PROVIDENCE REGIONAL MEDICAL CENTER EVERETT

MEDICAL STAFF BYLAWS

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APPENDIX A: MEDICAL STAFF CATEGORIES SUMMARY

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

Unless otherwise indicated, the definitions that apply to terms used in these Bylaws are set forth in the Medical Staff Credentials & Procedural Policy.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under these Bylaws is to be carried out by a member of Administrative Leadership, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(2) When an individual assigned a function under these Bylaws is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.C. SUBSTANTIAL COMPLIANCE

While every effort will be made to comply with all provisions of these Bylaws, technical or minor deviations from the procedures set forth within these Bylaws do not invalidate any review or action taken.

1.D. MEDICAL STAFF DUES

(1) Annual Medical Staff dues shall be as recommended by the MEC and may vary depending upon staff category and/or clinical privilege status.

(2) Dues shall be payable upon request in accordance with the Annual Medical Staff Dues policy.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Credentials & Procedural Policy are eligible to apply for appointment to one of the categories listed below. All categories, with the respective rights and obligations of each, are summarized in the chart attached as **Appendix A** to these Bylaws.

2.A. ACTIVE HOSPITAL-BASED STAFF

2.A.1. Qualifications:

The Active Hospital-Based Staff shall consist of Practitioners who:

(a) admit more than 10 patients to the Hospital per year;

(b) are involved in more than 10 inpatient encounters per year; or

(c) are in a hospital-based discipline, including, but not limited to, Diagnostic and Interventional Radiology, Radiation Oncology, Pathology, Emergency Medicine, and Hospitalists.

Members of the Active Hospital-Based Staff must also contribute or express a willingness to contribute to Medical Staff functions and/or have demonstrated a commitment to the Medical Staff and Hospital through service on committees, attendance at Medical Staff meetings, service in Medical Staff leadership, and/or active participation in performance improvement or peer review functions.

For purposes of these Bylaws, "patient encounters" means any admission, consultation, procedure, physical response to emergency call, evaluation, treatment or service performed in the Hospital or its hospital-based clinics. Patient contacts do not include referrals for diagnostic or laboratory tests or x-rays.

Guidelines:

If at the time of reappointment questions arise about whether an individual's relationship to the Hospital fits within the specified purpose of this category, the Credentials Committee has the discretion to assign the individual to another Medical Staff category that is more appropriate. This means that unless an Active Hospital-Based Staff member can demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his or her practice patterns have changed and that he/she will satisfy the requirements of this category:

* A member who does not meet the eligibility criteria for appointment to this category during his or her appointment term may not be eligible to request Active Hospital-Based Staff status at the time of his or her reappointment.

** The member may be transferred to another staff category that best reflects his or her relationship to the Medical Staff and the Hospital (options – Consulting, Active-Office Based, or Community).

2.A.2. Prerogatives and Responsibilities:

Active Hospital-Based Staff members:

(a) may admit and otherwise exercise such clinical privileges as are granted to them;

(b) may attend and participate in Medical Staff, Division, [section], and applicable committee meetings (with vote);

(c) may hold office, serve as Division Chiefs [or Section Medical Directors], and serve on and chair Medical Staff committees;

(d) are eligible to serve on the on-call roster for their specialty, as may be requested;

(e) must provide care for unassigned patients;

(f) will accept inpatient consultations, when requested;

(g) will actively participate in the Medical Staff's peer review and performance improvement processes;

(h) must pay applicable application fees and dues; and

(i) will perform other assigned duties, as may be requested.

2.B. ACTIVE OFFICE-BASED STAFF

2.B.1. Qualifications:

The Active Office-Based Staff consists of those Practitioners who:

(a) practice primarily in an outpatient setting and have less than 10 patient encounters/admissions per year at the Hospital; and

(b) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of any clinical privileges requested (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or

managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

Guidelines:

The Active Office-Based Staff shall consist of members of the primary care disciplines (i.e., Family Practice, Pediatrics, and Internal Medicine), as well as members of other medical or surgical specialties that do not qualify for appointment to the Active Hospital-Based Staff.

2.B.2. Prerogatives and Responsibilities:

Active Office-Based Staff members:

(a) may admit and otherwise exercise such clinical privileges as are granted to them;

(b) may attend and participate in Medical Staff, division, [section], and applicable committee meetings (with vote);

(c) may hold office, serve as Division Chiefs [or Section Medical Directors], and serve on and chair Medical Staff committees;

(d) are eligible to serve on the on-call roster for their specialty, as may be requested;

(e) may attend educational activities sponsored by the Medical Staff and the Hospital;

(f) are encouraged to submit their relevant outpatient records for inclusion in the Hospital's medical records for any patients who are referred;

(g) may refer patients to the Hospital's diagnostic facilities and order such tests;

(h) will actively participate in the Medical Staff's peer review and performance improvement processes;

(i) must pay applicable application fees and dues; and

(j) will perform other assigned duties, as may be requested.

2.C. COMMUNITY STAFF

2.C.1. Qualifications:

The Community Staff consists of those Practitioners who:

(a) desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital due to their outpatient medical practice;

(b) meet the eligibility criteria set forth in the Credentials & Procedural Policy with the exception of those criteria in Section 2.A.1 that are related to an inpatient clinical practice (e.g., emergency call coverage, coverage arrangements, etc.); and

(c) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Community Staff as outlined in Section 2.C.2.

Guidelines:

The primary purpose of the Community Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Hospital-Based Staff members for admission and care.

