MEDICAL STAFF BYLAWS

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Approved by Medical Staff 3/2011; Approved by Board of Directors 4/2011.

ARTICLE 1: DEFINITIONS

ADMINISTRATOR or OPERATIONS ADMINISTRATOR or any other title such as Chief Executive Officer, means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

ADVERSE RECOMMENDATION means a recommendation to impose requirements for consultation or conditions of probation, to deny, suspend or terminate Medical Staff membership or to deny, reduce, suspend or terminate clinical privileges of a practitioner, which shall entitle the affected practitioner to a hearing or an Appellate Review according to the Medical Staff Bylaws, Rules and Regulations, and Policies.

APPELLATE REVIEW COMMITTEE means the group designated under this Plan to hear an appeal properly requested and pursued by a practitioner.

ATTENDING PHYSICIAN means the Licensed Independent Practitioner who is the primary physician caring for the patient in the hospital. They must be credentialed by the Medical Staff to admit patients to their inpatient service in the Hospital.

BOARD means the Board of Directors responsible for conducting the affairs of Providence Regional Medical Center Everett, which for purposes of these Medical Staff Bylaws and except as the context otherwise require, shall be deemed to act through the authorized actions of the Northwest Washington Service Area, the officers of the corporation and through the Administrator of the Hospital.

DIVISION means the primary grouping of clinical sections of the Medical Staff as established by the Medical Executive Committee.

HEARING OR EVIDENTIARY HEARING means a proceeding before a Hearing Panel conducted pursuant to this Fair Hearing Plan.

HEARING PANEL means the committee appointed under this Plan to preside over an evidentiary hearing properly requested and pursued by a practitioner.

HEARING OFFICER means the individual selected to facilitate the hearing process and assure that the hearing is conducted in accordance with this Fair Hearing Plan.

MEDICAL EXECUTIVE COMMITTEE (MEC) means the Medical Executive Committee of the Medical Staff

HOSPITAL means the facilities known as Providence Regional Medical Center Everett (PRMCE).

LICENSED INDEPENDENT PRACTITIONER (LIP): An individual permitted by law and by the organization to provide care, treatment, and services without direct supervision of a physician or other independent health care practitioner. A licensed independent practitioner operates within the scope of his or her license, consistent with individually granted clinical privileges.

THE MEDICAL STAFF OF PROVIDENCE REGIONAL MEDICAL CENTER EVERETT, or MEDICAL STAFF means the LIPs who are members of the Medical Staff at the Hospital.

NORTHWEST WASHINGTON SERVICE AREA (NWSA) means the Sisters of Providence, Providence Health & Services, Washington, in Everett, which is comprised of the facilities of Providence Regional Medical Center Everett, as well as other health care related services.

OFFICIAL NOTICE means the act by which the hearing committee will recognize the relevance and existence of certain technical, scientific, and judicial facts relevant to the controversy and generally regarded as true.

PARTY" OR "PARTIES means the practitioner who requested the hearing or appellate review and the body or bodies who participate in the hearing or appellate review.

Physician: The term physician means:

1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action,
2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions,

3) a doctor of podiatric medicine, but only with respect to function which he is legally authorized to perform as such by the State in which he performs them,

4) a doctor of optometry, but only with respect to the provision of items or services he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or

5) a chiropractor who is licensed as such by the State (or state in which does no license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards, but only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided.

Source: Social Security Act, Sec. 1861.[42 U.S.C. 1395x]

POLICIES means the policies and procedures of the PRMCE Medical Staff.

Practitioner means any individual who is licensed and qualified to practice a health care profession (for example, physician, nurse, social worker, clinical psychologist, psychiatrist, or respiratory therapist) and is engaged in the provision of care, treatment, or services [source TJC glossary, 2010]. Practitioners are permitted to practice in the Hospital, either with or without the direction or supervision of a physician member of the Medical Staff. Examples of non-physician practitioners include ARNPs, CNMs, CRNAs, Clinical Psychologists, PAs, DAs, and RNFAs. In the context of the Fair Hearing Plan, the applicant or Medical Staff member against whom an adverse action has been considered or taken.

PRIVILEGES or CLINICAL PRIVILEGES means the permission, under these Medical Staff Bylaws, granted to a practitioner to render specific diagnostic and/or therapeutic services in the facilities of the Hospital.

REFERRAL BACK" OR "REFER BACK means the process whereby the Board of Directors or the Appellate Review Committee requires a body to reconsider its previous recommendation. Any referral back shall state the reasons, set a time limit within which a subsequent recommendation must be made, and may include a directive for additional investigation or hearing.

SECTION means a sub-grouping of practitioners by clinical specialty and/or practice within a Division as established by the Medical Executive Committee.

SPECIAL NOTICE means written notification either given by personal delivery or sent by certified or registered mail, return receipt requested. Refusal to accept such Special Notice shall constitute receipt thereof.

ARTICLE 2: PURPOSES

The practitioners granted patient care privileges in the Hospital are hereby organized into a Medical Staff to assist the Board in executing the following functions as delegated by the Board to the Medical Staff:

2.1. To strive toward assuring that the proper medical care is provided to patients and the community by the Hospital;

2.2. To be accountable to the Board for the quality of care provided and for Medical Staff activities;

2.3. To provide clinical leadership within the Hospital in order to address system and individual issues that will allow for continual improvements in care and services;

2.4. To conduct self-governance activities inherent to the provision of proper care in accordance with the Medical Staff Bylaws of the Board; and

2.5. To provide a structure whereby issues concerning Members may be addressed by other Members and presented by them to the Board.

ARTICLE 3: MEDICAL STAFF MEMBERSHIP

3.1 Nature of Membership

Membership on the Medical Staff is a privilege that may be granted to those Licensed Independent Practitioners who request it from the Hospital. All individuals exercising privileges within the Hospital shall meet the qualifications, standards, requirements and responsibilities set forth in the Medical Staff Medical Staff Bylaws and Policies, and the Hospital Medical Staff Bylaws and policies & procedures.

3.2 Categories

There are four categories for Medical Staff membership: Active-Hospital Based, Active-Office Based, Consultative, and Honorary. Assignment of members of the Medical Staff to one of these categories shall be made by the Credentials Committee, subject to approval by the Governing Body. The Credentials Committee, through the approval of the Medical Executive Committee may assign or re-assign a member to a different category. Assignment or re-assignment will be based on several criteria including; community and hospital needs, availability of specialty services, Emergency Room back-up needs, continuity of community call groups, and individual member preferences. Fees for appointment, reappointment, and membership fees for each category will be reviewed and assessed annually. Subsequent to March 2010, all new members of the Medical Staff assigned to Active Staff-Hospital Based category and Active Staff-Office Based, and Consultative Staff categories will be expected to be board certified or actively pursuing board certification within 5 years of appointment, and maintain board certification by the American board of Medical Specialties or the American Osteopathic Association Board, or certification by an equivalent board as determined by the Credentials Committee. All present members of the Active-Hospital Based, Active-Office Based, and Consultative Staff categories, who are already board certified, will be expected to maintain board certification.

3.2.1 The Active- Hospital Based Category shall consist of those members who admit at least 10 patients to the Hospital per year, or have at least 10 inpatient encounters per year. In addition, the Active-Hospital Based Category shall be comprised of members of hospital based disciplines including but not limited to; Diagnostic and Interventional Radiology, Radiation Oncology, Pathology, Emergency Medicine, and Hospitalists. Other members may be assigned or re assigned to this category by the Credentials Committee based on criteria described in 3.2 of these Medical Staff Bylaws. Members of the Active-Hospital Based Category may exercise all clinical privileges at the Hospital, as granted by the Governing Body. The first year of assignment to the Active-Hospital Based Staff will be a provisional period, (Active-Hospital Based Staff/Provisional). During the provisional period, the member may not hold office at any level or be chairman of a committee, but may serve as a committee member. During the provisional period, the member may vote at general or special meetings of the Medical Staff, Division, Section, or committees. During the provisional period, the member will be monitored by Medical Staff peer review, MSQRC, and Credentials Committee. During the provisional period the member will accept and follow Medical Staff proctoring per Medical Staff Policies and Rules and Regulations. After successful completion of the provisional period and proctoring as defined by Medical Staff Policy, the member shall be advanced to Active-Hospital Based Staff category, and shall be entitled to vote and hold office or be a chairman of a committee and exercise such clinical privileges as are granted to him/her consistent with the Policies and Hospital policies. Unsuccessful completion of the provisional period and/or suboptimal performance during proctoring shall be defined by Medical Staff Policy.

3.2.1.1 Qualifications for Active-Hospital Based Category Staff

An Active-Hospital Based Staff Member must:

a) Meet all qualifications for Medical Staff membership as set forth in the Medical Staff Medical Staff Bylaws and Policies.
b) Admit greater than 10 patients per year and/or have more than 10 inpatient procedures or management encounters per year, or be a Hospital based member as described in 3.2.1 of these Medical Staff Bylaws.
c) Provide continuous care to their admitted patients or make arrangements for appropriate coverage to do so.

3.2.1.2 Prerogatives of Active-Hospital Based Staff

a) Exercise all clinical privileges as granted by the Governing Body, including admitting patients consistent with Hospital and Medical Staff Medical Staff Bylaws and Policies.
b) May vote at general and special meetings of the Medical Staff, Division, Sections, or committees of which (s)he is a member.
c) May hold office of the Medical Staff per 3.2.1 of Medical Staff Medical Staff Bylaws.

3.2.1.3 Obligations of Active-Hospital Based Staff

An Active-Hospital Based Staff Member must:

a) Meet the basic obligations of Medical Staff membership set forth in Medical Staff Bylaws and Policies.

b) Actively participate in the recognized functions of the Medical Staff, including without limitation, quality improvement, professional review and other monitoring activities, and other Medical Staff functions that may be assigned.

c) Participate equitably in the discharge of Medical Staff functions by (1) serving on the on-call roster for the purpose of assignment to service or charity patients and for providing back-up coverage in the emergency department; (2) giving consultation to other staff members consistent with his/her delineated privileges; (3) reviewing the performance of practitioners during a provisional period; and (4) fulfilling such other Medical Staff functions as may be reasonably required.

3.2.2 The Active-Office Based Staff Category shall consist of those members whose practice is primarily an outpatient medical practice, and have minimal or no inpatient practice. The Active-Office Based Staff Category shall consist of members of primary care disciplines including Family Practice, Pediatrics, and Internal Medicine. Other medical or surgical disciplines may be assigned or re-assigned to this category by the Credentials Committee base on criteria described in 3.2 of these Medical Staff Bylaws. Members of the Active-Office Based Staff category may refer their patients to the Hospital and may follow their inpatient care, and/or they may independently admit and follow their patients (up to 10 patients per calendar year). They may exercise all clinical privileges at the Hospital, as granted by the Governing Body. The first year of assignment to the Active-Office Based Staff category will be a provisional period (Active-Office Based/Provisional). During the Active-Office Based/Provisional period, the member may not hold office at any level or be chairman of a committee, but may serve as a committee member. During the provisional period, the member may vote at general or special meetings of the Medical Staff, Division, Section or committees. During the provisional period, the member will be monitored by Medical Staff peer review, Medical Staff Quality Review Committee (MSQRC), and Credentials Committee. During the provisional period the member will accept and follow Medical Staff proctoring per Medical Staff Policies and Rules and Regulations. After the provisional period, and successful completion of Medical Staff proctoring, the member shall be advanced to Active-Office Based Staff, and shall be entitled to vote and hold office or be a chairman of a committee and exercise such clinical privileges as are granted to him/her consistent with the Policies and Hospital Policies. Unsuccessful completion of the provisional period and/or suboptimal performance during proctoring shall be defined by Medical Staff Policy.

3.2.2.1 Qualifications for Active-Office Based Staff

A member of the Active-Office Based Staff must:

a) Meet all qualifications for Medical Staff Membership as set forth in the Medical Staff Bylaw and Policies.

b) May admit patients, based on qualifications and privileges (admit 10 or less patients in the past calendar year).

c) Provide continuous care for the patients they admit and follow or provides appropriate coverage to do so.

3.2.2.2 Prerogatives of Active-Office Based Staff

a) Exercise all clinical privileges as granted by the Governing Body including admitting patients consistent with Hospital and Medical Staff Bylaws and Policies.

b) May vote at general and special meetings of the Medical Staff, Division, Section, or committees which he/she is a member

c) May hold office of the Medical Staff per 3.2.2 of the Medical Staff Bylaws

3.2.2.3 Obligations of the Active-Office Based Staff

An Active-Office Based Staff member must:

a) Meet the basic obligations of Medical Staff membership set forth in the Medical Staff Bylaws and Policies.

b) Participate equitably in the discharge of Medical Staff functions by (1) serving on the on-call roster for the purpose of assignment of service or charity

3.2.3 Consultative Staff Category shall consist of those members who are invited to be on the Consultative Staff based on providing a specialized service to the Medical Staff and Hospital. Assignment to the Consultative Staff will be made by the Credentials Committee, with approval of the Medical Executive Committee Governing Body.

3.2.3.1 Qualifications of Consultative Staff

A Consultative Staff member must:

a) Meet the qualifications of the Medical Staff membership set forth in the Medical Staff Bylaws and Policies.

3.2.3.2 Prerogatives of Consultative Staff

a) Attend meetings of the Divisions and Medical Staff
b) Not vote at general and special meetings of the Medical Staff, Divisions, and
c) Sections, but may vote on committees of which he/she is a member.
d) Serve on a committee provided he/she satisfies the specific
e) qualifications for the position involved and except as otherwise
f) provided in the Medical Staff Bylaws and Policies.
g) May not be an officer of the Medical Staff.

3.2.3.3 Obligations of Consultative Staff

a) Meet the obligations of Medical Staff membership set forth in the Medical Staff Bylaws, Rules and Regulations, and Policies.
b) Provide consultation, clinical procedures, consistent with his/her delineated privileges.
c) Specific functions or limitations which may be clarified by the Credentials Committee, or Division Chief.
d) Reviewing the performance of practitioners during a provisional period.

3.2.4 Honorary Staff Category shall consist of members who are considered by the Credentials Committee and consist of members who are retired from the Medical Staff, are honored by emeritus positions, or have outstanding professional achievements.

3.2.4.1 Qualification of Honorary Staff

a) None of the general qualifications provided for other staff categories is applicable.

3.2.4.2 Prerogatives of Honorary Staff

a) Attend meetings of the Medical Staff, Divisions, and Sections
b) Not vote at general and special meetings of the Medical Staff, Divisions, or Sections, but may vote on committees of which he/she is a member.
c) Not hold office at any level in the Medical Staff or be a chairperson of a committee, but may serve as a committee member.
d) Have no privileges to admit or treat patients in the Hospital
e) May be involved in education and/or administrative activities of the Medical Staff.

3.2.4.3 Obligations of the Honorary Staff

a) None of the general obligations provided for other staff categories is applicable. Honorary Staff applicants and members will be exempt from Medical Staff dues, fees, life support certification requirements and immunity requirements. If they are not transferring from another staff category, they will be asked to submit an initial application with curriculum vitae prior to appointment to the Honorary Staff.

3.3 Temporary Staff Category and Privileges

Practitioners who meet the qualifications for active staff membership and privileges may request temporary membership and privileges for care of a specific patient, for locum tenens, or for pendency of an application. Specific conditions and circumstances for temporary privileges are outlined in the Policies.

3.4 Referral Practitioner

Practitioners that are not members of the Medical Staff who refer patients to the hospital ~~request~~ to have tests or procedures performed at/by the hospital.

3.5 Leaves of Absence

A Member desiring a leave of absence must submit a written request to the Credentials Committee. Leaves of absence shall normally be granted for a maximum period of one year. Extensions of leaves may be granted by the Credentials Committee upon request of the Member. If the two year appointment lapses while the Member is on leave of absence, the Member must be reappointed to the Medical Staff and his/her Clinical Privileges must be approved prior to exercising those privileges in the Hospital. Dependant on the duration of the leave, proctoring, precepting, or other requirements for re-entry may be required.

3.6 Resignations

Resignations will be submitted in writing to the Medical Staff Office.

3.7 General Rules of Membership

3.7.1 Each Medical Staff Member with active privileges, upon appointment/reappointment to the Staff, shall file with the Medical Staff Office the name(s) of at least one appropriately qualified Staff Member or call group who has agreed to serve as his/her alternate. This alternate may be called to manage an urgent problem in the event that the Staff Member cannot be reached within a reasonable amount of time. In the unlikely event that the alternate cannot be reached, the President or the Administrator is empowered to appoint an available physician to serve until the emergency has passed or the Member is contacted.

3.7.2 The patients' privacy and the confidentiality of the medical record will be protected per Hospital policy and federal and state privacy laws (HIPAA). In all cases, any physician approached by the public media regarding operations or functions of the Hospital will notify the Hospital's designated spokesperson for communication of appropriate information to the media. The Medical Staff Office is designated as the responsible party for practitioner information. Any changes in information, i.e. addresses, FAX numbers, phone numbers, e-mail addresses; shall be communicated to the Medical Staff Office.

ARTICLE 4: APPOINTMENT AND REAPPOINTMENT

4.1 Term

Appointment and reappointment shall be for such a period as provided by the Policies, not exceeding 2 calendar years, upon the recommendation of the Credentials Committee, or otherwise as provided in these Medical Staff Bylaws. Appointments and reappointments shall be effective when approved by the Board.

