MISSION STATEMENT

As the leader in the provision of health services for our entire community, we emphasize clinical and service quality, promote accessible and affordable care, and work with others to improve health status.
BYLAWS OF THE MEDICAL STAFF
OF
PEACEHEALTH SOUTHWEST MEDICAL CENTER

ARTICLE I
DEFINITIONS

1. The Organized Medical Staff of PeaceHealth Southwest Medical Center is a self-governing organization of physicians (MDs and DOs) dentists and podiatrists. It may also include independent licensed practitioners who meet the qualifications for Associate Staff status. It oversees the quality of care provided by all physicians and other practitioners who are privileged through the medical staff process. It collaborates with the Governing Body to enhance the quality and safety of care, treatment and services provided to patients.

2. The term "governing body" means the Board of Directors of PeaceHealth Southwest Medical Center.

3. The term "executive committee" means the Executive Committee of the medical staff.

4. The term "chief executive officer" (CEO) means the president of the corporation or designee appointed by the governing body to act on its behalf in the overall management of the hospital.

5. The term "practitioner" means, unless otherwise expressly provided, any physician, dentist or podiatrist or Associate staff member applying for or exercising clinical privileges or any independent allied health professional applying for or exercising specific clinical responsibilities in the hospital.

6. The term "allied health professionals" are individuals other than a licensed physician, dentist or podiatrist or member who may qualify for Associate staff who are duly licensed in the State of Washington and qualified to render direct medical care and specified services under the appropriate level of supervision by or in collaboration with a physician who has been accorded privileges to provide such care in the hospital.

7. The term "special notice" means written notification by: (1) certified or registered mail, return receipt requested, dated the date of mailing and addressed to the affected practitioner at either the office or home address stated on his/her most recent application for staff appointment, or such other address as is contained in hospital files relating to that person, or (2) personal hand delivery or written notification to the affected practitioner, dated the date of delivery. Special notice shall have been deemed to have been given as of the date appearing on the face of the notice.
8. The term "physician" means a medical doctor (MD) or doctor of osteopathy (DO) duly licensed in the State of Washington.

9. The Medical Staff bylaws, rules and regulations and policies describe the organizational structure and the rules for the self-governance of the medical staff and establish the rights, responsibilities and accountabilities between the organized medical staff and the governing body. They are developed by, and may be amended or repealed by, a vote of those members of the medical staff with voting rights. Adoption or amendment of the bylaws can not be delegated. The bylaws must be compatible with law and regulation, and must be approved by the governing body. The medical staff and the governing body must comply with the medical staff bylaws. The medical staff enforces, and the governing body upholds, the medical staff bylaws, rules and regulations and policies.

10. The term "credentialing procedural policies" refers to the policies adopted by the medical staff or its Executive Committee and approved by the governing body in accordance with Article X of the bylaws which define the process of appointment, reappointment, disposition of privileges, fair hearings and medical staff committees.

11. The term "rules and regulations" refers to those rules adopted by the medical staff or its Executive Committee and approved by the governing body in accordance with Article X of the bylaws which describe the proper conduct of medical staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital.

12. The term "departmental rules" refers to those rules governing a department which are adopted by a medical staff department and approved by the Executive Committee and governing body which are consistent with the bylaws, policies and rules and regulations of the medical staff and the hospital.

13. "National Practitioner Data Bank" refers to the entity established by the Secretary of the United States Department of Health & Human Services to collect and release certain information relating to the professional competency and conduct of physicians, dentists and other health care practitioners pursuant to the Health Care Quality Improvement Act of 1986, as amended.

14. "Emergency Services" are those health care services provided to evaluate and treat medical conditions of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent and/or unscheduled medical care is required.

15. "Good Standing" means that the staff member is in compliance with the requirements and responsibilities of staff membership.

16. A “completed application” is defined as one that contains: (1) completion of all blanks on the application form including necessary additional explanations; (2) verification that the information is complete, that is, all information necessary to properly evaluate an applicant’s qualifications has been received and is consistent with the information
provided in the application form; (3) responsive letters of reference and information from training programs and past hospitals and other affiliations have been received, including letters from department chairpersons or other physicians who have worked with or observed the applicant; and (4) approval of the delineation of clinical privileges by the department chair.

17. “Executive Session.” As deemed appropriate, all committees as defined in Article VII may convene into Executive Session which is defined as the segment of a committee meeting in which matters that are of a privileged and confidential nature are discussed. Medical staff members and support staff assigned or appointed to the committee are indemnified by the Medical Center for their good faith participation in community activities and proceedings and qualified to participate in the executive session of the respective committee meeting. Others may be invited to attend as appropriate.

18. “City Call” is defined as the call system whereby medical staff members are obligated to provide medical care for unassigned patients. Unassigned patients are those who do not have an established primary care physician or physician providing care in the specialty relevant to the patient’s current presenting problem. The purpose of city call is to fairly distribute the responsibility for care of unassigned patients fairly among the medical staff.

19. “Medical Staff Year.” For the purposes of these bylaws, the medical staff year commences on the first day of February and ends on the thirty-first day of January each year.

20. Assignment, successors and affiliation: These bylaws and clinical privileges accorded under these bylaws will be binding upon the hospital and medical staff of any successor in interest in this hospital and any assignee or successor to the medical staff. The hospital’s affiliation with other hospitals, healthcare systems, or similar entities shall not affect these medical staff bylaws. The hospital may not transfer its interests or make any alliance or affiliation without the signed written assurance from the transferee or affiliating organization that it will accept and honor these bylaws.
ARTICLE II

APPOINTMENT

Section 1 - Nature of Medical Staff Membership

a. Membership on the medical staff of PeaceHealth Southwest Medical Center is a privilege which shall be extended only to professionally competent physicians, dentists and podiatrists and to the licensed independent practitioners who qualify for Associate staff status who continuously meet the qualifications, standards, and requirements set forth in these bylaws. Applicants in administrative positions, or providing patient care services pursuant to a contract, who desire membership are subject to same procedures.

b. Sex, age, race, creed, and/or national origin are not used in making decisions regarding the granting or denying of medical staff membership or clinical privileges.

Section 2 - Qualifications for Membership

a. Only physicians, dentists, podiatrists and licensed independent practitioners who qualify for Associate staff status licensed in the State of Washington, who can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation, their adequate physical and mental health status, and their ability to work with others to a sufficient degree to assure the medical staff and the governing body that any patient treated by them in the hospital will be given quality medical care, shall be qualified for membership on the medical staff. No physician, dentist or podiatrist shall be entitled to membership on the medical staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that he/she is duly licensed to practice in this or in any other state, or that he/she is a member of some professional organization, or that he/she had in the past, or presently has, such privileges at another hospital.

b. With exception of Honorary staff membership, each member of the medical staff and each applicant for such membership or for any clinical privileges at the hospital (with or without medical staff membership) shall, as a condition of membership or granting of such privileges, have and maintain malpractice insurance in a minimum amount of $1 million per occurrence/$3 million aggregate determined by the Executive Committee and the governing body. The insurance shall be issued by a company admitted in the State of Washington approved for issuance of such insurance by the Washington State Office of the Insurance Commissioner, and acceptable to both the Executive Committee and the governing body. The insurance company shall also be one that contributes to the guarantee fund designed to protect insurance in the event of insolvency. The policy shall be in a form and substance satisfactory to the Executive Committee and the governing body. Insurance must cover all services for which the medical staff member has privileges. Proof of compliance with this requirement, in the form of a current certificate of insurance evidencing compliance with all terms of the bylaws, or such other evidence as the executive committee shall specify, shall be submitted to the Executive Committee or its designee at the initial time of request for appointment or privileges and annually...
thereafter within 30 days of expiration of policy or on day specified by the Executive Committee and the governing body. Each member of the medical staff shall report to the Executive Committee any reduction, lapse, failure to maintain or termination of the member's malpractice insurance within fourteen (14) business days after such reduction, lapse, termination and/or failure to maintain. A medical staff member shall immediately cease the exercise of clinical privileges in the event that he or she no longer has the required insurance coverage. Medical staff membership may only be maintained when insurance has lapsed for special circumstances which will be documented and approved by the executive committee and the governing body.