2.C.2. Prerogatives and Responsibilities:

Community Staff members:

(a) may not: admit patients, attend patients, exercise clinical privileges, write inpatient orders, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

(b) may attend meetings of the Medical Staff and applicable Divisions or sections

(c) may not hold office, serve as Division Chiefs

(d) may be invited to serve on committees (with vote);

(e) may attend educational activities sponsored by the Medical Staff and the Hospital;

(f) may refer patients to the Hospital for admission and/or care;

(g) are encouraged to submit their relevant outpatient records for inclusion in the Hospital's medical records for any patients who are referred;

(h) are encouraged to communicate directly with Active Hospital-Based Staff members about the care of any patients referred, as well as to visit any such patients;

(i) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(j) may perform history and physical examinations in the office and have those reports entered into the Hospital's medical records;

(k) may be requested to accept referrals from the Emergency Department for follow-up care of patients treated and released from the Emergency Department;

(l) may refer patients to the Hospital's diagnostic facilities and order such tests;

(m) may be requested to participate in the Medical Staff's peer review and performance improvement processes; and

(n) must pay applicable application fees and dues

2.D. CONSULTING STAFF

2.D.1. Qualifications:

The Consulting Staff shall consist of Practitioners who:

(a) are of demonstrated professional ability and expertise in a specialty that is not otherwise available or in very limited supply on the Active Hospital-Based or Active Office-Based Staffs;

(b) provide services at the Hospital only at the request of other members of the Medical Staff; and

(c) at each reappointment time, provide such quality data and other information may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

Guidelines:

The primary purpose of the Consulting Staff is to provide the Hospital with access to specialists who are not available or are otherwise in short supply on the Active Hospital-Based or Active Office-Based Staffs.

- Should the specialty become readily available on the Medical Staff, the Consulting Staff members in that specialty would not be eligible to request continued Consulting Staff status at the time of their next reappointments and would have to transfer to a different staff category if they desire continued appointment.

- In addition, if at the time of reappointment questions arise about whether an individual's relationship to the Hospital fits within the specified purpose of this category, the Credentials Committee has the discretion to assign the individual to another Medical Staff category that is more appropriate. For example, if a

Consulting Staff member has more than 10 patient encounters per year, they may be transferred to the Active Hospital-Based Staff, at the discretion of the Credentials Committee.

2.D.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may exercise such clinical privileges as are granted to them (in conjunction with other members of the Medical Staff), but may not admit patients to the Hospital;

(b) are excused from providing specialty coverage for the Emergency Department and providing care for unassigned patients;

(c) may attend meetings of the Medical Staff and applicable Division, and section meetings with a vote

(d) may not hold office or serve as Division Chiefs, Section Medical Directors, but they may serve as committee chairs;

(e) may be invited to serve on committees (with vote);

(f) may be requested to participate in the Medical Staff's peer review and performance improvement processes; and

(g) shall pay applicable application fees and dues.

2.E. ADMINISTRATIVE STAFF

2.E.1. Qualifications:

The Administrative Staff will consist of Practitioners who:

(a) provide administrative services to the Medical Staff and Hospital but who do not have a clinical practice at the Hospital; and

(b) meet the eligibility criteria set forth in the Credentials & Procedural Policy with the exception of those related to the provisions of clinical services (e.g., emergency call coverage, coverage arrangements, etc.) and eligibility criteria for clinical privileges.

2.E.2. Prerogatives and Responsibilities:

Administrative Staff members:

(a) may not admit or attend to patients in the Hospital, be granted or exercise any clinical privileges, or otherwise actively participate in the provision or management of care to patients at the Hospital (except in a disaster or other extraordinary situation), but may be granted access to the EMR to perform their administrative duties;

(b) may attend meetings of the Medical Staff and applicable divisions or sections (without vote);

(c) may not hold office or serve as Division Chiefs, Section Medical Directors, but they may serve as committee chairs

(d) may be invited to serve on committees (with vote);

(e) may attend educational activities of the Medical Staff and the Hospital; and

(f) are not required to pay application fees or dues.

2.F. TELE-HEALTH STAFF

2.F.1. Qualifications:

The Tele-Health Staff shall consist of Practitioners who are licensed to practice medicine in Washington and who have been granted telemedicine privileges in accordance with Article 4 of the Credentials & Procedural Policy. Any telemedicine privileges that are granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

2.F.2. Prerogatives and Responsibilities:

Tele-Health Staff members:

(a) may exercise such clinical privileges as are granted to them, but may not admit patients to the Hospital;

(b) may attend meetings of the Medical Staff and applicable divisions or sections (without vote);

(c) may not hold office or serve as Division Chiefs, Section Medical Directors, or committee chairs; and

(d) may not be appointed to committees;

(e) must pay applicable application fees and dues.

2.G. HONORARY STAFF

2.G.1. Qualifications:

(a) The Honorary Staff shall consist of Practitioners who have retired from the practice of medicine in this Hospital, who are in good standing, and who have been recommended for Honorary Staff appointment by the MEC.

(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

2.G.2. Prerogatives and Responsibilities:

Honorary Staff members:

(a) may not exercise clinical privileges or otherwise consult, admit, or attend to patients;

(b) may attend Medical Staff, division, and section meetings (without vote);

(c) may be appointed to committees (with vote) and serve as a committee chair (during the first three years after appointment to the Honorary Staff only);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as Division Chiefs, or Section Medical Directors; and

(f) are not required to pay applicable application fees or dues.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

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

3.B. ELIGIBILITY CRITERIA

(1) Only those members of the Medical Staff, who satisfy the following criteria initially and continuously, as determined by the Medical Executive Committee shall be eligible to serve as an officer of the Medical Staff. They must:

(a) be appointed in good standing to the Active Hospital-Based Staff, Active Office-Based Staff, or, in the case of committee chairs only, Honorary Staff, and have served on the Medical Staff for at least three years;

(b) have no past or pending adverse recommendations such as a recommendation from MEC or the board to terminate, restrict, or suspend privileges

(c) not presently be serving as a Medical Staff officer, Board member or department chief at any other hospital outside of Providence Swedish and shall not so serve during their term of office;

(d) be willing to faithfully discharge the duties and responsibilities of the position;

(e) have experience in a leadership position or other involvement in performance improvement functions at this Hospital;

(f) attend continuing education relating to Medical Staff leadership, credentialing, and/or peer review functions prior to or during the term of the office, when requested;

(g) have demonstrated an ability to work well with others; and

(h) disclose any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a Practitioner's office and billed under the same provider number used by the Practitioner. The MEC shall assess any such conflicts to determine whether they are such that they render the individual ineligible for the position.

