THREE RIVERS HOSPITAL

Brewster, Washington

BYLAWS OF THE MEDICAL STAFF

Medical Staff Approval **June 15, 2016**

Governing Board of Directors Approval: **June 30, 2016**

Amended by the Medical Staff **February 15, 2017**

Approved by the Governing Board of Directors: **February 28, 2017**

THREE RIVERS HOSPITAL BYLAWS

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BYLAWS OF THE MEDICAL STAFF OF THREE RIVERS HOSPITAL

PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Three Rivers Hospital and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolutions of these purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Board of Directors (hereafter "Governing Board"), Hospital Administration (CEO, COO, CNO hereafter "Administration"), and relations with applicants to and members of the Medical Staff.

ARTICLE I - Name of Organization

The name of this organization shall be the Medical Staff of Three Rivers Hospital (hereafter "Medical Staff").

ARTICLE II - Medical Staff Membership

SECTION A. General Qualifications for Membership

Every practitioner who seeks or enjoys staff appointment must, at the time of application and initial appointment and thereafter, demonstrate to the satisfaction of the Medical Staff and of the Governing Board the following qualifications and any additional qualifications and procedural requirements as are set forth in other provisions of these Bylaws:

1. Licensure.

   A currently valid license issued by the State of Washington to practice medicine, osteopathy, dentistry, podiatry, nurse midwifery, or work as an independent nurse practitioner.

2. Professional Education, Training and Experience.

   The clinical privileges granted to any practitioner will be limited to those for which the practitioner has demonstrated appropriate prior and continuing education and training, prior and continuing experience, and current competence, including C.P.R. certification and recertification at least every two years, for those professionals who do ER call duty.

3. Clinical Performance.

   Appropriate training, current experience, clinical results and documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency given the current state of the healing arts in Washington and consistent with available resources.

4. Cooperativeness.

   Demonstrated ability to work cooperatively with others in the hospital environment, specifically to include refraining from conduct that over time constitutes a pattern of disruption such as to adversely affect the quality or efficiency of patient care services in the hospital.

5. Professional Ethics and Conduct.

   (a) To be of acceptable professional moral character; and

   (b) To adhere to generally recognized standards of medical and professional ethics.

6. Disability.

   (a) Physical or Mental Impairment: To be free of or have under adequate control any physical or mental health impairment that has a reasonable probability of interfering with clinical performance or cooperation in the hospital.

   (b) Substance/Chemical Abuse: To be free from abuse of any type of substance or chemical that has a reasonable probability of affecting the practitioner's clinical performance or cooperativeness in the hospital.

   In demonstrating satisfaction of the foregoing qualifications, a practitioner may, when suspicion or knowledge of a problem exists, be required to provide such information or to obtain such examinations or tests as may be reasonably requested by any two of the following, the chief of staff, the hospital Administrator, or a member of the Governing Board.

7. Verbal and Written Communication Skills.

   Ability to read and understand the English language, to communicate in writing and verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible and timely manner.

8. Professional Liability Insurance.

   Professional liability insurance consistent with the coverage requirements established by the Governing Board after consultation with the Medical Staff. The Governing Board resolution determining the amount of professional liability insurance coverage shall be appended to these Bylaws.

SECTION B. Effect of Other Affiliations

No practitioner shall be automatically entitled to appointment or to exercise particular clinical privileges merely because:

1. The applicant is licensed to practice in this or in any other state;

2. The applicant is certified by any clinical board; and

3. The applicant had, or presently has, staff appointment or those particular privileges at another hospital.

SECTION C. Basic Obligations Accompanying Staff Appointment

Each Medical Staff member, regardless of assigned staff category, and each practitioner exercising temporary privileges, as set forth in other provisions of these Bylaws, is expected to:

1. Provide patients with care at the level of quality and efficiency generally recognized as appropriate at facilities such as this hospital.

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

3. Discharge such staff, committee and hospital functions for which the staff member is responsible by staff category assignment, appointment, election, or otherwise.

4. Provide or arrange for appropriate and timely medical coverage and care for patients for whom the staff member is responsible.

Failure to satisfy any of these basic obligations is grounds as warranted by the circumstances, for non-reappointment or for such disciplinary action as deemed appropriate by the Governing Board.

SECTION D. Term of Appointment

Appointments and re-appointments to the medical and Allied Health Professional staff with granting of clinical privileges are for a period of two (2) years, except that:

1. New appointees to the staff are subject to an initial provisional period of six (6) months. Upon satisfactory conclusion of that period they are placed in the appropriate reappointment cycle according to their birthdates. This may result in the initial appointment period being less than two full years.

2. In the interim, each member shall be requested and required to provide evidence of renewed licensure, DEA registration, and professional liability insurance coverage prior to the expiration date of the same.

3. The Governing Board may after considering the recommendations of the Medical Staff, set a more frequent appraisal period for the exercise of particular privileges or in general for a Medical Staff member who has an identified health disability or for a Medical Staff member who has been the subject of disciplinary action.

4. Disciplinary action involving membership status and/or clinical privileges may be initiated and taken in the interim under the appropriate provisions of the Medical Staff Bylaws.

5. In the case of a practitioner providing professional services by contract or employment, termination or expiration of the contract or employment may result in a shorter period of appointment or privileges if required by the contract or employment arrangement or under the Medical Staff Bylaws.

ARTICLE III - Appointment and Reappointment

SECTION A. Initial Appointment Procedures

1. Application.

   An application for staff appointment must be submitted by the applicant in writing. Prior to acceptance of the application, the applicant will be provided:

   (a) A copy of the Medical Staff Bylaws and Medical Staff Rules and Regulations;

   (b) The hospital-approved forms for requesting clinical privileges; and

   (c) The attestation/authorization for release of information form.

2. Application Content.

   Every application submitted by an applicant must furnish complete information concerning at least the following:

   (a) current socioeconomic information including; full name, date of birth, place of birth, social security number, home mailing address and telephone, office mailing address and telephone, name of clinic, type of practice, and specialty or subspecialty;

   (b) undergraduate, medical school, school of osteopathic medicine, dental school, midwifery program, nurse practitioner school, or school of podiatry, the name of each institution, mailing address, degrees granted, program completed, dates attended, and, for all postgraduate training, names of practitioners responsible for monitoring the applicant's performance;

   (c) all past and current valid medical and other professional licensures, certifications, provider numbers, and Drug Enforcement Administration (DEA) controlled substance registration, with the date and number of each. A copy of the current DEA controlled substance certificate must accompany the application;

   (d) specialty or subspecialty board certification, recertification, or current qualification status to sit for the examination;

   (e) any health problem or disability, including alcohol or drug dependence, that may affect the applicant's ability to perform professional and Medical Staff duties fully; hospitalizations or other institutionalizations for any such health problem or disability during the past two year period; if any such health problem or disability is currently controlled by therapy, the date of last health examination, with name and address of performing physician, and findings related to that problem or disability;

   (f) professional liability insurance coverage and information on professional liability history and experience, claims, suits and settlements made, concluded and pending, including the names and addresses of present and past insurance carriers;

   (g) any proceedings initiated, pending or completed involving allegations or findings of professional misconduct;

   (h) any proceedings initiated, pending or completed involving denial, revocation, suspension, reduction, limitation, probation or nonrenewal of any of the following;

      (i) license or certification to practice profession in any state or country;
      (ii) Drug Enforcement Administration or other controlled substance registration;
      (iii) membership or fellowship in local, state or national professional organizations;
      (iv) faculty membership at any medical, dental, podiatry or other professional school;
      (v) appointment or employment status, prerogatives or clinical privileges at any other hospital, facility or organization; or
      (vi) limitation, cancellation, imposition of surcharge on professional liability insurance.

   (i) any instance in which the applicant did not renew, terminated, restricted, limited, withdrew or failed to proceed with an application for any of the elements listed in (h) immediately above in order to foreclose or terminate actual or possible investigation or disciplinary or adverse action;

   (j) any current felony criminal charges pending against the applicant and any past charges including their resolution;

   (k) location of offices; names and addresses of other practitioners with whom the applicant is or was associated and dates of such association; names and locations of any hospital or facility where the applicant had or

has any association, employment, privileges or practice with inclusive dates of each affiliation, status held, and general scope of clinical privileges; and

(l) staff category and specific clinical privileges requested.

3. References.

The applicant must provide the names of at least three (3) professional references not newly associated or about to become partners with the applicant in professional practice or personally related to the applicant who have personal knowledge of the applicant's current clinical ability, ethical character, health status and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from hospital or Medical Staff authorities.

The named individuals must have acquired the requisite knowledge through recent observation of the applicant's professional performance over a reasonable period of time. At least one must be from a colleague in the applicant's specialty not currently or about to become associated with the applicant in practice, and at least one must have had organizational responsibility for the applicant's performance.

4. Attestation/Authorization to Release Information.

The applicant must sign the "Attestation/Authorization to Release Information" and in so doing:

(a) attests to the correctness and completeness of all information furnished and acknowledges that any material misstatement in or omission from the application constitutes grounds for denial of appointment or for automatic revocation of staff membership and clinical privileges. For the purpose of this paragraph, "material" means that the misstatement or omitted information was important to evaluation of the application and may have resulted in a different action being taken or recommendation being made by the Medical Staff or Governing Board. A practitioner who is denied appointment to the Medical Staff or whose membership and privileges are revoked pursuant to this paragraph is entitled to the procedural rights afforded in Article VII, Fair Hearing provisions of these Bylaws for the sole purpose of determining the materiality of the misstatement or omission;

(b) signifies a willingness to appear for interviews in connection with the application;

(c) agrees to abide by the terms of the Bylaws, Rules and Regulations and policy manuals of the Medical Staff and those of the hospital if granted appointment and/or clinical privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment and/or privileges are granted;

(d) agrees to maintain an ethical practice and to provide for or arrange continuous care to patients;

(e) agrees to notify immediately the hospital Administrator of any changes made or proposed in the status of the applicant's professional license to practice, Drug Enforcement Administration or other controlled substance registration, professional liability insurance coverage, membership or clinical privileges at other institutions, and on the status of current or initiation of new professional liability claims;

(f) authorizes and consents to hospital and Medical Staff representatives consulting with prior associates or others who may have information bearing on professional or ethical qualifications and competence and consents to their inspecting all records and documents that may be material to such evaluation; and

(g) releases from any liability all those who in substantial good faith review, act on or provide information regarding the applicant's background, experience, clinical competence, professional ethics, character, health status and other qualifications for staff appointment and clinical privileges.

5. Processing the Application.

(a) The applicant has the burden of producing adequate information for a proper evaluation of his or her experience, training, current competence, ability to work cooperatively with others and health status; of resolving any doubts about any of the qualifications required; and of satisfying any requests for information or clarification, including health examinations, made by the Medical Staff or Governing Board.

(b) The designated hospital employee will be responsible to collect and verify quantitatively the information provided by the applicant. The applicant will be notified of any gaps in or any other problems in obtaining the information required by special notice with indication of the nature of the information the applicant is to provide.

(c) Verification shall include:

(i) Sending a copy of the list of clinical privileges requested by the applicant to relevant residency and fellowship training programs and to his/her hospital or other affiliations of the past ten (10) years with a request for specific information regarding his/her training and competence in exercising each of the privileges requested;

(ii) Requesting from any hospital with or at which the applicant had or has privileges, was associated, or was employed information relating to; any pending professional medical misconduct proceeding; and pending medical malpractice actions; any judgement or settlement of a medical malpractice action; any finding of professional misconduct in this state or another state by a licensing or disciplinary board; and any information required to be reported by hospitals to the medical disciplinary board, the osteopathic disciplinary board, the dental disciplinary board, midwifery disciplinary board, nursing review board, or the podiatry disciplinary board.

(iii) Requesting from the appropriate Medical Disciplinary Board, the Osteopathic Disciplinary Board, the Dental Disciplinary Board, midwifery disciplinary board, nursing review board, the Podiatry Disciplinary Board, or the National Practitioner Data Bank information regarding the applicant that has been reported pursuant to the Health Care Improvement Act of 1986.

(iv) Submitting a Request for Physician Profile Data from the American Medical Association or the American Osteopathy Association Physician Master file.

(v) Requesting from licensing authorities, all information relevant to any professional medical misconduct proceedings in this state or any other state.

(vi) Health and Human Services Office of Inspector General (OIG) inquiries will be made for all original and re-appointment applications. This website checks for parties that are excluded from participating in the Medicare, Medicaid and all Federal Health Care Programs.

(vii) Obtaining law enforcement background check.

6. Formal Interview.

The Chief of Staff or his/her designated alternate may conduct an interview with the applicant. This interview, when initiated, shall follow a protocol that involves at minimum; a detailed oral description by the applicant of formal training and experience to date; specific review of each clinical privilege being requested and the application evidence supportive thereof; analysis of clinical cases by the applicant with discussion of how the applicant would approach diagnosing and/or resolving the problem presented. A report of the interview should be prepared.

If further information is required the interviewer may defer this report, but generally for not more than thirty (30) days for good cause. In case of a deferral, the interviewer must notify the Medical Staff and the applicant in writing of the deferral and the grounds.

7. Schedule Medical Staff Review.

When collection and quantitative verification of information is accomplished, the Chief of Staff will review all information compiled. He or She may request additional information or clarification of information that he/she feels is pertinent to Medical Staff evaluation and recommendation. When the Chief of Staff is satisfied that information is sufficient for proper evaluation and recommendation, he/she will prepare a summary of results of investigation of applicant's credentials and will schedule review by the Medical Staff.

8. Medical Staff Input.

The Medical Staff Services Office will send a notice two weeks before the monthly Medical Staff meeting to each Active Medical Staff member of all providers applying for privileges. Any member of the Medical Staff may review the entire credential file of an applicant by going to the Medical Staff Services Office and request review. Any member may submit to the President, a written statement containing relevant information regarding an applicant's qualifications for membership or the privileges requested.

9. Action by the Medical Staff.

The regularly constituted Committee-of-the-Whole of the Medical Staff shall review the application, results of investigation and interviews, Medical Staff members' statements, as well as any other relevant information made available to or requested by it. The Chief of Staff shall cause prompt notification to the applicant of any gaps in or any other problems in obtaining the information required. This must be a special notice and must indicate the nature of the information the applicant is to provide and the time frame for response. Failure without good cause to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application. A written report with recommendations shall be submitted to the Governing Board.

10. Effect of Medical Staff Action.

    (a) Deferral: Action by the Medical Staff to defer the application for further consideration must, except for good cause be followed up within thirty (30) days with its report and recommendations. The President shall promptly send the applicant special notice through the Medical Staff Services Office of an action to defer, including a request for the specific data, explanation, release or authorization, if any, required from the applicant and the time frame for response. Failure without good cause to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application.

