Interim Bylaws of the Medical Staff
Of
Highline Medical Center

April 21, 2020
## MEDICAL STAFF BYLAWS

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DEFINITIONS

1. The term “MEDICAL STAFF” is defined as any licensed medical, osteopathic or podiatric practitioner, psychologist or dentist, who has Active, Provisional, Affiliate or Courtesy status at Highline Medical Center.

2. The term “ALLIED HEALTH PROFESSIONAL” (AHP) is defined as licensed independent practitioner or dependent practitioner who is not a member of the medical staff or Medical Center employee, but either is approved to practice or provides patient care services pursuant to practice prerogatives as described in a scope of practice or a job description. After approval by the Quality and Credentials Committee of the Medical Staff and the Governing Body, acting directly or through its authorized designee, this practitioner may perform specified services to patients at the Medical Center under the responsibility and supervision of a medical staff member.

3. The term “MEMBER” or “STAFF MEMBER” is defined as any licensed medical, osteopathic or podiatric practitioner, psychologist or dentist appointed to, and maintaining membership in any category of the Medical Staff in accordance with these bylaws.

4. The term “GOVERNING BODY” is defined as the group responsible for conducting the ordinary business affairs of Highline Medical Center in Burien, Washington; which for purposes of these Bylaws and, except as the context otherwise requires, shall be deemed to act through the authorized actions of the officers of the corporation and through the Chief Executive Officer of Highline Medical Center.

5. The term “CHIEF EXECUTIVE OFFICER” or “ADMINISTRATOR” is defined as the individual appointed by the Governing Body to act on its behalf in the overall management of the Medical Center. The term Chief Executive Officer includes a duly appointed acting administrator serving when the Chief Executive Officer is away from the Medical Center. The Medical Staff may rely upon all actions of the Chief Executive Officer as being the actions of the Governing Body taken pursuant to a proper delegation of authority from the Governing Body.

6. The term “PHYSICIAN” is defined as a licensed independent practitioner who holds a degree of MD or DO.

7. The term “PATIENT” is defined as any person at the Medical Center undergoing diagnostic evaluation or receiving medical treatment.

8. “JOINT CONFERENCE” is defined as a meeting between representatives of the Governing Body and the practitioner members of the Medical Executive Committee.

9. The term “MEDICAL CENTER” refers to Highline Medical Center.
ARTICLE 1  STATEMENT OF THE PURPOSES AND ROLE OF THE MEDICAL STAFF AND THESE BYLAWS

1.1  NAME

The name of this organization shall be the Medical Staff of Highline Medical Center.

1.2  THE PURPOSES OF THE MEDICAL STAFF ARE TO:

a. Provide one organized collegial body through which the benefits of Staff membership (Mutual education, consultation, and professional support) may be obtained by each Staff Member and their obligations of Staff membership may be fulfilled;

b. Serve as the primary means for relating to the Governing Body of the Medical Center on issues involving the quality and appropriateness of the professional performance, clinical standards, and the ethical conduct of its Members as well as of all Allied Health Professionals; and to strive for quality patient care efficiently delivered, consistent with applicable standards in the community;

c. Develop an organizational structure that defines the responsibility and when appropriate, the authority of each organizational component; and

d. Provide a means through which the Medical Staff actively and constructively may participate in the Medical Center’s policy-making and planning processes.

1.3  SELF-GOVERNING MEDICAL STAFF

The Medical Staff is comprised of practitioners holding privileges at Highline Medical Center (hereafter Medical Center). These Bylaws establish the manner by which the Medical Staff shall be a self-governing body that oversees the quality of care provided by all Medical Staff members, practitioners and AHPs who are privileged through a medical staff process, and is accountable to the Governing Body. It is the duty of the Medical Staff, its leaders, and members to comply with and enforce these Bylaws.
ARTICLE 2    MEDICAL STAFF MEMBERSHIP

2.1    QUALIFICATIONS FOR MEMBERSHIP

2.1-1 Applicants eligible for Medical Staff membership shall be licensed to practice in the State of Washington and document their background, experience, training, demonstrated competence, health status, medical liability experience, adherence to the ethics of their profession, good character and ability to work with others. They shall assure the Medical Staff and the Governing Body that any patients treated by them in the Medical Center will be given continuous quality care. No applicant shall be entitled to membership on the Medical Staff or to particular clinical privileges merely by virtue of being duly licensed to practice medicine, podiatry, psychology or dentistry in this or any other state. No applicant will be denied membership based on color, religion, national origin, race, creed, sex, disability, or age.

2.1-2 Every member seeking or holding appointment shall demonstrate satisfactorily to the Medical Staff, Administration, and Governing Body that they possess the following qualifications:

   a. A current unrestricted license to practice in the State of Washington

   b. Professional Education, Training, and Experience

      1) Proof of graduation from an appropriately accredited professional school and residency.

      2) Board certification within five (5) years of completion of training by a board recognized by the American Board of Medical Specialties or American Osteopathic Association or equivalent organization, in a specialty/subspecialty appropriate for the clinical privileges requested

      3) Board certification must be maintained.

      4) Training and experience sufficient to support competence in the areas of the clinical privileges requested.

   c. Current competence consistent with community standards.
d. Willingness and ability to refrain from disruptive and inappropriate behavior and as defined in the medical staff policy, “Disruptive Practitioners.”

e. Be free from any physical or mental impairment which might otherwise limit the individual’s ability to perform in the area of clinical privileges requested.

f. Be free from abuse of any type of substance or chemical which may affect cognitive, motor, or communication ability in a manner which has the potential to interfere with or which provides a reasonable possibility of interfering with the individual’s ability to meet the requirements of the Bylaws, Rules and Regulations and medical staff and Medical Center policies and procedures. In the event of suspicion or knowledge of a problem, the medical staff policy Impaired Practitioner procedure shall be followed.

g. Must demonstrate proof of continuous current professional liability insurance. The minimum policy limits in each instance shall not be less than the amount required by the Governing Body. The minimum amounts may be higher for certain activities.

Only the Governing Body on the recommendation of Medical Executive Committee may make exceptions to the above.

2.2 CONDITIONS AND DURATION OF MEMBERSHIP

2.2-1 Initial appointment and reappointment shall be made solely at the discretion of the Governing Body.

2.2-2 The Governing Body shall act on appointments, reappointments, revocation of or changes in appointments based on recommendations from the Medical Executive Committee.

2.2-3 Appointment and reappointment to the medical staff shall be for a maximum of twenty-four (24) months.

2.2-4 Initial appointment to the active staff shall be Provisional as described in Section 3.3, and shall be for a period of twelve (12) months. The Provisional period may be extended for an additional year if needed to
complete provisional requirements. The advancement to active staff may occur at six (6) months if the evaluation is completed satisfactorily.

2.2-5 By accepting appointment, a member:

a. Acknowledges agreement to abide by the Bylaws, Rules and Regulations and policies of the Medical Staff and Medical Center.

b. Agrees to act in an ethical and professional manner. Medical Staff members will treat other staff members, patients, families, other health care professionals, and Medical Center employees with professional respect and courtesy in conduct and communications at all times. Displays of anger, disrespect of an individual, and verbal or physical abuse of any person will not be permitted and can be grounds for termination of medical staff membership.

c. Agrees to provide continuous care for both inpatients and outpatients, either personally or by designating an appropriately qualified member of the Medical Staff who agrees to provide coverage or provide back-up assistance as needed.

d. Agrees to provide written information immediately to the Medical Staff Services Office regarding (i) any professional disciplinary actions, (ii) any liability actions including any final judgment of settlement, (iii) any voluntary or involuntary relinquishment or restriction of licensure, certification, medical staff membership or clinical privileges; or (iv) any failure to renew or any gap in malpractice insurance coverage.

e. Acknowledges any misrepresentation or misstatement or omission of information from the application for appointment or reappointment is grounds for termination, without appeal, if already conferred.

2.3 STAFF DUES

Annual Medical Staff dues shall be governed by the most recent action, which has been approved by the Medical Executive Committee.
ARTICLE 3 CATEGORIES OF THE MEDICAL STAFF

3.1 ACTIVE STAFF

3.1-1 Qualifications

Active Staff shall consist of members who:

a. Admit, attend, consult, or otherwise be involved in a minimum of ten (10) patient contacts at the Medical Center per year;

b. Meet the general qualifications for membership set forth in these bylaws;

c. Regularly care for patients in the Medical Center;

d. Have just satisfactorily completed requirements of the Provisional appointment as outlined in Section 3.3; and

e. Have offices or residences which, in the opinion of the Medical Executive Committee, are located close enough to the Hospital to provide appropriate continuity of quality patient care.

3.1-2 Department Assignment

Members appointed to the Active Staff shall be appointed to a specific Department, but shall be eligible for Joint Assignments or privileges in other Departments relevant to their practice and credentials as applied for and recommended by those Departments and the Credentials and the Medical Executive Committee.

3.1-3 Prerogatives

Except as otherwise provided, the prerogatives of Active Staff members shall be:

a. Admit or treat patients, and exercise such clinical privileges as are granted pursuant to these Bylaws;

b. Vote on all matters presented at general and special meetings of the Medical Staff, and meetings of department and committees to which the practitioner has been appointed
c. Hold office and sit on or be the chair of any committee, unless otherwise specified elsewhere in these bylaws

d. Attend educational events provided by the medical staff and Medical Center

3.1-4 Responsibilities

Responsibilities of the Active Staff shall be:

a. Actively participate in recognized Staff functions, including quality improvement and other monitoring activities, in mentoring initial appointees during their provisional period or assigned mentoring, and in performing other Staff functions as may be required by Medical Staff leadership.

b. Participate as and when requested by department chair, the President of the Medical Staff and the Medical Executive Committee in coverage of the emergency department and other special coverage programs.

c. Agree to practice in accordance with medical center policies, procedures, and protocols and in a manner consistent with current, evidence-based standards.

d. Review results of Ongoing Professional Practice Evaluation (OPPE) and make reasonable effort to meet or exceed the performance of the majority of members with the same privileges.

e. Participate in any Focused Professional Practice Evaluation (FPPE) in accordance with these Medical Staff Bylaws and the Medical Staff policies.

f. Accept referrals for follow-up care from the Emergency Department through participation in a rotation.

3.1-5 Transfer of Active Medical Staff Membership

After four consecutive years in which a member of the Active Staff fails to regularly care for patients in this Hospital or fails to be regularly involved in Medical Staff functions as determined by the Medical Staff,
that member shall be automatically transferred to the appropriate membership category, if any, for which the member is qualified.

3.2 COURTESY STAFF

3.2-1 Qualifications

Courtesy Staff shall consist of members who:

a. Meet the general qualifications for membership set forth in these bylaws;

b. Maintain Active Staff privileges at another Joint Commission (“TJC”) or comparably accredited Medical Center (although exceptions to this requirement may be made by the Medical Executive Committee for good cause); and

c. Are a member of a group practice, or a call coverage group that provides care at Highline Medical Center.

3.2-2 Prerogatives

Except as otherwise provided, the prerogatives of Courtesy Staff members shall:

a. Admit patients in the same manner as an Active Staff member and exercise such clinical privileges as are granted pursuant to these Bylaws;

b. not vote or hold office.

c. Attend, in a nonvoting capacity, Staff and department meetings of which they are a member and any Staff or Medical Center educational programs.

3.2-3 Responsibilities

Responsibilities of the Courtesy Staff are:

a. Participate, as required, in quality improvement and monitoring activities.
b. Agree to practice in accordance with medical center policies, procedures, and protocols and in a manner consistent with current, evidence-based standards.

c. Review results of Ongoing Professional Practice Evaluation (OPPE) and make reasonable effort to meet or exceed the performance of the majority of members with the same privileges.

d. Participate in any FPPE in accordance with these Medical Staff Bylaws and the Medical Staff policies.

3.3 PROVISIONAL STAFF

3.3-1 Qualifications

The Provisional Staff shall consist of members who:

a. Are newly appointed members to the Active Staff

b. Meet the general Medical Staff membership qualifications

c. Term of Provisional Staff Status: All initial appointments to Active Staff shall be provisional for a period of one (1) year from the date of appointment. The provisional member may be advanced to full active staff after six (6) months if all requirements are successfully completed sooner. Extensions may be granted for up to one (1) additional year. During the provisional period, a practitioner must meet all of the qualifications, may exercise all of the prerogatives, and must fulfill all of the designated requirements of active staff.

3.3-2 Prerogatives

Except as otherwise provided, the prerogatives of the Provisional Staff shall be:

a. Admit patients in the same manner as an Active Staff member and exercise such clinical privileges as are granted pursuant to these Bylaws;

b. Attend general and special meetings of the Medical Staff, committee and department meetings of which they are a member.
c. Shall not be eligible to hold any Medical Staff office or serve as department chair but may serve on committees.

3.3-3 Responsibilities

Responsibilities of the Provisional Staff shall be:

a. Request orientation to the practices and procedures of the organization and for training on equipment used in the care of patients the member has not used before.

b. Actively participate in recognized Staff functions, including quality improvement and other monitoring activities, and in performing other Staff functions as may be required by Medical Staff leadership.

c. Agree to practice in accordance with medical center policies, procedures, and protocols and in a manner consistent with current, evidence-based standards.

d. Reviews results of Ongoing Professional Practice Evaluations (OPPE) and make reasonable effort to meet or exceed the performance of the majority of members with the same privileges.

e. Participate in any FPPE in accordance with these Medical Staff Bylaws and the Medical Staff policies.

f. Participate as and when requested by department chair, the President of the Medical Staff or the Medical Executive Committee in coverage of the emergency department and other special coverage programs.

3.4 THE AFFILIATE STAFF

3.4-1 Qualifications

Affiliate Staff shall consist of members who use the Medical Center as their primary referral facility for inpatient, outpatient and procedural care; and meet all criteria for membership. Affiliate members are not granted clinical privileges.
3.4-2 Prerogatives

Except as otherwise provided, the prerogatives of Affiliate Staff members shall

a. Vote on all matters presented at general and special meetings of the medical staff, and meetings of department and committees to which the practitioner has been appointed

b. Hold office and sit on or be the chair of any committee, unless otherwise specified elsewhere in these bylaws

c. Attend educational events provided by the medical staff and Medical Center

3.4-3 Responsibilities

Responsibilities of the Affiliate Staff include:

a. Accept referrals for follow-up care from the Emergency Department through participation in a rotation.

b. Refer patients for outpatient procedures.

c. Establish an arrangement with a member of the Active or Provisional Staff for inpatient care of patients in their outpatient practice

d. Provide and dictate the history and physical examination, upon request from the admitting physician.

e. Visit the patient and review the medical record.

f. Not write in the medical record, including physician orders and progress notes.

3.4-4 Scope of Practice

a. Affiliate members are not eligible for clinical privileges.
3.4-5 Requirements

a. Initial Appointment to Affiliate Status
   1) Meet all requirements for membership on the medical staff

b. Reappointment to Affiliate Status
   1) Meet all requirements for membership on the medical staff; and
   2) Obtain satisfactory references from two (2) members of the medical staff.

3.4-6 Steps Required to Advance to Active Staff status

In the event Affiliate members wish to advance to Active status, they must meet the requirements of Active status by involvement in the care of the number of cases in accordance with the Department’s Rules and Regulations or Medical Staff policies. In this situation proctoring requires direct observation of all aspects of patient care. The Affiliate member must demonstrate competence to provide care to Medical Center patients. Evidence of competence may include:

a. Documentation of relevant continuing medical education as determined by the department chair, or

b. Proctored cases with evaluations by the proctoring physician; or

c. Proctored procedures with evaluations by the proctoring physician are required for those physicians who wish to perform procedures

3.4-7 Actions toward advancing to Active Staff will include:

a. Meet with the department chair to discuss intentions; and

b. Develop a plan with the department chair to complete FPPE proctoring for initial privileges for a number of cases in accordance with the Department’s Rules and Regulations or Medical Staff policies; and

   c. Plan is reviewed and approved by the department; and
d. Plan must be reviewed and approved by the Quality and Credentials Committee.

e. In the event an active member has changed status to Affiliate staff they must remain Affiliate for at least a twelve (12) month period before applying for a change of status to Active staff.

3.5 THE EMERITUS MEDICAL STAFF

3.5-1 Qualifications

3.5-1.1 The Emeritus Staff

The Emeritus Staff shall consist of physicians, dentists, podiatrists, and clinical psychologists who no longer actively practice at the Hospital and are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contribution to the health and medical sciences, or their previous long-standing service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct.

a. Recommendations are made by current Active staff members to the Quality and Credentials Committee, which will decide if granting Emeritus status is indicated.

b. The Recommendations should include a brief written summary of the contributions of the proposed Emeritus physician.

3.6 THE ADMINISTRATIVE STAFF

3.6-1 QUALIFICATIONS

Any practitioner who is engaged in any way by the Hospital or Medical Staff to use his or her professional training, expertise, and/or clinical judgment in a leadership role, or other activities must be a member of the Medical Staff.

The Administrative Staff category of membership shall be held by any practitioner who is retained by the Hospital or Medical Staff to perform ongoing medical administrative activities.
The Administrative Staff shall consist of members who:

a. Meet criteria for Active or Affiliate Staff membership and clinical privileges in their practice area.

b. Are charged with assisting the Medical Staff in carrying out medical-administrative functions.

3.6-2 PREROGATIVES

The Administrative Staff shall be entitled to:

a. Attend meetings of the Medical Staff and various Departments, including open Committee meetings and educational programs, but shall have no right to vote at such meetings, except to the extent the right to vote is specified in specific situations by these Bylaws. Administrative Staff members shall not be eligible to hold office in the Medical Staff organization. All other Prerogatives of Active or Affiliate Staff members.

3.7 THE RESIDENT PHYSICIANS, MEDICAL STUDENTS, AND SHADOWERS

Members of the Active medical staff may participate in the training or supervision of resident physicians, medical students or those interested in pursuing a career in medicine under the following conditions:

a. The Active member must sign a statement acknowledging their responsibility to protect the privacy and confidentiality of the patient and for assuring that the medical student or shadower does not function outside their role as described in this section. In this capacity, the Active staff member will be known as the supervising physician.

b. The Active member may not sign any agreement on behalf of the Medical Center with a training program, or identify themselves as the representative of the Medical Center.

Failure to follow these expectations may result in their loss of the ability to work with residents, medical students and shadowers.
The Medical Staff Services Office will maintain all documents related to resident physicians, medical students and shadowers.