The hospital agrees to provide proof of insurance coverage for agents of the hospital performing service to the hospital as a member of a formal credentials, standards review, or similar professional board or committee of the hospital or its medical staff or as a person charged with executing the directives of such board or committee on behalf of the hospital. Such insurance shall be in an amount not less than the highest amount required by hospital for any medical staff member.

c. Each newly appointed member of the medical staff who is expected to place orders for medication and other CPOE-related services shall complete the hospital’s CPOE training prior to exercising clinical privileges. Timely completion of CPOE training shall also be required of established medical staff members. Physicians shall be expected to use the CPOE at the point of service, or remotely, whenever possible.

d. Allied Health Professionals: Although not entitled to membership on the medical staff, allied health professionals shall nonetheless be governed by and subject to these medical staff bylaws. They shall be required to make application and meet the qualifications for appointment to the appropriate non-member category, perform all duties and obligations as may be required by these bylaws and the medical staff rules and regulations, strictly adhere to the ethical principles of their respective national, state and/or county associations, and be subject to all disciplinary proceedings as may hereinafter be set forth.

e. Board certification by an American Board of Medical Specialties (ABMS) board, an American Osteopathic Association (AOA) board, the Royal College of Physician and Surgeons of Canada (RCPSC), the College of Family Physicians of Canada (CFPC) or the American Board of Podiatric Surgery (ABPS) is a requirement for physician and podiatrist members of the medical staff. Board certification is expected in the specialty or subspecialty in which the physician is currently practicing. It is not required for dentists and members of the Associate staff. Certification must be completed within 5 years of initial appointment or within 2 years of the adoption of this rule, adopted 9/20/06, whichever is greater. If certification expires, recertification is required within 5 years. Members who have been on the medical staff for 5 years at the time of adoption of this rule are not required to maintain board certification.

After review of all criteria including, training, experience, competence, judgment and character, the governing body may exempt a physician from requirement for board
certification and select the applicant for appointment or reappointment when
recommended by the Medical Executive Committee. 1

f. Acceptance of membership on the medical staff shall constitute the staff member's
certification that he/she has in the past, and his/her agreement that he/she will in the
future, strictly abide by the Principles of Medical Ethics of the American Medical
Association, Code of Ethics of the American Osteopathic Association, by the Code of
Ethics of the American Dental Association, and the medical staff Code of Conduct, or
such Code of Ethics as may be applicable.

g. At the time of initial application:

1. Practitioners must have successfully completed a residency training program and/or
fellowship recognized by the Accreditation Council for Graduate Medical Education
(ACGME) or American Osteopathic Association (AOA) in the specialty for which
they are applying for privileges; or be board certified or board admissible by one of
the ABMS or AOA specialty boards in the specialty for which the practitioner is
applying for privileges.

2. The residency requirement may be waived by the governing body after considering
the special competence and experience of the applicant or by recommendation from
the Executive Committee.

Section 3 - Conditions and Duration of Appointment

a. Initial appointments and reappointments to the medical staff shall be made by the
governing body. The governing body shall act on appointments, reappointments, or
revocation of appointments only after there has been a recommendation from the medical
staff as provided in these bylaws. In the event of unwarranted delay on the part of the
medical staff, the governing body may act without such recommendation on the basis of
documented evidence of the applicant's or staff member's professional and ethical
qualifications obtained from reliable sources other than the medical staff. For the
purposes of this section, unwarranted delay means 120 days from the date of receipt of
the completed application by the Medical Executive Committee.

b. Appointments to the medical staff shall confer on the appointee such clinical privileges as
are specified in the notice of appointment, in accordance with these bylaws.

c. Every applicant and individual appointed to the medical staff agrees to the following:

1. To provide appropriate continuity of quality care and supervision of his/her patients.

¹The Centers for Medicare and Medicaid Services, HHS, (CMS) 42 CFR Ch.IV, 482.12 (7) states “[the
governing body must] ensure that under no circumstances is the accordance of staff membership or professional
privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or
society.” CMS Interpretive guidelines 482.12 (a) (7) states “A hospital is not prohibited from requiring board
certification when considering a MD/DO for medical staff membership. Rather the regulation provides that a
hospital may not rely
2. To abide by the medical staff credentialing procedural policies, rules and regulations, and hospital bylaws and administrative policies.

3. To accept committee assignments.

4. Prepare and complete in a timely fashion (as described in Section 2, Item 1 of the General Rules and Regulations) legible medical records for all patients in whose care he/she is involved, subject to review as part of performance improvement activities.

5. To participate in staffing the emergency care system (as described in Section 1 of the General Rules and Regulations).

6. Participate in the hospital disaster drills.

d. Each individual granted clinical privileges shall have the obligation to notify the Chief Medical Officer or CEO within fourteen (14) days in writing of any new information or change in the information provided in connection with his/her most recent application for appointment or reappointment to the medical staff. This obligation shall extend to but not be limited to information concerning malpractice judgments or settlements, any action on or withdrawal of liability insurance, whether the individual's medical staff appointment or clinical privileges have been denied, revoked, suspended, reduced, not renewed, or voluntarily while under investigation or involuntarily relinquished at any hospital or health care facility or by the Medical Disciplinary Board and whether the individual's membership in local, state or national medical societies is involuntarily terminated, his narcotics license or license to practice any profession in any state has been or involuntarily suspended, modified, or terminated, or any Medicare/Medicaid sanctions have been imposed.

Each individual granted clinical privileges shall have the obligation to report to the Chief Medical Officer or the Physician's Committee any physical or mental condition which could reasonably be expected to impair that person's ability to exercise privileges, or which could materially, adversely impact the well-being of others within fourteen (14) days of becoming aware of such condition. Failure to provide such notice to the Chief Medical Officer or Physician’s Committee may result in suspension of privileges or other corrective action.

Section 4 – Corrective Actions

a. The president of the medical staff, the vice president of medical affairs, the chairperson of the practitioner’s clinical department, the chairperson of the Credentials Committee, the chief executive officer, or the chairperson of the governing body shall each have the authority to suspend all or any portion of the clinical privileges of a medical staff member whenever there is reasonable basis to believe that failure to take such action may result in danger to the health and/or safety of any individual or there is reasonable basis to believe that failure to do so may interfere with the orderly operation of the hospital. The involved medical staff member shall be notified promptly in writing of the precautionary suspension and the reasons therefore.

b. The loss or lapse of a member’s professional license for any reason, including revocation or...
suspension of the license by the Washington State licensing body, shall result in automatic relinquishment of all hospital clinical privileges and medical staff membership as of that date, until the matter is resolved to the satisfaction of the Credentials Committee. In the event the involved medical staff member’s license is only partially restricted, the clinical privileges that would be affected by the license restriction shall be similarly restricted at the hospital.

c. Medical staff members who are convicted of Medicare/Medicaid fraud and who are suspended from participation in Medicare/Medicaid programs will be automatically suspended from the medical staff without right of appeal. The involved medical staff member shall be given notice by the CEO of the automatic suspension. When and if the exclusion from participation expires the former medical staff member may reapply for medical staff membership and appropriate privileges.

d. A detailed description of the mechanism to recommend terminations, suspensions or reduction in privileges is described in MSP policy #017 and Bylaws Article XVII.

Section 5 – Fair Hearing

a. Grounds for Hearing. Except as otherwise provided in these bylaws and procedural policies, the following recommendations or actions with respect to an individual practitioner, if deemed adverse under Section 1, Part b. below, are grounds for a hearing upon timely and proper request by the practitioner:

1. Denial of initial staff appointment
2. Denial of staff reappointment
3. Suspension of staff membership
4. Revocation of staff membership
5. Denial of appointment or appointment in requested staff classification or failure to advance
6. Reduction in staff classification
7. Suspension or limitation of the right to admit patients
8. Denial or restriction of requested clinical privileges
9. Reduction in clinical privileges
10. Suspension of clinical privileges
11. Revocation of clinical privileges
12. Application of a mandatory consultation or supervision requirement other than at the time of initial appointment or at the time of a request for additional privileges

b. Grounds for Appeal. The grounds for appeal from an adverse decision shall be that:

1. There was substantial failure to comply with the hospital or medical staff bylaws and credentialing procedural policies in the conduct of the hearings so as to deny due process or a fair Hearing; or
2. The decision was made arbitrarily or capriciously; or the evidence did not support the decision.

c. A detailed description of the Fair Hearing process is described in MSP# 019.
Section 6 – Credentialing, Privileging and Appointment

a. Credentials review is the process of obtaining, verifying and assessing the qualifications of an applicant to provide patient care, treatment and services. The credentials review process is the basis for making appointments to membership of the medical staff. It also provides information for granting clinical privileges. All appointments and privileges granted or renewed are not to exceed a period of two years.

b. A description of the credentialing process, privileging process including temporary and disaster privileging, and appointment to membership is described in the following policies: MSP# 001-MSP #007.
ARTICLE III

CATEGORIES OF THE MEDICAL STAFF

Section 1 - Active Clinical Staff and Active Community Based Medical Staff

a. The Active medical staff shall consist of two categories of physicians, dentists and podiatrists, Active Clinical staff and Active Community Based staff.