    (b) Favorable Recommendation: A Medical Staff recommendation that is favorable to the applicant in all respects is forwarded together with all supporting documentation to the Governing Board.

    (c) Unfavorable Recommendation: A Medical Staff recommendation that is unfavorable to the applicant in any respect is forwarded together with all supporting documentation to the Governing Board. The President shall inform the applicant by special notice of the exact nature of and the reasons for the unfavorable recommendation. The applicant shall be informed that the unfavorable recommendation has been transmitted to the Governing Board for action.

11. Governing Board Action on Credentials Matters.

    As part of any of its actions hereafter outlined, the Governing Board may at its discretion conduct an interview with the applicant or designate one or more individuals to do so on its behalf. If, as part of its deliberations the Governing Board determines that it requires further information, it may defer action but generally for not more than thirty (30) days except for good cause, and it shall notify the applicant and the President in writing of the deferral and the grounds.

    If the applicant is to provide additional information or a specific release or authorization to allow hospital representatives to obtain information, the notice to the applicant must so state, must be a special notice, and must include a request for the specific data, explanation, release or authorization required and the time frame for response. Failure without good cause to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application.

    (a) On Favorable Medical Staff Recommendations: The Governing Board may adopt or reject, in whole or in part, a favorable recommendation by the Medical Staff. If the Governing Board's action is favorable to the applicant, it is effective as its final decision.

    (b) Without Benefit Of Medical Staff Recommendation: The following procedures shall be followed if the Governing Board, in its determination, does not receive a recommendation from the Medical Staff within the time frame provided, or within any reasonable extension of that time frame resulting from deferral of a recommendation in order to obtain additional data, explanation or a specific release or authorization, or from any other good cause.

        The Governing Board may, after notifying the Medical Staff of its intent, including a reasonable period of time for response, take action on its own initiative employing the same type of information usually considered by the Medical Staff.

        Favorable action by the Governing Board is effective as the final decision. If the Governing Board's action is unfavorable in any respect, the Administrator shall inform the applicant by special notice of the Fair Hearing provisions of these Bylaws. The applicant is then entitled, upon proper and timely request, to the procedural rights provided therein.

    (c) On Unfavorable Medical Staff Recommendation: The Governing Board may adopt or reject, in whole or in part, an unfavorable recommendation by the Medical Staff. If the Governing Board's action is unfavorable in any respect, the Administrator shall inform the applicant by special notice of the Fair Hearing provisions of these Bylaws. The applicant is then entitled, upon proper and timely request, to the procedural rights provided therein.

    (d) Unfavorable Governing Board Action Defined: For the purposes of this subsection 11, "unfavorable action" by the Governing Board is defined in Article VI, Section D, of these Bylaws. If the Governing Board takes unfavorable action the applicant is entitled to the procedural rights in the Fair Hearing provisions of these Bylaws.

        The applicant is not entitled to the procedural rights in the Fair Hearing provisions until and unless the Governing Board takes unfavorable action.

12. Content of Report and Basis for Recommendation and Actions.

Each individual or group providing a recommendation or action on an application shall have available the full resources of the Medical Staff and the hospital, as well as the authority to use outside consultants as deemed necessary. The report of each individual or group must include recommendations as to approval or denial of, and any special limitations on, staff appointment, category of staff appointment and prerogatives, and clinical privileges. All documentation and information received by any individual or group during or as part of the evaluation process must be included with the application as part of the individual's central credentials file and, as appropriate or requested, transmitted with reports and recommendations. The reasons for each recommendation or action to deny restrict or otherwise limit must be stated.

13. Conflict Resolution.

Whenever the Governing Board determines that it will decide a matter contrary to the recommendation of the Medical Staff, the matter shall be submitted to a joint advisory committee composed of two members each from the Medical Staff and the Governing Board, appointed respectively by the President and the Governing Board chairperson, for review and report before the Governing Board takes final action.

14. Notice of Final Decision.

(a) The Administrator provides notice of the final decision to the applicant by special notice and to the Medical Staff through the President.

(b) A decision and notice to appoint includes; (1) the staff category to which the applicant is appointed; (2) the clinical privileges the applicant may exercise; and (3) any special conditions attached to the appointment.

15. Time Periods for Processing.

All individuals and groups required to act on an application for staff appointment must do so in a timely and good faith manner and, except for obtaining required information or for other good cause, each application should be processed within the following time periods;

INDIVIDUAL/GROUP		TIME
(a)	Medical Staff Services Office	60 days after receiving application.
(b)	Medical Staff	30 days after receiving report, if any, from (a)
(c)	Governing Board	30 days after receiving report, if any, from (b)

These time periods are to be deemed guidelines and are not directives such as to create any rights for a practitioner to have an application processed within these precise periods. If the Fair Hearing provisions are activated, the time requirements provided herein govern the continued processing of the application. If action does not occur at a particular step in the process within the time frame specified and the delay is unwarranted, the next higher authority may immediately proceed to consider the application and all supporting information or may be directed by the President on behalf of the Medical Staff or by the Administrator on behalf of the Governing Board to so proceed.

SECTION B. The Provisional Period

1. Applicability and Duration.

All new appointments to the medical and Allied Health Professional staff and all granting of initial or increased clinical privileges to new members or existing Medical Staff members are provisional for a maximum period of six (6) months, unless an extension is granted. The chief of staff shall establish the conditions for the provisional period. In unusual circumstances the Governing Board may, after receiving the recommendation, if any, of the Medical Staff, waive this requirement for existing Medical Staff members.

2. Status and Privileges During Provisional Period.

During the provisional period a practitioner must demonstrate all of the qualifications, may exercise all of the prerogatives, and must fulfill all of the obligations of the staff category; and the practitioner may exercise all of the clinical privileges granted. A practitioner's exercise of prerogatives and clinical privileges during the provisional period is subject to any conditions or limitations imposed as part of the appointment to the staff or grant of privileges, or as may be imposed during the term of the provisional period as a result of corrective action.

3. Review And Observation Required.

At the option of the Chief of Staff, a practitioner's performance may be reviewed and evaluated by a supervising physician designated by the Chief of Staff.

The designated supervising physician shall establish the number and types of cases and review requirements (prospective, concurrent, retrospective) for concluding the provisional period in the unit. It is the obligation of the practitioner in the provisional period to arrange for the required numbers and types of cases to be reviewed or directed by the supervising physician and, except for good cause, to do so within a time frame that results in the reviews being completed prior to the start of the formal evaluation process set forth in subsections 4 and 5 of this Section B. The supervising physician will prepare, as part of the process for reviewing the member in a provisional period, a summary for the member's file of the same type of information as is collected in connection with reappointments. Review during the provisional period may include review of cases managed at other hospitals.

4. Request To Conclude/Extend Provisional Period.

On or before forty-five (45) days prior to the completion of the practitioner's provisional period, the Medical Staff Services Office shall notify the practitioner of the date on which the period will end. No later than thirty (30) days prior to that date, the practitioner may forward to the Medical Staff service office either a request to initiate the evaluation process to conclude all or any part of his/her provisional period or a request for extension for a specified period of time.

The Medical Staff Service Office forwards the practitioner's request to conclude or extend the period, along with the results of the supervising physician's reviews/observations, and the summary prepared by the supervising physician pursuant to subsection 3 above to the Chief of Staff.

The evaluation process to be followed shall be as set forth in Section C, subsections 3, 4, and 5 of this Article III. Each individual or group providing recommendation or acting on the conclusion of a provisional period shall have available the full resources of the Medical Staff and the hospital, as well as the authority to use outside consultants as deemed necessary.

5. Procedural Rights.

Whenever a provisional period, including any period of extension, concludes with an unfavorable action, or whenever an extension is denied, the Administrator will provide the practitioner with special notice of the Fair Hearing provisions of these Bylaws. The practitioner shall then be entitled, upon proper and timely request, to the procedural rights provided therein.

SECTION C. Reappointment Procedures

1. Information and Collection.

(a) From Medical and Allied Health Professional Staff Member.

On or before ninety (90) days prior to **EACH APPOINTEES BIRTHDATE IN THE 2ND YEAR SINCE THE LAST APPOINTMENT/RE-APPOINTMENT**, the Medical Staff Services Office shall notify the member of the date of expiration and request an application for reappointment be completed. At least sixty (60) days prior to the expiration date, the Medical Staff member shall furnish, in writing:

(i) complete information and all documents necessary to bring the file current on the items listed in Article III, Section A, subsection 2 of these Bylaws including; current license, DEA registration, professional liability insurance coverage and experience; board certification status, professional medical misconduct or negligence proceedings and any other disciplinary proceeding initiated, pending, completed, and any health problem or disability, including alcohol or drug dependence, that may affect the applicant's ability to perform professional and Medical Staff duties fully; hospitalizations or other institutionalizations for any such health problem or disability during the past two year period; if any such health problem or disability is currently controlled by therapy, the date of last health examination, with name and address of performing physician, and findings related to that problem or disability;

(ii) Continuing training and education external to the hospital during the proceeding period;

(iii) Specific request for additions to or deletions from the clinical privileges presently held with any basis for changes; and

(iv) Requests for changes in staff category. The Medical Staff member must sign the Memorandum Of Understanding Between Three Rivers Hospital And Applicant, and in doing so accepts the same conditions as stated in Article III, Section A, subsection 4, of these Bylaws.

(b) If the Medical Staff member or Allied Health Professional has not returned his/her completed application for reappointment or request for extension by thirty (30) days before the expiration date, the Medical Staff Services Office shall send the Medical Staff member special notice that the application/extension request has not been received and that there is a fifteen (15) day grace period in which to submit the application/extension request.

(c) Failure without good cause to provide the fully completed reappointment application with all of the required information prior to or within the grace period is deemed a voluntary resignation and results in automatic termination of appointment and clinical privileges at the expiration of the current term, unless that Medical Staff member requests an extension prior to or within the grace period, and the time for return of the reappointment application is explicitly extended for good cause for not more than forty-five (45) days by action of the President. Only one extension is permitted. Failure to return the application within any period of extension provided shall result in automatic termination of appointment and clinical privileges. A practitioner whose appointment and clinical privileges are terminated under this provision is entitled to the procedural rights provided in the Fair Hearing provisions of these Bylaws for the sole purpose of determining the issue of good cause.

(d) The Medical Staff Services Office quantitatively verifies the information provided on the reappointment application. Such verification at reappointment shall include without limitation the matters stated in Section A, subsection 5(c) of this Article III. The Medical Staff Services Office notifies the Medical Staff member of any information inadequacies or verification problems by special notice and must indicate the nature of the additional information the Medical Staff member is to provide and the time frame for response. Failure without good cause to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application.

(e) If the Medical Staff member's level of clinical activity at this hospital is not sufficient to permit the Medical Staff and Governing Board to make an informed judgment as to competence in exercising the clinical privileges requested, the Medical Staff member shall have the burden of providing evidence of clinical performance at the practitioner's principal institution in such form as may be required by the Medical Staff and/or Governing Board.

(f) The Medical Staff Services Office transmits the reappointment application, supporting information and Medical Staff member's credentials file, or relevant portions thereof, with the required information to the President for review by the Medical Staff.

(g) From Internal Sources.

The Medical Staff Services Office collects for consideration, as part of the reappointment process, all relevant information regarding the individual's professional and collegial activities, performance and conduct in the hospital. Such information, which together with the information obtained under Section C, subsection 1(a) above shall form the basis for recommendation and action, shall include without limitation:

(i) patterns of care as demonstrated in the findings of quality review, professional liability prevention activities;
(ii) participation in relevant internal teaching and continuing education activities;
(iii) level/amount of clinical activity (patient care contacts) at the hospital;
(iv) sanctions imposed or pending and other problems;
(v) any health problem or disability, including alcohol or drug dependence, that may affect the applicant's ability to perform professional and Medical Staff duties fully; hospitalizations or other institutionalizations for any such health problem or disability during the past two year period; if any such health problem or disability is currently controlled by therapy, the date of last health examination, with name and address of performing physician, and findings related to that problem or disability;
(vi) attendance at required Medical Staff and committee meetings;
(vii) participation as a staff official, committee member, committee chairperson, proctor, and in on-call coverage rosters;
(viii) timely and accurate completion and preparation of medical records; (24hrs for H&P, 48hrs for discharge summary)
(ix) cooperativeness in working with other practitioners and hospital personnel;
(x) general attitude toward patients and the hospital;

(xi) compliance with all applicable Bylaws, policies, rules and procedures of the hospital and Medical Staff; and

(xii) any other pertinent information that may be relevant to the member's status and clinical privileges at this hospital, including the Medical Staff member's activities at other hospitals.

2. Basis for Recommendation and Action.

Each individual or group providing a recommendation or acting on a reappointment shall have available the full resources of the Medical Staff and the hospital, as well as the authority to use outside consultants as deemed necessary.

The report of each such individual or group shall state the reasons for each adverse recommendation made or action taken. In addition to any other information contained in a credentials file that may support a non-reappointment recommendation or action, any individual or group required to act on a reappointment may consider no or very minimal involvement at the hospital by a staff member over the last period of appointment in patient care, teaching or like activities as grounds for a recommendation/action to not appoint.

3. Medical Staff Evaluation.

The Medical Staff shall review and evaluate the reappointment application and its supporting information, the information gathered under Section C, subsection 1(a) (b) above, other pertinent aspects of the Medical Staff member's files and other relevant information available to it.

The Chief of Staff shall prepare a written report with recommendations for, and any special limitations on, reappointment or non-reappointment and staff category and clinical privileges. The Medical Staff's report is transmitted with supporting documentation to the Governing Board.

4. Final Processing and Governing Board Action.

Final processing of reappointments shall follow the same procedure as initial appointment.

5. Time periods For Processing.

Transmittal of the notice to a Medical Staff member and providing updated information is to be carried out in accordance with the provisions in subsection 3 of this Section C. Thereafter and except for good cause, all persons and groups required to act must complete such action so that all reappointment reports and recommendations are acted on by the Governing Board prior to the expiration date of the appointment of the Medical Staff member whose reappointment is being processed.

If reappointment processing has not been completed by an appointment expiration date through no fault of the Medical Staff member, the member maintains current appointment status and clinical privileges until the time that processing is completed, except where corrective action as set forth in these Bylaws has been taken with respect to all or any part thereof. If unwarranted delay occurs at any step in the processing and is attributable to a Medical Staff member or group or hospital authority, the next higher authority may immediately proceed to consider the reappointment application and all the supporting information, or may be directed by the President or by the Administrator respectively on behalf of the Medical Staff or the Governing Board to so proceed.

