions:

a. Develop/approve policies and procedures relating to the selection, distribution, handling, use, and administration of drugs and diagnostic testing materials;

b. Develop, maintain and periodically review the drug formulary;

c. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;

d. Establish standards concerning the use and control of investigational drugs, protocols and of research in the use of recognized drugs;

e. Define and review of all significant adverse drug reactions.

8.4-7 Trauma Committee

The Trauma Committee is a multidisciplinary committee with the authority to review all matters related to the care of the trauma patient. The committee is chaired by a general surgeon or other physician with special competence in care of the injured. Membership includes, but is not limited to, an emergency physician, an emergency department registered nurse, a general surgeon, an orthopedic surgeon, a pediatrician, an anesthesiologist, the physician director of the critical care service, the trauma care service nurse coordinator, a critical care registered nurse, and the trauma rehabilitation coordinator. The committee reviews and makes recommendations regarding all aspects of trauma patient care and provides education of the staff and community regarding injury prevention.

Section 5 Special Committees

Special committees shall be appointed by the President from time to time for the purpose of review and evaluation of the quality of patient care and/or as may be required to carry out properly the duties of the Medical Staff. Such a committee shall confine its work to the purposes for which it was appointed, and shall report to the Medical Executive Committee. It shall not have power of action unless such is specifically granted by the motion, which created the committee.

ARTICLE IX
SERVICES

Section 1 Services

9.1-1 There shall be services of Adult Medicine, Anesthesia, Cardiac Services, Emergency Services, Medical Imaging, Surgery, Pediatrics and Obstetrics/Gynecology.

9.1-2 The Dental Service shall be a division of the Surgical Service, and the Dental Staff shall conform, in general, to the standards established for the Medical Staff. In addition:

a. Members of the Dental Staff shall qualify legally, professionally, and ethically for the position to which they are appointed.

b. Patients admitted for dental services shall be admitted on a surgical service. It shall be the responsibility of the chief of that service to assure compliance with Bylaws relevant to dental privileges.

c. An adequate medical survey by a physician or qualified oral surgeon member of the Medical Staff shall be done on each patient before dental surgery. This survey will include the evaluation of those systems, which might complicate or contraindicate a dental/surgical procedure. The staff member must make his/her medical judgment regarding the proposed surgery and affix his/her signature to all such records. Indicated consultations shall be held in complicated cases. The physician who has done the history and physical shall be responsible for the patient's medical care.

9.1-3 Remuneration, if any, for direction of any service shall be that mutually agreed upon by the Governing Body and that service director.

Section 2 Medical History and Physical Requirements

Medical history and physical examinations are completed and documented by a physician, an oral-maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

9.2-1 Requirements for Completing a History & Physical

a. A complete history and physical examination shall in all cases be recorded or dictated within twenty-four (24) hours after admission of the patient. This report should include pertinent findings resulting from an assessment of all systems of the body.

b. If a complete history has been recorded, and a physical examination performed prior to patient's admission to the Hospital within the previous thirty (30) days, a durable, legible copy of these reports may be used in the patient's Hospital medical record in lieu of the admission history and report of Physical examination, provided these reports were recorded and authenticated by a member of the Medical Staff with privileges to perform history and physicals. In such instances, there must be an updated medical record entry in the patient’s medical record within 24 hours of admission and prior to any surgery documenting an examination for any changes in

the patient's current condition. The specific elements of History & Physicals are outlined in Medical Staff Policies and Procedure.

c. History and physicals performed by a referring physician who is not a member of the Medical Staff may be used if:

i. It has been performed within the previous thirty (30) days.
ii. It meets the pertinence requirements for history and physicals.
iii. A member of the Medical Staff with privileges to perform history and physical exams reviews and confirms the findings and authenticates the document.

9.2-2 Dental Care: A qualified oral surgeon may admit and perform the history and physical examination on oral surgery patients without known medical problems. Patients with medical problems admitted to the Hospital by qualified oral surgeons and all patients admitted by other dentists constitute a dual responsibility involving both a dental and a physician member of the Medical Staff, as follows:

a. Dentist's Responsibilities
i. A detailed dental history justifying hospital admission.
ii. A detailed description of the physical examination of the oral cavity, and a preoperative diagnosis.

b. Physician's Responsibilities
i. Medical history pertinent to the patient's general health.
ii. A physical examination to determine the patient's condition prior to anesthesia and surgery.

9.2-3 Podiatrist Care: A qualified podiatrist may admit and perform the portion of the history and physical examination relating to podiatric care. All patients admitted constitute a dual responsibility involving both a podiatrist and a physician member of the Medical Staff, as follows:

a. Podiatrist's Responsibilities
i. A detailed podiatric history justifying admission
ii. A detailed description of the physical examination and a pre-operative report

b. Physician's Responsibilities
i. Medical history pertinent to the patient's general health.
ii. A physical examination to determine the patient's condition prior to anesthesia and surgery.

9.2-4 Ambulatory Procedures
For day surgery patients the admitting physician shall be responsible for an appropriate history and physical which shall include:

a. The rationale for the procedure;

b. The relevant history regarding other disease, medication, previous anesthetic experience, and drug sensitivity;

c. A description of the general condition of the patient, examination of the systems relevant to the procedure, findings pertinent to the anticipated procedure;

d. Reports of all pertinent diagnostic procedures performed outside the hospital.

As is the case with other elective procedures, this information should be at the hospital at the time of the patient's admission as provided in the Rules and Regulations pertaining to medical records.

Section 3 Organization

The services shall be organized as divisions of the staff as a whole, and there should be supervision of each service by a committee of members of the Active Medical Staff. Each service committee shall be headed by a Chair, and at least two (2) members of each committee shall be non-specialty Practitioners on the Active Staff.

Section 4 Appointment of Service Committee Chair

Each service committee shall be chaired by a member of the Active Medical Staff who is Board Certified in the Specialty of the Committee for which they chair, appointed by the President of the Medical Staff on the basis of training, experience and demonstrated ability for the position. This Practitioner shall serve for two (2) years and shall be subject to Governing Body approval.

Section 5 Responsibilities of the Service Committee Chair

Each service committee Chair shall be responsible to the Chief of Staff for the functioning of his/her service, and shall have general supervision over the clinical work falling within his/her service. The committee Chair will be oversee all professional and administrative activities within his/her service; give guidance on the overall medical policies of the Hospital, specific recommendations and suggestions regarding his/her own service in order to assure quality patient care; maintain continual review of the professional performance of all Practitioners (including Allied Health Practitioners) for Clinical Privileges in his/her service, and report regularly thereon to the Medical Executive Committee; be responsible for enforcement of Hospital Bylaws and of the Medical Staff Bylaws, Rules and Regulations within his/her service; be responsible for implementation within his/her service of actions taken by the Medical Executive Committee of the Medical Staff; transmit to the Medical Executive Committee his/her service's recommendations concerning the classification, the reappointment and the delineation of clinical privileges for all Practitioners in his/her service, based upon review of the Practitioner's physical and mental capabilities; be responsible for the teaching, the education and research program in his/her service; participate in very phase of administration of his/her service through cooperation with the nursing service and Hospital Administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques and assist in the preparation of such annual reports, including the budgetary planning pertaining to his/her service as it is required by the Medical Executive Committee, the President of the Hospital, and the Governing Body.

Section 6 Functions of the Service

Each clinical service shall establish its own criteria consistent with the policies of the Medical Staff and of the Governing Body for the granting of Clinical Privileges in the service. These services will also perform the functions stated in 8.3-1 through 8.3-5 Service Committees.

Section 7 Assignment to Services

The Chair of each standing committee shall invite appropriate members of the Medical Staff to serve on the committee. These appointments are subject to the approval of the President of the Medical Staff. Only active staff members shall be able to vote or hold office.

ARTICLE X
MEDICAL STAFF MEETINGS

Section 1 Periodic Meetings

President of Medical Staff or the Governing Body may call meetings of the Medical Staff from time to time to address matters of the Medical Staff.

