MULTICARE HEALTH SYSTEM

Covington Medical Center

Medical Staff Bylaws

12/18/2017

Approved by:
Governing Board 12-18-2017

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PREAMBLE

These Medical Staff Bylaws are adopted to provide a framework of self-government for the organization of the Medical Staff of **Covington Medical Center** permitting 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. The Medical Staff recognizes that the Governing Body has, and may exercise at its discretion, full power and ultimate authority in all matters deemed necessary to the business and affairs of [Facility]. Further, the Medical Staff recognizes and acknowledges that providing quality medical care depends on the mutual accountability, interdependence and responsibility of the Medical Staff and the Governing Body for the proper performance of their respective obligations. In furtherance of these goals, the practicing physicians of **Covington Medical Center** hereby organize themselves in conformity with these Bylaws.

DEFINITIONS

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 applicable State laws; who is licensed or certified to render direct or indirect medical, dental, or podiatric care; and who may be eligible to exercise privileges and prerogatives in conformity with the rules adopted by the Governing Body, the Medical Staff and these Bylaws. AHPs are not eligible for Medical Staff membership.

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

CHIEF OF STAFF means the chief officer of Hospital's Medical Staff appointed by the Medical Staff in accordance with these Bylaws.

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.

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

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 or individual authorized to act on behalf of the Governing Body.

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

HOSPITAL means **Covington Medical Center** and the related facilities operating under Hospital's license.

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

MEDICAL EXECUTIVE COMMITTEE means the executive committee of the Hospital Medical Staff. This Committee constitutes the governing body of the Medical Staff as described in these Bylaws.

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

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

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

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

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. Unless otherwise stated, Notice shall be sent by the Chief of Staff or his/her designee. See also, definition of SPECIAL NOTICE

PATIENT CONTACT means admitting a patient to Hospital (including Hospital's Emergency Department and Hospital's outpatient departments); performing surgery at Hospital; assisting with surgery at Hospital; or consulting on a patient in Hospital, Hospital Emergency Department or a Hospital outpatient department.

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

PHYSICIAN EXECUTIVE means the person, appointed by the Chief Executive Officer to serve as a liaison between the Medical Staff, the Hospital and System staff.

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

PRIVILEGE OR PRIVILEGES means the permission granted by the Governing Body to a Medical Staff Member or AHP to render specific patient services.

RULES means the Medical Staff and/or Service rules adopted in accordance with these Bylaws unless specified otherwise.

SERVICE means a department of the Hospital Medical Staff. Services shall include Anesthesiology, Emergency Services, Medicine, Obstetrics and Gynecology, Pediatrics, Surgery and Radiology and any such additional Services as may be established in accordance with these Bylaws.

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.

SPECIAL NOTICE means a Notice sent by certified or registered mail, return receipt requested. Unless otherwise stated, Special Notices shall be sent by the Chief of Staff or his/her designee. See also, the definition of NOTICE above.

SYSTEM means MultiCare Health System.

SYSTEM AFFILIATE means a facility or entity (such as a hospital, clinic, urgent care center, surgery center, physician office, managed care program), department, committee, or other entity that is part of the System.

I. NAME

The name of this organization shall be the Medical Staff of **Covington Medical Center** ("Medical Staff").

II. PURPOSES of the MEDICAL STAFF

2.1 The Medical Staff's purposes shall include, but are not limited to:

2.1-1 Assuring that all patients admitted for or provided Hospital services receive care at a level of quality and efficiency consistent with generally-accepted standards of care attainable within the Hospital's means and circumstances.

2.1-2 Providing a level of professional performance that is consistent with accepted standards of care attainable within the Hospital's means and circumstances.

2.1-3 Providing a leadership role in Hospital and System performance improvement activities.

2.1-4 Providing a means for the Medical Staff, Governing Body, and Hospital administration to address issues of mutual concern.

2.1-5 Providing for accountability of the Medical Staff to the Governing Body.

2.1-6 Organizing and supporting professional education and community health education and support services.

2.1-7 Initiating and maintaining Rules for the Medical Staff to carry out its responsibilities for the professional work performed in Hospital, pursuant to the authority delegated by the Governing Body.

III. COORDINATED CREDENTIALING, PEER REVIEW, AND CORRECTIVE ACTION

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

3.1 Coordinated 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 from other healthcare organizations' and System Affiliates' credentials and peer review files when evaluating applications for

appointment, reappointment, and Privileges; utilizing other System Affiliates' medical or professional staff support resources when processing applications for appointment, reappointment, and Privileges; and using third parties to perform primary source verification of credentials.

3.2 Coordinated Corrective Action

The Medical Staff may work cooperatively with any System Affiliate to develop and impose coordinated, cooperative, and/or or joint corrective action measures as appropriate to the circumstances. This may include, but is not limited to, giving timely notice of emerging or pending problems, conducting joint corrective action investigations, sharing the results of corrective action investigations, providing notice of corrective action recommended or imposed, and/or in accordance with Article 14 (Peer Review and Corrective Action) of these Bylaws.

3.3 Coordinated Peer Review

The Medical Staff may enter into arrangements with System Affiliates and other healthcare organizations to assist it in peer review activities. This may include, without limitation, relying on information in System Affiliates' credentials and peer review files, utilizing the System Affiliates' or other healthcare organizations' medical or professional staff support resources to conduct or assist in conducting peer review activities, and engaging in coordinated peer review or proctoring, 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 applicable Washington State peer review, quality assurance and quality improvement laws and regulations.

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.

IV. MEDICAL STAFF MEMBERSHIP

4.1 Nature of Membership

Membership on the Medical Staff may be extended to and maintained by only those professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and Rules. Appointment to the Medical Staff shall confer only such rights 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 MHS or Hospital unless such a relationship is separately established between the MHS and the Member.

4.2 Indemnification

MultiCare Health System shall indemnify any Member of the Medical Staff who is a party to or is threatened to be made a party to any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative (other than an action by or in the right of MultiCare

Health System), arising from or related to the Member's actions or conduct within the scope of his/her Medical Staff duties conducted on behalf of Hospital pursuant to these Bylaws, which shall include indemnification for expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred by him or her in connection with such action or proceeding provided that he or she acted in good faith and in a manner consistent with the best interests of MultiCare Health System and with no reasonable cause to believe that his or her conduct was unlawful. Nothing within the foregoing indemnification provisions shall be interpreted so as to require indemnification of a Member for any matter pertaining to such Member's own clinical decisions or clinical care provided by such Member as a treating provider at Hospital

4.3 Qualifications for Membership

4.3-1 General Qualifications

The quality improvement and peer review responsibilities of the Medical Staff begin with the careful and candid evaluation of applications for medical staff membership and privileges as well as requests for new or additional privileges in order to assure to the extent possible that patients can reasonably expect to receive the generally recognized high professional level of quality of care for the community. 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 and qualified to practice medicine, podiatry, dentistry, or oral surgery in Washington. Practitioners must have a demonstrated ability to work with others sufficient to assist the Hospital to fulfill its responsibility without undue disruption.

4.3-2 Basic Qualifications

A Practitioner must demonstrate compliance with all the basic standards set forth in this Section 4.3-2 in order to have an application for Medical Staff membership considered. 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 Doctor of Medical Dentistry;

(3) A Doctor of Podiatric Medicine.

(b) If practicing clinical medicine, dentistry, oral surgery, or podiatry, have a current, valid federal DEA number if applicable

(c) Board certification, residency training. Practitioners must:

(1) Have successfully completed a residency approved by the Accreditation Council for Graduate Medical Education (ACGME), or American Osteopathic Association (AOA), that provided training in the specialty or subspecialty that the Practitioner will

primarily practice at the Hospital, and subsequent compliance with Section 4.3-2(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 Osteopathic Association, the National Board of Physician and Surgeons, the American Board of Podiatric Surgery, the American Council of Certified Podiatric Physician and Surgeons, the American Board of Medical Specialties in Podiatry, the American Board of Podiatric Orthopedics & Primary Podiatric Medicine, the American Board of Orthopedic Podiatric Medicine, the Royal College of Physicians and Surgeons of Canada, or a board or association with the equivalent requirements identified by the Service to which the Member will be assigned and approved by the Governing Body.

(3) If an oral or maxillofacial surgeon, demonstrate completion of an approved residency program and evidence of current board certification applicable to the type of practice;

(4) Satisfy any other board certification requirements specified in the Rules of the Service to which the Governing Body assigns the Practitioner.

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

(e) Have actively practiced an average of at least twenty (20) hours per week for 12 of the previous 24 months in the specialty he or she will practice at the Hospital (or have completed a residency or fellowship within the previous 18 months), proctoring may be required for practitioners lacking recent hospital experience

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

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

Except as otherwise specifically provided in these Bylaws, a Practitioner who does not meet these basic qualifications is ineligible to apply for Medical Staff membership and an application shall not be accepted. Applicants for the Honorary and Retired Medical Staff need not satisfy the basic qualifications. If it is determined during the processing that an applicant does not meet all of the basic qualifications, review of the application shall be discontinued. An applicant who does not meet the basic qualifications 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 under Section 4.3-5.

4.3-3 Exceptions to Basic Qualifications

The requirements of Section 4.3-2(c) (1) and (2) shall not apply to:

(a) Dentists other than oral and maxillofacial surgeons;

(b) Current Members of the Good Samaritan Hospital Medical Staff who were Members prior to January 1, 1999 and who continue to maintain Member status through consecutive, uninterrupted reappointments to the Good Samaritan Hospital Medical Staff;

(c) Any current Member of the Auburn Medical Center who was a member of Auburn Regional Medical Center on September 30, 2012 and whose continued membership on the Auburn Regional Medical Center Medical Staff was not contingent on completing or maintaining any board certification requirement, and who continues to maintain Member status through consecutive, uninterrupted reappointments to the Covington Medical Center Medical Staff;

(d) Current Members of the Tacoma General-Allenmore Hospital 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 continues to maintain Member status through consecutive, uninterrupted reappointments to the Tacoma General-Allenmore Hospital Medical Staff;

(e) Current Members of the Tacoma General-Allenmore Hospital 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 Tacoma General-Allenmore Hospital 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 Tacoma General-Allenmore Hospital Medical Staff;

(f) Current members of the Tacoma General-Allenmore Hospital 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;

(g) Current Members of the Mary Bridge Children's Hospital Medical Staff who were members of the medical staff of Mary Bridge Children's Hospital and Health Center as of June 30, 2004 with such continued membership not contingent on completing any board certification requirement, and who continue to maintain Member status through consecutive, uninterrupted reappointments to the Mary Bridge Medical Staff;

(h) A Member, previously certified by a board identified in Section 4.3-2(c) (2) whose certification expires, provided that such Member must achieve board recertification within one year following expiration.

4.3-4 Particular Qualifications

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) Agree 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; and, (iv) maintain a professional demeanor.

4.3-5 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.

4.4 Effect of Other Affiliations or Credentials

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. Disciplinary or corrective action by any state or federal licensing authority, professional organization, certification or accreditation board, or health care facility regarding a practitioner's license, certificate, membership, or privileges, whether contested or voluntarily accepted, shall constitute grounds for an unfavorable credentialing or peer review action by the Medical Staff and/or Governing Body. The Medical Staff and Governing Body shall consider the nature and gravity of charges, allegations and resulting disciplinary or corrective action, but shall not be obligated to conduct evidentiary proceedings regarding events that occurred elsewhere.