3.7-2 Resident Physicians

a. Resident physicians electing to participate in a training rotation at the Medical Center must meet the following criteria:

1) They must have a current WA state training license;

2) Documentation of a negative TB test or other evidence they are not putting patients at risk;

3) The training program has a written agreement with the Medical Center;

4) Agree to maintain patient confidentiality, introduce themselves as a resident physician and obtain patient permission to participate in their care, and abide by all the policies and procedures of the Medical Center;

5) Wear a current identification badge at all times;

6) They must have an agreement with a member in good standing of the Active medical staff who will provide supervision and training; and

7) They must agree to practice only within the scope of privileges for the specialty in which they are training and always in the presence of the supervising physician. All notes made in the medical record must be written under the direct supervision of and co-signed by the supervising physician.

3.7-3 Medical Students and Shadowers

a. Medical Students and Shadowers may observe interactions with patients under the supervision of a member of the Active staff when the patient has given permission. If the patient is not in agreement with having the medical student or shadower present, no further efforts will be made to attempt to obtain permission. In no way will patient care be compromised by the patient’s refusal.
1) Medical students agree to maintain patient confidentiality, introduce themselves as a medical student.

2) Wear a current identification badge at all times.

3) Medical Students are permitted to interact with patients and write notes in the medical record under close direct observation of the supervising physician.

4) If they have successfully completed training in physical examination, they may participate in that aspect of patient care under the direct observation of the supervising physician.

5) Shadowers agree to maintain patient confidentiality, introduce themselves as shadower.

6) Shadowers are permitted to talk with patients in a social context only and are not permitted to read or write in the medical record.

ARTICLE 4  APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL POLICIES

No person shall exercise clinical privileges in the Medical Center unless and until that person applies for and receives appointment to the Medical Staff or is otherwise granted privileges as set forth in these Bylaws. By applying to the Medical Staff the applicant acknowledges responsibility to review and adhere to the Medical Staff Bylaws and Rules and Regulations, and Medical Staff and Medical Center policies as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted in accordance with these Bylaws. Membership on the Medical Staff shall be extended only to those physicians, (hereinafter includes all MD’s and DO’s) dentists, podiatrists and psychologists who consistently meet the qualifications, standards, and requirements in the Bylaws, Rules and Regulations and policies of the medical staff.
4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing sufficient information of clinical and professional performance to permit an adequate evaluation of the applicant’s qualifications and suitability for the clinical privileges and staff category requested; to resolve any reasonable doubts about these matters; and to satisfy any requests for such information. The information required to be submitted may also include a complete history and physical examination, which may include blood and chemical analysis or psychological examination as deemed appropriate by the Medical Executive Committee. Any such examination shall be at the applicant’s expense and shall be performed by a practitioner approved by the President of the Medical Staff or designee. The applicant’s failure to produce any required information shall ender the application incomplete and it shall not be acted upon. The same burden of producing clinical, medical, and psychological information rests with any practitioner required to produce information as part of an authorized Medical Staff peer review activity. Failure of a practitioner to produce required information related to an authorized Medical Staff peer review, quality assurance, performance improvement or credentialing activity in a timely manner may result in automatic suspension of all clinical privileges until such time as the required information has been provided. 4.3

4.3 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointments to the Medical Staff shall be made as set forth in these Bylaws, but only after there has been a final recommendation from the Medical Executive Committee to the Governing Body. The Governing Body’s decision is final.

4.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Initial appointments and reappointments and renewals of clinical privileges shall not exceed a period of twenty-four (24) months.
4.5 APPLICATION FOR APPOINTMENT AND REAPPOINTMENT

4.5-1 INITIAL APPLICATION PROCESS

a. Application Request

The practitioner requesting an application for appointment to the Medical Staff will be sent a Request for Application form that provides the potential applicant the opportunity to determine whether or not the requirements for membership and clinical privileges can be met. The Request for Application form shall include the following:

1) Applicant demographic information
2) Washington license and DEA status
3) Current liability insurance coverage status
4) Anticipated practice plan indicating plans for utilizing the Medical Center
5) Board certification status
6) Education and training
7) The existence and circumstances of any professional liability complaint, claim or other cause of action that has been lodged against the practitioner, and the status or outcome of each such matter, including all final judgments or settlements involving the practitioner

Upon receipt of the Request for Application, and the information therein, licensure is verified online, the National Practitioner Data Bank is queried, an AMA Profile is obtained online, excluded parties check (EPLS and OIG) and a criminal background check is completed. In the event there are indications the applicant will not meet established criteria for membership the applicant will be notified and no further action will be taken. If no adverse indications are present, an Application for Appointment packet shall be sent.
b. Application for Appointment

All Applications for Appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Body after consultation with the Executive Committee. The Medical Staff application forms are created, collected, and maintained for the Quality and Credentials Committee, and are afforded all protections pursuant to RCW 4.24.240-250 and RCW 70.41.200. The Application for Appointment shall, at a minimum, require detailed information concerning:

1) Postgraduate training, including the name of each institution, degrees granted, programs completed, dates attended and names of practitioners responsible for the applicant’s performance

2) Specialty or subspecialty board certification and recertification dates

3) Professional qualifications, including but not limited to, current licensure, current DEA registration (if applicable), and special certifications as required by Department or State/Federal regulations

4) Request for clinical privileges as related to specialty or sub-specialty

5) Current and prior Medical Center and other healthcare organization affiliations

6) At least two (2) peer references acceptable by experience or reputation by the Medical Staff who have had extensive experience observing and practicing with the applicant and can provide information pertaining to the professional competence, interpersonal relationships and ethical character of the applicant

7) The applicant’s current ability to practice without limitation related to physical and mental health, as the
requests for such information conform to federal and state laws

8) The existence and circumstances of any professional liability complaint, claim or other cause of action that has been lodged against the practitioner, and the status or outcome of each such matter, including all final judgments or settlements involving the practitioner

9) The existence and circumstances of any past or pending professional disciplinary action or investigation involving the practitioner including the status or outcome of each such matter

10) Any voluntary or involuntary termination or denial of Medical Staff membership or voluntary or involuntary limitation, suspension, reduction, relinquishment, or other loss of clinical privilege at any other Medical Center or health care facility

11) Information that demonstrates the applicant’s ability to work collaboratively with Medical Center and Medical Staff in a manner that fosters quality health care, and the applicant’s ability to refrain from conduct that constitutes a pattern of disruption that adversely affects the quality or delivery of patient care, in accordance with the Medical Staff policy related to disruptive behavior

12) Information concerning the applicant’s current liability coverage and experience

13) Plans for the utilization of the Medical Center that are reasonable in terms of the services offered at the Medical Center

14) The applicant’s understanding and acceptance of the medical staff policies, “Disruptive Practitioners” and the “Code of Conduct” and documentation signed by applicant.
15) Application fee as determined by the Medical Executive Committee.

4.6 EFFECT OF APPLICATION

4.6-1 By applying for appointment to the Medical Staff, each applicant:

a. agrees to appear for interviews in regard to the application;

b. agrees that it is his/her responsibility to inform the Medical Center when any information contained in the application changes or should be supplemented to make the application complete and current;

c. authorizes Medical Center representatives to consult with others who have been associated with the applicant and/or who may have information bearing on his/her competence, character, ethics, health and other qualifications;

d. consents to Medical Center representatives inspecting all records and documents that may be material to an evaluation of (i) his/her professional qualifications and competence to carry out the Privileges requested, (ii) his/her moral and ethical qualifications, (iii) his/her physical and mental health status, and (iv) his/her professional conduct;

e. releases from any liability all Medical Center and Medical Staff representatives for their acts performed in good faith in connection with evaluating the applicant and his/her credentials;

f. releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Medical Center representatives in good faith without malice concerning the applicant’s competence, professional ethics, character, physical and mental health, emotional stability, behavior and other qualifications for Medical Staff appointment and Privileges;

g. authorizes and consents to Medical Center representatives providing other Medical Centers, medical associations, licensing boards, and other organizations concerned with provider
performance and the quality and efficiency of patient care with any information relevant to such matters that Medical Center may have concerning him/her, and releases Medical Center representatives from liability for so doing, provided that such furnishing of information is done in good faith;

h. agrees to immediately inform the Medical Center, at any time prior to or after appointment, of any changes in health status that could affect his/her ability to perform the Privileges granted, and to submit to a professional examination acceptable to the Medical Center, should this be considered necessary;

i. agrees to immediately inform the Medical Center of any changes, at any time prior to or after appointment, in staff membership or privileges at other Medical Centers;

j. agrees to immediately inform the Medical Center of any cancellation, failure to renew or other gap in the malpractice insurance coverage required by Section 4.5-1 (a.4);

k. agrees to immediately inform the Medical Center of any revocation, at any time prior to or after appointment, of his/her professional license(s), or of any statement of charges, notice of proceedings, or actions, whether or not final, relating to the applicant by the Medical Quality Assurance Commission or other professional licensure body of Washington or any other state;

l. agrees to inform the Medical Center at any time prior to appointment (or, upon request, after appointment or reappointment) of any pending or threatened claims related to professional liability, professional conduct or other conduct relevant to the Practitioner’s application, or settlements of any such claim, and consent to defense attorneys and insurance companies releasing information to the Medical Center regarding such claims;

m. agrees to provide complete, accurate and true information in his/her application and all communications to the Medical Center and the Medical Staff; and
n. agrees to provide identification or other information as requested to ensure that the applicant is the individual identified in the credentialing documents related to the application.

o. Any misstatement in or omissions from an application for appointment or reappointment shall constitute grounds for denial of the application or cause for revocation of Privileges.

p. The applicant shall be provided with a Statement of Applicant and Authorization to Release Information for his/her signature, agreeing to the above terms.

4.6-2 For purposes of this Section, the term “Medical Center representative” is intended to include the Governing Body and the Administrator and their authorized committees, representatives and agents; the Medical Staff and its officers, committees and representatives; and all Medical Center employees, agents and appointees to the Medical Staff who have committee or other responsibility for collecting and/or evaluating the applicant’s credentials and/or acting upon applications or who provide information relating to the applicant.

4.7 NOTICE OF DISCIPLINARY OR CORRECTIVE ACTION

4.7-1 As a condition of maintaining Medical Staff membership and privileges at the Medical Center, each practitioner is required to notify the chair of the Quality and Credentials Committee and the Administrator immediately upon the occurrence of any of the following:

a. The revocation, suspension, restriction, curtailment, probation, or limitation, whether voluntarily or involuntarily, of the practitioner’s professional license by any state licensing agency.

b. The revocation, suspension, restriction, curtailment, probation, or limitation, voluntary or involuntary, of medical staff membership or clinical privileges at any Medical Center or other health care institution.

c. The cancellation, termination, restriction, probation, limitation, or other curtailment, voluntary or involuntary, of practitioner’s status as a participating provider in any managed care organization or network.
d. The cancellation or restriction of practitioner’s professional liability insurance coverage.

e. The revocation, suspension, or voluntary relinquishment of any registration at the state, federal, or district level to prescribe any medications.

f. Any adverse determination by a state or federally qualified peer review organization concerning practitioner’s quality of care.

g. The commencement of any formal investigation or the filing of any charges by the Department of Health and Human Services or any law enforcement agency or health care regulatory agency of the United States or any state.

h. The filing of any lawsuit or the asserting of any claim against the practitioner alleging professional liability.

4.8 VOLUNTARY LEAVE OF ABSENCE

4.8-1 At the discretion of the Medical Executive Committee, a practitioner may obtain a voluntary leave of absence from the staff upon submitting a written request to the Quality and Credentials Committee stating the reason for the request and the approximate period of leave desired, which may not exceed one (1) year. During the period of leave, the practitioner shall not exercise clinical privileges at the Medical Center, and membership rights and responsibilities shall be inactive.

4.8-2 At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the practitioner may request reinstatement of privileges by submitting a written notice to that effect to the Quality and Credentials Committee. The practitioner shall submit a summary of relevant activities during his or her leave. The Quality and Credentials Committee shall review and verify this information and make a recommendation concerning the reinstatement of the practitioner’s privileges.

4.8-3 Failure to request reinstatement as described in Section 5.8-2 shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership and privileges. The practitioner shall be eligible to reapply for membership and be processed in the manner specified for application for initial appointment.
4.8-4  During the leave of absence, the period of appointment shall continue. If the leave of absence coincides with the end of the appointment period, the reappointment process must occur before the member returns to practice.

4.9  MEDICAL / MILITARY LEAVE OF ABSENCE

4.9-1  A practitioner may obtain a medical or military leave of absence from the staff upon submitting a written request to the Executive Committee stating the reason for the request and the approximate period of leave desired. During the period of leave, the practitioner shall not exercise clinical privileges at the Medical Center, and membership rights and responsibilities shall be inactive.

4.9-2  At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the practitioner may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The practitioner shall submit a summary of relevant activities during his or her leave. The Executive Committee shall review and verify this information and make a recommendation concerning the reinstatement of the practitioner’s privileges, or shall submit the practitioner’s file to the Quality and Credentials Committee for review and recommendation.

4.9-3  Failure to request reinstatement as described in Section 4.9-2 shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership and privileges. The practitioner shall be eligible to reapply for membership and be processed in the manner specified for application for initial appointment.

4.9-4  During the leave of absence, the period of appointment shall continue. If the leave of absence coincides with the end of the appointment period, the reappointment process must occur before the member returns to practice.

ARTICLE 5  CREDENTIALING POLICY

5.1  RECEIPT OF THE APPLICATION

An Application for Appointment shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied and all information verified. An application
shall become incomplete if the need arises for new, additional or clarifying information anytime during the evaluation. Any application that continues to be incomplete ninety (90) days after the applicant has been notified of the need for additional information shall be deemed to be voluntarily withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

5.2 VERIFICATION PROCESS

5.2-1 The Application for Appointment and supporting materials shall be submitted to the Administrator, or designee. Upon receipt of the application, the Administrator shall seek to verify, through the primary source where possible, its contents and collect additional information, including but not limited to the following:

a. On-line verification of license
b. Copy of current DEA registration; (certificate)
c. All information held by the Secretary of the Department of Health and Human Services or the agency designated by the Secretary, pursuant to the Health Care Quality Improvement Act of 1986;
d. Primary source verification of completion of an accredited medical school, osteopathic school, dental school, graduate school of psychology, or podiatric school and residency training program;
e. Professional liability insurance history, including information about any actions such as lawsuits, torts and settlements pending or closed at the time of the application.

f. Peer references and other materials deemed pertinent under the Bylaws and any Procedural Policies. At least two peer references shall be from practitioners in the same specialty.

5.3 ACTION ON THE APPLICATION

5.3-1 Following receipt of the completed Application for Appointment, verification of its contents and receipt of any necessary additional information, the Administrator or designee shall review the outcome of
the background verifications to determine if any of the following issues are present:

a. Any criminal activity discovered via Washington State Patrol background check or reported within application

b. Intermittent completion of internship, residency, or fellowship; failing to complete; unexplained changes

c. Any denial, revocation, suspension, reduction, limitation, probation, sanction, non-renewal, involuntary or voluntary relinquishment of a license, certification, staff membership, or clinical privileges

d. Any Medicare/Medicaid sanction activity or sanctions by a private insurance or payer organization

e. Inability to gain professional references, including non-committal responses or unexplained blanks on reference forms

f. Significant health problems creating limitations to practice in the area of clinical privileges requested as noted by the completed questionnaire

g. Any irregularities, recent claims, or past pattern of claims difficulties with healthcare insurance payers

h. Request for privileges inconsistent with background / training

i. Any unexplained inconsistency between application and curriculum vitae discovered during the verification process

j. Interpersonal problems discovered during verification or reference activities

k. Any unusual practice patterns such as unexplained gaps in practice history, unexplained address changes, extensive work as a locum tenens, or failure to establish definitive practice history.

l. Any lawsuits or claims of professional malpractice or negligence against the applicant
5.4  **STANDARD REVIEW**

If none of the issues described in Article 5, Section 5.3-1 are present, the application shall be reviewed and processed as follows: (If, at any time during the following review, an issue as noted in 5.3-1 is detected, the application will be submitted to the Quality and Credentials Committee and will be processed as described in Section 5.5-1 and Section 5.5-2.

5.4-1 The application shall be routed to the chair of the department. The department chair will review the application to determine competence and appropriate training and experience relevant to the requested privileges and prepare a recommendation specifically for the Quality and Credentials Committee. In the event the applicant demonstrates competence but does not meet all specific requirements for requested privileges, the chair may decide to recommend approval with provisions for proctoring or additional training to be completed within a designated time period or similar action. An evaluation and monitoring process to assure completion will accompany recommendations. If the application meets all other qualifications for membership and requested privileges, it will be forwarded with written recommendation for review by the Chair of the Quality and Credentials Committee.

5.4-2 The Chair of the Quality and Credentials Committee shall review the recommendations from the department chair, and the application for completeness and evaluation of the content. The Chair shall then make appropriate written recommendation to the Medical Executive Committee. The Chair of the Quality and Credentials Committee may bring any application to the Quality and Credentials Committee for full committee review when indicated.

5.4-3 The Medical Executive Committee shall review and make recommendations to the Governing Body, documented in writing, recommending approval, conditional approval, or denial of appointment. All recommendations to appoint must specifically recommend the clinical privileges to be granted.

5.4-4 If the recommendation of the Medical Executive Committee is favorable to the practitioner, the Administrator shall promptly forward it, together
with all supporting documentation, to the Governing Body for final review.

5.4-5 If the recommendation of the Medical Executive Committee is adverse to the applicant with respect to either appointment or clinical privileges requested, the Administrator shall promptly notify the applicant by certified mail, return receipt requested. All temporary privileges previously granted to the applicant, if any, shall be terminated or modified to comply with the Medical Executive Committee’s recommendations, pending final decision of the Governing Body.