Section 2 Special Meetings

Special meetings of the Medical Staff may be called at any time by the President and shall be called at the request of the Governing Body, the Medical Executive Committee, or any five (5) members of the Active Medical Staff. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Sufficient notice of any meeting shall be ~~a~~ mailed to each active staff member and posted both in the Surgical Doctor's Lounge and in the Physician Lounge at least forty-eight (48) hours before the time set for the meeting.

Section 3 Attendance at Meetings
Medical Staff members should regularly attend Medical Staff meetings.

Section 4 Quorum
Thirty percent (30%) of the total membership of the Active Medical Staff shall constitute a quorum for any meeting of the Medical Staff.

ARTICLE XI
COMMITTEE MEETINGS

Section 1 Regular Meetings

Committees may by resolution provide the time for holding regular meetings without notice within such resolution.

Section 2 Special Meetings

A special meeting of any committee may be called by or at the request of the Chair or chief thereof; by the President of the Medical Staff; or by one-third of the group's present members, but not less than two.

Section 3 Notice of Meeting

Written or oral notice stating the place, day and hour that any special meeting or of any regular meeting not held pursuant to resolution shall be given each member of the committee or service, not less than 48 hours before the time of such meeting.

Section 4 Quorum

Twenty-five percent (25%), but not less than two, of the Active Medical Staff members of a committee or service, shall constitute a quorum.

Section 5 Minutes

Minutes of each regular and special meeting of a committee or service shall be prepared and shall include a record of the attendance of members, and the vote taken on each matter. The minutes shall be signed by the committee chair and approved by the Committee.

Section 6 Attendance Requirements

11-6.1 Each committee member shall regularly attend meetings.

11.6-2 A member of any category of the Staff who has attended a case that is being presented for discussion shall be notified and may be required to be present.. Should any member of the staff be absent from any meeting in which a case he/she has attended is to be discussed, it shall be presented nevertheless, unless the member is unavoidably absent and has requested that discussion be postponed. In no case shall postponement be granted for a period longer than until the next regular meeting.

Section 7 Medical Staff Education Conferences

The continuing education program of the Medical Staff will include at least monthly educational conferences for the entire Medical Staff under the direction of the Medical Staff Education Co.

ARTICLE XII
IMMUNITY OF LIABILITY

The following are express conditions applicable to any applicant and to any person appointed to the Medical Staff and to anyone having or seeking privileges to practice his/her profession in the Hospital during his/her term of appointment or reappointment. By applying for appointment, reappointment or Clinical Privileges, the applicant expressly accepts these conditions during the processing and consideration of his/her application, regardless of whether or not he/she is granted appointment or Clinical Privileges. They shall also apply during his/her appointment and reappointment:

12.1-1 To the fullest extent permitted by law, the applicant or appointee extends absolute immunity to, and releases from liability, this Hospital and its representatives and any third party with respect to any and all civil liability which might arise from any acts, communications, reports, recommendations, or disclosures involving an applicant or appointee, performed, made, requested or received by this Hospital and its representatives, to, from, or by any third party, including other appointees to the Medical Staff concerning activities relating, but not limited, to:

a. Applications for appointment or Clinical Privileges, including temporary privileges;

b. Periodic reappraisals undertaken for reappointment or for increase or decrease in Clinical Privileges;

c. Proceedings for reduction or suspension of Clinical Privileges or revocation of Medical Staff appointment, or any other disciplinary sanction;

d. Summary suspension;

e. Hearings and appellate reviews;

f. Medical care evaluations;

g. Utilization reviews;

h. Other Hospital and Medical Staff, departmental, service or committee activities relating to the quality of patient care or the professional conduct of an appointee to the Medical Staff or of any individual granted privileges to practice in the

Hospital, and concerning matters or inquiries relating to an applicant's or appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter that might directly or indirectly have an affect on the individual's competence, or on patient care, or on the orderly operation of this Hospital or any other hospital or health care facility, including otherwise privileged or confidential information;

i National Practitioner Data Bank queries and reports, as well as the Washington State criminal and child/adult abuse background check and reporting to state and federal agencies as required by law.

12-1.2 Any act, communication, report, recommendation or disclosure, with respect to any such applicant or appointee, made in good faith and at the request of an authorized representative of this Hospital or any other hospital or health care facility anywhere at any time, for the purposes set forth in 12.1-1 above, shall be privileged to the fullest extent permitted by law. Such privileges shall extend to employees of the Hospital and its authorized representatives, and to any third parties that either supply or are supplied information and to any of the foregoing authorized to receive, release or act upon the same.

12.1-3 The Hospital and its authorized representatives are specifically authorized to consult with the appointees to the Medical Staffs of other hospitals or health care facilities or the management of such hospitals or facilities with which the applicant or appointee is or has been associated, and with others who may have information bearing on the applicant's or appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter, as well as to inspect all records and documents that may be material to such questions. The applicant or appointee grants immunity to any and all hospitals, health care facilities, individuals, institutions, organizations and their representatives who in good faith supply oral or written information, records or documents to the Hospital in response to any inquiry emanating from the Hospital or its authorized representatives.

12.1-4 As used in this section, the term "Hospital and its representatives" means the Hospital, the members of the Governing Body and its appointed representatives; Hospital’s consultants and attorneys; and all persons providing evidence or acting on behalf of the Medical Staff, the Hospital, the Governing Body, a department, or committee of any of these entities and all Medical Staff members who participate in the Medical Staff peer review, appointment, reappointment and corrective action processes.

12.1-5 As used in this section, the term "third parties" means all individuals, government, accrediting agencies, organizations, associations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives.

12.1-6 Information shared with governmental or accrediting agencies is considered part of the quality and performance improvement process and is therefore afforded the same immunity from liability and discovery.

ARTICLE XIII
CORRECTIVE ACTION

Section 1 Procedures

13.1-1 Any member or officer of the Medical Staff, the Chief of any service, the Chair of any standing, special or ad hoc committee of the Medical Staff, the President of the Hospital, Vice President of Medical Affairs, or the Governing Body may request initiation of a corrective action investigation of a Medical Staff Member. A request for corrective action may result from clinical practice or professional conduct that is considered:

a. Below the professional standards of the Medical Staff

b. Detrimental to the health and safety of patients or others.

c. Detrimental to delivery of quality patient care within the Hospital.

d. Contrary to the Medical Staff Bylaws, Rules and Regulations.

e. Disruptive to the operations of the Hospital or the Medical Staff.

13.1-2 All requests for corrective action originating outside of a Medical Staff committee meeting for which minutes are kept shall be in writing and shall be made to the Medical Executive Committee and shall be supported by reference to the specific activities and/or conduct which constitute the grounds for the request.

13.1-3 Upon receipt of a request for corrective action, the Medical Executive Committee or the President of the Medical Staff (or the) President Elect in President's absence shall notify the Practitioner of the specific reasons and request for corrective action and may:

a. Initiate efforts to resolve the issue

b. Issue a letter of warning or reprimand

c. Initiate an investigation pursuant to 13.1-1c

d. Summarily suspend all or a portion of the Practitioners Privileges pursuant to 13.2-1 through 13.2-4

13.1-4 Wherever the corrective action could result in a reduction or suspension of clinical privileges, the President of the Medical Staff shall immediately appoint a standing or an ad hoc committee (hereafter referred to as the Investigation Committee) to investigate the matter. At the discretion of the President, physicians from outside of the hospital Medical Staff may be appointed to participate on the Investigation Committee. The President will appoint the Chair of the Committee. Within thirty (30) days after receiving the request for corrective action, the Chair of the Investigation Committee shall make a report of the investigation to the Medical Executive Committee. Prior to the making of this report the Practitioner who is the subject of the corrective action investigation shall have an opportunity for an interview with the Investigation Committee. Before such interview, the Practitioner shall be informed of the specific allegations against him/her and shall be invited to discuss, explain or refute them. This interview shall not constitute

a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall thereto apply. The Practitioner shall have no right to legal counsel before the Investigation Committee. Minutes of such interviews shall be made by the Investigation Committee and included with its report to the Medical Executive Committee. A copy of the minutes, and the findings of the Investigation Committee, will be sent by Special Notice to the Practitioner.