If the delay is attributable to the practitioner's failure to provide information required under any provision of this Section C, the practitioner's staff appointment and clinical privileges shall terminate on the expiration date.

6. Requests for Modification of Appointment Category or Privileges and Notice of Relinquishment of Privileges.

A Medical Staff member may, either in connection with reappointment or at any other time, request modification of staff category or clinical privileges by submitting a written request to the Medical Staff Services Office. A modification request is processed according to the procedures outlined in Section A or C, as appropriate to the context, and must contain all pertinent information supportive of the request. A Medical Staff member who determines to no longer exercise, or to restrict or limit the exercise of, particular clinical privileges which have been granted shall send written notice to the President indicating the same and identifying the particular privileges involved and, as applicable, the restriction or limitation. This notice shall be included in the member's credential file.

ARTICLE IV - Delineation of Clinical Privileges

SECTION A. Exercise of Privileges

1. In General.

   A practitioner providing clinical services at this hospital by virtue of Medical Staff membership or in a temporary privileges situation may, in connection with such practice and except in emergency, exercise only those clinical privileges specifically granted to the practitioner by the Governing Board or as provided hereafter for temporary privileges. There may be attached to any grant of privileges to an individual practitioner, special requirements for consultation or supervision as a condition to the exercise of particular privileges. Practitioners must provide, consistent with their delineated privileges or arrange for, continuous medical care for their patients in the hospital and obtain appropriate consultation or supervision or refer the case to another qualified practitioner when appropriate or when required by the Bylaws, rules or other policies of the Medical Staff or hospital.

2. Experimental, New, Untried Or Unproven Procedures, Treatment, Modalities, Instrumentation.

   Experimental drugs, procedures, or other therapies or tests may be administered or performed only after approval of the protocols involved by the Medical Staff. Any experimental or other new, untried, or unproven procedure, treatment modality, or instrumentation may be performed or used only after the regular credentialing process has been completed and the privilege to perform or use said procedure, treatment modality, instrumentation has been granted to the individual practitioner.

   For the purpose of this section, a new, untried or unproven procedure, treatment modality, instrumentation is one that is not generalizable from an established procedure, treatment modality, instrumentation in terms of involving the same or similar skills, the same or similar instrumentation and technique, the same on similar complications, the same or similar indications, or the same or similar expected physical outcome for the patient as the established procedure, treatment modality, instrumentation.

SECTION B. Basis for Privileges Determination

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

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

3. The basis for privileges determinations for current staff members in connection with reappraisal, including conclusion of the provisional period, or with a requested change in privileges may also include observed clinical performance, documented results of quality review, and professional liability prevention program activities, and in the case of additional privileges requested, evidence of appropriate training and experience supportive of the request.

4. For the purpose of granting clinical practice privileges, the Medical Staff shall define the basic requisite training, experience, or other qualifications required for all operative, invasive and other special procedures; the medical conditions and problems that fall within its clinical area, including different levels of complexity and different age groupings, when appropriate. These definitions shall be appended to these Bylaws and shall be used for the requesting and granting of privileges and shall be approved by the Medical Staff and Governing Board.

SECTION C. Definition of Privileges

1. The Medical Staff clinical privilege forms shall be developed from the listing of the operative, invasive and other special procedures; and the medical conditions as defined in Article IV, Section B, subsection 4, of these Bylaws. The definitions and clinical privilege forms shall be reviewed at least every two years and revised as necessary to reflect new procedures, instrumentation, treatment modalities and like advances or changes. When the definitions or clinical privilege forms are revised by additions or deletions or the adoption of new forms, all staff members holding affected privileges in the hospital must, as appropriate to the circumstances complete the new form, at their next scheduled re-appointment time, request and be processed for privileges added, or comply with the fact that a privilege was deleted.

2. For the purpose of requesting and granting of privileges, classification of clinical privileges shall be defined as follows;

   (a) **Type I, Unsupervised Privileges.**

   Type I, unsupervised privileges for a specified operative, invasive or other special procedure or medical condition means that the practitioner may exercise these specifically defined privileges independently according to his/her own assessment of patient needs. In addition, the practitioner with Type I unsupervised privileges shall provide the necessary consultation and/or supervision as required to insure the orderly and proper discharge of the Medical Staff's responsibility in matters involving the quality of medical care.

   (b) **Type II, Consultation Required Privileges:**

   Type II, consultation required privileges for a specified operative, invasive or other special procedure or medical condition, means that the practitioner must have prior consultation with a practitioner who holds Type I, unsupervised privileges for the specific operative, invasive or other special procedure or as soon as possible after a patient is admitted or develops a medical condition requiring consultation. The consultant will document his/her findings and recommendations and there must be evidence that the practitioner with Type II privileges is cognizant of the specifics of the consultation. In any case where a practitioner with Type II, consultation required privileges fails to obtain or accept the findings and recommendations of a consulting physician, this case will automatically be transmitted to the Medical Staff for "quality of care" review. In the situation when no in-house specialist is available for consultation, a phone consultation will suffice with a written notation being made in the patient’s medical record.

   (c) **Type III, Supervision Required Privileges:**

   Type III, supervision required privileges for a specific operative, invasive or other special procedure means that the practitioner must have present in person supervision by a physician/surgeon who holds Type I, unsupervised privileges for the specific operative, invasive or other special procedure. Type III, supervision required privileges for a specific medical condition means that the practitioner must name and make arrangements with a physician who holds Type I, unsupervised privileges to provide proper supervised patient care as soon as possible after a patient is admitted or develops the medical condition requiring supervision. At a minimum, the supervising physician will document a consultation report of his/her findings and recommendations in a timely manner and there must be evidence that the practitioner with Type III, supervision required privileges is not only cognizant of the specifics of the consultation, but that patient care reflects adherence to the recommendations of the supervising physician. In any case where a practitioner with Type III, supervision required privileges fails to name or accept the findings and recommendations of the supervising physician, this case will automatically be transmitted to the Medical Staff for "quality of care" review.

   (d) **Type IV, May Assist Only Privileges:**

   Type IV, may assist only privileges for a specific operative, invasive or other special procedure means that the practitioner may not perform the specific operative, invasive or other special procedure, but may be named as the assistant to a physician/surgeon who holds Type I, unsupervised privileges or Type II, consultation required privileges for such case. Type IV may assist only privileges for a specific medical condition means that the practitioner may not independently admit or direct the care of a patient in such case. The attending physician shall conduct or supervise the admitting physical examination and assumes responsibility for the care of the patient. The practitioner with Type IV may assist only privileges may accept, document and direct patient care orders by the attending physician, or carry out orders and functions specifically outlined in established protocol for specific medical conditions and events which have been approved by the attending physician and/or the Medical Staff in the credentialing process for the practitioner. Except in emergency, in any case where a practitioner with Type IV, may assist only privileges,

exceeds his/her authority in the provision of patient care, all privileges shall automatically be suspended pending review by the Medical Staff and Governing Board.

(e) **Privileges of Limited License Practitioners:**

Dentists, oral surgeons and podiatrists who are members of the Medical Staff may independently provide outpatient services to patients according to specific privileges granted to each practitioner, provided the patient is not at risk because of known anesthesia, surgery or medically related condition.

Dentist, oral surgeons and podiatrists who are members of the Medical Staff may admit patients for services according to privileges specifically granted to each practitioner, provided that a physician member of the Medical Staff assumes responsibility for the assessment and management of any medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

Operative procedures performed by dentists, oral surgeons and podiatrists shall be under the general supervision of the medical director of surgery services. Present in person supervision is not required unless the practitioner holds Type III, supervision required surgery privileges, or the supervising physician determines there is some anesthesia, surgery or medically related risk factor. The supervising physician will assure that the CRNA is administering general, spinal or regional block anesthesia, as permitted by State Law and that a safe environment is maintained.

Failure by a dentist, oral surgeon or podiatrist to arrange for medical assessment and management of any risk factor or any effect of treatment or surgical procedure upon the general health status of a patient will cause such case to automatically be transmitted to the Medical Staff for "quality of care" review.

(f) **Privileges of Allied Health Practitioners:**

Members of the Allied Health Professional Staff may provide outpatient services to patients according to privileges specifically granted to them according to their job descriptions, contracts, or clinical privilege forms which have been approved by the Administrator or Medical Staff and Governing Board.

No Allied Health Practitioner may independently admit a patient or direct inpatient care services in this hospital. A physician member of the Medical Staff must assume responsibility for the ongoing assessment and management of inpatient care services provided by allied health practitioners.

Allied Health Practitioners may only assume responsibilities, perform duties, or provide clinical services according to their job descriptions, contracts, or clinical privilege forms as approved by the Administrator or Medical Staff and Governing Board. In any case where an allied health practitioner arbitrarily exceeds his/her authority in the provision of patient care, all or any part of the practitioner's privileges may be suspended consistent with the circumstances, pending review by the Administrator or Medical Staff and Governing Board.

SECTION D. Procedure for Delineating Privileges

1. Requests.

Each applicant for appointment and reappointment to the Medical Staff and, when applicable, each appointment to the Allied Health Professional Staff must contain a request for the specific privileges desired by the applicant or staff member. Specific requests must also be submitted for temporary privileges and for modification of privileges in the interim between appraisals.

2. Processing Requests.

All requests for clinical privileges, except those for temporary privileges, are processed according to the procedures outlined for the initial appointment and reappointment processes as applicable. Requests for temporary privileges are processed as outlined in Section F of this Article IV.

SECTION E. Privileges in Emergency Situations

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of the patient is in immediate danger and any delay in administering treatment could add to that danger, any practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license but regardless of staff category or privileges. A practitioner providing services in an emergency situation that are outside the practitioner's usual scope of privileges is obligated to summon all consultative assistance available as deemed necessary and to arrange for appropriate follow-up care.

SECTION F. Temporary Privileges

1. Conditions.

   Temporary privileges may be granted only in the circumstances and under the conditions described in subsection 2, hereafter stated; only to practitioners licensed in the State of Washington when the information available substantially supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested; and only after the practitioner has satisfied the hospital's professional liability insurance requirement.

   Special requirements of consultation and reporting may be imposed by the Medical Staff or hospital. Under all circumstances the practitioner requesting temporary privileges shall agree to abide by the Bylaws and related manuals, rules, and policies of the Medical Staff in all matters relating to the practitioner's activities in the hospital.

2. Circumstances.

   To meet the immediate needs of the community or an individual patient and upon the written recommendation of a Medical Staff member, the Administrator may grant temporary privileges in the following circumstances:

   (a) Pendency of Application.

   To an applicant for Medical Staff appointment but only after; receipt of a complete application for staff appointment including a written request for specific temporary privileges; telephone or written confirmation of current licensure, DEA registration, and adequate professional liability coverage; a fully positive written or oral reference specific to the privileges being requested from a responsible Medical Staff authority at the practitioner's current principal hospital affiliation. Temporary privileges may be granted in this circumstance for an initial period of ninety (90) days, with subsequent renewals not to exceed the pendency of the application. Any such renewal shall be made only upon the written recommendation of the President and the written concurrence of the Administrator, and may be made only when the information available continues to support a favorable determination regarding the practitioner's application for appointment and privileges. Under no circumstances may they be renewed if the application is still pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information. An unfavorable Medical Staff or Governing Board recommendation automatically terminates temporary privileges.

   (b) Care Of Specific Patient.

   To a practitioner for the care of a specific patient but only after; receipt of a written request for the specific privileges desired; telephone confirmation or receipt of a copy of current licensure, DEA registration and adequate professional liability coverage; a fully positive oral reference specific to the privileges being requested from a responsible Medical Staff authority at the practitioner's current principal hospital affiliation. Temporary privileges of this nature may not be granted in more than six (6) instances in any twelve (12) month period after which the practitioner must apply for Medical Staff appointment and are restricted to the specific patients and clinical privileges for which they are granted.

   (c) Locum Tenens.

   To a practitioner who will be serving as a locum tenens for a current staff member but only after; receipt of a complete application for appointment as a locum tenens including a request for specific privileges; at least telephone confirmation or receipt of a copy of current licensure, DEA registration, adequate professional liability coverage and a fully positive written reference specific to the privileges requested from a responsible Medical Staff authority at the practitioner's current principal hospital affiliation. The locum tenens may not exceed ninety (90) days in length.

3. Termination.

   The Administrator or President may terminate any or all of a practitioner's temporary privileges, provided that nothing therein shall be deemed to prevent any authority entitled to impose summary suspension under Article VII, Section B of these Bylaws from doing so under the circumstances set forth therein.

   In the event of any such termination, the practitioner will arrange for alternate medical coverage for his patients then in the hospital. The wishes of the patient will be considered, where feasible, in choosing a substitute practitioner.

4. Right of the Practitioner.

   A practitioner is not entitled to the procedural rights afforded by the Fair Hearing provisions of these Bylaws when his/her request for temporary privileges is refused in whole or in part or when all or any portion of his/her temporary privileges are terminated, not renewed, restricted, suspended or limited in any way.

ARTICLE V - Category of Membership

SECTION A. Categories

The categories of Medical Staff membership shall be: Active, Consulting, Associate, Emeritus, Allied Health Professional, Certified Nurse-Midwives, Advanced Registered Nurse Practitioner, and Telemedicine. Each application for appointment or reappointment must include a request for the desired category of Medical Staff membership.

SECTION B. Active Medical Staff

1. Qualifications.

   The Active Medical Staff shall consist of physicians who:

   (a) meet the qualifications for Medical Staff membership as set forth in Article II of these Bylaws;

   (b) have an office or residence that is located close enough to the hospital to provide timely and appropriate care to his/her patients;

   (c) takes emergency call duty or provides emergency specialty consultation or patient care services as determined by the Medical Staff;

   (d) are regularly involved in Medical Staff functions such as attendance at general and committee meetings and medical education programs as determined in the Bylaws and committee plans; and

   (e) have satisfactorily concluded the six (6) month provisional period or any extension thereof.

2. Prerogatives.

   Except as otherwise provided in these Bylaws, the prerogatives of an Active Medical Staff member shall be to;

   (a) independently admit patients and exercise such clinical privileges which are granted in accordance with these Bylaws, Rules and Regulations of the Medical Staff;

   (b) attend and vote on matters presented at general and special meetings of the Medical Staff and of the committees of which he/she is a member; and

   (c) hold Medical Staff office and serve as a voting member of committees to which he/she is duly appointed or elected as a representative of the Medical Staff.