5.5 ADVANCED REVIEW

5.5-1 Initial Appointment

If any of the issues described in Article 5, Section .3-1 are present, the application shall be reviewed and processed as follows:

a. The application shall be reviewed, on behalf of and at the direction of the Quality and Credentials Committee, by the chair of the department in which the applicant seeks privileges. The department chair will ask two other department members or members from another department to review the file. If the application includes information that indicates need for additional review and consideration, the department chair has the option of bringing the application to the department meeting for consideration. The department chair may meet with the applicant to gather further information. Additional department members may be asked to participate. Recommendations for action including approval, conditional approval or denial will be sent to the Quality and Credentials Committee.

b. The Quality and Credentials Committee shall review the information and recommendations of the department. The Committee may request additional information from the department. Only after the Quality and Credentials Committee has received adequate information to make a decision will a recommendation be made to the Medical Executive Committee for approval, conditional approval, or denial.
c. The Medical Executive Committee shall review all information from the department and Quality and Credentials Committee, and shall make a written report to the Governing Body, via the Administrator or designee, recommending approval, conditional approval, or denial of appointment.

d. If the recommendation of the Medical Executive Committee is adverse to the practitioner either in respect to appointment or clinical privileges requested, the Administrator shall promptly notify the practitioner by certified mail, return receipt requested. All temporary privileges previously granted to the applicant, if any, shall be terminated or modified to comply with the Medical Executive Committee’s recommendations pending final decision of the Governing Body.

e. The Governing Body shall review and consider all information and recommendations of the Medical Executive Committee and make a final decision for approval, conditional approval, or denial of the appointment.

f. Persons who submit a Request for Application form, but do not meet the minimum, objective qualifications for Medical Staff membership or Privileges and are not provided an Application are not entitled to a hearing and appeal. Notwithstanding the foregoing, Applicants who otherwise meet the minimum objective qualifications but are denied initial appointment based upon the practitioner’s competence or professional conduct are entitled to a hearing and appeal.

5.5-2 Reappointment

Steps 5.5-1(a)-(d) apply to reappointment applications, with the addition of:

a. The summary of OPPE and any FPPE since the last appointment will be reviewed by the department chair as part of the reappointment documents, and forwarded to the Quality and Credentials Committee.
b. The department chair or the Quality and Credentials Committee may request external review of cases to provide additional information.

c. Pending lawsuits or legal claims, or complaints brought to the Washington State Medical Quality Assurance Committee that have not been investigated may not require Advanced Review. This will be at the discretion of the department chair or Quality and Credentials Committee. At the time of completion of any legal action or any investigation, the case will be further reviewed by the department chair and proceed in accordance with the peer review process.

d. Applicants for reappointment who are not reappointed or reappointed with restrictions are entitled to a hearing and appeal.

5.6 REVIEW OF ADVERSE INFORMATION AT THE TIME OF REAPPRAISAL AND REAPPOINTMENT OF MEMBERSHIP

The following applies to the review of adverse information in the Medical Staff member’s credentials file and the member’s quality file at the time of reappointment and renewal of membership.

a. Prior to any recommendation on the renewal of membership, the Quality and Credentials Committee, as part of its reappointment function, shall review any adverse information in the credentials file or the quality file pertaining to the member;

b. Following this review, the Quality and Credentials Committee shall determine whether documentation warrants further action. If an investigation and/or adverse action at the time of membership renewal is warranted, the Quality and Credentials Committee shall so inform the Medical Executive Committee; and

c. With respect to such adverse information, if it does not appear that an investigation and/or adverse action at the time of membership renewal is warranted, the Credentials Committee shall so inform the Medical Executive Committee.
MEMBER’S OPPORTUNITY TO REQUEST CORRECTION OR DELETION OF AND TO MAKE ADDITION TO INFORMATION IN CREDENTIALS FILE

a. After review, a member, as provided above, may address to the President of the Medical Staff a written request for correction or deletion of information in the quality file. Such request shall include a statement of the basis for the action requested;

b. The President of the Medical Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, after such review, whether or not to make the correction or deletion requested. The Medical Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote;

c. The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee; and

d. In any case, a member shall have the right to add to the individual’s quality file a statement responding to any information contained in the quality file.

ARTICLE 6 PROVISIONAL APPOINTMENT

6.1 LENGTH OF PROVISIONAL APPOINTMENT

6.1-1 All initial appointments to Active Staff shall be provisional for a period of one (1) year from the date of appointment. The provisional member may be advanced to full active staff after six (6) months if all requirements are successfully completed sooner. Extensions may be granted for up to one (1) additional year. During the provisional period, a practitioner must meet all of the qualifications, may exercise all of the prerogatives, and must fulfill all of the designated requirements of provisional staff.

6.2 CONCLUSION OF PROVISIONAL APPOINTMENT

6.2-1 At the end of the provisional appointment period, based on the recommendation of the Department chair, the Quality and Credentials Committee will make a recommendation to the Medical Executive Committee that the practitioner be advanced from Provisional to Active
Staff status; or the provisional appointment period be extended for up to one (1) additional year to permit further evaluation; or membership and clinical privileges be automatically terminated.

6.2-2 Before the completion of the applicant’s year of provisional status, the practitioner’s Department chair shall review evidence of performance within the Medical Center and the community, professional competence and clinical judgment determined by observation and review of patient records, ethics and conduct, attendance at Medical Staff meetings, compliance with Medical Center policies and Medical Staff Bylaws, cooperation with Medical Center personnel, and the results of the mentorship as described in Section 6.4. A written recommendation shall be forwarded to the Quality and Credentials Committee, for further consideration and recommendation.

6.3 ACTION ON PROVISIONAL APPOINTMENT

6.3-1 When the recommendation of the Medical Executive Committee is favorable to advancement of the practitioner to Active Staff, or extension of provisional status for an additional year, with retention of unchanged or increased clinical privileges, the Committee shall forward this decision through the Administrator to the Governing Body for action at its next meeting.

6.3-2 When the recommendation of the Medical Executive Committee is non-advancement to full staff privileges or to such advancement with reduction in clinical privileges, the President of the Medical Staff shall promptly notify the practitioner by certified mail, return receipt requested, and the practitioner shall be entitled to the procedural rights established in Article 10 of these bylaws.

6.4 MENTORING

6.4-1 A member of the Active Staff shall be assigned to act as mentor to all newly appointed Provisional members of the Active Staff.

6.4-2 Physicians approved for membership in the Courtesy staff will not be assigned a Mentor, as they are required to maintain Active Staff membership with comparable privileges in another JC or comparably accredited Medical Center. Information related to their competence and
suitability for membership shall be obtained from that Medical Center and reviewed as part of the reappointment process.

6.4-3 Affiliate Staff members will not be assigned a mentor since they will not be providing any care in the Medical Center.

6.4-4 The Mentor will observe and evaluate the medical care delivered by and overall performance of the practitioner by means of Medical Center chart review, observation of procedures, meetings with the practitioner and feedback from other practitioners, nursing leadership and Medical Center staff. The number of patient contacts to be reviewed shall be determined by the Department to which the member has been assigned. If problems are identified, the chair of the Department will ask two (2) additional department members or members of another department to review the findings, and if appropriate, review relevant medical records. If determined by the department chair, an outside review will be obtained.

6.4-5 If the recommendations include extending the provisional period, a written statement by the mentor and signed by the department chair of expectations and plan of improvement will be forwarded to the Quality and Credentials Committee as part of the provisional member’s quality file.

6.4-6 At the end of the time period established for observation, the Mentor will direct a letter to the chair of the Department indicating recommendations.

6.5 PROCTORING

GENERAL PROVISIONS

Except as otherwise determined by the Medical Executive Committee, practitioners granted original or additional clinical privileges shall be subject to a period of FPPE proctoring in accordance with Department Rules and Regulations and any Medical Staff policies. Each Medical Staff member or recipient of new clinical privileges shall be assigned to a Department where performance on an appropriate number of cases, as established by the Medical Executive Committee or the Department as designee of the Medical Executive Committee, shall be directly observed in person by the Chair of the Department, or the Chair’s designee, during the period of FPPE proctoring specified in the Department’s Rules and
Regulations, to determine suitability to continue to exercise the clinical privileges granted in that Department.

The exercise of clinical privileges in any other Department shall also be subject to direct observation by that Department’s Chair or designee as part of the FPPE process, in accordance with Department Rules and Regulations and any Medical Staff policies. Observation of a practitioner shall adequately evaluate the practitioner and may include, but not be limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate proctoring reports shall be furnished to the Credentials Committee, with a copy to the proctored Medical Staff member, who shall be entitled to comment in writing thereon. The proctored Staff member shall have the right to provide his or her qualified observers whose reports shall also be considered by the Department Chair and the Quality and Credentials Committee. Observers who may not be member of the Medical Staff may apply for and be granted temporary privileges, for the purpose of performing proctoring duties. The practitioner shall remain subject to such proctoring until the Quality and Credentials Committee has furnished the Medical Executive Committee with:

a. A certification signed by the Chair of the Department to which the practitioner is assigned describing the types and numbers of cases observed and the evaluation of the practitioner’s performance, stating that the practitioner appears to meet all of the qualifications for unsupervised practice in that Department consistent with the clinical privileges granted, and, in the case of Staff members, stating that the Staff member has discharged all of the responsibilities of Staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and

b. A certification signed by the Chair of the other Department(s) in which the practitioner may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the practitioner’s performance and stating that the practitioner has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in such Department(s).
6.6 REAPPOINTMENT TO THE ACTIVE, AFFILIATE OR COURTESY STAFF

6.6-1 Within twelve (12) months of initial appointment or within twenty-four (24) months of reappointment, members of the medical staff will be invited to reapply for staff privileges. The Quality and Credentials Committee shall review recommendations from the Department, along with all pertinent information available on each practitioner for the purpose of determining its recommendations for reappointment to the Medical Staff and for granting of clinical privileges, and shall transmit its recommendations, in writing, to the Executive Committee. The Executive Committee shall review the recommendation of the Quality and Credentials Committee and, in turn, forward its recommendation in writing to the Governing Body. Where non-appointment or change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented. The process for reappointment shall be the same as for initial appointment as outlined in Article 5.

6.6-2 Recommendations that are adverse to granting reappointment shall follow procedures regarding corrective actions and right to hearing, as outlined Article 10.

6.7 FAILURE TO OBTAIN OR RETAIN BOARD CERTIFICATION

a. The failure to obtain certification for any specific clinical privilege shall not, of itself, preclude advancement from provisional status to regular status in the Medical Staff category of any Medical Staff member. If such advancement is granted absent satisfactory completion of proctoring, continued proctoring on any unapproved procedure shall continue for the specified time period.

b. In the event a member of the Medical Staff’s board certification expires without renewal, the member will have no more than three years to become re-certified.
ARTICLE 7 CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

7.1-1 Every practitioner practicing at this Medical Center, by virtue of Medical Staff membership, shall be entitled to exercise only those clinical privileges specifically granted by the Governing Body. Said privileges or practice prerogatives must be Medical Center specific and within the scope of the person’s license or certificate authorizing practice in this State. Clinical privileges and practice prerogatives shall be exercised pursuant to the Bylaws, and Medical Center policy, and subject to the authority of the department chairs, the Quality and Credentials Committee, and the Medical Executive Committee.

7.1-2 Every initial application for staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant’s education, training, experience, demonstrated competence, references and other relevant information. The applicant shall have the burden of establishing the qualifications and competency in the clinical privileges requested.

7.1-3 Minimum threshold criteria for requesting core and supplemental clinical privileges, as well as any requirements during the provisional period, shall be established by each department subject to the approval of the Medical Executive Committee and the Governing Body. An application for clinical privileges shall not be considered unless the practitioner documents satisfaction of the minimum or threshold criteria required of all practitioners seeking those privileges. Failure to consider a request for clinical privileges because of practitioner’s failure to satisfy the criteria shall not entitle the practitioner to any procedural rights of review.

7.1-4 Privileges granted to non-physician practitioners shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each such practitioner may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by such practitioners shall be under the overall supervision of the Department of Surgical Services. All dental, podiatry and psychology patients shall
receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Active, Courtesy, or Provisional Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. It shall be the responsibility of the dentist or podiatrist to arrange medical coverage prior to the patient’s admission.

7.2 TEMPORARY PRIVILEGES

7.2-1 Temporary privileges should only be granted for Interim Privileges or Case-by-Base Privileges and only after the delineated verifications have been obtained. (Any unsatisfactory response may result in further review and/or denial of temporary privileges.)

7.2-2 Temporary privileges may be granted in the following circumstances:

a. Interim Privileges

Upon receipt of a completed application for Medical Staff membership from an appropriately licensed practitioner, the Administrator may grant temporary admitting and clinical privileges to the applicant for a period not to exceed ninety 90 days. This applies only to an application that has been completely verified and awaiting committee approval. In exercising such privileges, the applicant shall act under the supervision of the department chair, or designee. Verifications requirements for granting Interim Privileges include:

1) Verification of Training, including residency and fellowships

2) Letter requesting temporary privileges

3) Current licensure verified with the State

4) Copy of current DEA (when applicable)

5) Copy of current required certification – ACLS, NRP, etc. (when applicable)

6) National Practitioner Data Bank Report
7) Current liability insurance coverage
8) Verification of residency by Program Director
9) Board certification status
10) One (1) peer reference
11) One (1) Medical Center affiliation
12) The existence and circumstances of any professional liability complaint, claim or other cause of action that has been lodged against the practitioner, and the status or outcome of each such matter, including all final judgments or settlements involving the practitioner
13) No current or previously successful challenge to licensure or certification
14) No subjection to involuntary termination of medical staff membership at another organization
15) No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges

b. Case-by-Case Privileges

The Administrator may grant temporary privileges for a period not to exceed ninety (90) days to a practitioner who is not an applicant or a Member for the care of a specific patient provided there is a valid patient care need which cannot reasonably be managed by a member of the Medical Staff. Privileges shall be restricted to the treatment of not more than two (2) patients in one calendar year by a practitioner, after which such practitioner shall be required to apply for membership on the Medical Staff. In addition to verifications required under Section 7.2-1, Privileges shall only be granted on this basis after a review of the following:

1) Verification of current liability coverage
2) National Practitioner Data Bank Report
3) One peer reference familiar with the practitioner’s practice
4) Patient and date of procedure

5) Name of staff member requesting the services of the practitioner

6) Verification of Active status at another Joint Commission accredited Medical Center

7.2-3 Emergency Disaster Privileges

a. In the case of an emergency or disaster situation, any practitioner, dentist or podiatrist member of the Medical Staff, to the degree permitted by practitioner license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Medical Center necessary, including the calling for any consultation necessary or desirable.

b. For the purpose of this section, an “emergency” is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

c. In the case of a disaster in which the disaster plan has been activated and the Hospital is unable to handle the immediate patient needs, the President of the Medical Staff, or in the absence of the President of the Medical Staff, the Vice-President of the Medical Staff, may grant disaster privileges. In the absence of the President of the Medical Staff, Vice-President of the Medical Staff, and Department Chair(s), the Chief Executive Officer of the Hospital or the CEO’s designee may grant the disaster privileges consistent with this subsection. The grant of privileges under this subsection shall be on a case-by-case basis at the sole discretion of the individual authorized to grant such privileges. An initial grant of disaster privileges, is reviewed by a person authorized to grant disaster privileges within 72 hours to determine whether the disaster privileges should be continued.

d. The verification process of the credentials and privileges of individuals who receive disaster privileges under this subsection
shall be developed in advance of a disaster situation. This process shall begin as soon as the immediate disaster situation is under control, and shall meet the following requirements in order to fulfill important patient care needs:

1) The Medical Staff identifies in writing the individual(s) responsible for granting disaster privileges;

2) The Medical Staff describes in writing the responsibilities of the individual(s) responsible for granting disaster privileges;

3) The Medical Staff describes in writing a mechanism to manage the activities of individuals who receive disaster privileges. There is a mechanism to allow Staff to readily identify these individuals;

4) The Medical Staff addresses the verification process as a high priority. The Medical Staff has a mechanism to ensure that the verification process of the credentials and privileges of individuals who receive disaster privileges begins as soon as the immediate situation is under control. This privileging process is identical to the process established under the Medical Staff Bylaws for granting temporary privileges to fulfill an important patient care need; and

5) Those authorized under subsection (a) may grant disaster privileges upon presentation of a valid picture ID issued by a state, federal or regulatory agency and at least one of the following:

   aa. A current picture Hospital ID card clearly identifying professional designation;

   bb. A current license to practice;

   cc. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups;
dd. Identification indicating that the individual has been granted authority by a federal, state, or municipal entity to render patient care in disaster circumstances; or

ee. Identification by current Hospital or Medical Staff member(s) with personal knowledge regarding the volunteer’s ability to act as a licensed independent practitioner during a disaster.

e. Current professional licensure of those providing care under disaster privileges is verified from the primary source as soon as the immediate situation is under control and completed within 72 hours, unless extraordinary circumstances prohibit verification, in which case the following is documented:

1) The reasons verification could not be performed within 72 hours;

2) Evidence of demonstrated ability to continue to provide adequate care, treatment, and services; and

3) An attempt to rectify the situation as soon as possible.

Members of the Medical Staff shall oversee those granted disaster privileges. Disaster privileges may be granted only when the Hospital’s Emergency Management Plan has been activated. Individuals with disaster privileges shall be identified and managed as described in the Hospital’s Emergency Management Plan. The Medical Staff Bylaws, rules, regulations, and policies control in all matters relating to the exercise of disaster privileges.

ARTICLE 8 CORRECTIVE ACTION

8.1 CORRECTIVE ACTION REVIEW AND INVESTIGATION PROCEDURE

8.1-1 Whenever a practitioner with clinical privileges engages in, makes or exhibits acts, statements, demeanor or conduct, either within or outside of the Medical Center, and the same is, or is reasonably likely to be, detrimental to patient safety or to the delivery of quality patient care, or is deemed to be unprofessional conduct as defined by RCW 18.130.180, corrective action review against such practitioner may be requested on
behalf of the Quality and Credentials Committee by any officer of the
Medical Staff, by the chair of any department, by the chair of any
committee of the Medical Staff, by the Administrator or the Governing
Body. All requests for corrective action review shall be in writing to the
Quality and Credentials Committee and shall be supported by reference to
the activities or conduct, which constitute the grounds for the request of
corrective action review. All documents created or gathered in
furtherance of this Section are created and gathered at the direction of and
on behalf of The Quality and Credentials Committee. The Quality and
Credentials Committee shall determine whether to initiate a formal
investigation. The results of any formal investigation and any
recommendations will be forwarded to the Medical Executive Committee.