13.1-5 Prior to taking action on a report recommending corrective action, or following the receipt of the report from a committee resulting from its investigation of a recommendation for corrective action, the Practitioner shall be permitted to request an appearance before the Medical Executive Committee. This appearance should be held within thirty (30) days following Practitioner's the receipt of the report and shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall thereto apply. Minutes of such an appearance shall be made by the Medical Executive Committee.

13.1-6 The action of the Medical Executive Committee on request for corrective action may be to reject or modify the request; to issue a warning, a letter of admonition or a letter of reprimand; to impose terms of probation, a requirement for consultation or other conditions through an agreement with the Practitioner in question (hereafter A Corrective Action Agreement); to recommend reduction, suspension or revocation of Clinical Privileges; to recommend that an already imposed suspension of Clinical Privileges be terminated, modified or sustained; or to recommend that the Practitioner's staff membership be suspended or terminated.

13.1-7 Any recommendation by the Medical Executive Committee for reduction, suspension or revocation of Clinical Privileges, or for the suspension or termination from the Medical Staff, that meets the National Practitioner Data Bank requirements for reporting will, if adopted, include the proposed text of the report and shall entitle the affected Practitioner the procedural rights provided in 14.1 through 14.1-11, of these Bylaws.

13.1-8 The President of the Medical Staff shall promptly notify the President of the Hospital in writing of all requests for corrective action received by the Medical Executive Committee, and shall continue to keep the President of the Hospital informed of all action taken in connection therewith.

13.1-9 Each member of the Medical Staff recognizes and acknowledges that it is his/her responsibility to understand the requirements of any Corrective Action Agreement ("Agreement") concerning his/her practice and to comply with and ensure the implementation of such Corrective Action Agreement without regard to whatever assistance may be offered to the practitioner to implement the Agreement. In the event a Practitioner fails to adhere to the terms or conditions of any Corrective Action Agreement entered into at any point in the corrective action process, the Medical Executive Committee may, in its discretion, recommend reduction, suspension or revocation of privileges or termination of Medical Staff membership. Any such recommendation shall entitle the affected Practitioner to only those procedural rights remaining as outlined in these Bylaws unless provided for in the Corrective Action Agreement. (14.10-2)

Section 2 Summary Suspension

13.2-1 The President of the Medical Staff, or Vice President of Medical Affairs, or the President of the Hospital, or their designees, will have the authority to suspend all or any portion of the Clinical Privileges of a Medical Staff Member or Allied Health Professional whenever failure to

take such action may result in an imminent danger to the health and/or safety of any individual. Among other possible reasons, a danger may be considered to be "imminent" if it is reasonably believed under the circumstances that the situation, condition or circumstances could cause harm to a present or future patient, increase the or likelihood of complications to a patient, complicate or delay a patient's recovery, or cause any similar threat to the patient's health, safety or recovery.

Such summary suspension shall become effective immediately upon imposition. It shall be deemed an interim precautionary step in the professional review activity that may be taken with respect to the suspended individual but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that lead to suspension. Reporting to the National Practitioner Data Bank shall not occur until final action has been taken by the Governing Body, unless such recommendation or action affects the Practitioner's Clinical Privileges of a Practitioner for a period of longer than thirty (30) days.

13.2-2 The Medical Executive Committee of the Medical Staff will meet and review the matter within five (5) days of the suspension. The Medical Executive Committee's action will take place within five (5) days. This shall not constitute a Hearing as described in 14.1-11.

13.2-3 If the Medical Executive Committee does not recommend immediate termination of the summary suspension, the affected Practitioner shall be entitled to the procedural rights provided in 14.1-11, but the terms of the summary suspension which are sustained or modified by the Medical Executive Committee shall remain in effect pending a final decision of the Governing Body.

13.2-4 Immediately upon the imposition of a summary suspension, the President of the Medical Staff or responsible chief of service shall have the authority to provide for alternative medical coverage for the suspended Practitioner's patients in the Hospital at the time of such suspension. The wishes of the patient shall be considered in the selection of such alternative Practitioner.

Section 3 Precautionary Action

13.3-1 The President of the Medical Staff and the Chair of the appropriate service, (or in the absence of either, another member of the Medical Executive Committee), will have the authority to temporarily remove from the Hospital or any part of the Hospital, for a period of up to fourteen (14) days, any Practitioner or Allied Health Professional whose conduct is disruptive or who is or appears to be intoxicated, otherwise impaired, or in any condition that threatens either the safe or efficient operation of any part of the Hospital or threatens any patient's or other person's health or safety. Such precautionary action may, but need not, result in a summary suspension. Such a precautionary action shall not entitle the Practitioners to any procedural rights specified in 14.1-11. If temporary removal results from suspected impairment, the matter will be referred to the Physician Advocacy Committee for review and/ or intervention.

13.3-2 Interim Precautionary Step

Summary suspensions imposed under section 13.2-1 and precautionary actions taken under section 13.3-1 shall be deemed interim precautionary steps in the professional review activity that may be taken with respect to the Practitioner and shall not be considered a complete professional review actions in and of themselves. Such actions do not imply any final finding of responsibility for the situation that led to the action. Reporting to the National Practitioner Data Bank shall not occur until final action has been taken by the Governing Body, unless such action affects the

Clinical Privileges of a Practitioner for a period of longer than thirty (30) days from the date of the action by a professional review body, or as otherwise required by law. A "professional review body" means any committee that engages in professional review activity on behalf of the Hospital, including the Governing Body and any committee of the Medical Staff.

Section 4 Automatic Suspension

13.4-1 Action by the Department of Health, Medical Quality Assurance Commission revoking or suspending a Practitioner's or Allied Health Professional's license, shall automatically suspend all of his/her Hospital privileges, as will loss of license for any other reason. Upon reinstatement of the Practitioner's or Allied Health Professional's license, the Practitioner or allied Health Professional must reapply for Medical Staff membership and/or Clinical Privileges.

13.4-2 A temporary suspension in the form of withdrawal of a Practitioner's admitting privileges, including the care of hospitalized patients already under his/her care, may be made for incomplete medical records, at the discretion of the Medical Executive Committee.

13.4-3 Failure by a Practitioner to renew his/her license to practice, or professional liability insurance shall automatically suspend all privileges.

13.4-4 Failure to renew his/her DEA registration shall automatically suspend all privileges to prescribe medications under the jurisdiction of the DEA.

13.4-5 Unauthorized removal or alteration of Hospital medical records shall be cause for suspension until records are returned and Medical Executive Committee approval has occurred.

13.4-6 Failure to cooperate and comply with the investigation and hearing processes described in these Bylaws shall automatically suspend all privileges.

13.4-7 It shall be the duty of the President of the Medical Staff to cooperate with the President of the Hospital, enforcing all automatic suspensions. Suspension pursuant to 13.4-1 through 5 shall not be entitled hearing rights of 14.1-11. Patient care will be assigned as per 13.2-4.

ARTICLE XIV
HEARINGS AND APPELLATE REVIEWS

Section 1 Appeals Procedure

14.1-1 The intent of these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect Practitioners and at the same time protect the peer review review participants from liability. It is further the intent to establish flexible procedures that do not create burdens that will discourage the Medical Staff and Governing Body from carrying out peer review. Accordingly, discretion is granted to the Medical Staff and Governing Body to (1) create a hearing process that provides for the least burdensome level of formality in the process and yet still provides a fair review, and (2) interpret these Bylaws in that light. Further, technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken. The Medical Staff, Governing Body and their officers, committees and agents hereby constitute themselves as peer review bodies under the federal Health Care Quality Improvement Act of 1986 and the Washington state peer review laws and claim all privileges and immunities afforded by federal and state laws.