3. Transfer of Active Staff Membership.

   An Active Medical Staff member shall be automatically transferred to the Associate Medical Staff for the remainder of his/her appointment period for the following reasons:

   (a) after twelve (12) consecutive months in which a member fails to regularly provide patient care services in this hospital;

   (b) failure to attend fifty percent (50%) or absence at three (3) consecutive regularly scheduled general or special meetings of the Medical Staff and of the committee(s) of which he/she is a member without excused absence for good cause; and

   (c) refusal to take emergency call duty or provide emergency specialty consultation or patient care services as reasonably determined by the Medical Staff.

4. Multiple hospitals.

   Physicians who have Active Medical Staff privileges at multiple hospitals will be required to attend three (3) regularly scheduled general or special meetings per year of the Medical Staff and of the committee (s) of which he/she is a member without excused absence for good cause.

SECTION C. Consulting Medical Staff

1. Qualifications.

   Any member of the Medical Staff in good standing may upon request provide consultation services within his/her area of competence. However, the Consulting Medical Staff shall consist of physicians who:

   (a) are not otherwise members of the Active Medical Staff and who meet the general qualifications as set forth in Article II of these Bylaws;

   (b) possess recognized professional ability in their area of expertise;

   (c) are willing to come to the hospital/community on a scheduled basis or promptly respond by telephone when called to render consultation or who accept patients upon referral within their area of competence;

   (d) are members of the Medical Staff of another hospital licensed by the State of Washington where ongoing monitoring and evaluation of credentials are required; and

   (e) have satisfactorily concluded the six (6) month provisional period or any extension thereof.

2. Prerogatives.

   Consulting Medical Staff members shall be entitled to:

   (a) admit patients and exercise such clinical privileges which are granted in accordance with applicable Bylaws, Rules and Regulations of the Medical Staff;

   (b) provide consultation and other patient care services upon request of any member of the Medical Staff, hospital Administration, or the Governing Board; and

   (c) attend open meetings of the Medical Staff and committees and medical education programs.

   Consulting staff members have no requirements for attendance at Medical Staff functions or for provision of emergency medical care. Consulting staff members shall not be eligible to hold office in the Medical Staff organization, nor to vote at any standing general or committee meeting of the Medical Staff. Consulting staff members may serve on special committees, accept chairmanship, and vote when the right to vote is specified at the time of appointment to a special committee.

SECTION D. Associate Medical Staff

1. Qualifications.

   The Associate Medical Staff shall consist of physicians, dentists or podiatrists who:

   (a) meet the general qualifications as set forth in Article II, but by reason of residency, inability to provide continuous coverage to patients in the hospital, or limited practice license are not eligible for active staff membership;

   (b) do not regularly attend general or committee meetings or medical education programs as determined by Medical Staff Bylaws; and

   (c) have satisfactorily concluded the six (6) month provisional period and any extension thereof.

2. Prerogatives.

   Except as otherwise provided, Associate Medical Staff members shall be entitled to:

   (a) admit patients and exercise such clinical privileges in the hospital in accordance with applicable Bylaws, Rules and Regulations of the Medical Staff. In the exercise of this prerogative, Associate Medical Staff members shall arrange for continuous coverage of their patients in their absence;

   (b) provide consultation and other patient care services at the request of any member of the Medical Staff, hospital Administration or the Governing Board; and

   (c) attend general and committee meetings and medical education programs of the Medical Staff.

3. Surgical requirement.

   Any surgical patient of an Associate Medical Staff provider must have a history and physical done by the patient's attending physician at the time of surgery. As well as an admit note stating what the intended surgery will be.

   Associate staff members have no requirements for attendance at Medical Staff functions or for provision of emergency medical care. Associate staff members shall not be eligible to hold office in the Medical Staff organization, nor to vote at any standing general or committee meeting of the Medical Staff. Associate Staff members may serve on special committees, accept chairmanship and vote when the right to vote is specified at the time of appointment to a special committee.

SECTION E. Emeritus Medical Staff

1. The Emeritus Medical Staff shall consist of physicians, elected or appointed, who are not active in the hospital and who are honored by emeritus positions. They may be physicians who have retired from active hospital service; or physicians of outstanding reputation not necessarily resident to the community.

   The Emeritus Medical Staff shall have no assigned duties, but may attend Staff meetings or education meetings. Emeritus Staff members shall not be eligible to vote or hold office in this Medical Staff.

2. Emeritus Staff members shall not be required to comply with either Article III or Article IV of these Bylaws. Emeritus Staff membership may be made upon a simple written request for appointment delivered to the Chief of Staff, and consideration and approval of such request by the Active Medical Staff and Governing Board. Appointment to the Emeritus Medical Staff shall continue in effect until withdrawn by the Governing Board.

SECTION F. Allied Health Professional Staff

1. Definition and Qualifications

   An Allied Health Professional (AHP) is an individual permitted by Washington State licensure and the Board to provide patient services for which the individual is fully licensed, qualified and clinically competent to perform independently in the Hospital. The Allied Health Professional must satisfy all requirements concerning his/her qualifications and clinical competence deemed necessary by the Medical Staff Quality Review Committee-of-the-Whole relative to his/her specific discipline and offer a clinical skill or service that is currently determined by the Governing Board to be consistent with Hospital policies and goals for patient care.

2. Application Procedure

   (a) Each individual desiring to practice as an Allied Health Professional in the Hospital shall file an application on a form provided by the Hospital specifying his/her qualifications and all privileges requested. Each application shall be evaluated in the same manner as provided in Articles II and III for Medical Staff appointments and reappointments.

   (b) Each Allied Health Professional who is granted privileges shall be assigned to the clinical department appropriate to his/her professional training and shall be subject to the Rules and Regulations of that department and applicable Hospital policies and procedures.

3. Privileges

   An Allied Health Professional granted privileges to practice within the Hospital may only engage in acts and services within the scope of practice and privileges specifically approved for him/her by the Governing Board. An Allied Health Professional may, subject to any licensure requirements or other legal limitations, exercise independent judgment within the areas of his or her professional competence, and participate directly in the medical management of patients only (1) where a physician on Active Staff is designated on the medical record as responsible for the care of the patient rendered by the Allied Health Professional, and (2) to the extent of the privileges specifically granted to that Allied Health Professional.

4. Conditions of Appointment

   (a) Allied Health Professionals shall be considered a subcategory of the Medical Staff, but are not entitled to any rights or prerogatives of a Medical Staff Member except as expressly granted by these Bylaws.

   (b) An Allied Health Professional shall not be permitted to vote or hold office on the Medical Staff, in departments, or on Medical Staff committees.

   (c) Allied Health Professional appointments are subject to the duration limitations specified in Articles II and III provided that all Allied Health Professional appointments are at the discretion of the Governing Board.

   (d) An Allied Health Professional must have, at all times, an Active Staff Member of record who is responsible for all actions of the Allied Health Professional in the Hospital.

   (e) Allied Health Professionals must abide by all ethical and professional standards of their profession and all applicable provisions of these Bylaws.

   (f) All Allied Health Professionals are subject to the minimum six (6) month provisional status identified in Article III, Section B of these Bylaws.

   (g) All Allied Health Professionals shall satisfy the appropriate liability insurance requirements as specified in Article II, Section A of these Bylaws.

5. Change in Employment Status

   A change in a practitioner's employment status, licensure or liability insurance is to be promptly reported to the Medical Staff President and Administration. This change will result in cancellation of staff membership with reapplication required. Temporary privilege status may be granted by the Administrator and Chief of Staff until the change is corrected through the normal channels as specified in Section C. Automatic Suspension of Article VII of these Bylaws.

SECTION G. Certified Nurse-Midwives Staff

1. Qualifications.

   (a) Completion of the American College of Nurse-Midwives (ACNM) accredited nurse-midwifery program within the past 12 months, or have practiced in accordance with ACNM Standards within the past 12 months.

   (b) Current competency must be documented through compliance with ACNM regulations for continued competency assessment and the legal requirements of the Washington State Nurse Practice Act.

   (c) Have an office or residence that is located close enough to the hospital to provide timely and appropriate care to his/her patients.

   (d) May participate in obstetrical call rotation when provider's practice is within 30 minutes from the hospital.

   (e) Regularly is involved in Medical Staff functions such as attendance at general and committee meetings.

   (f) Have satisfactorily concluded the six (6) month provisional period or any extension thereof.

2. Application Procedure.

   Each individual desiring Medical Staff membership as a Certified Nurse Midwife shall file an application form provided by the Hospital specifying his/her qualifications and all privileges requested. Each applicant shall be evaluated in the same manner as provided in Articles II and III for Medical Staff appointments and reappointments.

3. Prerogatives.

   Certified Nurse-Midwives shall be entitled to:

   (a) Independently admit patients and exercise such clinical privileges which are granted in accordance with these Bylaws of the Medical Staff. In all cases, hospital, Medical Staff and Certified Nurse Midwife polices regarding appropriate use of consultations will be observed. A specific physician/group must be designated as willing and able to provide consultation and/or assume care as needed. The Certified Nurse Midwife Medical Staff member will also practice in accordance with the Standards of the ACNM and his/her submitted guidelines for midwifery care. These guidelines will be approved by the Obstetrical Committee.

   (b) Attend and vote on matters presented at the general and special meetings of the Medical Staff and of the committees of which she/he is a member.

   (c) Hold Obstetric Committee chairman position and serve as a voting member of committees to which she/he is duly appointed or elected as a representative of the Medical Staff.

4. Conditions of Appointment.

   (a) Certified Nurse Midwife appointments are subject to the duration limitations specified in Articles II and III. Any change in employment licensure or liability insurance status will result in cancellation of staff membership with reapplication required. Temporary privilege status may be granted by the Administrator and Chief of Staff until the change is corrected through the normal channels as specified in Section C "Automatic Suspension" or Article VII of these Bylaws.

   (b) See prerogative # (a). re: designated consultant.

   (c) Certified Nurse Midwife must abide by all ethical and professional standards of the ACNM and all applicable provisions by these Bylaws.

   (d) Certified Nurse Midwife shall satisfy the appropriate liability insurance requirements as specified in Article II, Section A of these Bylaws.

   (e) Attend fifty percent (50%) of the regularly scheduled general or special meetings of the Medical Staff and of the committee(s) of which he/she is a member.

SECTION H. Advanced Registered Nurse Practitioner Staff

1. Qualifications.

   (a) Completion of an accredited Nurse Practitioner program within the past 12 months, or have practiced in accordance with ARNP Standards within the past 12 months.

   (b) Current competency must be documented through compliance with ARNP regulations for continued competency assessment and the legal requirements of the Washington State Nurse Practice Act.

   (c) Have an office or residence that is located close enough to the hospital to provide timely and appropriate care to his/her patients.

   (d) May participate in ED call rotation when provider's practice is within 30 minutes from the hospital.

   (e) Regularly is involved in Medical Staff functions such as attendance at general and committee meetings.

   (f) Have satisfactorily concluded the six (6) month provisional period or any extension thereof.

2. Application Procedure.

   Each individual desiring Medical Staff membership as an Advanced Registered Nurse Practitioner shall file an application form provided by the Hospital specifying his/her qualifications and all privileges requested. Each applicant shall be evaluated in the same manner as provided in Articles II and III for Medical Staff appointments and reappointments.

3. Prerogatives.

   Advanced Registered Nurse Practitioners shall be entitled to:

   (a) Independently admit patients and exercise such clinical privileges which are granted in accordance with these Bylaws of the Medical Staff. In all cases, hospital, Medical Staff and Advanced Registered Nurse Practitioner polices regarding appropriate use of consultations will be observed. The Advanced Registered Nurse Practitioner Medical Staff member will also practice in accordance with the Standards of the ARNP and his/her submitted guidelines for medical care. These guidelines will be approved by the Medical Staff Committee.

   (b) Attend and vote on matters presented at the general and special meetings of the Medical Staff and of the committees of which she/he is a member.

   (c) Hold Committee chairman position and serve as a voting member of committees to which she/he is duly appointed or elected as a representative of the Medical Staff.

4. Conditions of Appointment.

   (a) Advanced Registered Nurse Practitioner appointments are subject to the duration limitations specified in Articles II and III. Any change in employment licensure or liability insurance status will result in cancellation of staff membership with reapplication required. Temporary privilege status may be granted by the Administrator and Chief of Staff until the change is corrected through the normal channels as specified in Section C "Automatic Suspension" or Article VII of these Bylaws.

   (b) A specific physician/group must be designated as willing and able to provide consultation and/or assume care as needed.

   (c) Advanced Registered Nurse Practitioner must abide by all ethical and professional standards of the ARNP and all applicable provisions by these Bylaws.

   (d) Advanced Registered Nurse Practitioner shall satisfy the appropriate liability insurance requirements as specified in Article II, Section A of these Bylaws.

   (e) Attend fifty percent (50%) of the regularly scheduled general or special meetings of the Medical Staff and of the committee(s) of which he/she is a member.

SECTION I. Telemedicine Staff

Physicians may apply for telemedicine privileges without granting staff membership. The hospital can accept the credentialing and privileging decision from the distant/contracted site in lieu of on-site credentialing, providing the process and documents meet Joint Commission standards or are from a Medicare Conditions of Participation compliant organization. The Medical Staff will have the ability to determine for each applicant, which privileges are appropriate for telemedicine services; privileges will consist of consulting only on patients within their area of expertise and will not be required to fill out clinical privilege forms.

ARTICLE VI – Medical Student and Resident Physician Program

Section A. Purpose

As a method of continuing education for Medical Staff members, the hospital and its' personnel, and for those students and residents in training, members of the Medical Staff of Three Rivers Hospital may, at times, participate in educational programs for the medical students and residents. The following guidelines will apply to any person in training who may take part in patient care and treatment at Three Rivers Hospital.

The "Medical Student and Resident Program" hereinafter approved and adopted by the Medical Staff and Board is based on the following premises:

1. All physicians participating in the Program will be designated as participants by an approved School of Medicine and as such they shall be covered as individuals under the blanket professional liability malpractice insurance program of the respective university, i.e. as participants, they are extended insurance protection in their educational roles.

2. All medical students and residents participating in the Program shall be under the supervision of an Active Staff member participating in the Program. During their tenure as trainees in the Medical Student and Resident Program at this hospital, they are covered as individuals under the liability insurance policy of their University Medical School or Residency Program.

Section B. Program

With these premises in mind, we, the Medical Staff at Three Rivers Hospital endorse development of this Program and recommend the Governing Board do likewise, provided the following constraints are observed:

1. Any member of the Medical Staff may take part in the Medical Student Resident Program (hereafter "Program"). Each clinic or group of physicians shall have one staff member in charge of the training Program. The Chief of Staff shall appoint, annually, one staff member to be the coordinator of any or all Programs in the hospital. These training programs must be officially recognized in writing by the participating Medical School and Three Rivers Hospital. The coordinator will be the staff liaison with the Board through the hospital administrator.