8.1-2 The Quality and Credentials Committee may conduct the investigation or
delegate the investigation to another standing committee or an ad hoc
committee (the “Investigation Committee”), which shall follow the same
procedures under this Article 8. The Quality and Credentials Committee
shall make a report of its investigation to the Medical Executive
Committee. Prior to the making of such report, the practitioner who is the
subject of the investigation shall have an opportunity for an interview with
the Quality and Credentials Committee. The practitioner shall have
reasonable notice of the meeting and sufficient time to review relevant
medical records and other pertinent documentation. The practitioner shall
be informed of the specific nature of the charges against him/her, and shall
be invited to discuss, explain or refute them. This interview shall not
constitute a hearing, shall be preliminary in nature and none of the
procedural rules provided in these Bylaws with respect to hearings shall
apply thereto. A record of such interview shall be made by the Quality
and Credentials Committee and included with its report to the Medical
Executive Committee. The Quality and Credentials Committee report
may include recommendations for no action, remedial action or corrective
action.

Each Investigation Committee appointed by the Quality and Credentials
Committee to conduct a formal investigation on its behalf is deemed to be
a regularly constituted quality improvement committee pursuant to RCW
4.24.250 and 70.41.200 as well as a professional review body as defined
in the Health Care Quality Improvement Act of 1986. All minutes,
reports, recommendations, communications, and actions made or taken by an Investigation Committee are covered by the provisions of the Health Care Quality Improvement Act of 1986, RCW 4.24.250 and 70.41.200 or the corresponding provisions of any subsequent federal statute providing protection to quality improvement, peer review, or related activities.

8.1-3 Following receipt of a report from the Quality and Credentials Committee, the Medical Executive Committee shall take action upon the investigation.

8.1-4 The action of the Medical Executive Committee following an investigation may be to reject or modify any recommendation, or to make its own recommendation for no action, remedial action or corrective action, including any of the following; to issue a warning, a letter of admonition, or a letter of reprimand; to impose terms of probation or a requirement for consultation; to recommend reduction, suspension or revocation of clinical privileges; to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained; or to recommend that the practitioner’s staff membership be suspended or revoked.

8.1-5 Any recommendation by the Medical Executive Committee for reduction, suspension or revocation of clinical privileges, or for suspension or expulsion from the Medical Staff, shall entitle the affected practitioner to the procedural rights as outlined in Article 10 of these bylaws.

8.1-6 The chair of the Medical Executive Committee shall promptly notify the Administrator in writing of all requests for corrective action review received by the Executive Committee and shall continue to keep the Administrator fully informed of all action taken in connection therewith. After the Medical Executive Committee has made its recommendation in the matter, the procedure provided in Article 10 of these bylaws shall be followed, if applicable.

8.2 PRECAUTIONARY SUSPENSION

8.2-1 Imposition of Precautionary Suspension.

a. Suspension. The President of the Medical Staff, President-Elect, a department chair, the Administrator, or the Executive Committee of either the Medical Staff or the Governing Body
shall each have the authority to act on behalf of the Quality and Credentials Committee whenever the competence or professional conduct of any Member with clinical privileges affects or could affect adversely the health or welfare of a patient or patients, or is considered to be lower than the established standards or contrary to the aims of the Medical Staff, or to be disruptive to the operations of the Medical Center, to precautionarily suspend all or any portion of the clinical privileges of a Member. In no case shall a precautionary suspension exceed a time period of fourteen (14) continuous days, during which the MEC must meet and take action (See Section 8.2.2).

b. Notice. Such precautionary suspension shall become effective immediately upon imposition. Notice of the precautionary suspension shall be written and promptly forwarded to the Chair of the Medical Executive Committee, and delivered by certified mail, return receipt requested, or hand delivery to the Member.

c. Interim Nature of Suspension. Such precautionary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that will be taken with respect to the suspended Member, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.

8.2-2 Action and Investigation by the Medical Executive Committee.

a. The precautionary suspension should be fully investigated within fourteen (14) days of imposition to determine the need for a professional review action. To this end, the Medical Executive Committee, within fourteen (14) days of receipt of notice of imposition of a precautionary suspension shall meet to further investigate and review the matter and shall recommend modification, continuance, or termination of the terms of the suspension, and shall promptly notify the Member by certified mail, return receipt requested or by hand delivery.
b. Terms. If the Medical Executive Committee recommends modification or continuation of the suspension, the terms of the suspension as sustained or as modified by the Medical Executive Committee shall remain in effect unless or until modified by the Medical Executive Committee or the Governing Body.

c. Reinstatement. If the Medical Executive Committee recommends termination of the suspension, the Member’s privileges shall be reinstated. The Governing Body, following notice to it of reinstatement, may continue the suspension on terms directed by it. If the Medical Executive Committee does not recommend immediate termination of the precautionary suspension, the affected practitioner shall be entitled to the procedural rights set out in Article 10 of these bylaws; however, the terms of the precautionary suspension as sustained or modified by the Medical Executive Committee shall remain in effect pending a final decision thereon by the Governing Body.

8.2-3 Timelines and Reporting

a. Guidelines. Time and other technical requirements set forth herein shall be considered guidelines only, and failure of the Medical Executive Committee or its designee to adhere to such timelines and technical requirements shall not be grounds for invalidating any action taken. An exception is the fourteen (14) days in the precautionary suspension, Section 8.2.1.a., which is a firm requirement.

b. Data Bank. The National Practitioner Data Bank will be notified if the precautionary suspension is longer than thirty (30) days.

c. Department of Health. Upon determination that a health care practitioner has committed an action defined as unprofessional conduct under RCW 18.130.180 the Medical Center shall report the action to the Department of Health as stipulated in its guidelines

8.2-4 Continuity of Patient Care. Immediately upon the imposition of a precautionary suspension, the chair of the Medical Executive Committee or responsible department chair shall have the authority to provide for
alternative medical coverage for the patients of the suspended practitioner still in the Medical Center at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

8.3 AUTOMATIC SUSPENSION

The following shall result in automatic restriction or suspension of Medical Staff membership and/or clinical privileges and shall not entitle the Affected Practitioners to the hearing and appeal rights specified in these Bylaws, unless otherwise expressly provided;

8.3-1 MEDICAL RECORDS SUSPENSION

a. The patient’s medical record shall be complete at time of discharge, including progress notes, Operative Reports as applicable, discharge diagnosis and dictated discharge summary. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient’s record will be available for completion through the electronic health record system.

b. A medical record which has not been completed thirty (30) days after discharge is considered delinquent. However, those records missing History and Physical and/or Operative Reports (on surgical charts) will be considered delinquent four (4) business days after discharge. Practitioners who are responsible for completion of the delinquent medical record will have practice privileges suspended such that they may not admit new patients or schedule new procedures until records are completed. However, in order to provide for continuity of care, practitioners will maintain call responsibilities and continue to treat patients already in the hospital.

c. A practitioner is not relieved or excused from his or her obligations, and is not exempt from suspensions under this Section 8.3.1, when the practitioner takes a vacation or a leave of absence or the practitioner is subject to then-current automatic suspension. Additionally, each practitioner owes a duty of care to his or her patients, which includes the responsibility to complete
the patient’s record in a timely and accurate manner. The obligation to complete medical records survives a practitioner’s resignation or the involuntary suspension or termination of Medical Staff membership or privileges at the Hospital.

d. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered to be filed by the Medical Executive Committee.

8.3-2 LOSS OF MALPRACTICE INSURANCE SUSPENSION

Failure to maintain professional liability insurance shall be ground for automatic suspension of a member’s clinical privileges, and if within ninety (90) days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member’s membership shall be automatically terminated.

8.3-3 LICENSURE

8.3-3.1 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 clinical privileges shall be automatically suspended as of the date such action becomes effective. In the absence of any corrective action which has adversely affected the practitioner’s Staff membership or clinical privileges, the suspension described in this paragraph shall automatically terminate upon the reinstatement of the practitioner’s license by appropriate state licensing board.

8.3-3.2 RESTRICTION

Whenever a Member’s license or other legal credential authorizing practice in this State is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the Member has been granted at the Hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner as of the date such action becomes effective and throughout its term.
8.3-3.3 PROBATION

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

8.3-3.4 COURT ORDER

In the event a temporary restraining order or other type of court order or legal restriction is placed on a practitioner’s ability to practice by a court, his privileges shall be automatically restricted or suspended consistent with the terms of the court order until resolution of the matter.

8.4 DUES AND APPLICATION FEES

Members shall be required to pay Medical Staff dues to the Medical Staff. All checks shall be made payable to the Medical Staff of Highline Medical Center and shall be deposited to its separate bank account. The Hospital shall have no access to said funds or control over them.

An application fee is required at the time of initial application and is paid to the Medical Center.

Upon failure of the member to pay Medical Staff dues or submit the requisite initial application fee written notice shall be given by the Secretary/Treasurer of the Medical Staff to such member, by personal delivery or regular mail. The notice shall state the exact amount due, that such amount is delinquent and that if not paid within ten (10) days after the date of such notice, all of the member’s privileges shall be automatically suspended as of the eleventh (11th) day after the date of such notice, and the suspension shall continue until the delinquent fee is paid. A failure to pay dues or the application fees within thirty (30) days after the date of the automatic suspension shall be deemed a voluntary resignation by the practitioner from the Medical Staff and a relinquishment of clinical privileges.

8.5 FELONY

Any Practitioner who has been convicted of, or pled “guilty” to a felony in any jurisdiction shall be automatically suspended by the Chief of Staff or his designee.
Such suspension shall become effective immediately upon such conviction or plea, regardless of whether an appeal is filed. Such suspension shall remain in effect until the matter is reviewed by subsequent action of the Medical Executive Committee (who shall make its recommendation to the Governing Body) which shall act thereon. The Medical Executive Committee shall promptly investigate any practitioner who pleads nolo contendere to a felony to determine whether corrective action should be taken.

8.6 DEA CERTIFICATE

Whenever a member’s DEA certificate is revoked, limited, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term. 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. In the absence of any corrective action which has adversely affected the practitioner’s Staff membership or clinical privileges, the suspension described in this paragraph shall automatically terminate upon the reinstatement of the practitioner’s registration by the Drug Enforcement Administration or other applicable agency.

8.7 SPECIAL APPEARANCE REQUIREMENT

Failure of a member without good cause to provide information or appear when requested by a Medical Staff Committee as described in these Bylaws shall result in the referral to the Medical Executive Committee for action, which may include automatic suspension of all privileges. The automatic suspension shall remain in effect until the practitioner has provided requested information and/or satisfied the special attendance requirement which has been made by the Medical Staff Committee.

8.8 CORRECTIVE ACTION RELATED TO AUTOMATIC SUSPENSION

Notwithstanding the provisions of this Section 8.2, any Medical Staff member who accumulates forty-five (45) or more days of automatic suspension under said subsections in any one (1) calendar year may be subject to immediate corrective action pursuant to these Bylaws and the Staff Member may be considered to have voluntarily resigned from the Medical Staff.
8.9 RESPONSIBILITY OF THE PRESIDENT OF THE MEDICAL STAFF WITH REGARD TO AUTOMATIC SUSPENSIONS

It shall be the duty of the President of the Medical Staff to enforce all automatic suspensions and restrictions and to make necessary reports of same pursuant to Subsection 9.2.10. The President of the Medical Staff shall appoint a Practitioner to continue the care of the suspended Member’s patients, taking into account, insofar as possible, the wishes of the patient in this matter.

8.10 NOTICE OF AUTOMATIC SUSPENSION

The President of the Medical Staff or designee shall immediately notify the affected Staff Member in writing, either by personal delivery or mail, of any suspension or expulsion under this Section. Such notice shall set forth the effective date of and the reason for the suspension or restriction.

ARTICLE 9 PEER REVIEW

9.1 PURPOSES AND PRINCIPLES OF PEER REVIEW

The primary purpose of all peer review and quality assurance conducted by the Medical Staff, its Committees, and Departments shall be to educate practitioners and improve the overall level of patient care rendered by members of the Medical Staff individually and collectively. To that end, the Medical Staff shall consistently strive to help physicians through positive encouragement, routine monitoring, education, and peer-to-peer assistance.

In compliance with The Joint Commission standards requiring FPPE where questions arise regarding a practitioner’s ability to provide safe, high quality care, the Medical Executive Committee shall define, on a continuing basis, the circumstances warranting further intensive review of a member or other practitioner’s services provided under privileges held and establish the parameters for participation of the subject under the FPPE process, in accordance with these Bylaws and any Medical Staff policies.

The Multi-Specialty Peer Review Committee shall oversee the FPPE, as the Medical Executive Committee’s designee.

When circumstances warrant, the President of the Medical Staff shall appoint a special Committee of impartial Medical Staff members whose professional credentials establish their competence to analyze the grounds for the request and
the performance of the practitioner. Members of the Committee should not be economic competitors of the practitioner in question. The panel shall conduct the review as peers following the time frames set for that FPPE by the Medical Executive Committee. FPPE may result in recommendations for changes to improve the member’s performance, recommendations for system, protocol, or policy changes, a request for investigation or corrective action, or other action.

Any special Committee appointed by the Medical Staff President to conduct a review under this Section is deemed to be a regularly constituted quality improvement committee pursuant to RCW 4.24.250 and 70.41.200 as well as a professional review body as defined in the Health Care Quality Improvement Act of 1986. All minutes, reports, recommendations, communications, and actions made or taken by a special Committee are covered by the provisions of the Health Care Quality Improvement Act of 1986, RCW 4.24.250 and 70.41.200 or the corresponding provisions of any subsequent federal statute providing protection to quality improvement, peer review, or related activities.

Except in cases where necessary to protect patients from harm, corrective actions shall be progressive, with an effort first to impose the most effective, yet least restrictive measures before imposing restrictions on privileges or other reportable acts of discipline. To that end, the Medical Staff shall review relevant statistical data, as well as charts and other peer review materials.

Before initiating corrective action, representatives of Medical Staff shall make reasonable investigation, including investigation of factors other than the practitioner’s care that may have contributed to the outcome, incident, or issue under investigation. If the Medical Staff’s investigation does, in fact, uncover additional factors contributing to substandard care, which factors are not within the power of the Medical Staff or its members to remedy, the Medical Staff shall report its finding to the Governing Body so that the Hospital can address those factors using appropriate measures to improve patient care.

9.2 EXTERNAL PEER REVIEW

External peer review in the context of focused review, investigation, application processing, or as directed by the Medical Staff Department, Quality and Credentials Committee or the Medical Executive Committee or the Governing Body shall be appropriate:
9.2-1 To resolve irreconcilable ambiguities arising from vague or conflicting recommendations from Committee review(s), where conclusions from an outside review could directly impact an individual’s membership or privileges;

9.2-2 To address a lack of internal expertise, i.e., when no one on the Medical Staff has adequate expertise in the clinical procedure or area under review;

9.2-3 For evaluation of a quality file or for assistance in developing a benchmark for quality monitoring;

9.2-4 To promote impartiality in peer review so as to minimize or eliminate any potential bias arising from economic competition or other improper motives;

9.2-5 When the number of members of a department or specialty are too few to support an unbiased review or create an undue burden on the members or negatively impact the relationships within the department or group; or

9.2-6 A practitioner is also entitled to retain an external review at his or her own expense.

If the Medical Staff uses external peer review the affected practitioner shall be notified. The affected practitioner may also review the material furnished to the reviewer and may augment it. The external reviewer shall also discuss the case under review with the affected practitioner before reaching any conclusions or making any report. The affected practitioner shall be entitled to a copy of any report made by an external reviewer.

9.3 QUALITY FILE

A confidential quality file on each Medical Staff member and each individual exercising clinical privileges in the Hospital will be maintained in the Medical Staff Services Office under the jurisdiction of the President and the President-Elect of the Medical Staff. The quality file will contain:

9.3-1 All materials regarding the Medical Staff evaluation of credentials;

9.3-2 All current monitoring reports;

9.3-3 Any request for corrective action, which has been forwarded to the President of the Medical Staff; and
Any and all other data maintained by the Hospital or Medical Staff about the practitioner. In no case will a file be kept concerning a Medical Staff member’s competence, quality of care, or any attribute of his or her performance elsewhere in the Medical Center, including the Department to which the individual is assigned, other than the quality file in the Medical Staff Services Office. Nor shall the Medical Staff or Medical Center maintain any personal or private information about any Medical Staff member, except in the quality file. An individual has a right to examine his or her quality file under supervision, maintained in the Medical Staff Services Office at any reasonable time during ordinary working hours subject to confidentiality and privilege provided under state and federal laws. The quality file may be redacted to prevent disclosure of the identity of informants. The member may respond in writing to anything in the quality file and have the response included in the quality file.

9.4 INSERTION OF ADVERSE INFORMATION

The following applies to actions relating to requests for insertion of adverse information into the Medical Staff member’s quality file:

9.4-1 Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members;

9.4-2 The Governing Body, Administration, and Medical Center personnel shall respect the role of the Medical Staff in peer review and shall not solicit adverse information about a practitioner. Any investigation into the qualifications or quality of a practitioner’s care shall be done pursuant to these Bylaws;

9.4-3 When a request is made for insertion of adverse information into the Medical Staff member’s quality file, the respective Department Chair and President of the Medical Staff shall review such a request; and

9.4-4 After such a review a decision will be made by the respective Department Chair and President of the Medical Staff to:

9.4-4.1 Not insert the information;

9.4-4.2 Notify the member of the adverse information in a written summary and offer the opportunity for the practitioner to rebut
this assertion before a decision is made whether it will be entered into the member’s quality file; or

9.4-4.3 If after receiving the member’s written rebuttal, the Department Chair may insert the information along with a notation that a request has been made to the Medical Executive Committee for an investigation as outlined in these Bylaws.

9.4-5 The decision to insert the information into the quality file shall be reported to the Quality and Credentials Committee. The Quality and Credentials Committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

9.4-6 Member’s opportunity to request correction or deletion of and to make addition to information in the quality file:

9.4-6.1 After review, a member, as provided above, may address to the President of the Medical Staff a written request for correction or deletion of information in the quality file. Such request shall include a statement of the basis for the action requested;

9.4-6.2 The President of the Medical Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, after such review, whether or not to make the correction or deletion requested. The Medical Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote;

9.4-6.3 The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee; and

9.4-7 In any case, a member shall have the right to add to the individual’s quality file, a statement responding to any information contained in the file.