1. The Active Clinical staff members are those practitioners who are involved in the care and treatment of patients in the hospital setting, defined as admissions, consultations, procedures (inpatient and outpatient) and/or evaluations and services performed in the Emergency Department at PeaceHealth Southwest Medical Center and who hold clinical privileges.

2. The Active Community Based staff are those who maintain no clinical privileges. They are encouraged to visit their patients when hospitalized, review their medical records, and make medical record entries, other than orders.

   Active Community Based staff are practitioners who regularly utilize the Medical Center services, which provide longitudinal care to their patients and utilize an inpatient physician service to cover all patients requiring hospital care.

b. Responsibilities

Both Active Clinical and Community Based staff members shall:

1. Actively participate in medical staff activities and responsibilities, such as committee and department assignments.
2. Assume all the functions and responsibilities of appointment to the Active staff, including care for unassigned service patients, emergency service obligations and consultation, as defined in the General Rules and Regulations.
3. Faithfully perform the duties of any office or position to which elected or appointed.
4. Participate in performance improvement, monitoring, and peer review activities as may be assigned by department or committee chairs.
5. Pay all application fees, dues, and assessments.
6. Provide timely and continuous care for their patients.

   c. Prerogatives

Both Active Clinical and Community Based staff members may:

1. Vote in all general and special meetings of the medical staff and applicable departments and committees.
2. Hold office, serve on medical staff committees, and serve as chairs of such committees.
Section 2 – Courtesy Staff Members

a. The Courtesy medical staff shall consist of physicians, dentists and podiatrists qualified for staff membership who maintain active staff privileges at another hospital in the Vancouver or Portland metropolitan areas and who are involved in the care and treatment of no more than six (6) patients per year at the hospital as measured by patient contacts, which are defined as admissions, consultations, procedures (inpatient or outpatient) and/or evaluations and services performed in the Emergency Department, except patients acquired via the city call schedule. Courtesy staff members shall be appointed to a specific clinical department but shall not be eligible to vote or hold office in this medical staff organization. When a practitioner’s clinical activity exceeds six (6), his/her staff status will automatically be elevated to the Active staff, provided that the practitioner meets all other requirements.

b. Courtesy staff members shall:

1. Pay annual dues in the amount established by the Executive Committee to the medical staff account, which sum shall be used to support and compensate those Active staff appointees who perform the medical staff duties and responsibilities of the hospital.
2. Pay an application processing fee at the time of appointment and reappointment, established by the Executive Committee and approved by the medical staff.
3. Provide timely and continuous care for their patients.
4. Cooperate with the quality management and monitoring activities at the hospital, including responding fully and promptly to any inquiries regarding the care of patients at the hospital.
5. Be entitled to admit and treat patients within the limits of their assigned clinical privileges.

Section 3 - Consulting Medical Staff

a. The Consulting medical staff shall consist of physicians and podiatrists of recognized professional ability who are not active at PeaceHealth Southwest Medical Center and whose expertise is not normally available in this community. Consulting staff members must be members of the Active staff or equivalent of another hospital where they actively participate in a continuous quality improvement program and other quality review evaluation and monitoring activities similar to those required of the Active staff of this hospital. Under certain circumstances, Consulting staff members may admit patients to the hospital provided that an attending physician, who is a member of the active clinical staff, co-admits the patient and countersigns the admitting order within 72 hours. The attending physician has the ultimate responsibility for the patient's general medical condition throughout the hospitalization. The Consulting medical staff will not pay dues or be eligible to vote or hold office and shall be exempt from the requirement for Washington State licensure if he/she currently holds a current and valid license in another state.
Section 4 - Associate Staff

a. The Associate staff shall consist of those non-physician health care professionals who have extended education, training, and experience in the care of hospitalized patients within their area of expertise. These professionals include, but are not limited to, certified nurse midwives. They must hold a current Washington license to practice with delineated privileges that provide for independent practice.

Associate staff members shall be appointed to a specific department. Each department may determine the level of participation of the Associate members within the confines of their individual departments. They shall not be eligible to vote on general medical staff issues or hold office. They will be required to pay annual staff dues in an amount established by the Executive Committee with approval of the medical staff.

1. Advanced registered nurse practitioners members of the Associate staff must have a sponsoring physician who is a member of the Active staff. They may admit (or attend) patients to the hospital in collaboration with a physician member of the Active staff. Each admission must have clear documentation of this collaboration.

2. Certified nurse midwife members shall demonstrate a written contract of collaboration with a physician or group of physicians who is/are Active staff member(s). This letter of contractual agreement shall designate, according to ACOG guidelines, the availability of a MD OB-GYN with c-section privileges to respond with presence in the Family Birth Center immediately upon request by the Associate staff member. This agreement shall be on a 24-hour/7-day-a-week basis. CNMs shall admit and discharge patients independently within their scope of practice and in accordance with their delineation of obstetrical privileges.

Appointment and reappointment to the Associate staff for the CNMs will be contingent upon receipt of a written contract with evidence of MD obstetrical backup.

Section 5 - Honorary Medical Staff

a. The Honorary medical staff shall consist of physicians, dentists, and podiatrists recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the hospital. Honorary staff members shall not be eligible to admit patients to the hospital or to exercise clinical privileges in the hospital. They may, however, attend staff and department meetings and any staff or hospital educational meetings. Honorary staff members shall not be eligible to vote or to hold office in this medical staff organization or to serve on standing medical staff committees. They are not required to belong to any department of the staff or to pay dues.
ARTICLE IV

OFFICERS

Section 1 - Officers of the Medical Staff

a. The officers of the medical staff shall be:
   1. President
   2. President-Elect
   3. Immediate Past President

Section 2 - Qualifications of Officers

a. Officers must have been members of the Active medical staff for at least three (3) years at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

b. The officers must have demonstrated competence in their fields of practice and demonstrated qualifications on the basis of training, experience and ability to direct the medical administrative aspects of hospital and staff activities.

c. Officers must maintain an active clinical practice at the Medical Center.

d. Officers must have served actively on at least two medical staff committees, or have served as a chair of a clinical department.

e. Officers must be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected or appointed.

f. Officers must be knowledgeable concerning the duties of the office.

Section 3 - Election of Officers

a. Only members of the Active medical staff shall be eligible to vote. The election shall be held in accordance with Article XII, Section 1 – Voting Process. When there are two candidates for an office, that candidate receiving a majority of votes shall be elected. When there are three (3) or more candidates for an office and none receive a majority, successive balloting shall continue, that candidate receiving the fewest votes being dropped from the ballot, until one candidate receives a majority vote.

b. The Nominating Committee shall consist of the immediate past president and three (3) other members of the Active staff as appointed by the president. The chair shall be the immediate past president. This committee shall offer one or more nominees for president-elect and for members-at-large of the Executive Committee.
Three weeks prior to their meeting, a notification will be sent to all Active medical staff members soliciting their input and interest in any vacancies. These vacancies shall include officers of the medical staff and members-at-large to the medical staff Executive Committee.

c. Nominations will be accepted from the floor at the September general staff meeting.

Section 4 - Term of Office

a. All officers shall serve two-year terms from the beginning of the appropriate medical staff year or until a successor is elected. Officers shall take office on the first day of the medical staff year.

Section 5 – Recall of Officers

a. Recall can be initiated for:

1. Failure to discharge faithfully the duties and responsibilities of the position to which the individual is elected or appointed.
2. Malfeasance while in office.
3. Conduct detrimental to the interest of the hospital and/or medical staff.

b. In the event that an officer is no longer a member of the Active staff, that officer is no longer eligible to serve and is immediately removed from office without need for recall vote or other action.

c. Except as otherwise provided, recall of a medical staff elected officer may be initiated by a majority of the Medical Executive Committee or may be initiated by a petition signed by at least one-third of the members of the Active medical staff. Recall shall be considered at a special meeting called for that purpose.

      Recall shall require a majority of the vote of the Active medical staff who actually cast votes at the special meeting.