14.1-2 Except as otherwise provided in these Bylaws, a Practitioner shall be entitled to a hearing, upon timely and proper request, whenever a Practitioner receives notice of an adverse (14.1-3) recommendation or action by the Medical Executive Committee or by the Governing Body, where no prior right to a hearing existed.

14.1-3 Provided no prior right to a hearing has been exercised or waived, and provided the recommendations or actions are based upon the Practitioner's professional competence or professional conduct, only the following recommendations or actions are "adverse":

a. Denial of Medical Staff membership appointment, reappointment, and/or Privileges.

b. Revocation, suspension, restriction, or involuntary relinquishment of Medical Staff membership and/or Privileges.

c. Summary suspension of Medical Staff membership and/or Privileges following review by the Medical Executive Committee or during the pendency of corrective action and appeals procedures.

d. Involuntary imposition of significant consultation requirements (excluding observation incidental to proctoring or consultation that does not restrict the Practitioner's Privileges).

e. Any other disciplinary action or recommendation that in the reasonable opinion of the Medical Staff must be reported to the National Practitioner Data Bank or the Medical Quality Assurance Commission, or its successor.

14.1-4 No action taken by the Medical Executive Committee or the Governing Body, except as provided in 14.1-3 above, shall constitute grounds for a hearing, but the action shall take effect without any right of hearing or appeal.

14.1-5 In the event of an adverse action or recommendation for reappointment during the corrective action process, or in the event of adverse action or recommendation for corrective action during the reappointment process, the processes for review shall merge and there shall be a single investigation and the Practitioner shall have the right to a single hearing and appeal as otherwise provided in these Bylaws.

14.1-6 All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in 14.1-11, to assure the affected Practitioner is accorded all rights to which he/she is entitled.

14.1-7 The President of the Hospital shall be responsible for giving Special Notice of an adverse recommendation or action to any affected Practitioner. Such Special Notice shall state in concise language all of the following:

a. The action that has been proposed against the Practitioner

b. Whether the action, if adopted, must be reported to the National Practitioner Data Bank or Medical Quality Assurance Commission

c. A brief description of the reasons for the action or proposed action (including where applicable; a list of specific or representative patient records at issue)

d. That the Practitioner may request a hearing

e. That such hearing request must be submitted within thirty (30) calendar days following receipt of the Special Notice

f. That the Practitioner has the hearing rights described in 14.1-11 of the Medical Staff Bylaws and a summary of these hearing rights. .

Section 2 Request for Hearing or Appellate Review

14.2-1 The Practitioner shall have thirty (30) calendar days following receipt of Special Notice of such adverse action or recommendation to request a hearing or appellate review. The request shall be in writing addressed to the President of the Hospital. Failure of a Practitioner to request a hearing or appellate review to which he/she is entitled by these bylaws shall be deemed a waiver of the Practitioner's right to such hearing and/or appellate review and acceptance of the adverse action or recommendation**.**

14.2-2 If the Practitioner waives his/her right to a hearing or appellate review of an adverse action or recommendation of the Medical Staff or of a hearing committee appointed by the Governing Body, the action or recommendation shall become and remain effective against the Practitioner pending the Governing Body's decision on the matter. If the Practitioner waives his/her right to a hearing or appellate review of an adverse action by the Governing Body, the action shall become and remain effective against the Practitioner in the same manner as a final decision of the Governing Body provided for in 14.10-1 through 14.10-4. In either of such events, the President of the Hospital shall provide Special Notice to the affected Practitioner of his/her status.

14.2-3 By requesting a hearing or appellate review under these Bylaws, a Practitioner agrees to be bound by the provisions in the Bylaws, Rules and Regulations of the Medical Staff relating to immunity from liability for participants in the hearing process.

Section 3 Notice of Hearing or Appellate Review

Within five (5) days after receipt of a timely request for hearing or appellate review from a Practitioner entitled to the same, the Medical Executive Committee or the Governing Body, whichever is appropriate, shall schedule and arrange for such a hearing or appellate review, and shall, through the President of the Hospital notify the Practitioner of the time, place and date of the hearing which shall not be less than thirty (30) days or greater than (ninety) 90 days from the date of said Notices.

Section 4 Composition of Hearing Committee

14.4-1 All hearings shall be conducted by a hearing committee of not less than three (3) Members of the Medical Staff. Hearing Committee members:

a. Shall be appointed by the President of the Medical Staff in consultation with the Medical Executive Committee. The President shall designate one of the members as chair. The President may, at his/her discretion, appoint physicians and laypersons from outside of the hospital to participate on this committee.

b. Shall not have acted as accuser, investigator, fact finder, initial decision maker, or otherwise actively participated in the consideration of the matter resulting in the adverse recommendation or action. Knowledge of the matter involved shall not preclude a Member of the Medical Staff from serving as a member of the Hearing Committee.

c. May not be in direct economic competition with the Practitioner involved or stand to gain direct financial benefit from the outcome of the hearing.

14.4-2 The Practitioners shall be notified of the individuals appointed to the Hearing Committee and be given the opportunity to object if there are legitimate basis for objections, such as bias or direct economic competition.

14.4-3 The President of the Hospital, Vice President of Medical Affairs, and President of the Medical Staff, or their designees may attend the hearing, but may not participate in the deliberations or decision.

14.4-4 Each Hearing Committee member is required to represent that he/she is not in direct economic competition with the affected Practitioner.

Section 5 Conduct of Hearing

14.5-1 There shall be at least a majority of the members of the Hearing committee present throughout the hearing and deliberations. In unusual circumstances when a Hearing Committee member must be absent from any part of the proceedings he/she shall not be permitted to participate in the deliberations of the decision unless/until he/she has read the entire record of the portion of the hearing from which he/she was absent. The final decision of the Hearing Committee must be

sustained by a majority vote of the Committee members. No Hearing Committee member may vote by proxy.

14.5-2 An accurate record of the hearing must be kept. The Hearing Committee shall establish the mechanism. The Practitioner shall have the right to a copy of a written record of the proceeding and shall bear the costs of same based upon reasonable charges.

14.5-3 The personal presence of the Practitioner for whom the hearing had been scheduled shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights and to have accepted the adverse recommendation or action involved, and the same shall thereupon become and remain in effect as provided in 14.10-1 through 14.10-4.

14.5-4 Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the Hearing Committee. Granting of such postponements shall only be for good cause shown and at the sole discretion of the Hearing Committee. Postponements cannot exceed fourteen (14) days without another review of the requested postponement by the Hearing Committee.

14.5-5 The affected Practitioner shall be entitled to be accompanied and/or represented at the hearing by a Member of the Medical Staff in good standing; by a member of his/her local professional society; by an attorney; or by another person of his/her choice. The Practitioner shall inform the President of the Hospital in writing of the name and occupation his/her representative at least fourteen (14) calendar days prior to the hearing date. Failure to make such notification regarding the presence of an attorney representative shall result in forfeiture of that right. The payment of any fees associated with such attorney or representative shall be the responsibility of the Practitioner regardless of the outcome of the hearing. Notwithstanding the foregoing and regardless of whether the Practitioner elects to have attorney representation at the hearing, the Practitioner and the Medical Staff shall have the right to consult with legal counsel in preparation for a hearing or appellate review.