(2) All Medical Staff Officers, Division Chiefs, Section Medical Directors, and committee chairs must maintain such qualifications during their term of office. Failure to do so shall automatically create a vacancy in the office involved, unless an exception is recommended by the MEC and approved by the Board.

3.C. DUTIES

3.C.1. Medical Staff President:

The Medical Staff President shall:

(a) act in coordination and cooperation with Hospital administration in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies and needs, and report on the activities, of the Medical Staff to the CEO and the Board;

(c) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the MEC;

(d) chair the MEC with vote, as necessary and be a member of all other Medical Staff committees, *ex officio*, without vote;

(e) promote adherence to the Bylaws, policies, Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital; and

(f) perform all functions authorized in all applicable policies, including collegial efforts and progressive steps as referenced in the Credentials & Procedural Policy and other relevant Medical Staff policies.

3.C.2. Medical Staff President-Elect:

The Medical Staff President-Elect shall:

(a) assume all duties of the Medical Staff President and act with full authority as Medical Staff President when the Medical Staff President is unavailable within a reasonable period of time;

(b) serve on the MEC with vote;

(c) assume all such additional duties as are assigned to him or her by the Medical Staff President or the MEC; and

(d) become Medical Staff President upon completion of his or her term.

3.C.3. Immediate Past Medical Staff President:

The Immediate Past Medical Staff President shall:

(a) serve on the MEC, with vote;

(b) serve as an advisor to other Medical Staff leaders; and

(c) assume all duties assigned by the Medical Staff President or the MEC.

3.C.4. Secretary-Treasurer:

The Secretary-Treasurer shall:

(a) serve on the MEC and chair the Bylaws Committee;

(b) oversee the preparation of accurate and complete minutes of all MEC and general Medical Staff meetings;

(c) serve on the MEC with vote;

(d) be responsible for the collection of and accounting for any funds in the Medical Staff Fund and report to the Medical Staff; and

(e) assume all such additional duties as are assigned to him or her by the Medical Staff President or the MEC.

3.D. NOMINATIONS

(1) Nominations shall come from the MEC and the CMO. When possible, preference shall be given to individuals who have served in past Medical Staff leadership roles. The MEC will have the final decision, via standard vote, regarding whom to put forth as nominees.

(2) The committee shall convene at least 45 days prior to the election and shall submit the names of at least one qualified nominee for any vacant office. Nominations will be selected by the appropriate committee by methods described in the voting policy. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election.

(3) Additional nominations may also be submitted in writing by petition signed by at least 10% of the Voting Staff at least 14 days prior to the election. In order for a nomination to be added to the ballot, the candidate must meet the qualifications in Section 3.B, in the judgment of the MEC, and be willing to serve.

(4) Nominations from the floor shall not be accepted.

3.E. ELECTION

(1) Elections shall be held by Medical Staff Services in the manner as indicated on the ballot at the time it is distributed. Ballots shall be provided to all members of the Voting Staff and completed ballots must be received in Medical Staff Services by the date indicated on the ballot. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role.

(2) In the alternative, and in the discretion of the MEC, elections may occur at called meetings of the Medical Staff. Candidates receiving a majority of votes cast at the meeting by those members of the Voting Staff present and voting at that meeting shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

3.F. TERM OF OFFICE

Officers shall serve for a term of two years or until a successor is elected or appointed. The term of office will commence on the first day of the Medical Staff year following the election.

3.G. REMOVAL FROM OFFICE OR MEMBERSHIP ON THE MEDICAL EXECUTIVE COMMITTEE

(1) Removal of an elected officer or member of the MEC may be effectuated by a two-thirds vote of the MEC, or by a two-thirds vote of the Voting Staff, or by the Board. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to perform the duties of the position held;

(c) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(d) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC, the Voting Staff, or the Board, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Board.

3.H. VACANCIES

A vacancy in the office of Medical Staff President shall be filled by the Medical Staff President-Elect, who shall serve until the end of the Medical Staff President's unexpired term. In the event there is a vacancy in the Medical Staff President-Elect or Secretary-Treasurer position, the MEC shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, at the discretion of the MEC.

ARTICLE 4

CLINICAL DIVISIONS AND SECTIONS

4.A. ORGANIZATION

The Medical Staff shall be organized into divisions and sections as determined by the MEC and listed in the Organization Manual. The MEC may create new divisions, eliminate divisions, create or eliminate sections within divisions, or otherwise reorganize the division structure, in accordance with the amendment provisions contained in these Bylaws documents.

4.B. ASSIGNMENT TO DIVISIONS AND SECTIONS

(1) Upon initial appointment to the Medical Staff, each Medical Staff member shall be assigned to a clinical division and section, if applicable. Assignment to a particular division or section does not preclude a Medical Staff member from seeking and being granted clinical privileges typically associated with another department.

(2) A Medical Staff member may request a change in division or section assignment to reflect a change in his or her clinical practice.

(3) Division or section assignment may be transferred at the discretion of the MEC either independently or upon recommendations from the Credentials Committee.

4.C. FUNCTIONS OF DIVISIONS

The divisions shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the divisions, (ii) to monitor the practice of all those with clinical privileges in a given division, and (iii) to assure emergency call coverage for all patients.