9.5 CONFIDENTIALITY OF PEER REVIEW

All quality, peer review and credentialing proceedings involving practitioners must be held in the strictest confidence. Practitioners not directly involved in the peer review or credentialing process shall not to inquire into ongoing proceedings. The Governing Body will also cause the Administration and Medical Center
personnel to maintain in strictest confidence such portions of any peer review or credentialing proceedings as may come to their attention. Any breach of this confidentiality by Medical Staff members or Medical Center personnel will be considered grounds for strict disciplinary action.

9.6 DISRUPTIVE BEHAVIOR: MEDICAL STAFF CODE OF CONDUCT

9.6-1 PURPOSE

The purpose of this policy is to promote improvement in the quality of patient care and safety by defining and prohibiting disruptive behavior by members of the Medical Staff, identifying the mechanism by which complaints of such behavior are received, investigated and assessed, and providing appropriate responses to disruptive behavior.

9.6-2 DEFINITIONS

9.6-2.1 “Disruptive Behavior” means any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.

9.6-2.2 “Harassment” means conduct toward others based on their race, religion, gender, sexual orientation, nationality or ethnicity, which has the purpose or direct effect of unreasonably interfering with a person’s work performance or which creates an offensive, intimidating or otherwise hostile work environment.

9.6-2.3 “Sexual harassment” is defined as unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person’s work performance or which creates an offensive, intimidating or otherwise hostile work environment. (Based on federal laws prohibiting sexual harassment)

NOTE: sexual harassment is illegal. Any claim regarding sexual harassment must be treated as a disciplinary matter and addressed in the manner described in § 9.7 and the subsequent
sections which outline the investigative and hearing processes.

9.6-3 “Retaliation” is an action taken by an accused physician against the complainant or a person closely related to or associated with the complainant in return for the complaint. Retaliation may include threats, harassment, or other similar actions. Retaliation does not include petty slights or trivial annoyances. (Based on EEOC guidelines on retaliation)

TYPES OF CONDUCT

This section provides examples of inappropriate, and disruptive behavior. The behaviors cited are not intended to be an exhaustive list, but are to be used as a guideline for categorizing a practitioner’s actions. Disciplinary action may be brought only for behaviors that fall under the categories of “inappropriate” or “disruptive.”

9.7 INAPPROPRIATE BEHAVIOR

Inappropriate behavior by medical staff members is discouraged. Persistent inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.” Examples of inappropriate behavior include, but are not limited to, the following:

9.7-1 Belittling or berating statements;
9.7-2 Name calling;
9.7-3 Use of profanity or disrespectful language;
9.7-4 Inappropriate comments written in the medical record;
9.7-5 Blatant failure to respond to patient care needs or staff requests;
9.7-6 Personal sarcasm or cynicism;
9.7-7 Deliberate lack of cooperation without good cause;
9.7-8 Deliberate refusal to return phone calls, pages, or other messages concerning patient care or safety;
9.7-9 Use of language reasonably perceived as condescending language; and
9.7-10 Use of language reasonably perceived as degrading or demeaning comments regarding patients and their families; nurses, physicians, Medical Center personnel and/or the Medical Center.

9.8 DISRUPTIVE BEHAVIOR

Disruptive behavior by medical staff members is prohibited. Examples of disruptive behavior include, but are not limited to, the following:

9.8-1 Physically threatening language directed at anyone in the Medical Center including physicians, nurses, other medical staff members, or any Medical Center employee, administrator or member of the Governing Body;

9.8-2 Physical contact with another individual that is threatening or intimidating;

9.8-3 Throwing instruments, charts or other things;

9.8-4 Threats of violence or retribution;

9.8-5 Sexual harassment; and,

9.8-6 Other forms of harassment including, but not limited to, persistent inappropriate behavior.

9.9 CLASSIFICATION OF DISRUPTIVE BEHAVIOR

Disruptive behavior occurs in varying degrees, which are classified here into three levels of severity. Level I behavior is the most severe violation of this Policy. Any corrective action will be commensurate with the nature and severity of the disruptive behavior. Repeated instances of disruptive behavior will be considered cumulatively, and action shall be taken accordingly. Classification of severity shall follow these guidelines:

9.9-1 Level I: Physical violence or other physical abuse which is directed at people. Sexual harassment or harassment involving physical contact. Possession of weapons on hospital property.

9.9-2 Level II: Verbal abuse such as unwarranted yelling, swearing or cursing; threatening, humiliating, sexual or otherwise inappropriate comments directed at person or persons; visual abuse such as threatening, humiliating, sexual or otherwise inappropriate writing, picture(s) or
gestures directed at a person or persons or physical violence or abuse directed in anger at an inanimate object.

9.9-3 Level III: Verbal abuse which is directed at-large, but has been reasonably perceived by a witness to be disruptive behavior as defined above.

ARTICLE 10 HEARING AND APPELLATE REVIEW

10.1 GROUNDS FOR HEARING

10.1-1 DUTY TO EXHAUST REMEDIES

Each applicant and member agrees to follow and complete the procedures set forth in this Article, including appellate procedures, before attempting to obtain judicial relief related to any issue or decision, procedural or substantive, which may be related to or the subject of the hearing or appeal process set forth in this Article.

10.1-2 Any staff member has a right to a hearing and appeal pursuant to the institution’s hearing and appellate procedures as detailed in this Article 10 in the event any of the following actions (“Adverse Actions”) are taken or recommended based on the practitioner’s competence of professional conduct:

a. Denial of initial appointment
b. Denial of reappointment
c. Suspension of staff appointment
d. Termination of staff appointment
e. Suspension or limitation of admitting privileges
f. Denial or restriction of requested clinical privileges
g. Involuntary reduction of current clinical privileges
h. Suspensions of clinical privileges
i. Revocation of clinical privileges

10.1-3 Neither voluntary relinquishment of clinical privileges, as provided for elsewhere in these Bylaws, nor the imposition of a requirement for
retraining, additional training or continuing education, nor any other action taken by the Medical Executive Committee or the Governing Body, shall constitute grounds for a hearing. They shall take effect without any right of hearing or appeal.

10.1-4 All hearings shall be in accordance with the procedural safeguards set forth in this Article 10 to assure that the affected practitioner is accorded all rights to which the practitioner is entitled.

10.2 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 8.1, the President of the Medical Staff or designee on behalf of the Medical Executive Committee shall give the member prompt written notice of (1) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the State licensing board and/or to the National Practitioner Data Bank if required; (2) the reasons for the proposed action including the acts or omissions with which the member is charged; (3) the right to request a hearing pursuant to Section 10.1.8, and that such hearing must be requested within thirty (30) days; and (4) a summary of the rights granted in the hearing pursuant to the Medical Staff Bylaws. If the recommendation or final proposed action is reportable to the State licensing board and/or to the National Practitioner Data Bank, the written notice shall state the proposed text of the report(s).

10.3 REQUEST FOR HEARING

10.3-1 The failure of a practitioner to request a hearing to which the practitioner is entitled within thirty (30) days after receipt of the notice provided under Section 10.2, and in the manner herein provided, shall be deemed a waiver of his or her right to such

10.3-2 When the waived hearing relates to an adverse recommendation of the Executive Committee of the Medical Staff or of a Hearing Committee appointed by the Governing Body, the same shall remain effective against the practitioner pending the Governing Body’s decision on the matter. When the waived hearing relates to an adverse decision by the Governing Body, the same shall remain effective against the practitioner in the same manner as a final decision of the Governing Body provided for in these bylaws. In either of such events the Administrator shall promptly notify
the affected practitioner of practitioner status by certified mail, return receipt requested.

10.4 **NOTICE OF TIME AND PLACE OF HEARING**

10.4-1 If a hearing is requested on a timely basis under Section 10.3 above, the Administrator shall give the practitioner notice stating:

a. The place, time and date of the hearing, which date shall not be less than thirty (30) days, nor more than sixty (60) days, after the date of the notice;

b. A list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body; and

c. A statement of the nature of the adverse recommendation or action and grounds or reasons forming the basis for the adverse action or recommendation.

d. If the discovery of additional facts or additional occurrences warrant the addition or deletion of charges, upon a showing of good cause and good faith, amendments to the statement of charges and list of witnesses may be made, but not later than the close of the case by the Medical Staff representative at the hearing. Such amendments may delete, modify, or add to the acts, omissions, charts, or reasons specified in the original notice. Notice of each amendment shall be given to the Affected Practitioner, the Hearing Officer, and each party. If the Affected Practitioner promptly makes written request to the Hearing Officer, he shall be entitled to a reasonable postponement of the hearing to prepare a response or defense to any such amendment that adds acts, omissions, charts, or reasons to the original notice. The Hearing Officer shall give prompt notice to the parties of each such postponement.

**HEARING COMMITTEE**

10.4-2 Upon receipt of a proper and timely hearing request, the President of the Medical Staff, after conferring with the Administrator or designee, shall appoint a Hearing Committee of not more than three (3) physicians who are not in direct economic competition with the medical practice of the
practitioner involved. One of the members of the Hearing Committee so appointed shall be designated as chair.

10.4-3 An individual is not disqualified from serving on a Hearing Committee merely because he or she has heard of the case or has knowledge of the facts involved or what he or she supposes the facts to be. The individual or a member of a body whose adverse recommendation or action initiated the fair hearing shall not serve on the Hearing Committee. The Hearing Committee shall not include partners, business associates or relatives of the practitioner and none of the committee members may be in direct economic competition with the practitioner. The members of the Hearing Committee must give fair and impartial consideration of the case.

10.4-4 The President of the Medical Staff shall give notice to the parties of the names of the Hearing Committee members, the name of the Presiding Officer, if any, and the address to which statements, lists, and exhibits may be submitted.

10.4-5 Each Hearing Committee is deemed to be a regularly constituted quality improvement committee pursuant to RCW 4.24.250 and 70.41.200 as well as a professional review body as defined in the Health Care Quality Improvement Act of 1986. All minutes, reports, recommendations, communications, and actions made or taken by a Hearing Committee are covered by the provisions of the Health Care Quality Improvement Act of 1986, RCW 4.24.250 and 70.41.200 or the corresponding provisions of any subsequent federal statute providing protection to quality improvement, peer review, or related activities.

10.5 EX PARTE COMMUNICATIONS

Once nominated to serve on the Hearing Committee and continuing thereafter through the course of the hearing and deliberation, the Hearing Officer and members of its Hearing Committee shall not engage in any ex parte discussions with any of the parties to the hearing. Indeed, the Hearing Officer and members of the Hearing Committee shall treat the matter as jurors in a court of law and may not discuss the matter with anyone other than themselves while the case is pending (i.e. until the Governing Body takes its final action in the matter). Violation of this provision shall be grounds for disqualification of the Hearing Officer or Committee.
10.6 HEARING PREREQUISITES

10.6-1 RIGHTS OF INSPECTION AND COPYING

At all times in the peer review process, the Affected Practitioner shall have access to a copy of all medical records of his or her patients and shall have the right to copy said records at his or her expense. The Hospital shall cooperate by providing such copies promptly upon request. In addition, each party must provide access to any other documents relevant to the charges in its possession and control, for purposes of inspection and copying, at least fifteen (15) days prior to the commencement of the hearing. The failure by either party to provide access to this information at least fifteen (15) days before the hearing shall constitute good cause to grant a continuance or to limit introduction of any documents not provided to the other party in a timely manner. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable Practitioners other than the Affected Practitioner.

10.6-2 Submission to Opposing Party. No later than ten (10) business days before the hearing date, each party shall provide the other party (a) copies of the exhibits they intend to offer at the hearing; and (b) the identification of all witnesses they intend to call at the hearing with a short summary of the testimony expected from each such witness.

10.6-3 Submission to Hearing Committee. No later than five (5) business days before the date set for hearing each party shall submit a copy of its witness list and exhibits for each member of the Hearing Committee and presiding officer, if one is retained. In addition, each party may submit a brief description of the nature of the case that shall not exceed three (3) pages in length. Copies of any written description of the nature of the case submitted to the Hearing Committee shall be simultaneously provided to the other party.

10.6-4 Hearing Duration. All parties to the fair hearing shall prepare their presentations so that the hearing may be completed in no more than fifteen (15) hours including the presentation of all evidence and any oral comments before or after the presentation of evidence. Absent a showing
of good cause for a longer period, the total hearing time shall not exceed fifteen (15) hours.

10.6-5 Presiding Officer

a. The chair of the Hearing Committee shall preside over the hearing, unless an independent presiding officer is retained. An independent presiding officer should be an individual with legal training.

b. The presiding officer appointed under Section 10.6-4(a), or the chair of the Hearing Committee if no presiding officer is retained, shall:

1) Maintain decorum and assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence;

2) Determine the order of procedure during the hearing;

3) Make all rulings on matters of law, procedure and admissibility of evidence; and

4) At his or her discretion, limit the number of witnesses.

10.6-6 Pre-Hearing Conference. Either party may request a pre-hearing conference with the presiding officer to resolve all procedural matters prior to the hearing including objections to witnesses, documents, or the plan set forth for the conduct of the proceeding.

10.7 CONDUCT OF HEARING

10.7-1 A majority of the members of the Hearing Committee must be present when the hearing takes place. Any member of the Hearing Committee who must be briefly absent shall read the transcript of the portion of the hearing missed before participating in the Hearing Committee deliberations and recommendations.

10.7-2 An accurate record of the hearing must be kept.

10.7-3 The personal presence of the practitioner for whom the hearing has been scheduled shall be required. A practitioner who fails without good cause
to appear and proceed at such hearing shall be deemed to have waived his or her rights in the same manner as provided in Section 10.3 above and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in Section 10.3 above.

10.7-4 Postponement of hearings beyond the time as set forth in this policy shall be made only with the approval of the President of the Medical Staff or designee. Granting of such postponements shall only be for good cause shown.

10.7-5 The affected practitioner shall be entitled to be accompanied and represented at the hearing by an attorney or other person of the practitioner’s choice.

10.7-6 The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The practitioner for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact, and such memoranda or brief shall become part of the hearing record. Additionally, the affected practitioner may submit a written statement to the hearing panel at the close of the hearing. The Executive Committee or the Governing Body, when its action prompted the hearing, is entitled to submit memoranda or brief concerning its position on the adverse action.

10.7-7 The Medical Executive Committee, when its action has prompted the hearing, shall be entitled to be represented by counsel or one of its members or some other Medical Staff member to at the hearing to present the facts in support of its adverse recommendation and to examine witnesses. The Governing Body, when its action has prompted the hearing, shall be entitled to be represented by counsel or one of its members to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter be responsible for
supporting practitioner’s challenge to the adverse recommendation or decision by clear and convincing evidence that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable, or capricious.

10.8 ORGANIZATION AND CONDUCT OF HEARING PROCESS

10.8-1 During a fair hearing, each party shall have the right to equal portions of the hearing time not to exceed fifteen (15) hours in total during which time each party may:

a. Make any oral presentation it deems appropriate prior to presentation of evidence;

b. Call and examine witnesses, provided the other parties have been notified of witness names at least ten (10) business days prior to the fair hearing unless good cause for failure to notify is shown;

c. Introduce exhibits, provided the other parties have been furnished copies of the exhibits at least ten (10) business days prior to the fair hearing unless good cause for failure to furnish is shown;

d. Cross-examine any witness on any matter relevant to the issue of the hearing; and

e. Submit or make a written or oral statement at the close of the fair hearing.

10.8-2 If the practitioner does not testify on practitioner’s own behalf, the practitioner may be called and examined as if under cross-examination.

10.8-3 The Hearing Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration which could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.
10.8-4 Upon the close of all presentations and argument, the Hearing Officer shall declare the hearing finally adjourned, and all persons other than the Hearing Committee and Hearing Officer shall thereupon leave the hearing. The Hearing Committee shall report its recommendation to the practitioner, the Executive Committee of the Medical Staff, and the Governing Body within thirty (30) days of the hearing’s completion. This report shall be in writing and contain findings of fact and recommendation(s), including a statement of the basis of the recommendation(s). The practitioner and the Executive Committee shall have thirty (30) days from the date of the Hearing Committee report to appeal to the Governing Body as provided in Section 10.8 of these Procedural Policies.

10.9 APPELLATE REVIEW

10.9-1 Within thirty (30) days after receipt of the Hearing Committee report, the practitioner or the Medical Staff Executive Committee may submit a request for appellate review to the Governing Body. If such appellate review is not requested within thirty (30) days from receipt of the Hearing Committee report, the right to appellate review shall be deemed to be waived.

10.9-2 The appellate review shall be conducted by the Governing Body or by a duly appointed appellate review committee of the Governing Body of not less than three (3) members. The Governing Body or the committee thereof appointed to conduct the appellate review shall review the record created in the proceedings, and consider the written statements submitted pursuant to sub-paragraph (c) of this Section 10.8, for the purpose of determining whether the Hearing Committee’s action was arbitrary or capricious.

10.9-3 The party submitting the request for appellate review (“Appellant”) shall have fifteen (15) days from the date of receipt of the transcript of the hearing, or if no transcript is requested from the date of the request for appeal to submit a written statement specifying ways in which the Hearing Committee’s action was arbitrary or capricious. The other party (“Respondent”) shall have fifteen (15) days upon receipt of Appellant’s written statement to submit a written statement in response. Content of these written statements shall normally be limited to the matters
considered by the Hearing Committee. New or additional matters not
raised during the original hearing or in the Hearing Committee report, nor
otherwise reflected in the record, shall only be introduced under unusual
circumstances. The Governing Body or the committee thereof appointed
to conduct the appellate review shall, in its sole discretion, determine
whether such new matters shall are accepted.

10.9-4 The Governing Body or the committee thereof appointed to conduct the
appellate review shall complete its review and submit a written report to
all parties within thirty (30) days following receipt of the Respondent’s
written statement. This report shall contain a determination as to whether
the Hearing Committee’s action was arbitrary or capricious. In
conjunction with this report, the Governing Body or committee thereof
may request that the Medical Executive Committee arrange for a further
hearing to resolve specified disputed issues.

10.10 FINAL DECISION BY THE GOVERNING BODY

10.10-1 At its next regularly scheduled meeting after the appellate body submits
its report regarding the Hearing Committee action, the Governing Body
shall make its final decision in the underlying matter and shall send notice
thereof to the Executive Committee and the affected practitioner by
certified mail, return receipt requested.

10.10-2 Notwithstanding any other provision of the Bylaws or Operations Manual,
no practitioner shall be entitled as a right to more than one (1) hearing and
one (1) appellate review on any matter which shall have been the subject
of action by the Executive Committee of the Medical Staff, or by the
Governing Body, or by a duly authorized committee of the governing
body, or by both.