Section 6 - Vacancies in Office

a. Vacancies in office during the medical staff year, except for the presidency, shall be filled by the Executive Committee subject to the approval of the Active medical staff. If there is a vacancy in the office of the president, the president-elect shall serve out the remaining term.

Section 7 - Duties

a. President

The president shall serve as the chief administrative officer of the medical staff to:

1. Aid in coordinating the activities and concerns of the hospital administration and of the nursing and other patient care services with those of the medical staff.
2. Develop and implement, in cooperation with the department chairs and appropriate committees of the staff and subject to the approval of the Executive Committee and the Board, ongoing monitoring of practice, credentials review, delineation of privileges and specified services, continuing education, and utilization review.

3. Serve as a member of the governing board.

4. Call, preside at, and be responsible for the agenda of all general meetings of the medical staff.

5. Serve on the Medical Staff Executive Committee as chair.

6. Serve as ex-officio member of all other medical staff committees without vote.

7. Be responsible for the enforcement of medical staff bylaws, credentialing procedural policies, and rules and regulations, for implementation of sanctions where these are indicated, and for the medical staff's compliance with the procedural safeguards in all instances where corrective action has been requested against a practitioner.

8. Appoint committee members to all standing, special, and multi-disciplinary medical staff committees except the Executive Committee.

9. Represent the views, policies, needs and grievances of the medical staff to the governing body and to the CEO.

10. Receive the policies of the governing body and interpret them to the medical staff and report to the governing body on the performance and maintenance of quality with respect to the medical staff's delegated responsibility to medical care.

11. Be responsible for educational activities of the medical staff.

12. Be spokesman for the medical staff in its external professional and public relations.

13. Disburse and supervise the collection and accounting for any funds that may be collected in the form of staff dues, assessments or application fee. All annual income and expenses of this fund will be reported at the annual medical staff meeting held in December.

b. President-Elect

The President-Elect shall:

1. In the absence of the president, assume the duties, responsibilities and authority of the president. He/she shall be a member of the Executive Committee of the medical staff.
2. Develop and implement, in cooperation with the department chairs and appropriate medical staff committees, and subject to the approval of the Executive Committee and the Board, methods for continuous quality improvement. He/she shall also be a member of the Bylaws Committee.

c. Immediate Past President

The immediate Past President shall serve as:

1. A member of the Medical Staff Executive Committee
2. Chair of the Nominating Committee
3. Chair of the Credentials Committee

Section 8 – Stipends for Medical Staff Officers

Annually, the Executive Committee will assign a task force to review and evaluate the current stipends and make recommendations for any market adjustments. Recommendations will be reviewed and approved by the Medical Executive Committee. Medical staff funds will subsidize all of the Chair-Elect stipends and one half of the medical staff president’s and the Credentials Committee stipends. The hospital will subsidize one half of the president’s and Credentials Committee stipends and provide funding for all of department chair stipends. The general medical staff will be asked to approve any changes to the stipends. Any changes to the stipends must be ratified by a vote of the Active Medical Staff.
ARTICLE V

OTHER OFFICIALS OF THE STAFF

Section 1 - Department Chair and Chair-Elect

a. Qualifications, Selection, and Tenure of Department Chair and Chair-Elect

1. Each chair/chair-elect shall be a member of the active staff, be certified by an appropriate specialty board or possess comparable competence relevant to the services provided in the department as established through the privilege delineation process, and be actively practicing at the hospital. He/she shall have been a member of the committee of the department of which he/she is chair/chair-elect and be familiar with current functions and procedures of the department.

2. Each chair/chair-elect shall be elected by his/her respective department for a two-year term, and shall be approved by the Executive Committee of the medical staff and the Board of Directors. This shall not be interpreted to preclude his/her re-election to successive terms. Departments shall elect a chair-elect who may succeed to the chairmanship.

b. Recall of Chair/Chair-Elect

Except as otherwise provided, removal of a chair/chair-elect during his/her term of office may be initiated by a two-thirds (2/3) majority vote of all active staff members of the department or may be initiated by a petition signed by at least one-third of the Active staff members, but no such removal shall be effective unless and until it has been ratified by the Executive Committee and by the governing body. Recall shall be considered at a special meeting called for that purpose.

1. Recall can be initiated for:
   a) Failure to discharge faithfully the duties and responsibilities of the department chair position.
   b) Malfeasance while in office.
   c) Conduct detrimental to the interest of the hospital and/or medical staff.

2. In the event that the department chair/chair-elect is no longer a member of the Active staff, that chairperson is no longer eligible to serve and is immediately removed from office without need for recall vote or other action.

c. Responsibilities of Department Chair

Each chair shall:

1. Be accountable for all clinically and administratively related activities within his/her department and particularly for the uniform quality of patient care, treatment and services rendered by members of the department and for the effective conduct of
continuous quality improvement and other quality assurance, evaluation and
monitoring functions delegated to his department.

2. Develop and implement departmental programs and policies and procedures in
cooperation with the president of the staff and consistent with the provisions of
MSP#016, MSP#017 and MSP#018, and the Committee Manual, for continuous
quality improvement, ongoing monitoring of practice, credentials review and
privileges delineation, continuing medical education and utilization review.

3. Be a voting member of the Executive Committee, giving guidance on the overall
medical policies of the hospital and making specific recommendations and
suggestions regarding his/her own department in order to assure quality patient care.

4. Maintain continuing surveillance of the professional performance of all practitioners
with clinical privileges in his/her department and maintenance of quality control
programs as appropriate, and report regularly thereon to the Executive Committee.

5. Be responsible for enforcement of the hospital and medical staff bylaws, policies, and
rules and regulations within his/her department including initiating corrective action
and investigation of clinical performance and ordering consultations to be provided or
to be sought when necessary.

6. Be responsible for implementing, within his/her department, actions taken by the
Executive Committee of the medical staff.

7. Make a report to the Credentials Committee to recommend actions concerning
appointment and classifications, reappointment, delineation of clinical privileges or
specified services, and corrective action for all practitioners in his/her department.

8. Make recommendations to the Credentials Committee regarding the qualifications
and competence of department personnel who are not licensed independent
practitioners and who provide patient care services in the department.

9. Assist the hospital, in accordance with the provisions of these bylaws, with respect to
the granting of locum tenens privileges within the department, and with the evaluation
of requests for temporary privileges.

10. Appoint such committees as are necessary to conduct the functions of the department
specified in Article VI, Section 3 of the bylaws and designate a chair for each.

11. Be responsible for the teaching, education, research program and orientation of all
persons in his/her department.

12. Participate in every phase of administration of his/her department through cooperation
with the nursing service and the hospital administration in matters affecting patient
care, including personnel, supplies, special regulations, relevant off-site sources for
needed patient care services, recommendations for space and other resources needed
by the department, standing orders and techniques.
13. Assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her department as may be required by the Executive Committee, the CEO or the governing body.

14. Appoint a nominating committee to nominate members of the department for the office of chair and/or chair-elect and committee members whose terms have expired.

15. Develop and implement Rules and Regulations that guide and support the provisions of services in the department.

16. Recommend criteria for clinical privileges for each member of the department.

17. Assess and recommend to the hospital authority off-site sources for needed patient care services not provided by the department or organization.

18. Determine the qualifications and competence of the department or service personnel who are not licensed independent practitioners and who provide patient care services.

19. Continuously assess and improve the quality of care and services provided.

20. Be responsible for the integration of the department/service into the primary functions of the organization.

21. Be responsible for coordination and integration of interdepartmental and intradepartmental services.

22. Delegate to a chair-elect of the department such duties as appropriate.

23. Establish divisions, sections or services within the department and appoint chiefs thereof, subject to the approval of the Executive Committee and the Board.

24. Perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the president of the staff, the Executive Committee or the Board.

d. Chair-Elect Responsibilities

1. In the absence of the department chair he/she shall assume all the duties and have the authority of the department chair. The Chair-Elect will receive a monthly stipend. Medical staff funds will subsidize all of the Chair-Elect stipends.

e. Stipend - Department Chair

1. The department chair will receive a monthly stipend from Administration.
ARTICLE VI

CLINICAL DEPARTMENTS

Section 1 - Organization of Clinical Departments

a. The medical staff is organized in a manner approved by the governing body. The organized medical staff is responsible for enforcing and complying with the medical staff bylaws, rules and regulations and credentialing policies and procedures. There shall be clinical departments of Medicine, Surgery, OB/Gynecology, Pediatrics, Anesthesiology, Behavioral Health Services, Emergency Medicine, Radiology, Cardiology/Cardiothoracic, and Family Medicine. Each department shall be organized as a separate part of the medical staff and shall have a chair that shall be responsible for the overall supervision of the clinical work within his/her department.

b. Each department shall have a chair that is elected and has the authority, duties, and responsibilities as specified in Article V.

c. Each department shall participate in the quality measurement and improvement plan in accordance with the value measurement and improvement activities as defined by the Board of Directors of the hospital. The director of Quality Care Resources shall assist the department chair by providing technical assistance in developing assessment for evaluation procedures.