4.D. QUALIFICATIONS OF ELECTED DIVISION CHIEFS

Each Division Chief shall satisfy the eligibility criteria in Section 3.B.

4.E. APPOINTMENT AND REMOVAL OF DIVISION CHIEFS

(1) Division Chiefs eligibility will be a process open to medical staff members that meet eligibility criteria in Section 3B. The Medical Executive Committee and any other panel members they wish to invite will interview the candidates and jointly decide by majority vote which candidate to put forward to the Board as their nominee.

(2) Alternatively, if they decide multiple candidates are equally qualified, they will have the option of sending it to the Medical Staff for vote.

In this case, elections shall be held by Medical Staff Services in the manner as indicated on the ballot at the time it is distributed. Ballots shall be provided to all members of the Voting Staff within the candidate's division. Completed ballots must be received in Medical Staff Services by the date indicated on the ballot. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role.

(3) Any Division Chief may be removed by a two-thirds vote of the division or by a two-thirds vote of the MEC after reasonable notice and opportunity to be heard. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to perform the duties of the position held;

(c) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(d) an infirmity that renders the Medical Staff member incapable of fulfilling the duties of that office.

(4) Prior to the initiation of any removal action, the Medical Staff member shall be given written notice of the date of the meeting at which such action shall be taken at least 10 days prior to the date of the meeting. The Medical Staff member shall be afforded an opportunity to speak to the division or MEC, as applicable, prior to a vote on such removal being taken.

(5) Division Chief positions will be evaluated in two-year intervals at the Medical Executive Committee level. The timing of these evaluations will take place in the year where there is no Medical Staff President Elect to Medical Staff President transition. Each Chief will need to be ratified into their current role by majority vote of the Medical Executive Committee.

4.F. DUTIES OF DIVISION CHIEFS

Division Chiefs shall work in collaboration with Medical Staff Leaders and other Hospital personnel to collectively be responsible for the following:

(1) all clinically-related activities of the department;

(2) all administratively-related activities of the department, unless otherwise provided for by the Hospital;

(3) continuing surveillance of the professional performance of all individuals in the division who have delineated clinical privileges;

(4) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(5) evaluating requests for clinical privileges for each member of the department;

(6) the integration of the division into the primary functions of the Hospital;

(7) the development and implementation of policies and procedures that guide and support the provision of care, treatment and services;

(8) determination of the qualifications and competence of division personnel who are not licensed independent practitioners and who provide patient care, treatment and services;

(9) recommendations for a sufficient number of qualified and competent persons to provide care or services;

(10) continuous assessment and improvement of the quality of care and services provided;

(11) maintenance of quality monitoring programs, as appropriate;

(12) recommendations for space and other resources needed by the department;

(13) assessing and recommending off-site sources for needed patient care services not provided by the division or the Hospital;

(14) the orientation and continuing education of all persons in the department; and

(15) performing all functions authorized in the Credentials & Procedural Policy.

4.G. CLINICAL SECTIONS

4.G.1. Section Requirements:

Sections shall generally have no meeting or minutes requirements. Only when sections are making formal recommendations to a division will a report be required from the Section Medical Director.

4.G.2. Section Activities:

Sections may perform any of the following activities:

(a) continuing education;

(b) performance improvement opportunities;

(c) M&M

(d) discussion of policy or equipment needs; and/or

(e) development of recommendations for Division Chief.

4.G.3. Section Medical Directors:

The relevant Division Chief may appoint a Section Medical Director who will be responsible for calling special meetings to discuss specific issues as necessary and will also be involved with quality and credentialing issues as requested. Section Medical Directors may also be appointed by the MEC.

4.H. SERVICE LINES

(1) The Hospital may also establish multi-disciplinary service lines to facilitate the delivery of quality, safe, and effective patient care.

(2) When service lines exist, a physician shall be designated to serve as a Service Line Director who shall have the responsibility for the day-to-day operations of the service line. This physician will work closely with an individual designated by the Hospital to assist with day-to-day operations and overall management of the service line.

(3) Notwithstanding the creation of services lines, the primary responsibility for activities related to credentialing, privileging, and the evaluation of professional practice related to the Practitioners who function within the service line shall remain the responsibility of the relevant Division Chief or other appropriate Medical Staff Leader or Medical Staff committee.

(4) Service Line Directors may participate in credentialing, privileging, and evaluation of professional practice activities if requested by a Medical Staff Leader or Medical Staff committee. In these circumstances, the Service Line Directors must follow the processes and procedures outlined the Medical Staff Bylaws and policies and treat all such activities and documentation in a strictly confidential and privileged manner. Any documentation that is created by a Service Line Director in this regard will be maintained in the Practitioner's confidential Medical Staff file.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article and the Medical Staff Organization Manual outline the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) New committee members and chairpersonship will be decided in the respective committees. All voting should follow the Voting Policy. Advanced Practice Professionals and Licensed Independent Practitioners may be appointed to serve as voting members of Medical Staff committees. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws, and all committee members must signify their willingness to meet basic expectations of committee membership as set forth in Section 3.B of the Organization Manual.

(2) Committee chairs shall be appointed for initial terms of one year, but may be reappointed for additional terms. All appointed chairs and members may be removed and vacancies filled by vote of the Medical Executive Committee.

(3) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the CEO, in consultation with the CMO and the Medical Staff President. All such representatives shall serve on the committees, without vote.

(4) Unless otherwise indicated, the Medical Staff President, the CMO, Board members, and the CEO shall be members, *ex officio*, without vote, on all committees.

:

(5) Any committee member or committee chair may be removed by a two-thirds vote of the division or by a two-thirds vote of the MEC after reasonable notice and opportunity to be heard. Grounds for removal shall be
   (a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;
   (b) failure to perform the duties of the position held;
   (c) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or
   (d) an infirmity that renders the Medical Staff member incapable of fulfilling the duties of that office.