10.11 PROTECTION FROM LIABILITY

10.11-1 In matters relating to hearings and appellate review, all Medical Staff
members and other practitioners, and all appropriate Medical Center
personnel, including members of the Governing Body and Medical Center
management, shall be acting pursuant to the same rights, privileges,
immunity, and authority as are provided for in the Rules & Regulations.
10.12 INFORMAL INTERVIEWS

Nothing in these Bylaws shall be deemed to prevent any Committee or person contemplating any action or recommendation set forth in Section 8.1 above, from inviting the Affected Practitioner to participate in an informal discussion of the contemplated action or recommendation. Indeed, such informal discussion shall be encouraged and shall not be deemed to constitute a hearing under this Article 10. Likewise, in such informal discussions, statements made by the Affected Practitioner which are intended to help resolve issues or compromise shall not be used to prejudice the Affected Practitioner in any subsequent formal proceedings.

10.13 EXCEPTIONS TO HEARING AND APPEAL RIGHTS

In addition to other exceptions set forth in these Bylaws, the hearing and appeal rights under these Bylaws are not applicable under the following circumstances:

10.13-1 Medico-Administrative Practitioner. The hearing and appeal rights under these Bylaws do not apply to those persons serving the Hospital in a medico-administrative capacity. Termination of such persons’ rights to practice in the Hospital shall instead be governed by the terms of their individual contracts with the Hospital. However, the hearing and appeal rights of these Bylaws shall apply to the extent that Medical Staff membership status or clinical privileges, which are independent of the Medico-Administrative Practitioner’s contract, are also removed or suspended;

10.13-2 Automatic Suspension or Limitation of Privileges. No hearing is required when a Member’s Medical Staff membership or clinical privileges are automatically suspended in accordance with these Bylaws;

10.13-3 Removal from Emergency Room Call Panel. None of the hearing and appeal rights under these Bylaws are available for any actions or recommendations affecting a practitioner’s emergency room call panel obligations;

10.13-4 Denial of Applications for Failure to Meet the Minimum Qualifications. Practitioners shall not be entitled to any hearing or appellate review pursuant to this Article 10 if they are unable to apply for membership or privileges, or if they are denied or limited because of their failure: (i) to have a current unrestricted license to practice medicine, dentistry, or
podiatry in this State or to possess another appropriate license or certificate; (ii) to maintain an unrestricted Drug Enforcement Administration certificate (when it is required under these Bylaws or the Rules and Regulations); (iii) to maintain professional liability insurance as required by these Bylaws; (iv) to meet any of the criteria and qualifications specified in Article 8.2-1 to meet any generally applicable criteria or qualifications adopted by the Medical Staff or by a Clinical Department; or as noted in Section 4.5 to file a complete application or provide additional requested information in a timely manner after notice of omitted items.

ARTICLE 11  CONFIDENTIALITY, INDEMNIFICATION, AND IMMUNITY

11.1  AUTHORIZATIONS AND MEMBERS’ AGREEMENT TO MAINTAIN CONDITIONS OF CONFIDENTIALITY

11.1-1  PRACTITIONERS’ PLEDGE

By attaining and/or applying for Medical Staff membership and/or clinical privileges or providing specified patient care services within this Hospital, a practitioner:

a.  Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing on his or her professional ability and qualifications;

b.  Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of these Bylaws; and

c.  Acknowledges that the provisions of this Article are express conditions to his or her application for, or acceptance of, Staff membership and the continuation of such membership, or to his or her exercise of clinical privileges or provision of specific patient services at the Hospital.
11.1-2 ACTIVITIES AND INFORMATION COVERED

11.1-2.1 Application of confidentiality and immunity

Confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facilities or organization’s activities concerning, but not limited to:

a. Applications for appointment, clinical privileges, or specified services;

b. Periodic reappraisals for reappointment, clinical privileges, or specified services;

c. Corrective action;

d. Hearings and appellate reviews;

e. Patient care audits;

f. Utilization reviews; and

g. Other Hospital, Department, Service, or Committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

11.1-3 INDEMNIFICATION

11.1-3.1 IMMUNITY FROM LIABILITY

No representative of the Medical Center or Medical Staff shall be liable to a practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his or her duties as a representative, if such representative acts are made in good faith and without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts, and in the reasonable belief that the action, statement, or recommendation is warranted by such facts.

No representative of the Medical Center or Medical Staff and no third party shall be liable to a practitioner for damages or other
relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Medical Center or Medical Staff or to any other healthcare facility or organization of health professionals concerning a practitioner or affiliate who is or has been an applicant to be a member of the Medical Staff or who did or does exercise clinical privileges or provide specified services at this Medical Center, provided that such representative or third party acts in good faith and without malice.

No representative of the Medical Center or Medical Staff shall be liable to a practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his or her duties as a member of a medical review Committee or professional peer review body.

11.1-3.2 CONFIDENTIALITY OF COLLECTED INFORMATION

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

The following applies to records of the Medical Staff and its Departments and Committees responsible for the evaluation and improvements of patient care:

a. The records of the Medical Staff and its Departments and Committees responsible for the evaluation and improvement of the quality of patient care rendered in the Hospital shall be maintained as confidential.
b. Access to such records shall be limited to duly appointed officers and Committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

c. Information which is disclosed to the Governing Body of the Hospital or is appointed representatives – in order that the Governing Body may discharge its lawful obligations and responsibilities – shall be maintained by that body as confidential.

d. Information contained in the credentials file of any member may be disclosed with the member’s consent, to any Medical Staff or professional licensing board, or as required by law. However, any disclosure outside of the Medical Staff shall require the authorization of the Chief of Staff and the concerned Department Chair and notice to the member.

11.2 CONFIDENTIALITY OF PEER REVIEW

All quality, peer review and credentialing proceedings involving practitioners must be held in the strictest confidence in accordance with Section 9.5.

11.3 CUMULATIVE EFFECT

Provisions in these Bylaws and in application forms relating to authorizations, indemnification, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not be deemed to be a limitation thereof.

ARTICLE 12 OFFICERS

12.1 OFFICERS OF THE MEDICAL STAFF

12.1-1 The officers of the Medical Staff shall be:

a. President

b. President-Elect
c. Secretary-Treasurer

d. Immediate Past President

12.2 QUALIFICATIONS OF OFFICERS

12.2-1 Qualifications of Officers shall be:

Officers must be members of the Active Medical Staff in good standing and have demonstrated at least one (1) year experience on a major committee or as a member of the Medical Executive Committee at the time of nomination and election and must remain members in good standing during their terms of office. Officers may not simultaneously hold leadership positions on another hospital medical staff.

It is desirable for an officer to start as the Secretary-Treasurer and progress through each of the other positions in order to enhance continuity in the leadership of the Medical Staff.

12.3 ELECTION OF OFFICERS

12.3-1 The President, President-Elect and Secretary-Treasurer shall be elected biannually by the Medical Staff. Only members of the Active, Provisional and Affiliate Medical Staff shall be eligible to vote. All officers will be confirmed by the Governing Body.

12.3-2 The nominating committee shall be appointed by the President-Elect of the Medical Staff three (3) months prior to the annual Medical Staff meeting. This committee shall offer one or more nominees for each office. Nominations must be announced and the names of the nominees distributed to all members of the Active, Provisional, and Affiliate Medical Staff at least thirty (30) days prior to the annual meeting.

If one of the current officers is interested in progressing to the next level position, the nominating committee will not announce any additional nominees.

12.3-3 Nominations may also be made by petition signed by at least ten percent (10%) of the members of the Active, Provisional, and Affiliate Staff. Such petition must be submitted at least fifteen (15) days prior to the annual Medical Staff meeting.
12.4 **ELECTION PROCESS**

All Members of the Active, Provisional and Affiliate Medical Staff will receive a ballot to vote on the nominations.

Ballots must be returned to the Medical Staff Services Office within the designated time period, not to exceed two weeks.

a. 51% of the submitted ballots determine the outcome of the election.

12.5 **TERM OF OFFICE**

All officers shall serve a term of two (2) years in each role. Officers shall take office on the first day of the calendar year.

12.6 **VACANCIES IN OFFICE**

Vacancies in office during the Medical Staff year, except for the office of immediate past president, shall be filled as determined by the Medical Executive Committee of the Medical Staff until an open election can be held, within sixty (60) days, for remainder of the term. If there is a vacancy in the office of the President, the President-Elect shall serve the remainder of the term.

12.7 **DUTIES AND AUTHORITY OF OFFICERS**

12.7-1 The responsibilities, duties and authority of the President are as follows:

a. Calls, presides at, and determines the agenda of all general and special meetings of the Medical Staff.

b. Serves as Chair of the Medical Executive Committee, with tie-breaking vote prerogative only;

c. Serves as a non-voting ex officio member of all other Medical Staff Committees;

d. Is responsible for:

1) Enforcement of Medical Staff Bylaws and Rules and Regulations,

2) Implementation of sanctions when they are indicated, and
3) The Medical Staff’s compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a Practitioner.

e. Serves as a full voting member of the Governing Body, and in that capacity:

1) Represents the views, policies and procedures, concerns, needs, and grievances of the Medical Staff to the Governing Body and Administration; and

2) Advises the Governing Body on the effectiveness of the quality assessment/improvement program and the overall quality of patient care in the Medical Center, as well as on matters that impact on patient care and clinical services, including the need for new or modified programs or services.

12.7-2 The responsibilities, duties and authority of the President-Elect are as follows:

a. Assumes all the duties and has the authority of the President;

b. Serves as a member of the Medical Executive Committee;

c. Chairs a major committee of the medical staff, typically the Quality and Credentials Committee;

d. Serves as a full voting member of the Governing Body, in the same capacity as the President, described above; and

e. Performs other functions at the request of the President or the Medical Executive Committee

12.7-3 The responsibilities, duties and authority of the Secretary-Treasurer are as follows:

a. Serves as a member of the Medical Executive Committee;

b. Maintains accurate and complete minutes of all Medical Staff meetings with the assistance of support staff;
c. Is responsible for the collection and expenditure of all Medical Staff funds and the proper maintenance of all Medical Staff accounts;

d. Prepares, with the assistance of support staff, the Medical Staff’s budget for approval by the Medical Executive Committee;

e. Submits a financial report to the Medical Executive Committee and the Medical Staff at the Annual Meeting; and

f. Chairs a major committee of the medical staff, typically the Process Improvement Committee

12.7-4 The responsibilities, duties and authority of the Immediate Past President are as follows:

a. Assist the President as the President may from time to time request;

b. In the absence of the other officers, the Past President has the authority to take over their duties; and

c. Serves as a full voting member of the Governing Body, in the same capacity as the President, described above; and

12.8 REMOVAL FROM OFFICE

12.8-1 The Governing Body may remove any officer acting on its own initiative but only after a Joint Conference with representatives of the Medical Executive Committee. The affected individual will not be present for such a meeting except at the discretion of the Joint Conference.

12.8-2 The Medical Staff may remove any officer by petition of twenty-five percent (25%) of the Active, Provisional and Affiliate Staff members and a subsequent two-thirds (2/3) vote by ballot of the Active Staff. Removal shall be for failure to conduct those responsibilities assigned within these Bylaws or other policies and procedures of the Medical Staff.
12.9 ORGANIZATION OF DEPARTMENTS

The Medical Staff shall be organized into clinical Departments. Each Department shall have a Chair. Departments may be further sub-divided into Divisions which shall have a Division Chief.

The Medical Executive Committee may recommend to the Medical Staff the creation, definitions, modification, elimination or combination of Departments either along traditional Specialties, or along service lines, or along lines of members having common interests, practice characteristics or logical organization.

12.9-1 Departments

Subject to the qualifications in Section 12.9.7, each department shall have a chair who shall be elected, in accordance with Section 12.1-2(b), or appointed by the President of the Medical Staff with overall responsibility for the supervision and satisfactory discharge of the functions of the department.

12.9-2 Assignment to Departments

Each member shall be assigned membership in at least one Department, but may also be granted membership and/or clinical privileges in other Departments consistent with practice privileges granted.

12.9-3 Functions of Departments

The general functions of each Department shall include:

a. Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Department. The number of such reviews to be conducted during the year shall be as determined by the Medical Executive Committee in consultation with other appropriate committees including the Quality and Credentials Committee.

Each Department shall routinely collect information about important aspects of patient care provided in the Department, periodically assess this information, and develop objective criteria for use in evaluating patient care.
Patient care reviews shall include all clinical work performed under the jurisdiction of the Department, regardless of whether the member whose work is subject to such review is a member of the Department.

b. Recommending to the Medical Executive Committee criteria for the granting of clinical privileges and the performance of specified services within the department.

c. Evaluating and making appropriate recommendations regarding the qualifications of applicants seeking membership or renewal of membership and clinical privileges within the Department.

d. Reviewing and evaluating departmental adherence to Medical Staff policies and procedures and sound principles of clinical practice.

e. Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.

f. Formulating recommendations for the departmental policies and procedures reasonably necessary to meet its responsibilities for patient care to the Medical Executive Committee for approval.

12.9-4 Department Quality Improvement

Each Department shall participate in appropriate clinical review, and shall review and analyze the clinical work of the Department. Specifically each Department as a whole or through the Process Improvement Committee shall evaluate medical care on a retrospective basis and shall select cases for presentation at Department meetings that will contribute to the continuing education of its members.

The departmental Quality Improvement activities are part of the medical staff’s peer review process and as such is subject to confidentiality under Section 9.4. These processes are also considered components of the organizations Coordinated Quality Improvement Program.

Quality issues to be reviewed by the Department shall include at least Mortality data, Complications and Hospital Acquired Conditions, Use of
Blood Products, and medical care below the standard of the professional organization and community.

a. Departments may choose to have a Quality Assessment and Improvement Chair who provides oversight to the Department’s Quality process. The Quality Chair will serve as the Vice-Chair of the Department.

12.9-5 Surgical Review and Clinical Procedures Review (GI, Cardiology, etc.)
Each surgical or procedural Department shall also conduct comprehensive review to examine justification of surgery or procedure performed and to evaluate the acceptability of the procedure chosen. Complications will also be evaluated.

12.9-6 Department Meetings
Each Department shall meet at least four (4) times each year to accomplish the required functions.
Each member is expected to attend at least 50% of required minimum Department meetings.

12.9-7 Department Chairs
a. Qualifications. Each department chair shall 1) be a Member of the Active Staff; 2) have demonstrated an ability in at least one of the clinical areas covered by the department; 3) be willing and able to faithfully discharge the functions of his/her office; and 4) be certified by an appropriate specialty board, or affirmatively have established, through the privilege delineation process, that he/she is possessed of comparable competence.

b. Selection and Appointment. Each chair shall be appointed by the members of their department, in a manner determined by the department, for a minimum of one-year term. A chair may be reappointed for as many years as agreeable to the department members so long as he/she is carrying out the duties and responsibilities provided in these bylaws to the satisfaction of the members of the applicable department, of the Medical Executive Committee, and the Governing Body.
c. **Removal.** Removal of a chair during his/her term may be initiated by a vote of two-thirds of all Active Staff Members of the department, but no such removal shall be effective unless and until it has been ratified by the Medical Executive Committee and the Governing Body.

d. **Duties.** Each chair shall:

Generally monitor the quality of patient care and professional performance rendered by members with clinical privileges in the Department through a planned and systematic process;

1) Be accountable to the department, the Medical Executive Committee, the Governing Body for all professional and administrative activities within the department, and particularly to the Quality and Credentials Committee for the quality of patient care rendered by members of the department.

2) Under the supervision of and on behalf of the Quality and Credentials Committee or the Multi-Specialty Peer Review Committee, provide for the ongoing professional practice evaluation (OPPE) of the clinical performance of all practitioners exercising clinical privileges within the department in accordance with Medical Staff policies, and make recommendations for continuing clinical privileges at the time of reappointment for each member of the department as appropriate.

3) Under the supervision of and on behalf of the Medical Executive Committee or the Multi-Specialty Peer Review Committee, provide for the focused professional practice evaluation (FPPE), including privilege-specific clinical performance of practitioners exercising clinical privileges within the department for (i) all initially requested privileges, and (ii) when a question arises regarding a currently privileged practitioner’s ability to provide safe, high quality patient care. FPPE is performed in
accordance with these Bylaws and any Medical Staff policies.

4) Recommend the criteria for clinical privileges that are relevant to the care provided in the department.

5) Implement and maintain performance improvement, quality and patient safety activities within the department.

6) Appoint, and when appropriate, remove, the members of all committees of the department and designate the chair of each committee.

7) Develop and enforce the Medical Center and Medical Staff Bylaws, rules and regulations, and policies and procedures within the department that guide and support provision of services

8) Work with the Medical Center administration with regard to all administrative matters, patient care issues, and nursing care issues related to the department.

9) Delegate duties of the chair to such individuals or committees in the department as the chair determines appropriate.

10) Provide for the maintenance of complete and accurate minutes of all meetings of the department with the assistance of staff provided by the Medical Center.

11) Assess and recommend to the Medical Executive Committee off-site sources for needed patient care, treatment and services not provided by the department.

12) Coordinate and integrate inter-departmental and intra-departmental services.

13) Develop and implement policies and procedures that guide and support the provision of care, treatment, and services.
14) Make recommendations concerning sufficient number of qualified and competent persons to provide care, treatment, and services.

15) Help provide for the orientation and education for all members of the department.

16) Recommend space and other resources needed by the department or service.

17) Make recommendations regarding the oversight and maintenance of quality control programs, as appropriate.

18) Make recommendations to the Quality and Credentials Committee, Medical Executive Committee, and the Medical Center administration concerning any proposed new procedures and services, including the training education and experience required for practitioners to exercise clinical privileges for new procedures or services.

12.10 FUNCTIONS OF DEPARTMENTS

12.10-1 Each department shall recommend criteria consistent with and subject to these bylaws for the granting of clinical privileges as may be requested from time to time by the Quality and Credentials Committee or Medical Executive Committee.

12.10-2 Each department shall implement and conduct specific review and evaluation activities as delineated in Sections 6.4 and 6.5, that monitor the quality and appropriateness of care provided by department members and identifies opportunities for the improvement of patient care practices. Each department shall ensure that Ongoing Provider Performance Evaluation and Focused Provider Performance Evaluation is conducted.