4.5 Nondiscrimination

Medical Staff membership and/or 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 or System policies.

4.6 Administrative and Contract Practitioners

4.6-1 Contractors and Employed Practitioners without Clinical Duties.

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

4.6-2 Contractors with Clinical Duties; Effect of Exclusive Contract

(a) Certain Hospital services may and shall be provided to Hospital through exclusive contracts. In such 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 and provided under the contract. Practitioners who depart from a group with an exclusive contract, or whose group contract terminates and is awarded to another group, shall have their Privileges automatically expire immediately upon such departure or termination. 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 15 of these Bylaws.

(b) As of the effective date of these Bylaws, exclusive Hospital contracts for services include anesthesia, pathology, radiology, adult emergency medicine, neonatology and pediatric intensive care.

(c) Contracts between Practitioners and Hospital shall prevail over these Bylaws and the Rules, except that such contracts may not:

(i) Reduce any hearing rights granted when an action will be taken must be reported to the Washington Department of Health or the 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 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 from a group with an exclusive contract from maintaining Medical Staff membership and applying for Privileges not covered under an exclusive contract, provided the Practitioner otherwise meets the qualifications for such privileges under these Bylaws.

4.7 Basic Responsibilities of Medical Staff Membership

Except for Honorary and Retired Members, each Medical Staff Member and each Practitioner exercising Privileges shall continuously meet all of the following responsibilities:

4.7-1 Provide his or her patients with professional services within the generally recognized standard of care and efficiency.

4.7-2 Abide by the Medical Staff Bylaws and Rules and all other lawful standards, policies, and rules of the Medical Staff, the Hospital and the System.

4.7-3 Abide by all applicable laws and regulations of governmental agencies and comply with applicable standards of the Joint Commission

4.7-4 Discharge such Medical Staff, department, committee, and Service functions for which he or she is responsible by appointment, election, or otherwise.

4.7-5 Prepare and complete in a timely manner the medical and other required records for all patients to whom the Practitioner provides services in the Hospital. Complete electronic medical record training and demonstrate basic competency. Complete patient history and physical examinations within thirty (30) days prior to admission and/or procedure, or within twenty-four (24) hours after admission in compliance with Rules and policies. Histories and physical examinations completed prior to admission must be accompanied by either an updated physical exam documenting any changes to the patient’s condition, or the Practitioner’s written statement that he/she has examined the patient and that there have been no changes. Such history and physical examination or Practitioner’s statement must be completed prior to surgery. Additional requirements related to History and Physical exams may be found in the Medical Staff Rules and Regulations and policies.

4.7-6 Refrain from unlawful harassment, sexual harassment, or discrimination against any person (including, without limitation, any patient, System employee, Hospital 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. Allegations of harassment or discrimination should be reported to the Chief of Staff or Physician Executive. All allegations of harassment or discrimination shall be investigated by the Medical Staff pursuant to Article 14 and the appropriate parties notified of the findings. Harassment or discrimination that is confirmed will result in corrective action. No Practitioner will suffer retaliation for reporting instances of harassment or discrimination, and confidentiality will be maintained to the extent possible.

4.7-7 Refrain from inappropriate, disruptive, or unprofessional behavior. “Inappropriate, disruptive or unprofessional behavior” is defined as any conduct that disrupts the orderly operation of the Hospital or that adversely affects the ability of nurses, physicians or other Hospital employees to render patient care or do their job effectively. It also includes failures to fulfill Medical Staff responsibilities, as outlined in the Medical Staff Bylaws and Rules including, without limitation, emergency department call obligations. Examples of inappropriate, disruptive or unprofessional behavior include, but are not limited, to:

(a) Abusive behavior toward patients, visitors, colleagues, or hospital staff, including rudeness, discourtesy, or negative comments about other health care professionals with the intent to discredit;

(b) Physical or verbal harassment, threats or assault on a physician, nurse, or other Hospital employee;

(c) Falsification of medical or hospital records;

(d) Unauthorized handling, possession or use of any drugs or alcoholic beverages on Hospital premises or working under the influence of controlled substances or intoxicants;

(e) Refusal to answer calls or pages;

(f) Unauthorized possession, use, copying or reading of hospital records or disclosure of information contained in such records to unauthorized persons; and,

(f) Disregard of established safety or infection control requirements.

Allegations of inappropriate, disruptive or unprofessional behavior shall be investigated by the Medical Staff pursuant to Article 14 and the appropriate parties notified of the findings. Inappropriate, disruptive or unprofessional conduct that is confirmed will result in corrective action. No Practitioner will suffer retaliation for reporting instances of inappropriate or disruptive behavior, and confidentiality will be maintained to the extent possible. This requirement is not in any way intended to interfere with a Member's privilege to: (i) express opinions freely and to support positions whether or not they are in dispute with those of other Members; (ii) engage in honest differences of opinion with respect to diagnosis and treatment or basic program development that are debated in appropriate forums; or (iii) engage in the good faith criticism of others.

4.7-8 Abide by the ethical principles of his or her profession.

4.7-9 Refrain from unlawful fee-splitting or unlawful inducements relating to patient referral.

4.7-10 Refrain from delegating the responsibility for diagnosis or care of Hospital patients to a Practitioner or AHP who does not hold requisite Privileges, who is not adequately supervised, or who did not agree to care for the patient.

4.7-11 Seek consultation whenever warranted by the patient's condition or when required by the Rules.

4.7-12 Actively participate in and regularly cooperate with the Medical Staff in assisting the Hospital to fulfill its patient care obligations, 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.

4.7-13 Upon request from a Medical Staff committee or representative, 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.

4.7-14 Communicate with appropriate Medical Staff officers leaders and representatives of the Hospital when Practitioner obtains credible information 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 cooperate as reasonably necessary toward the appropriate resolution of any such matter.

4.7-15 Voluntarily participate in Medical Staff proctoring in accordance with the Rules and Bylaws.

4.7-16 Complete continuing medical education ("CME") necessary to meet all licensing, certification and accreditation requirements appropriate to the Practitioner's specialty.

4.7-17 All Members including specialist and sub specialists are required to participate in the emergency department call roster in their designated specialty and to respond, examine, and treat patients presenting to the Hospital with emergency medical conditions. However, emergency department call is not a right, privilege or other entitlement for any Member of the Medical Staff, regardless of whether the Member has participated on the call roster or has been requested to participate on the call roster 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. While on emergency department call, Medical Staff Members are required to respond to requests for inpatient consultations as specified in the Rules. 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 Privileges.

4.7-18 Cooperate with the Hospital to ensure all patients who present to the Hospital requesting examination or treatment for a medical condition or active labor receive a medical screening examination to determine the existence of an emergency medical condition. Medical screening examinations may be performed by a Member or by an AHP or registered nurse acting within the scope of his or her Privileges and pursuant to Rules and protocols approved by the Medical Staff and the Governing Body. Upon a determination that an emergency medical condition exists, all available medical treatment within the capacity and resources of the Hospital will be provided to stabilize the patient, deliver the infant, or transfer the patient to another hospital in accordance with the Hospital's emergency treatment and transfer policies.

4.7-19 Continuously and promptly inform the Medical Staff of any significant changes in the information required on appointment and reappointment, including without limitation, pending or threatened activity related to professional conduct. This obligation includes, but is not limited to immediately advising by telephone and in writing, to the Physician Executive and the Medical Staff Services Office any:

(a) Suspension, limitation, or revocation of Privileges by a healthcare facility;

(b) Investigation, reprimand, sanction, or discipline by a licensing or accreditation board;

(c) 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

(4) Notice of the Practitioner's exclusion from any healthcare program funded in whole or in part by the federal government, including Medicare or Medicaid.

4.7-20 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 Physician Executive. 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.

4.7-21 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.

4.7-22 Pay credentialing fees or dues, if any, assessed by the Medical Staff in the amounts specified in the Rules.

V. CATEGORIES OF THE MEDICAL STAFF

5.1 The Medical Staff

The Medical Staff shall include the following categories: Active, Courtesy, Affiliate, Telemedicine, Honorary/Retired, Administrative, and Locum Tenens. Each Medical Staff Member shall be assigned to a Medical Staff category as set forth 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 Bylaws and Rules. Changes in Medical Staff category or voting status shall not be grounds for a hearing unless they adversely affect the Member's Privileges.

5.2 Active Medical Staff

Members of the Active Medical Staff shall be appointed to a specific Service. Such Members will provide for the continuous care of their patients or arrange for admission, care and/or consultation of their patients with another appropriately credentialed member of the Medical Staff.

5.2-1 Eligibility

The Active Staff shall consist of Members who are regularly involved in caring for patients. Regular involvement in patient care shall mean admitting, attending, or consulting on at least twelve patients during a 12 consecutive month period at the Hospital

5.2-2 Prerogatives

Members of the Active Medical Staff may:

(a) Exercise Privileges approved by the Governing Body;

(b) Vote on all matters presented at general and special meetings of the Medical Staff, assigned Service and committee meetings of which he/she is a member;

(c) Hold office;

(d) Sit on and/or chair committees;

(e) Attend all Medical Staff, Service and committee meetings;

(f) Serve as proctors; and

(g) Attend educational programs of the Medical Staff.

5.2-3 Responsibilities

Members of the Active Medical Staff must:

(a) Conform to the provisions of the Medical Staff Bylaws, Rules, Hospital policies and Service rules, regulations and policies;

(b) Actively participate in recognized functions of the Medical Staff including quality improvement and other monitoring activities; and

(c) Participate in the emergency room call and other specialty coverage programs as specified in the Medical Staff and Service rules and regulations and approved by the Governing Body.

5.3 Administrative Medical Staff

5.3-1 The Administrative Medical Staff consists of Practitioners who hold professional administrative positions at Hospital. Administrative Medical Staff Members must meet all criteria for Medical Staff membership set forth in Article 4 of these Bylaws. Administrative Medical Staff may not vote and may not hold a position as an officer of the Medical Staff. Administrative Medical Staff Members may serve on Medical Staff service committees in an Ex Officio capacity.

5.4 Courtesy Medical Staff

Members of the Courtesy Medical Staff shall be appointed to a specific Service. Such Members will provide for the continuous care of their patients or arrange for admission, care and/or consultation of their patients with another appropriately credentialed member of the Medical Staff.

5.4-1 Eligibility

The Courtesy Medical Staff shall consist of Practitioners who occasionally practice in the Hospital and do not exceed eleven (11) direct patient contacts in a consecutive twelve (12) month period. Practitioners initially applying for Courtesy Medical Staff membership and privileges must hold current membership and privileges at another hospital.

5.4-2 Prerogatives

Members of the Courtesy Medical Staff may:

(a) Exercise clinical privileges approved by the Governing Body;

(b) Vote on all matters presented at general and special meetings of the Medical Staff, assigned Service and committee meetings of which he/she is a member

(c) Attend all Medical Staff, Service and Committee meetings; and

(d) Attend educational programs of the Medical Staff.

