Tacoma General Allenmore Hospital

Medical Staff Bylaws

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Medical Executive Committee
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Governing Body
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Tacoma General and Allenmore Hospital Medical Staff Bylaws

Effective April 1, 2005

PREAMBLE

These Bylaws are adopted to provide a framework for self-government for the organization of the Medical Staff of Tacoma General and Allenmore Hospital that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and to account to the Governing Body for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with applicants to and Members of the Medical Staff.

DEFINITIONS

1. **ALLENMORE CAMPUS** means the Hospital's facilities located in the area of Tacoma at 19th and Union Streets.

2. **ALLIED HEALTH PROFESSIONAL** or **AHP** means an individual, other than a licensed physician, dentist, oral surgeon or podiatrist, who exercises 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 under the supervision or direction of a Medical Staff Member possessing privileges to provide such care in the Hospital, and who may be eligible to exercise privileges and prerogatives in conformity with the rules adopted by the Governing Body, these Bylaws, and the Rules. AHPs are not eligible for Medical Staff membership.

3. **CAMPUS** means the **ALLENMORE CAMPUS** or **TACOMA GENERAL CAMPUS**, as in the context appropriate.

4. **CHIEF EXECUTIVE OFFICER** means the person appointed by the Governing Body to serve in this administrative capacity or his or her designee.

5. **CHIEF OPERATING OFFICER** means the person appointed by the Chief Executive Officer to serve in this administrative capacity or his or her designee.

6. **CLINICAL PRIVILEGES OR PRIVILEGES** means the permission granted to a Medical Staff Member or AHP to render specific patient services.

7. **DAY** means a 24-hour calendar day. In computing any period of time, the day of the act, event, or default from which the designated period begins to run shall not be included and the last day of the period shall be included unless it is a Saturday, Sunday, or legal holiday, in which event the period runs until the end of the next day that is not a Saturday, Sunday, or legal holiday. Anything required to be done on a particular day must be done during regular business hours on that day.

8. **SERVICE** means each Service of the Medical Staff at the Hospital. Such Services shall include Adult Medical Services, Pediatric Medical Services, Surgical Services, Diagnostic/Procedural Services and Women's Health Services.

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

10. **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 Professional Activities Committee or individual authorized to act on behalf of the Governing Body.

11. **HIPAA** stands for Health Insurance Portability and Accountability Act of 1996.

12. **HOSPITAL** means the inpatient and day surgery facilities of Tacoma General and Allenmore Hospital owned and operated by MultiCare Health System. Throughout these Bylaws, references to "Hospital" shall mean the two facilities collectively, or as otherwise specified.

13. **INTEGRATED COMMITTEE** means a committee established under these Bylaws within the scope of duties applicable to The Medical Staff of TG-AH Hospital, Mary Bridge Children's Hospital and Health Center and/or a committee established under the MultiCare Medical Associates Performance Improvement Plan or the MultiCare Health System Quality Improvement Plan.

14. **LIMITED LICENSE PRACTITIONER** means, unless expressly limited, any Practitioner who is currently licensed in Washington as a dentist, oral surgeon or podiatrist.

15. **MARY BRIDGE CHILDREN'S HOSPITAL** means the inpatient and day surgery facilities of Mary Bridge Children's Hospital and Health Center owned and operated by MultiCare Health System and located in the area of Tacoma at 317 Martin Luther King Way and 311 South “L” Street.

16. **MEDICAL EXECUTIVE COMMITTEE** means the integrated executive committee forTG-AH Hospital and Mary Bridge Children’s Hospital Medical Staffs; this Committee constitutes the governing body of the Medical Staff as described in these Bylaws.

17. **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.

18. **MEDICAL STAFF YEAR** means the period from January 1 through December 31.

19. **VICE PRESIDENT OF MEDICAL AFFAIRS** means the person, appointed by the Chief Operating Officer to serve as a liaison between the Medical Staff and Administration

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

21. **MULTICARE HEALTH SYSTEM** or **MHS** is the Washington not-for-profit corporation that owns and operates the Hospital.

22. **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, the definition of **SPECIAL NOTICE** below.

23. **PATIENT CONTACT** means the admission of a patient to the Hospital, the admission of a patient to the Emergency Department, the admission of a patient to a Hospital outpatient clinic, the performance of

outpatient surgery at the Hospital, assisting with surgery in the Hospital, or a consultation for a patient in either the Hospital or its Emergency Department or a Hospital outpatient clinic.

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

25. **PRACTITIONER** means, unless otherwise expressly limited, any currently licensed Physician (M.D. or D.O.), dentist, oral surgeon, or podiatrist.

26. **PRESIDENT** means the chief officer of the Medical Staff appointed by the Medical Executive Committee in accordance with these Bylaws.

27. **RULES** refers to the Medical Staff and/or service Rules adopted in accordance with these Bylaws unless specified otherwise.

28. **SPECIAL NOTICE** means a Notice sent by certified or registered mail, return receipt requested. See also, the definition of **NOTICE** above.

29. **SYSTEM** means MultiCare Health System.

30. **SYSTEM AFFILIATE** means a facility or entity such as an affiliated hospital, clinic, urgent care center, surgery center, physician office, managed care program, or other entity that is part of the System.

31. **TACOMA GENERAL CAMPUS** means the Hospital's facilities located in the area of Tacoma at 315 Martin Luther King Way and the ambulatory surgery center located in the area of Covington at 17700 S.E. 272nd Street.

ARTICLE 1
NAME AND PURPOSES

1.1 NAME

The name of this organization shall be the Medical Staff of Tacoma General Allenmore Hospital ("Medical Staff").

1.2 PURPOSES AND RESPONSIBILITIES

The Medical Staff's purposes are:

1.2-1 To assure that all patients admitted or treated in any of the Hospital's services receive care at a level of quality and efficiency at least consistent with generally accepted standards attainable within the Hospital's means and circumstances.

1.2-2 To provide for a level of professional performance that is consistent with generally accepted standards attainable within the Hospital's means and circumstances, and to provide a leadership role in organizational performance improvement activities.

1.2-3 To organize and support professional education and community health education and support services.

1.2-4 To initiate and maintain Rules for the Medical Staff to carry out its responsibilities for the professional work performed in the Hospital, pursuant to the authority delegated by the Governing Body.

1.2-5 To provide a means for the Medical Staff, Governing Body, and Administration to discuss issues of mutual concern.

1.2-6 To provide for accountability of the Medical Staff to the Governing Body.

1.3 HEALTH SYSTEM AFFILIATION; COOPERATIVE PEER REVIEW

The Hospital is part of the System. One of the purposes of the System is to maintain comparably high professional standards among its patient care facilities and to strive to provide efficient patient care and support services. In keeping with the foregoing, cooperative credentialing, peer review, corrective action, and procedural rights are hereby authorized, in accordance with the guidelines in these Bylaws as follows:

1.3-1 Credentialing

The Medical Staff may enter into arrangements with other System Affiliates and third parties to assist it in credentialing activities. This may include, without limitation, relying on information in other healthcare entities and System Affiliates' credentials and peer review files in evaluating applications for appointment and reappointment, utilizing the other System Affiliates' medical or professional staff support resources to process or assist in processing applications for appointment and reappointment, and using third parties to perform primary source verification of credentials.

1.3-2 Peer Review

The Medical Staff may enter into arrangements with System Affiliates and other healthcare entities to assist it in peer review activities. This may include, without limitation, relying on information in System Affiliates' credentials and peer review files, and utilizing the System Affiliates' and other healthcare entities' medical or professional staff support resources to conduct or assist in conducting peer review activities, provided that all such interaction shall be conducted in a manner consistent with the purpose and intent of the Health Care Quality Improvement Act [42 U.S.C. 11101, et. seq., as amended] and any applicable Washington State peer review or quality assurance provisions.

1.3-3 Corrective Action

The Medical Staff may work cooperatively with any System Affiliate to develop and impose coordinated, cooperative, or joint corrective action measures as deemed appropriate to the circumstances. This may include, but is not limited to, giving timely notice of emerging or pending problems, as well as notice of corrective actions imposed and/or reciprocal effectiveness of such corrective actions as provided in Section 12.6 of these Bylaws.

1.3-4 Joint Hearings and Appeals

The Medical Staff and Governing Body are authorized to participate in joint hearings and appeals provided the applicable procedures are substantially comparable to those set forth in the Hearing and Appellate Review Procedures established in these Bylaws.

1.3-5 Acknowledgement of and Adaptation to Range of Services at Each Campus

Tacoma General and Allenmore Hospitals are general acute care hospitals, each located on its own campus, that together provide a broad range of medical, surgical, and emergency services. The Medical Staff acknowledges that the differences in scope of services among these campuses may necessitate adoption of special rules, regulations, policies and procedures applicable on a campus-specific basis. However, wherever possible, the desire of the Medical Staff is to minimize duplication of efforts, to consolidate resources, to standardize policies and procedures, to operate as efficiently and effectively as possible, and to achieve a comparably high standard of care at both facilities, while at the same time recognizing the uniqueness of each campus. Members and AHPs agree to limit their practice to the scope of services provided at each Campus.

1.4 GOVERNING LAW, VENUE

These Bylaws and the Rules are a governing document for the Medical Staff. However, in the event that a dispute arises in which a determination requires selection of laws and venue, these Bylaws and the Rules shall be governed by, and construed in accordance with, the laws of the State of Washington without giving effect to its conflict of laws principles, and venue shall lie in Pierce County, Washington.

ARTICLE 2
MEDICAL STAFF MEMBERSHIP

2.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff and/or Privileges 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 and the Rules. 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 and the Rules. Appointment to the Medical Staff shall confer only such Privileges and prerogatives 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.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 General Qualifications

Membership on the Medical Staff and Privileges shall be extended only to Practitioners who are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and Rules. Medical Staff membership (except Honorary and Retired Medical Staff) shall be limited to Practitioners who are currently licensed or qualified to practice medicine, podiatry, dentistry, or oral surgery in Washington.

2.2-2 Basic Qualifications

A Practitioner must demonstrate compliance with all the basic standards set forth in this Section 2.2-2 in order to have an application for Medical Staff membership accepted for review. The Practitioner must:

(a) Hold a current, valid license to practice in the State of Washington and be either:

(1) A physician with a Doctor of Medicine or Doctor of Osteopathy degree;

(2) A dentist or oral surgeon with a Doctor of Dental Surgery degree; or

(3) A Doctor of Podiatric Medicine.

(b) If practicing clinical medicine and if required by the Rules and Regulations, dentistry, oral surgery, or podiatry, have a current, valid federal DEA number.

(c) Board certification, residency training:

(1) Have successfully completed a residency approved by the Accreditation Council for Graduate Medical Education, or American Osteopathic Association, that provided training in the specialty or subspecialty that the Practitioner will practice primarily at the Hospital, and subsequent compliance with 2.2(c)(2) within five (5) years of completion of said training program;

(2) Be certified by a Board recognized by the American Board of Medical Specialties, the American Board of Podiatric Surgery (ABPS), the American Council of Certified Podiatric Physician and Surgeons (ACCPS), the American Board of Medical Specialties in Podiatry (ABMSP), the American Board of Podiatric Orthopedics & Primary Podiatric Medicine (ABPOPPM), or a board or association with equivalent requirements approved by the Governing Body;

(3) Complied with any other board certification requirements specified in the Rules of the Service to which the Governing Body assigns the Practitioner, provided, however, current Members of the Medical Staff who were members of the medical staff of Allenmore Hospital (but not Tacoma General Hospital) as of December 30, 1997 are not subject to board certification rules of the department that were in effect on December 30, 1997, as long as they continue to maintain Member status through consecutive, uninterrupted appointments to the Medical Staff;

(4) The requirements of 2.2(c)(1) and (2) shall not apply to:

(i) Dental specialists other than oral and maxillofacial surgeons;

(ii) Current Members of the Medical Staff who were members of the medical staffs of Allenmore Hospital and Tacoma General Hospital as of December 30, 1997 with such continued memberships not contingent on completing any board certification requirement, and who continue to maintain Member status through consecutive, uninterrupted reappointments to the Medical Staff;

(iii) Current Members of the Medical Staff who were members of the medical staff of Allenmore Hospital but not the medical staff of Tacoma General Hospital (and current Members of the Medical Staff who were members of the medical staff of Tacoma General Hospital but not the medical staff of Allenmore Hospital) as of December 30, 1997 with such continued membership not contingent on completing any board certification requirements, and who continue to maintain Member status through consecutive, uninterrupted reappointments to the Medical Staff;

(iv) Current Members of the Medical Staff who were members of the medical staff of Tacoma General Hospital and/or the medical staff of Allenmore Hospital as of December 30, 1997, with such continued membership(s) contingent on completing board certification, who timely complete the board certification requirements in effect on December 30, 1997, and who continue to maintain Member status through consecutive, interrupted reappointments to the Medical Staff;

(v) Current members of the Medical Staff who were members of the Medical Staff of Covington Day Surgery Center as of January 14, 2000, with such continued membership(s) not contingent on completing any board certification requirement, and who continue to maintain Member status through consecutive, uninterrupted reappointments to the Medical Staff.

(d) Be eligible to receive payments from the federal Medicare and state Medicaid programs.

(e) Have liability insurance or equivalent coverage meeting the standards specified in the Rules.

(f) Have actively practiced for an average of at least 20 hours per week in the specialty he or she will practice at the Hospital for 12 of the previous 24 months (or have completed a residency or fellowship within the previous 18 months).

(g) Is able to provide, or arrange for provision of, continuous and appropriate care and supervision of his or her patients in the Hospital.

(h) Not be currently excluded from any healthcare program funded in whole or in part by the federal government, including Medicare or Medicaid.

(i) If requesting Privileges only in departments operated under an exclusive contract, be a member, employee, or subcontractor of the group or person that holds the contract.

A Practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review. Applicants for the Honorary and Retired Medical Staff do not need to comply with any of the basic standards. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific standards that adversely affected such Practitioner. Those comments and requests shall be reviewed by the Medical Executive Committee and the Governing Body, which shall have sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed by Section 2.2-4.

2.2-3 Particular Qualifications for Membership

In addition to meeting the basic qualifications set forth above, the Practitioner must:

(a) Document his or her (i) adequate experience, education, and training in the requested Privileges; (ii) current professional competence; (iii) good judgment; (iv) a proficiency in the English language in a degree commensurate with the Privileges sought and at a level appropriate for patient health and safety; and (v) adequate physical and mental health status (subject to any legally required reasonable accommodation offered by the Medical Staff) to demonstrate to the satisfaction of the Medical Staff that he or she is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized high professional level of quality of care for this community; and

(b) Be determined to (i) adhere to the ethics guidelines of the AMA; (ii) work cooperatively with others in the Hospital setting so as not to adversely affect patient care or Hospital operations; (iii) participate in and properly discharge Medical Staff responsibilities; (iv) maintain a professional demeanor; and (v) ability to work cooperatively with others in the Hospital setting so as not to adversely affect the patient care or hospital operations.

2.2-4 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, after consulting with 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.

2.3 EFFECT OF OTHER AFFILIATIONS

No Practitioner shall be entitled to Medical Staff membership merely because he or she holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because he or she had, or presently has, staff membership or privileges at another health care facility. However, a revocation, suspension, restriction, or other disciplinary or corrective action by any state licensing authority, professional organization, certification board, or health care facility regarding a practitioner's license, certificate, membership, or clinical privileges, whether contested or voluntarily accepted, shall constitute grounds for an unfavorable credentialing or peer review action by the Medical Staff and Governing Body. The Medical Staff and Governing Body shall consider the nature and gravity of the charges or allegations and the resulting disciplinary or corrective action, but shall not be obligated to conduct evidentiary proceedings regarding events that occurred elsewhere.

2.4 NONDISCRIMINATION

Medical Staff membership or particular Privileges shall not be denied on the basis of gender, race, creed, national origin, age, sexual orientation, religion, any other basis prohibited by law, or any physical or mental impairment that, after any legally-required reasonable accommodation, does not preclude compliance with the Medical Staff Bylaws or Hospital policies.

2.5 ADMINISTRATIVE AND CONTRACT PRACTITIONERS

2.5-1 Contractors with No Clinical Duties

A Practitioner employed by or contracting with the Hospital in a purely administrative capacity with no clinical duties or Privileges is subject to the terms of his or her contract or other conditions of employment and need not be a Member of the Medical Staff.

2.5-2 Contractors Who Have Clinical Duties; Effect of Exclusive Contract

(a) Certain Hospital services at either or both the Tacoma General campus or Allenmore campus are provided through exclusive contracts. When this is the case, only Practitioners who are members of the contracting group, who are otherwise qualified by training and experience, and who achieve status as a member of the Medical Staff by the procedures described in these Bylaws shall be eligible for Privileges that fall within the scope of services described in the contract. Practitioners who depart from an exclusive contract group, or whose group contract terminates and is then awarded to another group, shall have their Privileges automatically expire immediately upon such departure or termination. The Hospital may enforce such an automatic expiration even if the Practitioner's agreement with the group fails to recognize this right. Such Privilege determinations are deemed administrative actions, and shall not entitle the Practitioner to the review, hearing, and appeal procedures of Article 13 of these Bylaws.

(b) Current exclusive inpatient contracts at the Hospital are anesthesia, pathology, emergency care and radiology.

(c) Contracts between Practitioners and the Hospital shall prevail over these Bylaws and the Rules, except that the contracts may not (i) reduce any hearing rights granted when an action will be taken that must be reported to the Medical Quality Assurance Commission of Washington or the federal National Practitioner Data Bank, or (ii) reduce the requirements of credentials and qualifications stated in the Bylaws and Rules.