12.10-3 Department peer review will be based on the most recently available evidence-based best practice information. The department chair may request external review of a case when it is determined that it is indicated. Any and all documents created or generated for the purpose of department peer review are created and generated on behalf of and at the direction of the Quality and Credentials Committee and are covered by the provisions of RCW 4.24.250, RCW 70.41.200, the Health Care Quality Improvement
Act of 1986, or the corresponding provisions of any subsequent federal or state statute.

All documents shall be maintained in the Member’s quality file.

12.10-4 The departments shall encourage collegiality, professional interpersonal relationships, promote continuing education and make recommendations regarding procedural policies.

12.11 ASSIGNMENT TO DEPARTMENTS

The Medical Executive Committee shall, after consideration of the recommendations of the chair of the appropriate department as transmitted through the Quality and Credentials Committee, and after considering the practitioner’s request, recommend department assignments for all members in accordance with their qualifications.

ARTICLE 13 COMMITTEES

13.1 GENERAL FUNCTIONS

a. The committees of the medical staff are charged with conducting the designated business of the medical staff, which may include making reports, findings, recommendations or investigations pursuant to the Medical Staff Bylaws.

13.1-2 Appointment

Every two years, with the advice and consent of the Medical Executive Committee, the President shall appoint the members of each Committee, except the Medical Executive Committee, which shall be constituted according to these bylaws. Committee members shall serve a two-year term, with no limitation on the number of terms served.

The President of the Medical Staff shall be a member, ex-officio, without vote, on all Committees.

13.1-3 Removal

If a member of a Committee ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of clinical privileges, or no longer practices at the Medical Center, or any other good
cause exists, that member may be removed at the direction of the President of the Medical Staff, with the advice and consent of the Medical Executive Committee.

13.2 MEDICAL EXECUTIVE COMMITTEE

The Medical Executive Committee shall be composed of the following:

1) The officers of the Medical Staff, the chair of each department, and one physician representative from the Affiliate staff. Each member shall have one (1) vote.

2) The President of the Medical Staff may appoint or remove up to four (4) members-at-large. Members-at-large may not vote. Members-at-large may be removed with a fifty (50) percent vote of the Medical Executive Committee. When indicated, additional members-at-large may be added on a time limited basis.

3) The President of the Medical Staff shall be chair of the Medical Executive Committee.

4) The Chair of the Governing Body (or designee), the Administrator and Patient Care Services administrator or their designees may attend all meetings of the Medical Executive Committee and participate in its discussions, but without vote.

5) Representatives from the committees and departments may from time to time be requested by the President of the Medical Staff to attend the Medical Executive Committee meetings as is pertinent to a Medical Staff or Medical Center action item, but without vote.

The Medical Executive Committee Duties:

1) The Medical Executive Committee is hereby delegated broad authority to oversee the operations of the Medical Staff. Without limiting this broad delegation of authority, the duties of the Medical Executive Committee shall be to:

2) Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws
3) Receive and act upon reports and recommendations from Medical Staff Committees, all Clinical Departments, and Staff officers concerning quality assessment/improvement activities and the discharge of their delegated administrative responsibilities;

4) Cause, through evaluation by this Committee, the Quality and Credentials Committee or the Process Improvement Committee, Medical Staff peer evaluation and quality improvement activity to be performed effectively;

5) Fulfill the Medical Staff Organization’s accountability to the Governing Body for the medical care rendered to patients in the Hospital and consistent with its obligations under State law and accreditation standards without compromising the independence of the Medical Staff or its self-governance;

6) Take all reasonable steps to ensure professional, ethical conduct and competent clinical performance on the part of all members with clinical privileges;

7) Conduct such other functions as are necessary for the effective operation of the Medical Staff;

8) Report at each general Medical Staff meeting;

9) Initiate and oversee the ratification of the Medical Staff Bylaws and Rules and Regulations and other organizational documents pertaining to the Medical Staff;

10) Maintain a permanent record of its activities and deliberations (All meetings will be staffed by at least one designee from the Medical Staff Services Office to assist in maintaining accurate records of the proceedings);

11) Arrange for the performance of other Medical Staff functions such as institutional review of experimental procedures and research protocols, continuing medical education, a physician well-being process ethics and ethics review functions, as well as participation in policy and procedure development in all areas directly impacting upon the provision of medical care provided within the institution.

12) Coordinate the activities and general policies of the various departments
13) Receive and act upon committee reports

14) Perform the safety and disaster plan oversight on behalf of the Medical Staff

15) Implement policies of the Medical Staff not otherwise the responsibility of the departments

16) Provide liaison between the Medical Staff and the Chief Executive Officer

17) Recommend action to the Chief Executive Officer on matters of a medico-administrative nature

18) Make recommendations on Medical Center management matters (i.e., long-range planning) to the Governing Body

19) Ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Medical Center

20) Fulfill the Medical Staff organization’s accountability to the Governing Body for the medical care rendered to patients in the Medical Center

21) Review the report of the Quality and Credentials Committee on all applicants and make recommendations for staff membership to the Governing Body, assignments to departments and delineation of clinical privileges as provided in the Bylaws and the Procedural Policies

22) Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members with clinical privileges

23) Take all reasonable steps to act on instances of disruptive behavior in accordance with medical staff policy and procedure

24) Take all reasonable steps to address impaired practitioners in accordance with medical staff policy and procedure.

25) Receive and review reports from other Committees and functions within the Medical Staff to include Pharmacy and Therapeutics Committee, Blood Utilization, Infection Control Committee and Cancer Care Committee. Each group shall report at least annually.
The Medical Executive Committee meetings:

1) The Medical Executive Committee shall meet at least ten (10) times per year and maintain a permanent record of all its proceedings and actions. The President of the Medical Staff may call special meetings of the Medical Executive Committee at any time.

2) The Medical Executive Committee may go into Executive Session during which all non-members will be excused. The Chief Executive Officer may remain unless the Medical Executive Committee wishes to discuss matters regarding that individual.

3) Any medical staff member may submit a request for a meeting with the Medical Executive Committee at any regularly scheduled meeting. Such request shall be honored if approved by the appropriate department chair or chair of Medical Executive Committee.

13.3 QUALITY AND CREDENTIALS COMMITTEE

The Quality and Credentials Committee has as one of its responsibilities the review of medical services provided in the Medical Center with the objective of improving the quality of patient care. This committee is a regularly constituted review committee conducting quality assurance and related reviews in accordance with the applicable provisions of Washington law, including, without limitation, RCW 4.24.250 and RCW 70.41.200 and .230. All minutes, reports, recommendations, communications, and actions made by, for, or at the direction of or on behalf of the Quality and Credentials Committee are deemed to be covered by the provisions of RCW 4.24.250, RCW 70.41.200, the Health Care Quality Improvement Act of 1986, or the corresponding provisions of any subsequent federal or state statute.

COMPOSITION:

a. The Quality and Credentials Committee shall be composed of the following:

b. President-elect of the Medical Staff, who shall serve as the Chairperson

c. Minimum of 5 active or provisional members. If possible, one member represents a behavioral medicine specialty.
d. Non-voting participants in the Quality and Credentials Committee shall include the Administrator or designee, and Director of Patient Safety, Risk Management and Medical Staff Services and Manager of Medical Staff Services.

The Chair will assure the following occur:

a. Review the qualifications of applicants for staff membership and conduct investigations when questions of appropriateness for membership or privilege arise

b. Review all applications for staff membership and reappointment, or requests for changes in privileges, and any other matters relating to credentialing which are referred by a department chair, the Medical Executive Committee or the Governing Body. All recommendations based on these reviews shall be forwarded to the Medical Executive Committee for recommendation to the Governing Body.

c. Actively monitor the status of any medical staff member who is involved in any disciplinary, proctoring or improvement plans

d. When indicated, make referrals to resources supportive of physician well being, for purposes of evaluation, recommendations and treatment as needed.

e. Review progress reports from the resources and evaluate improvement. If adequate progress is not demonstrated, make recommendations for additional actions.

f. Evaluate clinical activities of the medical staff, and assure that all departments conduct routine peer review relating to patient management. Assist the Department Chairs in Quality and Peer Review efforts and programs.

g. Review and make recommendations regarding any proposed improvement plans or corrective actions for a medical staff member, in accordance with the medical staff bylaws. Situations requiring any form of improvement or corrective action shall be referred to the committee by the departments. Recommendations shall be made to the Medical Executive Committee.
h. Ensure confidentiality is maintained.

MEETINGS:

a. Meetings shall be sufficient in number to accomplish the duties of the Committee, and shall occur at least ten (10) times per year. The Committee shall prepare and maintain records of its deliberations, decisions, and actions.

b. Pursuant to RCW Chapter 70.41, the Quality and Credentials Committee shall make written reports to the Governing Body on a semiannual basis, or more frequently at the discretion of the chair, reviewing the activities conducted by the Committee, and any actions taken as a result of those activities. All minutes and other documents related to the committee are confidential and protected.

13.4 PROCESS IMPROVEMENT COMMITTEE

COMPOSITION:

The Process and Improvement Committee shall be composed of the following:

a. Secretary-Treasurer of the medical staff, who shall serve as the chair, representatives from departments who are appointed or elected by the department to serve on the Committee.

b. Non-medical staff voting members of the Process Improvement Committee shall include the Medical Center Administrator or designee, Nurse Executive, Clinical Executive, Director of Patient Safety, Risk Management and Medical Staff Services Office, and Director of Pharmacy.

c. A minimum of five (5) members of the Active and Provisional Staff. A majority of voting members shall be active members of the medical staff.

d. The Chair, with assistance from Medical Center staff, will assure that the following will occur:

e. Review all aspects of the quality of care rendered in the Medical Center, including but not limited to blood utilization, mortality,
medication management, adverse events, national clinical indicators and other functions as assigned by the President of the Medical Staff and the Medical Executive Committee.

f. Address procedures or systems related to medical or patient care needing to be changed or improved. The work of the Committee will focus on aspects of clinical services or operations that are in need of improvement and meet the following criteria:

g. Directly involve the Medical Staff or directly impact medical care; and

h. Are inter-professional in nature.

i. Appoint subcommittees or task forces to address specific issues and report to the larger group to finalize recommendations. The committee will also require reports indicating the actual effectiveness of changes initiated in response to identified problems.

j. Make regular reports to the Medical Executive Committee, providing information and status reports of the work it has undertaken.

k. Make regular reports to the Governing Body Quality and Patient Safety Committee, providing information and status reports of the work it has undertaken.

MEETINGS:

Meetings shall be sufficient in number to accomplish the duties of the Committee, and shall occur at least ten (10) times per year. The Committee shall prepare and maintain records of its deliberations, decisions, and actions.

13.5 INFECTION CONTROL COMMITTEE

COMPOSITION

a. The Infection Control Committee shall be composed of at least one (1) physician member with experience in infectious disease, a representative of administration; a representative of nursing and the infection control coordinator. The committee chair will be a
physician with interest and/or expertise in infectious disease and infection control.

b. Members of specific Medical Center departments will be invited to attend as needed

c. The chair of the Infection Control Committee or designee has the authority to institute any surveillance, prevention, or control measure or study when there is reason to believe that any patient or personnel may be in danger from a potential or actual outbreak of or exposure to disease.

DUTIES

a. Establish a surveillance system and regularly review surveillance data to determine the current magnitude of nosocomial infections and significant trends suggesting the need for policy or procedure modifications or education;

b. Identify the risks of endemic and epidemic nosocomial infections in patients and health care workers;

c. Identify strategies to reduce the risk of transmission of infections in patients, staff (including contracting), volunteers, students and visitors;

d. Review and approve policies and procedures designed to reduce the risks for transmission of infection in all areas of the Medical Center. These include, but are not limited to isolation criteria and techniques, diagnostic and therapeutic procedures, epidemiological follow-up and notification procedures, or vaccination requirements;

e. Review recommendations from the Pharmacy and Therapeutics Committee on the clinical use of antibiotics;

f. Provide assistance to the occupational health program through written policies and guidelines concerning prevention of Medical Center-associated infections and protection of health care providers and ancillary personnel;

g. Approve the written Infection Control Plan annually.
MEETINGS AND REPORTS

a. The Infection Control Committee shall meet at least every two (2) months, shall maintain a permanent record of its findings, proceedings and actions; and shall make a regular report to the Medical Executive Committee and the Administrator.

b. Pursuant to RCW Chapter 70.41, the Infection Control Committee shall report to the Medical Staff Process Improvement Committee and Governing Body through the Governing Body Quality Committee on an annual basis, or more frequently at the discretion of the chair, reviewing the activities conducted by the Committee and any actions taken as a result of those activities. All minutes and other documents related to the committee are confidential and protected.

13.6 PHARMACY AND THERAPEUTICS COMMITTEE

COMPOSITION

The Pharmacy and Therapeutics Committee shall be composed of at least one physician member. The pharmacist will act as staff to the chair of the committee.

DUTIES

a. Assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Medical Center.

b. Advise the medical staff on matters pertaining to the choice of available drugs.

c. Develop and periodically review a formulary for use in the Medical Center, prescribe the necessary operating rules and regulations for its use, and assure that said rules and regulations are available to and observed by all staff appointees.

d. Review of adverse drug events.
e. Develop and maintain surveillance over drug utilization policies and procedures

f. Evaluate clinical data concerning new drugs or preparations requested for use in the Medical Center

g. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs

MEETINGS AND REPORTS

a. The Pharmacy and Therapeutics Committee shall meet at least four (4) times per year, and shall maintain a permanent record of its findings, proceedings and actions;

b. The Pharmacy and Therapeutics Committee shall report to the Medical Staff Process Improvement Committee and the Governing Body on an annual basis concerning drug utilization policies and procedures in the Medical Center; and

c. Pursuant to RCW Chapter 70.41, the Pharmacy and Therapeutics Committee shall make written reports to the Governing Body on an annual basis, or more frequently at the discretion of the chair, reviewing the activities conducted by the Committee, and any actions taken as a result of those activities.

13.7 CANCER COMMITTEE

COMPOSITION

Committee members must include board certified physicians from Surgery, Medical Oncology, Radiation Oncology, Diagnostic Radiology, Pathology, and Internal Medicine/Family Practice. Physicians representing major sites diagnosed and treated at the Medical Center are recommended to be additional committee members, i.e., Gynecology, Urology, Thoracic Surgery and Otolaryngology. The Committee must include the Cancer Registry. Additional members include representatives from Administration, Social Work, Nursing (OCN Credentialing recommended) and Patient Safety and/or Quality Services.
DUTIES

a. Organize, publicize, conduct and evaluate regular educational and consultative cancer conferences (Tumor Board) are prospective, multidisciplinary, institution-wide and patient oriented;

b. Ensure that a full range of services is available to prevent, diagnose, treat, rehabilitate, and follow cancer patients. For those services not on site, referral to appropriate off-site resources is made available to the cancer patient. Referral processes are approved and/or arranged by the patient’s primary care physician to the appropriate off-site resource. This referral process may be initiated through the advice of the consulting physician. Consultative services are also available to patients with cancer through multidisciplinary physician attendance at conferences.

c. Evaluate quality of care of patients with cancer. Reevaluate effectiveness of the patient care evaluation program. Supervise the Cancer Registry for quality control of abstracting, staging and reporting cancer diagnoses by serving as registry physician advisor(s).

MEETINGS AND REPORTS

a. The Cancer Committee shall meet at least quarterly, document its activities and attendance, and publish an annual report; and

b. The Cancer Committee shall report to the Medical Executive Committee on an annual, basis or more frequently at the discretion of the chair, reviewing the activities conducted by the Committee, and any actions taken as a result of those activities.

13.8 MULTI-SPECIALTY PEER REVIEW Committee:

The Multi-Specialty Peer Review Committee is a multispecialty committee that acts as the designee of the Quality and Credentials Committee and the Medical Executive Committee to fulfill the Quality and Credentials Committee’s and Medical Executive Committee’s responsibilities for the review of medical services provided in the Medical Center, with the objective of improving the quality of patient care. The Multi-Specialty Peer Review Committee is a regularly constituted review committee conducting quality assurance and related reviews in
accordance with the applicable provisions of Washington law, including, without limitation, RCW 4.24.250 and RCW 70.41.200 and .230. All minutes, reports, recommendations, communications, and actions made by, for, or at the direction of or on behalf of the Multi-Specialty Peer Review Committee are deemed to be covered by the provisions of RCW 4.24.250, RCW 70.41.200, the Health Care Quality Improvement Act of 1986, or the corresponding provisions of any subsequent federal or state statute.

COMPOSITION: The Multi-Specialty Peer Review Committee shall be organized as follows:

a. The Multi-Specialty Peer Review Committee Chair will be selected by the Medical Executive Committee, following consideration of the recommendation of the Medical Staff President.

b. The Multi-Specialty Peer Review Committee shall be composed of a minimum of five (5) active or provisional members practicing in various specialties, not to exceed twelve (12) members, who are appointed by the Medical Executive Committee following consideration of the recommendation of the Multi-Specialty Peer Review Committee Chair.

c. Notwithstanding any other provision of these Bylaws, a quorum for meetings of the Multi-Specialty Peer Review Committee shall be defined as three (3) voting members.

d. Non-voting ex officio participants in the Multi-Specialty Peer Review Committee shall include the Administrator or designee, and representatives of Patient Safety, Risk Management and the Medical Staff Services Office.