4.2 Clinical Privilege/Limitations and Restrictions

Recommendations of appointments and reappointments shall set forth the privileges, with limitations and restrictions, to be accorded the practitioner. Final authority and responsibility for Privileges in the Hospital shall rest with the Board.

ARTICLE 5: CLINICAL AND OTHER PRIVILEGES

5.1 Clinical and Other Privileges

Every practitioner shall be entitled to exercise at the Hospital only those Clinical Privileges specifically granted to him/her by the Board following the processing of applications and reappointment procedures, except as provided in Section 5.3 and 5.4[must update numbers]. The evaluation of an applicant's or practitioner's request for Privileges, or for additional or increased Privileges, shall be based upon his/her current licensure, relevant training or experience, current competence, his/her ability to work with other practitioners and personnel in the Division and Section, references and other relevant information, including appraisal by the clinical Division and Section, in which such Privileges are sought. The applicant or practitioner shall have the burden of establishing his/her qualifications and competency. Periodic re-determination of Clinical Privileges and the increase or curtailment of the same shall be based upon the foregoing and upon the direct observation of care provided, review of the records of patients treated, and review of records of the Medical Staff and of any other body or agency which document the evaluation of the practitioner's participation in the delivery of medical care.

Privileges granted to non-MD and/or non-DO providers shall be based on their current licensure, relevant training or experience, current competence, ability to work with other practitioners, and Hospital personnel. All practitioners who are not MDs or DOs, unless granted specific independent admitting Privileges, shall be required to have their inpatients co-admitted by a physician who is an MD or DO and is credentialed as a Licensed Independent Practitioner of the appropriate clinical specialty.

When surgical privileges are exercised by dentists and non-physician providers, the patient shall receive the same basic medical appraisal as patients admitted to other surgical services. A Physician Member with independent admitting privileges assigned to the Active Staff category shall be responsible to perform an admission medical evaluation and for the ongoing inpatient medical care, including care of any medical problem which may be present at the time of admission or which may arise during hospitalization.

The Attending Physician or designee must evaluate all new patients within 24 hours of admission. Inpatients must be rounded on at least daily, with a progress note made to document that visit. The Attending Physician is ultimately responsible for the care of the patient. Upon admission to the Critical Care Unit, the Attending Physician will be notified immediately. The Attending should see the patient within a period of time commensurate with the medical needs of the patient. If there is any significant change in the patient's condition, the Attending Physician should be called immediately. The Attending Physician or designee will be available in a timely manner for emergent cases.

5.2 Patients on the Inpatient Rehabilitation Facility must be admitted by a rehabilitation specialist and seen at least three times per week.

5.3 Patients under the General Inpatient Hospice Benefit: Since Inpatient Hospice patients are seen and assessed daily by the Hospice Interdisciplinary Team, LIP rounds may occur less frequently than daily, although they must occur at least every other day.

1.1. A podiatrist may perform the admission history and physical on patients who fall within American Society of Anesthesiologists (ASA) Class 1 and 2 classifications, in accordance with the privileging criteria as determined by the Credentials Committee. At a minimum, this includes completion of an education program for training in performing history and physical examinations that has been approved by the Council on Podiatric Medical Education.

Observation and monitoring of clinical activity will be in accordance with the Credentialing and Peer Review policies.

5.5 Hospital and Community Need, and Ability to Accommodate.

In acting on new applications for appointment and Clinical Privileges, and on applications for changes in privileges in staff appointment status, or in principal Division or Section affiliation, the Board may also consider any policies, plans, and objectives formulated by it, concerning; current and projected Hospital patient care needs, and the ability to provide the physical, personnel and financial resource in the Hospital that will be required if the application is approved.

5.6 Exclusive Contract

The Board may choose, with concurrence by the Medical Staff Medical Executive Committee, to develop exclusive contractual arrangements with specialty groups in order to enhance the quality and efficiency of Hospital services. If an exclusive contract is formed between the Board and a physician group, then applicants for Medical Staff membership or reappointment within these specialties will be advised that they may not apply for those privileges which are covered by the exclusive contract while the exclusive contract is in place. If the exclusive contract is discontinued or the applicant affiliates with the contracted specialty group, then the applicant will be free to apply for privileges through the standard credentialing process. If the medical staff member already has privileges when the Hospital initiates an exclusive contract with a specialty group, and the member is not a member of said specialty group, then that member cannot exercise privileges until they are a member of that specialty group, or until the exclusive contract is terminated.

5.7 Emergency Privileges

In the case of an Emergency, any Member, to the degree permitted by his/her license and regardless of service or staff status, shall be permitted to do everything reasonably and prudently possible to alleviate the emergency, including calling for any consultation that he or she deems to be necessary or desirable. 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 harm. *Reference RCW 4.24.300, Immunity from liability for certain types of medical care.*

When the emergency situation is no longer present, care of the patient shall be assigned to an appropriate Member of the Medical Staff.

5.8 Disaster Privileges

Practitioners who do not posses clinical privileges at Providence Regional Medical Center Everett may be granted temporary disaster privileges by the CEO or the Medical Staff President or their designee(s) when the PRMCE Disaster Plan has been activated for a Level III Disaster (defined by the PRMCE Disaster Plan), and the hospital is unable to handle the immediate patient needs. The CEO or Medical Staff President or their designee(s) is not required to grant privileges to any individual, and they are expected to make such decisions on a case-by-case basis at his or her discretion.

The granting of Disaster Privileges may be considered upon presentation of any of the following:

A current license to practice and a valid picture ID issued by a state, federal, or regulatory agency and at least one of the following:

- a current picture hospital ID card that clearly identifies professional designation
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT)
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)
- Identifications by current hospital or medical staff members(s) with personal knowledge regarding practitioner's qualifications.

The Medical Staff will address the verification process as a high priority, and will begin the verification process of the credentials and privileges of individuals who receive disaster privileges as soon as the immediate situation is under control. The verification process will be identical to the process described in the Medical Staff Policy on Temporary Privileges.

In the extraordinary circumstance that primary source verification of licensure, certification, or registration cannot be completed in 72 hours, it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the reasons that primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment and services; and the attempt to rectify the situation as soon as feasible.

The Hospital Disaster Policy defines the mechanism for staff members to readily identify the practitioner with disaster privileges. The practitioner will be paired with a currently credentialed Medical Staff member and should act only under the direct supervision of a Medical Staff member. The practitioner's privileges will be for the period needed during the duration of the disaster only. They will automatically

be cancelled at the end of needed services as determined by the CEO or the Medical Staff President or their designee(s).

A practitioner's disaster privileges will be immediately terminated by the CEO or the Medical Staff President or their designee(s) in the event that (1) based on the information received through the verification process, there is concern that the provider is not capable of rendering services in an emergency or (2) information is discovered or an event occurs which raises concerns about a practitioner's professional qualifications or ability to practice. Any such termination of disaster privileges shall not entitle the practitioner to the procedural rights afforded by the Fair Hearing Plan and is not considered an adverse action that would be reportable to the National Practitioner Data Bank. Nothing contained in this policy shall be construed to confer Medical Staff membership to practitioners granted temporary disaster privileges.

5.9 Proctoring through Focused Professional Practice Evaluation (FPPE)

Focused Professional Practice Evaluation allows the organized medical staff to focus evaluation on a specific aspect of a practitioner's performance. This process is used in the following two circumstances:
1) When a practitioner has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm competence in the organization's setting,
2)If questions arise regarding a practitioner's professional practice during the course of the Ongoing Professional Practice Evaluation [source, TJC standards MS.06.01.01].

Each practitioner appointed to the Medical Staff shall complete a period of proctoring. Such proctoring (which may include direct observation of the practitioner's performance and/or chart review) shall be structured so as to ensure that a more informed determination can be made regarding the initial appointee's eligibility for Medical Staff membership and/or eligibility to exercise the clinical privileges granted to him/her.

Each initial appointee shall be assigned to a clinical division and section in which Section performance shall be overseen by the Division Chief and/or Section Medical Director/Leader or designee during the period of proctoring required. Whenever an initial appointee has been granted clinical privileges in one or more clinical Sections other than the one to which he/she has been assigned, his/her performance within each such section shall be proctored in like manner.

A recommendation from the clinical section(s) to the Division Chief and/or Section Medical Directors/Leaders to which the initial appointee has been assigned that the initial appointee is no longer subject to any continued proctoring will be made. This is based upon the type and number of cases that have been proctored; the initial appointee's clinical performance while under proctorship; and the fact that the initial appointee satisfactorily has demonstrated his/her ability to exercise the clinical privileges tentatively granted Except as otherwise provided within Section III, no initial appointee shall be removed completely from proctoring without the full approval from the Credential Committee.)

Except as otherwise might be recommended by the Medical Executive Committee and Credentials Committee and approved by the Board, each member who has been granted additional clinical privileges shall be required to complete a period of proctoring in accordance with the procedures outlined, for initial appointees, as explained in the previous section.

5.10 Ongoing Professional Practice Evaluation (OPPE)

The ongoing professional practice evaluation (OPPE) is designed to continuously evaluate a practitioner's performance. The OPPE process requires an ongoing evaluation of each practitioner's professional performance. OPPE not only allows any potential problems with a practitioner's performance to be identified and resolved as soon as possible, but also fosters an efficient, evidence-based privilege renewal process [source, TJC standards MS.06.01.01].

On an ongoing basis, more than annually, currently credentialed medical staff will be evaluated on the basis of their practice patterns in at least one of the following six general competencies: patient care, medical-clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice.

The OPPE helps ensure care provided meets division approved standards of practice, quality, and optimized patient safety, as well as facilitating the identification of trends that may require a focused professional evaluation at any point during the credentialing cycle.

ARTICLE 6: DIVISIONS AND SECTIONS

6.1. Division and Section Organization

In order to promote effective Medical Staff management and in order to enhance the quality of medical care the Medical Staff shall be organized into four Divisions, Medicine, Surgery, Women and Children's Services, and Ambulatory Medicine; and each Division into clinical sections with each Member assigned to the Division/Section in which he/she has the majority of clinical privileges. It is understood that some members will have clinical activity in more than one division or section.

6.1.1. The Medicine Division will be organized to include inpatient medical services. Disciplines/Sections in this Division may include: General and Family Medicine; Emergency Medicine; Radiology; Internal Medicine with associated medical subspecialties; Psychiatry and Psychology; and Hospitalists from the above specialties (i.e. Internal Medicine, Neurology).

6.1.2. The Surgery Division will be organized to include primarily surgical services. Disciplines/Sections in this Division may include all Surgical Specialties; Anesthesia; and Professional Services including Pathology.

6.1.3. Women and Children's Services Division will be organized to include OB/GYN and Pediatric inpatient services. Disciplines/Sections in this division may include Obstetrics; Gynecology; Pediatrics; Family Medicine; Midwives; and Pediatric Subspecialty Services.

6.1.4. The Ambulatory Medicine Division will be organized to include outpatient medical services. Disciplines/Sections in this division may include: General and Family Medicine; Internal Medicine; Medical Specialties; and Pediatrics.

6.2. The Medical Executive Committee may periodically review this structure and recommend to the Board the modification of the above organization, including the creation, elimination, or combining of Divisions and/or Sections for greater organizational efficiency and improved patient care. Any Division and/or Section created must satisfy the functions of Divisions and/or Sections.

6.3. Assignments.

6.3.1. After consideration of the recommendations for membership and privileges by the affected Divisions, the Credentials Committee shall make recommendations to the Board for medical staff membership and recommendations for Privileges for each applicant prior to appointment and reappointment. Each Member will be assigned to the Division in which he/she has been granted the majority of clinical privileges or in which he/she treats the majority of cases

6.4. The following criteria shall apply in making Clinical Division and/or Section designations:

6.4.1. The area of practice represents a general, distinct field of medical practice at the Hospital.

6.4.2. The level of clinical activity at the Hospital is substantial enough to warrant imposing the functions assigned to Clinical Divisions and Sections.

6.4.3. An individual practitioner, based on clinical privileges, may be part of one or more Division or Section.

6.5. Functions of Clinical Divisions

6.5.1. The Clinical Divisions and their leadership fulfill certain clinical, administrative, quality improvement/risk management/utilization management, and collegial and education functions as set forth in the Medical Staff Bylaws and Policies of the Medical Staff including but not limited to:

6.5.1.1. Clinically related activities of the division

6.5.1.2. Administratively related activities of the division, unless otherwise provided by the hospital

6.5.1.3. Continuing surveillance of the professional performance of all individuals in the division who have delineated clinical privileges

6.5.1.4. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the division
6.5.1.5. Recommending clinical privileges for each member of the division
6.5.1.6. Assessing and recommending to the relevant hospital off-site sources for needed patient care, treatment, and services not provided by the division or the hospital
6.5.1.7. The integration of the division or service into the primary functions of the hospital
6.5.1.8. The coordination and integration of departmental services
6.5.1.9. The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services
6.5.1.10. The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services
6.5.1.11. The determination of the qualifications and competence of division or service practitioners who are not physicians and who provide patient care, treatment, and services
6.5.1.12. The continuous assessment and improvement of the quality of care, treatment, and services
6.5.1.13. The maintenance of quality control programs
6.5.1.14. The orientation and continuing education of all persons in the division or service
6.5.1.15. Recommending space and other resources needed by the division or service

6.5.2. Credentialing Functions

Each Division shall integrate and cooperate with the Credentials Committee to establish, implement and monitor its members' adherence to clinical standards, policies, procedures and practices relevant to various clinical disciplines under its jurisdiction; develop consistency in patient care standards, policies and procedures within the Division and across any of its constituent sections; develop and recommend, in consultation with various specialists and sub-specialists, criteria for use in making credentialing and privileging recommendations for initial appointments, reappointments, and other credentialing matters.

6.5.3. Administrative and Clinical Functions.

Each Division shall provide a forum for its members to contribute their professional views and insights to the formulation of Section, Medical Staff and Hospital policy and plans; provide a multi-specialty forum for matters of clinical concern and for resolving clinical issues arising out of the interface between its members' activities and the activities of other patient care administrative services.

6.5.4. Quality Improvement

Each Division shall review quality improvement data and findings pertinent to the Division and make recommendations to take action as appropriate; conduct reviews and special studies of processes and outcomes of care, perform specified monitoring and evaluation; and report findings of studies and other activities by serving as a conduit with the Medical Staff Quality Review Committee.

Each Division may form a Division or Section committee assigned to perform peer review and other related activities bringing identified issues to the overall Division or Section for resolution, including reporting on a regular schedule to the Medical Staff Quality Review Committee.

All activities described in this section will be protected from discovery under R.C.W. 4.24.250 and Chapter 300 of the 1986 laws of Washington State.

6.5.5. Collegial and Education Functions

Each Division and Section shall serve as a peer group for providing clinical support among and between peers; teaching, research, continuing education and sharing new knowledge relevant to the practice of medicine with their Division or Section Members; and providing consultative advice in their area to other staff Members.

6.6. Functions of Sections

6.6.1. Sections are defined as a clinical subspecialty of a Division. Any policy or procedure that may be discussed or formulated by a Section must be recommended to the section's Clinical Division Chief for final consideration before being sent to the Executive Committee.

6.6.2. Each Section may be delegated the responsibility by its Division Chief for its quality review, credentialing and planning. It is expected that members of each Section will communicate and integrate with other members of the section, other sections of the Division, nursing and ancillary staff, and administration

6.7. Meetings

6.7.1. Divisions and Section meetings shall be held as often as necessary in order to conduct the business of the Division or Section.

6.7.2. All Division and Section meetings are open to any Medical Staff Member.

ARTICLE 7: OFFICERS, DIVISION CHIEFS, SECTION MEDICAL DIRECTORS

7.1. Officers of the Medical Staff

The elected officers of the Medical Staff shall be the President, Past President, President Elect and the Secretary-Treasurer.

7.2. Qualifications of Officers
Each officer must be a Member of the Active Medical Staff at the time of nomination and election. Failure to maintain such status during the term of office shall immediately create a vacancy in the office involved. All Officers of the Medical Staff must be a MD or DO.

7.3. Election of Officers/Nominating Committee

7.3.1. The President Elect completing his/her two year term shall assume the office of the President for a succeeding term. The President, upon completion of a two year term, will assume the office of Past President. The President Elect and Secretary-Treasurer shall be nominated by the Medical Executive Committee. Additional nominations may be submitted by Voting Staff Members. The latter nominations must be submitted with signatures of at least 5% of voting members of the Medical Staff. Additional nominations by Medical Staff Members must be submitted to the Medical Executive Committee at least one month prior to election. Election shall be by a majority of the ballots cast of the members voting of the Medical Staff.

7.3.2. If only one candidate is nominated for any open position, and no further nominations are received, the election of those candidates may be declared by the Medical Executive Committee without a distributed ballot.

7.3.3. Election of officers shall take place biannually. Election shall be done in a manner determined by the Medical Executive Committee.

7.4. Term of Office
The term of office of President shall be two years. The term of office of the President Elect shall be two years. The term of office of the Past President shall be two years. The term of office of the Secretary-Treasurer shall be two years. Officers will assume duties the first day of January following the election.