(d) Practitioners who subcontract with practitioners or entities who contract with the Hospital shall lose any Privileges granted pursuant to an exclusive or semi-exclusive arrangement (but not their Medical Staff membership) if their relationship with the contracting practitioner or entity terminates, or the Hospital and the contracting practitioner's or entity's agreement or exclusive relationship terminates. Privileges of such Practitioners shall be deemed to have expired on the earlier of the date that their contractual relationship with the contracting entity terminates, or the entity's agreement with the Hospital terminates. The Hospital may enforce such an automatic termination even if the subcontractor's agreement fails to recognize this right.

(e) Nothing herein shall preclude a Practitioner who departs an exclusively contracting group from maintaining Medical Staff membership and applying for Privileges not covered under an exclusive contract, provided that the Practitioner otherwise meets the qualifications for such privileges under these Bylaws.

2.6 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for Honorary and Retired Members (see Article 3 regarding Categories of Medical Staff), each Medical Staff Member and each Practitioner exercising Privileges shall continuously meet all of the following responsibilities:

2.6-1 Provide his or her patients with professional services within the generally recognized standard of care and efficiency.

2.6-2 Abide by the Medical Staff Bylaws and Rules and all other lawful standards, policies, and rules of the Medical Staff and the Hospital.

2.6-3 Abide by all applicable laws and regulations of governmental agencies and comply with applicable standards of the Joint Commission.

2.6-4 Discharge such Medical Staff, department, section, committee, and service functions for which he or she is responsible by appointment, election, or otherwise.

2.6-5 Prepare and complete in a timely manner the medical and other required records for all patients to whom the Practitioner in any way provides services in the Hospital. Complete electronic medical record training and demonstrate basic competency. History and Physical examinations are completed within 30 days prior to patient admissions and procedures, or within 24 hours after admission. If History and Physical examinations are completed prior to admissions, they are accompanied by an update to the physical exam documenting any changes, or a statement indicating no change.

2.6-6 Abide by the ethical principles of his or her profession.

2.6-7 Refrain from unlawful fee-splitting or unlawful inducements relating to patient referral.

2.6-8 Refrain from unlawful harassment or discrimination against any person (including any patient, System employee, Hospital independent contractor, Medical Staff Member, volunteer, or visitor) based upon the person's age, mental disability, medical disability, marital status, gender or sexual orientation, religion, race, ancestry, color, national origin, health status, physical disability, ability to pay, or source of payment.

"Sexual harassment" is unwelcome verbal or physical conduct either of a sexual nature or based on one's gender that may include verbal harassment (such as epithets, derogatory comments, or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct that indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

All allegations of harassment or discrimination should be reported to the President. If the Member is uncomfortable discussing the matter with the President or if the President is unavailable, the Practitioner should make the report to the Vice President of Medical Affairs. All allegations of harassment or discrimination shall be investigated by the Medical Staff pursuant to Article 12 and the appropriate parties notified of the findings. Harassment or discrimination that is confirmed will result in corrective action, from reprimands up to and including termination of Medical Staff privileges or membership, if warranted by the facts. No Practitioner will suffer retaliation for reporting instances of harassment or discrimination, and confidentiality will be maintained to the extent possible.

2.6-9 Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a Practitioner or AHP who is not privileged at the Hospital to undertake this responsibility, who is not adequately supervised, or who did not agree to care for the patient.

2.6-10 Seek consultation whenever warranted by the patient's condition or when required by the Rules.

2.6-11 Actively participate in and regularly cooperate with the Medical Staff in assisting the Hospital to fulfill its obligations related to patient care, including, but not limited to, continuous quality improvement, peer review, utilization management, quality evaluation and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time.

2.6-12 Upon request from the Medical Staff, provide information from his or her office records or from outside sources as necessary to facilitate the care of or review of the care of specific patients.

2.6-13 Recognize the importance of communicating with appropriate department officers and/or Medical Staff officers when he or she obtains credible information indicating that a fellow Medical Staff Member may have engaged in unprofessional or unethical conduct, may have provided substandard patient care, or may have a health condition that poses a significant risk to the well-being or care of patients, and then cooperate as reasonably necessary toward the appropriate resolution of any such matter.

2.6-14 Accept responsibility for participating in Medical Staff proctoring in accordance with the Rules.

2.6-15 Complete continuing medical education ("CME") that meets all licensing requirements and is appropriate to the Practitioner's specialty.

2.6-16 Avoid disruptive behavior and work cooperatively and professionally with Members, nurses and other clinical staff, Hospital administrative staff, and others so as not to adversely affect patient care or Hospital operations. Disruptive behavior includes attacks leveled at Practitioners or healthcare personnel that are personal and irrelevant; impertinent or inappropriate comments in medical records impugning quality of care in the Hospital or attacking an individual Practitioner, healthcare personnel, or policy; nonconstructive criticism addressed in a manner to intimidate or undermine confidence; verbally or physically abusing others; damaging Hospital property; or behavior that, in general, compromises the effectiveness of fellow Practitioners or other healthcare personnel. This requirement is not in any way intended to interfere with a Member's privileges: (1) to express opinions freely and to support positions whether or not they are in dispute with those of other Members; (2) to engage in honest differences of opinion with respect to diagnosis and treatment or basic program development that are debated in appropriate forums; or (3) to engage in the good faith criticism of others.

2.6-17 All Members including specialist and sub specialists are required to participate in call in their designated specialty to respond, examine, and treat patients presenting to the Hospital with an emergency medical condition. However, emergency call is not a right, privilege or other entitlement for any member of the Medical Staff, regardless of whether the individual has regularly served on the call schedule or has been requested to serve on the call schedule in the past. When requested or assigned, such duty shall include timely response to the Emergency Department, appropriate participation in call rosters and follow-up care for patients presenting with an emergency medical condition as specified in the Rules and Regulations. While on Emergency Department call, Medical Staff Members are required to respond to requests for inpatient consultations as specified in the Rules and Regulations. Members of the Medical Staff shall also participate in the care of individuals transferred to the Hospital for specialty care subject to the Medical Staff Member's clinical Privileges.

2.6-18 Cooperate with the Hospital to ensure all patients who present to the Hospital and who request examination or treatment for a medical condition or active labor, are evaluated for the existence of an emergency medical condition or active labor. This screening examination may be performed by a Member or AHP, within the scope of his or her Privileges, or a registered nurse; provided, however, a social worker may perform the screening exam if the patient exhibits only psychological symptoms. All such screening shall comply with Medical Staff protocols and be performed or supervised by a Member. Upon a determination that an emergency medical condition or active labor exists, all available medical treatment within the capability of the Hospital will be provided to the patient to alleviate the emergency, deliver the child, or transfer the patient to another hospital in accordance with the Hospital's emergency treatment and transfer policies.

2.6-19 Continuously and promptly inform the Medical Staff of any significant changes in the information required on appointment and reappointment, including professional liability activity. This obligation includes, but is not limited to: immediately advising by telephone and in writing, the Vice President of Medical Affairs of any suspension, curtailment, or revocation of clinical privileges by a healthcare facility; investigation, reprimand, sanction, or discipline by a licensing board; any Medical Staff or other peer review action or recommendation that would entitle the Practitioner to a hearing under Washington law, or of any state licensing or federal regulatory agency accusation or action; and any notice of the Practitioner or his or her representative of actual exclusion from any healthcare program

funded in whole or in part by the federal government, including Medicare or Medicaid.

2.6-20 Continuously meet the qualifications for and perform the responsibilities of membership as set forth in these Bylaws. A Member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws upon the reasonable request of the Medical Executive Committee or the Vice President of Medical Affairs. Members shall cooperate in any physical or mental health evaluation and any other information deemed necessary by the Medical Executive Committee to enable an adequate evaluation of their qualifications.

2.6-21 Cooperate in responding to requests for information (including information from a patient's office medical record) as necessary to enable a full evaluation of the Member's qualifications and current professional competence.

2.6-22 Pay any credentialing fees assessed by the Medical Staff in the amounts specified in the Rules.

ARTICLE 3
CATEGORIES OF THE MEDICAL STAFF

3.1 CATEGORIES

Each Medical Staff Member shall be assigned to a Medical Staff category based upon the qualifications defined in the Rules. The Members of each Medical Staff category shall have the prerogatives and carry out the duties defined in the Bylaws and Rules. Action may be initiated to change the Medical Staff category or terminate the membership of any Member who fails to meet the qualifications or fulfill the duties described in the Rules. Changes in Medical Staff category or voting status shall not be grounds for a hearing unless they adversely affect the Member's Privileges.

ARTICLE 4
PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

The Medical Staff shall consider each application for appointment, reappointment, and privileges, and each request for modification of Medical Staff category using the procedure and the standards set forth in the Bylaws and Rules. The Medical Staff shall also perform this function for Practitioners who seek Temporary Privileges and for AHPs. The Medical Staff shall investigate each applicant before recommending action to the Governing Body, and the Governing Body is ultimately responsible for granting membership and Privileges (provided, however, that these functions may be delegated to the President of the Medical Staff and Chief Executive Officer or their authorized designees with respect to requests for Temporary Privileges). The Medical Staff shall perform this function also for Practitioners who seek Temporary Privileges and for AHPs. By applying to the Medical Staff for appointment or reappointment (or by accepting Honorary and Retired Medical Staff appointment), the applicant agrees that regardless of whether he or she is appointed or granted the requested Privileges, he or she will comply with the responsibilities of Medical Staff membership and with the Medical Staff Bylaws and Rules as they exist and as they may be modified from time to time.

4.2 APPLICANT'S BURDEN

An applicant for appointment, reappointment, advancement, transfer, and/or Privileges shall have the burden of producing accurate and adequate information for a thorough evaluation of the applicant's qualifications and suitability for the requested status or Privileges, resolving any reasonable doubts about these matters and satisfying requests for information. The provision of information containing significant misrepresentations or omissions and/or a failure to sustain the burden of producing information shall be grounds for denying an application or request. This burden may include submission to a medical or psychological examination as provided in the Bylaws or Rules. If membership or Privileges are denied or terminated for misstatements or omissions on the application, the applicant or Member shall not be entitled to any hearing or review unless it is determined that the denial or termination is reportable to the National Practitioner Data Bank or the Washington Medical Quality Assurance Commission, in which case the member or applicant is entitled to a hearing under Article 13.

4.3 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

An applicant for appointment and reappointment shall complete written application forms that request information regarding the applicant and document the applicant's agreement to abide by the Medical Staff Bylaws and Rules (including the standards and procedures for evaluating applicants contained therein) and to release all persons and entities from any liability that might arise from their investigating and/or acting on the application. The information shall be verified and evaluated by the Medical Staff using the procedure and standards set forth in the Bylaws and Rules. Following its investigation, the Medical Executive Committee shall recommend to the Governing Body whether to appoint, reappoint, and grant specific Privileges.

4.3-1 Basis for Appointment

Recommendations for appointment to the Medical Staff and for granting of Privileges shall be based upon the applicant's training, experience, professional references, professional performance at this Hospital and in other settings, whether the applicant meets the qualifications and can carry out all of the responsibilities specified in these Bylaws and the Rules, and upon the Hospital's patient care needs and ability to provide adequate support services and facilities for the Practitioner. The applicant will be notified of the governing body’s decision regarding membership and/or privileges

within 30 days.

4.3-2 Basis for Reappointment

Recommendation for reappointment to the Medical Staff and for renewal of Privileges shall be based upon a reappraisal of the member's performance at this Hospital and in other settings. The reappraisal is to include confirmation of adherence to Medical Staff membership requirements as stated in these bylaws, the Medical Staff Rules, the Medical Staff and Hospital policies, and the applicable service rules. Such reappraisal should also include relevant practitioner-specific information from performance or quality improvement activities and, where appropriate, comparisons to aggregate information about performance, judgment, and clinical or technical skills. Where applicable, the results of specific peer review activities and peer recommendations shall also be considered. The applicant will be notified of the governing body's decision regarding renewal of membership and/or privileges within 30 days.

4.3-3 No Extension of Appointment

If the reappointment application has not been fully processed before the Member's appointment expires, the Medical Staff Member's membership status and Privileges shall be automatically suspended, without entitlement to any hearing or review, until the review is completed. If, in such circumstances, good cause exists for the care of a specific patient or patients and no other health professional currently privileged possesses the necessary skills and is available to provide care to the specific patient(s), the Member may apply for Temporary Privileges while his or her full credentials information is verified and approved. If the delay is due to the Member's failure to timely return the reappointment application form or provide other documentation or cooperation, the appointment shall terminate as provided in the next section. Temporary Privileges do not create a vested right for the Member to be reappointed.

4.3-4 Failure to File Reappointment Application

Failure without good cause to timely (as defined in the Rules) file a completed application for reappointment shall result in the automatic suspension of the Member's admitting and other Privileges and prerogatives at the end of the current Medical Staff appointment unless otherwise extended by the Medical Executive Committee or the President, or the President-Elect, with the approval of the Governing Body. If the Member fails to submit a completed application for reappointment within the time specified in the Rules, the Member shall be deemed to have resigned membership in the Medical Staff. In the event membership terminates for the reasons set forth herein, the Member shall not be entitled to any hearing or review.

4.4 DEPARTURE FROM THE MEDICAL STAFF

4.4-1 Leave of Absence

Members may request a leave of absence, which must be approved by the Medical Executive Committee and cannot exceed 2 years. Reinstatement at the end of the leave must be approved in accordance with the standards and procedures set forth in the Rules for reappointment review. The Member must provide information regarding his or her professional activities during the leave of absence. During the period of the leave, the Member shall not exercise Privileges at the Hospital, and membership rights and responsibilities shall be inactive. Failure to request reinstatement in a timely manner or to provide a requested summary of activities shall be deemed a voluntary resignation from the Medical Staff.

4.4-2 Voluntary Resignation

Any Member who desires to resign from the Medical Staff shall submit a letter of resignation to the President or Medical Staff Services. The effective date of resignation shall be the date of the acknowledgement. The letter shall be acknowledged by and retained in Medical Staff Services. A Member shall not be considered to have resigned from the Medical Staff in good standing until all obligations to the Hospital have been satisfactorily met by the Member, including completion of all medical records.

4.5 WAITING PERIOD AFTER ADVERSE ACTION

4.5-1 Who Is Affected

(a) A waiting period of 24 months shall apply to the following Practitioners:

(1) An applicant who (i) has received a final adverse decision regarding appointment or (ii) withdrew his or her application or request for membership or Privileges following an adverse recommendation by the Medical Executive Committee or the Governing Body;

(2) A former Member who has (i) received a final adverse decision resulting in termination of Medical Staff membership and/or Privileges or (ii) resigned from the Medical Staff or relinquished privileges while an investigation was pending or following the Medical Executive Committee or Governing Body issuing an adverse recommendation; or

(3) A Member who has received a final adverse decision resulting in (i) termination or restriction of his or her Privileges or (ii) denial of his or her request for additional Privileges.

(b) Ordinarily the waiting period shall be 24 months. However, for Practitioners whose adverse action included a specified period or conditions of retraining or additional experience, the Medical Executive Committee may exercise its discretion to allow earlier reapplication upon completion of the specified conditions. Similarly, the Medical Executive Committee may exercise its discretion, with approval of the Governing Body, to waive the 24-month period in other circumstances where it reasonably appears, by objective measures, that changed circumstances warrant earlier consideration.

(c) An action is considered adverse only if it is based on the type of occurrences that might give rise to corrective action. An action is not considered adverse if it is based upon reasons that do not pertain to professional competence or conduct, such as actions based on a failure to maintain a practice in the area (which can be remedied by a move), to pay credentialing fees (which can be remedied by paying credentialing fees), or to maintain professional liability insurance (which can be remedied by obtaining the insurance).

4.5-2 Date When the Action Becomes Final

The 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 Hospital proceedings.

4.5-3 Effect of the Waiting Period

Except as otherwise allowed (per Section 4.5-1(b)), Practitioners subject to waiting periods cannot reapply for Medical Staff membership or the Privileges affected by the adverse action for at least 24 months after the action became final. After the waiting period, the Practitioner may reapply. The application will be processed as an initial application or request, plus the Practitioner shall document that the basis for the adverse action no longer exists, that he or she has corrected any problems that prompted the adverse action, and/or he or she has complied with any specific training or other conditions that were imposed.

4.6 CONFIDENTIALITY; IMPARTIALITY

To maintain confidentiality and to assure the unbiased performance of appointment and reappointment functions, participants in the credentialing process shall limit their discussion of the matters involved to the formal avenues provided in the Bylaws and Rules for processing applications for appointment and reappointment.

4.7 SYSTEM-WIDE COOPERATION

4.7-1 Cooperation in Medical Staff Matters

The Medical Staff may develop, in cooperation with other facilities or entities in the System, a consolidated appointment, reappointment, proctoring, and peer review process that includes, but is not limited to, one application form that will be shared by the facilities, a single investigation and verification of information resulting in information that will be shared by the facilities, sharing of information among the facilities and entities about applicants and members, and joint review of applications. The results of any review and investigation shall be reported to this Medical Staff's committee responsible for credentialing and processing in accordance with these Bylaws and Rules.

4.7-2 General Rules for System-wide Cooperation for Appointments and Reappointments

Practitioners desiring to exercise Privileges through more than one System Affiliate are subject to the following provisions regarding System-wide appointments and reappointments.

4.7-3 System Application Form

A single application form shall be developed for all participating System Affiliates to use, and the applicant shall indicate those System Affiliates in which he or she desires appointment or reappointment to exercise Privileges together with the Privileges desired.

(a) An applicant requesting Privileges in a facility or department subject to an exclusive contracting arrangement must first demonstrate a contractual or employment relationship with the party holding the exclusive contract.