2. The name of any trainee participating in the Program shall be transmitted to the Board via the hospital's administrator from the Program coordinator or, in their absence, the faculty member appointed to represent him/her to ensure Three Rivers Hospital that the student or resident is, in fact, enrolled in the School of Medicine or Residency and verify their qualifications, i.e. 3rd or 4th year student. All such communication shall be on file in the hospital prior to the student's participation in the Program.

3. All chart entries by the student shall be identified as observations by a student and will be countersigned by the attending physician.

4. Any orders written by medical students shall be countersigned by the responsible physician prior to implementation. No verbal orders will be given by a medical student. Residents are permitted to write patient care orders; however, this does not prohibit a member of the medical staff from writing orders in patients under the care of a resident.

5. Resident entries of face sheet, history and physical, discharge summary, operative, procedure, delivery, progress notes, discharge order, and final death note shall be countersigned by the attending physician.

6. In case of hospital employees questioning the orders, actions, standard of care, or judgement by the student/resident, they shall contact the attending physician, coordinator of the hospital program or the hospital administrator.

7. To ensure the appropriate safeguards are provided, the responsible physician shall determine when "remote supervision" as opposed to "present in person" supervision would suffice for routine technical procedures. More immediate supervision must be provided for specialized procedures. It shall be the responsibility of the attending physician to decide when supervision should be provided, based on the experience and capabilities of the trainee.

8. The above-mentioned criteria shall be distributed to all trainees at the start of their tenure to:

   (a) Familiarize the trainee with the requirements of the Program.

   (b) Provide guidelines and thus avoid misunderstanding within the facility.

9. Copies of the Medical Student and Resident Program will be distributed to the supervisors in all departments within the hospital.

10. Residents taking part in the Three Rivers Hospital Training Program shall be duly licensed in Washington State to practice medicine or their orders, history and physical examination, and progress notes must be countersigned by their supervising staff member.

11. The coordinator will monitor each training program during the year and submit an annual report to the sponsoring Medical Staff and Board.

While it is recognized that the Program is not primarily a hospital based program, during the course of their training in Brewster they will be involved in the care and treatment of patients hospitalized at this facility. For that reason, the hospital's Medical Staff and Board of Commissioners accept and assume responsibility for the quality of medical care provided. To ensure that the best interests of the patient are protected, the rules and regulations as set forth in the "Medical Student and Resident Program" are adopted. Such rules and regulations shall be made part of the Three Rivers Hospital Medical Staff Bylaws except that they may be amended at any regular meeting without previous notice by a two-thirds vote by the Active Medical Staff present. Such amendments shall become effective when approved by the Board.

The Medical Student and Resident Program shall be adopted at any regular meeting of the Active Medical Staff and shall become effective when approved by the Board.

ARTICLE VII - Corrective Action

SECTION A. Corrective Action, Except Summary or Automatic Suspension

1. Criteria for Initiating an Investigation.

   Whenever a practitioner with staff appointment or clinical privileges engages in, makes or exhibits acts, statements, demeanor or professional conduct, either within or outside of the hospital, and the same is, or is reasonably likely to be either:

   (a) contrary to the Bylaws, rules, regulations, policies or standards of the Medical Staff or Governing Board;

   (b) detrimental to patient safety or to the delivery of quality or efficient patient care in the hospital;

   (c) disruptive to hospital operations such that the quality or efficiency of patient care is or is likely to be affected; or

   (d) contrary to the minimal standard of care in the State of Washington.

   Corrective action against the practitioner may be initiated by any of the following:

   (a) any Medical Staff member;

   (b) any standing or special committee or subcommittee of the Medical Staff, or a chairperson thereof;

   (c) the Administrator; or

   (d) the Governing Board.

2. All requests for corrective action must be in writing, submitted to the Administrator, and supported by reference to the specific activities or conduct which constitute the grounds for the request. The Administrator shall promptly notify the President in writing of all requests.

3. Investigation.

   The President shall; take summary action on the request in accordance with Section B, hereafter stated; determine that the request has no basis; or, direct that investigation concerning the grounds for the request be undertaken. If an investigation is deemed appropriate, the President shall appoint a committee of two (2) members of the Medical Staff, any staff category, to undertake investigation of the grounds for corrective action.

   This investigation process is not a "hearing" as that term is used in the Fair Hearing provisions of these Bylaws. The committee shall have the full resources of the Medical Staff and the hospital as well as the authority to use outside consultants as deemed necessary. It may include a conference with the practitioner involved, with the individual or group making the request, and other individuals who may have knowledge of the events involved.

   As part of the investigation, the committee may for good cause require the practitioner involved to procure an impartial physical or mental evaluation within a specified time by a practitioner named by the committee. Fees for an evaluation shall be paid by the hospital. Failure without good cause to obtain the evaluation shall result in immediate suspension of Medical Staff appointment and all clinical privileges until such time as the evaluation is obtained. The results of evaluation shall be reported to the committee.

   A written report of the investigation must be made. The committee may at any time within their discretion, and shall at the request of the Governing Board, terminate the investigation process. All reports shall be forwarded to the President.

4. Medical Staff Action.

   At the next regularly scheduled meeting of the Committee-of-the-Whole after conclusion of the investigative process if any, and after receipt of the report of investigation, but in any event within sixty (60) days after receipt of the request for corrective action, the committee shall act upon the request. Their action may include without limitation any one or combination of the following:

   (a) recommend rejection of the request for corrective action;

   (b) recommend a verbal warning or formal letter of reprimand;

   (c) recommend individual medical/psychiatric evaluation;

(d) recommend a provisional period of prescribed duration with retrospective review of cases and/or other review of professional behavior, but without special requirements of prior or concurrent consultation or direct supervision;

(e) recommend suspension of appointment prerogatives that do not affect clinical privileges;

(f) recommend an individually imposed requirement of prior or concurrent consultation or direct supervision;

(g) recommend a limitation on the practitioner's right to admit patients;

(h) recommend reduction, suspension or revocation of all or any part of the clinical privileges granted; and

(i) recommend suspension or revocation of staff appointment.

5. Governing Board Action.

(a) Governing Board action to approve Medical Staff recommendation pursuant to Section A, subsection 4, (a), (b), (c), or (d) to reject the request for corrective action or to modify it to lesser sanction not triggering procedural rights is deemed final action and the involved practitioner will be notified of Governing Board action by the Administrator.

(b) Medical Staff recommendation which restricts, suspends, or revokes clinical privileges or staff appointment will be transmitted to the Governing Board together with all supporting documentation. If the Governing Board acts to approve the changes recommended of the Medical Staff, this decision will be effective immediately and the practitioner is entitled to a fair hearing, upon timely and proper request to the procedural rights contained in the Fair Hearing provisions of these Bylaws. If the Governing Board action is favorable to the involved practitioner, the Governing Board's action is deemed final and the involved practitioner will be notified of the Governing Board action by the Administrator.

(c) If in the Governing Board's determination, the Medical Staff fails to act in a timely fashion in processing and recommending action on a request for corrective action, the procedure to be followed is as provided in Article III, Section A, subsection 11(b) of these Bylaws.

SECTION B. Summary Suspension

1. Criteria for Imposing.

Either the clinical directors of clinical services, the Administrator, or the Governing Board has the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges of a practitioner where the failure to take such action may result in an imminent danger to the health or safety of any individual. A summary suspension is effective immediately upon imposition and the person or group imposing the suspension is to follow it up promptly by giving special notice of the suspension to the practitioner.

A suspended practitioner shall make proper arrangements for his patients then in the hospital to be assigned to another practitioner, considering the wishes of the patient where feasible in choosing a substitute practitioner.

2. Committee Action.

As soon as possible, but in any event within fourteen (14) days after summary suspension is imposed, a special meeting of the Committee-of-the-Whole will be convened to review and consider the action taken. It may recommend modification, continuation or termination of the terms of the suspension. A recommendation to continue the suspension or take other unfavorable action shall be transmitted to the Governing Board and the procedure in Section A, subsection 5 of this Article VII is followed.

A recommendation to terminate the suspension or to modify it to a lesser sanction not triggering procedural rights is reported to the Governing Board at its next regularly scheduled meeting. The terms of the summary suspension as originally imposed shall remain in effect pending a final decision by the Governing Board.

3. Governing Board Action.

(a) Governing Board action to approve Medical Staff recommendation to terminate the suspension or to modify it to a lesser sanction not triggering procedural rights is effective immediately and the Administrator will notify the practitioner of the Governing Board action on the matter.

(b) Governing board approval of a Medical Staff recommendation to continue the suspension or to take any other unfavorable action as defined in Section D, hereafter stated, entitles the practitioner, upon timely and proper request to the procedural rights contained in the Fair Hearing provisions of these Bylaws. Governing

board action adverse to Medical Staff recommendation, but favorable to the practitioner shall be deemed final action, and the involved practitioner shall be notified of the Governing Board action by the Administrator.

(c) If in the Governing Board's determination, the Medical Staff fails to act in a timely fashion in processing and recommending action on a summary suspension, the procedure to be followed is as provided in Article III, Section A, subsection 11(b) of these Bylaws.

SECTION C. Automatic Suspension

1. External Disciplinary Action.

(a) Whenever a practitioner's license to practice or controlled substance registration is revoked, restricted or suspended; or when put on probation, the practitioner must immediately report it to the President and the Administrator. Failure to so report without good cause shall be considered a resignation of staff appointment and clinical privileges.

(b) As soon as possible (1) after a practitioner's license is suspended, restricted or placed on probation, or (2) after the practitioner's DEA registration is revoked, restricted, suspended or made probationary, the President shall convene a meeting of the committee-of-the-whole to review and consider the facts under which such action was taken. The committee may then recommend such further corrective action as is appropriate to the facts disclosed in the investigation. The practitioner's privileges shall be limited to conform to such suspension, restriction, probation or revocation. Thereafter, the procedure in Article III, Section A, subsections 10(a) and (b), as appropriate, are followed, but only with respect to any additional corrective action recommended by the Medical Staff or taken by the Governing Board.

2. Medical Records

All portions of the medical record shall be completed in the time period as specified by the Medical Staff Rules and Regulations in compliance with state and federal regulations.

Temporary Sanctions for Failure to Complete Medical Records

(a) A temporary suspension in the form of withdrawal of admitting privileges of a practitioner, effective until medical records are completed, will be imposed after warning of delinquency for failure to complete medical records within fifteen (15) days of each patient’s discharge.

(b) All records will be reviewed weekly after discharge. The Administrator will be notified weekly of any incomplete records.

(c) Any logical reason for delay in completing medical records will be considered by Administration, but they will be guided by the following factors:
   (i) if the responsible practitioner is ill, on vacation, out of town, or otherwise not available for a period of time - it will be considered sufficient reason for delay;
   (ii) if a practitioner is waiting for the results of a late report, i.e., culture, pathology, etc, and the medical record is otherwise complete except for the final diagnosis, it will be considered sufficient reason;
   (i) if the practitioner has dictated reports and is waiting for hospital personnel to transcribe the reports it will be considered sufficient reason; and
   (iv) if the practitioner has not had the medical record available to him in the week preceding the deadline date - it will be considered sufficient reason.

(d) In any case where the Administrator acts to suspend privileges based upon incomplete records, the practitioner, the nursing service, business office/admitting office, and the surgery department will be notified of the suspension. The practitioner will be permitted to attend those patients he/she has hospitalized at the time such action is taken, and in case of emergency, be permitted to exercise full hospital privileges. The practitioner could be suspended from all elective admissions and procedures including surgery, assisting in surgery, administering anesthesia and other diagnostic and/or therapeutic procedures and admitting non-emergency patients to the hospital.

(e) The Administrator will have the authority to reinstate privileges when notified by the Health Information Supervisor that the outstanding records are complete. The practitioner, the nursing service, business office/admitting dept., and the surgery department will be notified that the privileges of the practitioner have been reinstated. All such action will be reported to the Medical Staff and Board of Commissioners at their next regular meeting and the reasons therefore will be stated.

(f) Any practitioner who feels there was not sufficient reason to suspend his/her privileges may appeal to the Administrator. At the discretion of the Administrator, a special meeting of the Board of Commissioners may be called. In this case, the Administrator and the practitioner will be expected to attend the special meeting. The Board of Commissioners will make the final determination in any such case.

(g) Action taken by the State Board of Medical Examiners revoking or suspending the license of a practitioner or placing them on probation will automatically suspend all hospital privileges.

(h) It will be the duty of the Chief of Staff to cooperate with the Administrator in enforcing suspensions.

3. Professional Liability Insurance.

For failure to maintain the minimum amount of professional liability insurance required under Article II, Section A, subsection 8, of these Bylaws, a practitioner's staff appointment and clinical privileges shall be immediately temporarily suspended.

A practitioner whose staff appointment and clinical privileges are so suspended may request reinstatement of appointment and appropriate privileges by sending to the Administrator, a certified copy of the insurance certificate from the insurance company and a written statement explaining the circumstances of the previous insurance being cancelled or not renewed and any limitations on the new policy. The practitioner must submit a written summary of relevant activities during the period of suspension if the Medical Staff or Governing Board so requests. The procedures in Article III, Section A, subsections 5, 6, 7, 9 and 10 are followed to reinstate the practitioner.

SECTION D. Exhaustion of Remedies

1. Unfavorable Recommendations/Actions Giving Rise to Hearing Rights.

(a) Recommendations or Actions.

Subject to the exceptions set forth in subsection (c) hereafter stated, the following actions or recommended actions, if deemed unfavorable under subsection (b) hereafter stated, entitle the practitioner to a hearing upon timely and proper request:

(i) Denial of initial staff appointment;
(ii) Denial of reappointment;
(iii) Suspension of appointment provided that summary suspension entitles the practitioner to request a hearing only as specified in subsection xiii of this section D.
(iv) Revocation of appointment;
(v) Denial of requested appointment to or advancement in staff category;
(vi) Reduction in staff category;
(vii) Special limitation of the right to admit patients;
(viii) Denial or restriction of requested clinical privileges;
(ix) Reduction in clinical privileges;
(x) Suspension of clinical privileges, provided that summary suspension entitles the practitioner to request a hearing only as specified in subsection xiii, of this Section D;
(xi) Revocation of clinical privileges;
(xii) Individual application of or individual changes in mandatory consultation or supervision required; and
(xiii) Summary suspension of appointment or clinical privileges, provided that the action by the Governing Board under Section B, of this Article VII, is to continue the suspension or to take other action which would entitle the practitioner to request a hearing under this section.