Section 2 - Assignment to Departments

a. The Credentials Committee will assign each member of the staff to one department based on major area of clinical interest and qualifications. The granting of clinical privileges will be based upon the member's training, experience and demonstrated competence and may include areas outside the usual scope of the department to which they are assigned.

Section 3 - Functions of Clinical Departments

The primary responsibility delegated to each department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department.

To carry out this responsibility:

a. Each clinical department may, for purposes of governance and patient care, elect a committee of sufficient number of members, including the chair, but not fewer than six (6) to conduct the functions of the department. They shall elect one-half (1/2) of the committee members annually for two- (2) year terms.

b. Each department committee shall meet to review and analyze on a peer-group basis the clinical work of the department members at a frequency to assure that effective peer
review and quality improvement occurs. The findings, recommendations, and any corrective action shall be documented in the departmental committee minutes.

c. The clinical department committee shall recommend to the Credentials Committee written criteria for the assignment of clinical privileges within the department and each of its divisions. Such criteria shall be consistent with and subject to the bylaws, policies, rules and regulations of the medical staff and the hospital. These criteria shall be effective when approved by the Board. Clinical privileges shall be specific to this hospital and based upon demonstrated competence, training and experience within the specialties covered by the department.
ARTICLE VII

COMMITTEES

Section 1 - The Executive Committee

The Medical Executive Committee is elected by the medical staff, and serves as a voice for the medical staff to communicate to the governing body. It is therefore accountable to the organized medical staff. It acts on behalf of the medical staff between meetings of the organized medical staff, within the scope of its responsibilities as defined by the organized medical staff. It is incumbent upon the medical executive committee to convey accurately to the governing body the views of the medical staff on all issues. All authority of the executive committee is delegated by the organized medical staff. Such authority is delegated or removed by a vote of the organized medical staff. The medical executive committee includes medical and osteopathic physicians, and may include other practitioners as determined by the organized medical staff.

If a conflict arises between the medical staff and the executive committee regarding medical staff bylaws, rules and regulations or policies, the issue will be presented to, and settled by a vote of the entire organized medical staff as described in Article XII – Voting Process.

a. Composition

The Executive Committee shall be a standing committee and shall consist of the officers of the medical staff, the chair of each clinical department. The departments of Medicine and Surgery, in addition, shall be represented by a member-at-large elected by their respective departments. One member-at-large will also be elected by the Medical Staff as a whole. The majority of the voting members shall be fully licensed doctors of Medicine or Osteopathy who are actively practicing at the hospital. Any active Medical Staff member is eligible for membership on the Executive Committee, regardless of his or her professional discipline or specialty. The Executive committee may include other non voting licensed independent practitioners who are actively practicing at the hospital. The chair shall be the president of the medical staff. Non-voting members will include the director of the Family Practice Residency Program. The CEO of the hospital, or his or her designee, shall attend all Executive Committee meetings as a non-voting ex-officio member.

Executive Committee meetings will be open to all members of the Medical Staff as non-voting observers. Such non-voting observers may speak upon recognition by the Executive Committee chair.

b. The duties of the Executive Committee shall be:

1. To represent and to act on behalf of the medical staff, in the intervals between medical staff meetings, subject to such limitations as may be imposed by these bylaws.
2. To coordinate the activities and general policies adopted by the staff, departments, and committees.

3. To receive and act upon reports and recommendations from the committees, clinical services and officers of the staff or the administration concerning patient care quality and appropriateness of reviews, performance improvement evaluations and monitoring functions and the discharge of their delegated administrative responsibilities and recommend to the governing body specific programs and systems of implementation of these functions.

4. To provide for effective communication among the medical staff, hospital administration, and governing body.

5. To make recommendations to the governing body on all matters relating to appointments, reappointments, staff category, department assignments, clinical privileges, corrective action and structure of the medical staff.

6. To account to the governing body and to the staff for the overall quality of physician patient care by the members of the medical staff in the hospital.

7. To take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members, including initiating investigations and fair hearing proceedings as provided in the credentialing procedural policies of the medical staff.

8. To make recommendations on clinical and hospital management matters to the CEO.

9. To inform the medical staff of the JCAHO accreditation program and the accreditation status of the hospital.

10. To provide for the preparation of all meeting programs, either directly or through delegation to the clinical department or suitable agent.

11. To cooperate with the governing body and the CEO in securing proper execution of the health care policies and procedures of the hospital and the medical staff and in securing compliance with these bylaws and all hospital rules and regulations. Care is taken to assure the policies and Rules and Regulations do not conflict with the governing body’s bylaws.

12. To participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs.

13. To report at each general staff meeting and periodic written communications to medical staff regarding revisions to medical staff bylaws, credentialing procedural policies, and rules and regulations.
14. To make recommendations to the governing body regarding the mechanism by which membership on the medical staff may be terminated and for fair hearing procedures.

d. Meeting Frequency

The Executive Committee shall meet at least once a month and maintain a permanent record of its proceedings and actions. If there is insufficient business before the committee, the monthly meeting may be canceled until the next regularly scheduled meeting.

Section 2 - Credentials Committee

a. Composition

The Credentials Committee shall consist of the immediate past-president of the medical staff, who will be chair, and will serve a total of four years, and a minimum of three and a maximum of ten Active staff members appointed by the medical staff president to serve three-year terms. The medical staff president will select appointees who have been a medical staff president, department chair, or who have other extensive medical staff committee experience. A lay member of the Board of Directors will attend the meetings in an ex-officio capacity. Service on this committee shall be considered as the primary medical staff obligation of each member of the committee and other medical staff duties shall not interfere. The president of the medical staff may appoint additional members to the committee, as needed. To assist in the workload of the Chair and to enhance continuity of experience in credentialing, the President of the Medical Staff may appoint a Vice-Chair of the committee.

In the absence of an immediate past president of the medical staff to serve as the chair, the medical staff president shall select a member of the committee to serve as the chair and designate the term of service.

b. Duties. The duties of the Credentials Committee shall be:

1. To review the credentials of all applicants for medical staff appointment, reappointment, and clinical privileges, to make investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations.

2. To review the credentials of all applicants who request to practice at the hospital as allied health professionals, to make investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations.

3. To review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the medical staff and of allied health professionals and, as a result of such review, to make a written report of its findings and recommendations.
c. Meetings, Reports and Recommendations.

The Credentials Committee shall meet monthly or more often if necessary to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Executive Committee, the chief executive officer and the Board. The chairperson of the Credentials Committee shall be available to meet with the Executive Committee, Board or its applicable committee on all recommendations that the Credentials Committee may make. If there is insufficient business before the committee, the monthly meeting may be canceled until the next regularly scheduled meeting.

Section 3 - Peer Review Committee (PRC)

a. Composition

The Peer Review Committee (PRC) will be comprised of twelve (12) voting members who are active members of the medical staff from each of the following specialties: Internal Medicine Hospitalist, Critical Care Intensivist, 2 additional medical Subspecialty(s), Family Medicine, General Surgery, 1 Surgical Specialty(s), OB/GYN, Emergency Medicine, Anesthesiology, and Radiology and the current Medical Staff President Elect regardless of specialty. Practitioners from other specialties may be invited to the meeting as needed. Current department chairs and voting MEC members are not eligible to be PRC members.

Non-voting ex-officio members will include: The Medical Staff President, Chief Medical Officer (CMO), Medical Director for Quality, the Chief Nursing Officer (CNO), a representative Allied Health Professional, a representative Board member, the director of Quality and Patient Safety (QPS) and QPS support staff.

Non-voting ex-officio members shall not participate in the votes and final determinations.

The voting PRC members will be appointed by the Medical Staff President based on the recommendations from the department chairs and the PRC Chair and approved by the MEC. Voting members will be appointed for a three-year term except for initial committee members who will have staggered terms to initiate the process. Voting members may serve up to two consecutive terms and are eligible for reappointment to the committee after one year after their last term is completed. However, voting members may serve more than two consecutive terms if no one else is available to serve from that specialty with the approval of the MEC for each additional term.