(b) In addition to the provisions of subparagraph (a) above, Privileges at any System Affiliate shall be hospital-specific limited by and specific to the scope of services available at that System Affiliate.

4.7-4 System Investigation; Peer Review

(a) A coordinated investigation, peer review, or proctoring of an applicant, Member, or AHP may be conducted with System Affiliates.

(b) The results of the investigation shall be reported to the Medical Executive Committee for processing in accordance with Sections 4.1 to 4.6 and applicable Medical Staff rules.

4.7-5 Sharing of Information

Information obtained from the application, the verification of information contained in and resulting from the application, and the results of the application review and investigation shall be reported to System Affiliates responsible for credentialing and processing applications.

ARTICLE 5
PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws or the Rules, every Practitioner or AHP providing direct clinical services at this Hospital shall be entitled to exercise only those Privileges specifically granted to him or her.

5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2-1 Requests

(a) Each application for appointment and reappointment to the Medical Staff must contain a request for the specific Privileges desired by the applicant. A request for a modification of Privileges must be supported by documentation of training and/or experience supportive of the request. Privileges are hospital-specific.

(b) Each Service will be responsible for developing Privilege delineation and criteria for granting Privileges, and including such delineation and criteria in the Service's Rules.

(c) Privileges may be requested only if the applicant has the qualifications and credentials required by the Governing Body for exercise of the Privilege.

5.2-2 Bases for Privilege Determinations

Requests for Privileges shall be evaluated on the basis of the Practitioner's education, training, experience, demonstrated professional competence and judgment, clinical performance, the documented results of patient care and other quality improvement review and monitoring, performance of a sufficient number of procedures each year to develop and maintain the Practitioner's skills, knowledge and compliance with any specific criteria applicable to the Privileges, and ethical behavior. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a Practitioner exercises or has had privileges.

5.3 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

5.3-1 Admissions

(a) Dentist, oral surgeon, and podiatrist Members may admit patients only if a physician Member is notified prior to admission and agrees to assume responsibility for the care of the patient's medical problems during hospitalization that are outside of the limited license Practitioner's lawful scope of practice.

(b) Limited license Practitioners are responsible for the part of the patient's history and physical examination that relates to their area of practice for which they hold Privileges. All ambulatory surgery patients admitted by limited license Practitioners must have medical histories taken and appropriate physical examination performed by a qualified physician Member.

5.3-2 Surgery and High Risk Intervention

The findings, conclusions, and assessment of risk must be confirmed or endorsed by a Physician Member with appropriate Privileges, prior to major high-risk (as defined by the responsible department) diagnostic or therapeutic interventions.

5.3-3 Medical Appraisal

All patients admitted for care in a Hospital by a dentist, oral surgeon, or podiatrist shall receive the same basic medical appraisal as patients admitted by other physician Members, and a physician Member or a limited license Practitioner with appropriate Privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician Member and a limited license Practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license Practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Services; if the treatment cannot reasonably be suspended, the judgment of the physician Member shall prevail.

5.4 TEMPORARY PRIVILEGES AND LOCUM TENENS

5.4-1 Circumstances

Temporary Privileges may be granted by the CEO or authorized designee on recommendation of the Medical Staff President or authorized designee after appropriate application:

(a) For a 60-day period, subject to one 60-day renewal during the pendency of an application; or

(b) For Practitioners who will serve as locum tenens for a Medical Staff Member, for a period not to exceed 90 days;

(c) All individuals with Temporary Privileges granted under this paragraph shall be under the supervision of the department Chair or his or her designee;

(d) As otherwise necessary to fulfill an important patient need.

5.4-2 Application and Review

(a) Temporary Privileges may be granted after the Practitioner or AHP completes the application procedure and the Medical Executive Committee completes the application review process described in the Rules.

(b) There is no right to Temporary Privileges. Accordingly, Temporary Privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting Practitioner's or AHP's qualifications, ability, and judgment to exercise the Privileges requested, and only after the Practitioner or AHP has demonstrated compliance with the Rules upon favorable recommendation to the Medical Executive Committee.

(c) If the available information is inconsistent or casts any reasonable doubts on the applicant's qualifications, action on the request for Temporary Privileges be deferred until the doubts have been satisfactorily resolved.

(d) Temporary Privileges may be granted by the Chief Executive Officer (or his or her designee), on the recommendation of the Campus Chief of Staff or the Service chair where the Privileges will be exercised, or either's designee.

(e) A determination to grant Temporary Privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff.

5.4-3 General Conditions and Termination

(a) Practitioners granted Temporary Privileges shall be subject to the proctoring or supervision specified in the Rules.

(b) Temporary Privileges shall automatically terminate at the end of the designated period, unless earlier terminated or affirmatively renewed as provided in the Bylaws or the Rules.

(c) Temporary Privileges may be terminated with or without cause at any time by the President, Campus Chief of Staff, the responsible Service chair, or their designees, with the concurrence of the Vice President of Medical Affairs, or by the Vice President of Medical Affairs after conferring with the Chief of Staff or the responsible Service chair. In all cases of termination of or deferral in acting on a request for Temporary Privileges, the Practitioner shall not be entitled to any procedural rights afforded by Bylaws Article 13 based upon any adverse action involving Temporary Privileges.

(d) Whenever Temporary Privileges are terminated, the appropriate department chair or, in the chair's absence, the President shall assign a Member to assume responsibility for the care of the Practitioner's patients. The wishes of the patients and affected Practitioner shall be considered in the choice of a replacement Member.

(e) All persons requesting or receiving Temporary Privileges shall be bound by the Bylaws and Rules.

5.5 EMERGENCY PRIVILEGES

5.5-1 In the event of an emergency, any Member of the Medical Staff or credentialed AHP shall be permitted to do everything reasonably possible, within the scope of his or her education, training, experience, and licensure, to save the life of any patient or to save any patient from serious harm. The Member or AHP shall promptly yield such care to a more qualified Member when one becomes available.

5.5-2 In accordance with MHS' policy & procedure for emergency credentialing, the Vice President of Medical Affairs or designee, the President of the Medical Staff, or designee, and/or the Campus Chief of Staff, may grant temporary emergency privileges to Physicians and Allied Health Professionals in the event of an emergency or disaster situation in which the credentialed and privileged Medical Staff and/or Allied Health Professionals are unable to meet MHS' patient care needs.

5.6 PROCTORING AND MONITORING

5.6-1 General Proctoring and Monitoring Requirements

(a) Except as otherwise determined by the Medical Executive Committee or Governing Body, all initial appointees to any category of the Medical Staff and all Members granted new Privileges may be subject to a period of monitoring or proctoring in accordance with standards and procedures set forth in the Rules. In addition, Members may be required to be monitored or proctored as a condition of renewal of Privileges (for example, when a Member requests renewal of a Privilege that has been performed so infrequently that it is difficult to assess the Member's current competence in that area). Proctoring and monitoring may also be implemented whenever a Medical Executive Committee or Governing Body determines that additional information is needed to assess a Practitioner's performance. Proctoring and monitoring are not viewed as a disciplinary measure, but rather is an information-gathering measure. Therefore, it should be imposed for the specific period and/or number of cases, determined by the Medical Executive Committee or Governing Body to be reasonably necessary to enable such assessment. Proctoring and monitoring do not give rise to the procedural rights described in Article 13. Proctoring is arranged by the Member, is at his or her expense, and is subject to the approval of the responsible Service Chair. Proctors shall not be practice partners or other Practitioners with a direct financial interest in the Member’s practice.

(b) During the monitoring or proctoring, the Practitioners must demonstrate they are qualified to exercise the Privileges that were granted and are carrying out the duties of their Medical Staff category.

5.6-2 Completion of Monitoring or Proctoring

Monitoring or Proctoring shall be deemed successfully completed when the Practitioner completes the required number of monitored or proctored cases within the time frame established in the Bylaws and the Rules, and the Practitioner's professional performance in the cases met the standard of care of the Hospital.

5.6-3 Effect of Failure to Complete Monitoring or Proctoring

(a) Failure to Complete Necessary Volume: Any Member who fails to complete the required number of monitored or proctored cases within the time frame established in the Rules shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant Privileges), and he or she shall not be afforded the procedural rights provided in Article 13. However, the department has the discretion to extend the time for completion of monitoring or proctoring in appropriate cases subject to ratification by a Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in Article 13.

(b) Failure to Satisfactorily Complete Monitoring or Proctoring: If a Practitioner completes the necessary volume of monitored or proctored cases but fails to perform satisfactorily during monitoring or proctoring, he or she may be terminated as a Member (or the relevant Privileges may be revoked), and he or she shall be afforded the procedural rights as provided in Article 13.

(c) Services Provided in Absence of Required Proctor: Any Practitioner who provides services when a proctor is required but when no proctor is present, shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant Privileges), and he or she shall not be afforded the procedural rights provided in Article 13. In addition, such a Practitioner is subject to disciplinary action by the Medical Staff.

(d) If a change in membership category is approved prior to completion of monitoring or proctoring, the monitoring or proctoring will continue for the specified Privileges. The specific Privileges may be voluntarily relinquished or terminated if monitoring or proctoring is not completed thereafter within a reasonable time.

5. 7 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT

Every Practitioner or AHP providing direct clinical services at this Hospital agrees to participate in the "organized health care arrangement" described in and on the terms set forth in the Rules. The organized health care arrangement described in the Rules has been declared and established in accordance with the HIPAA "Standards for Privacy of Individually Identifiable Health Information" ("Privacy Rules"), 45 C.F.R. Subtitle A, Subchapter C, Parts 160 and 164. The organized health care arrangement participation terms set forth in the Rules have been established to allow MHS and the independent Practitioners and AHPs providing care at the Hospital to better serve MHS patients, and to facilitate the exchange of "protected health information" (as such term is used in the Privacy Rules) among MHS, Practitioners, AHPs and other health care professionals providing care in a clinically integrated care setting at the Hospital.

ARTICLE 6
ALLIED HEALTH PROFESSIONALS

6.1 QUALIFICATIONS OF ALLIED HEALTH PROFESSIONALS

Allied health professionals (AHPs) are not eligible for Medical Staff membership, and accordingly, have none of the privileges of Medical Staff membership. They may be granted practice Privileges if they hold a license, certificate, or other credentials of a type of AHPs that the Governing Body (after securing Medical Executive Committee comments) has identified as eligible to apply for practice Privileges, and only if the AHPs are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and Rules.

6.2 TYPES

The Governing Body shall determine, based upon comments of the Medical Executive Committee and such other information as it has before it, those types of AHPs that shall be eligible to exercise Privileges in the Hospital. Such AHPs shall be subject to the supervision requirements developed in each department and approved by the Medical Executive Committee and the Governing Body.

6.3 PRIVILEGES AND RESPONSIBILITIES

6.3-1 AHPs may exercise only those Privileges specifically granted them by the Governing Body. The range of Privileges for which each AHP may apply and any special limitations or conditions to the exercise of such Privileges shall be based on recommendations of the Medical Executive Committee, subject to approval by the Governing Body. The Governing Body has final authority in granting Privileges and may grant AHPs Privileges without recommendation of any Committee.

6.3-2 Application for privileges from AHPs will be rejected unless the Governing Body has approved exercise of the requested Privileges by the type of AHP making application. In determining the need for a type of AHP to have a particular Privilege, the Governing Body shall consider, on the recommendation of the Medical Executive Committee, types of AHPs required to appropriately render care to hospitalized patients.

In determining need, the Governing Body will also consider at least the following:

1) Licensure as an independent practitioner; i.e., scope of practice allows patient management functions independent of requesting physician's direct supervision;

2) Availability of the same services offered by the Medical Staff, accepting the highest standard of care; and

3) Standard of care in the community.

Licensure shall not be the sole criterion for determining need and scope of services.

6.3-3 An AHP must apply and qualify for practice Privileges, and Practitioners who desire to supervise or direct AHPs who provide dependent services must apply and qualify for Privileges sufficient to supervise approved AHPs. Applications for initial granting of practice Privileges and biennial renewal thereof shall be submitted and processed in a similar manner to that provided for Practitioners, unless otherwise specified in the Rules.

6.3-4 Each AHP shall be assigned to the department appropriate to his or her occupational or professional training and, unless otherwise specified in these Bylaws or the Rules, shall be subject to terms and conditions similar to those specified for Practitioners as they may logically be applied to AHPs and appropriately tailored to the particular AHP.

6.4 PROCEDURAL RIGHTS OF ALLIED HEALTH PROFESSIONALS

6.4-1 Overview

(a) Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an AHP to the procedural rights set forth in Article 13.

(b) A MHS employed AHP shall have procedural rights, if any, as provided under the Hospital's standard terms of employment.

(c) An AHP not employed by MHS shall have a right to informal hearing and appeal proceedings to challenge any action that would constitute grounds for a hearing under Section 13.2 of the Bylaws by filing a written grievance with the campus Medical Executive Committee within 30 days of notification of such action. Upon receipt of such a grievance, the Medical Executive Committee shall authorize the Chief Executive Officer or his or her designee to arrange an informal hearing to be conducted by one or more persons to be appointed by the Chief Executive Officer. The hearing committee may, but need not, be comprised of AHPs or members of the Medical Staff; however, in cases involving clinical competency or clinical performance, and subject to feasibility, the Chief Executive Officer 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 13, subject to the discretion of the Chief Executive Officer 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 Professional Activities Committee of 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 Body (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, prerogatives, or conditions of such decision.

6.4-2 Automatic Termination

Notwithstanding the provisions of Section 6.4-1 above, an AHP's Privileges shall automatically terminate or be suspended, without review pursuant to Section 6.4-1 or any other section of these Bylaws, in the event:

(a) The Medical Staff membership of the supervising Practitioner is terminated or suspended, whether such termination is voluntary or involuntary;

(b) The supervising Practitioner no longer agrees to act as the supervising Practitioner for any reason, or the relationship between the AHP and the supervising Practitioner is otherwise terminated, regardless of the reason therefore;

(c) The AHP's certification or license expires, is revoked, or is suspended, or the AHP is excluded from a federally-funded healthcare program.

(d) The AHP's employment at MHS is terminated.

6.4-3 Review of Type of AHP Decisions

The rights afforded by this section shall not apply to any decision regarding whether a type of AHP shall or shall not be eligible for practice Privileges and the terms, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the Governing Body, which has the discretion to decline to review the request or to review it using any procedure the Governing Body deems appropriate.

6.5 PREROGATIVES

The prerogatives that may be extended to an AHP shall be defined in the Rules and/or Hospital policies. Such prerogatives may include:

6.5-1 Provision of specified patient care services under the supervision or direction of a Medical Staff Member and consistent with the practice Privileges granted to the AHP and within the scope of the AHP's licensure or certification.

6.5-2 Service on Medical Staff, department, and Hospital committees without vote unless the statement of committee composition designates otherwise.

6.5-3 Attendance at meetings of the department to which the AHP is assigned, as permitted by the department Rules, and attendance at Hospital education programs in the AHP's field of practice.

6.6 RESPONSIBILITIES

Each AHP shall:

6.6-1 Meet those responsibilities required by the Rules and as specified for Practitioners in Section 2.6, as modified to reflect the more limited practice of the AHP.

6.6-2 Retain appropriate responsibility within the AHP's area of professional competence for the care and supervision of each patient in the Hospital for whom the AHP is providing services.

6.6-3 Participate in peer review and quality improvement and in discharging such other functions as may be required from time to time.

6.6-4 Act with professional demeanor and follow professional ethical guidelines of applicable professional societies.

ARTICLE 7
MEDICAL STAFF OFFICERS, AT-LARGE MEMBERS, AND VICE PRESIDENT OF MEDICAL AFFAIRS

7.1 MEDICAL STAFF OFFICERS - GENERAL PROVISIONS

7.1-1 Identification

(a) There shall be the following general officers of the Medical Staff:

(1) President;

(2) Two Campus Chiefs of Staff, one each from the Tacoma General campus and the Allenmore campus; and

(3) Two Campus Chiefs of Staff Elect, one each from the Tacoma General campus and the Allenmore campus.

(b) In addition, the At-Large Members, Medical Staff Service committee chairs, and ad hoc committee chairs shall be deemed Medical Staff officers within the meaning of state and federal laws.

7.1-2 Qualifications

All Medical Staff officers shall:

(a) Understand the purposes and functions of the Medical Staff and demonstrate willingness to assure that patient welfare always takes precedence over other concerns;

(b) Understand and be willing to work towards attaining the Hospital's lawful and reasonable policies and requirements;

(c) Have administrative ability as applicable to the respective office;

(d) Be able to work with and motivate others to achieve the objectives of the Medical Staff and Hospital;

(e) Demonstrate clinical competence in his or her field of practice;

(f) Be Active Medical Staff Members (and remain in good standing as Active Medical Staff Members while in office);

(g) Not have any significant conflict of interest; and

(h) Not presently serve as a medical staff officer or employee, department chief, or committee chair, or equivalent, at another hospital, HMO, or PHO, and not so serve during the term of office.

7.1-3 Disclosure of Conflict of Interest

All nominees for election or appointment to Medical Staff offices (including those nominated by petition of the Medical Staff pursuant to Section 7.2-3) shall, at least 20 days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. A conflict of interest occurs if an outside interest or activity may influence a person's ability to exercise objectively or meet the person's responsibilities for the Medical Staff. The Medical Executive Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a nominee with a significant conflict remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

7.2 METHOD OF SELECTION - GENERAL OFFICERS, AT-LARGE MEMBERS

7.2-1 Selection of President, Campus Chiefs of Staff, Campus Chiefs of Staff Elect, and At-Large Members

(a) The office of President will alternate between Campus Chiefs of Staff who shall successively accede to the position upon completion of their term. The term of this office will be two (2) years. The President of Tacoma General/Allenmore Hospital and the President of Mary Bridge Children's Hospital will alternate, annually, serving as Chair of the Medical Executive Committee.