(b) When Deemed Unfavorable.

Except as provided under subsection (c) hereafter stated, any action listed in subsection (a) of this Section D, is deemed unfavorable to the practitioner when taken by the Governing Board under circumstances where no prior right to request a hearing existed.

(c) Exceptions to Hearing Rights.

Notwithstanding any provision in the Fair Hearing provisions of these Bylaws or any other official policy or Rules and Regulations to the contrary, the following actions do not entitle the practitioner to a hearing:

(i) the issuance of a verbal warning or formal letter of reprimand;
(ii) the imposition of a monitoring or consultation requirement as a condition attached to the exercise of clinical privileges during the provisional period;

(iii) the imposition of a probationary period involving review of cases but with no requirement either for direct, concurrent supervision or for mandatory consultation;
(iv) the removal of a practitioner from a medico-administrative office within the hospital unless a contract or employment arrangement provides otherwise; and
(v) any other action or recommended action not listed in subsection (a) above.

Other Situations: An action listed in subsection (a) above does not entitle the practitioner to request a hearing when it is:

(i) voluntarily imposed or accepted by the practitioner;
(ii) automatic pursuant to Section C, of this Article VII; or
(iii) taken or recommended with respect to temporary privileges.

2. Exhaustion of Administrative Remedies.

Every applicant to and member of the Medical Staff agrees that, when corrective action is initiated or taken pursuant to Article VII, or when an unfavorable action as defined in Section D, subsection 1, is made, the applicant or staff member will exhaust the administrative remedies afforded in the various Medical Staff Bylaws prior to pursuing any other remedy.

3. Reapplication after Unfavorable Credentials Decision.

Except as otherwise provided in the Medical Staff Bylaws or as determined by the Medical Staff in light of exceptional circumstances, an applicant or staff member who has received a final unfavorable decision or who has voluntarily resigned or accepted a condition, regarding limitation or restriction on, or withdrawing an application for, appointment, staff category or clinical privileges is not eligible to reapply to the Medical Staff or for the applicable category or privileges for a period of twelve (12) months from the date of the notice of the final unfavorable decision or the effective date of the resignation, or application withdrawal.

Any such reapplication is processed in accordance with the procedures set forth in Article III, Section A, subsection 3 of these Bylaws and the applicant or staff member must submit such additional information as the Medical Staff and the Governing Board may reasonably require in demonstration that the basis of the earlier unfavorable action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be further processed.

4. Reporting Requirements.

(a) The Administrator shall comply with Washington State reporting requirements established in 1950 and federal reporting requirements of the Federal Health Care Quality Improvement Act of 1986.

(b) The Administrator will be responsible for reporting to the National Practitioner Data Bank and Washington State Medical Quality Assurance Commission any Adverse Clinical Privilege Actions that are made against a physician or dentist, pursuant to the Health Care Improvement Act of 1986, within 15 days when the decision is effective. The following actions must be reported:

(i) Professional review action based on the physician's or dentist's professional competence or professional conduct that adversely affects his/her clinical privileges for a period of more than 30 days. Such adverse actions include reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges. Adverse actions involving censures, reprimands, or admonishments need **NOT** be reported.
(ii) The acceptance of the surrender or restriction of clinical privileges while the physician or dentist is under investigation **OR** in return for not conducting an investigation by the health care facility relating to possible professional incompetence or improper professional conduct.

(c) When an Adverse Action necessitates a report to the National Practitioner Data Bank a copy of the narrative summary will be given to the practitioner involved. The practitioner will have five (5) days to respond if any discrepancy is noted. If no response is received the narrative summary will presumed to be accurate. If a discrepancy exists an appeal may be made to the Hospital's Quality Assurance Committee for rewording of the summary. Their decision will be final.

(d) CONFIDENTIALITY POLICY:

The National Practitioner Data Bank files will be disclosed only to those hospital officials who are responsible for reviewing a practitioner's application and/or clinical privilege application or reapplication for Medical Staff appointment. This information will be viewed only **IN** the office of the Medical Staff Coordinator with copies released only to the Chief of Staff, Administrator or Chairman of the Governing Board.

The National Practitioner Data Bank Reports will be a permanent part of each practitioner's credential files, and will not be released to any other institution.

ARTICLE VIII - Fair Hearing

SECTION A. Definitions

The following definitions, apply to the Fair Hearing provisions of this Article VIII.

1. **Appellate Review Body** means the group designated under these provisions to hear a request for appellate review properly filed and pursued by a practitioner.

2. **Days** means regular calendar days, i.e., including Saturdays, Sundays and official hospital holidays. If the day on which a notice, request or report under these provisions must be received or sent falls on a Saturday, Sunday or official hospital holiday, the deadline shall be set to be the next regular working day thereafter.

3. **Hearing Panel** means a committee appointed under these provisions to hear a request for an evidentiary hearing properly filed and pursued by a practitioner.

SECTION B. Initiation of Hearing

1. Events Giving Rise to Hearing Rights.

   Definition of the unfavorable actions or recommended actions which entitle the practitioner to a hearing, upon timely and proper request, is set forth in Article VII, Section D, of these Bylaws. Each such action shall be deemed a "professional review action" as that term is defined in the Health Care Quality Improvement Act of 1986.

2. Notice of Unfavorable Action.

   The Administrator, within five (5) days of receiving written notice of an unfavorable action as defined in subsection 1 above, give the practitioner special notice thereof. The notice shall:

   (a) advise the practitioner of the nature of the proposed action, the reasons for the proposed action and of his/her right to a hearing upon timely and proper request pursuant to subsection 3 below;

   (b) contain a concise statement of the practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question, and/or the other reasons or subject matter forming the basis for the unfavorable action which is the subject of the hearing;

   (c) specify that the practitioner has thirty (30) days after receiving the notice within which to submit a request for hearing and that the request must satisfy the conditions of subsection 3 below;

   (d) state that failure to request a hearing within that time period and in the proper manner constitutes a waiver of rights to a hearing and to an appellate review on the matter that is the subject of the notice; and

   (e) state that as soon as possible after receipt of his/her hearing request, the practitioner will be notified of the date, time and place of the hearing, and the grounds upon which the unfavorable action is based.

3. Request For Hearing.

   The practitioner shall have thirty (30) days after receiving the above notice to file a written request for hearing. The request must be delivered to the Administrator by special notice.

4. Waiver By Failure To Request A Hearing.

   A practitioner who fails to request a hearing within the time and in the manner specified in subsection 3 above waives his/her right to any hearing or any appellate review to which he/she might otherwise have been entitled. Such waiver shall apply only to the matters that were the basis for the unfavorable action triggering the subsection 2 notice. A waiver constitutes acceptance of the action, which immediately becomes the final decision in the matter. The Administrator shall, as soon as reasonably practicable, send the practitioner special notice of each action taken and shall notify the chief of staff of each such action.

SECTION C. Hearing Prerequisites

1. Notice of Date, Time and Place for Hearing.

   Upon receiving a timely and proper request for a hearing, the Administrator shall notify the chairman of the Governing Board on whose action prompted the hearing request, and shall schedule a hearing. The Administrator shall send the practitioner special notice of the hearing, including the date, time and place thereof. The hearing date shall be not less than thirty (30) days nor more than sixty (60) days from the date of the special notice of the hearing; provided, however, that a hearing for a practitioner who is under suspension then in effect may be held sooner than thirty (30) days from the date of the special notice of the hearing if requested in writing by the practitioner.

   The special notice shall also include the names of individuals who, as far as is then reasonably known, will give testimony or evidence in support of the action which gave rise to the hearing rights under these Fair Hearing provisions.

2. Appointment of Finder of Fact.

   When a hearing has been requested, the Administrator, after considering any recommendations of the chairman of the Governing Board and the affected practitioner shall designate a finder of fact to conduct a hearing.

   The hearing shall be held, as determined by the hospital, before:

   (a) an arbitrator mutually acceptable to the practitioner and the hospital, or

   (b) a hearing officer who is appointed by the hospital and who is not in direct economic competition with the practitioner involved, and/or a panel of not less than three (3) and not more than seven (7) individuals who are appointed by the hospital Administrator.

   The following are eligible for nomination or appointment to membership on the hearing panel:

   (a) Members of the Medical Staff except for any such member who:
      (i) initiated the request for corrective action or otherwise made any report or complaint which resulted in the unfavorable action which gave rise to the request for hearing;
      (ii) was present at the Committee-of-the-Whole meeting which conducted interviews, heard testimony, considered evidence or undertook any recommended action or review with respect to the unfavorable action which gave rise to the request for hearing; or
      (iii) is in direct economic competition with the practitioner involved or otherwise has a direct, personal interest in the outcome of the hearing such that, in the opinion of the Administrator, his/her impartiality is in doubt.

   (b) Persons not members of the Medical Staff who:
      (i) are not and have not within the preceding five (5) years been employees, members of the Governing Board, consultants or legal counsel to the hospital;
      (ii) have no spouse, parents or children who are employees, Medical Staff members, members of the Governing Board, consultants or legal counsel to the hospital; and
      (iii) are not in direct economic competition with the practitioner involved or otherwise have no direct, personal interest in the outcome of the hearing such that, in the opinion of the Administrator, their impartiality is in doubt.

   An individual shall not be disqualified from serving as an arbitrator, hearing officer or on a hearing panel merely because he or she has heard of the case or has knowledge of the facts involved or what the facts are supposed to be.

3. List of Witnesses.

   At least five (5) days prior to the scheduled date for commencement of the hearing, each party shall give the other party by special notice a list of the names of the individuals who, as far as is then reasonably known, will give testimony or evidence in support of that party at the hearing. Such list shall be amended as soon as possible when additional witnesses are identified. The hearing panel or arbitrator may permit a witness who has not been listed in accordance with this subsection 3 to testify if it finds that the failure to list such witness was justified, that such failure did not prejudice the party entitled to receive such list, or that the testimony of such witness will materially assist the arbitrator or hearing panel in making its report and recommendation under Section D, of this Article VIII.

SECTION D. Hearing Procedure

1. Personal Presence.

   The personal presence of the practitioner is required throughout the hearing, unless such personal presence is excused for any specified time by the finder of fact. The presence of the practitioner's legal counsel or other representative does not constitute the personal presence of the practitioner. A practitioner who fails without good cause to be present throughout the hearing unless excused, or who fails to proceed at the hearing in accordance with this Fair Hearing Plan, shall be deemed to have waived his or her rights in the same manner and with the same consequence as provided in Section D, subsection 4 of this Article VIII.

2. Presiding Officer.

   The hearing officer, arbitrator, or hearing panel chairman shall be the presiding officer. The presiding officer shall maintain decorum and assure that all participants have a reasonable opportunity to present relevant evidence. The presiding officer shall determine the order of procedure during the hearing and make all rulings on matters of procedure and the admissibility of evidence. The presiding officer shall not act as a prosecuting officer or as an advocate to any party to the hearing. If a hearing officer is appointed, he or she shall not be entitled to vote. If the chairman of the hearing panel serves as the presiding officer, he or she shall be entitled to vote.

3. Representation.

   The practitioner may be represented by an attorney or other person of his or her choice. The practitioner shall inform the Administrator in writing of the name of that person at least five (5) days prior to the hearing date. The body whose recommendation or action prompted the request for hearing shall appoint an individual to represent it at the hearing. Nothing contained herein shall be construed to prevent either party from using legal counsel in connection with preparation for or attendance at a hearing. An attorney representing the hospital may be present.

4. Rights of Parties.

   During the hearing, each party shall have the following rights which shall be exercised in a manner so as to permit the hearing to proceed efficiently and expeditiously:

   (a) call and examine witnesses;

   (b) introduce exhibits;

   (c) cross-examine any witness on any matter relevant to the issue;

   (d) impeach any witness; and

   (e) rebut any evidence.

   If the practitioner does not testify on his or her own behalf, the practitioner may be called and examined as if under cross-examination.

5. Procedure and Evidence.

   The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. In the discretion of the presiding officer, any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Each party shall be entitled, prior to or during the hearing; to submit memoranda concerning any issue of law or fact, and those memoranda shall become part of the hearing record. Written memoranda, if any, must be presented to the presiding officer and a copy must be provided to the other party. The hearing panel or arbitrator may ask questions of the witnesses, call additional witnesses, or request documentary evidence if deemed appropriate. Exhibits admitted into evidence before the hearing panel shall be identified as the presiding officer may direct.

6. Burden Of Proof.

   (a) For action denying requested new status or privileges:

   When a hearing relates to an unfavorable action involving denial or status or privileges not currently held by the practitioner, the practitioner shall have the burden of coming forward with evidence and of proving that the unfavorable action lacks any substantial factual basis or is otherwise arbitrary, unreasonable or capricious.

   (b) For action changing current status or privileges.

When a hearing relates to any unfavorable action involving a change in status or privileges currently held by the practitioner, the body whose unfavorable action occasioned the hearing shall have the burden of coming forward with evidence in support thereof. Thereafter, the practitioner shall have the burden of coming forward with evidence and proving that the unfavorable action lacks any substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.

7. Hearing Record.

A record of the hearing shall be kept. The presiding officer shall determine whether this shall be done by use of a court reporter or a tape recording of the proceedings. If the practitioner requests a transcript of the hearing record, the practitioner shall bear the cost of the same. If a court reporter is used, those giving testimony need not be sworn by the reporter.

8. Postponement.

Requests for postponement or continuance of a hearing may be granted by the presiding officer upon a timely showing of good cause.

9. Presence of Hearing Panel Members and Vote.

A majority of the hearing panel must be present throughout the hearing and deliberations. If a panel member is absent from any part of the hearing or deliberations, the presiding officer has discretion to rule that such member may or may not participate further in the hearing or deliberations or in the decision of the hearing panel.

10. Recesses and Adjournment.

The presiding officer may recess and reconvene the hearing, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation, without special notice and with such written or oral notice as deemed appropriate. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. The hearing panel shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

SECTION E. Hearing Panel Report and Further Action

1. Hearing Panel or Arbitrator's Report.

Within five (5) days after adjournment of the hearing, the hearing panel or arbitrator shall make a written report of findings and recommendations. The hearing panel or arbitrator shall forward the report to the Governing Board whose unfavorable action occasioned the hearing. The practitioner shall also be given a copy of the report by special notice. The hearing record and other documentation shall be transmitted to the Medical Staff Services Office for safekeeping as official records and minutes of the Quality Assurance Committee.