5.4-3 Responsibilities

Members of the Courtesy Medical Staff must:

(a) Conform to the provisions of the Medical Staff Bylaws, Rules, and other requirements set forth in the Hospital bylaws and Medical Staff and Service rules, regulations and policies;

(b) Have at least one (1) but not more than eleven (11) patient contacts during a consecutive 12-month period. (Members of the Courtesy Medical Staff who fail to maintain the minimum number of required contacts (1) or who exceed the maximum number of patient contacts (11) shall be notified in writing. Sixty (60) days from such notification, such Courtesy Member shall be automatically assigned to the appropriate category);

(c) Serve on Emergency Department outpatient call rosters as required in the Rules.

(d) Actively participate in recognized functions of the Medical Staff including quality improvement and other monitoring activities, as those functions apply to such Courtesy Members of the Medical Staff.

5.5 Affiliate Medical Staff

Members of the Affiliate Medical Staff shall be appointed to a specific Service.

5.5-1 Eligibility

Affiliate Medical Staff are Members of the Medical Staff who, by their association advance the mission of the Hospital as determined by the Governing Body. Affiliate Medical Staff are not granted Privileges and do not admit or provide clinical services in the Hospital.

5.5-2 Prerogatives

Members of the Affiliate Medical Staff may:

(a) Perform social visits and may document in the medical record while their patients are inpatients. (Affiliate Staff Members may not hold clinical privileges or write orders);

(b) Vote on all matters presented at general and special meetings of the Medical Staff, assigned Service and committee meetings of which he/she is a member;

(c) Hold office;

(d) Sit on and/or chair committees;

(e) Attend Medical Staff, Service and Committee meetings; and

(f) Attend educational programs of the Medical Staff.

5.5-3 Responsibilities

Members of the Affiliate Medical Staff must:

(a) Abide by the Medical Staff Bylaws, Rules, Hospital policies and Service rules and policies;

(b) Actively participate in recognized functions of the Medical Staff including quality improvement and other monitoring activities, as those functions apply to such Affiliate Members of the Medical Staff.

5.6 Telemedicine Medical Staff

Members of the Telemedicine Medical Staff shall be appointed to a specific Service.

5.6-1 Eligibility

The Telemedicine Staff shall consist of Members who provide diagnostic or treatment services to Hospital patients via telemedicine devices pursuant to a written contract between the Hospital and a distant site (either entity or hospital) at which the telemedicine practitioner is credentialed

and privileged. (”Telemedicine device” means audio or video devices that allow for interactive, two-way transfer of medical information. Telemedicine devices do not include telephone or electronic mail.)

Telemedicine Medical Staff:

(a) Must meet the general qualifications as set forth in sections 4.3-1 and 4.3-2 of these Medical Staff Bylaws but by reason of residency, inability to provide continuous coverage to patients in the hospital, or limited practice license are not eligible for Active Staff membership;

(b) May be granted Medical Staff Membership and clinical privileges in reliance on the distant site credentialing as permitted under the Medical Staff Bylaws;

(c) Do not regularly attend general or committee meetings or medical education programs as determined by Medical Staff bylaws; and

(d) Must adhere to any requirements of the Washington State Medical Quality Assurance Commission or any other applicable state agencies with respect to the provision of Telemedicine Services to patients residing in Washington State.

5.6-2 Prerogatives

Except as otherwise provided, Telemedicine Staff Members may:

(a) Exercise clinical Privileges in the hospital in accordance with applicable bylaws, Rules and regulations of the Medical Staff;

(b) Provide consultation and other patient care services at the request of another Member of the Medical Staff, Hospital administration or the Governing Board; and

(c) Attend general Medical Staff, Service and committee meetings and medical education programs of the Medical Staff.

Telemedicine staff members have no requirements for attendance at Medical Staff functions or for provision of emergency medical care. Telemedicine staff members shall not be eligible to hold office in the Medical Staff organization, or to vote at any standing general or committee meeting of the Medical Staff.

For purposes of its recommendations to the Governing Board with respect to the appointment, reappointment and privileges of a Telemedicine Medical Staff applicant, the Medical Executive Committee may rely on the credentialing and privileging of the Practitioner by a contracted distant site at which the Practitioner maintains membership and privileges. Telemedicine membership and privileges are contingent upon the telemedicine Practitioner maintaining privileges at the distant site, membership in any group providing telemedicine services under contract with the Hospital and the continuation of the contract for telemedicine services.

Telemedicine privileges granted in conjunction with a contractual agreement for the provision of telemedicine services shall be incident to the contract. Such privileges shall terminate upon contract termination without any of the process provided in these Bylaws and policies related to corrective action or fair hearings.

If the medical staff relies upon the credentialing and privileging decision of the distant site at which the Telemedicine practitioner has privileges for its recommendation to the Governing Board, the Hospital shall collect, maintain and periodically transmit to the distant site information regarding the telemedicine practitioner's quality of care, treatment and services provided Hospital patients.

Unless/until the MHS Governing Board authorizes delegated credentialing by the distant site as specified in this Section 5.6, all Telemedicine Providers must apply for Telemedicine Privileges in accordance with the Medical Staff Bylaws.

5.6-3 Responsibilities

Members of the Telemedicine Medical Staff must conform to the provisions of the Medical Staff Bylaws and other Medical Staff Rules, and other requirements set forth in the Hospital bylaws and Medical Staff and Service rules and policies

5.7 Honorary Medical Staff

5.7-1 Eligibility

Honorary Medical Staff shall consist of physicians and oral surgeons who are not active in the Hospital and who are honored by emeritus positions. They may be (1) physicians/oral surgeons who have retired from active Hospital service; or (2) physicians/oral surgeons of outstanding reputation not necessarily residing in the community. To be appointed to the Honorary Staff, recommendation by the Medical Executive Committee or Medical Staff to the Governing Body is required.

5.7-2 Prerogatives

Members of the Honorary Staff may:

(a) Perform social visits.

(b) Vote on all matters presented at general and special meetings of the Medical Staff, assigned Department and committee meetings of which he is a member;
(c) Attend educational programs of the Medical Staff.

VI. ALLIED HEALTH PROFESSIONALS

6.1 General

Allied Health Professionals (AHPs) are not eligible for Medical Staff membership, and accordingly, have none of the privileges of Medical Staff membership. The Governing Body, aided by the concurrence of the Medical Executive Committee, may grant clinical Privileges to appropriately credentialed AHPs who are professionally competent and who continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and Rules. The Governing Body exercises its discretion in determining whether to approve, deny, or review a Privilege request and such decisions are not subject to appeal.

6.2 Privileges and Responsibilities

6.2-1 AHPs may exercise only those Privileges recommended by the Medical Executive Committee and granted by the Governing Body. The range of Privileges for which each AHP may apply and any special limitations or conditions thereon 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.

6.2-2 In determining the need for and type of Privileges for which an AHP may be eligible, the Governing Body shall consider, on the recommendation of the Medical Executive Committee, the types of AHPs and Privileges required to care for Hospital's patients. In determining need, the Governing Body will consider at least the following:

(a) AHP scope of license;

(b) The availability of the same services offered by the Medical Staff, accepting the highest standard of care; and,

(c) The standard of care in the community. Licensure shall not be the sole criterion for determining need and scope of services.

6.2-3 An AHP must apply and qualify for Privileges. Practitioners who desire to supervise or direct AHPs providing dependent services must apply and qualify for Privileges sufficient to supervise approved AHPs.

6.2-4 Initial applications for AHP Privileges and biennial reapplication shall be submitted and processed in a similar manner to that provided for Practitioners, unless otherwise specified in the Rules.

6.2-5 AHPs granted Privileges are subject to the supervision requirements (if any), and terms and conditions developed by the Service to which they are assigned.

6.3 Procedural Rights

6.3-1 Overview

(a) Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an AHP to the procedural rights set forth in Article 15.
(b) A MHS employed AHP shall have procedural rights, if any, as provided under MHS's standard terms of employment.

(c) AHPs not employed by MHS shall have a right to informal hearing and appeal process proceedings to challenge any action that would constitute grounds for a hearing under Section 15.2 of these Bylaws by filing a written grievance with the Medical Executive Committee within thirty (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 or his/her designee. 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, the Chief Executive Officer or his/her designee should attempt to include, as is feasible, at least one professional peer of the affected AHP. This informal hearing need not be conducted in accordance with the

provisions of Article 15, subject to the discretion of the Chief Executive Officer or designee. At a minimum, however, the following provisions shall apply: (i) 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; (ii) evidence in support of the adverse action will be presented by an authorized representative of the Medical Executive Committee; (iii) the AHP shall have the burden of proving his or her competence and that the action leading to the hearing was arbitrary or capricious; (iv) a record of the proceeding shall be made; and (v) the resulting finding and recommendation shall be reported to the AHP and Medical Executive Committee, and shall be appealable to an appeal committee appointed by the Governing Body or authorized committee thereof.

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 6.3-1 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

6.3-2 Automatic Termination

Notwithstanding the provisions of Section 6.3-1, an AHP's Privileges shall automatically terminate or be suspended, without review pursuant any section of these Bylaws, in the event of any of the following:

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

(b) The AHP’s 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;

(d) The AHP is excluded from a federally-funded healthcare program; or,

(e) The AHP’s employment at MHS is terminated.

6.4 Prerogatives

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

6.4-1 Provision of specified patient care services, as granted by the Governing Body and consistent with the AHP’s licensure;

6.4-2 Service on Medical Staff, Service, and Hospital committees without vote unless otherwise specifically authorized; and

6.4-3 Attendance at meetings of the Service to which the AHP is assigned, as permitted by the Service Rules, and attendance at Hospital education programs.

6.5 Responsibilities

Each AHP shall:

6.5-1 Meet those responsibilities required by the Rules and as specified for Practitioners in Section 4.7, as modified to reflect the more limited practice of the AHP.

6.5-2 Retain responsibility within the AHP's Privileges and professional competence for care and supervision of Hospital patients to whom the AHP provides services.

6.5-3 Participate in peer review and quality improvement and such other functions as may be required from time to time.

6.5-4 Act with professional demeanor and comply with professional ethical guidelines of applicable professional societies.

6.5-5 If required by the Service to which AHP is assigned and/or by the Rules, participate on the Emergency Department call roster.

6.5-6 Maintain liability insurance or equivalent coverage meeting the standards specified in the Rules.

6.5-7 If required by state licensing laws to have sponsoring physician, identify his/her supervising physician

VII. PRIVILIEGES

7.1 Overview

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

7.2 Delineation of Privileges in General

7.2-1 Requests

Each application for appointment and reappointment to the Medical Staff must include a request for the specific Privileges desired by the applicant. A request for Privileges must include documentation of training and/or experience sufficient to establish the applicant's qualification for such Privileges. Each Medical Staff Service shall develop a list of Privileges and the criteria for granting the same. Privileges will be granted only if the applicant meets the qualifications approved by the Governing Body for exercise of such Privileges.

7.2-2 Privilege Determinations

Requests for Privileges shall be evaluated based on the applicant's education, training, experience, demonstrated professional competence and judgment, clinical performance, quality improvement review, number of procedures performed, knowledge of and compliance with specific criteria applicable to the Privileges, and professional conduct. The Medical Staff and Governing Board may consider information related to clinical performance obtained from other institutions and health care facilities in making Privilege determinations. For Telemedicine Medical Staff applicants, the Medical Staff may rely on the privileging and credentialing of the contracted distant site at which the applicant has privileges for its recommendation to the Governing Board. The Medical Staff and Governing Board may also consider factors such as patient care needs, hospital capability to support the requested privileges, geographic location of the Practitioner/AHP in terms of his/her personal availability to provide timely coverage for his/her patients, the availability of qualified medical coverage in his/her absence, and an adequate level of professional liability insurance.