7.5. Vacancies and Tenure
In the event of a vacancy, the President Elect shall fill any unexpired term of the President. In the event of a vacancy in the office of the President Elect or Secretary-Treasurer, the Medical Executive Committee will submit nominations. The election to fill the vacant office shall occur in a manner determined by the Medical Executive Committee, and requires a majority vote of Voting Staff who cast their ballot in this election. If there is only one nomination for each position, the election may be declared by the Medical Executive Committee without distribution of a ballot. In the event of a vacancy for the office of Past President, the

7.6. Removal of Officers

Any person elected to serve in any position of the Medical Staff (including officers, elected committee members, may be subject to removal from office by petition and vote. This removal may be based upon failure to perform the duties of the position held and described in the Medical Staff Bylaws and Policies. A removal petition to be effective must be signed by 30% of the Medical Staff for confirmation of a nomination to such position. The petition shall be filed to the Medical Executive Committee. The Medical Executive Committee will direct the election to occur as reasonably soon as possible. If a majority of eligible vote for the removal from office, the position will be declared vacant. The vacant position shall be filled for the remainder of the term in the manner provided by these Medical Staff Bylaws and Rules and Regulations.

7.7. Duties of Officers,

7.7.1. The President is authorized and responsible to manage the Medical Staff as its elected leader and representative in accordance with these Medical Staff Bylaws, the Hospital Medical Staff Bylaws, and Policies of the Medical Staff. The President is responsible for establishing and maintaining the functions and responsibilities of the Medical Staff Officers subject to the approval of the Medical Staff Medical Executive Committee. The President is considered an ex-officio member of all Medical Staff Committees.

7.7.2. The President Elect and the Past President are authorized and responsible for assisting the President in accordance with these Medical Staff Bylaws, the Hospital Medical Staff Bylaws and Policies of the Medical Staff. The President Elect shall assume the authority and responsibilities of the President in the absence of the President.

7.7.3. The Secretary-Treasurer of the Medical Staff shall exercise authority as specified in these Medical Staff Bylaws and Policies of the Medical Staff. He/she shall oversee notice of meetings and maintaining minutes of Medical Executive Committee and Medical Staff meetings. He/she shall oversee the collection, disbursement and accounting of Medical Staff funds. The Secretary-Treasurer shall assume the authority and responsibilities of the President and the President Elect in their absence.

7.8. Compensation of Officers

Selected officers of the Medical Staff may be compensated for their services with funds derived in whole or in part from Medical Staff funds. The specific officers to be paid, and the amount of compensation, shall be determined by the Medical Executive Committee annually.

7.9. Division Chiefs

7.9.1. Qualifications of Division Chiefs

7.9.1.1. Administrative experience as determined by the Hospital's job description for this position.

7.9.1.2. Part-time clinical practice in the community as determined by the Hospital's job description for this position.

7.9.1.3. The practitioner is or will become a member of the medical staff.

7.9.1.4. Hold current board certification in their primary specialty of practice.

7.9.2. Nominating Committee and Election of Division Chiefs.

7.9.2.1. Nominations will be made by the Joint Operations Committee.

7.9.2.2. The candidate(s) will be approved by the division members by majority vote.

7.9.2.3. The approved candidate is accepted by the Medical Executive Committee and the Hospital's administration.

7.9.3. Term of Office
The Division Chief term of office will be a renewable two-year term. This position will have an annual evaluation with input from the members of the Division and the Hospital's administration.

7.9.4. Vacancies and/or Terminations
In the event of a vacancy, the matter will be referred to the Joint Operations Committee to begin the recruitment for the vacated position. The Medical Executive Committee may, during the interim, appoint one of the section's medical directors as an interim Division Chief until the recruitment and election process, described herein, has been completed.

7.9.5. Removal of Division Chiefs
Division Chiefs may be subject to removal from their position. This may be based upon failure to perform the duties of the position held and failure to fulfill duties as noted in the Medical Staff Bylaws and Policies or job description. A removal from office may be based on an unsatisfactory or incomplete annual review and is subject to approval of the Joint Operations Committee.

7.9.6. Duties of Division Chiefs

7.9.6.1. Report to President of Medical Staff on medical staff issues such as credentialing, quality improvement and other clinical concerns within the division or section.

7.9.6.2. Report to CHIEF MEDICAL OFFICER (CMO) for hospital operational or administrative concerns.

7.9.6.3. Member of Credentials, Medical Staff Quality Review Committee, The Joint Operations committee, Medical Executive Committee and other committees as appropriate.

7.9.6.4. Responsible for quality assurance, credentialing, and strategic planning in their division, and for communication in their division.

7.9.6.5. Oversight for the quality assurance for their division, and present issues to Medical Staff Quality Review Committee.

7.9.6.6. Implementation of Medical Staff Bylaws policies for Medical Executive Committee

7.9.6.7. Oversight and monitoring of medical staff quality performance through the Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) processes.

7.9.6.8. The Division Chief will be subject to other duties as defined by the hospital job description.

7.10. Section Medical Directors and Leaders

7.10.1. Qualifications of Section Medical Directors/Section Leaders

7.10.1.1. The practitioner is or will become a member of the medical staff.

7.10.1.2. The practitioner is or will become a member of the Section s/he would be serving

7.10.1.3. The practitioner will hold current board certification in their primary specialty of practice.

7.10.2. Duties of Section Medical Directors

7.10.2.1. Report to the Medical Staff Division Chief on medical staff and operational issues.

7.10.2.2. Oversight for quality assurance, credentialing, and strategic planning in their section and report and make recommendations to the Division Chief.

7.10.2.3. Chair Quality Review committees for their section, and present issues to the Division Chief.

7.10.2.4. Implementation of hospital and medical staff policies.

7.10.2.5. Have Section Meetings as needed.

7.10.2.6. Attend Section Medical Directors meetings when called by the Division Chief or Chief Medical Officer.

7.10.3. Nominating Committee and Election of Section Medical Directors/Section Leaders.

7.10.3.1. Nominations will be made by either the members of the Section or the Medical Executive Committee. The candidate(s) will be approved by the section and ratified by the Medical Executive Committee by majority vote and be accepted by the Hospital's administration.

7.10.3.2. Nominations will initially be made by the Joint Operations Committee.

7.10.3.3. The candidate(s) will be approved by the section members by majority vote.

7.10.3.4. The approved candidate is accepted by the Medical Executive Committee and the Hospital's administration.

7.10.4. Term of Office

The Section Medical Director's term of office will be a renewable two-year term. This position will have an annual evaluation with input from the members of the Section and Hospital's administration.

7.10.5. Vacancies and Terminations

In the event of a vacancy, the matter will be referred to the Joint Operations Committee (JOC) to begin the process of the recruitment process for the vacated position. The JOC may, during the interim, appoint one of the section's members as an interim Section Medical Director until the recruitment and election process, described herein, has been completed.

7.10.6. Removal of Section Medical Director

Section Medical Directors may be subject to removal from their position. This may be based upon failure to perform the duties of the position held as outlined in the Medical Staff Bylaws, Policies, or job description or may be based on an unsatisfactory or incomplete annual review.

7.10.7. Compensation and Benefits

7.10.7.1. Division Chiefs will receive compensation for their services with funds derived from the hospital as well as in part from Medical Staff funds

7.10.7.2. Section Medical Directors will receive compensation for their services regarding Hospital operational issues with funds derived from the hospital via their medical director contract. These Section Medical Directors may also receive compensation for medical staff business as determined by the Medical Executive Committee.

ARTICLE 8: COMMITTTEES

Committees will be established by the Executive Committee to meet the responsibilities of the Medical Staff, and to carry out the functions, as assigned. The function and composition of each committee, as well as its rules and procedures, will be subject to review and approval by the Medical Executive Committee.

There shall be four standing committees of the Medical Staff: the Medical Executive Committee, the Credentials Committee, the Joint Operations Committee, and the Medical Staff Quality Review Committee. The Medical Executive Committee may create further standing and special committees.

Each Medical Staff Committee will be expected to report, in person or through another approved body, to the Executive Committee no less than annually.

8.1. Medical Executive Committee

8.1.1. Membership

The Medical Executive Committee shall consist of Medical Staff officers, Division Chiefs (or designated temporary alternates), the chairperson of the Credentials Committee and the chairperson of the Medical Staff Quality Review Committee. Non-voting members shall include the Hospital CEO or designee, the Chief Medical Officer, and representation from the Board and the Medical Staff Office. The President shall preside as chairperson, and vote only in case of tie.

8.1.2. Meetings

The Medical Executive Committee shall meet monthly, or as often as determined by the Chair, and maintain a record of its procedures and actions.

8.1.3. Duties and Responsibilities

The Medical Executive Committee shall provide liaison between the Medical Staff, the Administration and the Board. It shall, on a regular basis, approve the sources of patient care provided outside the hospital; and review and approve exclusive contracts. It shall discharge the duties and responsibilities specifically charged to it in these Medical Staff Bylaws and Policies. It shall further, via its individual members, transmit decisions to the clinical Divisions and Sections, committees, and sub-committees. It shall receive and review recommendations and actions from all Medical Staff committees, Divisions, and Sections and shall decide and initiate appropriate action. It shall be empowered to act for the Medical Staff in the intervals between General Medical Staff meetings. The ~~Steering~~ Medical Executive Committee is responsible for nominating candidates for President-Elect, Secretary-Treasurer, the Credentials Committee and the Quality Review Committee, and for filling any vacancies that occur.

8.2. Credentials Committee

8.2.1. Membership

The Credentials Committee shall consist of five voting members who are members of the Active Staff at the time of election, and one voting lay member appointed from the Board. The Chairperson shall be one of the voting members and be selected by the committee. Non-voting members shall include the Medical Staff officer(s), the Chief Medical Officer, the Chief Nursing Officer, Medical Staff Office representation, and/or an administrative representative(s), and Division Chiefs. In the event of a tie vote, the President of the Medical Staff will be permitted to cast the deciding vote.

8.2.2. Election

Annually, the Medical Executive Committee will submit the name of an eligible candidate for a five year term. Additional nominations may be submitted by Voting Staff Members. The latter nominations must be submitted with signatures of at least 5% of voting members of the Medical Staff. Additional nominations by Medical Staff Members must be submitted to the Medical Executive Committee at least one month prior to election.

Election shall be by a majority of the ballots cast of the members voting of the Medical Staff. The elected member(s) will take office on the first day of January following the election with other elected officers of the Medical Staff. In the event of a vacancy, the Medical Executive Committee will submit nomination(s). The election to fill the vacant office shall occur in a manner to be determined by the Medical Executive Committee and require a majority vote of the Active Staff voting. If there is only one nominee, the election may be declared by the Medical Executive Committee without a vote by the Active Staff.

8.2.3. Meetings

The Credentials Committee shall meet as often as necessary to discharge its responsibilities, and maintain a record of its procedures and actions. Recommendations shall be made, as appropriate, to the Board and/or the Medical Executive Committee.

8.2.4. Duties and Responsibilities

The Credentials Committee is responsible for the evaluation of Applicants for initial appointment

8.2.5. Reporting Accountability

Reports directly to the Medical Executive Committee

8.3. Medical Staff Quality Review Committee (MSQRC)

8.3.1. Membership

The MSQRC shall consist of five voting members who are members of the Active Staff at the time of election, and one voting lay member appointed from the Board. The Chairperson shall be one of the voting members and be selected by the committee. Non-voting members shall include the Medical Staff officer(s), the Chief Medical Officer and/or an administrative representative(s), the Chair of the Practitioner Well-Being Committee (as needed), the Division Chiefs, nursing leadership, Medical Staff Office representation, and a representative of Risk Management. In the event of a tie vote, the Medical Staff President will be permitted to cast the deciding vote.

8.3.2. Election

Annually the Medical Executive Committee will submit the name of an eligible candidate for a five-year term. Additional nominations may be submitted by Voting Staff Members. The latter nominations must be submitted with signatures of at least 5% of voting members of the Medical Staff. Additional nominations by Medical Staff Members must be submitted to the Medical Executive Committee at least one month prior to election. Election shall be by a majority of the ballots cast of the members voting of the Medical Staff. The elected member(s) will take office on the first day of January following the election with other elected officers of the Medical Staff. In the event of a vacancy, the Medical Executive Committee will submit nomination(s) to the medical staff for a vote. The election to fill the vacant office shall occur in a manner to be determined by the Medical Executive Committee and require a majority vote of the Active Staff voting. If there is only one nominee, the election may be declared by the Medical Executive Committee without a vote by the Active Staff

8.3.3. Meetings

The MSQRC shall meet as often as necessary to discharge its responsibilities, and maintain a record of its procedures and actions. Recommendations shall be made, as appropriate, to the Board and/or the Medical Executive Committee.

8.3.4. Duties and Responsibilities

8.3.4.1. The MSQRC will provide ongoing monitoring, evaluation and feedback regarding the quality of physician performance at the individual, Division and overall Medical Staff levels.

8.3.4.2. It will provide oversight for the peer review process by reviewing matters affecting the clinical competency and/or professional conduct of Medical practitioners and the quality of patient care rendered.

8.3.4.3. The MSQRC will review and make recommendations on an Annual Quality Plan that will identify key clinical, patient satisfaction and utilization indicators to be used in ongoing evaluation.

8.3.4.4. The MSQRC, with the Division Chiefs and Section Medical Directors, will develop, coordinate and provide oversight for individual physician quality issues.

8.3.4.5. The MSQRC may request quality assessment activity from other members of the Medical Staff, when appropriate.

8.3.4.6. The Chair, based on the MSQRC's activities and findings, will provide recommendations to the Medical Education Committee for appropriate medical education to Divisions, sections, or to the entire Medical Staff.

8.3.4.7. The Chair will be furnished with the medical staff quality files of those practitioners applying for reappointment, and will provide pertinent information from the peer review process to the Division Chiefs and Credentials Committee regarding the practitioner's reappointment to the medical staff.

8.3.4.8. The MSQRC, including its reports to Medical Executive Committee, shall be afforded the protections and immunities provided by RCW 4.24.250 and Chapter 300 of the 1986 laws of Washington State as now or hereafter amended. The files of the MSQRC shall be retained and destroyed subject to the Hospital's record retention policies and/or as approved by the Board and the Medical Executive Committee.

8.3.5. Reporting Accountability: Reports directly to the Executive Committee.

8.4. Medical Staff Bylaws Committee

8.4.1. Membership
The Medical Staff Secretary-Treasurer is the chair of this committee. Other members shall be appointed by the Secretary-Treasurer, with approval by the Medical Executive Committee.

8.4.2. Meetings shall occur at the discretion of the chair.

8.4.3. Duties and Responsibilities

8.4.3.1. The Bylaws Committee shall ensure that the Medical Staff Bylaws and the Policies appropriately and accurately reflect current Medical Staff practice, applicable legal requirements, and applicable standards of The Joint Commission and CMS.

8.4.3.2. The Bylaws Committee shall review the Medical Staff Bylaws and the Policies at least every 3 years and present its report to the Executive Committee.

8.4.3.3. The Bylaws Committee will draft amendments as directed by the Medical Executive Committee.

8.4.4. Reporting Accountability
The Bylaws committee will report at least annually to the Medical Executive Committee.

8.5. Medical Records

8.5.1. Membership
Representative members of the Medical Staff, including the Chair, which will be appointed by the President. Membership also includes representatives from the medical records department, compliance and/or accreditation, and patient services. The Chair shall be appointed by the President for a two-year term. Additional physicians may serve on the committee as Division Representatives.

8.5.2. Meetings
The Committee shall meet at least quarterly, or at the discretion of the chair, as appropriate to the Committee's function and responsibility.

8.5.3. Duties and Responsibilities are to approve policies and procedures used by the Medical Records Department, and to review records for timeliness and adequacy. Any issues which concern the

8.5.4. Reporting Accountability

The Committee will report at least quarterly to the Medical Executive Committee.

8.6. Practitioner Well-Being (PWBC)

8.6.1. Membership

This ad hoc Committee will consist of at least three members of the Medical Staff, appointed by the Medical Staff President, with one member being appointed as Chairperson by the President. The Chairperson is also an ad hoc member of the Medical Staff Quality Review Committee.

8.6.2. Meetings

Shall meet at the discretion of the Chair, as appropriate to the Committee's function and responsibilities.

8.6.3. Duties and Responsibilities

To investigate and evaluate all reports regarding possible impairment, due to mental, emotional, behavioral, or physical (including infection with blood-borne pathogen[s]) causes of a physician or non-physician Health Professional and to recommend and monitor appropriate courses of action. The PWBC has no independent authority regarding status or privileges.

8.6.4. Reporting Accountability

When indicated, any reports of this committee will be considered a part of the Medical Staff's Quality Review program, and therefore protected from discovery by RCW 4.24.250 and Chapter 300 of the 1986 Laws of Washington. The Committee shall keep and maintain separate records, reports, and proceedings, and the right to privacy for every practitioner shall be protected. Reporting requirements established by the National Practitioner Data Bank, the Washington State Disciplinary Board, and other legal entities shall be followed. Report, at least annually, non-practitioner-specific data.

8.7. Trauma Committee

8.7.1. Membership

The Chair will be appointed by the President for a two-year term. Committee members shall represent those specialties and divisions most involved with trauma. Hospital representation shall include administration, nursing, and other specialties such as pharmacy, nutrition, clergy and rehabilitation. Representatives from community agencies dealing with trauma (e.g. Emergency Medical Services) could also be included.

8.7.2. Meetings

Shall meet at least quarterly, or at the discretion of the Chair, as appropriate to the Committee's function and responsibilities.