(b) Each Campus Chief of Staff Elect shall each accede to the position of Campus Chief of Staff at his or her campus upon completion of his or her term.

(c) Each Campus Chief of Staff Elect shall be elected by the Medical Staff. A qualified Member of the Medical Staff may vote only for a candidate seeking election as a Campus Chief of Staff Elect at a campus to which the Member is assigned for voting purposes.

(d) Each At-Large Member shall be elected by the Medical Staff. A qualified Member of the Medical Staff may vote only for a candidate seeking election as an At-Large Member at a campus to which the Member is assigned for voting purposes.

7.2-2 Nominating Committee

At each campus, an ad hoc nominating committee composed of the President, the Campus Chief of Staff, the Campus Chief of Staff Elect, the two most recent available past Campus Chiefs of Staff (or equivalent), Vice President of Medical Affairs and the Campus Administrator shall develop a slate of candidates meeting the qualifications of office, as described in Section 7.1-2 above. This slate shall be developed at least 45 days prior to the scheduled election. At least one candidate shall be nominated at each campus for Chief of Staff Elect and each expiring At-Large Member position.

7.2-3 Nomination by Petition

The Medical Staff may nominate candidates for office by a petition signed by at least 25 Members who are eligible to vote and a statement from the candidate signifying willingness to run. Such nominations must be received by the President at least 30 days prior to the scheduled elections.

7.2-4 Election

The nominees shall be submitted to the Medical Staff for election. The election shall be by mail ballot, and the outcome shall be determined by a majority of the votes cast by mail ballots that are returned to Medical Staff Services within 15 days after the ballots were mailed to the voting Medical Staff Members. A Medical Staff Member may vote only for the nominees standing for election as the Chief of Staff Elect and At-Large Member at a campus to which he or she is qualified for voting purposes.

7.2-5 Governing Body Approval

The slate of officers elected together with the disclosure information provided pursuant to Section 7.1-3, will be presented to the Governing Body for its approval. Governing Body disapproval of any or all officers elected must be accompanied by a written statement to all voting Medical Staff Members of the specific reasons therefore. Thereafter a new slate or individuals shall be nominated and the process, including election, repeated. The officers elected shall be deemed approved unless the Governing Body acts otherwise within 45 days.

7.2-6 Term of Office

(a) Officers shall be elected in the fall of every other year and shall take office the following January 1.

(b) Beginning with those elected for the 2009 Medical Staff year, the term of office shall be two years.

7.2-7 Qualification for Voting Purposes

An Active Member who had in excess of 12 patient contacts at the campus in the past Medical Staff Year may vote at that campus. If such a member desires a ballot but does not receive one, he or she shall immediately contact Medical Staff Services.

7.3 RECALL OF OFFICERS

A Medical Staff officer may be recalled from office for any valid reason, including, but not limited to, failure to carry out the duties of his or her office. Except as otherwise provided, recall of a Medical Staff officer may be initiated by the Medical Executive Committee or by a petition signed by at least 33-1/3 percent of the Medical Staff Members eligible to vote for the Medical Staff officer; but recall itself shall require a 66-2/3 percent vote of a quorum of the Medical Executive Committee or 66-2/3 percent vote of a quorum of the Medical Staff Members eligible to vote for the Medical Staff officer.

7.4 FILLING VACANCIES

Vacancies created by resignation, removal, death, or disability shall be filled as follows:

7.4-1 A vacancy in the office of President shall be filled by a selection by the Medical Executive Committee.

7.4-2 A vacancy in the office of Campus Chief of Staff shall be filled by the Chief of Staff Elect of the same campus. A vacancy in the office of a Campus Chief of Staff Elect or a Member At-Large shall be filled by special election held in general accordance with Section 7.2.

7.5 DUTIES OF OFFICERS

7.5-1 President

The President shall serve as the chief officer of the Medical Staff. The duties of the President shall include, but not be limited to:

(a) Enforcing the Medical Staff Bylaws and Rules, promoting quality of care, implementing sanctions when indicated, and promoting compliance with procedural safeguards when corrective action has been requested or initiated;

(b) Calling, presiding at, and being responsible for the agenda of all meetings in which the entire Medical Staff is invited;

(c) Serving as a member of the Medical Executive Committee;

(d) Serving as an Ex Officio member of all other Medical Staff committees except Hearing Committees;

(e) Appointing, after consulting with the Medical Executive Committee, committee members for any standing, ad hoc, and special Medical Staff liaison, or multi-disciplinary committees that are not appointed by the Campus Chiefs of Staff, and designating the chairs of these committees;

(f) Coordinate Medical Staff external professional and public relations with the Vice President of Medical Affairs;

(g) Serving on liaison committees with the Governing Body and Administration, as well as outside licensing or accreditation agencies;

(h) Regularly reporting to the Governing Body on the performance of Medical Staff functions and communicating to the Medical Staff any concerns expressed by the Governing Body;

(i) In the interim between Medical Executive Committee meetings, performing those responsibilities of the Committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the Committee;

(j) Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff, or the Medical Executive Committee; and

(k) Appointing a Campus Chief of Staff to act in the President's absence.

7.5-2 Campus Chief of Staff

The Campus Chief of Staff shall serve as the chief officer of the Medical Staff at the campus at which he or she was elected. The duties of the Campus Chief of Staff shall include, but not be limited to the following at the campus at which he or she was elected:

(a) Enforcing the Medical Staff Bylaws and Rules, promoting quality of care, implementing sanctions when indicated, and promoting compliance with procedural safeguards when corrective action has been requested or initiated;

(b) Calling, presiding at, and being responsible for the agenda of all meetings at which the entire campus Medical Staff is invited;

(c) Serving as a member of the Medical Executive Committee;

(d) Serving as an Ex Officio member of all other campus Medical Staff committees except Hearing Committees;

(e) Appointing, after consulting with the campus Medical Executive Committee, campus-specific committee members for all standing, ad hoc, and special Medical Staff liaison, or multi-disciplinary committees, and designating the chairs of these committees unless provided otherwise in the provision creating the committee;

(f) Coordinate the campus Medical Staff external professional and public relations with the Vice President of Medical Affairs;

(g) Serving on liaison committees with the Medical Executive Committee and Administration, as well as outside licensing or accreditation agencies;

(h) Regularly reporting to the Medical Executive Committee on the performance of campus Medical Staff functions and communicating to the campus Medical Staff any concerns expressed by the Medical Executive Committee;

(i) In the interim between Medical Executive Committee meetings, performing those responsibilities of the Committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meting of the Committee;

(j) At the request of the President, fulfilling the duties of the President in his or her absence; and

(k) Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff, or the Medical Executive Committee.

7.5-3 Chiefs of Staff Elect at Each Campus

The Chief of Staff Elect at each campus shall assume all duties and authority of the Campus Chief of Staff of that campus in the absence of the Campus Chief of Staff. The Chiefs of Staff Elect shall be members of the Medical Executive Committee and shall perform such other duties as the Campus Chief of Staff may assign or as may be delegated by these Bylaws or the campus Medical Executive Committee.

7.5-4 [Reserved]

7.6 VICE PRESIDENT OF MEDICAL AFFAIRS

7.6-1 Appointment

The. Vice President of Medical Affairs shall be appointed by the Chief Operating Officer.

7.6-2 Responsibilities

(a) The Vice President of Medical Affairs' duties shall be delineated by the Chief Operating Officer in keeping with the general provisions set forth in subparagraph (b) below. An officer of the Medical Staff shall approve any Vice President of Medical Affairs duties that relate to authority to perform functions on behalf of the Medical Staff or directly affect the performance or activities of the Medical Staff. The Vice President of Medical Affairs may designate another MHS employed physician to act on his or her behalf.

(b) In keeping with the foregoing, the Vice President of Medical Affairs shall:

(1) Serve as administrative liaison among Hospital administration, the Governing Body, outside agencies, and the Medical Staff;

(2) Perform those duties assigned to him or her in the Bylaws and Rules;

(3) Assist the Medical Staff in performing its assigned functions and coordinating such functions with the responsibilities and programs of the Hospital; and

(4) In cooperation and close consultation with the President and the Medical Executive Committee, supervise the day-to-day performance of Medical Staff Services and the Hospital's quality improvement personnel.

(5) The Vice President of Medical Affairs also serves as a representative and agent of all quality management and peer review committees. Acts taken by the Vice President of Medical Affairs separate from but on behalf of quality assurance and peer review committees are fully protected by all state and federal quality assurance and peer review laws.

7.6-3 Participation in Medical Staff Committees

The Vice President of Medical Affairs:

(a) Shall be an Ex Officio member, without vote, of all Medical Staff committees, but shall not be a member on Hearing committees.

(b) May attend any meeting of any Service or section.

ARTICLE 8
COMMITTEES

8.1 GENERAL

8.1-1 Designation

The Medical Executive Committee, Service Committees and the other committees described in these Bylaws and the Rules shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee or a Service to perform specified tasks. Any committee, including department or other clinical unit, or standing or ad hoc, that is carrying out all or any portion of a function or activity required by these Bylaws is deemed a duly appointed and authorized committee of the Medical Staff.

8.1-2 Appointment of Members

(a) Unless otherwise specified, the chair and members of all campus-specific committees shall be appointed by and may be removed by that campus's Campus Chief of Staff, and all integrated committees shall be appointed by and may be removed by the President, subject to consultation with and approval by the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee.

(b) A Medical Staff committee created in these Bylaws is composed as stated in the description of the committee in these Bylaws or the Rules. Except as otherwise provided in the Bylaws, committees established to perform Medical Staff functions required by these Bylaws may include any category of Medical Staff Members; allied health professionals; representatives from Hospital departments such as Administration, Nursing Services, or Health Information Management; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff Member who serves on a Committee participates with vote and non-Medical Staff Members serve without a vote unless the statement of committee composition designates otherwise.

(c) The Chief Executive Officer, or his or her designee, in consultation with the President, shall appoint any non-Medical Staff members who serve in non-Ex Officio capacities.

(d) The committee chair, after consulting with the President (or Campus Chief of Staff) and Vice President of Medical Affairs (or his or her designee), may call on outside consultants or special advisors.

(e) Each committee chair shall appoint a Chair Elect to fulfill the duties of the chair in his or her absence and to assist as requested by the chair. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

8.1-3 Representation on Hospital Committees and Participation in Hospital Deliberations

The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing Medical Staff representation on Hospital committees established to perform such functions.

8.1-4 Ex Officio Members

The President, Campus Chiefs of Staff, Campus Chiefs of Staff Elect, the Chief Executive Officer, the Medical Staff Services Officer, Chief Operating Officer, , or their respective designees, are Ex Officio members of all standing and special committees, except hearing committees, of the Medical Staff and shall serve without vote unless provided otherwise in the provision or resolution creating the committee.

8.1-5 Action Through Subcommittees

Any standing committee may use subcommittees to help carry out its duties. The Medical Executive Committee shall be informed when a subcommittee is appointed. The committee chair may appoint individuals in addition to or other than members of the standing committee to the subcommittee after consulting with the President or Campus Chief of Staff regarding Medical Staff Members, and the Vice President of Medical Affairs regarding Hospital staff. Each chair shall designate which members are eligible to vote on subcommittee actions.

8.1-6 Terms and Removal of Committee Members

Unless otherwise specified, a committee member shall be appointed for a term of two years, subject to unlimited renewal, and shall serve until the end of this period or until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee. Any committee member who is appointed by the President or Campus Chief of 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 a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

8.1-7 Vacancies

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

8.1-8 Conduct and Records of Meetings

Committee meetings shall be conducted and documented in the manner specified for such meeting in Article 10 of the Bylaws.

8.1-9 Attendance of Nonmembers

Any Medical Staff Member who is in good standing may ask the chair of any committee for permission to attend a portion of that committee's meeting dealing with a matter of importance to that Practitioner. The committee chair shall have the discretion to grant or deny the request and shall grant the request only if the Member's attendance will reasonably aid the committee to perform its function. If the request is granted, the invited Member shall not vote, shall abide by all Bylaws and Rules applicable to that committee, and shall attend only the portion of the meeting dealing with the matter about which an invitation to attend was extended.

8.1-10 Accountability

All Medical Staff committees shall be accountable to the Medical Executive Committee.

8.2 MEDICAL EXECUTIVE COMMITTEE

8.2-1 Composition

The Medical Executive Committee shall be composed of the following voting members: President Tacoma General/Allenmore Hospital; President Mary Bridge Children's Hospital; President-Elect Mary Bridge Children's Hospital; Campus Chiefs of Staff Tacoma General and Allenmore Hospital; 3 Members-at-Large from each of Tacoma General campus, Allenmore Campus and Mary Bridge Children's Hospital; Service Committee Chairs, 3 representatives from the Professional Activities Committee; Representative of MultiCare Medical Associates; P & T Committee Chair; GME Committee Chair; Family Practice Representative.

The following shall serve as Non-voting members: Vice President of Medical Affairs; Chief Nurse Executive; Quality Management Department representative; Medical Director, Mary Bridge Children's Hospital; MHS Legal Services representative and Medical Staff Office representative.

8.2-2 Duties

The Medical Executive Committee shall:

(a) Oversee the performance of all Medical Staff functions, which shall include:

(1) Requiring regular reports and recommendations from the Medical Staff committees;

(2) Issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and

(3) Following up to assure implementation of all directives.

(b) Coordinate the activities of the Medical Staff committees.

(c) Based upon input from the Service Committees, make recommendations to the Governing Body regarding applications for Medical Staff appointment, reappointment, and Privileges.

(d) When indicated, initiate and/or pursue disciplinary or corrective actions affecting Medical Staff Members.

(e) With the assistance of the President, oversee the Medical Staff's compliance with:

(1) The Medical Staff Bylaws, Rules, and policies;

(2) The Hospital's Bylaws, Rules, and policies;

(3) State and federal laws and regulations; and

(4) Joint Commission accreditation requirements.

(f) Ensure that the Medical Staff committees have set objectives for establishing, maintaining and enforcing professional standards within the Hospital, and for the continuing improvement of the quality of care rendered in the Hospital.

(g) Regularly report to the Governing Body through the President on at least the following:

(1) The outcomes of Medical Staff quality improvement programs with sufficient background and detail to assure the Governing Body that quality of care is consistent with professional standards; and

(2) The general status of any Medical Staff disciplinary or corrective actions in progress.

(h) Make recommendations to the Governing Body regarding the structure of the Medical Staff, the Medical Staff Bylaws and Rules, the mechanism used to review credentials and to delineate individual Privileges, the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities, the mechanism by which membership on the Medical Staff may be terminated, and the mechanism for hearing procedures.

(i) Establish, as necessary, such ad hoc committees that will fulfill particular functions for a limited time.

(j) Establish the date, place, time, and program of any meetings of the entire Medical Staff.

(k) Oversee the activities of the Pediatric Trauma Committee, Clinical Oversight Group, Physician Wellness, Cancer, Pharmacy and Therapeutics, Bylaws, Adult Trauma and Allied Health Committees.

8.2-3 Meetings

The Medical Executive Committee should be scheduled to meet on a monthly basis and shall meet at least 10 times during the calendar year.

8.3 MEDICAL STAFF OPERATIONS COMMITTEE

8.3-1 Composition

The Medical Staff Operations Committee shall be composed of the TG Campus Chief of Staff, the AH Campus Chief of Staff; President-elect, Mary Bridge Children's Hospital; Medical Director, Mary Bridge Children's Hospital; one Representative from each of the following: Adult Medical Services, Pediatric Medical Services, Graduate Medical Education, Surgical Services, Diagnostic/Procedural Services; Women's Health Services; Adult and Pediatric Trauma Services; MHS Administration. The TG Campus Chief of Staff, AH Campus Chief of Staff or the President-elect, Mary Bridge Children's Hospital or such other member appointed by the Medical Executive Committee shall chair the Medical Staff Operations Committee.

8.3-2 Duties

The Medical Operations Committee shall:

(a) Oversee the development of medical staff policies, approve (or disapprove) all such policies, and oversee the implementation of such policies.

(b) Ensure implementation of the approved policies of the Hospital as they relate to the medical staff.

(c) Coordinate and oversee the activities of the Transfusion, New Technology, Ethics, Radiation Safety and Imaging Services, Infection Control, Code 4, Sedation , and Clinical Documentation Committees.

(d) Regularly report to the Medical Executive Committee.

8.3-3 Meetings

The Medical Staff Operations Committee should be scheduled to meet on a monthly basis and should meet at least 10 times during the calendar year.

8.4 PEER REVIEW COMMITTEE

8.4-1 Composition

The Peer Review Committee shall be composed of 10 members from the Active Staff categories of the Tacoma General-Allenmore and Mary Bridge Children's Hospital medical staffs. There shall be two Members elected by and representing from each of the following Services: Pediatric Medical Services, Adult Medical Services, Diagnostic/Procedural Services, Women's Health Services, and Surgical Services.

The following shall serve as non-voting members:

8.4-2 Duties

The Peer Review Committee shall:

(a)

(b)

(c)

(d) When indicated, initiate peer review and/or recommend disciplinary or corrective actions affecting Medical Staff Members.

(e) Regularly report to the Medical Executive Committee.