7.3 Special Conditions Applicable to Limited License Practitioners

7.3-1 Admissions

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 condition(s) during hospitalization that are outside of the Limited License Practitioner's lawful scope of practice. Limited License Practitioners are responsible for completing a patient history and physical examination related to the Limited License Practitioner's area of practice for which they hold Privileges. Each surgery patient admitted by Limited License Practitioners must have a completed medical history and physical examination performed by a qualified physician member.

7.4 Temporary Privileges and Locum Tenens

7.4-1 Circumstances

Temporary privileges may be granted by the Chief Executive Officer ,acting on behalf of the Governing Body or authorized designee on recommendation of the Chief of Staff or his/her designee, acting on behalf of the MEC to meet an important patient care need for the time period defined in the medical staff bylaws. Examples of important patient care need include but are not limited to: the need for a specific service not available from currently privileged practitioners; patient volumes exceeding the capacity of the current Members; the absence (planned or unplanned) from the Medical Staff of a Practitioner resulting in an inability to meet patient care needs; and for practitioners who will serve as locum tenens for a Medical Staff Member.

Temporary Privileges may be granted when a completed application meeting all the qualifications for membership on the Medical Staff is awaiting approval by the Medical Executive Committee and the Governing Body. Temporary privileges may be granted for a period not to exceed 120 consecutive days.

All individuals with temporary privileges granted under this paragraph shall be under the supervision of the Service Chairperson or his/her designee.

7.4-2 Application and Review

Temporary Privileges may be granted only after the Practitioner or AHP completes the application procedure. There is no right to temporary privileges. Temporary privileges shall be granted only if the available information supports the Practitioner's or AHP's qualifications, ability, and judgment necessary to exercise the Privileges requested, and upon favorable recommendation to the Chief of Staff. A grant of temporary privileges shall not be binding or conclusive with respect to an applicant's pending request for permanent appointment to the Medical Staff.

7.4-3 General Conditions and Termination

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

(b) Temporary Privileges may be terminated with or without cause at any time by the Chief of Staff, with the concurrence of the Physician Executive, or by the Physician Executive after conferring with the Chief of Staff. 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 15 based upon any adverse action involving temporary Privileges.

(c) Whenever temporary Privileges are terminated, the appropriate Service chair or, in the chair's absence, the Chief of Staff shall assign a Member to assume responsibility for the care of the affected Practitioner's patients. The wishes of the patients and affected Practitioner shall be considered in the choice of a replacement Member. All persons requesting or receiving temporary Privileges shall be bound by the Bylaws and Rules.

7.4-4 Locum Tenens

(a) A locum tenens is a practitioner who is appointed to assist or temporarily fulfill the responsibilities of an active member of the medical staff within the same specialty.
(b) A practitioner applying for privileges in a locum tenens capacity shall meet the same qualification and follow the same procedure required for all new applicants. An appropriately licensed Practitioner of documented competence may be granted privileges for 12 months with limitation of no more than a total of 90 days (within the 12 month period)
(c) Dues may be assessed as determined by the Medical Executive Committee
(d) Locum Tenens members shall have no voting privileges

7.5 Emergency Privileges

7.5-1 In the event of an emergency, any Member of the Medical Staff or privileged 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. Emergency privileges persist only as long as the emergency situation exists, after which the Member or AHP must request Privileges necessary to continue to treat the patient. If the Member or AHP does not make such request, or if such request is denied, the Member or AHP shall promptly yield such care to a Member holding the necessary Privileges when available.

7.6 Disaster Privileges

7.6-1 In accordance with Hospital's policy and procedures for emergency credentialing/privileging-licensed volunteers, disaster privileges are granted when the emergency management plan has been activated and the Hospital is unable to meet immediate patient needs. The Hospital may temporarily utilize volunteers who are not credentialed, privileged or employed by MHS for the duration of any such disaster.

7.6-2 Physician and Allied Health Professional volunteers will be granted disaster privileges at the discretion of the Incident Commander, or designee.

7.6-3 The Incident Commander or designee under the MHS Disaster management plan will assign the physician and Allied Health Professional volunteers to partner with a member of the medical staff or an MHS employee whenever feasible. The patient care, treatment, and services provided by the volunteer will be monitored and overseen by a medical staff designee Disaster privileges shall automatically terminate once the state of emergency no longer exists or when the volunteer's services are no longer required, as determined by the Incident Commander or designees.

7.6-4 Every attempt shall be made to verify credentials as soon as possible. In the event that verification cannot be completed prior to the need to place such individuals in a direct patient care setting, verification will occur as soon as practical after the immediate situation is under control and, except in extraordinary circumstances, will be completed within 72 hours from the time disaster privileges were granted. The time the privileges were granted will be documented and the Incident Commander or designee will make a decision within 72 hours regarding whether to continue the privileges, based on information obtained regarding the Volunteer’s professional practice.

7.7 Proctoring and Monitoring

7.7-1 General Proctoring and Monitoring Requirements

(a) Except as otherwise determined by the Medical Executive Committee or Governing Body, all initial appointees to the Medical Staff and all Members granted new Privileges will be subject to a period of monitoring or proctoring in accordance with standards and procedures set forth in the Rules. Proctoring or monitoring may also be required of Members as a condition for renewing Privileges (e.g., Privileges exercised too infrequently to permit adequate assessment of skill) or to assess a Member's general competency and performance. Proctoring and monitoring required under this provision are information- gathering measures and should be imposed only to the extent that the Medical Executive Committee or Governing Body determines reasonably necessary to assess the Practitioner’s or AHP’s qualification for Privileges. Proctoring and monitoring do not give rise to the procedural rights described in Article 15. Responsibility for arranging proctoring or monitoring and for any expense associated with the same rests with Practitioner requesting the Privileges and is subject to approval of the appropriate

Service Chair. Proctors or monitors may not be practice partners of or Practitioners having a direct financial interest in the applicant's practice.

(b) During monitoring or proctoring, the Practitioner must demonstrate competency in exercising the Privileges requested.

7.7-2 Completion of Monitoring or Proctoring

Monitoring or Proctoring shall be deemed successfully completed when the Practitioner completes, within the standard of care as determined by the Medical Executive Committee or its designee, the required number of monitored or proctored cases within the time frame established in the Bylaws and the Rules.

7.7-3 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 requested Privileges, and he or she shall not be entitled to the procedural rights provided in Article 15. However, the Service to which the Practitioner is assigned may extend the time for completion of monitoring or proctoring in appropriate cases subject to approval of the Medical Executive Committee. The denial of such extension shall not give rise to procedural rights described in Article 15.

(b) Failure to Satisfactorily Complete Monitoring or Proctoring. If a Practitioner fails to perform satisfactorily during monitoring or proctoring, his/her Membership and/or requested Privileges may be revoked or denied. In such event, he or she shall be afforded the procedural rights as provided in Article 15.

(c) Services Provided in Absence of Required Proctor. Any Practitioner who provides services subject to proctoring or monitoring without the presence of a proctor or monitor, shall be deemed to have voluntarily withdrawn his or her request for membership or requested Privileges, and he or she shall not be afforded the procedural rights provided in Article 15. In addition, such Practitioner is subject to corrective 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.

VIII. PROCEDURES OF APPOINTMENT AND REAPPOINTMENT

8.1 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 these Bylaws and the Rules. The Medical Staff shall investigate each applicant before recommending action to the Governing Body. The Governing Body is ultimately responsible for granting membership and

Privileges (provided, however, that these functions may be delegated to the Chief of Staff and Chief Executive Officer or their authorized designees with respect to requests for temporary Privileges).

By applying to the Medical Staff for appointment or reappointment (or by accepting honorary and retired Medical Staff membership), the applicant agrees that regardless of whether he or she is appointed and/or granted 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.

8.2 Applicant's Burden

An applicant for appointment, reappointment, Privileges and/or change of membership category shall have the burden of producing accurate and adequate information sufficient to permit thorough evaluation of the applicant's qualifications and suitability for the membership or Privileges, to resolve any reasonable doubts about his/her qualifications and suitability for membership and/or Privileges and satisfy all 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 require the applicant to undergo a medical or psychological examination as provided in the Bylaws or Rules. If membership and/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 State Department of Health, in which case the member or applicant is entitled to a hearing under Article 15.

8.3 Application for Initial Appointment and Reappointment

Applicants seeking appointment and reappointment shall submit completed and signed applications supplying all requested information and agreeing 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 investigation of or action 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/or to grant Privileges. Recommendations for appointment and reappointment to the Medical Staff and for granting of Privileges shall be based on the applicant's training, experience, professional references, and professional conduct and clinical performance at this Hospital and in other settings; a determination that the applicant meets the requirements and can fulfill the responsibilities specified in these Bylaws and the Rule the Hospital's patient care needs; and the Hospital's resources.

8.3-1 Basis for Appointment

Applicants seeking appointment and reappointment shall submit completed and signed applications supplying all requested information and agreeing 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 investigation of or action 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/or to grant Privileges.

8.3-2 Basis for Reappointment

Recommendation for reappointment to the Medical Staff and/or for renewal of Privileges shall be based on a reevaluation of the Member's professional conduct and clinical performance at this Hospital and in other settings. The reevaluation will include confirmation of the Member's compliance with Medical Staff membership requirements, Medical Staff Bylaws and Rules, and Medical Staff and Hospital policies. Where applicable and available, the results of peer review and quality improvement/quality assessment activities shall be considered. The applicant will be notified of the Governing Body's decision regarding reappointment of membership and/or granting of privileges within 30 days after review of a complete application. Any Practitioner owing the Hospital or MultiCare Health System a sum in excess of five thousand dollars ($5,000) arising from his or her role as a Member of any Medical Staff is ineligible for and cannot apply for the granting or renewal of credentials or privileges until the amount owed is paid to the Hospital or the System.

8.3-3 Failure to Submit Reappointment Application

Failure without good cause to timely submit a completed application for reappointment shall result in the automatic termination of the Member's Medical Staff membership and Privileges upon expiration of the current Medical Staff appointment.

8.4 Departure from the Medical Staff

8.4-1 Leave of Absence

At the discretion of the Medical Executive Committee, a Member may obtain a voluntary leave of absence from the Medical Staff by submitting a written request to the Medical Executive Committee stating the reasons for and period of leave desired, not to exceed the end of his or her current term of appointment. During the leave of absence, the Member may not exercise Privileges at the Hospital, and Membership rights and responsibilities shall be inactive. Unless waived by the Medical Executive Committee, the Member's obligation to pay Medical Staff fees or dues, if any, shall continue. Reinstatement of membership and Privileges following a leave of absence may be granted subject to monitoring and/or proctoring as determined by the Medical Executive Committee or its designee.

8.4-2 Voluntary Resignation

Any Member who wishes to resign from the Medical Staff shall submit a letter of resignation to the Chief of Staff or Medical Staff Services Office. The letter shall be acknowledged by and retained in the Medical Staff Services Department. The resignation shall be effective upon satisfaction of Member's Medical Staff and Hospital obligations (including completion of medical records) as set forth in the Medical Staff Services acknowledgement letter.