14.5-6 The Chair of the Hearing Committee, or a Hearing Officer appointed by the Chair and approved by the Medical Executive Committee, shall preside over the hearing. The Hearing Officer (if one is appointed) may be an attorney at law, but may not be the legal counsel for the Hospital. Reasonable justification for determining a proposed Hearing Officer to be unacceptable must be provided by the Practitioner to the Medical Executive Committee which shall have sole authority to render a decision on the matter. The Hearing Officer (or Chair of the Hearing Committee if no Hearing Officer is appointed) to be heard shall endeavor to assure that all participants in the hearing have a reasonable opportunity and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. the Hearing Officer shall determine the order of or procedure for presenting evidence and argument during the hearing and shall have discretion to make all rulings on questions that pertain to procedure or the admissibility of evidence that are raised prior to, during, or after the hearing. The Hearing Officer shall participate in the deliberations of the hearing committee and be a legal advisor to it, but shall not be entitled to vote. The appointed Chair of the Hearing Committee shall participate in the deliberation and vote regardless of whether he/she presides over the hearing.

14.5-7 The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. The hearing shall be limited to the adverse action or

recommendation and reasons stated in the Special Notice of such adverse recommendation or action. No information reasonably considered relevant will be excluded. Any relevant information upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule, which might make evidence inadmissible over objection in civil or criminal action. Both parties have a right to submit a written statement concerning any issue of procedure or a fact prior to, during, or at the close of the hearing, which shall become a part of the hearing record.

14.5-8 The Medical Staff or the Governing Board, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present the facts in support of its adverse recommendation.

Section 6 Burdens of Presenting Evidence and Proof

14.6-1 The body making the adverse action or recommendation will have the initial duty to present evidence in support of that action or recommendation. The Practitioner shall then present evidence in response; however, the Practitioner shall not be permitted to introduce information not produced upon request of the peer review body during the investigation process, unless the Practitioner establishes that the information could not have been produced previously in the exercise of reasonable diligence.

14.6-2 The Practitioner shall bear the burden of proving to the Hearing Committee by clear and convincing evidence that the adverse recommendation or action should not be sustained because it lacks a factual basis or the conclusions drawn from the facts are arbitrary or capricious.

14.6-3 During the hearing, each party shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness, to rebut any evidence, and to submit a written statement concerning any issue of fact or procedure. The Practitioner shall be responsible for supporting his/her challenge to the adverse recommendation or action by presenting relevant evidence as rebuttal. If the Practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

Section 7 Discovery

14.7-1 There is no right to discovery in connection with the hearing. However, the subject to a stipulation signed by both parties that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing, shall be entitled, upon specific request, to the following:

a. Copies of, or reasonable access to, all patient medical records referred to in the Special Notice of adverse action. Practitioner shall be responsible for copying fees.

b. Reports of experts relied upon by the Medical Executive Committee or the Governing Body;

c. Portions of relevant committee that reflect the decision by the Medical Executive Committee or Governing Body to impose the adverse recommendation or action;

d. Copies or summaries of any other documents relied upon by the Medical Executive Committee or Governing Body; and

14.7-2 Prior to the hearing, on dates set by the Hearing Officer, if none is appointed, the Hearing Committee Chair, each party shall provide the other party with a list of proposed exhibits and witnesses. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing in advance of the hearing. The hearing officer or chair shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

14.7-3 Prior to the hearing, on dates set by the hearing officer or chair the individual requesting the hearing shall, upon specific request, provide the Medical Executive Committee (or the Governing Body) copies of any expert report or other documents relied upon by the individual.

14.7-4 Neither the affected Practitioner, nor his/her attorney, nor any other person on behalf of the affected Practitioner shall contact Hospital employees appearing on the Hospital's witness list concerning the subject matter of the hearing, unless specifically agreed upon by Hospital counsel. Such agreement shall not be unreasonably withheld. Final decision rests with the Hearing Committee Chair or the Hearing Officer.

14.7-5 Practitioners are required to cooperate and comply with the investigation and hearing processes as described in these Bylaws. Failure to cooperate and comply with the investigation and hearing process will result in automatic suspension and may result in termination of staff membership and Privileges.

Section 8 Pre-hearing Conference

14.8-1 The Hearing Officer or Hearing Committee chair may require representative of the Practitioner and the Hospital's Medical Executive Committee (or Governing Body, if applicable) to participate in a pre-hearing conference for purposes of resolving all procedural questions in advance of the hearing. The Hearing Officer or Hearing Committee Chair may, without limitation:

a. Require submission of all documentary evidence relied on by the parties at this conference; any objections to the documents shall be made at the time and the Hearing Officer or Hearing Committee Chair shall resolve such objections;

b. Exclude evidence irrelevant to the adverse recommendation or action;

c. Require exchange of the names of all witnesses and a brief statement of their anticipated testimony be submitted if not previously provided;

14.8-2 The Hearing Officer or Chair shall use his/her best efforts to assure that the hearing is completed in an expeditious manner. Subject to the foregoing, postponements, continuances, and extension of time beyond the time permitted in these Bylaws may be permitted by the Hearing Officer (or Chair if no Hearing Officer has been appointed) within his/her discretion Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee may thereupon at a time convenient to itself, conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened.

14.8-3 Within ten (10) days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation, which shall include the recommendation(s) of the Hearing Committee and findings of fact and conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Final adjournment shall be when the Hearing Committee has concluded its deliberations. The Hearing Committee shall forward its report and recommendations(s) together with a copy of the hearing record to the Governing Body. The Practitioner shall be provided a copy of the report by certified mail. The Medical Executive Committee shall also be provided a copy of the report. The report, based on majority vote of the Hearing Committee, may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Staff or decision by the Governing Body. The report shall not reflect the number of votes for or against the Practitioner. Thereafter, the procedure to be followed shall be as provided in 14.2-1 through 14.2-3.

14.8-4 The decision of the Hearing Committee shall be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The role of the Hearing Committee is not to substitute its judgment for the judgment of the Medical Executive Committee or Governing Body recommending the adverse action. Rather, the Hearing Committee is to determine whether there is a factual basis for there commendation of adverse action or whether the conclusions drawn from the facts are arbitrary capricious. The Hearing Committee shall uphold the recommendation(s) of the Medical Executive Committee or Governing Body unless the Hearing Committee finds by clear and convincing evidence that the recommendation(s) lack(s) any factual basis or the conclusions drawn from the facts are arbitrary and capricious.

Section 9 Appeal to the Governing Body

14.9-1 Within thirty (30) days after receipt of the Hearing Committee report, the Practitioner may submit a request for appellate review by the Governing Body. A written request for such review shall be delivered to the President of the Hospital. Practitioner's request for appellate review shall include a concise statement of the specific grounds for appeal. In addition, the Practitioner and Medical Executive Committee or Hearing Committee may present a written statement supporting his/her or its position on appeal. The parties' legal counsel may assist in preparation of such statements.

14.9-2 If appellate review is not requested within thirty (30) days from receipt of the Hearing Committee report, the right to appellate review shall be waived and that action or recommendation shall become the final action of the Hearing Committee. The Governing Body shall consider the decision of the Hearing Committee at its next regularly scheduled meeting and shall give it great weight.

14.9-3 If an appellate review is requested, the Governing Body or by duly appointed appellate review committee of the Governing Body of not less than three (3) members, at least one of whom is a member of the Governing Body, shall conduct such review. Knowledge of the matter involved shall not preclude any person from serving as a member of the appellate review body so long as that person did not take part in a prior hearing on the matter. A representative of the Hospital administration and President may be members, but may not participate in deliberations and may not vote. The appellate review body may select an attorney to assist it in the proceeding, provided such attorney shall not be entitled to vote with respect to the appeal. The appellate review body shall have such powers as are necessary to discharge its responsibilities.

14.9-4 The Governing Body or its duly appointed appellate review committee shall review the record created of the hearing and shall consider the written statement(s) submitted pursuant to 14.8-3 for the purpose of determining whether the adverse recommendation or decision against the affected Practitioner was justified and was not arbitrary and capricious. If oral argument is requested as part of the review procedure, the affected Practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him by any member of the appellate review body. A representative of the Medical Executive Committee or the Governing Body, whichever is appropriate, shall be permitted to speak in support of the adverse recommendation or decision and shall answer questions put to him/her by any member of the appellate review body.