The Medical Staff President Elect shall serve as the Chair of the PRC throughout his/her two-year term. To assist with the workload of the Chair and to enhance continuity of experience the Medical Staff President will appoint a co-chair with the approval of the MEC. To be eligible for appointment as Co-Chair, the individual must be a current voting PRC member and have served as a voting PRC member at some point in time for at least one year. The Co-Chair will serve for a term of one year and may have an unlimited number of consecutive terms as long as the co-chair is eligible to be a PRC member. The PRC co-chair will be an ex-officio member of the MEC without vote.
b. The duties of the Peer Review Committee shall be:

1. To monitor and evaluate the ongoing professional practice (OPPE) of individual practitioners with clinical privileges.
2. To conduct case review based on review indicators that have been approved by the Departments and the MEC and make determinations regarding individual practitioner opportunity for improvement based on individual or multiple case reviews.
3. To create a culture with a positive approach to peer review by recognizing practitioner excellence as well as identifying improvement opportunities.
4. To recommend external peer review when there is a lack of internal expertise, or conflicts of interest requiring an outside review.
5. To send reminder letters to the medical staff when established rules, approved by the Departments and the MEC, have been broken and to perform regular review of medical staff Rule or Rate indicator data for individual practitioner outliers. Reminder letters are not part of the medical staff members peer review file unless the established threshold has been exceeded at which time the PRC will notify the Department Chair who will be responsible to follow-up with the medical staff member.
6. To annually review all the indicators, attribution, targets, screening tools and referral systems for effectiveness in collaboration with the medical staff department chairs and recommend changes to the MEC.
7. To design and approve focused professional practice evaluation (FPPE) studies in collaboration with the Department Chair when necessary to further analyze practitioner performance.
8. In coordination with the Credentials Committee, define the appropriate content and format for practitioner performance feedback reports and reappointment profiles as approved by the MEC.
9. To identify potential Hospital systems or nursing practice opportunities for improvement and refer to appropriate hospital leader for follow-up.

c. Medical Staff Rights and Conflict Resolution

The medical staff will be given the opportunity to respond to any opportunities for improvement identified by the PRC. All responses will be included with the peer review documentation.

The Department Chair maintains the authority to initiate any follow-up required when opportunities for improvement have been identified. If the Chair does not agree with the PRC recommendations, the conflict may be addressed with the Credentials Committee or MEC to resolve any disagreements. External review may also be initiated to assist with conflict resolution when indicated.

d. Meetings, Reports and Recommendations

The PRC will meet at least 10 times per year. A quorum for purposes of making final determinations or recommendations for individual case reviews or improvement
opportunities based on aggregate data will require the presence of 50% of the voting PRC members at a regularly scheduled meeting. A majority will consist of a majority of voting PRC members present.

The PRC provides recommendations to the Department Chairs/Committees. The PRC will provide summary reports to the Departments, which will include a summary of the type of cases reviewed and any educational opportunities identified. The PRC does not have the authority to initiate any disciplinary actions. The PRC reports to the MEC. No changes can be made to the PRC charter and policies without MEC review and medical staff approval. The PRC Chair will provide a report to the MEC on the recommendations/actions taken at each PRC meeting, at a minimum of 4 times per year.

Section 4 - Other Committees and Functions

a. The Executive Committee shall establish, modify or dissolve appropriate committees by resolution or policy, from time to time as needed, with appropriate composition, duties, meeting and reporting requirements. The Executive Committee shall provide for the satisfaction of all functions and duties requiring medical staff involvement imposed by accreditation, licensure or other applicable requirements, including but not limited to: utilization review, disaster planning, infection control, pharmacy and therapeutics, drug usage, tissue and transfusion review, radiation safety and cancer registry. Other committees or task forces may be formed or dissolved as necessary relating to interdisciplinary coordination and cooperation, quality assurance and education.
ARTICLE VIII

MEDICAL STAFF MEETINGS

Section 1 - Regular Meetings of the Medical Staff

a. Regular staff meetings shall be held four times a year in the months of March, June, September and December. The agenda of such meetings shall include reports of review and evaluation of the work done in the clinical departments and the performance of the required medical staff functions.

b. No binding votes will be taken after the original scheduled time for adjournment.

Section 2 - Special Meetings of the Medical Staff

a. The president of the medical staff, the Executive Committee, or not less than one-fourth (1/4) of the members of the active medical staff may at any time file a written request with the president of the medical staff that within fifteen (15) days of the filing of such request, a special meeting of the medical staff be called.

b. The Executive Committee shall designate the time and place of any such special meeting.

c. Written or printed notice stating the place, day, and hour of any special meeting of the medical staff shall be delivered, either personally or by mail, or e-mail, to each member of the Active medical staff, not less than seven (7) days before the date of such meeting, by or at the direction of the president. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his/her address as it appears on the records of the hospital. Notice may also be sent to members of other medical staff groups who have so requested. The attendance of a member of the medical staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 3 – Quorum

a. Members present at the meeting shall constitute a quorum for any regular or special meeting of the medical staff.

Section 4 - Attendance Requirements

a. Each member of the Active medical staff will be encouraged to attend regular medical staff meetings. Emphasis will be placed on the importance of the dissemination of information at the meetings for physicians actively practicing at PHSW. The importance of Active staff members exercising their voting rights will also be stressed.

Section 5 - Participation by Chief Executive Officer
The Chief Executive Officer and any representative assigned by him may attend any regular and special meetings of the medical staff.
ARTICLE IX

COMMITTEE AND DEPARTMENT MEETINGS

Section 1 - Regular Meetings

a. Department committees shall hold regular meetings to review and evaluate the clinical work of practitioners with privileges in the department. The committees shall establish the number and time of meetings accordingly.

Section 2 - Special Meetings

a. A special meeting of any committee or department may be called by or at the request of the chair or chief thereof, by the president of the medical staff, or by one-third (1/3) of the group's then members, but not fewer than two (2) members.

Section 3 - Notice of Meetings

a. Written or oral notice stating the place, day, and hour of any special meeting or of any regular meeting shall be delivered either personally or by mail or email to each member of the committee or department not fewer than seven (7) days before the time of such meeting, by the person or persons calling the meeting. Notice of department or committee meetings may be given orally. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his/her address as it appears on the records of the hospital with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

Section 4 – Quorum

The quorum requirement for meetings shall be as follows:

a.. Medical Executive Committee and Credentials Committee meetings will require one-half (1/2) of the voting members of the respective committee.

b. Other medical staff committee and department meetings: Two members shall constitute a quorum at any committee or department meeting.

Section 5 - Manner of Action

a. Formal Action

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or department.
b. Informal Action

No action of a committee or department shall be valid unless taken at a meeting at which a quorum is present except that any action may be taken without a meeting if unanimous consent in writing setting forth the action so taken shall be signed by each member entitled to vote thereat.

Section 6 - Rights of Non-Staff Committee members

a. Persons who are not members of the medical staff serving under these bylaws shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum, nor shall they have a vote.

Section 7 - Participation by Chief Executive Officer

a. The chief executive officer and any representatives assigned by the CEO may attend any departmental or committee meeting, in a non-voting status.

Section 8 – Minutes

a. Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. Each committee and department shall maintain a permanent file of the minutes of each meeting. Medical staff members who are not members of the department may review the department minutes upon request and approval by the respective department chair.

Section 9 - Attendance Requirement - Patient Clinical Course

a. In the event that a department committee reviews a case and may recommend an assessment of “unsatisfactory,” the committee will schedule a time and date for final review. The involved practitioner shall be so notified and invited to comment in writing and attend such meeting and may be required to attend. The practitioner shall be provided advance notice of the time and place of the meeting at which his/her attendance is expected.

b. Failure by a practitioner to attend any meeting with respect to which he/she was given notice that attendance was mandatory, unless excused by the Executive Committee upon a showing of good cause, shall result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the Executive Committee may direct, and such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate including corrective action, if necessary. In all other cases, if the practitioner shall make a timely request for postponement supported by an adequate showing that his/her absence will be unavoidable, such presentation may be postponed by the chair of his/her department, or by the Executive Committee if the chair is the practitioner involved, until not later than the next regular departmental meeting; otherwise the pertinent clinical information shall be presented and discussed as scheduled.
ARTICLE X

RULES, REGULATIONS AND PROCEDURAL POLICIES

The medical staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within the bylaws, subject to the approval of the governing body. These shall relate to the proper conduct of medical staff organizational activities as well as embody the level of current practice that is to be required of each practitioner in the Medical Center.