8.5 Waiting Period after Adverse Decision or Action

8.5-1 Application

A waiting period of twenty-four (24) months shall apply to the following Practitioners:

(a) 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.

(b) 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 issuance of an adverse recommendation by the Medical Executive Committee or Governing Body.

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

A decision is adverse only if it meets the requirements set forth in Section 15.2. A decision is not adverse if it does not concern professional competence or conduct, such as actions based on a failure to maintain a practice in the area, to pay credentialing fees, or to maintain professional liability insurance.

8.5-2 Waiver of Waiting Period

Ordinarily the waiting period shall be twenty-four (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 satisfactory completion of the conditions. Similarly, the Medical Executive Committee may exercise its discretion, with approval of the Governing Body, to waive the twenty-four (24)-month period in circumstances where it reasonably appears, by objective measures that changed circumstances warrant earlier reinstatement.

8.5-3 Date When Action Becomes Final

An adverse 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.

8.5-4 Effect of the Waiting Period

Except as otherwise permitted under these Bylaws, Practitioners subject to waiting periods may not reapply for Medical Staff membership or the Privileges affected by the adverse action for at least twenty-four (24) months after the action became final. Upon reapplication, the Member’s application will be processed as an initial application and must include documentation that he or she has corrected the issues that resulted in adverse action, and/or has satisfied any training or other requirements imposed by the corrective action.

8.6 Confidentiality; Impartiality

To maintain confidentiality and to assure the unbiased appointment and reappointment processes, participants in the credentialing process shall limit discussion to the formal processes provided in the Bylaws and Rules for evaluating applications for appointment and reappointment.

IX. MEDICAL STAFF OFFICERS

9.1 Medical Staff Officers

9.1-1 Officers

There shall be the following general officers of the Hospital Medical Staff: Chief of Staff; Past Chief of Staff; and Chief of Staff Elect. Service, standing committee, and ad hoc committee chairpersons shall be deemed Medical Staff officers within the meaning of state and federal laws.

9.1-2 Qualifications

All Medical Staff officers shall:

(a) Be Active or Affiliate Medical Staff Members (and remain in good standing as Active or Affiliate Medical Staff Members while in office).

(b) Demonstrate clinical competence in their field of practice.

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

(d) Have administrative ability applicable to the respective office.

(e) Understand and comply with Hospital and Medical Staff requirements.

(f) Be able to work with and motivate others to achieve Medical Staff and Hospital objectives.

(g) Not presently or during the term of office, serve as a medical staff officer, employee, Service or committee chair, or equivalent, at another non MHS hospital, health maintenance organization, or physician-hospital organization.

(h) Not have any significant conflicts of interest.

9.1-3 Conflict of Interest Disclosure

All nominees to Medical Staff office shall, prior to 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 exists when a Member’s outside interest or activity may influence his/her ability to objectively exercise or

satisfy the Member's duties as a Medical Staff officer. The Medical Executive Committee shall evaluate such disclosures and discuss any significant existing or potential conflict 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.

9.2 Selection and Duties of Officers and Physician Executive

9.2-1 The Medical Staff Officers shall be elected by the Medical Staff.

9.2-2 The Nominating Committee

An ad hoc nominating committee composed of the Chief of Staff; the Chief of Staff Elect, the two most recent available past Chiefs of Staff, and the Hospital Physician Executive shall develop a slate of candidates meeting the qualifications of office, as described in Section 9.1-2. This slate shall be developed at least sixty (60) days prior to the scheduled election.

9.2-3 Nomination by Petition

The Medical Staff may nominate candidates for office by a petition signed by at least twenty-five (25) Members who are eligible to vote accompanied by a statement from the candidate affirming his/her willingness to run. Such nominations must be received by the Chief of Staff at least thirty (30) days prior to the scheduled elections.

9.2-4 Election

The nominees shall be submitted to the Medical Staff for election. The election shall be by mail and/or electronic ballot as determined by the Medical Executive Committee. The outcome shall be determined by a majority of the votes cast and received by Medical Staff Services within fifteen (15) days after the date on which the ballots were mailed or provided or made electronically available to the voting Medical Staff Members.

9.2-5 Governing Body Approval

The slate of officers elected together with the conflict of interest disclosure information provided pursuant to Section 9.1-3, 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 of individuals shall be nominated and the process, including election, repeated. Officers elected by the Medical Staff shall be deemed approved unless the Governing Body acts otherwise within thirty (30) days.

9.2-6 Term of Office

Officers shall be elected in the fall of every other year and shall take office the following January 1. The term of office shall be two years.

9.3 Duties of Officers

9.3-1 Chief of Staff

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

(a) Serving as the Chair of the Medical Executive Committee.

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

(c) Calling, presiding at, and setting the agenda for meetings of the entire Medical Staff.

(d) Appointing, after consulting with the Medical Executive Committee, members for any standing, ad hoc, and special committees of the Medical Staff.

(e) Regularly reporting to the Governing Body on the activities of the Medical Staff.

(f) Communicating to the Medical Staff concerns expressed by the Governing Body and to the Governing Body concerns expressed by the Medical Staff.

(g) Serving on liaison committees with the Governing Body, Hospital administrators, and outside licensing or accreditation agencies.

(h) Coordinating Medical Staff external professional and public relations with the Physician Executive.

(i) Performing those responsibilities of the Medical Executive Committee that, in his or her reasonable opinion, must be accomplished between Committee meetings.

(i) Enforcing the Medical Staff Bylaws and Rules.

(k) Promoting quality of care and compliance with Medical Staff and Hospital policies.

(l) Participating in the corrective action process.

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

9.3-2 Chief of Staff Elect

The Chief of Staff -Elect shall assume all duties and authority of the Chief of Staff in his/her absence. The Chief of Staff Elect shall be a member of the Medical Executive Committee and shall perform such other duties as assigned or delegated by the Chief of Staff or the Medical Executive Committee.

9.3-3 The Immediate Past Chief of Staff shall be a member of the Medical Executive Committee and shall have such duties as assigned by the Chief of Staff or Medical Executive Committee.

9.4 Physician Executive

9.4-1 Responsibilities

The Physician Executive's duties shall be delineated by the Chief Executive Officer. An officer of the Medical Staff shall approve any Physician Executive duties that relate to the performance of functions on behalf of the Medical Staff. The Physician Executive may designate another physician employed by the Hospital to act on his/her behalf during periods in which the Physician Executive is unavailable. In keeping with the foregoing, the Physician Executive shall:

(a) In cooperation and after consultation with the Chief of Staff, the Medical Executive Committee and the Quality Management Department, supervise the day-to-day performance of the Medical Staff.

(b) Serve as the liaison between the Medical Staff and Hospital administration, and outside agencies.

(c) Assist the Medical Staff in performing its obligations.

(d) Serve as a representative and agent of Hospital quality management and peer review committees. Acts taken by the Physician Executive on behalf of quality assurance and peer review committees are protected by all state and federal quality assurance and peer review laws.

(e) Serve as an Ex Officio member of all Medical Staff committees other than any hearing committee.

(f) Perform those duties assigned to him or her in the Bylaws and Rules.

9.5 Filling Vacancies

A vacancy in the office of Chief of Staff shall be filled by the Chief of Staff Elect. A vacancy in the office of Chief of Staff Elect position of shall be filled by special election of the Medical Staff conducted in accordance with Section 9.2. Any other vacancies may be filled by appointment by the Medical Executive Committee until the next election cycle.

9.6 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; 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.

X. COMMITTEES

10.1 General

10.1-1 Categories

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 Service Committees to perform specified tasks. Any committee, 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.

10.1-2 Committee Member Appointment and Removals

(a) Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the Chief of Staff subject to consultation with and approval by the Medical Executive Committee. Medical Staff committees shall be responsible and accountable 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; AHPs; representatives from Hospital departments; representatives from the community; and persons with special expertise necessary to carry out a committee function. Each Medical Staff Member serving on a committee shall be eligible to vote. Committee members who are not Members serve without a vote unless the statement of committee composition designates otherwise

(c) A committee chair, after consulting with the Chief of Staff and Hospital Physician Executive (or his or her designee), may call on outside consultants or special advisors.

(d) Each committee Chair shall ensure that there is a designee to fulfill the duties of the Chair in his or her absence and to assist as requested by the Chair.

10.1-3 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.

10.1-4 Ex Officio Committee Members

The Chief of Staff, Chief Executive Officer, Chief Operating Officer or their respective designees, and the Physician Executive shall be Ex Officio members of all standing and special committees (except peer review and hearing committees) of the Medical Staff and shall serve without vote unless provided otherwise in the provision or resolution creating the committee.

10.1-5 Subcommittees

Any standing or ad-hoc committee may appoint 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 Chief of Staff regarding Medical Staff Members, and the Physician Executive regarding Hospital staff.

10.1-6 Terms and Removal of Committee Members

Unless otherwise specified, committee members shall be appointed for two-year terms, subject to unlimited renewal, and shall serve until the end of their terms or until their successor is appointed, unless the committee member shall sooner resign or be removed from the committee. Any committee member who is appointed by the Chief of Staff may be removed by a majority vote of the Medical Executive Committee. Any committee member who is appointed by a Service Chair may be removed by a majority vote of the Service committee or by the Medical Executive Committee. The removal of any committee member who is a Medical Staff officer shall be governed by the provisions pertaining to removal of such officer.

10.1-7 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.

10.1-8 Conduct and Records of Meetings

Committee meetings shall be conducted and documented in the manner specified for such meeting in Article 12 of the Bylaws.

10.1-9 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 Member. The committee Chair shall have 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 may 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.

10.1-10 Accountability

All committees shall be accountable to the Medical Executive Committee.

10.2 Medical Staff Committees

The Medical Staff shall have a Medical Executive Committee and the other committees described in these Bylaws and Rules and appendices. The composition of Medical Staff Committees shall be as set forth in these Bylaws or as determined by the Medical Executive Committee.

10.2-1 Medical Executive Committee

(a) Composition

The Medical Executive Committee shall be comprised of the Medical Staff officers listed in Section 9.1.1, the Chair of each Service, and the Chair of each standing committee of the Medical Staff. The Chief Operating Officer and Chief Executive Officer shall serve as *ex officio* members without vote. The following Hospital staff shall serve as non-voting members: Physician Executive, Nurse Executive, Quality Management representative, Legal Services department representative and Medical Staff Services department representative.

(b) Duties

The Medical Executive Committee shall:

(i) Oversee the performance of all Medical Staff functions, which shall include requiring regular reports and recommendations from the Medical Staff committees; issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and developing and implementing all directives and Medical Staff policies.

(ii) Coordinate the activities of the Medical Staff committees and Services.

(iii) Make recommendations to the Governing Body regarding all applications for Medical Staff and AHP appointment, reappointment, and Privileges.

(iv) Investigate, recommend and/or initiate corrective action.

(v) Supervise and ensure Medical Staff Member compliance with Medical Staff Bylaws, Rules, and policies; Hospital and MHS policies; state and federal laws and regulations; and Joint Commission accreditation requirements.

(vi) Ensure Medical Staff committees develop, maintain and enforce professional standards and quality improvement programs.

(vii) Regularly report to the Governing Body the outcomes of Medical Staff quality improvement programs, and status of Medical Staff corrective action investigations and recommendations.