5.C. MEDICAL EXECUTIVE COMMITTEE

5.C.1. Composition:

(a) The MEC shall consist of the following voting members:

- Medical Staff Officers;
- Division Chiefs (or designated temporary alternates);
- Chair, Credentials Committee;
- Chair, Medical Staff Quality Review Committee; and
- A representative from the Board.

(b) The CEO, CMO, CAO, Medical Director of Graduate and Undergraduate Medical Education, and representatives from the Board, the Patient Family Advisory Committee, and the Medical Staff Office.

(c) The Medical Staff President will chair the MEC.

(d) Other Medical Staff members or Hospital personnel may be invited to attend a particular MEC meeting (as guests, without vote) in order to assist the MEC in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the committee's functioning and are bound by the same confidentiality requirements as the standing members of the MEC.

5.C.2. Duties:

The MEC has the primary oversight authority related to professional activities and functions of the Medical Staff and performance improvement activities regarding the professional services provided by Medical Staff members with clinical privileges. This authority may be removed or modified by amending these Bylaws and related policies. The MEC is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings;

(b) recommending directly to the Board on at least the following:

(1) the Medical Staff's structure;

(2) the mechanism used to review credentials and to delineate individual clinical privileges;

(3) applicants for Medical Staff appointment and reappointment;

(4) delineation of clinical privileges for each eligible individual;

(5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(6) the mechanism by which Medical Staff appointment may be terminated; and

(7) hearing procedures;

(c) consulting with the CEO on quality-related aspects of contracts for patient care services;

(d) receiving and acting on reports and recommendations from Medical Staff committees, divisions, and other groups as appropriate, and making appropriate recommendations for improvement when there are significant departures from established or expected clinical practice patterns;

(e) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(f) providing leadership in activities related to patient safety;

(g) providing oversight in the process of analyzing and improving patient satisfaction;

(h) prioritizing continuing medical education activities;

(i) reviewing, or delegating to the Bylaws Committee the responsibility to review, at least once every three years, the Bylaws, policies, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable; and

(j) performing such other functions as are assigned to it by these Bylaws, the Credentials & Procedural Policy, the Board or other applicable policies.

5.C.3. Meetings:

The MEC shall meet as often as necessary to fulfill its responsibilities and shall maintain a permanent record of its proceedings and actions.

5.D. PERFORMANCE IMPROVEMENT FUNCTIONS

The Medical Staff may be actively involved in performance improvement functions, which may include reviewing data and recommending and implementing processes to address the following:

(1) patient safety, including processes to respond to patient safety alerts, meet patient safety goals and reduce patient safety risks;

(2) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(3) medical assessment and treatment of patients;

(4) use of information about adverse privileging determinations regarding any practitioner;

(5) medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

(6) the utilization of blood and blood components, including review of significant transfusion reactions;

(7) operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(8) appropriateness of clinical practice patterns;

(9) significant departures from established patterns of clinical practice;

(10) education of patients and families;

(11) coordination of care, treatment and services with other practitioners and Hospital personnel;

(12) accurate, timely and legible completion of medical records;

(13) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in **Appendix B** of these Bylaws;

(14) the use of developed criteria for autopsies;

(15) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(16) nosocomial infections and the potential for infection;

(17) unnecessary procedures or treatment; and

(18) appropriate resource utilization.

5.E. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Organization Manual, the MEC may establish additional committees to perform one or more staff functions and may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual Medical Staff member, a standing committee, or a special task force shall be performed by the MEC.

5.F. SPECIAL COMMITTEES

Special committees shall be created and their Medical Staff members and chairs shall be appointed by the Medical Staff President. Such committees shall confine their activities to the purpose for which they were appointed and shall report to the MEC.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least annually, and more often as needed on dates and at times set by the MEC. Meetings can be either virtual, in person, or a hybrid.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the Medical Staff President, the MEC, the Board, or by a petition signed by not less than 10% of the Voting Staff.

6.C. DIVISION AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Medical Staff Organization Manual, each division and committee shall meet as often as necessary to fulfill their responsibilities, at times set by the Presiding Officer.

6.C.2. Special Meetings:

A special meeting of any division or committee may be called by or at the request of the Presiding Officer, the Medical Staff President, or by a petition signed by not less than 10% of the Voting Staff members of the division or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of divisions and committees at least 14 days in advance of the meetings. The primary mechanism utilized for providing notice will be e-mail; however, notice may also be provided by mail, facsimile, hand delivery, posting in a designated electronic or physical location, or telephone at least 14 days

prior to the meetings. All notices shall provide the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a division, and/or a committee is called, all of the provisions in paragraph (a) shall apply except that the notice period shall be reduced to 48 hours and posting may not be the sole mechanism used for providing notice of a special meeting.

(c) The attendance of any individual Medical Staff member at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, division, section, or committee, those voting members present (but not fewer than two) shall constitute a quorum. Exceptions to this general rule are as follows:

(1) for meetings of the MEC, the presence of at least 50% of the voting members of the committee shall constitute a quorum; and

(2) for amendments to these Medical Staff Bylaws, at least 10% of the voting staff shall constitute a quorum.

(3) if reasonable and prudent efforts are made to advertise proposed bylaws modifications and to encourage voting from the medical staff at large and quorum cannot be reached, the MEC can vote to accept results based on votes received to that point. The Board must be informed of this decision explicitly.

(b) The Presiding Officer may permit some members of the Medical Staff or a division, section, or committee that is meeting in person to participate in the meeting via telephone, videoconference, or other approved modes of communication. All such individuals shall count for purposes of calculating the quorum and for voting.