8.7.3. Duties and Responsibilities

The committee shall oversee the planning and execution of trauma care at the Hospital, as directed through the standards set by the State of Washington and other regulating entities. It shall maintain liaison with the appropriate local, state and federal organizations; and shall work with Administration to maintain a comprehensive community-wide trauma program as outlined by State of Washington Code. It shall work with the Medical Education Committee to organize and present regular trauma conferences that are multidisciplinary, hospital-wide and case-oriented. It shall work with the Board Planning Committee to plan and implement the delivery of trauma care within the serviced area, and shall work with the Executive Committee to assess the level of trauma and follow-up services which are available in the community, and develop appropriate responses to identified deficiencies.

The committee may, as necessary, convene a quality improvement sub-committee to review studies of significant processes and outcomes. This sub-committee will report to the Quality Review Committee and be afforded the protections of RCW 4.24.250 and Chapter300 of the 1986

8.7.4. Reporting Accountability
The committee shall provide an annual report to the Executive Committee.

8.8. Joint Operations Committee

8.8.1. Membership
The President of the Medical Staff will be the Chair of this Committee. The Committee members include representatives from the Hospital's administration and Board of Directors, the Division Chiefs, and the elected Medical Staff Officers.

8.8.2. Meetings
The meetings will be held monthly, or at the discretion of the Chair.

8.8.3. Duties and Responsibilities
This is a collaborative committee of the Hospital and medical staff whose function is to develop and institute the Hospital's operational strategy and give recommendations to appropriate governing bodies, hospital administration and medical staff leadership

ARTICLE 9: MEETINGS

9.1. General Medical Staff Meetings
At least one meeting of the full Medical Staff shall be held each calendar year. Additional meetings of the Medical Staff may be held at times and intervals specified by the Medical Executive Committee in accordance with these Medical Staff Bylaws and Policies.

9.2. Special meetings of the Medical Staff
May be called at any time by the President or by petition of 5% of the Voting Staff. The agenda of the Medical Staff meetings will be prepared by the Medical Executive Committee. On matters submitted for vote, election will be done by ballot in a manner determined by the Medical Executive Committee. Only members of the Voting Staff will be permitted to vote. Minutes of meetings of the Medical Staff shall be maintained. Election shall be by a majority of the ballots cast of the members voting of the Medical Staff.

9.3. Division, Section and Committee Meetings
The schedule and notice of meetings, agenda, and functions of Divisions, sections, and committee meetings shall be in accordance with these Medical Staff Bylaws and Policies.

A quorum to conduct business and set policy within each division, section, or committee will be determined by each division, section, or committee and shall be in accordance with medical staff Medical Staff Bylaws, rules and regulations and medical staff policies.

ARTICLE 10: PHYSICIAN ORDERS

10.1. All orders for treatment shall be in writing or electronic order entry and must be authenticated in accordance with Washington State law. Authentication includes the practitioner's signature, date, time and physician number or electronic authentication. Written orders shall be authenticated at the time of entry.

10.2. Verbal and Telephone Orders

10.2.1. Verbal orders shall only be used in emergency or unusual circumstances and are not acceptable when the practitioner is present and able to write the order. Verbal or telephone orders shall not be given for chemotherapy.

10.2.2. Verbal and telephone orders shall be documented within the medical record and shall include the name of the licensed practitioner and shall be signed, dated and timed within 48 hours by a practitioner responsible for the care of the patient

10.2.3. All verbal and telephone orders require the person accepting the order to write the order and then read it back to the ordering practitioner. The ordering practitioner must state his/her physician number for identification purposes and acknowledge the accuracy of the read-back order before the order will be accepted.

10.3. All orders prior to surgery or other invasive procedure performed in a dedicated operative or procedural room will be canceled at the time the surgery or procedure is finished. The intent is to cancel all orders for procedures that involve the physical movement and transfer of care of the patient from one section of the Hospital to another (i.e. from inpatient floor to operating room, cardiovascular lab, or interventional radiology procedural suite). It is not the intent to cancel orders for invasive procedures done at the bedside (central venous catheters, emergency intubation, lumbar punctures, thoracostomy tubes at the bedside, etc.).

10.4. Only practitioners holding a currently valid DEA Controlled Substances Registration Certificate may write orders for narcotics or drugs classified in the DEA Controlled Substances Category. If available, Medical Residents may utilize an institutional DEA license when prescribing within the hospital.

10.5. The Pharmacy and Therapeutics Committee may enact time limitations for specific open-ended medication orders. The dispensing pharmacist will immediately rewrite the medication order with the time limitation to provide written notification to the prescribing practitioner.

10.6. Abbreviations and chemical symbols used in order writing must appear on a list approved by the Executive Committee of the Medical Staff. Any abbreviations, acronyms, and symbols noted on the "prohibited list" shall not be used in order writing. Both a record of approved and prohibited symbols and abbreviations shall be kept on file in the Medical Records department.

10.7. Drug names shall not be abbreviated in order writing. Orders shall not be written with a zero after the decimal point of whole numbers (such as 1.0). Orders shall always be written with a zero before decimal doses (such as 0.5).

10.8. In order for patients to receive or self-administer medication not issued by the hospital pharmacy, its identity must first be verified by the pharmacy, its container labeled with the name and strength of the drug and an order for same (including name, strength, route, and frequency of administration) must be written by a practitioner. A patient's medications not issued by the hospital pharmacy shall be returned to him at the time of discharge, unless otherwise directed by the practitioner.

10.9. All preprinted orders require approval by appropriate hospital and Medical Staff committees prior to use.

10.10. Use of any non Federal Drug Administration (FDA) approved drug or medical device or the collection of any patient information for the purposes of investigative studies requires approval by an Institutional Review Board listed on PRMCE's Federal Wide Assurance (FWA) and approved by PRMCE's internal oversight committee, TeCRA (Technology and Clinical Research Assessment Committee) prior to use or collection of data. The investigator will comply with all policies issued by the Institutional Review Board. The investigator will surrender all medications and devices to the Pharmacy and Biomedical Departments for proper control and certification prior to use.

10.11. Orders for restraints shall be per hospital policy.

ARTICLE 11: MEDICAL RECORDS

11.1. The content of the medical record, which includes written and electronic documents, must be sufficiently detailed, legible, and organized to enable the practitioner responsible for the patient to identify the patient, provide continuing care, determine the patient's condition at a specific time, review the diagnosis and therapeutic procedures performed and the patient's response to treatment; a consultant to render an opinion after a patient examination and review of the medical record; another practitioner to assume patient care at any time; and the retrieval of information required for utilization review, quality review and transfer recommendations.

11.2. History and Physical Assessment

11.2.1. The admitting/attending practitioner is responsible for completion of the history and physical assessment. Non-physician members not holding privileges for history and physicals are responsible for the portion of the history and physical related to their area of expertise. An assessment conducted by a practitioner with appropriate privileges participating in the care of the patient other than the admitting/attending practitioner, and containing all required elements is acceptable; i.e. ED physician, consulting physician, surgeon.

A written or dictated (and accessible) history and physical is required for all inpatients within 24 hours of admission and prior to any Category I (operative or other high risk) procedure. If a history and physical is done by a member of the medical staff within thirty (30) calendar days prior to admission or date of the procedure, a durable, legible copy of this report may be used in the patient's medical record, provided that, at the time of admission, a licensed independent practitioner with appropriate privileges:

11.2.1.1. Reviews the history and physical assessment documents

11.2.1.2. Conducts a second assessment to confirm the information and findings;

11.2.1.3. Updates any information and findings, as necessary, including a summary of the patient's condition and course of care during the interim period, and the current physical/psychosocial status; and

11.2.1.4. Signs, dates, and times the information as an attestation to it being current.

11.2.2. An abbreviated assessment is acceptable for Outpatient Category I (operative or other high risk) procedures. An abbreviated assessment shall include the chief complaint, history of present illness, physical examination specific to the proposed procedure with heart and lungs by auscultation, current medications, allergies, and impression with approach to treatment.

In an emergency, a written progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis recorded before surgery will suffice.

A prenatal record, updated throughout the course of pregnancy, may be utilized as the history and physical for obstetric patients, provided it is updated to reflect the patient's condition upon admission.

11.3. Invasive Procedure Categories

11.3.1. Category I: Operative or other high-risk procedure

11.3.1.1. This category contains any high-risk procedure and/or any procedure that may involve moderate, deep, general, or regional anesthesia and may cause a lack of protective reflexes requiring extended pre-or post-procedure monitoring. Protective reflexes are defined as the ability to maintain a patent airway and to clear the airway of occlusions such as secretions or emesis without aspiration, and the ability to maintain spontaneous and effective ventilation effort.

11.3.1.2. Procedures such as the following are included in this category:
Any procedure with sedation, percutaneous visceral aspirations or biopsies (excludes skin, bone marrow, muscle, breast, thyroid, paracentesis, thoracentesis, lymph nodes, etc), gastrostomy placements, cardiac and vascular catheterizations, angioplasties, discograms, dilatation and curettage, diagnostic imaging exams and procedures with IV sedation, endoscopies, and implantations.
(editorial note: omits myelograms, fistulograms)

11.3.1.3. Category I procedures require, at a minimum, an abbreviated assessment/history and physical assessment and post-procedure or post-operative note and appropriate discharge documentation.

11.3.2. Category II: Non-operative and other low-risk procedures

11.3.2.1. This category contains any low risk procedure involving light (anxiolysis) or no sedation where protective reflexes are expected to remain unchanged, no amnesia experienced, and pain or anxiety is reduced.

11.3.2.2. Procedures such as the following are included in this category: diagnostic imaging without IV sedation, lumbar punctures, amniocentesis, arthrography, sinograms, voiding cystourethrogram, paracentesis, thoracentesis, PICC placement, and injections.

11.3.2.3. Category II procedures require, at a minimum, a procedural note. A radiology imaging report or result in the chart suffices.

11.4. Informed Consent

11.4.1. The general consent signed by a patient, or his/her representative, on admission to the Hospital does not constitute informed consent. Informed consent must be obtained prior to any invasive and/or operative procedure.

11.4.2. A practitioner performing invasive procedures is responsible for the informed consent process. Informed consent is required for all invasive procedures performed under non-emergent conditions. Invasive procedures are defined as any procedure involving puncture or incision of the skin or insertion of an instrument of foreign material into the body, including, but not limited to: percutaneous aspirations and biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations. Excluded are minimally invasive procedures such as venipunctures, placement of Foley catheters, nasogastric tubes, and peripheral IV lines.

11.4.3. Informed consent must contain a discussion of the risks, benefits, and alternatives of the invasive and/or operative procedure. Evidence of discussion of informed consent must be documented in the medical record. Informed consent includes the name of the condition under treatment, proposed operation/procedure; risk, benefits, and alternatives of such. When informed consent cannot be obtained in an emergency situation, the physician shall document the evidence supporting the emergent need for the procedure.

11.4.4. Following the informed consent discussion and prior to an operation or invasive procedure, patient or legal representative signature on a procedural consent should be obtained.

11.5. Operative Report.

11.5.1. Operative reports shall be dictated as soon as possible and no later than 72 hours after Category I procedure, by the primary surgeon or practitioner performing the procedure.

11.5.2. Uncomplicated vaginal deliveries and Category II procedures require either a dictated operative report or a brief procedure note.

11.5.3. All Category I and Category II procedures require a procedure note immediately after the procedure and placed in the chart before the patient is transferred to the next level of care.

11.5.4. At a minimum, all operative notes shall include the name of the primary surgeon and assistants, findings, procedures performed with description of each, estimated blood loss as indicated, description of the findings, specimens removed (if applicable) and postoperative diagnosis (JC Standard RC.02.01.03, 2009)

11.5.5. Helpful hints
Invasive Procedure = needs informed and procedural consent
Operative & Other High Risk Procedure = H&P required PLUS a dictated AND written post procedure note.

11.6. Consultation Reports

11.6.1. A consultation report may be submitted by the practitioner who is privileged in the field in which the opinion is sought. The consultation report shall show evidence of review of the patient's existing record, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. The consultation report will be made a part of the patient record, and may be utilized as a history and physical provided the report contains all the required elements.

11.7. Discharge Documentation

11.7.1. Discharge summaries shall be dictated by the attending/discharging practitioner at discharge for all inpatients discharged by the physician greater than 48 hours after admission, and for all expired inpatients or transfer patients.

11.7.2. Dictated discharge summaries shall include the reason for hospitalization; significant findings/hospital course; principal diagnosis and all relevant diagnoses established during the course of care; procedures performed and treatment rendered; patient's condition at discharge; and instructions to the patient and caregiver, if any.

11.7.3. An electronically generated discharge summary, hand-written note or use of the Day of Discharge form may be utilized for the following:

11.7.3.1. Newborns with uncomplicated deliveries or hospitalized for greater than 48 hours due to maternal conditions

11.7.3.2. Uncomplicated obstetrical patients with vaginal deliveries hospitalized for less than 48 hours in the postpartum stay or cesarean deliveries hospitalized for less than 72 hours

11.7.3.3. Patients undergoing Category 1 outpatient invasive procedures

11.7.3.4. Or for patients hospitalized for less than 48 hours with only minor problems, provided it documents the patient's condition at discharge, discharge instructions and required follow-up care, if applicable.

11.7.4. For transfers of patients from acute to sub-acute level of care within PRMCE and the caregivers change, a transfer summary indicating the patient's condition at the time of transfer and the reason for the transfer is required. When the caregivers remain the same, a progress note may suffice.

11.8. Progress Notes

11.8.1. Progress notes shall be documented by practitioners, including members of the Medical Staff, participating in the care and treatment of the patient. Progress notes shall give a pertinent daily chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment.

11.8.2. Emergency Department records must include the following: patient identification (if not available, the reason should be documented in the chart); pertinent history of illness or injury and physical findings, including the patient's vital signs; summary of emergency care given to the patient prior to arrival; diagnostic and therapeutic orders; clinical observations, including the results of treatment; reports of procedures, tests and results; diagnostic impression; conclusion at the termination of evaluation/treatment; final disposition; the patient's condition on discharge or transfer; and instructions to the patient/caregiver for follow-up care.

11.8.3. In the event of transfer to another facility, the following information will be documented in the medical record: the name of the receiving facility; the stability of the patient; the risks, benefits and alternatives of the transfer; the name of the person responsible for the patient during the transfer; name of the receiving practitioner; consent to the transfer; and pertinent medical information which will accompany the patient.

11.9. Anesthesia Record

11.9.1. Pre-Anesthesia Evaluation
A pre-anesthesia evaluation must be completed and documented for each patient who receives general, regional, or monitored anesthesia. A pre-anesthesia evaluation is not required for moderate sedation because it is not considered to be anesthesia. [482.52(b)(1)]

11.9.1.1. The evaluation must be performed by an individual with the privilege to administer anesthesia within PRMCE, and may not be delegated to an individual without such privileges.

11.9.1.2. The pre-anesthesia evaluation must be completed and documented within 48 hours immediately prior to the first dose of medication(s) for the purpose of inducing anesthesia associated with any procedure requiring anesthesia. The pre-anesthesia evaluation of the patient includes, at a minimum:

11.9.1.2.1. Review the medical history, including anesthesia, drug and allergy history

11.9.1.2.2. Interview and examination of the patient

11.9.1.2.3. The following elements of the pre-anesthesia evaluation must be reviewed and updated as necessary within 48 hours, which may also have been performed within 30 days prior to the 48-hour time period:

11.9.1.2.3.1. Notation of anesthesia risk according to established standards of practice (e.g., ASA classification of risk).

11.9.1.2.3.2. Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);

11.9.1.2.3.3. Additional pre-anesthesia data or information, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation);

11.9.1.2.3.4. Development of the plan for the patient's anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or patients representative) of the risks and benefits of the delivery of anesthesia.

11.9.2. Intraoperative Anesthesia Record
An Intraooperative anesthesia record or report for each patient who receives general, regional, or monitored anesthesia, including deep sedation, shall include, at a minimum, [482.52(b)(1)]: Name and hospital identification number of the patient;

11.9.2.1. Name(s) of practitioner(s) who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist or operating practitioner

11.9.2.2. Name, dosage, route and time of administration of drugs and anesthesia agents; Technique(s) used and patient position(s), including the insertion/use of any intravascular or airway devices;

11.9.2.3. Name and amounts of IV fluids, including blood or blood products if applicable; Timed-based documentation of vital signs as well as oxygenation and ventilation parameters; and

11.9.2.4. Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

11.9.3. Post Anesthesia Evaluation
An Intraoperative anesthesia record or report for each patient who receives general, regional, or monitored anesthesia, including deep sedation, shall include, at a minimum, [482.52(b)(1)]:

11.9.3.1. The post-anesthesia evaluation must be performed by an individual with the privilege to administer anesthesia within PRMCE, and may not be delegated to an individual without such privileges.

11.9.3.2. The post-anesthesia evaluation must be completed within 48 hours following the completion of the surgery or procedure that required anesthesia services.

11.9.3.3. The calculation of the 48-hour time frame begins at the point the patient is moved into the designated recovery area.

11.9.3.4. The evaluation may occur in the PACU, Critical Care, or other designated recovery location. However, the evaluation should not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation. The evaluation may occur in the PACU, Critical Care, or other designated recovery location.