All rules and regulations and policies of the medical staff shall be reviewed a minimum of once every three years. Rules and regulations will be reviewed by the Bylaws Committee. Policies will be reviewed by the Credentials Committee. Proposed amendments of these rules and regulations or policies shall be referred to the Executive Committee.

Proposed amendments to the rules and regulations or policies initiated by the medical staff shall first be communicated to the executive committee. If the executive committee proposes a rule, regulation, policy or amendment thereto, it first communicates the proposal to the medical staff. Amendments must be ratified by a vote of the medical staff as defined in Article XII.

In cases of documented need for an urgent amendment to rules and regulations or policies necessary to comply with law or regulation, the medical executive committee may provisionally adopt and the governing body may provisionally approve the urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the executive committee. The medical staff shall have the opportunity to review and vote on the provisional amendment. A revised amendment may be submitted to the governing body if approved by a vote of the medical staff.
ARTICLE XI

ADOPTION AND AMENDMENTS TO BYLAWS

Any proposed repeal, amendment or adoption of these bylaws shall be accomplished through a cooperative process involving both the medical staff and the governing body. Any proposed repeal, amendment or adoption of these bylaws shall be communicated to the medical staff in accordance with the following:

Proposed amendments of these bylaws initiated by the Bylaws Committee or medical staff shall be referred to the Executive Committee. The proposed amendments shall be posted in the medical staff lounge and distributed to all voting members for review and discussion one (1) month prior to commencement of voting on the proposed revisions. A medical staff listserv will be established for the purpose of discussion. The vote shall be initiated and carried out as defined in Article XII – Voting Process.

The Executive Committee shall have the power to adopt such amendments to the bylaws as are, in the committee’s judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the medical staff or the Board within sixty (60) days of adoption by the Executive Committee. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Executive Committee. Immediately upon adoption, such amendments shall be sent to the chief executive officer, and posted on the medical staff bulletin board for fourteen (14) days, and distributed electronically to the active members of the medical staff.

If the medical staff submits an approved repeal, amendment or adoption of these bylaws to the governing body and no action is taken within 90 days of such submittal, the adoption, amendment or repeal actions submitted shall be conclusively deemed approved by the governing body.

The bylaws of the medical staff shall be reviewed a minimum of once every three years.
ARTICLE XII

VOTING PROCESS

Section 1 – Prior to Voting

A vote to amend the bylaws, rules and regulations, or policies may be initiated by the medical executive committee or by the members of the organized medical staff. The medical staff may initiate a vote by submitting a proposal to the medical executive committee which has been signed by at least 5% of the active voting members. The proposed amendments shall be posted in the medical staff lounge and distributed by email or fax to all voting members for review and discussion one (1) month prior to commencement of voting on the proposed revisions. A medical staff listserv will be established for the purpose of discussion.

Section 2 – The Ballot

Once the revisions have been posted for 30 days, ballots will be distributed to all voting members.

Voting on elections, bylaws, rules and regulations and other committee business may be initiated through distribution of ballots by email, fax or mail. Email will be the preferred distribution method. Any voting members who do not have email will receive their ballot by fax or mail.

Voting members must sign and date their ballots to be valid, unless they vote electronically, in which case, electronic ballots must include the name of the voting member in order to be valid.

All votes will be verified by the medical staff office to ensure that each member who votes has voting rights and to ensure that each vote is only counted once.

During the voting period, ballots will always be available to all voting members in the medical staff office.

Section 3 – Vote Results

Ballots shall be returned within two weeks from the date the ballots were sent out. A return of 25% of the ballots will constitute a valid vote.

The final changes will be communicated to the medical staff and the allied health professional staff via email, mailed letter or fax.
ARTICLE XIII

INITIAL APPOINTMENTS

Purpose: To establish an efficient and consistent mechanism to process an initial application for membership on the Medical Staff or Allied Health Professional Staff.

Section 1 - Application for Appointment

All initial applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Body after consultation with the Executive Committee. The application form shall require:

1. A copy of curriculum vitae to include detailed information concerning the applicant's professional qualifications.
2. Names of at least two (2) practitioners in the same professional discipline as the applicant who can provide adequate references pertaining to professional competence, ethical character, physical and mental health.
3. Information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced, voluntarily or involuntarily relinquished, or not renewed at any other hospital or institution, and to whether his/her membership in local, state, or national medical societies, his/her narcotics license or his/her license to practice any profession in any jurisdiction, has ever been suspended or terminated, or involuntarily or voluntarily relinquished while under investigation.
4. Documentation of malpractice claims including final settlements or judgments, and litigation history in the last ten years must also be declared.
5. Proof of the existence of acceptable malpractice insurance coverage as required by these bylaws.
6. A request for the category of staff membership, and a completed delineation of clinical privileges or scope of practice desired.
7. A communicable disease record to include a PPD skin test, if applicable.
8. Information to explain any gaps in practice greater than 30 days.
9. The applicant shall sign a copy of the Medical Staff Confidentiality and the Code of Conduct Agreements and by accepting appointment to the Medical Staff agrees to abide by the terms within.
10. The applicant shall provide a photo or electronic image which will be attached to the release form and sent to organizations for personal verification.

The applicant shall have the burden of completing the application form and producing all information for a proper evaluation of his/her competence, character, ethics, health status, and for resolving any doubts about such qualifications.

By applying for and signing the application for appointment to the Medical Staff each applicant thereby:

1. Attests to the correctness and completeness of all information furnished.
2. Signifies his/her willingness to appear for interviews in regard to his/her application.
3. Authorizes the hospital to consult with members of professional staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on
his/her competence, character and ethical qualifications.

4. Consents to the hospital’s inspection of all records and documents that may be material to an evaluation of his/her professional, moral and ethical qualifications and competence to carry out the clinical privileges he/she requested.

5. Releases PeaceHealth Southwest Medical Center all representatives of the hospital including members of the Governing Body and hospital management, the Medical Staff and all members and representatives of the Medical Staff from all liability for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials.

6. Releases from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant’s competence, ethics, character, and other qualifications for staff appointment and clinical privileges.

When an applicant requests an application form, the applicant shall be given a copy of the Bylaws, Credentialing Procedural Policies and Rules and Regulations. The application form shall include a statement that the applicant has received the Bylaws, Credentialing Procedural Policies and Rules and Regulations of the Medical Staff and that he/she agrees to be bound by the terms thereof if he/she is granted membership and/or clinical privileges and agrees to be bound by the terms thereof without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of his/her application and agrees to provide to the hospital, with or without request, new or updated information that is pertinent to any question on the application form.

The applicant will be informed of the status of his/her credentialing or recredentialing application upon request. Each practitioner is notified at the time of application that he/she has the right to review the information submitted in support of his or her credentials application. Review of the application contents will be initiated as outlined in Medical Staff Credentials and Peer Review Files, MSP#016. In the event erroneous information has been submitted by another source, the applicant will be provided the opportunity to review and correct this information. The applicant will be given the opportunity to respond to Medical Staff Services within 5 days of receipt of notice.

1. The practitioner shall review documents in the presence of the Medical Staff Director or Coordinator.

2. Upon completion of the review, the practitioner may submit a signed and dated written response.

Section 2 – Verification Process

The completed application shall be submitted, stamped with the date of receipt, and forwarded to the Director of Medical Staff Services or his/her designee. Upon receipt of the completed application, the Director of Medical Staff Services or his/her designee will seek to verify its contents and collect additional information, from the primary source(s), when feasible, within 180 days from the date of the applicant’s signature on the application.

A documented telephone conversation can be utilized as primary source verification for all information including licensure, education, training and experience, competence and peer references. When verifying information via telephone, the following information shall be documented:
An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied and all information verified. An application shall become incomplete if the need arises for new, additional or clarifying information anytime during the evaluation. Any application that continues to be incomplete 60 days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

Section 3 – Appointment Procedure

Department Chair Review & Recommendation:
After receipt of the completed application, verification of its contents and receipt of additional information, the CEO or designee shall notify the appropriate clinical department chair. The chair of the clinical department in which the applicant seeks membership and clinical privileges shall review the applicant’s qualifications and forward a recommendation to the Credentials Committee Chair. The department chair, or the individual(s) or committee within the department shall evaluate the applicant's education, training and experience and make inquiries with respect to the same to the applicant's past or current department chief(s), and/or the residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others. Criteria related to quality of care must also be considered. The department chair has the right to meet with the applicant to discuss any aspect of the application, qualifications and requested clinical privileges.