8.4-3 Meetings

ARTICLE 9
SERVICES

9.1 CURRENT MEDICAL STAFF SERVICES The current medical staff Services are:

Surgical Services
Diagnostic/Procedural Services
Adult Medical Services
Pediatric Medical Services
Women's Health Services

9.2 FUTURE MEDICAL STAFF SERVICES

The Medical Executive Committee will periodically restudy the designation of the medical staff Services and recommend to the Governing Body what action is desirable in creating, eliminating, or combining Services for better organizational efficiency and improved patient care. Action shall be effective upon approval by the Governing Body.

9.3 ASSIGNMENT TO SERVICES; CAMPUS

Each Member shall be assigned membership in a Service, but may also be granted Privileges in other Services consistent with the Privileges granted. Each Member shall be assigned to one or both campuses to fulfill the responsibility of participating on a roster providing backup call for the Emergency Services and initial follow-up care for patients seen in the Emergency Services. Such assignment shall be made following review of the Member's request for assignment, practice activity at each campus, and other factors by the Medical Executive Committee.

9.4 FUNCTIONS OF SERVICES

The Services shall fulfill the clinical, administrative, quality improvement/risk management/utilization management, and collegial and education functions described in the Rules. When the Service or any of its committees meet to carry out the duties described below, the meeting body shall constitute a peer review committee, which is subject to the standards and entitled to the protections and immunities afforded by federal and state law for peer review committees. Each Service or its committees, if any, must meet regularly to carry out its duties.

9.5 SERVICE CHAIR AND SERVICE CHAIR ELECT

9.5-1 Qualifications

Each Service Chair and Service Chair Elect shall be Active Medical Staff Members, shall have demonstrated ability in at least one of the clinical areas covered by the Service and shall be willing and able to faithfully discharge the functions of his or her office. Specific qualifications shall be set forth in the Rules.

9.5-2 Selection

Service chairs shall be elected by the Service committee and approved by the Medical Executive Committee. Candidates shall be selected by the nominating procedures described in the Rules.

9.5-3 Term of Office Each Service Chair and Chair Elect shall serve a 2-year term, the expiration of which coincides with the Medical Staff Year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or Privileges in that Service. Service officers are eligible to succeed themselves.

9.5-4 Removal

A Service officer may be removed for failure to cooperatively and effectively perform the responsibilities of his or her office. Removal may be initiated by the Medical Executive Committee or by written request from 20 percent of the Members of the Service committee who are eligible to vote on Service matters. Such removal may be effected by a 66-2/3 percent vote of a quorum of the Medical Executive Committee members or by a 66-2/3 percent vote of a quorum of the Service committee. The procedures for effecting removal shall be as described in the Rules.

9.5-5 Responsibilities of Service Officers

Specific responsibilities of Service officers shall be as set forth in the Rules.

9.6 SECTIONS

Within each Service, the Practitioners of the various specialty groups may organize themselves as a clinical section. Each section may develop Rules specifying the purpose, responsibilities, and method of selecting officers. These Rules shall be effective when approved as required by Article 14. While sections may assist Services in performance of service functions, responsibility and accountability for performance of Service functions shall remain at the Service level.

ARTICLE 10
MEETINGS

10.1 MEDICAL STAFF MEETINGS

10.1-1 Medical Staff Meetings

Meetings of the entire Medical Staff may be called at any time by the President, Medical Executive Committee, or Governing Body, or upon the written request of 10 percent of the voting Members. The meeting must be called within 30 days after receipt of such request. No business shall be transacted at any special meeting except that stated in the Notice calling the meeting.

10.1-2 Combined or Joint Medical Staff Meetings

The Medical Staff may participate in combined or joint medical staff meetings with staff members from other hospitals, healthcare entities, or the Pierce County Medical Society; however, precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed, and to assure that the Medical Staff (through its authorized representative) maintains access to and approval authority of all minutes prepared in conjunction with any such meetings.

10.2 SERVICE AND COMMITTEE MEETINGS

10.2-1 Regular Meetings

Services and committees, by resolution, may provide the time for holding regular meetings and no Notice other than such resolution shall then be required. Each Service shall meet regularly, at least quarterly, to review and discuss patient care activities and to fulfill other departmental responsibilities.

10.2-2 Special Meetings

A special meeting of any Service or committee may be called by, or at the request of, the chair thereof, the Medical Executive Committee, President, Campus Chief of Staff, or by 33-1/3 percent of the Service's current members, but not fewer than 3 members. No business shall be transacted at any special meeting except that stated in the Notice calling the meeting.

10.2-3 Combined or Joint Service or Committee Meetings

The Services or committees may participate in combined or joint Service or committee meetings with staff members from other hospitals, healthcare entities, or the Pierce County Medical Society; however, precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed, and to assure that the Medical Staff (through its authorized representative) maintains access to and approval authority of all minutes prepared in conjunction with any such meetings.

10.3 NOTICE OF MEETINGS

Written Notice stating the place, day, and hour of any regular or special Medical Staff meeting or of any regular or special Service or committee meeting shall be delivered either personally, electronically, or by mail

to each person entitled to be present not fewer than 2 working days nor more than 30 days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of Notice of such meeting.

10.4 QUORUM

10.4-1 Meetings of the Entire Medical Staff

Those present and voting Medical Staff Members at any regular or special meeting of the entire Medical Staff shall constitute a quorum.

10.4-2 Committee Meetings

The presence of fifty percent (50%) of the voting members shall be required for Medical Executive Committee, Medical Staff Operations Committee and Service Committee meetings. For other committees a quorum shall consist of no less than 3 committee members eligible to vote. The meeting chair shall refrain from voting except when necessary to break a tie.

10.4-3 Service Meetings

The presence of fifty percent (50%) of the members eligible to vote at any regular or special Service meeting shall constitute a quorum. (Only those service committee members who are Medical Staff Members are eligible to vote on issues concerning credentialing and privileging recommendations). The meeting chair shall refrain from voting except when necessary to break a tie.

10.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be required by these Bylaws. Committee action may be conducted electronically or by telephone conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting if it is acknowledged in writing setting forth the action so taken which is approved by at least 66-2/3 percent of the committee members entitled to vote. The meeting chair shall refrain from voting except when necessary to break a tie.

10.6 MINUTES

Minutes of all meetings shall be documented and approved by the committee and shall include a record of the attendance of members and the action taken on each matter. The minutes shall be recorded by the recorder and forwarded to the campus Medical Executive Committee, or other designated committee and Governing Body. Each committee shall maintain a permanent file of the minutes of each meeting. When meetings are held with outside entities, access to minutes shall be limited as necessary to preserve the protections from discovery as provided by state and federal laws.

10.7 ATTENDANCE REQUIREMENTS

Each Member of the Medical Staff is encouraged to attend Medical Staff meetings; however, meeting attendance will not be used in evaluating physicians, dentists, oral surgeons, and podiatrists at the time of reappointment. Members of the Medical Executive Committees shall attend at least fifty percent (50%) of the meetings held.

10.7-1 Special Appearance

A committee, at its discretion, may require the appearance of a Practitioner during a review of the clinical course of treatment regarding a patient. If possible, the chair of the meeting should give the Practitioner at least 10 days' advance written Notice of the time and place of the meeting. In addition, whenever an appearance is requested because of an apparent or suspected deviation from standard clinical practice, the chair shall give Special Notice and shall include a statement of the issue involved and that the Practitioner's appearance is mandatory. Failure of a Practitioner to appear at any meeting with respect to which he or she was given Special Notice shall (unless excused by a Medical Executive Committee upon a showing of good cause) result in an automatic suspension of the Practitioner's Privileges for at least two weeks, or such longer period as the Medical Executive Committee deems appropriate. The Practitioner shall not be entitled to the procedural rights described in Article 13.

10.8 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical failures to follow such rules shall not invalidate action taken at such a meeting.

ARTICLE 11
CONFIDENTIALITY, IMMUNITY, AND RELEASES

11.1 GENERAL

Medical Staff, Service, section, or committee minutes, files and records, including information regarding any Member or applicant to the Medical Staff shall, to the fullest extent permitted by law, be confidential and protected from discovery. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff committee files and shall not become part of any particular patient's file or of the general Hospital records. Dissemination of such information and records shall be made only where expressly required by law, pursuant to officially adopted policies of the Medical Staff, or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee or its designee and the Chief Executive Officer, Chief Operating Officer or Vice President of Medical Affairs.

11.2 BREACH OF CONFIDENTIALITY

Effective credentialing, quality improvement, peer review, and consideration of the qualifications of Medical Staff Members and applicants to perform specific procedures must be based on free and candid discussions. Practitioners and others participate in credentialing, quality improvement, and peer review activities with the reasonable expectation that this confidentiality will be preserved and maintained. Any breach of confidentiality of the discussions or deliberations of Medical Staff Services, sections, or committees, except in conjunction with another System Affiliate, health facility, professional society, or licensing authority peer review activities, is outside appropriate standards of conduct for the Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, a Medical Executive Committee may undertake such corrective action as it deems appropriate.

11.3 IMMUNITY AND RELEASES

11.3-1 Immunity from Liability for Providing Information or Taking Action

All applicants for Privileges, Members of the Medical Staff, persons seeking or holding status as AHPs, and anyone subject to these Bylaws specifically agree to the immunity and releases here stated. These provisions continue after all reviews are completed and are not dependent on the Medical Staff membership or AHP status and are to be interpreted broadly. Each representative of the Medical Staff and Hospital and all third parties shall be exempt from liability to an applicant, Member, or Practitioner for damages or other relief by reason of providing information to a representative of the Medical Staff, Hospital, System Affiliate, or any other health-related organization concerning such person who is, or has been, an applicant to or Member of the Medical Staff or who did, or does, exercise Privileges or provide services at this Hospital or by reason of otherwise participating in a Medical Staff or Hospital credentialing, quality improvement, or peer review activities. All persons providing evidence or acting on behalf of the Medical Staff, the Hospital, the Governing Body, a department, or any committee of any of these entities, or of a Hearing Committee shall be presumed to act in good faith and without malice, and the burden of proving otherwise, when relevant, shall be upon the person claiming a lack of good faith and/or claiming malice.

11.3-2 Activities and Information Covered

(a) Activities

The immunity provided by this Article and State and Federal law shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

(1) Applications for appointment, Privileges, or specified services;

(2) Periodic reappraisals for reappointment, Privileges, or specified services;

(3) Corrective action;

(4) Hearings and appellate reviews;

(5) Quality improvement review, including patient care audit;

(6) Peer review;

(7) Utilization reviews;

(8) Morbidity and mortality conferences; and

(9) Other Hospital, department, section, or committee activities related to monitoring and improving the quality of patient care and appropriate professional conduct.

11.4 INFORMATION

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

11.5 REQUIRED ASSERTION OF IMMUNITIES

Except as required by law or in the discharge of other responsibilities for the Hospital, all participants in activities described in this Article are required to maintain and assert the immunity, privilege, and confidentiality described herein in all appropriate circumstances.

11.6 RELEASES

Each Practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article; however, execution of such release shall not be deemed a prerequisite to the effectiveness of this Article.

11.7 CUMULATIVE EFFECT

Provisions in these Bylaws and in Medical Staff application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law.

ARTICLE 12
PEER REVIEW AND CORRECTIVE ACTION

12.1 PEER REVIEW PHILOSOPHY

12.1-1 Role of Medical Staff in Organizational Quality Improvement Activities; Routine Monitoring, Education, and Review

(a) Members of the Medical Staff are expected to actively and cooperatively participate in a variety of peer review activities to measure, assess, and improve performance of their peers in the Hospital.

(b) The initial goals of the peer review processes are to prevent, detect, and resolve problems and potential problems through routine collegial monitoring, education, and counseling. However, when necessary, remedial measures, including formal investigation and discipline must be implemented and monitored for effectiveness.

(c) Peers on the Medical Staff are responsible for carrying out delegated review and quality improvement functions in a manner that is consistent, timely, defensible, balanced, useful, and ongoing. The term "peers" generally requires that a majority of the peer reviewers be Members holding the same license as the practitioner being reviewed, including, where possible, at least one Member practicing the same specialty as the Member being reviewed. Notwithstanding the foregoing, D.O.s and M.D.s shall be deemed to hold the "same licensure" for purposes of participating in peer review activities.

(d) The Service chairs, Services, and committees are responsible for carrying out delegated peer review and quality improvement functions, which may be with the assistance of the Vice President of Medical Affairs. The Peer Review Committee is responsible for carrying out delegated peer review which may be in consultation with aMedical Staff officer, Service chair, Service, or committee. The Peer Review Committee may review, interview, issue letters of comment or determination of findings, request consultations on a case-by-case basis or imposed by rules and regulations, or recommend retrospective or concurrent monitoring in the course of carrying out those duties without initiating formal corrective action. Such review and/or consultation may include outside consultants and may be conducted to determine whether corrective action may be warranted or whether a corrective action investigation should be initiated. The procedures, including review, described in this Section 12.1-1 do not waive or limit the procedures otherwise available or required for handling investigations directed by a Medical Executive Committee. The procedures, including reviews, described in this Section 12.1-1 do not constitute a hearing or a recommendation of corrective action, and the person affected shall not be entitled to a hearing or other procedural rights specified in Article 13. Comments, suggestions, and warnings may be issued orally or in writing. At the discretion of the person(s) conducting the review, the Practitioner may be given notice of the review and an opportunity to respond in writing or an opportunity to meet with the Service chair, Vice President of Medical Affairs, or Peer Review Committee; such notice, opportunity to respond, and opportunity to meet, if any, shall be when the person(s) conducting the review deems it most beneficial. Any informal actions, including oral warnings, monitoring, or counseling shall be documented in the Member's file. The Member may make a written response to any such action, which response shall be placed in the Member's file. Medical Executive Committee approval is not required for such informal actions, although the informal actions

shall be reported to the Medical Executive Committee. These actions shall not constitute a restriction of Privileges or grounds for any formal hearing or appeal rights under Article 13 and shall not constitute an investigation as defined under the National Practitioner Data Bank reporting requirements.

12.1-2 Criteria for Initiation of Formal Corrective Action

A formal corrective action investigation may be initiated whenever reliable information indicates a Member may have exhibited acts, demeanor, or conduct, either within or outside of the Hospital, that is reasonably likely to be (a) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (b) unethical; (c) contrary to the Medical Staff Bylaws or Rules; (d) below professional standards of the Medical Staff; (e) disruptive of Medical Staff or Hospital operations; or (f) an improper use of Hospital resources. Generally, formal corrective action measures should not be initiated unless reasonable attempts at informal resolution have failed; however, this is not a mandatory condition, and formal corrective action may be initiated whenever circumstances reasonably appear to warrant formal action.

12.1-3 Initiation

(a) Any person who believes that corrective action may be warranted may provide information to the President, any other Medical Staff officer, any Service chair, any Medical Staff committee, the chair of any Medical Staff committee, the Vice President of Medical Affairs, the Governing Body, or the Chief Executive Officer.

(b) If the President, any other Medical Staff officer, any Service chair, any Medical Staff committee, the chair of any Medical Staff committee, the Vice President of Medical Affairs, the Governing Body, or the Chief Executive Officer determines that corrective action may be warranted under section 12.1-2, that person, entity, or committee may request the initiation of a formal corrective action investigation or may recommend particular corrective action. Such requests may be conveyed to the Medical Executive Committee orally or in writing.

(c) The President shall notify the Chief Executive Officer, or his or her designee in his or her absence, and the Medical Executive Committee and shall continue to keep them fully informed of all action taken. In addition, the President shall immediately forward all necessary information to the committee or person that will conduct any investigation; provided, however, that the President or the Medical Executive Committee may dispense with further investigation of matters deemed to have been adequately reviewed by a committee pursuant to Section 12.1-5 or otherwise.

12.1-4 Expedited Initial Review

(a) Whenever information suggests that corrective action may be warranted, the President or his or her designee, and/or Vice President of Medical Affairs, may, on behalf of a Medical Executive Committee, immediately conduct whatever reviews (including those from outside consultants) and interviews may in that individual's discretion be indicated. The information developed during this initial review shall be presented to the Medical Executive Committee once the reviewer has obtained what he or she believe is sufficient information. The Medical Executive Committee shall then decide whether to initiate a corrective action investigation.

(b) In cases of complaints of harassment or discrimination involving a patient or other person connected with the Hospital, an expedited initial review shall be conducted on behalf of the Medical Executive Committee by the Campus Chief of Staff, the Campus Chief of Staff's designee, the service chair, and/or the Vice President of Medical Affairs, together with representatives of Administration, or by an attorney for the Hospital. In cases of complaints of harassment or discrimination where the alleged harasser is a Medical Staff Member and the complainant is not a patient, an expedited initial review shall be conducted by the Vice President of Medical Affairs and the Hospital's Human Resources Director or their designee, or by an attorney for the Hospital. The Campus Chief of Staff shall be kept apprised of the status of the initial review. The information gathered from an expedited initial review shall be documented and referred to the Medical Executive Committee if it is determined that corrective action may be indicated against a Medical Staff Member.

12.1-5 Formal Investigation

(a) If the Medical Executive Committee concludes action is indicated but that no further investigation is necessary, it may proceed to take action without further investigation. If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself or may assign the task to an appropriate officer or standing or ad hoc committee, to be appointed by the President. The investigating body should not include partners, associates, or relatives of the individual being investigated. Additionally, the investigating person or body may, but is not required to, engage the services of one or more outside reviewers as deemed appropriate or helpful in light of the circumstances (e.g., to help assure an unbiased review, to provide an outside review on a controversial matter, or to engage specialized expertise). If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. If the Medical Executive Committee concludes action is indicated but no further investigation is necessary, it may proceed to take action.