(c) As an alternative to an in-person meeting, at the discretion of the Presiding Officer, meetings of the Medical Staff or a division, section, or a Medical Staff committee may be conducted entirely by telephone or videoconference or the voting members may also be presented with a question by mail, facsimile, e-mail, hand delivery, website posting, or telephone and their votes returned to the Presiding Officer by the method designated in the notice. Except for amendments to these Bylaws (which require a 10% quorum) and actions by the MEC (which require a 50% quorum), a quorum for purposes of these votes shall be the number of responses returned to the Medical Staff Office by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.

(d) When determining whether a specific percentage or a majority has been achieved with respect to a vote of the Medical Staff or a division, section, or committee, an individual who has recused himself or herself from participation in the vote shall not be counted as a voting member (for example, if there are ten voting members of a committee and one recuses himself or herself on a particular matter, the majority vote for that matter would be calculated as five of the remaining nine votes).

(e) Recommendations and actions of the Medical Staff, divisions, sections, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those individuals present. Voting may be by written ballot at the discretion of the Presiding Officer.

6.D.3. Agenda:

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, division, or committee.

6.D.4. Rules of Order:

The latest edition of Robert's Rules of Order Revised may be used for reference at all meetings and elections, but shall not be binding. Specific provisions of these Bylaws and Medical Staff, division, or committee custom shall prevail at all meetings, and the Presiding Officer (Medical Staff Officer, Division Chief, or committee chair, as applicable) shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, divisions, and committees shall be prepared and shall include a record of the attendance of Medical Staff members and the recommendations made and the votes taken on each matter. The minutes shall be approved in accordance with Medical Staff, division, or committee custom, as applicable.

(b) Unless otherwise indicated, a summary of all recommendations and actions of the Medical Staff, divisions, and committees shall be transmitted to the MEC and to the CEO for purposes of keeping the Board apprised of the activities of the Medical Staff and its divisions and committees.

(c) The minutes of all meetings shall be maintained by the Hospital in accordance with the current Records Retention and Disposal policy

6.D.6. Confidentiality:

All Medical Staff business conducted by committees or divisions is considered confidential and proprietary and should be treated as such. However, members of the Medical Staff

who have access to, or are the subject of, credentialing and/or peer review information understand that this information is subject to heightened sensitivity and, as such, agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials & Procedural Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality with regard to any Medical Staff information may result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

(a) Attendance at meetings of the MEC and the Credentials Committee is required. All members are required to attend at least 75% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.

(b) Each Active Hospital-Based Staff member is expected, but not required, to attend and participate in all Medical Staff meetings and applicable division and committee meetings each year.

(c) Participation at a meeting by telephone, video conference, or other approved modes of communication may constitute attendance at the discretion of the Presiding Officer.

ARTICLE 7

LEGAL PROTECTIONS FOR PRACTITIONERS PERFORMING MEDICAL STAFF FUNCTIONS

Practitioners have significant personal legal protections from various sources when they perform functions pursuant to these Bylaws, the Credentials & Procedural Policy, the Medical Staff Organization Manual, and all other policies of the Medical Staff and Hospital, as long as they maintain confidentiality and act in accordance with these Bylaws and related policies. The sources of these legal protections include:

(a) As set forth in the Credentials & Procedural Policy, all Practitioners agree, as a condition of applying for appointment, reappointment, and/or clinical privileges, to release from liability, extend immunity to, and not sue other Practitioners for any actions, recommendations, communications, and/or disclosures made or taken in the course of credentialing and peer review activities.

(b) All applicants for appointment, reappointment, and clinical privileges sign an application form by which they release from liability and agree not to sue other Practitioners who participate in credentialing and peer review activities.

(c) Protections are also available under both the Washington peer review statute and the federal Health Care Quality Improvement Act ("HCQIA") for Practitioners who participate in credentialing and peer review activities. The Medical Staff Bylaws and related policies have been structured to take full advantage of these legal protections.

(d) The Hospital will indemnify Practitioners who perform functions under these Bylaws and related policies for any claims made against the Practitioner that are not completely covered by an applicable insurance policy, in accordance with the Hospital's corporate bylaws.

ARTICLE 8

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials & Procedures Policy in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials & Procedures Policy.

8.B. PROCESS FOR PRIVILEGING

Requests for clinical privileges are provided to the Division Chief, who evaluates the quality and efficiency of services ordered or performed by the individual and reviews the individual's education, training, and experience. The Credentials Committee then reviews the Division Chief's report and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant clinical privileges is favorable, it is forwarded to the Board for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

8.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the Division Chief, who evaluates the quality and efficiency of services ordered or performed by the individual and reviews the individual's education, training, and experience. The Credentials Committee then reviews the Division Chief's report and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant appointment or reappointment is favorable, it is forwarded to the Board for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

8.D. TEMPORARY PRIVILEGING

Temporary privileges may be granted by the CEO as per the Credentials Policy to (i) applicants for initial appointment and (ii) individuals seeking privileges when there is an

emergent patient care, treatment, or service need. In either situation, the grant of temporary privileges will not exceed 120 days for new applicants or 60 days for temporary privileges for an emergent patient care need.

8.E. DISASTER PRIVILEGING

When the disaster plan has been implemented, the CEO, CMO, or Medical Staff President may use a modified credentialing process to grant disaster privileges after verification of the volunteer's identity and licensure.

8.F. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) satisfy threshold eligibility criteria;

(ii) notify the Hospital of changes in information pertaining to qualifications;

(iii) provide requested information;

(iv) attend a mandatory meeting to discuss issues or concerns;

(v) comply with request for fitness for practice evaluation; or

(vi) comply with request for competency assessment;

(b) is involved in defined criminal activity;

(c) makes a misstatement or omission on an application form;

(d) remains absent on leave for longer than one year, unless an extension is granted; or

(e) is involved in other activities that may trigger an automatic relinquishment under Medical Staff policy.