11.9.3.5. The evaluation should be clearly documented and conform to current standards of anesthesia care, including at a minimum:

11.9.3.5.1. Respiratory function, including respiratory rate, airway patency, and oxygen saturation;

11.9.3.5.2. Cardiovascular function, including pulse rate and blood pressure;

11.9.3.5.3. Mental status;

11.9.3.5.4. Temperature;

11.9.3.5.5. Pain;

11.9.3.5.6. Nausea and vomiting; and

11.9.3.5.7. Postoperative hydration.

11.10. Timeliness Requirements and Incomplete Medical Record Process.

11.10.1. Medical Records personnel will review charts for completeness. If at the time of review, a chart does not contain the elements required in these rules and regulations, the deficiencies will be recorded and the practitioner(s) will be notified. The record must be complete within 14 days of notification of the practitioner.

11.10.2. A chart lacking the following items shall be considered incomplete: history and physical; consultation reports; operative report(s); discharge summary/documentation.

11.10.3. Written entries in the medical record must be timed, dated, include the physician's ID number and authenticated by the responsible practitioner by signature or initials at the time of entry.

11.10.4. A stamped physician or practitioner signature is not acceptable

11.10.5. Electronic signature authentication shall be acceptable for electronic records.

11.10.6. Practitioners will be expected to review the patient's orders that are written within the previous 24 hours.

1 11.10.7. It is expected that a practitioner responsible for the care of the patient will have the
2 knowledge of the patient's hospital course, medical plan of care, condition and current status;
3 therefore, it is expected that the covering practitioner will 'cosign' (as noted in 8.3.2.1) any
4 unsigned order unless the order is clearly inappropriate.

5 11.10.8. A record lacking the required documentation will be marked incomplete by the Medical
6 Records Department and the physician will be notified. An initial Notification of Incomplete
7 Medical Records will be sent to the practitioner. Seven (7) days after the date of the initial
8 notification, a second notice will be sent to the practitioner warning that he/she will be placed
9 on probation if the chart(s) is not completed within one additional week, or seven (7) days.

10 11.10.9. If the record remains incomplete for a total of 28 days (14 days after the date of initial
11 notification), it will be considered overdue and the practitioner will be notified by special
12 notice that he/she is being placed on probationary status for one year.

13 11.10.9.1. When the overdue charts have been completed and the practitioner has
14 completed his/her probationary period, he/she will be automatically
15 reinstated with full privileges.

16 11.10.9.2. If a subsequent incident occurs within the probationary period, the practitioner
17 will be referred to the Credentials Committee who will have the latitude to
18 recommend disciplinary action.

19 11.10.9.3. The care of current inpatients of the practitioner must be arranged through the
20 Division Chief or designee of the appropriate Medical Staff Division.

21 11.10.10. Practitioners with (5) occurrences of charts lacking valid History and Physicals within a twelve-
22 month period without remediation within the 28-day period above (8.3.4), will be notified by
23 special notice that he/she is being placed on probationary status for one year. Charts lacking
24 History and Physicals include charts without any H&P or with an outdated (over 30 calendar
25 days) H&P.

26 11.10.10.1. If a subsequent incident of two (2) more occurrences of charts lacking History
27 and Physicals within the probationary period, the practitioner will be referred
28 to the Credentials Committee who may recommend disciplinary action.

29 11.10.10.2. The care of current inpatients of the practitioner must be arranged through the
30 Division Chief or designee of the appropriate Medical Staff Division

31 11.10.11. Refusal to accept and/or pick up Special Notice or Certified letter shall constitute receipt.

32 11.10.12. Practitioners on vacation, ill, or attending a professional seminar shall notify the Medical
33 Records Department of the specific time period they will be absent. The practitioner will be
34 required to complete his/her overdue medical records upon return to practice to avoid
35 probationary action.]

36 11.10.13. The above requirements may be waived in cases in which the chart deficiencies are judged by
37 the Chair of the Medical Records Committee to be trivial in nature. Only the Chair may make
38 this determination. A practitioner with a pattern of minor deficiencies in chart completion will
39 be identified statistically to the Medical Records Committee, notified in writing and identified
40 to the appropriate Division Chief. If the pattern persists, the Chair of the Medical Records
41 Committee may refer the issue to the Credentials Committee for corrective action.

42 11.10.14. Incomplete medical records will be considered delinquent and will be included in the Chart
43 Delinquency Rate as calculated for The Joint Commission, if not completed within thirty (30)
44 days of discharge.

45 11.11. Other

46 11.11.1. A pre-anesthesia evaluation should be documented for each patient undergoing anesthesia.
47 Just prior to the induction of anesthesia, a reassessment should be done and the results of the

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5 **11.11.2.** A practitioner who has appropriate clinical privileges and who is familiar with the patient, is
6 responsible for the decision to discharge a patient from a post-anesthesia recovery unit, based
7 on direct assessment or criteria established and approved by the Medical Staff (i.e., Aldrete
8 score).

9 **11.11.3.** All clinical entries in the patient's record shall be authenticated. Written entries in the
10 medical record must be timed, dated, include the practitioner's ID number, and authenticated
11 by the responsible practitioner by signature or initials at the time of entry.

12 **11.11.3.1.** A stamped physician or practitioner signature is not acceptable.

13 **11.11.3.2.** Electronic signature authentication shall be acceptable for electronic records.

14 **11.11.3.3.** Practitioners will be expected to review the patient's orders that are written within
15 the previous 24 hours.

16 **11.11.3.4.** It is expected that a practitioner responsible for the care of the patient will have
17 the knowledge of the patient's hospital course, medical plan of care, condition
18 and current status; therefore, it is expected that the covering practitioner will 'co-
19 sign' (as noted in 8.4.3) any unsigned order unless the order is clearly
20 inappropriate.

21 **11.11.3.5.** The practitioner is responsible for the content and shall notify Medical Records of
22 any changes within seven (7) days.

23 **11.11.4.** An addendum may be incorporated into a medical record at the discretion of the responsible
24 practitioner and shall include the following:
25 Present date
26 Reason for addendum
27 Documentation of diagnosis or procedure changes or further relevant follow-up
28 Signature of the practitioner

29 **11.11.5.** Symbols and abbreviations may be used only when they have been approved by the Medical
30 Records Committee or their designee. Any abbreviations, acronyms and symbols noted on the
31 "prohibited list" shall not be used in the medical record. Both a record of approved and
32 prohibited symbols and abbreviations shall be kept on file in the Medical Records department.

33 **11.11.6.** Access to a patient's medical record is limited to practitioners who are involved in the care of
34 the patient and/or review of care provided, hospital employees involved in the current care of
35 the patient, and appropriate Allied Health personnel. Unobstructed access to medical records
36 shall be given to members of the Medical Staff and hospital staff for bona fide research and
37 study consistent with preserving confidentiality, and subject to the conditions imposed by the
38 Hospital policy(s) regarding clinical research.

39 **11.11.7.** Preliminary report of gross autopsy findings must be provided within (2) working days from
40 the date of the autopsy. Final autopsy reports should be available no later than (60) days
41 after the death. Allowance may be needed if portions of a case are referred for external
42 consultation, and completion of the case is dependent upon information from those
43 consultants.

44 **11.11.8.** Each practitioner involved in the management of a cardiac or respiratory arrest Code Blue
45 shall dictate or write a note within 24 hours of the event, documenting his/her actions,
46 including medications or procedures ordered or performed. The Code Blue record may be
47 used to verify dictation.

1 11.11.9. The Medical Staff shall not include derogatory or inflammatory comments directed towards
2 patients, hospital staff, medical staff, policies, or care provided by others in the medical
3 record.

4 **ARTICLE 12: CONSULTATION**

5 12.1. Any practitioner with privileges in the Hospital may be called upon for consultation within his/her area of
6 privileges as sanctioned by the respective Division and the Credentials Committee.

7 12.2. Consultants are required to provide consultation when requested without exception, or to arrange an
8 alternative consultant.

9 12.3. The response time for consultation will be determined by the requesting physician. It is expected that the
10 requesting physician will communicate the response time to the consultant at the time of the request.

11 12.4. Consultation requests are customarily initiated by the attending practitioner.

12 12.5. In unusual circumstances, however, the Chief or the Chief's designee of the practitioner's Division and/or
13 section after satisfying him/herself that a patient needs consultation and, after failing in an attempt to
14 convince the attending practitioner that such is indicated, may him/herself order consultation for the
15 patient in question.

16 12.6. Consults ordered through HUC's (Health Care Unit Coordinators), or nursing staff will not be recognized,
17 except if the situation is emergent, or a routine procedure is requested.

18 12.7. Emergencies excepted, consultation is recommended when:

19 12.7.1. The diagnosis is obscure,

20 12.7.2. A questions exists as to whether or not a specific surgical procedure or proposed method of
21 therapy is appropriate, or

22 12.7.3. The patient has failed to respond to therapeutic measures over an extended period of time.

23 12.8. Physicians with ICU admitting privileges that are not critical care board certified will be able to admit
24 patients to the ICU but will require a mandatory critical care consult. This patient population includes
25 surgical patients as well as medical subspecialty patients. ICU patients will remain under the primary
26 care of their admitting physicians while Intensivists actively co-manage their care.

27 12.8.1. Patients admitted to the ICU require a consult by an intensivist. The intensivist will co-manage
28 the care of the patient with the attending physician.

29 12.8.2. The intensivist providing the consultation is defined as:

30 12.8.2.1. Board certified physicians who are additionally certified in the subspecialty of critical
31 care medicine, or…

32 12.8.2.2. Physicians board certified in emergency medicine that have completed a critical care
33 fellowship in an ACEP accredited program, or…

34 12.8.2.3. Physicians board certified in Medicine, Anesthesiology, Pediatrics or Surgery who
35 completed training prior to availability of subspecialty certification in critical care and
36 have provided at least six weeks of full-time ICU care annually since 1987, or…

37 12.8.2.4. Neuro-intensivists are an approved alternative to intensivists in providing care in
38 neuro-ICU's.

39 12.8.3. Board certified cardiologists and cardiothoracic surgeons who admit patients to the ICU and
40 who are caring for patients with specific cardiac diagnosis or procedures do not require an
41 intensivist consult.

42 **ARTICLE 13: PROFESSIONAL SERVICES**

13.1. Laboratory/Pathology

13.1.1. No laboratory tests are done routinely on admission unless dictated otherwise by specific nursing unit policies or standing orders.

13.1.2. Blood may be administered only by the written order of a qualified medical staff member. The anesthesia graphic record, with evidence of blood administration and signed by the responsible anesthesiologist, will suffice for patients transfused in the operating room. Pre- and post-transfusion hemoglobins/hematocrits should be done.

13.1.3. Tissues and foreign bodies removed shall ordinarily be sent to the department of Pathology for examination. A written report by a medical staff pathologist will be made a part of the patient's medical record.

13.1.4. Exemptions from the requirement that specimens removed are to be examined by a pathologist may be made, but only when the quality of care is not compromised by the exemption, when another suitable means of verification of the removal has been routinely used, and when a procedure note documents the removal. Categories of specimens that may be exempted are included in the Medical Staff Policies.

13.1.5. Authority for the performance of autopsies will be in accordance with the laws of the State of Washington. All autopsies shall be performed by a medical staff pathologist or by a physician he/she designates. The completed autopsy report is to be included in the patient record within sixty (60) days unless exceptions for special studies are established by the Medical Staff.

13.2. Medical Imaging

13.2.1. Orders for medical imaging examinations must include the reason the study is being performed.

13.2.2. Use of radiation-producing devices and materials will be monitored by the Radiation Safety Committee.

13.2.3. Invasive medical imaging studies must be ordered by a member of the medical staff. Outpatient medical imaging studies requested by nonmembers of the medical staff will be dealt with through Hospital policy.

13.2.4. Invasive imaging studies requiring the injection of contrast material into the arteries of the head or heart must have prior consultation by the appropriate specialty (e.g. Neurology, Neurosurgery, Cardiology, and Vascular Surgery) before the exam is performed.

ARTICLE 14: TRAUMA SERVICES

14.1. As part of their duty to provide backup to the Hospital Emergency Department, members of the medical staff will be responsible for the care of trauma patients. The schedule of specialists/sub-specialists for unassigned patients will be used for assignment of trauma patients who present to the Emergency Department.

14.2. Physicians on call for general surgery are expected to come to the Hospital within 30 minutes of a call notifying them of Trauma Activation. The only exception is in the case of an isolated head injury when only neurosurgical treatment is required. Other physicians whose services are determined necessary will be expected to come to the Hospital within 30 minutes of a call requesting their services.

14.3. Physicians expected to respond within 30 minutes will arrange for back-up if they become involved in a case that will prevent a timely response to a call for trauma services. If unable to arrange back-up coverage, they will notify the Emergency Department of their unavailability.

1 **ARTICLE 15: ANESTHESIA SERVICES**

2 **15.1.** The Department of Anesthesiology shall include members of the medical staff who have successfully
3 completed a training program recognized by the American Board of Anesthesiology or the American
4 Association of Nurse Anesthetists (AANA). Each anesthesiologist or nurse anesthetist who provides
5 anesthesia services may do so only after requesting and being permitted privileges as outlined in the
6 Medical Staff Bylaws. Anesthesiologists and Nurse Anesthetists are licensed independent practitioners
7 who have been granted independent practice privileges within the Hospital and are organized under one
8 department with a clearly defined leadership structure led by the section medical Directors(s). Active
9 Staff members shall be assigned by the Section Medical Directors(s) or designee on a daily basis to share
10 in the care of all surgical and obstetrical patients, and provide consultations when requested. The exact
11 duties of each clinician shall be determined by the Section Medical Director(s) or their designee within
12 the guidelines established by the Credentials Committee.

13 **15.2.** CMS Conditions of Participation require that Anesthesia Services throughout the hospital are organized
14 into one anesthesia service, under the direction of the Director(s) of Anesthesia Services(§482.52). The
15 Director(s) must be a qualified doctor of medicine (MD) or doctor of osteopathy (DO) who is a board
16 certified Anesthesiologist. (§482.52). Such anesthesia services are divided into two categories;
17 anesthesia and Analgesia/Sedation. The definitions of these categories are included in the CMS
18 Clarification of the Interpretive Guidelines for the Anesthesia Services Condition of Participation
19 (§482.52).

20 **15.3.** "Anesthesia", specifically includes(§482.52):

21 **15.3.1.** General anesthesia.

22 **15.3.2.** Regional anesthesia.

23 **15.3.3.** Monitored anesthesia care (MAC).

24 **15.3.4.** Deep sedation/analgesia is included in MAC. An example of deep sedation would be a
25 screening colonoscopy when there is a decision to use propofol.

26 **15.4.** General anesthesia, regional anesthesia and monitored anesthesia, including deep sedation/analgesia,
27 may only be administered by (§482.52(a)):

28 **15.4.1.** A qualified and privileged anesthesiologist

29 **15.4.2.** An qualified and privileged MD or DO (other than an anesthesiologist);

30 **15.4.3.** A dentist, oral surgeon or podiatrist who is qualified and privileged to administer anesthesia
31 under State law

32 **15.4.4.** A qualified and privileged CRNA

33 **15.5.** Clinical privileges in anesthesiology are granted to physicians and other providers qualified to administer
34 anesthesia who are qualified by training to render patients insensible to pain and to minimize stress
35 during surgical, obstetrical, and certain medical procedures.

36 **15.6.** Anesthesia Administration by a Physician (as defined by CMS)
37 The Hospital's anesthesia services policies address the circumstances under which an MD or DO who is
38 not an anesthesiologist, a dentist, oral surgeon or podiatrist is permitted to administer anesthesia. In the
39 case of a dentist, oral surgeon or podiatrist, administration of anesthesia must be permissible under
40 State law and comply with all State requirements concerning qualifications. Generally accepted
41 standards of anesthesia care govern the Hospital's policies regarding administration of anesthesia by
42 these types of practitioners as well as MDs or DOs who are not anesthesiologists. (§482.52(a))

43 **15.7.** "Sedation/analgesia", specifically includes (§482.52):

44 **15.7.1.** Topical or local anesthesia

45 **15.7.2.** Minimal sedation

15.7.3. Moderate sedation/analgesia ("Conscious Sedation")

15.8. Who May Administer Topical/local anesthetics, Minimal sedation, Moderate sedation:
The requirements above concerning who may administer anesthesia do not apply to the administration of topical or local anesthetics, minimal sedation, or moderate sedation. However, they must be given by appropriately trained medical professionals within their scope of practice. The Hospital has policies and procedures, consistent with State scope of practice law, governing the provision of these types of anesthesia services. Hospital must assure that all anesthesia services are provided in a safe, well-organized manner by qualified personnel. (§482.52(a).

15.9. Clinical privileges are also granted to practitioners who are not anesthesia professionals to administer sedative and analgesic drugs to establish a level of moderate or minimal sedation.

15.10. Rescue Capacity
Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, hospitals must ensure that procedures are in place to rescue patients whose level of sedation becomes deeper than initially intended, for example, patients who inadvertently enter a state of Deep Sedation/Analgesia when moderate sedation was intended. "Rescue" from a deeper level of sedation than intended requires an intervention by a practitioner with expertise in airway management and advanced life support. The qualified practitioner corrects adverse physiologic consequences of the deeper than intended level of sedation and returns the patient to the originally intended level of sedation. (§482.52). Individuals administering Moderate Sedation/Analgesia should be able to rescue patients who enter a state of Deep Sedation/Analgesia, while those administering Deep Sedation/Analgesia should be able to rescue patients who enter a state of General Anesthesia.