(b) Prior to any adverse action being recommended, the Medical Executive Committee shall ensure that the Member was given an opportunity to provide information in a manner and upon such terms as the Medical Executive Committee, investigating body, or reviewing committee deems appropriate. The investigating body or reviewing body may, but is not obligated to, interview persons involved; however, such an interview shall not constitute a “hearing” as that term is used in Article 13, nor shall the hearing or appeal rules apply.

(c) Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary action.

12.1-6 Medical Executive Committee Action

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall make a recommendation to the Governing Body, including, without limitation:

(a) Determining no corrective action should be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, clearly

documenting those findings in the Member's file;

(b) Deferring action for a reasonable time;

(c) Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude Service or committee chairs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected Member may make a written response that shall be placed in the Member's file;

(d) Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of Privileges, including, without limitation, requirements for mandatory consultation, or monitoring;

(e) Recommending reduction, modification, suspension, or revocation of Privileges. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated;

(f) Recommending reductions of membership status or limitation of any prerogatives directly related to the Member's delivery of patient care;

(g) Recommending suspension, revocation, or probation of Medical Staff membership. If suspension or probation is recommended, the terms and duration of the suspension or probation and the conditions that must be met before the suspension or probation is ended shall be stated; and

(h) Taking other actions deemed appropriate under the circumstances.

Insofar as possible, considering the size and composition of the Medical Staff, the Medical Executive Committee members who have participated in investigating or formulating Service or committee recommendations should not participate in the Medical Executive Committee's deliberations or vote on the matter; however, such members may be in attendance at the Medical Executive Committee meeting, may present the report and any related recommendations, and may answer questions posed by the Medical Executive Committee.

12.1-7 Time Frames

Insofar as feasible under the circumstances, formal and informal investigations should be conducted expeditiously, with the following as guidelines:

(a) Informal investigations should be completed and the results should be reported within sixty (60) days.

(b) Expedited initial reviews should be completed and the results should be reported within thirty (30) days.

(c) Other formal investigations should be completed and the results should be reported within ninety (90) days.

12.1-8 Procedural Rights

(a) If the Medical Executive Committee determines that no corrective action is required or only a letter of warning, admonition, reprimand, or censure should be issued, the decision shall be transmitted to Governing Body. The Governing Body may affirm, reject, or modify the action. The Governing Body shall give great weight to the Medical Executive Committee's decision and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the Medical Executive Committee, and the Medical Executive Committee still has not acted. The decision shall become final if the Governing Body affirms it or takes no action on it within 70 days after receiving the Notice of decision.

(b) If the Medical Executive Committee recommends an action that is grounds for a hearing under Section 13.2, the President shall give the Practitioner Special Notice of the adverse recommendation and of the right to request a hearing. The Governing Body may be informed of the recommendation, but shall take no action until the Member has either waived his or her right to a hearing or completed the hearing, whichever occurs first.

12.1-9 Initiation by Governing Body

If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Governing Body may direct the Medical Executive Committee to initiate an investigation or disciplinary action, but only after consulting with the Medical Executive Committee. If the Medical Executive Committee fails to act in response to that Governing Body direction, the Governing Body may initiate corrective action, but must comply with applicable provisions of Articles 12 and 13 of these Bylaws. The Governing Body shall inform the Medical Executive Committee in writing of its actions.

12.1-10 When Corrective Action Takes Effect

Any corrective (adverse) action described in Section 12.1-7(b) or 12.1-8 shall not take effect until the affected Practitioner has waived any right to a hearing as provided in Article 13 or until any hearing process is completed and final pursuant to Article 13, whichever occurs sooner. However, this shall not qualify the right or power to impose a summary or automatic suspension or revocation pursuant to Sections 12.2 or 12.3.

12.2 SUMMARY RESTRICTION OR SUSPENSION

12.2-1 Criteria for Initiation

(a) Whenever a Practitioner's conduct is such that a failure to take action may result in an imminent danger to the health or safety of any individual, or result in a severe disruption of Medical Staff or Hospital operations of a type that might result in a danger to the health or safety of an individual, the following may summarily restrict or suspend the Medical Staff membership or Privileges of such Member, after consultation with the Hospital's legal staff: (i) the Medical Executive Committee, or (ii) any three of the following together: the President, a Chief of Staff, the chair of the service in which the Member holds Privileges, the Vice President of Medical Affairs, the Chief Operating Officer, or the Chief Executive Officer, or their designees. The Governing Body or Chief Executive Officer may summarily suspend or restrict Privileges of a Practitioner, under the same circumstances, when no authorized Medical Staff Officer is available, provided the Governing Body or Chief Executive Officer has made reasonable attempts to contact the persons so authorized.

(b) Among other possible reasons, a danger will be considered to be "imminent" if it is reasonably believed under the circumstances that the situation, condition, or circumstance could cause harm to the person's present patient or future patient or could increase the risk or likelihood of complications to such a patient, or could complicate or delay such a patient's recovery, or could cause any similar threat to the next patient's good health, safety, or recovery if not remedied.

(c) Unless otherwise stated, such summary restriction or suspension ("summary action") shall become effective immediately upon imposition, and the person or body responsible shall promptly give Special Notice to the Member and written Notice to the Governing Body, the Medical Executive Committee, and the Chief Executive Officer. The Notice shall generally describe the reasons for the action.

(d) The summary action may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary action, the Member's patients shall be promptly assigned to another Member by the department chair or by the Chief of Staff considering, where feasible, the wishes of the patient and the affected Practitioner in the choice of a substitute Member.

(e) The Notice of the summary action given to the Medical Executive Committee shall constitute a request to initiate corrective action and the procedures set forth in Section 12.1 shall be followed.

12.2-2 Medical Executive Committee Action

The affected Practitioner may request an interview with the Medical Executive Committee. The interview shall be convened as soon as reasonably possible under all circumstances and shall be informal and not constitute a hearing, as that term is used in the Bylaws. The Practitioner shall not be entitled to have legal counsel present at the interview. The Medical Executive Committee may thereafter continue, modify, or terminate the terms of the summary action. It shall give the Practitioner Special Notice of its decision, which shall include the information specified in Section 13.3-1 if the action is adverse.

12.2-3 Procedural Rights

Unless the Medical Executive Committee terminates the summary action, it shall remain in effect during the pendency and completion of the corrective action process and of the hearing and appellate review process. When a summary action is continued, the affected Practitioner shall be entitled to the procedural rights afforded by Article 13, but the hearing may be consolidated with the hearing on any corrective action that is recommended so long as the hearing commences within 75 days after the hearing on the summary action was requested, absent extension of the time for commencement of the Hearing by the Medical Executive Committee for good cause as determined by the Committee. There shall be no procedural rights associated with any such suspension or restriction of fourteen days or less that is rescinded or not ratified by the Medical Executive Committee.

12.2-4 Initiation by Governing Body

(a) If no one authorized under Section 12.2-1(a) to take a summary action is available to summarily restrict or suspend a Member's membership or Privileges, or if deemed necessary, the Governing Body (or its designee) may immediately suspend or restrict a Member's Privileges if a failure to act immediately may result in imminent danger to the

health of any individual, provided that the Governing Body (or its designee) made reasonable attempts to contact the President and the chair of the department to which the Member is assigned before acting.

(b) Such summary action is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such summary action within 5 working days, excluding weekends and holidays, the summary action shall terminate automatically.

12.2-5 Precautionary Actions

Without more, it shall not be considered to be a summary suspension or corrective action to temporarily remove from the Hospital or any part of the Hospital for a period of up to 14 days, any Practitioner whose conduct is disruptive or who is or who 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 a precautionary action may, but need not, result in a summary suspension. Such a precautionary action shall not entitle the Practitioner to any procedural rights specified in Article 13. The Practitioner agrees not to exercise his or her privileges during the period of the precautionary action.

12.2-6 Interim Precautionary Step

Action under this section 12.2, including both summary restrictions or suspensions and precautionary actions, shall be deemed an interim precautionary step in the professional review activity that may be taken with respect to the Practitioner and shall not be considered a complete professional review action in and of itself. 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 recommendation or action affects the clinical privileges of a Practitioner for a period of longer than thirty (30) days from the date of recommendation 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.

12.3 AUTOMATIC SUSPENSION OR LIMITATION

Suspension under this Section shall not entitle the Practitioner to the procedural rights specified in Article 13. In the following instances, the Member's Privileges or membership may be suspended or limited as described:

12.3-1 Licensure

(a) Revocation, Suspension, or Expiration: Whenever a Member's license or other legal credential authorizing practice in this state is revoked, suspended, or expired without an application pending for renewal, Medical Staff membership and Privileges shall be automatically revoked as of the date such action becomes effective.

(b) Restriction: Whenever a Member's license or other legal credential authorizing practice in Washington is limited or restricted by the applicable licensing or certifying authority, any Privileges that are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

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

(d) Review of Restriction or Probation: As soon as practical after notice of a Practitioner's probation or restrictions of licensure, or at the time a Practitioner seeks reinstatement following suspension or revocation (and reinstatement) of a license, the committee of the Service to which the Practitioner is assigned will consider the facts under which the Practitioner was placed on probation or his or her license was revoked, suspended, or restricted and shall forward its recommendation to the Medical Executive Committee, which shall review and consider the recommendation. The Medical Executive Committee may then take such further corrective action as is appropriate to the facts disclosed in the investigation.

12.3-2 DEA Certificate

(a) Revocation, Suspension, and Expiration: Whenever a Member's DEA certificate is revoked, limited, suspended, or expired, the Member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term. If the DEA certificate expired and the Member is required by the Rules and Regulations to have a DEA certificate, the Member shall cause the DEA certificate to be reinstated within ninety (90) days (or such larger period if approved by the Medical Executive Committee). Failure to timely cause reinstatement of the DEA certificate shall constitute voluntary resignation from the Medical Staff.

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

(c) Review of Restriction or Probation: The committee of the Service to which the Practitioner is assigned will consider the facts under which the Practitioner was placed on probation or his or her DEA certificate was revoked, suspended, or restricted and shall forward its recommendation to the Medical Executive Committee, which shall review and consider the recommendation. The Medical Executive Committee may then take such further corrective action as is appropriate to the facts disclosed in the review.

12.3-3 Failure to Satisfy Special Appearance Requirement

A Member who fails without good cause to appear and satisfy the requirements of Section 10.7-1 shall automatically be suspended from exercising his or her Clinical Privileges for a period of at least two weeks, or such longer period as the Medical Executive Committee shall determine. Such a suspension for two weeks shall, in all cases, be deemed administrative and not "medical disciplinary" regardless of the facts giving rise to the special appearance requirements; suspensions in excess of two weeks may or may not be "medical disciplinary", depending upon the facts and circumstances.

12.3-4 Medical Records

Medical Staff Members are required to complete medical records within the time prescribed by the Medical Executive Committee. Removal of patient records from the Hospital or failure to timely

complete medical records may result in a limited automatic suspension of admitting and other related Privileges after Notice by the President, or his or her designee, is given as provided in the Rules. For the purpose of this Section, "related privileges" means voluntary on-call service for the Emergency services, scheduling surgery, assisting in surgery, consulting on Hospital cases, and providing professional services within the Hospital for future patients. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the President or his or her designee. In determining the length of the suspension, the President may take into consideration the frequency with which the Member's Privileges have been suspended for medical record noncompliance. Following suspension, failure to complete medical records within the time frames provided in the Medical Staff Rules shall result in automatic termination of the Member's Staff membership in accordance with those Rules.

12.3-5 Cancellation or Expiration of Professional Liability Insurance

Failure to maintain professional liability insurance as required by these Bylaws shall be grounds for automatic suspension of a Member's Privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of Privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage for any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage.

12.3-6 Failure to Pay Credentialing Fees

For failure to pay any credentialing fees within 30 days after written warning of delinquency, a Practitioner's Medical Staff membership and Privileges shall be automatically suspended and shall remain so suspended until the Practitioner pays the delinquent credentialing fees.

12.3-7 Failure to Comply With Government and Other Third Party Payor Requirements

Whenever a Practitioner is excluded from a federally-funded healthcare program, his or her Medical Staff Membership and Privileges shall be automatically revoked as of the date such action becomes effective. In addition, the Medical Executive Committee shall be empowered to determine that noncompliance with certain specific third party payor, government agency, and professional review organization rules or policies adversely impacts Hospital and/or Medical Staff operations and that compliance with such requirements can be objectively determined. These Bylaws may authorize the automatic suspension of a Practitioner who fails to comply with such requirements. The suspension shall be effective until the Practitioner complies with such requirements.

12.3-8 Failure to Satisfy Qualification or Credential for a Privilege

If a Practitioner does not have a qualification or credential that is required by the Medical Staff as a condition to exercise a particular clinical privilege, the Practitioner shall not be eligible to apply for such Privilege, and such Privilege is automatically removed if the Privilege was previously granted.

12.3-9 Disruptive Conduct; Failure to Meet On-Call Emergency Department Obligations

A Practitioner may be automatically suspended for inappropriate, disruptive, or unprofessional conduct, or an apparent offense related to on-call ED obligations, as determined by the Medical Executive Committee. This provision does not preclude the imposition of other lesser or greater corrective actions that may be necessitated by the circumstances.

12.3-10 Automatic Termination

If a Practitioner is suspended for more than 6 months, his or her membership (or the affected Privileges, if the suspension is a partial suspension) shall be automatically terminated, unless there is a pending Corrective Action Review that cannot reasonably be completed within said 6-months, in which event Practitioner's suspension may continue until such time as the Corrective Action Review process has been completed or terminated in accordance with these Bylaws. Thereafter, reinstatement to the Medical Staff shall require application and compliance with the appointment procedures applicable to applicants.

12.3-11 Medical Executive Committee Deliberation and Procedural Rights

(a) Whenever the automatic suspension is required to be reported to the Medical Quality Assurance Commission of Washington or the National Practitioner Data Bank ("NPDB"), the Practitioner shall be entitled to a hearing pursuant to Article 13;

(b) In all other cases (i.e., whenever a Medical Quality Assurance Commission of Washington or National Practitioner Data Bank report is not required), anyone whose membership has been automatically suspended or terminated shall not be entitled to a hearing pursuant to Article 13, but shall be entitled at his or her request to meet with the Medical Executive Committee to review the action. Practitioners whose Privileges are automatically suspended, limited, revoked, restricted, resigned subject to probation, divested, or terminated (collectively "suspended"), and/or who have been deemed to have automatically resigned their Medical Staff membership shall not be entitled to a hearing. However, such a Practitioner shall be entitled at his or her request to meet with the Medical Executive Committee to review the action. The meeting shall be informal and the Practitioner shall not be entitled to have legal counsel present. The review must be requested within ten days after notification of action; should be conducted within 90 days of such notification; and shall be limited to whether the conditions described in these sections had in fact occurred. There shall be a right to only one Medical Executive Committee review of the reasons for suspension and/or termination; if there is a review conducted after a suspension, there shall be no right of additional review in the event a suspended practitioner is later terminated. The formal hearing procedures described at Article 13 shall not apply, and the decision of the Medical Executive Committee shall then become and remain effective pending the final decision of the Governing Body.

(c) Practitioners whose Privileges are automatically suspended and/or who have been deemed to have automatically resigned their Medical Staff membership shall not be entitled to a hearing.

12.3-12 Notice of Automatic Suspension or Action

Special Notice of an automatic suspension or adverse action shall be given to the affected individual, and regular Notice of the suspension shall be given to the Medical Executive Committee, Chief Executive Officer, and Governing Body, but such Notice shall not be required for the suspension to become effective. Patients affected by an automatic suspension shall be assigned to another Member by the department chair or Chief of Staff, or designee. The wishes of the patient and affected Practitioner shall be considered, where feasible, in choosing a substitute Member.

12.4 INTERVIEWS, REVIEWS, AND INVESTIGATIONS

12.4-1 General

Interviews, reviews, and investigations, whether formal or informal, shall neither constitute nor be deemed a “hearing” as described in Articles 12 and 13, shall be preliminary in nature, an administrative matter and not an adversarial proceeding, and shall not be conducted according to the procedural rules applicable with respect to hearings. During the course of a review or investigation, a Practitioner shall not be entitled to have legal counsel present at any interviews, meetings, or discussions between the Practitioner and those conducting the review or investigation. The Medical Executive Committee shall be required, at the Practitioner's request, to grant an interview only when so specified in Section 12.2-2. In the event an interview is granted, the Practitioner shall be informed of the general nature of the reasons for the recommendation and may present relevant information. A record of the matters discussed and the findings resulting from an interview shall be made.

12.4-2 Investigation Defined

The term "investigation" means the process specifically initiated by the Medical Executive Committee, or the Governing Body, to determine the validity, if any, of a concern or complaint raised against a Member of the Medical Staff, and does not include any action, including a review, by any other committee or person, or any action by a Medical Executive Committee or Governing Body, prior to initiation of such an investigation. Commencement of an investigation shall be documented in the records and proceedings of the committee or body described herein whose decision prompted the investigation.

12.5 CONFIDENTIALITY

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for peer review and discipline.

12.6 SYSTEM-WIDE CORRECTIVE ACTION

12.6-1 Notice of Pending Investigations/Joint Investigations

(a) The President and the Chief Executive Officer, or their designees, each shall have the discretion to notify the officers at System Affiliates whenever a request for corrective action has been received.

(b) In addition, the Medical Executive Committee may authorize a coordinated investigation and may appoint individuals associated with System Affiliates to assist in the coordinated investigation.

(c) The President and the Chief Executive Officer, or their designees, are authorized to disclose to another System Affiliate's peer review body (or an authorized representative of that body) information from Hospital and Medical Staff records to assist in the System Affiliate's independent or joint investigation of any Practitioner.

(d) The results of any joint investigation shall be reported to each System Affiliate's peer review body for its independent determination of what, if any, corrective action should be taken.