2. Action on hearing panel report.

The hearing panel or arbitrator's report shall be transmitted to the chairperson of the Governing Board within five (5) days. The chairperson of the Governing Board shall schedule a meeting of the Governing Board to consider the findings and recommendations of the hearing panel or arbitrator. The meeting scheduled to consider the findings and recommendations of the hearing panel or arbitrator shall be at least thirty (30) but not more than sixty (60) days from the date the chairperson received the report. The decision of the Governing Board is final.

ARTICLE IX - Officers

SECTION A. Officers of the Medical Staff

1. Identification.

   The officers of the Medical Staff shall be the President (Chief of Staff), Vice President, and Secretary/Treasurer.

2. Qualifications.

   Officers must be members of the Active Medical Staff at the time of their nominations and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

3. Nominations.

   Nominations shall be called for and made from the floor at the Annual Meeting of the Medical Staff every year.

4. Elections.

   Voting shall be by secret ballot by voting members of the Medical Staff who are in attendance at the annual meeting. A nominee shall be elected upon receiving a majority of the valid votes cast. In any situation where no candidate receives a majority, successive balloting will be conducted with the candidate receiving the fewest votes omitted from each successive slate until a majority is obtained by one candidate.

5. Term of Elected Office.

   Term of elected office is for one (1) year, commencing on January 1, of each year following his/her election and ending on December 31. Each officer shall serve until the end of his or her term or until a successor is elected, unless he/she shall sooner resign or be removed from office.

6. Recall of Officers.

   Except as otherwise provided, recall of a Medical Staff officer shall be initiated by a petition signed by at least one-third (1/3) of the members of the Medical Staff eligible to vote for officers. Recall shall be considered at a special closed meeting of the Medical Staff called for that purpose. Recall shall require two-thirds (2/3) vote of the Medical Staff members eligible to vote for Medical Staff officers who are present at the closed meeting.

7. Vacancies In Elected Office.

   Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of active staff membership. If there is a vacancy in the office of President, the then Vice President Elect shall serve out the remaining term. If there is a vacancy in the office of Vice President or Secretary/Treasurer, the vacancy shall be filled by election at the next regular Medical Staff meeting.

SECTION B. Duties of Officers

1. President.

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

   (a) enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions when they are indicated, and promoting compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a practitioner.

   (b) calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff.

   (c) serving as chairman of the committee-of-the-whole of the Medical Staff.

   (d) appointing committee members for all special Medical Staff, liaison, or multi-disciplinary committees, except where otherwise indicated, designating the chairperson of these committees.

   (e) serving as ex officio member of all special Medical Staff committees without vote, unless his or her membership in a particular committee is required by these Bylaws.

(f) interacting with the Administrator and Governing Board in all matters of mutual concern within the hospital.

(g) representing the views and policies of the Medical Staff to the Governing Board and to the Administrator.

(h) being spokesman for the Medical Staff in external professional and public relations.

(i) serving as Medical Staff representative to outside professional meetings, organizations or agencies.

(j) performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff, or by the Governing Board commensurate with his or her position as chief officer of the Medical Staff.

2. Vice President.

The Vice President shall assume all duties and authority of the President in the absence of the President. In addition, the duties of the Vice President shall include, but not be limited to:

(a) call, presiding at, and being responsible for the professional education programs of the Medical Staff.

(b) serving as the Medical Staff liaison with the hospital's internal professional staff.

(c) performing such other duties as may be assigned from time to time by the chief of staff.

3. Secretary-Treasurer.

In the absence of the President and the Vice President, the Secretary/Treasurer shall assume all duties and authority of the President. In addition, the duties of the Secretary/Treasurer shall include, but not be limited to:

(a) serving as a Medical Staff representative to outside professional organizations, agencies or meetings.

(b) performing such other duties as may be assigned from time to time by the President.

ARTICLE X – Clinical Divisions

SECTION A. Organization of Clinical Divisions

1. The Medical Staff shall be organized into a non-departmentalized structure for Medical Staff operations, organized Medical Staff relations with Governing Board, and relations with applicants to and members of the Medical Staff.

2. The Medical Staff as-a-whole shall perform the functions of clinical departments such as; conducting patient care reviews; recommending guidelines for the granting of clinical privileges; evaluating and making appropriate recommendations regarding clinical privileges and practice of applicants and members of the Medical Staff; conducting, participating and making recommendations regarding continuing education programs pertinent to clinical practice; reviewing and evaluating departmental adherence to (1) Medical Staff policies and procedures; and (2) sound principles of clinical practice; coordinating patient care with nursing and ancillary patient care services; and establishing and implementing an appropriate "Quality Assurance Program".

3. The delivery of patient services shall be divided into six major clinical services, as follows:

   (a) Medical Services: Shall include; general medical patient care services; critical care including coronary care and intensive care service; medical short-stay services; and swing bed services.

   (b) Surgery Services: Shall include; surgery suite services; recovery room services; anesthesia services; general surgical patient care services; surgery short-stay services; day surgery services; and pathology services.

   (c) Obstetrical Services: Shall include; delivery room services; birthing room services; labor room services; and general obstetrical patient care services.

   (d) Pediatric/Neonatal Services: Shall include; nursery services; rooming in newborn services; emergency transport newborn services; and general medical and surgical patient care services provided to infants and children up through eleven years of age.

   (e) Ambulatory Care Services: Shall include; emergency room services; non-emergent outpatient services; referred outpatient services; and specialty clinic services.

   (f) Diagnostic Imaging Services: Diagnostic imaging services shall include radiology, ultrasound, and nuclear medicine services provided to inpatients and outpatients.

4. For the purpose of these Bylaws, the hospital ancillary services shall be identified as; pharmacy, clinical laboratory, physical therapy and cardiopulmonary services.

5. Contracted services may include any of the above which are provided by an individual or group through a contract with the hospital.

SECTION B. Functions of Ancillary Services

1. Subject to the approval of the Medical Staff, each clinical and ancillary service is expected to develop, implement and maintain policies and procedural rules appropriate to the scope of services offered in each clinical and ancillary service.

2. Each clinical or ancillary service is expected to develop, implement and maintain a quality assurance program appropriate to the scope of services offered in each clinical or ancillary service.

3. Each clinical and ancillary service is expected to develop, implement and maintain a safety program including; infection control, patient safety, personnel safety and equipment safety appropriate to the scope of services offered in each clinical or ancillary service.

4. The director/supervisor of each clinical and ancillary service, including clinical director, is expected to serve as resource advisor or consultant in matters relating to the scope of services offered in each clinical and ancillary service.

SECTION C. Clinical Directors

1. Qualifications.

   Each clinical and ancillary service shall have a clinical director who shall be a member of the Medical Staff and who shall be qualified by training, experience, demonstrated ability and interest to provide guidance, direction and consultation in matters relating to the clinical and ancillary services he or she directs.

2. Selection.

   Each clinical director shall be appointed by the President and shall be accountable to the Medical Staff for performance of duties as hereafter described.

3. Term of Office.

   Each clinical director shall serve a one year term which coincides with the calendar year or until his or her successor is chosen, unless he or she shall sooner resign or be removed from office or loses Medical Staff membership. Clinical directors shall be eligible to succeed themselves.

4. Removal.

   After appointment, a clinical director may be removed for cause by the President. A clinical director who is removed from office is entitled, upon timely and proper request, to the procedural rights set for in the Fair Hearing section of these Bylaws.

5. Authority, Responsibilities and Duties.

   Each clinical director shall have the following authority, responsibilities and duties;

   (a) when called, act as presiding officer at clinical or ancillary service meetings;

   (b) report to the Medical Staff regarding professional and administrative activities within his or her service;

   (c) give guidance on the overall medical policies of the Medical Staff and hospital and make specific recommendations and suggestions regarding his or her service;

   (d) endeavor to enforce the Medical Staff Bylaws, rules, policies and regulations within his or her service;

   (e) implement within his or her service appropriate actions taken by the Medical Staff;

   (f) conduct immediate investigation and act on behalf of the Medical Staff on any disciplinary action required to assure patient safety and well being in the intervals between Medical Staff meetings. All such action shall be retrospectively investigated and acted upon by the Medical Staff;

   (g) participate in every phase of Administration of his or her service, including cooperation with the hospital's professional and administrative staff in matters such as personnel, supplies, equipment, special regulations, standing orders and techniques;

   (h) participate in the Medical Staff and hospital quality assurance programs such as guidance to develop and monitor the quality of patient care and professional performance rendered by medical and professional members of the Medical Staff and hospital staff through a planned and systematic process;

   (i) assist in the preparation of such annual reports, including professional activities and budgetary planning pertaining to his or her service as may be required by the Medical Staff;

   (j) recommend delineated clinical privileges for each professional employee of the service or Medical Staff member; and

   (k) perform such other duties commensurate with the office as may from time to time be reasonably requested by the chief of staff or the Medical Staff.

ARTICLE XI - Medical Staff Business Meetings

SECTION A. Meetings

1. Annual Meeting.

   There shall be an annual meeting of the Medical Staff. The annual meeting shall be held on the 3rd Wednesday of December of every year.

2. Regular Meetings.

   The regular meeting of the Medical Staff shall be held on the 3rd Wednesday of every month at 07:00 a.m.

3. Special Meetings.

   Special meetings of the Medical Staff may be called at any time by the President or by not less than one-fourth (1/4) of the members of the Active, Certified Nurse-Midwives, and Advanced Registered Nurse Practitioner Medical Staff. At any special meeting no business may be transacted other than that stated in the notice calling the meeting. Sufficient notice of any special meeting will be delivered or mailed to each active staff member seven days prior to the date of the meeting.

SECTION B. Notice of Meetings

1. Notice of the annual meeting of the Medical Staff shall be delivered or mailed to the President and clinical directors at least thirty (30) days prior to the meeting.

2. The master calendar published yearly will specify the dates and times of the regular Medical Staff meetings.

3. The published notice each year, which is sent to the practitioner's appointment clerk, office nurse or aide, and the hospital admitting office, radiology and surgery department, will include the dates and times of all regularly scheduled Medical Staff meetings.

4. A written notice stating the place, date, time of each regular and special meeting shall be delivered to each active staff member not less than two days before the date of such meetings.

SECTION C. Attendance

1. All members of the Active, Certified Nurse-Midwives, and Advanced Registered Nurse Practitioner Medical Staff is expected to regularly attend and participate in Medical Staff meetings. Failure to attend fifty percent (50%) of the scheduled regular and special meetings in each calendar year, or absence at three (3) consecutive scheduled meetings without excused absence for good cause may be deemed resignation of their staff membership.

2. Any member who is compelled to be absent from any scheduled meeting shall promptly provide to the Medical Staff Services Office, the reason for such action. Unless excused for good cause by the President, failure to attend the scheduled meeting shall be listed in the member's file as an unexcused absence.

3. At the discretion of the President, when a member's practice or conduct is scheduled for discussion at a regular meeting, the member shall be notified and may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting, regardless of staff category, with respect to which he or she was given such notice, unless excused by the President, upon showing of good cause, shall be a basis for corrective action.

4. Members who have active staff privileges at multiple hospitals will be required to attend three (3) regularly scheduled meetings per year, as set forth in Article V, Section B #4 of these Bylaws.

SECTION D. Agenda

The order of business at a meeting of the Medical Staff shall be determined by the President. The agenda shall include, insofar as feasible:

1. Call to order.

2. Acceptance of minutes of previous meeting.

3. Communications.

4. Routine business.

5. Unfinished business.

6. Committee Reports.

7. New business.

8. Adjournment.

SECTION E. Quorum

The presence of two-thirds (2/3) of the total members of the Active, Certified Nurse-Midwives, and Advanced Registered Nurse Practitioner Medical Staff at any regular or special meeting in person or through written ballot shall constitute a quorum for the purpose of amending these Bylaws or the Rules and Regulations of the Medical Staff or for election or removal of Medical Staff officers. The presence of thirty percent (30%) of the total members of the Active, Certified Nurse-Midwives, and Advanced Registered Nurse Practitioner Medical Staff shall constitute a quorum for all other actions.

SECTION F. Manner of Action

Except as otherwise specified in previous section, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the Medical Staff.

A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specified by these Bylaws.

Valid action may be taken without a meeting by the Medical Staff if it is acknowledged by writing, setting forth the action so taken, which is signed by at least two-thirds (2/3) of the members entitled to vote.

SECTION G. Duties and Responsibilities

The Medical Staff duties and responsibilities shall include, but not be limited to;

1. Establishing the structure of Medical Staff organization, the mechanisms of the Medical Staff, termination of Medical Staff membership and fair hearing procedures, as well as all matters relevant to the operation of an organized Medical Staff;

2. Participating in the development of all Medical Staff and hospital policy, practice and planning; and

3. Reviewing Medical Staff Bylaws, as well as Rules and Regulations and forms promulgated by the Medical Staff and its clinical and ancillary services. Submitting recommendations to the Governing Board or hospital Administration for changes in these documents as necessary to reflect current Medical Staff practices.

SECTION H. Record-keeping

1. Minutes of each regular and special meeting of the Medical Staff shall be prepared, including a record of attendance, summary of topics discussed, and the vote taken on significant matters.

2. All minutes, correspondence and any other supporting documentation relevant to Medical Staff action shall be maintained in the Medical Staff Coordinator's Office. Such information shall be transmitted to the Governing Board together with the record of Medical Staff action or recommended action when appropriate.

3. Actions taken by the Medical Staff to amend the Bylaws, Rules and Regulations or to adopt or change policy shall be written as resolutions, numbered, signed and appended to these Bylaws when formally approved as set forth in these Bylaws.

ARTICLE XII - Quality Review Committee-of-the-Whole

SECTION A. Designation

The committee-of-the-whole described in this Article XI shall be a standing committee of the Medical Staff. The name of this committee shall be the "Quality Review Committee" of the Medical Staff.

SECTION B. General Provisions

1. Chairperson.

   The chairperson of the committee shall be the President, who shall be responsible to call, preside at, and be responsible for the agenda of all meetings of the committee.

2. Composition.

   (a) All members of the Active, Certified Nurse-Midwives, and Advanced Registered Nurse Practitioner Medical Staff membership shall be required to serve on the Committee-of-the-Whole, to participate in committee functions and to assume reasonable committee assignments as a condition of their Medical Staff membership.

   (b) Practitioners with Consulting or Associate Medical Staff membership may attend open meetings of the committee, but committee meeting attendance is not a condition of Consulting or Associate Staff membership.

   (c) Unless the committee chairperson specifically asks for a closed meeting, hospital administrative resource personnel who may attend meetings regularly or upon invitation of the committee chairperson include; Administrator or designee, Governing Board member, Medical Staff Coordinator, director of nursing services, pharmacist, nurse surveillance officer for infection control, utilization review coordinator, discharge planner, in-service education director and supervisors of clinical and ancillary services.