15.11. Anesthesia Quality Assessment & Performance Improvement
Anesthesia Services involves multiple hospital departments and services to focus on indicators related to improve health outcomes and the prevention and reduction of medical errors, track quality indicators, including adverse patient events, use[s] the data collected to monitor the effectiveness and safety of the services and quality of care and take[s] actions aimed at performance improvement.

ARTICLE 16: BACKUP COVERAGE FOR UNASSIGNED PATIENTS

16.1. All physician members of the Medical Staff are required to provide backup for unassigned patients, with the following exceptions:

16.1.1. Physicians with thirty (30) years of practice in the Hospital or over sixty (60) years of age may be excused from mandatory backup coverage for unassigned patients.

16.1.2. Physicians employed as full-time hospitalists or solely employed in an urgent care clinic will be excused from outpatient follow-up

16.1.3. The Executive Committee may grant exemptions to this obligation based on the following or other voted upon criteria:

16.1.3.1. A Division Chief may request of the Medical Executive Committee that a physician be excused when the Chief is of the opinion, based upon facts submitted with the request, that the assignment of such services to the Practitioner would impose an undue burden in light of extenuating personal or professional circumstances.

16.1.3.2. Physicians with no office practices in Snohomish County may be granted exemptions.

16.1.3.3. Members of the Honorary or consultative staff categories will be excluded from backup for unassigned patients. When requested, all other members of the medical staff will provide consultation in their specialty area.

16.2. There will be both primary care and subspecialty backup lists. All practitioners are required to provide backup coverage for those areas in which they have privileges. The Medical Executive Committee

16.2.1. Primary care.

16.2.1.1. The primary care backup list will be generated from the members of the Medical Staff who are practicing general Internal Medicine or Family Practice. This list will serve as the list for those patients who do not have a primary care practitioner on PRMCE's Medical Staff.

16.2.1.2. Physicians who wish to sign up in advance may do so during the designated signup period, which may begin 60-90 days prior to the six month period. The backup schedule will be developed for each six month period, and distributed to all physicians on the schedule. Changes to the monthly schedules may be made by agreement between affected physicians and notification to the Medical Staff Office.

16.2.1.3. Primary care physicians may refer unassigned patients requiring inpatient care to the Hospitalist program. Primary care physicians are responsible for notification to the Medical Staff Office and to the Hospitalist team of the intent to refer unassigned patients to the Hospitalist program.

16.2.2. Specialty/Subspecialty Care.

16.2.2.1. Call schedules of specialists/sub-specialists will be generated for each of the following Divisions: Medicine, Surgery, Women and Children's Services (sections of OB/GYN and inpatient Pediatrics), and Ambulatory Medicine. These schedules will serve as the call schedules for patients who have not previously been assigned to a specialist/sub-specialist.

16.2.2.2. The specialty/subspecialty call schedules may be developed by each specialty/subspecialty and forwarded to the Medical Staff office two weeks prior to the schedule month. If a backup schedule is not received in the Medical Staff office by one week prior to the schedule month, a schedule will be developed for that specialty/subspecialty by the Medical Staff office, using a rotation system.

16.3. Responsibilities of physicians for unassigned patients.

16.3.1. All physicians are expected to respond to calls by assuming care of the patients to the extent of their privileges, regardless of the patient's ability to pay. If it is determined that care is beyond the scope of their capabilities as defined by granted privileges, they are responsible for arranging for the appropriate consultant to assume care of the patient. Refusal to respond without personally evaluating the patient shall be subject to the Corrective Action process.

16.3.1.1. When the physician does not agree with the Emergency practitioner's request to admit a patient, s/he is responsible for personally evaluating the patient and arranging for the appropriate consultant to assist in and/or assume the care of the patient.

16.3.1.2. All members of the Medical Staff are expected to follow the requirements of EMTALA (Emergency Medical Treatment and Labor Act), available on the PRMCE's Medical Staff Website.

16.3.1.3. Both specialists and primary care physicians will be available for consultation to those admitting physicians who feel that the consultation is appropriate for optimal care.

16.3.1.4. The physician to be consulted will be the physician on call for unassigned patients at the time the consultation is ordered unless a previously consulting physician wishes to continue care.

16.3.2. If a patient is re-admitted within two weeks for the same problem and there has been no interval follow-up by another practitioner, the original admitting physician (or group) will be expected to care for the patient except as follows:

16.3.2.1. Any physician performing a procedure on a patient will be responsible for treating that patient for any complication of the procedure or diagnosis that prompted it for a period of time equivalent to the normal follow-up time frame for the procedure/diagnosis, not limited to two weeks.

16.3.3. If a patient has been seen by a primary care practitioner (except a hospitalist) in the hospital, that primary care practitioner is responsible for follow-up after discharge.

16.3.4. If an unassigned patient is admitted to a sub-specialist but only needs primary care follow-up after discharge, the name of the primary care practitioner on-call for unassigned patients the day of admission will be given to the patient for follow-up. The admitting practitioner is expected to contact the primary care practitioner to assure continuity of care.

16.3.5. Patients who are not admitted but referred from the Hospital's Emergency Departments will be given two weeks in which to call the referred physician's office to make an initial appointment. After that time the physician is no longer obligated to make an appointment.

16.3.6. Patients referred from the Hospital's Emergency Departments will be seen without requirement of payment of any type PRIOR to the office visit. After the visit is completed the patient or his/her insurance may be billed.

16.4. Refusal Or Failure Of An On-Call Physician To Respond: (reference EMTALA regulations)

16.4.1. An on-call physician's unavailability when on call, or refusal to respond to a call from the Emergency Department, is a serious matter. Such violations can result in an investigation of the Hospital and physician involved and an assessment of a fine of up to $50,000.00 per incident, civil lawsuits, and/or exclusion from participation in Medicare and Medicaid programs for the Hospital and/or the physician.

16.4.2. Qualified medical personnel to perform a medical screening exam include a physician, a midwife, an ARNP or PA credentialed through the medical staff. Additionally, for purposes of the Obstetrical Service and pursuant to hospital policy 12203 "Family Maternity Center Scope of Service", the qualified medical personnel may be a registered nurse.

16.4.3. All members of the Medical Staff are expected to follow the requirements of EMTALA, which are posted on the PRMCE's Medical Staff website. Accordingly, a refusal or failure of an on-call physician to respond timely shall be reported immediately to the President of the Medical Staff and the Chief Executive Officer, who shall review the matter and determine how to address the situation. If the refusal or failure to respond is found to be deliberate, or if it is a repeated occurrence, the matter shall be referred to the Credentials Committee for further investigation and appropriate action. This may include but is not limited to:

16.4.3.1. A first violation may result in a letter of counsel.

16.4.3.2. A second violation may result in a letter of warning and the immediate suspension of clinical privileges for seven calendar days.

16.4.3.3. A third violation may result in a letter of warning and the immediate suspension of clinical privileges for 14 calendar days.

16.4.3.4. A fourth violation indicates an inability or unwillingness to fulfill Medical Staff responsibilities as set forth in the Medical Staff Medical Staff Bylaws and/or Medical Staff Policies. Accordingly, it may result in the automatic relinquishment of Medical Staff appointment and clinical privileges, pending a hearing or appeal.

16.4.3.5. These Bylaws, as noted in this article, outline collegial steps (i.e., counseling, warnings, and meetings with a practitioner) that can be taken to address

16.5. Responsibilities of Emergency Department physicians.

16.5.1. When a patient without a primary care practitioner who is a member of the PRMCE's medical staff requires admission, the ER practitioner is expected to assign that admission on certain criteria:

16.5.1.1. The diagnosis for which the patient needs admission; and

16.5.1.2. The specialty best qualified to care for that diagnosis

16.5.2. It is expected that Emergency Department physicians will make appropriate physician assignment for patients discharged from the Emergency Department, utilizing specialty call schedules as often as appropriate, as well as primary care call schedules.

16.5.3. It is expected that Emergency Department physicians will provide single visit follow up for wound checks, suture removal and minor trauma. Abnormal lab and imaging results on unassigned patients will also be reviewed by Emergency Department physicians on a timely basis.

16.5.4. Emergency Department physicians may refer patients for follow-up care with a physician follow-up is required for outpatients.

16.5.5. Discharge instructions regarding follow up care will be specific regarding time for appointments with follow up physicians for outpatient care.

16.6. In cases of disagreement regarding the admission, assignment or consultation for a patient, the practitioners are expected to follow the Medical Staff Chain of Communication.

ARTICLE 17: NON-PHYSICIAN SERVICES

17.1. Non-physician services shall be understood to include those whose license limits their services to a particular area of health care, but who need *not*, by law or Board policy, practice under the supervision of a physician (e.g. ARNP, CNM, CRNA, Clinical Psychologists). Complementary and alternative medicine providers may provide non-physician services, under the supervision of a physician, upon approval of the Board.

17.2. Care rendered for patients will adhere to the following guidelines:

17.2.1. Care will be limited to those services permitted by the practitioner's license and the privileges granted by the Board.

17.2.2. The medical record must meet the requirements detailed in medical staff bylaws and hospital policy.

17.3. Co-admission

17.3.1. A doctor of medicine or osteopathy manages and coordinates the care of any patient's medical or psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, optometry, chiropractor, or clinical psychologist. In treating patients hospitalized as inpatients, the practitioners who are not MDs or DOs shall be responsible for provision of a written record relevant to his/her area of expertise, including history of present illness, examination of the patient, operative and procedure notes, diagnosis and treatment plan. These same practitioners are also responsible for ensuring that daily progress notes are entered, and will prepare the appropriate discharge summary.

17.3.2. The co-admitting Practitioner (MD/DO) is responsible for the provision of a written history and physical examination relating to the general health status of the patient, as well as management of any conditions which are outside the realm of the limited practitioner. The co-admitting Practitioner (MD/DO) will also dictate a discharge summary.

17.3.3. When a patient under the care of a non-physician Member requires emergency admission to the Hospital and no co-admitting physician can be readily identified, the emergency room physician is to be notified and the usual emergency room backup mechanisms will be used to assign a physician to the patient.

ARTICLE 18: MEDICAL STUDENTS, RESIDENTS, FELLOWS & PDAHP STUDENTS

18.1. The Graduate Medical Education Committee, a hospital committee, shall have the responsibility for monitoring all aspects of residency education, maintain records as required by accreditation bodies or applicable laws, and report to and advise the Medical Executive Committee and the Board on all issues covering graduate medical education at the hospital. It will oversee and support compliance with Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME). The committee shall provide to the medical staff written descriptions of the roles, responsibilities and patient care activities of the participants of all graduate medical education programs. These descriptions will include identification of mechanisms by which the supervisor (s) and graduate education program director make decisions about each participants progressive involvement and independence in specific patient care activities

18.2. All students/residents/fellows shall be registered in the Medical Staff Office by the physician with whom they are working. Prior to beginning any work at the Hospital, they will personally sign in and read this Article. The Medical Staff Office will be informed of the expected duration of their preceptorship/observation in the Hospital.

18.3. Students/residents/fellows shall, at all times, wear nametags that clearly identify them.

18.4. Students/residents/fellows shall be introduced to the Nursing Leadership on all units where they are expected to be present.

18.5. Students/residents/fellows shall introduce themselves, and their status, to any patient with whom they come in contact and a verbal consent regarding participation in care shall be obtained from the patient.

18.6. Students/residents/fellows who are scrubbing in an Operating Room or Delivery Room shall have his/her scrubbing and sterile technique reviewed by the nursing staff in those areas.

18.7. Students/residents/fellows who are part of an approved, formalized preceptor program recognized by the Medical Staff and approved by the Board may be permitted to perform procedures, assist in surgery, and render other aspects of patient care in the Hospital under the direct supervision of the preceptor and to an extent consistent with the privileges of the preceptor and within the limits of the student/resident/fellow's abilities as identified by the sponsoring institution.

18.8. Residents/fellows training at the Hospital shall not hold appointments to the Medical Staff and will not be granted specific Clinical Privileges. They are permitted to perform only those functions set out in training protocols developed by the respective residency/fellowship programs and approved by the Credentials Committee, Executive Committee and the Board. The residency/fellowship program is responsible for verifying the qualifications and credentials of each resident/fellow permitted to function in the Hospital. The care of the patient shall be the responsibility of the member. Residents/fellows may participate as ex-officio appointees of the Medical Staff and Divisions for the purpose of education as to peer-review and administrative responsibilities.

18.9. All other students/residents/fellows shall function only as observers and shall not perform any procedures in the Hospital.

18.10. Residents/fellows may write and dictate history and physical examination reports, operative reports, and discharge summaries, which must be reviewed and countersigned by the preceptor physician. Medical students may write progress notes which can serve as accepted progress notes if countersigned by the preceptor physician.

18.11. Appropriately precepted student healthcare practitioners may write orders in the presence of a duly licensed and privileged practitioner but the orders may not be implemented until they are countersigned by the practitioner. Residents/fellows may write orders which must be countersigned by the attending physician within 48 hours.

18.12. For a formal preceptorship, the sponsoring institution will provide the Medical Staff and the Hospital with the objectives of the program, as well as evidence of liability coverage. In addition, they will indicate the general level of a student/resident/fellow's clinical abilities and the time frame of the preceptorship.

18.13. The Credentials Committee shall be informed of those students/residents/fellows that are fulfilling preceptorship in the Hospital.

18.14. The preceptor must be an Active member of the medical staff.

ARTICLE 19: CHAIN OF COMMUNICATION

19.1. Medical Staff members will take appropriate actions to intervene in a patient's medical plan of care if there are concerns regarding the appropriateness of care by a physician, or issues regarding physician behavior.

19.2. If the issue cannot be resolved, the Chain of Communication shall be utilized, as follows:

19.2.1. Division Chief, Section Medical Director or Section Leader

19.2.2. On-call Medical Staff Leaders: President, President-Elect, Past President

19.3. The individual initiating the Chain of Communication shall document the situation on a UOR (Unusual Occurrence Report).

ARTICLE 20: PRECAUTIONARY SUMMARY SUSPENSION

20.1. Any two of the following–(1) the President of the Medical Staff, (2) the President-elect or Past-President, (3) a Division Chief, (4) the CEO or designee or the Chief Medical Officer, (5) the Board of Directors or any duly authorized committee of the Board shall have authority to issue a precautionary summary suspension to suspend all or any portion of the clinical privileges of a practitioner whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual or to the orderly operations of the Hospital. Such precautionary summary suspension shall become effective immediately upon imposition. Notice of the precautionary summary suspension shall include the circumstances resulting in the precautionary summary suspension and the degree by which the privileges of the affected practitioner have been reduced, and shall promptly be forwarded to the Credentials Committee, to the Service Area Chief Executive, to the CEO or designee, and, by Special Notice, to the affected practitioner. Such precautionary summary suspension shall be deemed an interim precautionary step in the professional review activity and not a professional review action. It shall not imply any final finding of responsibility for the situation that caused the action.

20.1.1. Action by Credentials Committee
The Credentials Committee (with the Medical Staff President, the president-elect and the past president) within fourteen days of a precautionary summary suspension, shall terminate or recommend modification or continuance of the terms of the precautionary summary suspension, and shall promptly notify the Service Area Chief Executive, the CEO or designee, and, by Special Notice, the affected practitioner of its action. If the action is a recommendation to modify or continue the precautionary summary suspension, the notice shall advise the practitioner of his or her right to a hearing pursuant to the Fair Hearing Plan. Such notice shall comply with the requirements as stated in the Fair Hearing Plan, and shall be accompanied by a copy of the Fair Hearing Plan.

If the Credentials Committee terminates the precautionary summary suspension or if for any reason the Credentials Committee does not make a disposition within fourteen days of a precautionary summary suspension, the suspended individual shall automatically be reinstated to the status previously held. If the Credentials Committee recommends continuance or modification, the terms of the precautionary summary suspension as

sustained or as modified by the Credentials Committee shall remain in effect pending action by the Board of Directors.

20.1.2. Continuity of Patient Care
Immediately on the imposition of a precautionary summary suspension, the President, or responsible Division Chief, shall have responsibility to provide for alternative medical coverage for the patients of the affected practitioner still in the Hospital(s) at the time of such suspension. The wishes of the patient and the practitioner shall be considered in the selection of such alternative coverage.

20.2. Automatic Suspension
Automatic suspension shall be initiated whenever there is revocation, suspension, restriction or probation of the practitioner's state license or DEA certificate; failure to pay annual Medical Staff dues; failure to maintain malpractice insurance required by the Board; exclusion from Medicare, Medicaid or other Federal Health Care Programs; and failure to complete medical records in a timely manner. Hearing and appellate review rights outlined in the Fair Hearing Plan do not apply to the imposition of automatic suspension.

20.2.1. State License

20.2.1.1. Revocation: When a Member's license to practice in the state of Washington is revoked, there is immediate and automatic revocation of Medical Staff appointment and all clinical privileges as of the date such action becomes effective. Upon reinstatement of the health professional's license to practice, he or she must reapply for Medical Staff appointment and clinical privileges.