14.9-5 New or additional matters not raised during the original hearing or in the Hearing Committee report, or otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Governing Body or the appellate review committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be introduced.

14.9-6 If the appellate review is conducted by the Governing Body, the Governing Body as its next regularly scheduled meeting after adjournment of the appellate review proceeding shall render a final decision in writing which shall then be effective. Final adjournment shall not occur until the Governing Body has completed its deliberations. The Governing Body may affirm, modify or reverse the decision, or remand the matter back to the Hearing Committee or any other body designated by the Governing for further review and recommendation.

14.9-7 If the appellate review is conducted by a duly appointed appellate review committee of the Governing Body, such appellate review committee shall, within five (5) business days after adjournment of the appellate review proceeding make a written report to the Governing Body recommending a decision on the appeal or recommending remand for further review. Final adjournment shall not occur until the appellate review committee has completed its deliberations

14.9-8 If the matter on appeal is remanded to the Hearing Committee or any other body designated by the Governing Body for further review, such review shall be completed within thirty (30) days unless the parties agree otherwise or for good cause determined by the Governing Body.

14.9-9 Where permitted by MultiCare Health system Bylaws, all action required of the Governing Body may be taken by a committee of the Governing Body duly authorized to act.

Section 10 Final Decision by Governing Body

14.10-1 At its next regularly scheduled meeting, after adjournment of the appellate review proceeding conducted by the governing Body or after receipt of the written report of the appellate review committee, the Governing Body shall make its decision in the matter and shall send Special Notice thereof to the Medical Staff and, through the President of the Hospital to the affected Practitioner. Such notice shall specify the reasons for the action taken and, findings of fact and conclusions. If such findings and conclusions differ from those of the Hearing Committee and shall include the text of the report, if any, which will be submitted to the National Practitioner Data Bank and/or Department of Health.

14.10-2 Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the

subject of action by the Medical Staff, or by the Governing Body (or by a duly authorized committee of the Governing Body), or by both.

14.10-3 Exhaustion of Remedies. In the event an adverse recommendation or action is taken under these Bylaws, the Practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

14.10-4 SubstantialCompliance. Technical, insignificant or non-prejudicial deviations from the procedures set forth in these Bylaws, including but not limited to the failure of any committee to adhere to timelines, shall not be grounds for invalidating the action taken.

14.10-5 Hearings Requested Prior to April 7, 2010 But Not Held. All hearings requested prior April 7, 2010 but held thereafter shall be in accordance with the terms in these Bylaws and Rules. All corrective action underway April 8, 2010 shall proceed to the extent possible in accordance with the terms in these Bylaws and Rules.

Section 11 Re-application After Final Adverse Action and/or Voluntary Withdrawal of Application

Except as otherwise provided in the*se* Medical Staff Bylaws, or as determined by the Medical Staff in light of exceptional circumstances, an applicant or Member who has received a final adverse decision regarding appointment; who has withdrawn his/her application or request for membership and/or Privileges following an adverse recommendation by the Medical Executive Committee or Governing Body; who has received a final adverse decision resulting in termination or restriction of his/her Privileges or denial of request for additional Privileges; or who resigned from Medical Staff or relinquished privileges while an investigation was pending or following the Medical Executive Committee or Governing Body issuing an adverse recommendation is not eligible to re-apply to the Medical Staff for membership and/or privileges for a period of 24 months from the date of the notice of the final adverse action or the effective date of the resignation, or application withdrawal. An action is considered final on the latest date on which the application or request was withdrawn, a Member's resignation became effective, or upon completion of (i) all Medical Staff and Hospital hearings and appellate reviews and (ii) all judicial proceedings pertinent to the action served within two (2) years after the completion of the Medical Staff and Hospital proceedings. Any re-application is processed in accordance with the procedures set forth in 4.1-1 through 4.1-28 above, and the applicant must submit such additional information as the Medical Staff and the Governing Body may reasonably require to demonstrate that the circumstances resulting in the adverse action have been resolved. If such information is not provided, the re-application will be considered incomplete and voluntarily withdrawn, and will not be further processed.

ARTICLE XV
HOSPITAL GOVERNANCE AND MANAGEMENT

Ongoing and effective communication between the Medical Staff, Governing Body and the President of the Hospital is of critical importance to patient care. Such communication is furthered by:

a. The Governing Body of Good Samaritan Community Healthcare shall include in its membership at least two physicians and the President of the Medical Staff shall also attend in an ex-officio status.

b. Board members are invited to attend Medical Staff meetings and are encouraged to join physicians at their educational meetings as desired.

c. Officers of the Medical Staff, Governing Body, and the President of the Hospital meet periodically.

d. Certain multi-disciplinary committees shall include members of the Governing Body and the Medical Staff as appropriate (i.e., Ethics Committee, Performance Improvement Committees).

e. The Medical Staff shall be represented and participate in Hospital Governing Board deliberations that affect the Medical Staff.

ARTICLE XVI
RULES AND REGULATIONS

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Practitioner in the Hospital. Such Rules and Regulations shall be a part of these Bylaws except that they may be amended or repealed at any regular meeting by the affirmative vote of two-thirds (2/3) of the active Medical Staff that vote. Thirty (30) days written notice to active Medical Staff members of the Rules and Regulation changes is required. Thirty percent (30%) of the active Medical Staff membership present or returning ballots within fifteen (15) days shall constitute a quorum to validate the vote. The Medical Executive Committee will deem whether a meeting of the Medical Staff, a ballot by mail or electronic vote is desirable.

The Medical Executive Committee shall have the power to adopt such technical and editorial amendments to the rules and regulations as are, in its judgment, technical modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression or inaccurate cross-reference. After approval, such amendments shall be communicated in writing to the Medical Staff and Governing Body by posting, newsletter or other means as appropriate. Such amendments shall be effective immediately and shall be permanent if less than 10% of the active Medical Staff members object in writing to the Medical Executive Committee within 90 days and approved by the Governing Body.

Such change approved by the Active Medical Staff shall become effective upon approval of the Governing Body of the Hospital.

ARTICLE XVII
AMENDMENTS

These Bylaws may be amended or repealed or new Bylaws may be adopted only by the affirmative vote of two-thirds (2/3) of the active Medical Staff that vote. Thirty (30) days written notice to active Medical Staff members of the bylaw changes is required. Thirty (30%) of the active Medical Staff membership present or returning ballots within fifteen (15) days shall constitute a quorum to validate the vote. The Medical Executive Committee will deem whether a meeting of the Medical Staff, a ballot by mail or electronic vote is desirable.

The voting members of the Medical Staff may propose to adopt a Rule and Regulation, policy or procedure, or amendment to the Bylaws. They must first communicate, however, said proposal to the Medical Executive Committee. If necessary, the Bylaws Committee will meet to review said proposal.

In cases of a documented need for an urgent amendment to the Medical Staff Bylaws (i.e., compliance with state or federal law or regulatory agencies), the Medical Executive Committee, in coordination with the Bylaws Committee, may provisionally adopt and the Board's delegated representative provisionally approve an urgent amendment without prior notification to the Medical Staff. The Medical Executive Committee, however, shall inform the organized medical staff of said provisional amendments as soon as reasonably possible for review and comment and in accordance with the Conflict Management policy.

Waiver of Bylaws or Rules: Insofar as is consistent with applicable laws, the Medical Executive Committee, in consultation with the Governing Body or its designated representative, or the Governing Body in consultation with the Medical Executive Committee, has the discretion to waive a provision of the Bylaws or Rules if either determines that this waiver is necessary to serve the best interests of the patients and of the Hospital. There is no obligation to grant any such waiver and Practitioners have no right to have a request for a waiver considered and/or granted.