(viii) Make recommendations to the Governing Body regarding Medical Staff structure, credentialing and privileging processes; Medical Staff quality assessment and improvement activities; and corrective action and hearing process.

(ix) Establish ad hoc committees necessary to conduct particular functions.

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

(xi) Oversee the activities of all Medical Staff committees.

(c) Meetings

The Medical Executive Committee should be scheduled to meet monthly at least ten (10) times during the calendar year. Meetings may be conducted in person or, when appropriate, electronically.

10.2-2 Other Committees

The Hospital Medical Staff shall have such other standing committees as set forth in Appendix A, attached hereto and incorporated herein. The Medical Executive Committee may as needed establish additional committees. Medical Staff Committees from System hospitals may meet together if approved by the Medical Executive Committee of each hospital.

10.3 Joint Committees

The Medical Staff, in cooperation with the medical staffs of other System hospitals may establish a joint committee (or committees) for the purpose of carrying out functions required at and common to all System hospitals. Upon approval of Hospital Medical Executive Committee and the Medical Executive Committees of each System hospital, a proposal for a joint committee shall be sent to the Governing Body for final approval and implementation. Each joint committee established shall have at least three (3) representatives from each System Hospital. The Joint Committees of System hospital Medical Staffs established as of the effective date of these Bylaws are set forth in Appendix B, attached hereto and incorporated herein,

XI. SERVICES

11.1 Medical Staff Services

There will be Medical Staff Services. They will be outlined in the Rules. The Medical Executive Committee may recommend to the Governing Body the creation, elimination, or combination of Services which action shall be effective upon approval by the Governing Body.

11.2 Assignment to Service

For credentialing and quality review, each member shall be assigned to a Service based on the Privileges requested.

11.3 Functions of Service

The Services shall perform the clinical, administrative, quality improvement, risk management, utilization management, collegial and education duties described in the Rules.

11.4 Service Chair and Service Chair Elect

11.4-1 Qualifications

The Chair and Chair Elect of each Service shall be Active or Affiliate 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.

11.4-2 Selection and Removal

Service chairs shall be recommended by members of the Service committee and appointed by the Chief of Staff.

11.4-3 Terms and Removal

Each Service Chair and Chair Elect shall serve a 2-year term, the expiration of which shall coincide with the Medical Staff Year or until a successor is chosen, unless he/she shall sooner resign, be removed from office, or lose Medical Staff membership or Privileges. A Service Committee may recommend to the Chief of Staff removal of the service chair by a majority vote. The Chief of Staff shall respond to the service committee recommendation by calling a vote of the Medical Executive Committee.

A Service Chair shall be removed by a majority vote of the Medical Executive Committee.

11.4-4 Responsibilities of the Service Chair

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

XII. MEETINGS

12.1 Medical Staff Meetings

12.1-1 Medical Staff Meetings

Meetings of the entire Medical Staff may be called at any time by the Chief of Staff, Medical Executive Committee, or Governing Body, or upon the written request of ten (10) percent of the voting Members. The meeting must be called within thirty (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.

12.1-2 Combined or Joint Medical Staff Meetings

The Medical Staff may participate in combined or joint medical staff meetings with medical staff members from other System hospitals and healthcare entities; 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 representatives) maintains access to and approval authority of all minutes prepared in conjunction with any such meetings.

12.2 Service and Committee Meetings

12.2-1 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 Service responsibilities.

12.2-2 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, the Chief of Staff, or by thirty-three and one-third (33-1/3) percent of the Service Committee's current members, but not fewer than three (3) members. No business shall be transacted at any special meeting except as stated in the Notice calling the special meeting.

12.3 Notice of Meetings

Regular Meetings. Written Notice stating the place, day, and hour of any regular meeting of the Medical Staff or of any regular Service or committee meeting shall be delivered personally, electronically, or by mail to each person entitled to be present not fewer than five (5) working days prior to the date of such meeting. Personal attendance at a meeting shall constitute a waiver of Notice of such meeting.

Special Meetings. Written Notice stating the place, day, and hour of any special meeting of the Medical Staff or of any special Service or committee meeting shall be delivered personally, electronically, or by mail to each person entitled to be present not fewer than two (2) working days prior to the date of such meeting. Personal attendance at a meeting shall constitute a waiver of Notice of such meeting.

At the discretion of the Chair of the Service or Committee, Chief of Staff or his/her designee emergency meetings do not require written notice.

12.4 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 therein. Valid action may be taken without a meeting if it is acknowledged in writing setting forth the action so taken which is approved by a majority of the committee members entitled to vote. The meeting chair shall refrain from voting except when necessary to break a tie.

12.5 Quorum

12.5-1 Committee Meetings.

The presence of twenty-five percent (25%) (but not less than two) committee members eligible to vote plus the chair or chair designee shall constitute a quorum.

12.5-2 General Medical Staff Meetings:

Quorum: Twenty-five percent (25%), of the total membership of the Active Medical Staff shall constitute a quorum for any meeting of the Medical Staff.

12.6 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 Medical Executive Committee or other designated committee and to the 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.

12.7 Meeting Attendance

12.7-1 Regular Attendance

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.

12.7-2 Special Appearance

A committee, at its discretion, may require the appearance or written response of a Practitioner during a review of clinical patient care or professional conduct. If possible, the chair of the committee should give the Practitioner at least ten (10) days' advance written Notice of the time and place of the meeting. In addition, whenever an appearance or written response 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 or written response is mandatory

12.8 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.

XIII. CONFIDENTIALITY, IMMUNITY, AND RELEASES

13.1 General

Medical Staff, Service, 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 Hospital Physician Executive.

13.2 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, 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, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

13.3 Immunity and Releases

13.3-1 Immunity from Liability for Providing Information or Taking Action

All applicants for Privileges, Members of the Medical Staff, AHPs seeking or holding Privileges, 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 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 Service, 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.

13.3-2 Activities and Information Covered

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 Medical Staff, Hospital, System or other health-related institution's or organization's activities concerning, but not limited to: applications for Memberships or Privileges; reevaluations for reappointment or Privileges; corrective action; hearings and appellate reviews; quality improvement activities, including but not limited to patient care audits; peer review; utilization review; morbidity and mortality conferences; and other Hospital, Medical Staff, Service, section, or committee activities related to monitoring and improving the quality of patient care and professional conduct.

13.4 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.

13.5 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.

13.6 Releases

Each Practitioner or AHP 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.

13.7 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.

XIV. PEER REVIEW AND CORRECTIVE ACTION

14.1 Peer Review Philosophy

14.1-1 Role of Medical Staff

(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 corrective action must be implemented and monitored for effectiveness.

(c) Peers on the Medical Staff are responsible for carrying out 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 Peer Review Committee is responsible for carrying out practitioner-specific peer review. In conducting such peer review, the Peer Review Committee may consult with a Medical Staff officer, Service chair, or Service 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 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 external consultants and may be conducted to determine whether corrective action may be warranted.

(e) The procedures, including review, described in this Section 14.1.1 do not waive or limit the procedures otherwise available or required for handling investigations conducted or directed by the Medical Executive Committee.

(f) The procedures, including reviews, described in this Section 14.1.1 do not constitute hearings or recommendations for corrective action, and the person affected shall not be entitled to a hearing or other procedural rights specified in Article 15. Comments, suggestions, and warnings may be issued verbally or in writing.

(g) 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 Peer Review Committee. Such notice, opportunity to respond, and opportunity to meet, if any, shall be provided when the person(s) conducting the review deems it most beneficial. A record of the matters discussed and the findings resulting from such meeting shall be made.

(h) Any informal actions, including verbal 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 informal actions shall not constitute a restriction of Privileges or grounds for any formal hearing or appeal rights under Article 15 and shall not constitute an investigation as defined under the National Practitioner Data Bank reporting requirements.

14.2 Interviews, Reviews, and Investigations

14.2-1 General

Interviews, reviews, and investigations, shall neither constitute nor be deemed a "hearing" as described in Articles 14 and 15, shall be preliminary in nature, an administrative matter not an adversarial proceeding, and shall not be conducted according to the procedural rules applicable with respect to hearings. During the course of an interview, 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 interview, 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 14.3-2. 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.

14.2-2 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 related to such Member's clinical competence or professional conduct, 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

14.2-3 Criteria for Initiation of Formal Corrective Action

Formal corrective action may be initiated whenever reliable information indicates a Member may have exhibited acts, demeanor, or conduct, either within or outside the Hospital that is reasonably likely to be:

(a) Contrary to the Medical Staff Bylaws or Rules.

(b) Detrimental to patient safety or to the delivery of quality patient care within the Hospital.

(c) An improper use of Hospital resources.

(d) Disruptive of Medical Staff or Hospital operations.

(e) Below professional standards of the Medical Staff.

(f) Unethical.

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.

14.2-4 Initiation and Notification

(a) Any person who believes that corrective action may be warranted may provide information to the Chief of Staff, any other Medical Staff officer, any Service chair, any Medical Staff committee, or any member of the Hospital executive team, or the Governing Body.

(b) If the Chief of Staff, any other Medical Staff officer, any Service chair, any Medical Staff committee, the Physician Executive, the Governing Body, or Hospital executive team determines that corrective action may be warranted under section 14.2-3, that person, body, or committee may request that the Medical Executive Committee initiate a formal corrective action investigation or may recommend particular corrective action. Such requests may be conveyed to the Medical Executive Committee verbally or in writing.

(c) The Chief of Staff shall notify the Chief Executive Officer or his or her designee and the Medical Executive Committee. In addition, the Chief of Staff shall immediately forward all necessary information to the Medical Executive Committee or the committee or person appointed by the Medical Executive Committee to conduct the investigation; provided, however, that the Medical Executive Committee may dispense with further investigation of matters deemed to have been adequately reviewed by a committee pursuant to Section 14.2-3 or otherwise.

14.2-5 Expedited Initial Review

(a) Whenever information suggests that corrective action may be warranted, the Chief of Staff or his or her designee, and/or Hospital Physician Executive, may, on behalf of a Medical Executive Committee, immediately conduct whatever review (including by external consultants) and interviews may in that individual's discretion be indicated. The information obtained from this initial review shall be presented to the Medical Executive Committee after the reviewer has completed the review. The Medical Executive Committee shall determine 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 Chief of Staff or his/her designee, the Service chair, and/or the Physician Executive, together with representatives of Hospital administration, or Hospital legal counsel. In cases of complaints of harassment or discrimination where the alleged harasser is a Medical Staff Member and the complainant is a Hospital employee, an expedited initial review shall be conducted by the Physician Executive and the Hospital's Human Resources Director or their designees, or by Hospital legal counsel. The 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 corrective action against a Medical Staff Member is requested.

14.2-6 Formal Investigation Procedures

(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 Chief of Staff. 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 an external reviewer (or reviewers) as deemed appropriate or helpful in light of the circumstances (e.g., to help assure an unbiased review, to provide external 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 recommending any adverse action, 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 15, 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.

14.2-7 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) 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.

(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 Peer Review 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) 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.

(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 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.

(g) Recommending limitation of any membership prerogatives.

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

14.2-8 Time Frames

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

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

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

14.2-8 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 sixty (60) days after receiving the Notice of decision.

(b) If the Medical Executive Committee recommends an action that is grounds for a hearing under Section 15.2, the Chief of Staff 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.