The Multi-Specialty Peer Review Committee is responsible for the following delegated responsibilities, subject to reporting and approval of the Quality and Credentials Committee or the Medical Executive Committee, as applicable:

a. Receive and consider incident reports and complaints that address any acts, omissions, inappropriate behavior, disruptive behavior, or professional conduct of an individual Practitioner that may affect the quality of care or patient safety, or present concerns regarding the Practitioner’s clinical competence.
b. Track results of OPPE for individual Practitioners to identify any trends or opportunities for improvement. Ensure the OPPE results and trends are retained in the practitioner’s quality file, and reported to the Quality and Credentials Committee.

c. Evaluate and score any cases involving individual Practitioners brought to the Multi-Specialty Peer Review Committee from any source, in accordance with any Medical Staff policies.

d. Recommend FPPE or an investigation to the Quality and Credentials Committee when a question arises regarding a currently privileged Practitioner’s ability to provide safe, high quality patient care.

e. Conduct of formal investigations, as directed.

f. Actively monitor the status of any practitioner who is subject to a FPPE based on the practitioner’s ability to provide safe, high quality patient care, including any disciplinary, proctoring or improvement plans.

g. When indicated, make referrals to the appropriate committees for practitioner well-being, for purposes of evaluation, recommendations and treatment as appropriate.

h. Review progress reports from individual practitioner FPPE and other resources and evaluate improvement. If adequate progress is not demonstrated, make recommendations for additional actions.

i. Review and make recommendations regarding any proposed improvement plans or corrective actions for a practitioner, in accordance with the Medical Staff Bylaws and policies.

j. Refer any matters requiring improvement or corrective action shall be referred to the committee by the departments.

k. Make recommendations for corrective action to the Medical Executive Committee.

l. Ensure confidentiality is maintained.
MEETINGS:

a. Meetings shall be sufficient in number to accomplish the duties of the Multi-Specialty Peer Review Committee, and shall occur at least ten (10) times per year. The Multi-Specialty Peer Review Committee shall prepare and maintain records of its deliberations, decisions, and actions.

b. Pursuant to RCW Chapter 70.41, the Multi-Specialty Peer Review Committee shall make written reports to the Quality and Credentials Committee, to be transmitted to the Governing Body on a semiannual basis, or more frequently at the discretion of the chair, reviewing the activities conducted by the Committee, and any actions taken as a result of those activities. All minutes and other documents related to the committee are confidential and protected.

ARTICLE 14    ARTICLE 14 MEDICAL STAFF FUNCTIONS

The Medical Staff assures the effective performance of assigned functions through assignment to the Medical Executive Committee, its committees, departments, interdisciplinary Medical Center committees, and the medical staff officers. The required functions are defined in these bylaws and the Rules and Regulations and may be determined by the Medical Executive Committee or the Governing Body.

14.1 MEDICAL STAFF FUNCTIONS

14.1-1 Monitor and evaluate care provided in and develop clinical policy for special care areas such as critical care units, patient care units, patient care support services, such as respiratory therapy, physical medicine and anesthesia, emergency, outpatient, home care and other ambulatory care services.

14.1-2 Conduct or coordinate quality assessment and improvement activities, including peer review, review of invasive procedures, blood usage, drug usage reviews, medical record and other reviews.

14.1-3 Conduct or coordinate utilization review activities.

14.1-4 Conduct or coordinate credentials investigations regarding staff membership and clinical privileges and specified services.
14.1-5 Provide continuing education opportunities related to quality assurance/improvement activities, technological advances and other perceived needs and supervise the Medical Center’s professional library services

14.1-6 Develop and maintain surveillance over drug utilization, policies and practices

14.1-7 Investigate and control nosocomial infections and monitor the Medical Center’s infection control program

14.1-8 Plan for response to fire, hazardous materials, and other disasters, for Medical Center growth and development, and for the provision of services required to meet the needs of the community

14.1-9 Direct staff organizational activities, including medical staff Bylaws review and revision, staff officer and committee nominations, liaison with the Governing Body and Medical Center administration, and review and maintenance of Medical Center accreditation.

14.1-10 Coordinate the care provided by members of the Medical Staff with the care provided by the nursing service and with the activities of other Medical Center patient care and administrative services

14.1-11 Assure the hospital is in compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA).

14.1-12 Engage in other functions reasonably requested by the Medical Executive Committee and Governing Body

14.1-13 Encourage continuity of Medical Services to patients, regardless of site of care

14.2 HISTORY AND PHYSICAL

Each Member who is credentialed to perform a history and physical is responsible for completing and documenting medical histories and physical examinations as specified in these Bylaws and the Medical Staff Rules and Regulations to include.

The history and physical examination shall be completed and documented for each patient no more than 30 days before, or within 24 hours after
admission or registration, but prior to surgery or a procedure requiring anesthesia services, except in the case of emergency;

The history and physical examination must be completed and documented by the attending practitioner or other qualified licensed individuals in accordance with Washington State Laws, Hospital policy and the Medical Staff Rules and Regulations; and

In cases where a history and physical examination has been performed within 30 days of admission or registration, the attending practitioner or other qualified licensed individuals shall re-evaluate and re-examine the patient’s condition, and note any changes within 24 hours after admission or registration, but prior to surgery or procedure requiring anesthesia services.

ARTICLE 15  MEDICAL STAFF MEETINGS

15.1  ANNUAL MEDICAL STAFF MEETINGS

15.1-1 An annual meeting of the Medical Staff shall be held during the last quarter of each year. Written notice of the meeting shall be sent to all Medical Staff members and conspicuously posted. The agenda of the meeting may include: reports on review and evaluation of the work performed in the departments; election of officers; the conduct of other Medical Staff business; and Continuing Medical Education. Written minutes of all meetings shall be recorded.

15.2  SPECIAL MEETINGS OF MEDICAL STAFF

15.2-1 The President of the Medical Staff may call a special meeting of the Medical Staff at any time. A special meeting may be called by the President to manage conflict between the Medical Staff and the Medical Executive Committee. The President shall set a special meeting date within thirty (30) days after receipt of a written request signed by not less than ten percent (10%) of the Active Medical Staff; or upon a resolution by the Medical Executive Committee. Such request or resolution shall state the purpose of the meeting. The President shall designate the time and place of any special meeting.
Written or printed notice stating the time, place and purpose of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff at least fourteen (14) days before the date of such meeting. No business shall be transacted at any special meeting, except as stated in the notice of such meeting.

15.3 MEETINGS OF DEPARTMENTS AND COMMITTEES

The following provisions shall apply to departments and committees as defined in the Medical Staff Bylaws and Policies and Procedures:

15.3-1 Departments shall hold meetings at least quarterly to review the clinical practice of members with privileges in the department and to conduct department business.

15.3-2 Attendance at all committee meetings shall be limited to committee members unless otherwise permitted under the Bylaws or Policies and Procedures, or by approval of the committee chair. Members may vote by written proxy stating their position and directing the committee chair to vote on their behalf.

15.3-3 Members may attend the meetings of any department at the discretion of the department chair; however, members shall be entitled to vote only at meetings of the department to which they are assigned.

15.4 QUORUM

A quorum for meetings shall be defined as fifty percent (50%) of the voting members of the medical staff, unless otherwise specified in these Bylaws.

15.5 SPECIAL MEETINGS OF DEPARTMENTS AND COMMITTEES

15.5-1 A special meeting of any committee or department may be called at the request of the department or committee chair, or by the President of the Medical Staff.

15.5-2 Written notice stating the time, place, and purpose of any special meeting shall be sent to each member of the committee or department not less than fourteen (14) days before the time of such meeting by the person calling the meeting, with such notice waived for emergent or pressing Medical Staff issue(s).
15.6 ATTENDANCE REQUIREMENTS

15.6-1 Members of the Medical Staff are expected but not required to attend meetings of the Medical Staff.

15.6-2 Members are required to attend any meeting at which their participation is specifically requested related to peer review, performance or patient safety.

15.7 PARTICIPATION BY CHIEF EXECUTIVE OFFICER

The Chief Executive Officer and any representative designated by the Chief Executive Officer may attend any committee or department meeting of the Medical Staff.

15.8 ROBERT’S RULES OF ORDER

The latest edition of Roberts Rules of Order shall prevail at all meetings of the Medical Staff, Medical Executive Committee, and departments and committees unless waived; except that the chair of any meeting may vote.

15.9 MINUTES

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. Each committee and department shall maintain a permanent file of the minutes of each meeting.

15.10 CREATION AND DISSOLUTION OF SPECIAL COMMITTEES

Special Committees shall be created and their members appointed by the President of the Medical Staff, with the advice and consent of the Medical Executive Committee. Such Committees shall confine their activities to the purposes for which they were appointed and shall report to the Medical Executive Committee. Special Committees may be dissolved at the determination of the Medical Executive Committee of the Medical Staff President.

ARTICLE 16 MEDICAL STAFF MEMBER RIGHTS

16.1 MEETING WITH EXECUTIVE COMMITTEE

16.1-1 Each member on the Medical Staff has the right to meet with the Medical Executive Committee. In the event a member is unable to resolve a
difficulty working with their respective department chair, that individual may, upon presentation of a written notice, meet with the Medical Executive Committee to discuss the issue.

16.2 RECALL ELECTION

16.2-1 Any member has the right to initiate a recall election of a Medical Staff officer or department chair. A petition for such recall must be presented and signed by at least ten percent (10%) of the members of the Active Staff. Upon presentation of such valid petition, the Medical Executive Committee will schedule a special Staff meeting for purposes of discussing the issue and (if appropriate), hold a recall vote.

16.3 SPECIAL STAFF MEETING

16.3-1 Any member may request a special staff meeting upon presentation of a petition signed by ten percent (10%) of the members of the Active Staff. The President of the Medical Staff will schedule a special staff meeting for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted.

16.4 CHALLENGE TO POLICIES AND RULES

16.4-1 Any medical staff member may challenge any medical staff or department rule or policy adopted by the Medical Executive Committee by submitting a petition signed by the initiating individual and at least four other members of the active staff. When such petition has been received by the Medical Executive Committee, a meeting with the petitioner(s) to discuss the issue will be scheduled.

16.5 ACTION OUTSIDE OF MEETING

In the event that it is necessary for a Committee or Department to act on a question without being able to meet, the voting members may be presented with the question, in person, electronically, or by mail, and their vote returned to the Chair of the Committee or Department. Such a vote shall be binding so long as the question is voted on by a majority of the Committee or Department eligible to vote. A formal vote in Committee must be taken if there is objection by any Committee or Department member to the above process.
16.6 EXECUTIVE SESSION

Executive session is a meeting of a Medical Staff Committee or Department of the Medical Staff as a whole which only active voting Medical Staff members are present, unless others are expressly requested by the member presiding at the meeting to attend. An executive session may be called by the presiding member at the request of any Medical Staff Committee member, and shall be called by the presiding member pursuant to a duly adopted motion. An executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

16.7 ATTENDANCE REQUIREMENTS

All members of the Staff are entitled to attend annual, regular and special Staff meetings. Voting rights shall be determined by Staff category as indicated in Article 3 of these Bylaws.

Any person appointed to the Medical Staff whose clinical work is scheduled for discussion at a regular or special Departmental or Committee meeting shall be so notified and shall be expected to attend such meeting. If such individual is not otherwise required to attend the meeting, the Chair of the Department or Committee shall give the practitioner advance written notice of the time and place of the meeting at which his attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the individual shall so state, and the practitioner’s attendance at the meeting at which the alleged deviation is to be discussed shall be mandatory.

16.8 LIMITATION OF RIGHTS

16.8-1 The provisions of this Article shall not pertain to issues involving disciplinary or corrective action, denial of requests for appointment or reappointment, or denial of clinical privileges or any other matter relating to individual credentialing actions. Article 10 provides recourse in these matters.

ARTICLE 17 ALLIED HEALTH PROFESSIONALS

17.1 ALLIED HEALTH PROFESSIONALS (AHP’S)

17.1-1 Allied Health Professionals include the following specialties:
17.1-2 All applicants must meet criteria, eligibility and qualification requirements and be approved by the department of the medical staff in which they will practice.

17.1-3 AHPs are individuals who may participate directly in the medical management of patients, but only under the supervision of a member of the Active Medical Staff who has ultimate responsibility for the patients’ care and who has been accorded clinical privileges under these bylaws. The AHP shall have a written agreement for supervision by the Medical Staff Member. AHPs, although not entitled to membership on the Medical Staff or the rights associated with such membership, shall nonetheless be governed by and subject to these Bylaws (provided, however, AHPs shall be entitled to a Fair Hearing under Article 10 of these Bylaws). Accordingly, AHPs are not eligible for Active or Courtesy membership, but must make application for appointment according to these Bylaws.

17.1-4 All Allied Health Professionals may attend department meetings as voting members and may attend educational events provided by the medical staff and Medical Center and the Annual Meeting of the Medical Staff.

17.1-5 Applications for authorization to practice as an AHP shall be processed as follows:

a. Certified Nurse Midwives, Advanced Registered Nurse Practitioners and Physician Assistants must complete an application and Request for authorization to Practice form which outlines the area of patient care in which they want to function, list of procedures and description of their scope of practice or role in patient care.

b. Documentation indicating agreement to the expectations of supervision of the AHP must be completed and signed by the
Active medical staff member who will be supervising them. This document must include specific plans for oversight and backup coverage.

c. CNM’s, ARNP’s, and PA-C’s applications will be processed in the same manner as medical staff members, including approval by the department chair, Quality and Credentials Committee, Medical Executive Committee and the Governing Body.

d. Surgical Assistants must meet the criteria outlined in the Job Description prepared by the Department of Surgery. Surgical Assistants will be approved by the chair of the Department of Surgery or other surgical departments, and the Director of Surgical Services and shall be reviewed for approval by the Quality and Credentials Committee, Medical Executive Committee and the Governing Body.

17.2 AFFILIATE ALLIED HEALTH PROFESSIONALS

a. Affiliate Allied Health Professionals, are defined as described in section 17.1-1 a.-c. who use the Medical Center as their primary facility for inpatient, outpatient and procedural care and are not directly involved in the medical management of patients at the Medical Center.

b. The AHP shall have a written agreement for sponsorship by a member of the Medical Staff that describes their relationship with the AHP. Although not entitled to membership on the Medical Staff or the rights associated with such membership, an Affiliate AHP shall nonetheless be governed by and subject to these Bylaws (provided, however, AHPs shall be entitled to a Fair Hearing under Article 10 of these Bylaws).

c. Affiliate AHP’s applications and reappointment applications will be processed in the same manner as affiliate medical staff members, including approval by the department chair, Quality and Credentials Committee, Medical Executive Committee and the Governing Body.
d. Affiliate AHP’s may visit any patient in their outpatient practice who is admitted to the hospital and review the medical record.

e. May not write in the medical record, including physician orders and progress notes.

f. Affiliate AHP’s are expected to pay an application fee and dues in accordance with members of the medical staff.

ARTICLE 18  BYLAW ADOPTION AND AMENDMENT

18.1 MEDICAL STAFF RESPONSIBILITY

18.1-1 The organized medical staff adopts and amends medical staff bylaws. After adoption or amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval.

18.2 METHODS OF ADOPTION AND AMENDMENT

AMENDMENTS TO BYLAW

Neither the Medical Staff nor the Governing Body may unilaterally amend the Medical Staff Bylaws. The procedure for amending Bylaws is as follows:

All proposals for adoption of Bylaws or amendments to these Bylaws must be initiated by the Medical Staff. As a matter of procedure, any proposals to amend or adopt Bylaws may be proposed by the medical staff directly to the Governing Body pursuant to Section 18.2-1

18.2-1 Proposals for adoption of Bylaws or amendments to these Bylaws may be made by the Medical Staff directly to the Governing Body. Copies of the proposed Bylaws or amendments to the Bylaws may be sent to each voting member of the Medical Staff by mail or electronically with a summary of the proposed changes with voting by ballot. The copies and summary will be sent to each voting member at least ten (10) days in advance of the close of voting. The copies and summary will also be provided to the Medical Executive Committee sufficiently before the close of voting to allow the Medical Executive Committee to review and comment on the proposals. If there is a conflict regarding any of the proposals, the President of the Medical Staff may call a special meeting.
pursuant to Section 15.2. To be adopted, a proposed Bylaw or Bylaw amendment must receive the affirmative vote of a majority of the voting members.

18.2-2 Bylaws and Bylaw amendments adopted pursuant to Section 18.2-1 shall be transmitted to the Governing Body for consideration at its next regularly scheduled meeting occurring at least fifteen (15) days after transmission. Any such Bylaws or Bylaw amendments shall be approved by the Governing Body prior to becoming effective.

18.2-3 The Medical Executive Committee may make minor corrections and Bylaw changes when such correction or change is necessary due to spelling, punctuation, grammar, and context or if required by law. No prior notice of such change is required. All changes thus made will be reported at the next meeting of each department.

**ARTICLE 19 MEDICAL STAFF POLICY**

Such rules, regulations, and policies as may be necessary to implement more specifically the general principles found within bylaws and to regulate the proper conduct of Medical Staff organization activities and the clinical practices that are required of each practitioner in the Medical Center may be proposed for adoption or amendment by the Medical Executive Committee, pursuant to Section 19.2, or by majority vote of the Medical Staff, pursuant to Section 19.3, subject to the approval of the Governing Body.

Any Policy, Rule, or Regulation proposed for adoption or amendment by the Medical Executive Committee must first be communicated to the Medical Staff for review and comment before submittal to the Governing Body for approval. If there is a conflict regarding any proposed Policy, Rule, or Regulation, the President of the Medical Staff may call a special meeting pursuant to Section 15.2.

Policies, Rules, and Regulations may also be proposed to the Governing Body by the Medical Staff by majority vote of the members of the Active Staff entitled to vote. Proposed Rules, Regulations, or Policies may be brought before the Active Medical Staff by petition signed by ten percent (10%) of the members of the Active Staff. Copies of the proposed Policies, Rules, or Regulations may be sent to each voting member of the Medical Staff by mail or electronically with a summary of the proposals with voting by ballot. The copies and summary will be sent to each voting member at least ten (10) days in advance of the close of voting. Any such proposed Rules, Regulations, or Policies shall be submitted to the Medical Executive Committee for review and comment before
such Rules, Regulations or Policies are voted on by the Active Staff. If there is a conflict regarding any proposed Rule, Regulation, or Policy, the President of the Medical Staff may call a special meeting pursuant to Section 15.2. Any Rule, Regulation, or Policy approved by the Active Staff shall be presented to the Governing Body along with any comments from the Medical Executive Committee.

All proposed Policies, Rules, and Regulations shall become effective and part of these Bylaws only after approval by the Governing Body. The Governing Body shall consider all such proposed Policies, Rules, or Regulations at its next regular meeting scheduled for a date at least fifteen (15) days after the proposed Policies, Rules, or Regulations have been submitted for approval.

In cases of a documented need for an urgent amendment to the rules, regulations and policies necessary to comply with law or regulation, the Medical Executive Committee may provisionally adopt and the Governing Body may provisionally approve an urgent amendment without prior notification to the Medical Staff. In such cases, the Medical Staff will be immediately notified by the Medical Executive Committee. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, a special meeting, pursuant to Section 15.2, may be called by the President of the Medical Staff.

ADOPTED BY THE GOVERNING BODY ON APRIL 21, 2020 AFTER RECEIPT OF A RECOMMENDATION BY THE MEDICAL STAFF.