The Medical Executive Committee shall have the power to adopt such technical and editorial amendments to the bylaws as are, in its judgment, technical modifications or clarifications; reorganization or renumbering; or amendments made necessary because of punctuation, spelling or other errors of grammar or expression or inaccurate cross-reference. After approval, such amendments shall be communicated to the Medical Staff and Governing Body by posting, newsletter or other means as appropriate. Such amendments shall be effective immediately. They shall be permanent unless 10% of the active Medical Staff members object in writing to the Medical Executive Committee within 90 days of notification. Amendments so made shall be effective when approved by the Governing Body. The Bylaws Committee shall review these Bylaws biennially at a minimum.

ARTICLE XVIII
ADOPTION

These Bylaws, together with the amended Rules and Regulations, shall be adopted at any regular meeting of the Active Medical Staff, shall replace any previous bylaws, rules and regulations, and shall become effective when approved by the Governing Body of the Hospital. They shall, when adopted and approved, be equally binding on the Governing Body and Medical Staff.

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Adopted by Medical Staff of MultiCare Good Samaritan Hospital, Puyallup, Washington on Tuesday, May 17, 2011.

Signature on File
President of Medical Staff

Approved by the MultiCare Good Samaritan Regional Oversight Board, Puyallup, Washington, on Tuesday, June 21, 2011.

Signature on File
Secretary, MultiCare Good Samaritan Regional Oversight Board, Puyallup, Washington

RULES AND REGULATIONS

A. ADMISSION AND DISCHARGE OF PATIENTS

1. A patient may be admitted to the Hospital only by a member of the Medical Staff with Clinical Privileges. A patient requiring admission who has no attending physician shall be assigned to a member of the Medical Staff. All physicians shall be governed by and adhere to the official admitting policy of the Hospital.

2. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completion and accuracy of the medical record and for transmitting reports of the condition of the patient to the referring Practitioner and to relatives of the patient.

3. No patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated.

4. The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the appropriate utilization of hospital beds.

   If any questions as to the validity of admission to, or discharge from, a special care unit should arise, that decision is to be made through consultation with the director of the special care unit involved.

5. The admitting Practitioner shall be responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his/her patients might be a source of danger from any cause whatever.

6. The President of the Hospital, Vice President of Medical Affairs, President of the Medical Staff, or chief of the service concerned, shall have authority to call any member of the Active Staff for assistance in case of an emergency.

7. The attending Practitioner is required, upon request to furnish information by which a proper review of utilization of service can be determined. This documentation may include:

   a. An adequate written record of the reason for continued hospitalization.

   b. The estimated period of time the patient will need to remain in the Hospital.

   c. Plans for post-hospital care.

   d. Other information as required by existing utilization review regulations.

8. Patients shall be discharged only on order of a Practitioner with appropriate privileges. Should the patient leave the Hospital against the advice of a physician or without proper discharge, a notation of the incident shall be made in the patient's medical record.

9. In the event of a death in the Hospital, the deceased shall be pronounced dead, according to established Hospital policies. The body shall not be released until an entry has been made in the medical record. Policies with respect to the release of dead bodies shall conform to local law.

10. Every member of the Medical Staff shall be actively interested in securing autopsies whenever possible. An autopsy may be performed only with written consent, signed in accordance with state law. All autopsies shall be performed by the Hospital Pathologist, or by a physician delegated this responsibility. Provisional anatomic diagnoses shall be recorded in the medical record within seventy-two (72) hours, and the complete report should be made a part of the record within sixty (60) days. The next of kin authorized to give consent for autopsy in the State of Washington are as follows: spouse, parent, child, brother, sister, or any other next of kin or other person who has responsibility for burial.

B. MEDICAL RECORDS

1. The attending physician shall be held responsible for a legible medical record for each patient.

2. This record shall include identification data; chief complaint; history of present illness, past medical history; family history; treatments, physical examination; special reports such as consultations, clinical laboratory, and radiology treatment; operative report; pathological findings; progress notes; final diagnosis and autopsy report when performed.

3. A complete history and physical examination shall in all cases be recorded or dictated within twenty-four (24) hours after admission of the patient. This report should include all pertinent findings resulting from an assessment of all systems of the body. If a complete history has been recorded, and a physical examination performed prior to a patient's admission to the Hospital within the previous thirty (30) days, a durable, legible copy of these reports may be used in the patient's Hospital medical record in lieu of the admission history and report of Physical examination, provided these reports were recorded and authenticated by a member of the Medical Staff with privileges to perform H&P's. In such instances, there must be an updated medical record entry in the patient's medical record within 24 hours of admission and prior to any surgery documenting an examination for any changes in the patient's current condition. The specific elements of History & Physicals are outlined in Medical Staff Policies and Procedure.

   History and physicals performed by a referring physician who is not a member of the Medical Staff may be used if:

   a. It has been performed within the previous thirty (30) days.

   b. It meets the pertinence requirements for history and physicals.

c. A member of the Medical Staff with privileges to perform history and physical exams reviews and confirms the findings and authenticates the document.

4. An Emergency Room report cannot be used in lieu of an Admission History and Physical as it does not contain the required elements of a history and physical report.

5. When a history and physical examination have not been recorded before an operation or any potentially hazardous, diagnostic procedure, the operation or procedure shall be delayed or canceled, unless the attending physician states in writing such a delay would constitute a hazard to the patient.

6. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Progress notes shall be written at least daily on all acute care patients.

7. All operations performed shall be dictated by the attending surgeon within 12 hours after completion of the surgery, and the report promptly signed or authenticated by the surgeon and made a part of the patient's current medical record. An operative progress note should be written in the medical record immediately after the conclusion of any surgery and prior to transferring the patient to the next level of care. This note should provide pertinent information for anyone required to attend to the patient. The information should include comparable operative note information, minimal elements include; name of primary surgeons and assistants, findings, technical procedures used, specimens removed, postoperative diagnosis and estimated blood loss.

8. Consultations shall include pertinent history, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

   The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical finding.

9. Clinical entries in the patient's medical record shall be accurately dated and authenticated. This will include the report of history and physical examination, preoperative notes, operative reports, consultations, prenatal reports, progress notes, and discharge summaries or notes. Symbols and abbreviations approved by the Medical Executive Committee may be used. All outpatient and observation patient records should reflect appropriate documentation of indications for and results of procedures/tests.

10. A discharge summary shall be recorded on all medical records of patients hospitalized over forty-eight (48) hours, except for normal obstetrical deliveries and normal newborn infants. A discharge summary is required on all patient deaths. In all instances, the content of the medical record shall contain the diagnosis, the treatment, and discharge plans.

11. At all times members of the Medical Staff and Allied Health Staff shall act in good faith to protect the confidentiality of patient health care information as required by Hospital policy. In addition, in performing services at Hospital, members of the Medical Staff will comply with all federal and state laws and regulations regarding the confidentiality of patient health care information. Written authorization of the patient is required for release of medical information to persons not authorized to receive this information.

12. All medical records are the property of the Hospital and shall be properly filed and protected, and shall not be taken out of the Hospital without approval of the President of the Hospital or their designee and the physician on the case, except by subpoena, court order or applicable statute.

13. The President of the Hospital or their designee shall notify any physician who has incomplete charts of more than thirty (30) days standing, following discharge of the patient, with the request that the records be completed. In the event such records are not completed within the thirty (30) -day period following notification, the offending physician shall be notified by the President of the Medical Staff of the imposition of an administrative sanction which will rescind the right to admit to, or perform elective surgery within, the Hospital until such time as all delinquent medical records are completed. (Any physician who receives administrative sanctions due to incomplete medical records three (3) or more times in one calendar year shall be referred to the Medical Executive Committee for appropriate action.)

C. GENERAL CONDUCT OF CARE

1. All orders for inpatient treatment shall be documented, including date and time.

2 Symbols and abbreviations on the "Do Not Use Abbreviation" list approved by the Medical Executive Committee shall not be used when documenting in the medical record.