20.2.1.2. Restriction: During the period in which a practitioner's license is partially limited or restricted in any way, those clinical privileges that he or she has been granted that are within the scope of the limitation or restriction are similarly limited or restricted, automatically, as of the date such action becomes effective and throughout its term. Upon reinstatement of the health professional's license to practice without such restrictions or limitations, he or she must reapply for those clinical privileges that were limited or restricted.

20.2.1.3. Suspension: If a license is suspended, the practitioner's Medical Staff appointment and clinical privileges are automatically suspended as of the date such action becomes effective. Upon reinstatement of the health professional's license to practice, he or she must apply for reinstatement of appointment and clinical privileges.

20.2.1.4. Probation: If a Member is placed on probation by the relevant licensing 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. Further, his or her office and/or Division Chief role, Section Medical Director Role or Section Leader role shall be automatically terminated. Upon termination of the probation, he or she must reapply for those clinical privileges that were subject to the probation.

20.2.2. Exclusion from Medicare, Medicaid or other Federal Health Care Programs
If a Member is excluded from participation in the Medicare, Medicaid, or other Federal health care programs and is so listed on the Office of the Inspector General's List of Excluded Individuals/Entities, such Member's Medical Staff membership and Privileges shall be automatically suspended. The member will be eligible to reapply for Medical Staff privileges upon the Member's reinstatement with the applicable Federal health care program.

20.2.3. Drug Enforcement Administration (DEA) Certificate
If a Member's right to prescribe controlled substances is revoked, restricted, suspended or placed on probation by a proper licensing authority, his or her privileges to prescribe such substances in the Hospital(s) will also be revoked, restricted, suspended or placed on probation automatically. Upon reinstatement of the Member's DEA certificate, he or she must reapply for the privilege to prescribe controlled substances in the Hospital.

20.2.4. Medical Records
The Executive Committee of the Medical Staff shall adopt as part of its Rules and Regulations, rules processes to provide for the temporary suspension of all of a practitioner's Privileges, including the Privilege of admitting patients to the Hospital, which shall remain effective until medical records are completed. These processes rules shall provide for the automatic imposition of the temporary suspension within a reasonable specified time after notification by Special Notice from the CEO or designee or Chief of Staff of a delinquency for failure to complete medical records within a reasonable time as specified in the rules. The time shall be in accord with applicable law, regulations and accreditation standards. These rules processes shall also provide appropriate sanctions for repeated violations, delinquencies, and/or suspensions.

20.2.5. Professional Liability Insurance
A practitioner's Medical Staff appointment and Clinical Privileges are immediately suspended for failure to maintain the minimum amount of professional liability insurance required by the Board. The practitioner may be reinstated when proof of coverage is provided to the Medical Staff Office within six months with a satisfactory written explanation of the Member's failure to maintain the minimum amount of professional liability insurance as required. If proof of coverage is not provided to the Medical Staff Office within six months of the initiation of the suspension, the practitioner's Medical Staff membership and Clinical Privileges shall be terminated.

20.2.6. Nonpayment of Dues
Any practitioner who fails to comply with Medical Staff policies regarding payment of dues and surcharges shall be immediately and automatically suspended until account is made whole.

20.2.7. Failure to Comply with Emergency Department Backup Requirements
Any practitioner who fails to comply with the Emergency Department Backup Requirements shall be subject to corrective action, including automatic summary suspension, as outlined in the Medical Staff Policy for Corrective Action for Failure to Fulfill Emergency Department Backup Responsibilities.

20.2.8. Continuity of Patient Care: Immediately on the imposition of an automatic suspension, the President or responsible Division Chief shall have responsibility to provide for alternative medical coverage for the patients of the suspended practitioner still in the hospital at the time of such suspension. The wishes of the patient and the practitioner under suspension shall be considered in the selection of such alternative coverage.

20.2.9. No Appeal: A practitioner subject to automatic suspension of admitting privileges or Clinical Privileges or termination of Medical Staff membership, pursuant to this article shall not be entitled to any of the procedure rights of the Fair Hearing Plan, as such a suspension or termination is not the result of an adverse recommendation.

ARTICLE 21: CORRECTIVE ACTION

21.1. Corrective action may be requested by a Quality Review Committee of the Medical Staff, a Division Chief of the Medical Staff, a Medical Staff Officer, or the Chief Medical Officer following initial evaluation to assess any practitioner whose conduct, competence or activities may be below or substantially different from the standards of the Medical Staff or to be disruptive to the operations of the Hospital. Initial evaluation may be through a review by a Quality Review Committee of the Medical Staff or through completion of a Focused Professional Practice Evaluation.

21.2. Requests for Review shall be directed to the Credentials Committee. Requests shall be in writing, shall specify the concerns, activities or conduct that constitutes the grounds for requesting corrective action, and may also include the results of a Focused Professional Practice Evaluation and/or investigation by the Quality Committee of the Medical Staff, and a proposed corrective action.

21.3. Initial Review by the Credentials Committee
The Credentials Committee at its first regular meeting following receipt of such a request shall consider the request for review and may undertake such additional preliminary investigation as it deems

21.4. Investigation

21.4.1. The Credentials Committee may authorize the investigation they are presented or conduct further investigation through the appointment of an ad hoc committee, use the Division Chief or other designees. No individual with a direct conflict of interest shall be a member of any ad hoc or investigative process.

21.4.2. Such investigative panel or organization shall have the right to review all relevant documents and to interview persons with information relevant to the complaint and the affected practitioner. The practitioner who is under investigation may be invited to appear before the committee or individuals conducting the investigation. The practitioner's appearance shall be informal in nature. There is no right to have an attorney present, nor are the procedural rights under the Fair Hearing Plan applicable. If the requested investigation is conducted by any individual or group other than the full Credentials Committee, that investigating individual or group will submit a written report to the Credentials Committee within two weeks after completing the investigation.

21.5. Credentials Committee Action

21.5.1. Following acceptance of the investigation the committee is presented, or completion of further investigation requested by the Credentials Committee, a report of the findings shall be sent to the practitioner by Special Notice. The Credentials Committee shall meet to consider the matter and the affected practitioner shall be invited to attend the meeting. The practitioner shall be given an opportunity to present any information (including written and verbal testimony) to support his actions and/or controvert the report of the investigation.

21.5.2. The Credentials Committee shall act on each request for corrective action through any of the following actions:

21.5.2.1. Take no correction action;

21.5.2.2. Accept, reject or modify the proposed correction action, if any;

21.5.2.3. Issue a letter of admonition, reprimand or warning (this is not considered to be an adverse action);

21.5.2.4. Recommend mentoring or collegial intervention.

21.5.2.5. Recommend ongoing Focused Professional Practice Evaluation or proctoring

21.5.2.6. Impose terms of probation on the individual's membership and/or Clinical Privileges, or individual requirements for consultation or observation;

21.5.2.7. Recommend reduction, restriction, suspension, revocation, or denial of Medical Staff membership and/or Clinical Privileges;

21.5.2.8. Recommend suspension of clinical privileges or Medical Staff membership until completion of specific conditions or requirements;

21.5.2.9. Any other action deemed appropriate by the Credentials Committee.

21.6. Procedures After Investigation and Credentials Committee Recommendation

21.6.1. If the Credentials Committee recommends no corrective action or if the recommendation is not an adverse action, the recommendation and supporting documentation shall be forwarded

21.6.2. If the Executive Committee adopts the recommendation of the Credentials Committee, a Credentials Committee representative shall be available to the Board if requested. If the Executive Committee modifies the recommendation of the Credentials Committee, representatives from both the Executive Committee and the Credentials Committee shall be available to the Board if requested.

21.6.3. The Board of Directors shall adopt, modify or reject the Credentials Committee's and Executive Committee's recommendation or defer action and remand the recommendation back to the Credentials Committee for further consideration. The Board shall state in writing the reasons for the deferral and set a reasonable time when a subsequent recommendation shall be made. At the next regular meeting after receiving the subsequent recommendation, the Board shall make a decision on the recommendation of the Credentials Committee. If the action of the Governing Board is favorable to the individual, the action shall become final, and the Chief Executive Officer or designee shall notify the individual. If the action of the Governing Board is adverse, the Chief Executive Officer or designee shall notify the practitioner of his or her rights under the Fair Hearing Plan.

21.6.4. If the recommendation of the Credentials Committee is an adverse recommendation, the applicant shall be notified by Special Notice of the recommendation and of his or her procedural rights under the Fair Hearing Plan prior to mandated reporting to the national Practitioner Data Bank (NPDB).

ARTICLE 22: FAIR HEARING PLAN

22.1. The Credentials Committee and Medical Executive Committee shall adopt procedures necessary to implement more specifically the general principles found within these Medical Staff Bylaws, the Medical Staff Bylaws of the Board, and applicable laws regarding hearings and contested matters. These procedures are entitled the Fair Hearing Plan. An applicant for or a Member who is the subject of an adverse recommendation of the Credentials Committee as defined in these Medical Staff Bylaws is entitled to a hearing and to appellate review as provided in the Fair Hearing Plan.

22.2. Initiation of Hearing

22.2.1. Right to a Hearing – An individual is entitled to a hearing only if one of the adverse actions or recommendations listed below is (a) taken or made by the Credentials Committee, or (b) taken by the Board of Directors under circumstances in which no prior right to request a hearing existed:

22.2.1.1. Denial of initial Medical Staff appointment;

22.2.1.2. Denial of reappointment;

22.2.1.3. Suspension of Medical Staff appointment;

22.2.1.4. Revocation of Medical Staff appointment;

22.2.1.5. Denial of requested appointment to or advancement in Staff category;

22.2.1.6. Involuntary reduction in Medical Staff category;

22.2.1.7. Suspension or limitation of the right to admit patients;

22.2.1.8. Denial of requested Division affiliation;

22.2.1.9. Denial or restriction of requested clinical privileges in which privileging criteria are met;

22.2.1.10. Involuntary reduction in clinical privileges;

1 22.2.1.11. Suspension of clinical privileges;

2 22.2.1.12. Revocation of clinical privileges; and

3 22.2.1.13. Involuntary imposition or increased scope of mandatory consultation requirement
4 after the completion of the provisional period.

5 22.2.2. Notice of Adverse Recommendation or Action
6 When a recommendation is made or an action taken which entitles a Medical Staff Member
7 to a hearing, the Credentials Committee shall promptly notify the affected individual by
8 Special Notice. The notice shall:

9 22.2.2.1. Advise the practitioner of the recommendation or action, the reasoning behind
10 that recommendation or action and his or her right to request a hearing pursuant
11 to the provisions of the Bylaws;

12 22.2.2.2. Summarize the rights of the practitioner in the hearing;

13 22.2.2.3. Specify that the practitioner has thirty (30) days after receiving the notice within
14 which to submit a request for a hearing and that the request must satisfy the
15 conditions of Section 22.2.3;

16 22.2.2.4. State that failure to request a hearing within the specified time period and in the
17 proper manner will result in loss of rights to any hearing or appellate review on
18 the matter that is the subject of the notice;

19 22.2.2.5. State that any higher authority required or permitted under this Plan to act on the
20 matter will not be bound by the adverse recommendation or action but may take
21 any action, whether more or less severe, that it deems warranted by the
22 circumstances.

23 22.2.3. Request for Hearing
24 The practitioner shall have thirty days after receiving a notice under Section to file a written
25 request for a hearing. The request must be in writing and must be personally delivered to the
26 Chief Executive Officer or designee or sent to the Chief Executive Officer or designee by
27 certified or registered mail.

28 22.2.4. Waiver by Failure to Request a Hearing
29 A practitioner who fails to request a hearing within the time and in the manner specified will
30 lose his or her right to any hearing or appellate review to which he or she might otherwise
31 have been entitled. The recommendation of the Credentials Committee will be sent to the
32 Board for action. The Chief Executive Officer or designee shall promptly notify the practitioner
33 by Special Notice of each action taken under any of the following sections and shall notify the
34 Medical Staff President of each action.

35 22.2.5. After Adverse Recommendation by the Credentials Committee, the Board of Directors shall
36 consider the Adverse Recommendation within thirty days of receipt of the recommendation.

37 22.2.5.1. If the action of the Board accords in all respects with the Credentials Committee's
38 recommendation, it shall then become effective as the final decision of the Board.

39 22.2.5.2. If, on the basis of the same information and material considered by the
40 Credentials Committee in formulating its recommendation, the Board of Directors
41 proposes a different action, then the matter shall be referred back to the
42 Credentials Committee for further consideration.

43 22.2.5.3. After receiving a subsequent recommendation and any new evidence, the Board
44 of Directors shall then take final action on the reconsidered recommendation. If
45 the Board proposes to take an action adverse to the practitioner after a favorable
46 recommendation by the Credentials Committee, the Board will submit the matter

22.2.5.4. The Chief Executive Officer or designee shall send the practitioner Special Notice of any such referral, the subsequent recommendation of the Credentials Committee, and the action taken by the Board thereon. If the rights to a hearing apply, the Special Notice shall include notification of the practitioner's procedural rights under this Fair Hearing Plan.

22.2.6. After an Adverse Action by the Board as allowed.
The Adverse Action of the Board shall become effective as the final decision of the Board.

22.3. Hearing Prerequisites

22.3.1. Notice and Time and Place for Hearing
When a Request for a Hearing is received, the Chief Executive Officer or designee shall deliver it to the Medical Staff Coordinator and notify the Chief Executive Officer or designee and the Medical Staff President. The Medical Staff Coordinator shall arrange for and schedule a hearing, and the Medical Staff President shall send the practitioner Special Notice of the time, place and date of the hearing. The hearing date shall not be less than thirty nor more than forty-five days after receipt of the Special Notice, unless the practitioner requests an expedited hearing, in which case the hearing shall be arranged as soon as convenient for the parties, but in no event more than twenty-one days after the request for an expedited hearing.

22.3.2. Statement of Issues, Events, and Witnesses
The notice of hearing must contain a concise statement of the practitioner's alleged acts or omissions, a list by number of the specific patient records in question, and any other reasons or subject matter forming the basis for the adverse action or recommendation. In addition, the notice shall include a proposed list of the witnesses (if any) expected to testify at the hearing in support of the adverse recommendation or decision. This statement, including the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing, so long as the additional material is relevant to the continued appointment or clinical privileges of the practitioner requesting the hearing, and the practitioner and the practitioner's counsel have sufficient time to study this additional information and rebut it.

The practitioner requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on the affected practitioner's behalf within ten (10) days after receiving the Notice of Hearing.

22.3.3. Witness List
Each witness list shall include a brief summary of the nature of the anticipated testimony. The witness list of either party may, in the discretion of the Hearing Officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The Hearing Officer shall have the authority to limit the number of witnesses.

22.3.4. Appointment of Hearing Committee:

22.3.4.1. Hearing Panel
When a hearing is requested, the Medical Staff President, after consulting with the Chief Executive Officer or designee, will appoint an impartial Hearing Panel composed of three Active Staff Members. No person who participated in the adverse recommendation or action or in an investigation associated with the recommendation or action at any previous time shall be appointed to this Hearing Panel. The Hearing Panel shall not include any individual who is in direct economic competition or who is professionally associated with or related to the affected practitioner. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel. The members of the Hearing Panel must give fair and impartial consideration of the case.

22.3.4.2. Hearing Officer
The Hearing Officer shall be nominated by the Medical Staff President subject to final approval of the Chief Executive Officer or designee. He/she may be an attorney, retired judge, a physician, hospital medical director, or other person knowledgeable about and experienced in the conduct of hearings.

22.4. Hearing Procedure

22.4.1. Presence Required
The personal presence of the practitioner is required at the hearing. A practitioner who, without good cause, fails to appear and respond to questions at the hearing, shall lose his or her right to a hearing.

22.4.2. Hearing Officer
The Hearing Officer shall serve only to facilitate the hearing process and assure that the hearing is conducted in accordance with this Fair Hearing Plan. He shall not participate in the private deliberations of the Hearing Panel nor shall he be entitled to deliberate or vote on its recommendations. The Hearing Officer shall act to assure that all participants in the hearing have reasonable opportunity to be heard and to present all oral and documentary evidence, that decorum is maintained throughout the hearing and that no intimidation is permitted. He shall determine the order and format of procedure throughout the hearing, and shall have the authority and discretion, in accordance with this Fair Hearing Plan, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence. It shall be the responsibility of the Hearing Officer to assure that each party presents evidence relevant to its case in the most efficient and expeditious manner practical.

22.4.3. Representation
The practitioner may be accompanied and represented at the hearing by an attorney or other person of the practitioner's choice. The Credentials Committee, and the Board of Directors, if its recommendation or action prompted the hearing, shall appoint an individual to represent it. Representation of either party by an attorney at law is governed by this Fair Hearing Plan.

22.4.4. Rights of Parties: During a hearing, each party may:

22.4.4.1. Call and examine witnesses;

22.4.4.2. Introduce exhibits;

22.4.4.3. Cross-examine any witness on any matter relevant to the issues (If the practitioner does not testify on his or her own behalf, he or she may be called and examined as if under cross-examination); and

22.4.4.4. Request that a record of the hearing be made by use of a court reporter or an electronic recording unit.

22.4.5. Procedure and Evidence
The hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons might customarily rely in the conduct of serious affairs may be considered regardless of the admissibility of such evidence in a court of law. The committee is also entitled to consider all other relevant information that can be considered under the Bylaws in connection with credentialing matters. Each party shall be entitled, prior to, during, or at the close of the hearing, to submit memoranda concerning any issue of law or fact, and those memoranda shall become part of the hearing record. Oral evidence shall be taken only on oath or affirmation.