3. Terms of Office.

   The terms of committee members shall be continuous, unless the member resigns or loses staff membership.

4. Meetings.

   The regularly scheduled meetings of this committee shall be held on the 3rd Wednesday of every month to commence at 08:00 a.m. or at the conclusion of the Medical Staff business meeting.

5. Notice of Meetings.

   (a) A master calendar shall be published yearly which lists the date and time of all scheduled meetings. Such calendar shall be posted in the doctor's lounge and in the conference room.

   (b) A notice shall be published each year which lists the date and time of all scheduled meetings. A copy of the notice shall be mailed to each practitioner's appointment clerk, office nurse or aide, and the hospital admission office, radiology service and surgery department.

   (c) A written notice stating the place, date, time of each meeting shall be delivered to each member not less than seven days before the time of such meetings.

6. Agenda.

   The agenda of the committee shall be:

   (a) Call to order.

   (b) Acceptance of previous minutes.

   (c) Communications.

   (d) Review Activities.

   (e) Staff Applications.

   (f) Unfinished business.

(g) New business.

(h) Adjournment.

7. Manner of Action.

At least thirty percent (30%) of the Active, Certified Nurse-Midwives, and Advanced Registered Nurse Practitioner Medical Staff members must be present to constitute a quorum to conduct the business of the committee.

The action of a majority of the voting members present at a meeting at which a quorum is present will constitute the action of the committee.

Action may be taken without a meeting by a unanimous consent in writing, setting forth the action so taken, and signed by each member of the committee entitled to vote.

Action or recommended action of the committee will be considered final insofar as the Medical Staff is concerned and shall be transmitted on to the Governing Board or other appropriate individual or group affected by such action or recommended action.

8. Records.

Minutes of the Quality Review Committee (QRC) shall be prepared by the Secretary of the meeting or his/her designee and shall include a record of attendance, topics discussed, and the vote taken on each matter.

All minutes, correspondence, and any other supporting documentation concerning committee review and action will be marked “Confidential” and shall be maintained in the Medical Staff Coordinator’s Office without copies being made for distribution.

9. Attendance Requirements.

(a) Each member of the committee is expected to regularly attend and participate in committee meetings.

(b) Failure to attend fifty percent (50%) of the scheduled meetings in each calendar year, or absence at three (3) consecutive regularly scheduled meetings without excused absence for good cause may be deemed resignation of their staff membership.

(c) Members who have active staff privileges at multiple hospitals will be required to attend three (3) regularly scheduled meetings per year, as set forth in Article V, Section B #4 of these Bylaws.

10. Removal.

If a member of the committee ceases to be a member in good standing of the Medical Staff, loses employment or a contract relationship with the hospital, or if any other good cause exists, the member may be removed from the committee by the President.

SECTION C. Duties

The duties of the committee shall include, but not be limited to:

1. Reviewing and evaluating medical records, or a representative sample, to determine whether they; (1) properly describe the condition, diagnosis and progress of the patient during hospitalization and at the time of discharge, the treatment and tests provided, the results thereof, and adequate identification of individuals responsible for orders given and treatment rendered; and (2) are sufficiently complete at all times to facilitate continuity of care and communications between individuals providing patient care services in the hospital;

2. Review and make recommendations for Medical Staff and hospital policies, Rules and Regulations relating to medical records including completion, forms and formats, availability and methods of enforcement;

3. Conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services, and make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety;

4. Evaluating the appropriateness of blood transfusions;

5. Review of surgical cases in which a specimen, tissue or non-tissue is removed, as well as from those cases in which no specimen is removed. A screening mechanism based upon pre-established criteria may be established. The review criteria shall include indications for surgery and all cases in which there is a major discrepancy between preoperative and postoperative, including pathological diagnosis;

6. Develop and implement plans for maintaining quality patient care within the hospital. These may include mechanisms to:

   (a) establish systems to identify potential problems in patient care.

   (b) set priorities for action on problem correction.

   (c) refer priority problems for assessment and corrective action to appropriate individuals or clinical or ancillary services.

   (d) monitor the results of quality assurance activities.

   (e) coordinate quality assurance activities with the Governing Board's quality assurance committee; and

7. Developing a system for identifying, reporting and analyzing the incidence and cause of nosocomial infections;

8. Assisting in the development and implementation of a preventive and corrective program designed to minimize infection hazards including establishing, reviewing and evaluating aseptic and sanitation techniques and isolation requirements.

9. Establishing the mechanism to review credentials and delineate individual privileges and the organization of quality assurance activities and mechanisms of the Medical Staff.

10. Reviewing the qualifications, credentials, performance and professional competence and character of applicants and staff members and making recommendations to the Governing Board regarding staff appointments and reappointments, clinical privileges and corrective action;

11. Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in Medical Staff corrective or review measures when warranted;

12. Submitting required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, clinical privileges and special conditions;

13. Receive reports related to the health, well being, or impairment of Medical Staff members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual Medical Staff members, the committee may on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a Medical Staff member poses an unreasonable risk of harm to hospitalized patients, that information may be referred for corrective action. The committee shall also consider general matters related to the health and well being of the Medical Staff.

SECTION D. Special Committees

Special committees may be appointed by the President from time to time as may be required to properly carry out the responsibilities of the Medical Staff. Special committees shall confine their work to the purpose for which they were created and will report to the Medical Staff. They will have no power of action unless such is specifically granted by the Medical Staff action which created the committee. Special committees shall be terminated when they have carried out the functions for which they were created.

Record-keeping for special committees shall be the same as herein described for the standing committee-of-the-whole.

Special committees shall not be deemed permanent committees. Permanent standing committees shall only be formed by amendment to this Article XI of these Bylaws.

SECTION E. Functions

The primary responsibility of the Quality Review Committee is to oversee and evaluate the quality and efficiency of patient care provided at Three Rivers Hospital.

SECTION F. Confidentiality

The activities of this QR Committee are covered under RCW 70.41.200 (1) and are, therefore, subject to confidentiality regulations.

ARTICLE XIII - Confidentiality, Immunity And Releases

SECTION A. Special Definitions

For the purpose of this Article only, the following definitions shall apply:

1. **Good Faith** means having an honest purpose or intent and being free from intention to defraud.

2. **Information and Documents** means record of proceedings, minutes, interviews, records, reports including incident reports, forms, memoranda, statements, investigations, examinations, hearings, meetings, recommendations, findings, evaluations, disclosures or communication whether in written or oral form relating to any of the subject matter specified in Section E of this Article XIII.

3. **Malice** means the dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.

4. **Practitioner** means a Medical Staff member or applicant.

5. **Representative** means the Governing Board of the hospital and any member thereof; the President or his or her designee; registered nurses and other employees of the hospital; the Medical Staff and any member, officer or committee thereof; and any individual authorized by any of the foregoing to perform specific information gatherings, analysis, use or disseminating functions.

6. **Third Parties** means both individuals and organizations providing information to any representative.

SECTION B. Authorizations and Conditions

By submitting an application for staff appointment or reappointment, or by applying for or exercising clinical privileges, a practitioner:

1. authorizes representatives of the hospital to solicit, provide and act upon information bearing on his or her professional ability, utilization practices and other qualifications;

2. agrees to be bound by the provisions of this section and to waive all legal claims against any representative who acts in accordance with the provisions of this section; and

3. acknowledges that the provisions of this section are express conditions to his or her application for, or acceptance of, staff appointment and the continuation of such appointment and to his exercise of clinical privileges at this hospital.

SECTION C. Confidentiality of Information

Information and documents submitted, collected or prepared by any representative of this or any other health care facility or organization or Medical Staff for the purpose of evaluating, monitoring or improving the quality and efficiency of patient care, reducing morbidity and mortality, or contributing to teaching or clinical research shall, to the fullest extent permitted by law, be confidential. Such information shall not be disseminated to anyone other than a representative or other health care facility or organization of health care professionals engaged in official, authorized activity for which the information is needed, nor shall such information be used in any way except as provided herein or as otherwise required by law.

Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's record. It is expressly acknowledged by each practitioner that violation of the confidentiality provided herein is grounds for immediate and permanent revocation of Medical Staff membership and clinical privileges.

SECTION D. Immunity from Liability

1. For Action Taken.

   No representative shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of the representative's duties as a representative, if such acts are:

   (a) in substantial good faith and without malice within the scope of the assigned function;

   (b) in the reasonable belief that the action is in furtherance of quality or efficient health care;

   (c) after a reasonable effort to obtain the facts of the matter;

   (d) in substantial accordance with the procedures specified in the hospital and Medical Staff Bylaws; and

   (e) in the reasonable belief that the action was warranted by the facts known.

2. For Providing Information.

   No representative and no third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any other health care facility or organization of health professionals concerning said practitioner, provided that such representative or third party acts in substantial good faith, or unless such information is false and such representative or third party knew it was false.

SECTION E. Activities and Information Covered

1. Activities.

   The confidentiality and immunity provided by this Article applies to all information or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

   (a) applications for appointment or clinical privileges;

   (b) periodic reappraisals for reappointment or clinical privileges;

   (c) corrective or disciplinary action;

   (d) hearings and appellate reviews;

   (e) quality review program activities;

   (f) utilization review and management activities;

   (g) claims reviews;

   (h) profiles and profile analysis;

   (i) professional liability prevention program activities; and

   (j) other hospital, committee, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

2. Information.

   The information referred to in this Article may relate to a practitioner's professional licensure or certification, education, training, clinical ability, judgment, utilization practices, character, physical or mental health, emotional stability, professional ethics or any other matter that might directly or indirectly affect the quality or efficiency of patient care provided in the hospital.

SECTION F. Releases

Each practitioner shall upon request of the hospital execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, as may be applicable under relevant Washington Law. Execution of such releases is not a prerequisite to the effectiveness of this Article. Failure to execute such releases shall result is an application for appointment, reappointment or clinical privileges being deemed incomplete and voluntarily withdrawn, and it will not be further processed. Failure to execute such releases in connection

with conclusion of the provisional period shall be deemed a voluntary resignation of Medical Staff membership or particular clinical privileges as appropriate to the context. Failure to execute such releases in connection with a disciplinary or corrective action shall result in a presumption that the facts or circumstances that are the subject matter of the particular releases reflect adversely on the practitioner involved. This presumption will stand unless the practitioner presents verifiable facts to the contrary.

SECTION G. Cumulative Effect and Severability

Provisions in the Medical Staff Bylaws, in application forms relating to authorizations, confidentiality of information and immunities from liability are in addition to other protections provided by relevant Washington state and federal law and not in limitation thereof. A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provisions or any other provision.

ARTICLE XIV - Rules And Regulations

The Medical Staff shall initiate and adopt such Rules and Regulations as it may deem necessary for the proper conduct of its work and shall periodically, at least every two (2) years, review and revise its Rules and Regulations to comply with current staff practice. Recommended changes to the Rules and Regulations shall be submitted to the Medical Staff for review and evaluation at least thirty (30) days prior to presentation for action by the Medical Staff as a whole. The presence of two-thirds (2/3) of the total qualified voting members of the Medical Staff at any regular or special meeting in person or through written ballot shall constitute a quorum for the purpose of amending the Rules and Regulations of the Medical Staff. The action of a majority of the members present and voting and through written ballot present at the meeting shall be the action of the Medical Staff.

Following adoption, such Rules and Regulations shall become effective following approval of the Governing Board, which approval shall not be withheld unreasonably or automatically within ninety (90) days if no action is taken by the Governing Board.

Applicants to and members of the Medical Staff shall be governed by such Rules and Regulations as are properly initiated and adopted. If there is a conflict between the Bylaws and the Rules and Regulations, the Bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Rules and Regulations.

ARTICLE XV - Policies And Procedures

The Medical Staff shall initiate and adopt such clinical and ancillary service policies and procedures as it may deem necessary for the proper conduct of its work and shall periodically, at least every two years, review and revise its policies and procedures to comply with current staff practice. Recommended changes to the policies and procedures may be submitted to the Medical Staff at any meeting where a majority of the active staff members are present to constitute a quorum to conduct the business of the Medical Staff. The action of a majority of the members present and voting shall be the action of the Medical Staff. Following adoption, such policies and procedures shall become effective following approval of the hospital Administrator.

ARTICLE XVI - Periodic Review And Amendments

The Medical Staff shall periodically, at least every two years, review the Medical Staff Bylaws and make recommendations for amendment to comply with current practice or regulations. The presence of two-thirds (2/3) of the total qualified voting members of the Medical Staff at any regular or special meeting in person or through written ballot shall constitute a quorum for the purpose of amending the Bylaws of the Medical Staff.

The action of a majority of the members present and voting and through written ballot present at the meeting shall be the action of the Medical Staff.

Following adoption, such amendments to the Bylaws shall become effective following approval of the Governing Board, which approval shall not be withheld unreasonably or automatically within ninety (90) days if no action is taken by the Governing Board.

ARTICLE XVII - Adoption, Approval, Effective Date

These Bylaws shall be submitted to individual members of the Medical Staff for review and evaluation at least twenty (20) days prior to consideration by the Medical Staff. The Administrative Committee shall accept all recommendations and suggestions of individual Medical Staff members in the consideration of these Bylaws.

These Bylaws, as recommended by Administrative Committee shall be submitted to individual members of the Medical Staff for review and evaluation at least twenty (20) days prior to presentation for action by the Medical Staff as a whole. The presence of two-thirds (2/3) of the total qualified voting members of the Medical Staff at a regular or special meeting in person or through written ballot shall constitute a quorum for the purpose of adopting these Bylaws of the Medical Staff. The action of a majority of the members present and voting and through written ballot present at the meeting shall be the action of the Medical Staff.

Following adoption, the Bylaws shall be submitted to the Governing Board for final action. If there is any significant change in the scope or affect of any of the substantive provisions of these Bylaws, a special joint conference committee shall be established which shall be composed of two qualified voting members of the Medical Staff appointed by the President and two members of the Governing Board appointed by the board chairman to endeavor to reach an amicable agreement with respect to any proposed changes in the Bylaws.

The Governing Board shall have final decision in all matters relating to the provisions of these Bylaws. Approval will occur when final favorable action is taken by the Governing Board. Following approval by the Governing Board, the effective date for implementation shall be fifteen (15) days from the date of approval during which time a copy of the Bylaws as approved by the Governing Board shall be delivered or mailed special delivery to all members of the Medical Staff.

ADOPTED:
Three Rivers Hospital Governing Board of Directors: 06/30/2016
REVISED:
February 15, 2017

Signature page on file in Medical Staff Services Office