3. Legibility of all documentation is expected.

4. Verbal and telephone orders from credentialed members of the Medical Staff may be accepted by a registered nurse, a licensed practical nurse, respiratory therapist, pharmacist, physical therapist, occupational therapist or speech therapist. The authorization of this regulation, which allows respiratory therapists, pharmacists, physical therapists, occupational therapists and speech therapists to accept verbal and telephone orders, shall only apply to those orders directly related to their areas of expertise. Verbal and telephone orders must identify the provider giving the order and be signed by the individual authorized to accept such orders. The recorder is expected to read back a verbal or telephone order back to the ordering provider for confirmation of the orders accuracy.

5. Authentication of verbal and telephone orders is done at the earliest opportunity of the ordering provider, but no later than 48 hours after the order is recorded. Verbal and telephone orders will be utilized according to Hospital policy and procedures.

6. Pre-printed orders and protocols shall be reviewed and approved on a regularly scheduled basis.

7. Any physician performing a therapeutic abortion in a pregnancy of more than four (4) lunar months must have a written consultation from at least one member of the Active or Courtesy Staff with whom he/she is not associated.

8. A general consent form, signed by or on behalf of every patient admitted to the Hospital must be obtained at the time of admission. The admitting officer shall notify the attending physician whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be a physician's obligation to obtain proper consent before the patient is treated in the Hospital. The attending physician must inform the patient of the nature of, and risk inherent in, any special diagnostic, treatment, or surgical procedures, as well as complications and alternative treatments. A signed authorization for consent for such procedures shall be part of the patient's permanent medical record.

9. All drugs and medications administered to patients shall be those listed in the latest editions of: United States Pharmacopoeia National Formulary, American Hospital Formulary Service, or AMA Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. Those shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

10. A psychiatric and mental health consultation and/or treatment shall be offered to all patients who have attempted suicide or who have taken a chemical overdose. The medical records shall contain documentation that such services were offered to the patient.

D. GENERAL RULES REGARDING SURGICAL CARE

1. Policies, rules and regulations governing the use of the Surgical Suite will be the responsibility of the Surgery Committee. The Surgery Committee will adopt and revise such rules as are necessary to insure the proper utilization of operating rooms and the provision of high quality care. Medical Staff members using the Operating Suite will abide by such rules.

2. Dental Care: A qualified oral surgeon may admit and perform the history and physical examination on oral surgery patients without known medical problems. Patients with medical problems admitted to the Hospital by qualified oral surgeons and all patients admitted by other dentists constitute a dual responsibility involving both a dental and a physician member of the Medical Staff, as follows:

   Dentist's Responsibilities

   a. A detailed dental history justifying hospital admission.

   b. A detailed description of the physical examination of the oral cavity, and a preoperative diagnosis.

c. A complete operative report, describing the procedure, findings, and technique. All tissue including teeth and fragments shall be sent to the Hospital pathologist for examination.

d. Progress notes and discharge summary.

e. Discharge of the patient upon written order.

Physician's Responsibilities

a. Medical history pertinent to the patient's general health.

b. A physical examination to determine the patient's condition prior to anesthesia and surgery.

c. Supervision of the patient's general health status while hospitalized.

3. Podiatry Care: A qualified podiatrist may admit and perform the portion of the history and physical examination relating to podiatric care. All patients admitted constitute a dual responsibility involving both a podiatrist and a physician member of the Medical Staff, as follows:

Podiatrist's Responsibilities

a. A detailed podiatric history justifying admission.

b. A detailed description of the physical examination and a pre-operative report.

c. A complete operative report, describing the procedure, findings and technique.

d. Progress notes and a discharge summary.

e. Discharge of the patient upon written order.

Physician's Responsibilities

a. Medical history pertinent to the patient's general health.

b. A physical examination to determine the patient's condition prior to anesthesia and surgery.

c. Supervision of the patient's general health status while hospitalized.

4. Anesthetists shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.

5. In any surgical procedure with unusual hazard to life, there must be a qualified assistant scrubbed and present.

6. Tissues removed during the operation shall be sent to the Hospital Pathologist who shall make such examination as considered necessary in order to arrive at a pathological diagnosis. The Pathologist's authenticated report shall be made part of the patient's

record. The Surgery Committee will maintain an approved list of tissues and specimens that may be exempt from routine pathological examinations.

The surgeon determines whether or not the specimen should be sent to Pathology. If the surgeon elects not to have any specimens sent to pathology, the type of specimen and the surgeon's request will be documented on the operative room record.

The Surgical Committee will also maintain a list of tissues and specimens that have been authorized for gross pathological exam only. At the surgeon's request, a microscopic exam will also be done.

E. EMERGENCY SERVICES

1. The duties and responsibilities of all personnel serving patients within the emergency area shall be defined in a procedure manual, relating specifically to this outpatient facility.

2. An appropriate medical record shall be kept for every patient receiving emergency service, and shall be incorporated in the patient's Hospital record, if such exists. The record shall include:

   a. Adequate patient identification.

   b. Information concerning the time of the patient's arrival, means of arrival, and by who transported.

   c. Pertinent history of the injury or illness, including details relative to his/her arrival at the Hospital.

   d. Description of significant clinical, laboratory, and X-ray findings.

   e. Diagnosis.

   f. Treatment given.

   g. Condition of the patient upon transfer or discharge.

   h. Final disposition, including instruction given to the patient and/or his/her family, relative to necessary follow-up care.

   i. Signature of the Practitioner in attendance, including date and time.

3. Emergency Services Committee will review emergency care.

4. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's abilities, in conjunction with other emergency facilities in the community. All physicians on the Medical Staff shall be familiar with this plan, and in the event of its implementation, shall assume their responsibilities and duties accordingly.

F. IMAGING SERVICES

1. The Hospital shall operate and maintain a Radiology department, which will be under the supervisory direction of a Diplomat of the American Board of Radiology, to be called the Medical Director.

2. A written, signed report for every x-ray procedure performed must be on the patient's chart within seventy-two (72) hours after the procedure.

3. Technical work will be done by a qualified technician employed by the Hospital.

4. Day-to-day conduct of the professional work of the Department will be carried on by the regular Department personnel (professional, technical, and clerical), under rules agreed upon by Administration and the Medical Director.

G. OBSTETRICAL SERVICES

Policies, rules and regulations governing the use of the Obstetrical Suite will be the responsibility of the Obstetrical/Gynecology Committee. The Obstetrical/ Gynecology Committee will adopt and revise such rules as are necessary to ensure the proper utilization of labor and delivery rooms and the provision of high quality care. Medical Staff members using the Obstetrical Suite will abide by such rules.

H. RESIDENT MEDICAL STAFF

1. The Resident Medical Staff must adhere to the Medical Staff Bylaws, Rules and Regulations.

2. Orders and notes by Resident Medical Staff may be treated as valid physician orders and acted on by the hospital staff.

3. The residency faculty or responsible attending Medical Staff must make a final review and co-sign the medical records of any patients treated by the Resident Medical Staff and are responsible for the quality of care provided.

I. PROFESSIONAL CONDUCT OR BEHAVIOR

All patients, visitors, Medical Staff members, and hospital employees have the right to be treated with courtesy, dignity, and respect. To further this objective, all members of the Medical Staff will be expected to abide by all of the organizational policies, as set forth by the Governing Body, governing professional conduct in the workplace. Medical Staff members found in violation of these policies will be subject to Corrective Action as described in Article IV, Section 6 of the Medical Staff Bylaws. Applicable policy and procedures will be reviewed and approved by the Medical Staff Medical Executive Committee prior to implementation.

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Adopted by Medical Staff of MultiCare Good Samaritan Hospital, Puyallup, Washington, on Tuesday, May 17, 2011

Signature on File
President of Medical Staff

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Approved by the MultiCare Good Samaritan Regional Oversight Board, Puyallup, Washington, on Tuesday, June 21, 2011.

Signature on File
Secretary, MultiCare Good Samaritan Regional Oversight Board, Puyallup, Washington

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