(2) Automatic relinquishment will take effect immediately and will continue until the matter is resolved, if applicable.

8.G. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, and two of the following: the CEO, Medical Staff President, relevant Division Chief, CMO, MEC, or Board Chair is authorized to (i) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being reviewed or (ii) suspend or restrict all or any portion of an individual's clinical privileges.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the CEO or the Board.

(3) The individual will be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The MEC will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 days.

(5) Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC.

8.H. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an Investigation or a determination that there is sufficient information upon which to base a recommendation, the MEC may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) clinical competence or practice; (b) safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, rules, and regulations of the Hospital or the Medical Staff; or (d) conduct that is considered lower than the standards of the Medical Staff or is disruptive to the orderly operation of the Hospital or its Medical Staff.
If the MEC terminates the precautionary summary suspension or if for any reason the Medical Executive Committee does not make a disposition within 21 days of a precautionary summary suspension, the suspended individual shall automatically be reinstated to the status previously held.

8.I. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

(1) Hearing and appeals will follow detailed processes described in the Credentials Policy unless otherwise noted here.

(2) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

(3) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

(4) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(5) A stenographic reporter will be present to make a record of the hearing.

(6) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit proposed findings, conclusions, and recommendations to the Hearing Panel in the form of a post-hearing statement submitted at the close of the hearing.

(7) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

(8) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

(9) The affected individual and the MEC may request an appeal of the recommendations of the Hearing Panel to the Board.

ARTICLE 9

RESPONSIBILITIES OF PHYSICIANS FOR UNASSIGNED PATIENTS

9. A. CALL COVERAGE

(1) Admission and consultation

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

(b) When the practitioner does not agree with the requesting practitioner's request to treat or admit a patient, they are responsible for personally evaluating the patient and arranging for the appropriate consultant to assist in and/or assume the care of the patient.

(c) All members of the Medical Staff are expected to follow the requirements of EMTALA (Emergency Medical Treatment and Labor Act).

(d) Both specialists and primary care practitioners will be available for consultation to those admitting practitioners who feel that the consultation is appropriate for optimal care.

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

(2) Readmission

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

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

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

(3) Discharge and follow-up

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

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

(c) Patients referred from the Hospital's Emergency Departments as described in the above section will be seen without requirement of payment of any type PRIOR to the office visit. After the visit is completed the patient or his/her insurance may be billed.

9.B REFUSAL OR FAILUR OF AN ON-CALL MEDICAL STAFF MEMBER TO RESPOND

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

(2) All members of the Medical Staff are expected to follow the requirements of EMTALA. Accordingly, a refusal or failure of an on-call physician to respond timely shall be reported immediately to the President of the Medical Staff and the Chief Executive Officer, who shall review the matter and determine how to address the situation. If the refusal or failure to respond is found to be deliberate, or if it is a repeated occurrence, the matter shall be referred to the Medical Executive Committee for further investigation and appropriate action.

ARTICLE 10

AMENDMENTS

10.A. MEDICAL STAFF BYLAWS

(1) Amendments to these Bylaws may be proposed by a petition signed by at least ten members of the Voting Staff, by the Bylaws Committee, or by the MEC.

(2) In the discretion of the MEC, amendments to the Bylaws shall be presented to the Medical Staff in one of the following two ways:

(a) Amendments Subject to Vote at a Meeting: The MEC shall report on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, (i) a quorum of at least 10% of the voting staff must be present, and (ii) the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(b) Amendments Subject to Vote via Written or Electronic Ballot: The MEC shall present proposed amendments to the voting staff by written or electronic ballot, to be returned by the date and in the manner indicated on the ballot, which date shall be at least 14 days after the proposed amendment was provided to the voting staff. Along with the proposed amendments, the MEC shall provide a written report on the amendments either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 10% of the voting staff, and (ii) the amendment must receive a majority of the votes cast.

(3) The MEC shall have the power to adopt such clarifications to these Bylaws which are needed because of renumbering, punctuation, spelling or errors of grammar, or change of name(s) or title(s).

(4) All amendments shall be effective only after approval by the Board.

(5) If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request for same submitted by the Medical Staff President.

(6) Neither the Medical Staff nor the Board shall unilaterally (without seeking the advice of the other party) amend these Bylaws.

10.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures and rules and regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges. All such Medical Staff policies, procedures, and rules and regulations shall be considered an integral part of the Medical Staff Bylaws and may be amended by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists.

(2) Unless otherwise indicated, notice of all proposed amendments to these documents shall be provided to each member of the Voting Medical Staff at least 14 days prior to the MEC meeting where the amendment will be considered. Any Voting Staff member may submit written comments to the MEC regarding the proposed amendment prior to the MEC's meeting.

(3) Adoption of and changes to Medical Staff policies, procedures and rules and regulations will become effective only when approved by the Board.

(4) The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rules and Regulations are inconsistent with these Bylaws, they are of no force or effect. Furthermore, the MEC and the Board will have the power to provisionally adopt urgent amendments to the Rules and Regulations that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of provisionally adopted amendments will be provided to each member of the Voting Staff as soon as possible. The Voting Staff members will have 30 days to review and provide comments on the provisional amendments to the MEC. If there is no conflict between the Medical Staff and the MEC, the provisional amendments will stand. If there is conflict over the provisional amendments, the process for resolving conflicts set forth below will be implemented.

10.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations,

(b) a new policy proposed or adopted by the MEC, or

(c) proposed amendments to an existing policy that is under the authority of the MEC,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by at least 20% of the Voting Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

(2) If the differences cannot be resolved, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the members of the Voting Staff, to the Board for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Bylaws, the Medical Staff Rules and Regulations, or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the CEO, who will forward the request for communication to the Chair of the Board. The CEO will also provide notification to the MEC by informing the Medical Staff President of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical Staff member(s).