12.6-2 Notice of Actions

(a) In addition to the discretionary reporting and joint investigation provisions set forth at Section 12.6-1, the President and/or the Chief Executive Officer and Vice President of Medical Affairs are authorized to inform his or her counterpart officer at any System Affiliate where the Practitioner is known to practice whenever any of the following actions has been taken:

(1) Summary suspension of clinical Privileges should be reported promptly upon imposition (other than automatic suspensions of less than 14 days for failure to complete medical records).

(2) Other corrective actions may be reported at any time the President, Vice President of Medical Affairs, or Chief Executive Officer determines such a report to be appropriate, and should be reported promptly upon final action by the Governing Body.

(b) The effect of such action on the involved Practitioner's Privileges or practice at another System Affiliate shall be determined by the Medical Staff Bylaws or other applicable policies of that System Affiliate; or if there are no applicable bylaws or policies, the information shall be deemed transmitted for the receiving System Affiliate's independent review and action.

(c) The President, Vice President of Medical Affairs, and Chief Executive Officer are authorized to disclose to another System Affiliate's peer review body (or an authorized representative of that body) information from the Hospital and Medical Staff records regarding such a Practitioner or AHP.

12.6-3 Effect of Actions Taken by System Affiliate

Except as provided in Section 12.6-1, whenever the President or the Medical Executive Committee receives information about an action taken at another System Affiliate and involving a Practitioner or AHP holding Privileges at the Hospital, the President or Medical Executive Committee shall, if time permits, independently assess the facts and circumstances to ascertain whether to take comparable action. However, when the Practitioner or AHP was summarily suspended or restricted at the other System Affiliate, any person authorized under Section 12.2-1 to impose a summary action is authorized to immediately impose a comparable suspension or restriction at the Hospital, subject to review by the Medical Executive Committee in accordance with the provisions of Section 12.2.

12.7 ACTIONS TAKEN BY ANOTHER (NON-SYSTEM AFFILIATE) PEER REVIEW BODY

The Practitioner shall provide prompt and full disclosure of any adverse action taken by another (non-System Affiliate) institution and shall execute a release of liability to enable Hospital or System to fully investigate the matter and reach an independent determination regarding the professional competence or professional conduct of the Practitioner. An adverse action taken by the institution’s peer review body includes, but is not limited to, denying membership and/or privileges, restricting privileges, or terminating membership and/or privileges. A summary suspension or precautionary action may be imposed while the matter is investigated by the Hospital or System.

ARTICLE 13
HEARINGS AND APPELLATE REVIEWS

13.1 GENERAL PROVISIONS

13.1-1 Review Philosophy

The intent in adopting these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect Practitioners (as defined below) and at the same time protect the peer 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 nonprejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken. The Medical Staff, the 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 peer review laws and claim all privileges and immunities afforded by the federal and state laws.

13.1-2 Exhaustion of Remedies

If an adverse action as described in Section 13.2 is taken or recommended, the Practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

13.1-3 Intra-Organizational Remedies

The hearing and appeal rights established in the Bylaws are strictly "judicial" rather than "legislative" in structure and function. The hearing committees have no authority to adopt or modify rules and standards to hold quasi-legislative, notice-and-comment type hearings, to make quasi-legislative determinations, or to decide questions about the merits or substantive validity of Bylaws, Rules, or policies. However, the Governing Body may, in its discretion, entertain challenges to the merits or substantive validity of Bylaws, Rules, or policies and decide those questions. If the only issue in a case is whether a Bylaw, Rule, or policy is lawful or meritorious, the Practitioner is not entitled to a hearing or appellate review. In such cases, the Practitioner must submit his or her challenges first to the Governing Body and only thereafter may he or she seek judicial intervention.

13.1-4 Joint Hearings and Appeals

The Medical Staff and Governing Body are authorized to participate in joint hearings and appeals in accordance with Section 13.10 of these Bylaws.

13.1-5 Definitions

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article:

(a) "Body whose decision prompted the hearing" refers to the Medical Executive Committee in all cases where the Medical Executive Committee or authorized Medical Staff officers, Members, or committees took the action or rendered the decision that resulted in a hearing being requested. It refers to the Governing Body in all cases where the Governing Body or its authorized officers, directors, or committees took the action or rendered the decision that resulted in a hearing being requested.

(b) "Practitioner," as used in this Article, refers to the Practitioner who has requested a hearing pursuant to Section 13.3-2 of this Article.

13.1-6 Substantial Compliance

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

13.1-7 Hearings Requested Prior to April 1, 2005 But Not Held

All hearings requested prior to April 1, 2005 but held thereafter shall be in accordance with the terms in these Bylaws and Rules. All corrective action underway on April 1, 2005 shall proceed to the extent possible in accordance with the terms in these Bylaws and Rules.

13.2 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws, (including those Exceptions to Hearing Rights specified in Section 13.9) any one or more of the following actions or recommended actions, if based on professional competence or conduct, shall be deemed actual or potential adverse action and only these constitute grounds for a hearing:

13.2-1 Denial of Medical Staff membership and/or Privileges.

13.2-2 Denial of Medical Staff reappointment and/or renewal of privileges.

13.2-3 Revocation, suspension, restriction, involuntary reduction of Medical Staff membership and/or Privileges.

13.2-4 Involuntary imposition of significant consultation requirements (excluding proctoring incidental to provisional staff status, or the granting of new Privileges, or imposed because of insufficient activity, or proctoring, or consultation that does not restrict the Practitioner's Privileges), or as imposed by the Rules, or on a case-by-case basis.

13.2-5 Summary suspension of Medical Staff membership and/or Privileges during the pendency of corrective action and hearings and appeals procedures.

13.2-6 Any other disciplinary action or recommendation that in the reasonable opinion of the Medical Staff must be reported to the Medical Quality Assurance Commission of Washington or its successors or to the National Practitioner Data Bank.

13.3 REQUESTS FOR HEARING

13.3-1 Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in Section 13.2, the Practitioner shall be given Special Notice of the recommendation or action and of the right to request a hearing pursuant to Section 13.3-2. The Notice must state:

(a) What action has been proposed against the Practitioner;

(b) Whether the action, if adopted, must be reported to the Medical Quality Assurance Commission of Washington or the National Practitioner Data Bank;

(c) A brief indication of the reasons for the action or proposed action;

(d) That the Practitioner may request a hearing;

(e) That a hearing must be requested within 30 days; and

(f) That the Practitioner has the hearing rights described in the Medical Staff Bylaws, including those specified in Section 13.4.

13.3-2 Request for Hearing

(a) The Practitioner shall have 30 days following receipt of Special Notice of such action to request a hearing. The request shall be in writing addressed to the President with a copy to the Chief Executive Officer. If the Practitioner does not request a hearing within the time and in the manner described, the Practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Such final recommendation shall be considered by the Governing Body within 70 days and shall be given great weight by the Governing Body although it is not binding on the Governing Body.

(b) The Practitioner shall state, in writing, his or her intentions with respect to attorney representation at the time he or she files the request for a hearing. Notwithstanding the foregoing and regardless of whether the Practitioner elects to have attorney representation at the hearing, the parties shall have the right to consult with legal counsel to prepare for a hearing or an appellate review.

(c) Any time attorneys will be allowed to represent the parties at a hearing, the hearing officer may limit the attorneys' role to advising their clients rather than presenting the case.

(d) Refusal on behalf of the Practitioner to accept written notice from the Chief Executive Officer shall constitute the practitioner's receipt and waiver of his or her right to the Hearing and appellate review proceedings of Article 13.

13.3-3 Indemnification of Members

The Hospital shall indemnify and hold Medical Staff Members harmless for good faith participation in peer review/quality management activities and other activities specified in Section 11.3-2. Medical Staff Members shall fully cooperate with the Hospital in the event any claim is raised. The

Hospital, at its expense, may retain legal counsel to assist in any response or defense that is appropriate.

13.4 HEARING PROCEDURE

13.4-1 Hearings Prompted by Governing Body Action

If the hearing is based upon an adverse action by the Governing Body, the Chair of the Governing Body or his or her designee shall fulfill the functions assigned in this section to the President.

13.4-2 Time and Place for Hearing

Upon receipt of a request for hearing, the President shall schedule a hearing and, within 30 days from the date he or she received the request for a hearing, give Special Notice to the Practitioner of the time, place, and date of the hearing. The date of the commencement of the hearing shall not be less than 30 days nor be more than 60 days from the date the President received the request for a hearing, absent approval of the President or Chair of the Hearing Committee for an extension of time.

13.4-3 Notice of Charges

Together with the Notice stating the place, time, and date of the hearing, the President shall state clearly and concisely in writing the reasons for the proposed adverse action taken or recommended, including the acts or omissions with which the Practitioner is charged and a list of the charts in question, where applicable. A supplemental Notice may be issued at any time, provided the Practitioner is given sufficient time to prepare to respond.

13.4-4 Hearing Committee

(a) When a hearing is requested, the President shall appoint a Hearing Committee that shall be composed of not less than 3 Members who shall gain no direct financial benefit from the outcome, who are not in direct economic competition, and who have not acted as accuser, investigator, fact finder, initial decision maker, or otherwise have not actively participated in the consideration of the matter leading up to the 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. In the event that it is not feasible to appoint a Hearing Committee from the Active Medical Staff, the President may appoint Members from other Medical Staff categories or Practitioners who are not Medical Staff Members. Such appointment shall include designation of the chair. When feasible, the Hearing Committee shall include at least one Member who has the same healing arts licensure as the Practitioner and who practices the same specialty as the Practitioner. In addition, the President may appoint alternates who meet the standards described above and who can serve if a Hearing Committee member becomes unavailable. An alternate may attend all sessions of the hearing, and may attend and, in the discretion of the hearing officer, participate in deliberations. An alternate shall not vote unless a Hearing Committee member is absent from or otherwise unable to vote due to failure to meet the attendance requirements of Section 13.4-19.

(b) Alternatively, and only if all parties agree, an arbitrator may be used who is selected using a process mutually accepted by the body whose decision prompted the hearing and the Practitioner. The arbitrator need not be a health professional or an attorney. The arbitrator

shall carry out all of the duties assigned to the Hearing Officer and to the Hearing Committee.

(c) The Hearing Committee, or the arbitrator, if one is used, shall have such powers as are necessary to discharge its or his or her responsibilities.

13.4-5 The Hearing Officer

The President shall appoint a Hearing Officer to preside at the hearing. The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney utilized within the last 12 months by the Hospital for legal advice regarding its affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer shall not be biased for or against any party, shall gain no direct financial benefit from the outcome, and must not act as a prosecuting officer or as an advocate. The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions that pertain to matters of law, procedure, or the admissibility of evidence that are raised prior to, during, or after the hearing, including deciding when evidence may not be introduced, granting continuances, ruling on disputed discovery requests, and ruling on challenges to Hearing Committee members or himself or herself serving as the Hearing Officer. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances. The Hearing Officer should participate in the deliberations of the Hearing Committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote.

13.4-6 Representation

The Practitioner and Medical Staff shall have the right, at their expense, to attorney representation in an advisory capacity at the hearing. Such attorney may, at the discretion of the Hearing Officer present evidence, question, or cross-examine parties or witnesses, or address the Hearing Committee and take such other action at the discretion of the Hearing Officer.

13.4-7 Failure to Appear or Proceed

Failure, without good cause of the Practitioner to personally attend and proceed at a hearing in an efficient and orderly manner, shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

13.4-8 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the Hearing Officer within his or her discretion.

13.4-9 Discovery

(a) No Right of Discovery

Except as provided herein, there is no right of discovery in the hearing or any subsequent review. The Practitioner shall be provided with access during reasonable working hours to

any patient records or other Hospital documents (except as qualified below) cited in the Notice of Hearing or shall be permitted to copy those records and documents at Practitioner's expense. The Practitioner shall not, however, be entitled to access or copy medical peer review committee records or incident reports, but shall be provided with those portions of committee minutes that reflect the decision by the Medical Executive Committee or Governing Body to impose the adverse recommendation or action.

(b) Limits on Contacting Hospital Employees

Neither the affected individual, nor his or her attorney, nor any other person on behalf of the affected individual, 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 Officer.

(c) Objections to Introduction of Evidence Previously Not Produced for the Medical Staff

The body whose decision prompted the hearing may object to the introduction of the evidence that was not provided during an appointment, reappointment, or Privilege application review or during corrective action, despite the requests of the peer review body for such information. The information may be barred from the hearing by the Hearing Officer unless the Practitioner can prove he or she previously acted diligently and could not have submitted the information.

13.4-10 Pre-Hearing Document Exchange

At the request of either party, the parties must exchange all documents that will be introduced at the hearing. The documents must be exchanged at least 10 days prior to the hearing. A failure to comply with this rule is good cause for the Hearing Officer to grant a continuance. Repeated failures to comply shall be good cause for the Hearing Officer to limit the introduction of any documents not provided to the other side in a timely manner, absent grant of shorter period by the Hearing Officer.

13.4-11 Witness Lists

Not less than 10 days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least 10 days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

13.4-12 Continuances; Completion of the Hearing

The Hearing Officer shall use his or her best efforts and discretion to assure that the hearing is completed in an expeditious manner. Subject to the foregoing, continuances may be effected by agreement of the parties or by action of the Hearing Officer. Requests for continuance shall be processed as described in Section 13.4-8.

13.4-13 Procedural Disputes

(a) It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

(b) The parties shall be entitled to file motions as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the full Hearing Committee. Such motions shall be in writing and shall specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving party shall deliver a copy of the motion to the opposing party, who shall have five days to submit a written response to the Hearing Officer, with a copy to the moving party. The Hearing Officer shall determine whether to allow oral argument on any such motions. The Hearing Officer's ruling shall be in writing and shall be provided to the parties promptly upon its rendering. Such rulings shall not be subject to appeal prior to the decision of the Hearing Committee. All motions, responses, and rulings thereon shall be entered into the hearing record by the Hearing Officer.

13.4-14 Record of the Hearing

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings if deemed appropriate by the Hearing Officer. The cost of attendance of the court reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The Practitioner is entitled to receive a copy of the transcript upon paying the reasonable cost for preparing the record. The Hearing Officer may, but shall not be required to, order that all evidence shall be taken only on oath or customary affirmation administered by any person lawfully authorized to administer such oath, the Hearing Officer, or the court reporter.

13.4-15 Rights of the Parties

Within reasonable limitations, both sides at the hearing may ask the Hearing Committee members and Hearing Officer questions that are directly related to evaluating their qualifications to serve and for challenging such members or the Hearing Officer, call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witness who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, receive all information made available to the Hearing Committee, and to submit a written statement at the close of the hearing, as long as these rights are exercised in an efficient and expeditious manner. The Practitioner may be called by the body whose decision prompted the hearing or the Hearing Committee and examined as if under cross-examination. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

13.4-16 Rules of Evidence

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which

responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

13.4-17 Burdens of Presenting Evidence and Proof

(a) When a hearing relates to an adverse action or recommendation as set forth in Section 13.2, the body making the adverse action or recommendation shall have the initial obligation to present evidence in support of that action or recommendation. The Practitioner shall then be obligated to present evidence in response; however, Practitioners shall not be permitted to introduce information not produced upon request of the peer review body during the application process, unless the Practitioner establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(b) Throughout the hearing, the Practitioner shall bear the burden of proving to the Hearing Committee by clear and convincing evidence that the Medical Affairs Committee's or other appropriate body's recommendation of adverse action should not be sustained because it lacks factual basis or the conclusions drawn from the facts are arbitrary or capricious.

13.4-18 Adjournment and Conclusion

The Hearing Officer may adjourn the hearing and reconvene the same without Special Notice at such times and intervals as may be reasonable and warranted with due consideration for reaching an expeditious conclusion to the hearing.

13.4-19 Basis for Decision

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 other body recommending particular Adverse Action. Rather, the Hearing Committee is to determine whether there is a factual basis for the recommendation of Adverse Action or whether the conclusions drawn from the facts are arbitrary or capricious. The Hearing Committee shall uphold the recommendation(s) of the Medical Executive Committee, or other appropriate 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.

13.4-20 Presence of Hearing Committee Members and Vote

A majority of the Hearing Committee must be present throughout the hearing and deliberations. In unusual circumstances when a Hearing Committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent. The final decision of the Hearing Committee must be sustained by a majority vote of the number of members appointed.

13.4-21 Decision of the Hearing Committee

Within 15 days after final adjournment of the hearing, the Hearing Committee shall render a written decision. Final adjournment shall be when the Hearing Committee has concluded its deliberations. A copy of the decision shall be forwarded to the Chief Executive Officer, the Medical Executive

Committee, the Governing Body, and to the Practitioner. The report shall contain the Hearing Committee's findings of fact and conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the Practitioner and the body whose decision prompted the hearing shall be provided a written explanation of the procedure for appealing the decision. The decision of the Hearing Committee shall be considered final, effective when made, and subject only to such rights of appeal or Governing Body review as described in these Bylaws.

13.5 APPEAL

13.5-1 Time for Appeal

Within 20 days after receiving the decision of the Hearing Committee, either the Practitioner or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the President, the Chief Executive Officer, and the other side in the hearing. If appellate review is not requested within such period, that action or recommendation shall thereupon become the final action of the Hearing Committee. The Governing Body shall consider the decision of the Hearing Committee within 70 days, and shall give it great weight.

13.5-2 Time, Place, and Notice

If an appellate review is to be conducted, the Appeal Board shall, within 30 days after receiving a Notice of appeal, schedule a review date and cause each side to be given Notice (with Special Notice to the Practitioner) of the time, place, and date of the appellate review. The appellate review should commence within 45 days from the date of such Notice provided; however, the time for appellate review may be extended by the Appeal Board for good cause.