22.4.6. Official Notice
In reaching a decision, the Hearing Panel may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of Washington. Parties present at the hearing must be informed of the

22.4.7. Scope of Review and Burden of Proof

The party whose Adverse Action or Recommendation gave rise to the hearing shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. Thereafter, the burden shall shift to the practitioner who requested the hearing to come forward with evidence in response. After all the evidence has been submitted by both sides, the Hearing Panel shall recommend in favor of the Credentials Committee or the Board of Directors unless it finds that the practitioner who requested the hearing has proved that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by substantial evidence.

22.4.8. Hearing record

A record of the hearing must be kept that is sufficient to permit an informed judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The Chief Executive Officer or designee may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. The hearing record shall also contain all exhibits or other documentation considered written statements submitted by the parties, and correspondence between the parties or between the hearing committee and the parties, if any, during the hearing process. If a court reporter is used, the cost of recording and transcribing the proceedings shall be shared equally by the practitioner and the hospital. The Practitioner's share shall be promptly paid by him upon request and prior to his or her receipt of a copy of the record.

22.4.9. Postponement

Requests for postponement of a hearing may be granted by the Hearing Panel only upon showing of good cause and only if the request is made as soon as is reasonably practical.

22.4.10. Presence of Hearing Panel Members and Vote

The entire Hearing Panel must be present throughout the hearing and deliberations.

22.4.11. Recesses and Adjournment

The Hearing Panel may recess and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The Hearing Panel must reconvene in a timely manner and in any event the recess must not exceed ten days except by written consent of the practitioner. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The Hearing Panel shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be adjourned. Adjournment shall be no later than ten days after the hearing is closed.

22.5. Hearing Committee Report and Further Action

22.5.1. Hearing Committee Report

Within ten days after final adjournment of the hearing, the Hearing Panel shall make a written report of its findings and recommendations after review of the evidence, and shall forward the report along with the record and other documentation to the Credentials Committee. The Chief Executive Officer or designee shall promptly send a copy of the Hearing Panel report to the practitioner by Special Notice.

22.5.2. Action on Hearing Committee Report

Within ten days after receiving the Hearing Panel report, the Credentials Committee shall consider it and adopt, modify or change the recommendation or action. It shall transmit the recommendation together with the hearing record, and the Hearing Panel report to the Chief Executive Officer or designee.

22.5.3. Notice and Effect of Result

22.5.3.1. The Chief Executive Officer or designee shall promptly send a copy of the recommendation to the practitioner by Special Notice, to the President, and to the Board of Directors.

22.5.3.2. Favorable Recommendation of the Credentials Committee
If the Credentials Committee's result is favorable to the practitioner, the Chief Executive Officer or designee shall promptly forward it, together with all supporting documentation, to the Board, which, acting through the Chief Executive Officer or designee, may adopt or reject the recommendation, in whole or in part, or refer the matter back to the Credentials Committee for further consideration. After receiving a subsequent recommendation and any new evidence, the Board, acting through the Chief Executive Officer or designee, shall make a decision. If the Board's action is favorable, it becomes the final decision. If the Board's action is adverse, the matter shall be referred back to the Credentials Committee for reconsideration. If the Board's action after receiving the reconsidered recommendation of the Credentials Committee remains adverse, the Special Notice shall inform the practitioner of his or her right to request an Appellate Review by the Board as provided in this Fair Hearing Plan. The Chief Executive Officer or designee shall promptly send the practitioner Special Notice informing him or her of each action taken under this Section, including a statement of the basis for the Board's decision.

22.5.3.3. Adverse Recommendation of the Credentials Committee
If the Board, acting through the Chief Executive Officer or designee, adopts the adverse recommendation of the Credentials Committee, the Special Notice shall inform the practitioner of his or her right to request an Appellate Review by the Board of Directors as provided in this Fair Hearing Plan. If, however, the Board of Directors, acting through the Chief Executive Officer or designee, renders a decision different from the recommendation of the Credentials Committee, the matter shall be referred back to the Credentials Committee for reconsideration. If the action of the Board, acting through the Chief Executive Officer or designee, after receiving the reconsidered recommendation of the Credentials Committee is favorable to the practitioner, it shall become the final decision in the matter. If the action of the Board, acting through the Chief Executive Officer or designee, is adverse to the practitioner, the Special Notice shall include a statement of the basis for the Board's decision and shall inform him or her of his or her right to request an Appellate Review by the Board as provided in this Fair Hearing Plan.

22.6. Initiation and Prerequisites for Appellate Review

22.6.1. Request for Appellate Review
If after a hearing, the decision of the Board, acting through the Chief Executive Officer or designee, is adverse, a practitioner shall have ten days after receiving Special Notice to file a written request for an Appellate Review. The request must be delivered to the Chief Executive Officer or designee in person or by certified or registered mail and may include a request for a copy of the Hearing Panel report and record of all material not previously furnished to him or her that was considered.

22.6.2. Failure to Request Appellate Review
A practitioner who fails to request an Appellate Review within the time and in the manner specified loses any right to an Appellate Review.

22.6.3. Notice of Time and Place for Appellate Review

22.6.3.1. The Chief Executive Officer or designee shall deliver a timely and proper request to the Chairman of the Board. As soon as practicable, the Board shall schedule and arrange for an Appellate Review that shall be not less than twenty-one days nor more than thirty-five days after the Chief Executive Officer or designee received the request; provided, however, that Appellate Review for a practitioner who is under a suspension then in effect shall be held as soon as the

22.6.3.2. At least ten days prior to the Appellate Review, the Chief Executive Officer or designee shall send the practitioner Special Notice of the time, place and date of the review. The time may be extended by the Appellate Review Committee for good cause and if the request is made as soon as is reasonably practical after discovery of the need for extension. If the practitioner wishes to be represented by an attorney at any Appellate Review, he or she must so notify the Chief Executive Officer or designee at least five days prior to the Appellate Review.

22.6.3.3. Appellate Review Committee
The Board of Directors shall appoint an Appellate Review Committee. The Appellate Review Committee shall consist of five members, two of whom shall be members of the Active Staff who are not in direct economic competition with the practitioner, two of whom shall be members of the Board of Directors and one who shall be a representative of Chief Executive Officer. No one appointed to the appellate review committee shall be a person who has instigated or participated in earlier proceedings in the case.

22.7. Appellate Review Procedure and Final Action

22.7.1. Nature of Proceedings

22.7.1.1. The proceedings by the Appellate Review Committee are a review based upon the Hearing record, the Hearing Panel's report, all subsequent results and action, the written statements submitted], and any other material that may be presented and accepted.

22.7.1.2. The purpose of Appellate Review is to review the record of earlier proceedings to determine if the recommendations and the action taken (1) involve substantial procedural compliance with this Fair Hearing Plan, (2) are not arbitrary or capricious, and (3) are supported by substantial evidence. The Appellate Review Committee may make a recommendation different than the recommendation and action appealed only if the Appellate Review Committee finds that one or more of the requirements are not supported by the record. “Substantial evidence” shall mean evidence that a reasonable person could accept as adequate to support a conclusion. It is not the task of the Appellate Review Committee to substitute its judgment for the Board's judgment or determine which side presented the greater weight of evidence.

22.7.2. Written Statements
The practitioner may submit a written statement containing objections to the findings, actions, and procedural rulings, together with his or her reasons. This written statement may cover any matters raised at any step in the Hearing process. The statement shall be submitted to the Appellate Review Committee and the other parties through the Chief Executive Officer or designee at least ten days prior to the scheduled date of the review, except if the Appellate Review Committee waives the time limit. A similar statement may be submitted by the group whose adverse action occasioned the review, and, if submitted, the Chief Executive Officer or designee shall provide a copy to the practitioner at least ten days prior to the scheduled date of the Appellate Review.

22.7.3. Presiding Officer
The chair of the Appellate Review Committee is the Presiding Officer. He or she determines the order or procedure during the review, makes all required rulings with the advice of the committee, and maintains decorum.

22.7.4. Oral Statements
The Appellate Review Committee, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions.

22.7.5. Consideration of New or Additional Matters

New or additional evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the Appellate Review (1) only in the discretion of the Appellate Review Committee and as the Appellate Review Committee deems appropriate, and (2) only if the party requesting consideration of the new or additional evidence shows that it could not have anticipated the production of such evidence at an earlier point in the proceedings. The requesting party shall submit to the Chief Executive Officer or designee a written description of the new or additional evidence as soon as it becomes aware of the evidence, but in no event later than three days prior to the scheduled date of the review. The Chief Executive Officer or designee shall immediately transmit the description to the Appellate Review Committee and the other party.

22.7.6. Presence of Members and Vote

All members of the Appellate Review Committee must be present throughout the review and deliberations.

22.7.7. Recesses and Adjournments

At the conclusion of the oral statements, if allowed, the Appellate Review shall be closed. The Appellate Review Committee shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The Appellate Review shall be adjourned at the conclusion of those deliberations.

22.7.8. Action by Appellate Review Committee

The Appellate Review Committee may recommend that the Board affirm, modify or reverse the adverse result or action, or, in its discretion, may refer the matter back for further review and recommendation to be returned to it within twenty-one days. Within ten days after receipt of such recommendation after referral back, the Appellate Review Committee shall take action. The Appellate Review Committee shall promptly forward a report containing its recommendation, the hearing record, and all documentation to the Board of Directors. A copy of the report shall be sent to the practitioner by Special Notice.

22.7.9. Action by Board of Directors

Within ten days after receipt thereof, the Board of Directors shall act upon the recommendation of the Appellate Review Committee. It may confirm, modify, or reject the decision that was appealed. If the decision of the Board is in accord with the last recommendation of the Credentials Committee, it shall be immediately effective. If the action of the Board has the effect of changing the Credentials Committee's last Recommendation, the matter shall be referred to a Joint Conference Committee as provided in Section 7.10. at the request of either the Credentials Committee or the Board of Directors. The action of the Board of Directors after receiving the Joint Conference Committee's recommendation shall be effective as the final decision on the matter. The Board of Directors shall inform the practitioner of its decision by Special Notice.

22.7.10. Joint Conference Review: The Joint Conference Committee shall consist of five members. The Board of Directors shall appoint three members, two from its own members, and one from hospital's administration. The President shall appoint two members from the Medical Staff. Within ten days after receiving a matter referred to it under this Fair Hearing Plan, the Joint Conference Committee shall convene to consider the matter and shall submit its Recommendations to the Board of Directors.

22.8. General Provisions

22.8.1. Hearing Officer Appointment and Duties

The Hearing Officer shall preside at the hearing. The Hearing Officer may not vote and may not be in direct economic competition with the practitioner.

22.8.2. Attorneys

22.8.2.1. At Hearing: The practitioner may be represented by an attorney at the Hearing, provided he or she notifies the Chief Executive Officer or designee at least five days prior to the Hearing.

22.8.2.2. At Appellate Review: The practitioner may be represented by an attorney at an Appellate Review provided he or she so notified the Chief Executive Officer or designee at least five days prior to the Appellate Review.

22.8.2.3. Responsibility for Attorneys: If a practitioner elects to be represented by an attorney, he or she will be solely responsible for payment of all his or her attorney fees no matter which party prevails at the Hearing.

22.8.2.4. Equal Representation and Preparation Assistance: Only if the practitioner has requested representation by an attorney at the Hearing or Appellate Review may the Credentials Committee or the Board of Directors be allowed such representation. The Credentials Committee or the Board of Directors shall then give the practitioner or his or her attorney notice of who will represent the Credentials Committee or the Board. The foregoing provisions shall not be deemed to deprive the practitioner, the Credentials Committee, or the Board of Directors of the right to legal counsel in connection with preparation for a hearing or an appellate review.

22.8.3. Number of Hearings and Review: Notwithstanding any other provision of the Bylaws, no practitioner is entitled to request more than one evidentiary Hearing and one Appellate Review with respect to the adverse recommendation or action triggering the right.

22.8.4. Failure to accept any Special Notice prescribed in these Bylaws shall constitute receipt thereof. None of the following actions or recommendations shall be deemed to be an Adverse Recommendation or otherwise entitle a Practitioner to a Hearing; and no suit ever shall be commenced or maintained by a Practitioner with respect to any such matter:

22.8.4.1. Letters of warning, admonition, censure or reprimand;

22.8.4.2. Automatic suspension of Privileges or termination of Medical Staff membership pursuant to the Summary Suspension Policy;

22.8.4.3. Denial, termination or reduction of temporary or emergency Privileges;

22.8.4.4. Denial of an application for initial appointment to the Medical Staff because proper responses from references have not been timely received;

22.8.4.5. Denial of Staff reappointment because of failure to complete and timely return an application for reappointment or interval information form;

22.8.4.6. Denial of Staff reinstatement following leave-of-absence because of failure to timely request reinstatement or provide a statement of activities and completed current interval information form; and

22.8.5. Exhaustion of Remedies: No suit shall be commenced by any Practitioner concerning membership on the Medical Staff or Privileges at the Hospital until all remedies with respect to those subjects pursuant to these Bylaws have been finally exhausted.

ARTICLE 23: CONFIDENTIALITY, IMMUNITY, & LIABILITY

23.1. Authorization and Conditions

As a condition of applying for, or exercising Medical Staff membership and clinical privileges within the Hospital, the practitioner:

23.1.1. Authorizes representatives of the Hospital and staff to solicit, provide and act upon information bearing on the practitioner's professional ability and qualifications;

23.1.2. Agrees to be bound by the Medical Staff Bylaws and the Policies of the Medical Staff and of the Hospital;

23.1.3. Acknowledges that the provisions of this article and the application are express conditions to the practitioner's staff membership and the exercise of clinical privileges at the Hospital.

23.2. Confidentiality of Information

Information regarding the maintenance of quality patient care shall, to the fullest extent permitted by laws, is to be kept confidential. This information shall not become part of any particular patient's file or of the general records of the Hospital.

23.3. Immunity from Liability

No representative of the Hospital or Medical Staff shall be liable for damages or other relief for any action, statement or recommendation made within the scope of the person's duties as a representative, if such representative acts in good faith, makes a reasonable effort to ascertain the truthfulness of the facts, and reasonably believes that the action, statement, or recommendation is warranted by such facts. No representative of the Hospital, Medical Staff or third party shall be liable for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of the Hospital, Medical Staff, other health care facility, or organization of health professionals concerning a practitioner who is or has been an applicant to or a Member of the staff, or who did or does exercise clinical privileges or provide specified services at the Hospital, provided that such representative or third party acts in good faith.

23.4. Releases

Each practitioner shall upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this article. Execution of such releases shall not be a prerequisite to the effectiveness of this article.

ARTICLE 24: POLICIES: ADOPTION AND AMENDMENT

24.1. The Medical Executive Committee shall adopt such Medical Staff Policies as may be necessary for the proper conduct and function of the Medical Staff and to more specifically implement the general provisions and principles of the Medical Staff Bylaws, subject to the approval of the Board.

24.2. Any Medical Staff Division, Medical Staff Committee, or Medical Staff Member may propose a new or amended change the Medical Staff Policies to the Medical Executive Committee. An individual Member's proposal must be approved by a signed petition of at least 3% of the voting Medical Staff. The Medical Executive Committee shall give reasonable notice of the proposed new or amended change of the Policy to the Medical Staff and invite review and comment. The final adoption of the proposed new or amendment to the Policies shall be by approval of the Medical Executive Committee, subject to the approval of the Board. If the Medical Staff Executive Committee does not approve a proposed Policy, the sponsoring Medical Staff Division, Committee, or Medical Staff Member may submit the proposal to the next general Medical Staff Meeting, or to the Medical Executive Committee for a Medical Staff membership vote, at which time a 2/3 favorable vote of the voting members shall be necessary for passage, and be effective upon approval by the Board.

Article 25: Medical Staff Bylaws, Adoption and Amendment

25.1. The Medical Staff shall adopt Medical Staff Bylaws as may be necessary for the proper conduct and function of the Medical Staff, subject to approval of the Board. Medical Staff Bylaws or amendments may be proposed by any Medical Staff Division, Medical Staff Committee, or Member. An individual Member's proposal must be approved by a signed petition of at least 3% of the voting Medical Staff.

25.2. These Medical Staff Bylaws may be amended by a vote of the Medical Staff after consideration by the Medical Executive Committee which will recommend the approval or disapproval of the proposed amendment. The proposed amendment shall be distributed to all members of the Medical Staff entitled to vote at least 30 days prior to the date upon which a vote shall be taken. During this time, Medical Staff Members are invited to review and comment on proposed changes to the Medical Executive Committee. Passage of any proposed amendment shall require two-thirds (2/3) approval of those voting. If a

25.3. In cases of a documented need for urgent amendment to the Bylaws or Medical Staff Policies, necessary *only* to comply with law or regulation, the Medical Executive Committee may provisionally approve and adopt urgent amendment, without prior notification of 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 and comment on the provisional amendment. The provisional amendment shall be distributed to all members of the Medical Staff entitled to vote at least 30 days prior to the date upon which a vote shall be taken. Passage of the provisional amendment shall require (2/3) approval of those voting.

25.4. The approved Medical Staff Bylaws shall replace any and all previously existing Medical Staff Bylaws. They shall become effective when approved by the Board.