14.2-9 Initiation by Governing Body

If the Medical Executive Committee fails to investigate or take corrective 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 14 and 15 of these Bylaws. The Governing Body shall inform the Medical Executive Committee in writing of its actions.

14.2-10 When Corrective Action Takes Effect

Any corrective (adverse) action described in Section 14.2-8(b) shall not take effect until the affected Practitioner has waived any right to a hearing as provided in Article 15 or until any hearing process is completed and final pursuant to Article 15, whichever occurs sooner. However, this shall not qualify the right or power to impose a summary or automatic suspension or revocation pursuant to Sections 14.3 or 14.4.

14.3 Summary Restriction or Suspension

14.3-1 Criteria for Summary Restrictions and Suspensions

(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 Chief of Staff, the chair of the Service in which the Member holds Privileges, the Physician Executive, the Chief Executive Officer (or his/her designee). 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 a present 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 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 Service 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 14.2-4 shall be followed.

14.3-2 Medical Executive Committee Action

The Medical Executive Committee shall schedule an interview with the affected Practitioner promptly in order to complete its investigation of the need for a professional review action within no more than fourteen (14) days from the imposition of the summary restriction. The interview shall be informal and shall 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. A record of such interview shall be created. 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 15.3-1 if the action is adverse.

14.3-3 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 15, but the hearing may be consolidated with the hearing on any corrective action that is recommended so long as the hearing commences within ninety (90) 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 (14) days or less that is rescinded or not ratified by the Medical Executive Committee.

14.3-4 Action by the Governing Body

If no one authorized under Section 14.3-1(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 Chief of Staff and the

chair of the Service to which the Member is assigned before acting. Such summary action is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such summary action within fourteen (14) days, the summary action shall terminate automatically.

14.3-5 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 fourteen (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. The following, after consultation with the Hospital's legal staff, may temporarily remove a Practitioner from the Hospital for up fourteen (14) days under this section 14.3-5: the Chief of Staff, the chair of the Service in which the Member holds Privileges, the Physician Executive, or the Chief Executive Officer (or his/her designee). A panel of not less than three members of the Medical Executive Committee will convene to review the appropriateness of the action as soon as reasonably practicable following any precautionary temporary suspension or removal, which in any event will occur no later than noon of the next business day following the effective date of the action. If any two of the three MEC members meeting determine that the precautionary suspension is not supported by the facts then known, the precautionary suspension will be lifted. Such a precautionary action shall not entitle the Practitioner to any procedural rights specified in Article 15. The Practitioner agrees not to exercise his or her privileges during the period of the precautionary action.

14.3-6 Interim Precautionary Step

Action under this Section 14.3, including both summary restrictions or suspensions and precautionary actions, shall be deemed an interim 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 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.

14.4 Automatic Suspension or Limitation

Suspension under this Section 14.4 shall not entitle the Practitioner to the procedural rights specified in Article 15. In the following instances, the Member's Privileges or membership may be suspended or limited as described:

14.4-1 Licensure

(a) 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.

(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) 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.

(d) Review of Restriction or Probation: As soon as practical after notice of a Practitioner's probation or restriction of licensure, or at the time a Practitioner seeks reinstatement following suspension or revocation (and reinstatement) of a license, the Service committee 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.

14.4-2 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 Medical Staff Rules 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 Service committee 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.

14.4-3 Failure to Satisfy Special Appearance requirement

A Member who fails without good cause to appear and satisfy the requirements of Section 12.7-2 shall automatically be suspended from exercising his or her Privileges for a period of fourteen 14 days, or such period as the Medical Executive Committee shall determine.

14.4-4 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 following Notice by the Chief of Staff or his or her designee, as provided in the Rules. For the purpose of this Section, "related privileges" means on-call service for the Emergency Department, 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 the Member has completed his/her delinquent records. 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.

14.4-5 Expiration or Cancellation of Professional Liability Insurance

Failure to maintain professional liability insurance as required by these Bylaws or Rules 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.

14.4-6 Failure to Pay Medical Staff Fees

For failure to pay fees or dues assessed by the Medical Staff, if any, within thirty (30) days after written warning of delinquency, a Practitioner's Medical Staff membership and Privileges may be automatically suspended and shall remain so suspended until payment is received.

14.4-7 Failure to Comply with Governments and Other Third Party Payor Requirements

If a Practitioner becomes 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 has discretion to determine whether noncompliance with certain third party payor,

government agency, and professional review organization rules or policies could adversely impact Hospital and/or Medical Staff operations. In such event, these Bylaws 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.

14.4-8 Failure to Satisfy Qualification or Credential for a Privilege

If a Practitioner lacks a qualification or credential required by the Medical Staff as a condition to exercise a Privilege, the Practitioner shall be ineligible to apply for such Privilege, and such Privilege shall be automatically revoked if previously granted.

14.4-9 Automatic Termination

If a Practitioner's membership and/or Privileges are/is suspended for more than six (6) months such membership and/or Privileges shall be automatically terminated, unless there is a pending Corrective Action that cannot reasonably be completed within that six (6) month period, in which event Practitioner's suspension will continue until such time as the Corrective Action 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.

14.4-10 Medical Executive Committee Deliberation and Procedural Rights

Whenever the automatic suspension must be reported to the Washington State Department of Health or the National Practitioner Data Bank ("NPDB"), the Practitioner shall be entitled to a hearing pursuant to Article 15. In all other cases (i.e., whenever a Department of Health or National Practitioner Data Bank report is not required), a Practitioner whose membership has been automatically suspended or terminated shall not be entitled to a hearing pursuant to Article 15, 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, 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 (10) days after notification of action; should be conducted within ninety (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 a review is 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 15 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. 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.

14.4-11 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 a Practitioner's automatic suspension shall be assigned to another Member by the Service 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.

14.5 System Wide Corrective Action

14.5-1 Notice of Pending Investigations/Joint investigations

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

14.5-2 Notice of Actions

(a) In addition to the discretionary reporting and joint investigation provisions set forth at Section 14.5-1, the Chief of Staff, Chief Executive Officer, Chief Operating Officer and Physician Executive are authorized to inform their counterparts at any System Affiliate where the Practitioner or AHP is known to practice whenever any of the following actions has been taken:

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

(2) Other corrective actions may be reported at any time the Chief of Staff, Physician Executive, 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 or AHP'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 Chief of Staff, Physician Executive, 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.

14.5-3 Effect of Actions Taken by System Affiliate

Except as provided in Section 14.5-1, whenever the Chief of Staff or the Medical Executive Committee receives information about an action taken at another System Affiliate and involving a Practitioner or AHP holding Privileges at Hospital, the Chief of Staff 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 14. 3-1 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 14.3.

14.6 Actions Taken by Other Healthcare Organization or Regulatory Agencies

The Practitioner shall provide prompt and full disclosure of any adverse action taken by another health care organization or regulatory agency 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 a healthcare organization or regulatory agency includes, but is not limited to, denial, restriction, revocation or termination of membership, privileges or license. A summary suspension or precautionary action for up to fourteen (14) days may be imposed while the matter is investigated by the Hospital or System

XV. HEARINGS AND APPELLATE REVIEW

15.1 General Provisions

15.1-1 Philosophy

These hearing and appellate review procedures are intended to provide for a fair review of decisions that adversely affect Practitioners (as defined below) while simultaneously protecting the peer review participants from liability. Furthermore, these procedures are intended to establish flexible procedures and avoid burdens that would otherwise discourage the Medical Staff and Governing Body from carrying out the peer review process. 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 while providing a fair review, and (2) interpret these Bylaws in that light. 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.

15.1-2 Scope of Review

The hearing and appeal rights established in the Bylaws are strictly “judicial” rather than “legislative” in structure and function. The hearing procedures described in these Bylaws are

intended for 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. 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.

15.1-3 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 15.3-2.

15.1-4 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.

15.1-5 If an adverse action as described in Section 15.2 is taken or recommended, the Practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

15.1-6 The Medical Staff and Governing Body are authorized to participate in joint hearings and appeals in accordance with Section 15.10 of these Bylaws.

15.1-7 All hearings requested prior to the effective date of these Bylaws but held thereafter shall be in accordance with the terms of these Bylaws. All corrective action pending on [effective date of adoption] shall proceed to the extent possible in accordance with the terms in these Bylaws.

15.2 Grounds for Hearing

Except as otherwise specified in these Bylaws, (including those Exceptions to Hearing Rights specified in Section 15.9), 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:

15.2-1 Denial of Medical Staff membership and/or Privileges.

15.2-2 Denial of Medical Staff reappointment and/or renewal of privileges.

15.2-3 Revocation, suspension, restriction, involuntary reduction of Medical Staff membership and/or Privileges.

15.2-4 Involuntary imposition of significant consultation requirements (excluding proctoring incidental to provisional staff status, or the granting of new Privileges, or imposed for insufficient activity, or proctoring, or consultation that does not restrict the Practitioner's Privileges), or as imposed by the Rules.

15.2-5 Summary suspension of Medical Staff membership and/or Privileges during the pendency of corrective action and hearings and appeals procedures.

15.2-6 Any other disciplinary action or recommendation that in the reasonable opinion of the Medical Staff must be reported to the Washington State Department of Health or its successors and/or to the National Practitioner Data Bank.

15.3 Requests for Hearing

15.3-1 Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in Section 15.2, the Practitioner shall be given Special Notice of the recommendation or action and of the right to request a hearing pursuant to Section 15.3-2. The Notice must state:

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

(b) Whether the action, if adopted, must be reported to the Washington Department of Health 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 15.4.

15.3-2 Request for Hearing

(a) The Practitioner shall have thirty (30) days following receipt of Special Notice of such action to request a hearing. The request shall be in writing addressed to the Chief of Staff 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 seventy (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 representation by legal counsel 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 the Special Notice issued under section 15.3-1 shall constitute the Practitioner's receipt and waiver of his or her right to the Hearing and appellate review proceedings of Article 15.

15.3-3 Indemnification of Members

The Hospital shall indemnify and hold Medical Staff Members harmless for good faith participation in peer review/quality assurance activities and other activities specified in Section 13.3. 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 for defense that is appropriate.

15.4 Hearing Procedure

15.4-1 Time and Place for Hearing

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within thirty (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 thirty (30) days nor be more than sixty (60) days from the date the Practitioner received the Special Notice of the hearing date, absent approval of the Chief of Staff or Chair of the Hearing Committee for an extension of time.

15.4-2 Notice of Charges

Together with the Notice stating the place, time, and date of the hearing, the Chief of Staff 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 medical records in question, where applicable. A supplemental Notice may be issued at any time, provided the Practitioner is given sufficient time to prepare to respond.

15.4-3 Hearing Committee

(a) When a hearing is requested, the Chief of Staff shall appoint a Hearing Committee that shall be composed of not less than three (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 Chief of Staff 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 Chief of Staff 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 15.4-18.

(b) The Hearing Committee shall have such powers as are necessary to discharge its or his or her responsibilities.

(c) The Practitioner shall be notified of the individuals appointed to the Hearing Committee and be given the opportunity to object if there are legitimate basis for objections, such as bias or direct economic competition.

(d) The Chief of Staff, Hospital Physician Executive, and, Chief Operating Officer or their designees may attend the hearing, but may not participate in the deliberations or decision.

15.4-4 The Hearing Officer

The Chief of Staff 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 twelve (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.

15.4-5 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.