13.5-3 Appeal Board

The Governing Body may sit as the Appeal Board, or it may appoint an Appeal Board that shall be composed of at least three persons, one of whom is a member of the Governing Body. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding. If an attorney is selected, he or she may act as an appellate Hearing Officer and shall have all of the authority of and carry out all of the duties assigned to a Hearing Officer as described in this Article 13. That attorney shall not be entitled to vote with respect to the appeal. The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

13.5-4 Appeal Procedure

The proceeding by the Appeal Board shall, in the sole discretion of the Appeal Board, either be a new hearing or an appellate hearing based upon the record of the hearing before the Hearing Committee, provided that the Appeal Board may in its sole discretion accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing; or the Appeal Board may send back the matter to the Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel or any other representative designated by that party in connection with the appeal. The appealing party shall submit a written statement concisely stating the specific grounds for appeal. In addition, each party shall have the right to present a written statement in support of his, her, or its position on appeal. The appellate Hearing Officer may establish

reasonable time frames for the appealing party to submit a written statement and for the responding party to respond. Each party has the right to personally appear and make oral argument. The Appeal Board may then, at a time convenient to itself, deliberate outside the presence of the parties.

13.5-5 Decision

(a) Within 30 days after the adjournment of the Appellate Review proceeding, the Appeal Board shall render a final decision in writing, which shall then be effective. Final adjournment shall not occur until the Appeal Board has completed its deliberations.

(b) The Appeal Board may affirm, modify, reverse the decision, or remand the matter for further review by the Hearing Committee or any other body designated by the Appeal Board.

(c) The Appeal Board shall not act arbitrarily or capriciously. The Practitioner or Medical Affairs Committee has the burden of proving that the Hearing Committee recommendation should not be sustained because it lacks factual basis or the conclusions drawn from the facts are arbitrary or capricious. The decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such findings and conclusions differ from those of the Hearing Committee.

(d) The Appeal Board shall forward copies of the decision to each side involved in the hearing.

(e) The Appeal Board may remand the matter to the Hearing Committee or any other body the Appeal Board designates for reconsideration or may refer the matter to the full Governing Body for review. If the matter is remanded for further review and recommendation, the further review shall be completed within 30 days unless the parties agree otherwise or for good cause as determined by the Appeal Board.

13.5-6 Right to One Hearing

No Practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter that shall have been the subject of adverse action or recommendation; in addition, in the event multiple adverse actions occur simultaneously, or in close proximity in time, with respect to the same Practitioner, the review process(es) shall merge, there shall be a single investigation, and the Practitioner shall be entitled to a single hearing and appeal under the terms of these Bylaws.

13.6 CONFIDENTIALITY

To maintain confidentiality in the performance of peer review, disciplinary, and credentialing functions, participants in any stage of the hearing or appellate review process shall limit their discussion of the matters involved to the formal avenues provided in the Medical Staff Bylaws.

13.7 RELEASE

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

13.8 GOVERNING BODY COMMITTEES AND INTERVENTIONS

In the event the Governing Body should delegate some or all of its responsibilities described in this Article 13 to its committees, the Governing Body shall nonetheless retain ultimate authority to accept, reject, modify, or return for further action or hearing the recommendations of its committee. Notwithstanding anything else in these Bylaws, the Governing Body may intervene in, make orders regarding, take over, or otherwise become directly involved in a formal corrective action process at any time if it reasonably believes that it must or should act in the interest of maintaining quality health care in the Hospital. Any such action shall take into account the need to provide a fair procedure to the person affected, always subject, however, to the need to maintain quality health care in the Hospital and to protect the health, safety, and welfare of Hospital patients or other persons in the Hospital.

13.9 EXCEPTIONS TO HEARING RIGHTS

13.9-1 Exclusive Use Departments, Hospital Contract Practitioners

(a) Exclusive Use Departments

The hearing or appellate review rights of Article 13 do not apply to a Practitioner whose application for Medical Staff membership and Privileges was denied or whose Privileges were terminated on the basis the Privileges he or she seeks are granted only pursuant to an exclusive services contract. Such Practitioners shall have the right, however, to request that the Governing Body review the denial and the Governing Body shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the Practitioner may personally appear before and/or submit a statement in support of his or her position to the Governing Body.

(b) Hospital Contract Practitioners

The hearing rights of Article 13 do not apply to Practitioners who have contracted with the Hospital to provide clinical services. Removal of these Practitioners from office and of any exclusive Privileges (but not their Medical Staff membership) shall instead be governed by the terms of their individual contracts and agreements with the Hospital. The hearing rights of Article 13 shall apply if an action is taken that in the reasonable opinion of the Medical Staff must be reported to the Washington Medical Quality Assurance Commission or the National Practitioner Data Bank and/or the Practitioner's Medical Staff membership status or Privileges that are independent of the Practitioner's contract are removed or suspended.

(c) Other

The hearing rights of Article 13 do not apply to the denial or limitation of Medical Staff membership and/or Privileges on the basis of any of the following:

(1) Limitations on membership and/or Privileges adopted by the Governing Body;

(2) Inability of the Hospital to accommodate additional services in a particular specialty;

(3) If a particular service or procedure is not offered in the Hospital;

(4) The issuance of a warning, a letter of admonition, a letter of reprimand, or the denial, termination or reduction of Temporary Privileges without medical-disciplinary cause, or any other actions except those specified in Section 13.2;

(5) Lack of a qualification for a Privilege that has been adopted by the Governing Body;

(6) Any other circumstance that does not involve the competence or professional conduct of the Practitioner.

Further, the hearing procedures described in these Bylaws are intended for the resolution of factual disputes, or to challenge whether the provisions of these Bylaws have been followed. The Hearing is not a mechanism to challenge the substantive validity of the Medical Staff or Hospital Bylaws, Rules, regulations, or policies, and the Hearing Committee appointed pursuant to these Bylaws shall not be empowered to hold quasi-legislative, notice-and-comment-type hearings, or to make quasi-legislative determinations, or determinations as to the substantive validity of bylaws, rules, regulations, or other intra-organizational legislation. Such challenges shall, instead, be made through the mechanism described at Article 15 of these Bylaws.

A Practitioner whose Privileges are removed or denied as the result of one of the criteria provided in this Section 13.9-1(c) shall have the right to request that the Governing Body review the denial and the Governing Body shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the Practitioner may personally appear before and/or submit a statement in support of his or her position to the Governing Body.

13.9-2 Allied Health Professionals

Allied Health Professionals (AHPs) are not entitled to the hearing rights set forth in this Article.

13.9-3 Denial of Applications for Failure to Meet the Minimum Qualifications

Persons shall not be entitled to any hearing or appellate review rights if their membership, Privileges, applications, or requests are denied because of a circumstances that does not involve the competence or professional conduct of the person or because of their failure to have a current Washington license to practice medicine, dentistry, oral surgery, or podiatry; to maintain a current unrestricted Drug Enforcement Administration certificate (when it is required under these Bylaws or the Rules); to maintain professional liability insurance as required by the Rules; to apply for a Privilege offered in the Hospital to persons with the same credentials; to meet any of the other basic standards specified in Section 2.2-2; to file a complete application; or to have or maintain any qualification or credential required to obtain or maintain a Privilege.

13.9-4 Automatic Suspension or Limitation of Privileges

No hearing is required when a Member's license or legal credential to practice has been revoked or suspended as set forth in Section 12.3-1. In other cases described in Sections 12.3-1 and 12.3-2, the issues that may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or the DEA was unwarranted, but only whether the Member may continue practice in the Hospital with those limitations imposed.

Practitioners whose Privileges are automatically suspended (as earlier defined herein) and/or who have resigned their Medical Staff membership for failing to satisfy a special appearance (Section 12.3-3), failing to complete medical records (Section 12.3-4), failing to maintain malpractice insurance (Section 12.3-5), failing to pay credentialing fees (Section 12.3-6), failing to comply with particular government or other third party payor rules or policies so long as compliance with such rules and policies may be objectively determined (Section 12.3-7), disruptive conduct or failure to comply with on-call ED obligations (Section 12.3-8); or failure to satisfy a qualification or credential for a privilege so long as the qualification or credential may be objectively determined (12.3-9) are not entitled under Section 12.3-9 to any hearing or appellate review rights.

13.9-5 Failure to Meet Minimum Activity Requirements

Practitioners shall not be entitled to the hearing and appellate review rights if their membership, voting rights, or Privileges are denied, restricted, or terminated or their Medical Staff categories are changed or not changed because of a failure to meet the minimum activity requirements set forth in the Medical Staff Bylaws or Rules. In such cases, the only review shall be provided by a Medical Executive Committee through a subcommittee consisting of at least 3 Medical Executive Committee members. The subcommittee shall give the Practitioner Notice of the reasons for the intended denial or change in membership, Privileges, voting rights, and/or category and shall schedule an interview with the subcommittee to occur no less than 30 days and no more than 60 days after the date the Notice was given. At this interview, the Practitioner may present evidence concerning the reasons for the action, and thereafter the subcommittee shall render a written decision within 45 days after the interview. A copy of the decision shall be sent to the Practitioner, Medical Executive Committee, and Governing Body. The subcommittee decision shall be final unless reversed by the Governing Body.

13.10 JOINT HEARINGS AND APPEALS FOR SYSTEM AFFILIATES

13.10-1 Joint Hearings

(a) Whenever a Practitioner is entitled to a hearing because a coordinated, cooperative, or joint credentialing or corrective action has been taken or recommended pursuant to Section 12.6, a single joint hearing may be conducted in accordance with hearing procedures that have been jointly adopted by the involved entities, provided such procedures are substantially comparable to those set forth in Section 13.4 and further provided at least one member of the Hearing Committee is a Member of the Hospital's Medical Staff.

(b) In the event there is such a joint hearing, the recommendation of the Hearing Committee shall be reported to this Hospital's Governing Body for final action.

13.10-2 Joint Appeals

The procedures may also call for joint appeal rights, provided such procedures are substantially comparable to those set forth in Section 13.5 and, further, provided that at least one member of the Appeal Board is a representative of this Hospital's Governing Body.

13.10-3 Effect of Joint Hearings/Appeals

A joint hearing and/or appeal in accordance with the foregoing shall be deemed to satisfy procedural rights afforded to the Practitioner pursuant to the federal Health Care Quality Improvement Act of 1986.

13.10-4 Provision for Separate Hearing

Notwithstanding the foregoing, if a Practitioner can demonstrate to the Medical Executive Committee (in the case of a hearing based on a recommendation of the Medical Executive Committee) or the Governing Body (in the case of a hearing based on a recommendation of the Governing Body or in the case of an appeal) prior to the initiation of a joint hearing and/or appeal that the benefits of quasi-judicial economy and efficiency are outweighed by particular burdens or unfairness unique to the individual Practitioner's circumstances, the Medical Executive Committee or Governing Body may, in its sole discretion, order that a separate hearing and/or appeal be conducted solely with respect to Privileges at this Hospital, in accordance with this Hospital's Hearing and Appellate Review Provisions. (Examples of such unique burdens or unfairness would include unavailability of witnesses or documents to the joint proceeding; but the mere fact that the outcome would affect Privileges at more than one facility would not ordinarily be deemed sufficient to preclude a joint hearing.)

ARTICLE 14
GENERAL PROVISIONS

14.1 RULES AND POLICIES

14.1-1 General Medical Staff Rules

The Medical Staff shall initiate and adopt such Rules as it may deem necessary and shall periodically review and revise its Rules to comply with current Medical Staff practice. Recommended changes to the Rules shall be submitted to the Medical Executive Committees for review and approval. Following approval by the Medical Executive Committee, a Rule shall become effective following approval by the Governing Body, which approval shall not be withheld unreasonably, or automatically within 60 days if no action is taken by the Governing Body. If there is a conflict between the MHS and Medical Staff Bylaws and the Rules, the Bylaws shall prevail. The Rules shall be deemed an integral part of the Medical Staff Bylaws.

14.1-2 Service Rules and Campus-Specific Rules

Subject to the approval of the campus Medical Executive Committee and Governing Body, each Service and campus-specific committee shall formulate its own Rules for conducting its affairs and discharging its responsibilities. Such Rules shall not be inconsistent with the Medical Staff or MHS Bylaws, Rules, or other policies. The department and campus-specific Rules shall be deemed an integral part of the MHS and Medical Staff Bylaws.

14.1-3 Section Rules

Subject to the approval of the committee of the service that oversees the section, the Medical Executive Committee and the Governing Body, each section may formulate its own Rules for conducting its affairs and discharging its responsibilities. Such Rules shall not be inconsistent with the Medical Staff or MHS Bylaws, Rules, or policies.

14.1-4 Medical Staff Policies

Policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff Rules. The policies may be adopted, amended, or repealed by majority vote of the Medical Executive Committee and approval by the Governing Body. Such policies shall not be inconsistent with the Medical Staff or MHS Bylaws, Rules, or similar policies at System Affiliates.

14.2 FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with Medical Staff appointments, reappointments, delineation of Privileges, corrective action, notices, recommendations, reports, and other matters shall be approved by the Medical Executive Committee. Upon adoption, they shall be deemed part of the Medical Staff Rules. They may be amended by approval of the Medical Executive Committee and the Governing Body.

14.3 CREDENTIALING FEES OR ASSESSMENTS

The Medical Executive Committee shall have the power to recommend a reasonable amount of annual credentialing fees or assessments, if any, for each category of Medical Staff membership, subject to the Governing Body's approval, and to determine the manner of expenditure of such funds received provided, however, that such expenditures shall not jeopardize the tax exempt nonprofit status of the Hospital. Once paid credentialing fees or assessments are not refundable, in whole or in part.

14.4 AUTHORITY TO ACT

Any Member who acts in the name of the Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

14.5 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.

ARTICLE 15
ADOPTION AND AMENDMENT OF BYLAWS

15.1 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

15.1-1 The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments that shall be effective when approved by the Governing Body. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Governing Body.

15.1-2 Amendments to these Bylaws shall be submitted for vote upon the request of the Medical Executive Committee or upon receipt of a petition signed by at least 10 percent of the voting Medical Staff Members.

15.1-3 Proposed amendments shall be submitted to the Governing Body for comments before they are distributed to the Medical Staff for a vote. The Governing Body has the right to have its comments regarding the proposed Amendments circulated with the proposed amendments.

15.2 METHODOLOGY

Medical Staff Bylaws may be amended or repealed by the following combined actions:

15.2-1 All proposed amendments, whether originated by the Medical Executive Committee, another standing committee or by a Member of the Active category of the Medical Staff, must be reviewed and discussed by the Medical Executive Committee prior to any Medical Staff vote on the matter. Such amendment may be recommended to the Governing Body by the Medical Executive Committee after a majority vote by a quorum of the Medical Executive Committee, provided that the proposed amendment was first distributed or made available at the Hospital to the Members of the Active category at least fourteen (14) days prior to a Medical Executive Committee vote. The Medical Executive Committee's recommendation may be acted upon by the Governing Body unless more than ten percent (10%) of the Active Staff Members object in writing. If more than ten percent (10%) of the Active Staff Members so object to a proposed amendment, or the Medical Executive Committee deems a meeting of the Medical Staff or a ballot by mail to be desirable, then the President or the Medical Executive Committee may call a meeting of the Medical Staff or cause a ballot by mail. A majority of ballots returned within fifteen (15) days of mailing is required for passage.

15.2-2 The approval of the Governing Body, which shall not be unreasonably withheld. Following such approval, copies of the revised Bylaws shall be made available to all individuals who have delineated clinical privileges under the Bylaws. If approval is withheld, the reasons for doing so shall be specified by the Governing Body in writing, and shall be forwarded to the President, the Medical Executive Committee, and the Bylaws Committee.

In recognition of the ultimate legal and fiduciary responsibility of the Governing Body, the organized Medical Staff acknowledges, in the event the Medical Staff has unreasonably failed to exercise its responsibility and after notice from the Governing Body to such effect including a reasonable period of time for response, the Governing Body may impose conditions on the Medical Staff that are required for continued state licensure, approval by accrediting bodies, or to comply with a court

judgment. In such event, Medical Staff recommendations and views shall be carefully considered by the Governing Body in its actions.

15.3 TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, or inaccurate cross-references. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Governing Body within 90 days after adoption by the Medical Executive Committee. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated in writing to the Medical Staff by posting, newsletter, or other means and to the Governing Body.

15.4 APPROVAL AND ADOPTION

These Bylaws of the Medical Staff of Tacoma General Allenmore Hospital were approved by the Governing Body on March 2, 2005, pursuant to Medical Staff recommendations based on affirmative votes, to be effective April 1, 2005, in full substitution and replacement for any and all previous medical staff Bylaws applicable to the licensed facility now known as Tacoma General Allenmore Hospital.

Notes/Revisions/Amendments/Additions

Consent Resolution
Presented to the Quality Committee

On March 15, 2005, the Quality Committee, being fully advised and after thorough discussion, hereby appoints a special committee to review and approve, on behalf of the Governing Board, requests for appointments and reappointments to the TG-AH and MBCH medical staffs and for privileges and to make any adverse recommendations to the Quality Committee, pursuant to the Medical Staff Bylaws credentialing provisions. The Chair of the Quality Committee and two MHS Board directors are designated to participate in the review and recommendations regarding appointment, reappointment and privileging. At least two of such Board directors must vote on and approve any recommendation to grant membership and/or privileges. Any adverse recommendation by the Medical Executive Committee shall be referred to the Quality Committee for further review and action under the applicable Medical Staff Bylaws and Rules.