10.D. UNIFIED MEDICAL STAFF PROVISIONS

If the Board elects to adopt a single Unified Medical Staff that includes the Hospital, the Voting Staff may approve or opt out of the Unified Medical Staff structure by conducting a vote in accordance with the process outlined in Section 9.A for amending these Medical Staff Bylaws.

10.D.1. Bylaws, Policies and Rules and Regulations of the Unified Medical Staff:

Upon approval of a Unified Medical Staff structure, the Unified Medical Staff will adopt Medical Staff Bylaws, policies and rules and regulations that:

(a) take into account the unique circumstances of each participating hospital, including any significant differences in the patient populations that are served and the clinical services that are offered; and

(b) address the localized needs and concerns of Medical Staff members at each of the participating hospitals.

10.D.2. Opt-Out Procedures:

If a Unified Medical Staff structure is approved, the voting members of the Unified Medical Staff may later vote to opt out of the Unified Medical Staff. Any such vote will be conducted in accordance with the process outlined in the Unified Medical Staff Bylaws at the time of the vote.

ARTICLE 11

ADOPTION

These Medical Staff Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter thereof. Appendices as outlined below, are incorporated herein and shall be considered an integral part of these Bylaws, to be treated with the same authority

Medical Staff: ______________________________

Board: ______________________________

APPENDIX A
MEDICAL STAFF CATEGORIES SUMMARY

	Active Hospital-Based	Active Office-Based	Community	Consulting	Administrative	Tele-Health	Honorary
Category Description							
	Practice within the Hospital and meet minimum activity requirements	Practice primarily in an outpatient setting and have minimal or no inpatient practice	Desire to be associated with Hospital, but do not intend to establish a clinical practice and do not exercise any clinical privileges	Provide a service not otherwise available or in very limited supply but do not meet patient contacts requirements for the Active Hospital-Based Staff	Provide administrative services to the Hospital but do not have a clinical practice	Practice exclusively from a distant site and have no physical presence at the Hospital	Retired from practice in good standing, as recommended by the MEC
Basic Requirements							
Number of patient encounters/admissions per year	≥ 10	< 10	NA	NA	NA	NA	NA
Rights & Responsibilities							
May admit patients (Based on privileges granted)	Y	Y	N	N	N	N	N
May exercise clinical privileges	Y	Y	N	Y	N	Y	N
May attend Medical Staff and Division meetings	Y	Y	Y	Y	Y	Y	Y
Voting privileges at all Medical Staff and Division meetings	Y	Y	Y	Y	N	N	N
May hold office or serve as Division Chief	Y	Y	N	N	N	N	N
May serve as a committee chair	Y	Y	Y	Y	Y	N	Y
May serve on committees (with vote)	Y	Y	Y	Y	Y	N	Y
Eligible for ED Call (when requested)	Y	Y	N	N	N	N	N
Subject to OPPE & FPPE	Y	Y	N	Y	N	Y	N
Pay Dues	Y	Y	Y	Y	N	Y	N

Y = Yes
N = No
NA = Not Applicable

APPENDIX B

HISTORY AND PHYSICAL EXAMINATIONS

(a) General Documentation Requirements

(1) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted clinical privileges by the Hospital to perform histories and physicals.

(2) The scope of the medical history and physical examination will include, as pertinent:

- chief complaint;
- details of present illness;
- review of systems and physical examination, to include pertinent findings in those organ systems relevant to the presenting illness;
- relevant medical history, appropriate to the age of the patient;
- medications and allergies;
- assessments, including problem list; and
- plan of treatment.

(b) H&Ps Performed Prior to Admission

(1) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record by an individual who has been granted clinical privileges to complete histories and physicals.

(3) The update of the history and physical examination shall be based on an examination of the patient and must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.

(4) In the case of readmission of a patient, all previous records will be made available by the Hospital for review and use by the attending physician.

(c) Cancellations, Delays, and Emergency Situations

(1) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operating suites, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until an appropriate history and physical examination is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

(2) In an emergency situation, when there is no time to record either a complete or a Short Stay history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a complete history and physical examination.

(d) Short Stay Documentation Requirements

A Short Stay History and Physical Document, approved by the MEC, may be utilized for (i) ambulatory or same day procedures, or (ii) short stay observations which do not meet inpatient criteria. These forms shall document the chief complaint or reason for the procedure, the relevant history of the present illness or injury, and the patient's current clinical condition/physical findings.

APPENDIX C

INVASIVE PROCEDURE CATEGORIES

(a) Category I: Operative or other high-risk procedure

(1) This category contains any high-risk procedure and/or any procedure that may involve moderate, deep, general, or regional anesthesia and may cause a reduction in, or complete absence of, protective reflexes requiring extended pre-or post-procedure monitoring. Protective reflexes are defined as the ability to maintain a patent airway and to clear the airway of obstructions such as secretions or emesis without pulmonary aspiration, and the ability to maintain spontaneous and effective ventilatory effort.

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

(b) Category II: Non-operative and other low-risk procedures

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

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

APPENDIX D

INFORMED CONSENT

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

(b) A practitioner performing invasive procedures is responsible for the informed consent process. Informed consent is required for all invasive procedures performed under non-emergent conditions. Invasive procedures are defined as any procedure involving puncture or incision of the skin or insertion of an instrument of foreign material into the body, including, but not limited to: percutaneous aspirations and biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations. Excluded are minimally invasive procedures such as venipunctures, placement of Foley catheters, nasogastric tubes, acupuncture, diagnostic imaging without IV sedation, and peripheral IV lines.

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

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