15.4-6 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.

15.4-7 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.

15.4-8 Burdens of Presenting Evidence and Proof

(a) When a hearing relates to an adverse action or recommendation as set forth in Section 15.2, 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 Executive 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.

15.4-9 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 Contracting 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.

15.4-10 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 ten (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.

15.4-11 Witness Lists

Not less than ten (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 ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

15.4-12 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 affected by agreement of the parties or by action of the Hearing Officer. Requests for continuance shall be processed as described in Section 15.4-8.

15.4-13 Procedural Disputes

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. 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 (5) 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.

15.4-14 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.

15.4-15 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.

15.4-16 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.

15.4-17 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.

15.4-18 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.

15.4-19 Decision of the Hearing Committee

Within fifteen (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.

15.4-20 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.

15.4-21 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 Chief of Staff.

15.5 Appeal

15.5-1 Time of Appeal

Within twenty (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 Chief of Staff, 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 seventy (70) days, and shall give it great weight.

15.5-2 Notice of Appellate Review

If an appellate review is to be conducted, the Appeal Board shall, within thirty (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 forty-five (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.

15.5-3 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 (3) 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 15. 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.

15.5-4 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.

15.5-5 Decision

(a) Within thirty (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 appealing party 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 thirty (30) days unless the parties agree otherwise or for good cause as determined by the Appeal Board.

15.5-6 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.

15.6 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.

15.7 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.

15.8 Governing Body Committee and Interventions

In the event the Governing Body should delegate some or all of its responsibilities described in this Article 15 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.

15.9 Exceptions to Hearing Rights

15.9-1 Exclusive Use Departments, Hospital Contract Practitioners

(a) Exclusive Use Departments

The hearing or appellate review rights of Article 15 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.

(b) Hospital Contract Practitioners

The hearing rights of Article 15 do not apply to Practitioners with whom the Hospital has contracted to provide clinical and/or administrative services. Removal of Practitioners from such contracted positions 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 15 shall apply if an action is taken that in the reasonable opinion of the Medical Staff must be reported to the Washington Department of Health 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 15 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 15.2;

(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.

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 15.9-1(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.

15.9-2 Allied Health Professionals

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

15.9-3 Denial of Applications for Failure to Meet the Minimum Qualification

Persons shall not be entitled to any hearing or appellate review rights if their membership, Privileges, applications, or requests are denied because of a circumstance 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 meet any of the other basic standards specified in Section 4.3-2; to file a complete application; or to have or maintain any qualification or credential required to obtain or maintain a Privilege.

15.9-4 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 14.4-1.

In other cases described in Sections 14.4-1 and 14.4-2, 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 administratively suspended (as earlier defined herein) and/or who have resigned their Medical Staff membership for

- failing to satisfy a special appearance (Section 14.4-3),
- failing to complete medical records (Section 14.4-4),

- failing to maintain malpractice insurance (Section 14.4-5),
- failing to pay credentialing fees (Section 14.4-6),
- 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 14.4-7),
- failure to comply with on-call ED obligations (4.7-17)
- failure to satisfy a qualification or credential for a privilege so long as the qualification or credential may be objectively determined (14.4-9)

are not entitled under Section 14.4-9 to any hearing or appellate review rights.

15.9-5 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.

15.10 Joint Hearings and Appeals for system Affiliates

15.10-1 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 14.5, a single joint hearing may be conducted in accordance with hearing procedures set forth in Section 15.10-1(b) provided such procedures are substantially comparable to those set forth in Section 15.4.

(b) Establishment of Joint Hearing Committee

Whenever a Joint Hearing Committee is formed pursuant to Section 15.10-1, such Joint Hearing Committee shall include at least one representative from each Medical Staff involved. The Joint Hearing Committee chair shall be selected by those designated representatives. The Joint Hearing Committee's report shall be shared with the Medical Executive Committee of each represented Medical Staff and all actions taken by such Joint Hearing Committee shall be deemed to be actions of each of the represented Medical Staffs participating in such Joint Hearing Committee. The privileges and immunities applicable to members of this Medical Staff will apply to all members of the Joint Hearing Committee.

(c) The hearing shall be conducted in accordance with the procedures set forth in Section 15.4.

- Whenever reasonably feasible to do so, the Joint Committee will make recommendations applicable to each of the involved Medical Staffs, the intent being to invoke consistent standards and consistent outcomes across the System, taking into account local or regional variations that might call for some variation in how the Joint Committee recommendations are imposed at one hospital versus another. Whenever the applicable outcome of a Joint Committee recommendation will be different at one

hospital as compared to others, the Joint Committee shall state the reasons for such recommendation and the basis for such variance. Absent such differentiation, the recommendations of the Joint Committee shall be deemed applicable at all participating facilities and locations.

(d) The recommendation of the Joint Hearing Committee shall be reported to each participating Hospital's Governing Body for final action.

15.10-2 Joint Appeals

The procedures may also call for joint appeal rights, provided such procedures are substantially comparable to those set forth in Section 15.5 and, further, provided that at least one member of the Appeal Board is a representative of this Hospital's Governing Body.

15.10-3 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.

15.10-4 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.)

XVI. GENERAL PROVISIONS

16.1 Rules and Policies

16.1-1 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 or review and approval. Following approval by the Medical Executive Committee, a Rule shall

become effective following approval by the Governing Body or automatically within sixty (60) days if no action is taken by the Governing Body. In the event of a conflict between the MHS bylaws and Medical Staff Bylaws and the Rules, the Bylaws shall prevail. The Rules shall be deemed an integral part of the Medical Staff Bylaws.

16.1-2 Hospital-Specific Rules and Regulations

The Medical Staff acknowledges that the differences in scope of services among each of the several System hospitals may necessitate adoption of rules, regulations, policies and procedures unique to a particular System hospital. 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 consistent and comparably high standard of care at all System hospitals and facilities, while at the same time recognizing the uniqueness of each System hospital.

16.1-3 Service and Committee Rules

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

16.1-4 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 Hospital Medical Staff or MHS Bylaws, Rules, or similar policies at System Affiliates.

16.2 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.

16.3 Credentialing Fees or Assessments

Subject to Governing Body approval, the Medical Executive Committee may assess a reasonable credentialing fee or dues for each category of Medical Staff membership and determine the manner of expenditure of such fees of dues provided, however, that such expenditures shall not jeopardize MHS's or Hospital's tax exempt nonprofit status. Once paid credentialing fees or dues shall not be refundable, in whole or in part.

16.4 Compensation

Any compensation of Medical Staff Members for performing Medical Staff duties and services shall require Governing Board approval.

16.5 Acting without Authority

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.

16.6 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 waiver is in the best interests of patients and of 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.

16.7 Governing law; Venue

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.

16.8 Conflict Resolution

Disputes arising between the Medical Staff and the Governing Body, or between the Medical Executive Committee and the Medical Staff, are addressed exclusively by the following processes.

16.8-1 Medical Staff and Medical Executive Committee Disputes.

In the event of conflict between the Medical Staff Executive Committee and the Medical Staff (as represented by written petition signed by at least 25 percent of the voting members of the Medical Staff) regarding a proposed action (other than peer review) or other issue of significance to the Medical Staff, the Physician Executive will convene a meeting with the petitioners' representative(s). The foregoing petition will include a designation of up to five Medical Staff Members eligible to vote to serve as the petitioners' representatives. The Medical Staff Executive Committee will be represented by an equal number of Medical Staff Executive Committee members appointed by the Chief of Staff. The Medical Executive Committee's and the petitioners' representatives will exchange information relevant to the conflict and work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Staff Executive Committee, and the safety and quality of patient care at the Hospital. Resolution at this level requires a majority vote of the Medical Staff Executive Committee's representatives at the meeting and a majority vote of the petitioners' representatives.

16.8-2 Medical Staff and Governing Body Disputes.

Whenever the Governing Body determines that it will decide a matter contrary to the recommendation of the Medical Executive Committee (other than peer review recommendations) or the Governing Body, the Medical Executive Committee, or the Medical Staff refers a matter for dispute resolution, the matter will be submitted to a Joint Conference Committee comprised of the Medical Staff officers and an equal number of Governing Body members selected by the chair of the Governing Body. The Joint Conference Committee chair will alternate at each meeting between Governing Body and Medical Staff representatives. Disputes shall be managed, and where possible, resolved by consensus after sufficient opportunity for the Committee to receive and review any documentation or other appropriate input, including meeting and working with any involved parties.

16.8-3 External Dispute Resolution.

Should the internal dispute resolution process established for the Medical Staff and Medical Executive Committee set forth in section 16.8-1, or the Medical Staff and Governing Body set forth in section 16.8-2 fail after reasonable attempts to resolve the dispute, the dispute shall be referred to a mutually acceptable mediation process for resolution. In the event that the parties cannot agree on a mutually acceptable mediation process for resolution, the matter will be resolved in accordance with the Judicial Arbitration & Mediation Service (JAMS) binding arbitration provisions, with venue and jurisdiction for such proceedings in Tacoma, Pierce County, WA.

16.8-4 Disputes Involving Medical Staff Bylaws, Rules and Regulations and Policies

No conflict management or dispute resolution process can amend the Medical Staff Bylaws, rules and regulations or policies. Bylaws, rules and regulations and policy amendments proposed as a result of a dispute management process must be acted upon by the Medical Staff and Governing Body as required by these Bylaws.

16.9 Participation in Organized Health Care Arrangement

Every Practitioner and AHP providing direct clinical services at the 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 the Hospital and the independent Practitioners and AHPs providing care at the Hospital to better serve the Hospital patients, and to facilitate the exchange of “protected health information” (as such term is used in the Privacy Rules) among the MHS, Practitioners, AHPs and other health care professionals providing care in a clinically integrated care setting at the Hospital.

XVII. ADOPTION AND AMENDMENT OF BYLAWS

17.1 Medical Staff Authority and Responsibility

17.1-1 The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments subject to the approval of 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 quality and efficient patient care, and maintaining a harmony of purpose and effort with the Governing Body.

17.1-2 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 fifteen (15) percent of the Medical Staff Members eligible to vote.

17.1-3 Proposed amendments shall be submitted to the Governing Body for comments before distribution for a vote of the Medical Staff. The comments of the Governing Body regarding the proposed Amendments shall accompany the proposed amendments to the Medical Staff if requested by the Governing Body.

17.2 Methodology

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

17.2-1 All proposed amendments must be reviewed and discussed by the Medical Executive Committee prior to any Medical Staff vote. Proposed amendments 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 the proposed amendments were 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 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 Chief of Staff 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.

17.2-2 The approval of the Governing Body shall not be unreasonably withheld. Following such approval, copies of the revised Bylaws shall be made available to all individuals who have delineated 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 Chief of Staff and the Medical Executive Committee.

17.2-3 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.

17.3 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 ninety (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.

17.4 Approval and Adoption

These Bylaws of the Hospital Medical Staff were approved by the Governing Body on December 18, 2017 on behalf of the Medical Staff, to be effective April 24, 2018 in full substitution and replacement for any and all previous medical staff Bylaws applicable to the licensed facility now known as **Covington Medical Center**

APPENDIX A

STANDING COMMITTEES OF COVINGTON MEDICAL CENTERMEDICAL STAFF

TBD

APPENDIX B

JOINT COMMITTEES OF SYSTEM HOSPITALS