Credentials Committee Review & Recommendation:
The Credentials Committee, Chair of the Committee or designee on behalf of the Committee, shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including the report and findings from the chair of each clinical department in which privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the clinical privileges requested. If references suggest any potential concerns, the Credentials Committee designee shall direct the application to the Credentials Committee for review and action.

As part of the process of making its recommendation, the Credentials Committee may require a physical and/or mental examination of the applicant by a physician or physicians satisfactory to the Credentials Committee and shall require that the results be made available for the committee's consideration. Failure of an applicant to procure such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary withdrawal of the application for appointment and clinical privileges, and
all processing of the application shall cease. The Credentials Committee shall have the right to require the applicant to meet with the committee to discuss any aspect of the applicant's application, qualifications, or clinical privileges requested. The Credentials Committee may use the expertise of the department chair, or any member of the department, or an outside consultant, if additional research is required into the applicant's qualifications. If the Credentials Committee recommends that the applicant does not meet criteria for membership or information has been identified that varies substantially from the original application, the applicant will be notified within 14 days of the determination by the Credentials Committee. The applicant will be given an opportunity to respond and clarify information before a final recommendation will be made to the Executive Committee. If the applicant does not respond within 30 days after the applicant has been notified, the application shall be deemed to be withdrawn.

Not later than 90 days from its receipt of the application and all required and requested information, the Credentials Committee, or designee, shall send its recommendation and written findings in support thereof to the Executive Committee. Each recommendation shall recommend one of the following:

1. That the applicant be appointed to the Medical Staff;
2. That the applicant's application be deferred for further consideration; or
3. That the applicant be denied for Medical Staff appointment. The Chairperson of the Credentials Committee shall be available to the Executive Committee (and to the Board) to answer any questions that may be raised with respect to the Credentials Committee's recommendation.

PHSW Medical Staff will not discriminate against an applicant on the basis of sex, age, race, creed, mental or physical disability, religion, sexual orientation and/or national origin in making decisions regarding the granting or denying of medical staff membership or clinical privileges. To ensure that all applications are handled in a non discriminatory manner, the following processes are in place:

- Any practitioner complaints alleging discrimination will be evaluated and follow-up will be documented by the Credentials Committee.
- All new applicant and reappointment denials will be reviewed annually by the Credentials Committee. Meeting minutes will provide documentation of the reason for any denials.
- Upon appointment to the Credentials Committee, all members will be asked to sign an affirmation statement to make decisions in a nondiscriminatory manner.

Executive Committee Review & Recommendation:
At its next regular meeting after receipt of the completed application, and the written findings and recommendations of the Credentials Committee, the Executive Committee shall determine whether to recommend to the Governing Body that the applicant be appointed to the Medical Staff, that the application be deferred for further consideration, or that the application for staff appointment or clinical privileges be denied. If the Executive Committee recommends appointment, it shall transmit its recommendation through the Chief Executive Officer or designee to the Governing Body (or its committee), including the findings and recommendation of the Credentials Committee. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any proctoring or other conditions or restrictions relating to such clinical privileges. If the Executive Committee
has determined to make a recommendation contrary to the recommendation of the Credentials Committee, the Executive Committee shall either:

1. Remand the matter to the Credentials Committee for its further investigation and preparation of responses to specific questions raised by the Executive Committee prior to its final recommendation; or

2. Set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation, and forward its recommendation together with the Credentials Committee's findings and recommendation to the Governing Body through the Chief Executive Officer or designee.

When the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed up within thirty (30) days with a subsequent recommendation for provisional appointment with specified clinical privileges, or denial of staff membership.

When the Executive Committee recommends appointment of the practitioner, the CEO or designee shall promptly forward it, together with all supporting documentation, to the Governing Body, or its committee.

When the recommendation of the Executive Committee is adverse to the practitioner, either in respect to appointment or clinical privileges, the CEO or designee shall promptly so notify the practitioner by special notice and the applicant shall be entitled to the procedural rights provided in MSP#019 of these procedural policies. No such adverse recommendation shall be forwarded to the Governing Body until after the practitioner has exercised or has been deemed to waive his/her right to a Hearing as provided in MSP#019 of these Credentialing Procedural Policies.

Board of Directors Review & Recommendation:
At its next regular meeting the Governing Body shall act as follows:

1. If the Governing Body appoints the applicant to membership, the CEO or designee shall transmit this decision to the Chair of the Executive Committee, the relevant clinical departments and to the practitioner by special notice within 30 days of the decision.

2. If the Governing Body's decision is adverse to the practitioner in respect to either appointment or clinical privileges, the CEO or designee shall within 10 working days notify him of such adverse decision by special notice, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived his/her rights under MSO#019 of these Credentialing Procedural Policies.

Section 4 – Clinical Department Assignment

Each new Medical Staff member shall be assigned to a clinical department.
ARTICLE XIV

REAPPOINTMENTS

Section 1 – Procedure for Reappointment

1. Application for Reappointment. Each current member who is eligible to be reappointed to the Medical Staff shall be responsible for completing the reappointment application form approved by the Governing Body. Failure to submit a reapplication will result in automatic expiration of the appointee’s appointment and clinical privileges at the end of the current appointment period. Reappointment, if granted by the Governing Body, shall be for a period of not more than two years from the date of initial appointment and every two (2) years thereafter. If an application for reappointment is filed and the Governing Body has not acted on it prior to the expiration of the appointee’s current term of appointment, the member’s appointment will expire. The following information will be gathered and (verified as noted in MSP#001 Initial Appointments Table 1-Verification) for the reapplication process:

a. Documentation of completed Computerized Physician Computer Order Entry (CPOE) training if applicable.
b. Current licenses where the practitioner provides care for the hospital
c. Health status changes
d. Communicable Disease Record and PPD skin test
e. Professional liability insurance coverage and experience, to include final judgments or settlements
f. Other institutional affiliations and status to include involuntary or voluntary relinquishment of clinical privileges or staff membership while under investigation at another hospital or institution
g. Disciplinary actions pending or completed
h. Board certification, if applicable
i. All information held by the Secretary of the Department of Health and Human Services or the agency designated by the Secretary, pursuant to the Health Care Quality Improvement Act, as amended, of 1986.
j. Previously successful and currently pending challenges to any licensure or regulation (State or Drug Enforcement Administration); and
k. The voluntary or involuntary relinquishment of such licensure or registration, and
l. Signature on the Reapplication attesting to his/her attendance at CME programs that relate to the applicant’s area of practice, with the stipulation that proof of attendance and program content will be submitted upon request.

2. Specific requests for additions to or deletions from the clinical privileges presently held, with any basis for changes.
3. Any request for changes in staff category or clinical department assignments.
4. The staff member must sign the reappointment application and in so doing accepts the same conditions as stated in Section 1 of MSP#001 in connection with the initial application. As with the initial application, the staff member shall bear the burden of completing the application form and producing all information requested.
5. In the event the applicant has inadequate clinical activity to evaluate competency, the applicant may be required to furnish the names of two peers in the same professional
discipline as the applicant who have firsthand knowledge of the applicants current competence and fulfillment of obligations as a medical staff member and any effects of health status on the privileges being requested.

6. Staff members aged 70 and older applying for privileges will be required to provide: (a) two peer references attesting to their professional qualifications and competence, ethical character, physical and mental health and ability to work with peers (b.) and documentation of continued training and or experience of privileges being requested.

Section 2 - Reinstatement

1. If a practitioner allows his/her appointment to expire and then chooses to be reappointed within 12 months, the applicant shall submit a request to the Department Chair summarizing the professional activities undertaken and shall provide other information as may be requested by the Department Chair at that time. The applicant will be asked to verify information in their provider profile and complete a reinstatement application along with a new request for clinical privileges. An application fee will be assessed. After Board approval, the original appointment date will be maintained but the next reappointment date will be changed based on the most current Board approval date.

2. If a practitioner chooses to resign from membership for greater than one year or they have allowed their appointment to expire for more than twelve months, the applicant will be asked to verify information in their provider profile and complete a reinstatement application along with a new request for clinical privileges. An application fee will be assessed. The original appointment date will be changed to the date that the applicant receives Board approval.

3. The practitioner applying for reinstatement must sign the reinstatement application and in so doing accepts the same conditions as stated in Section 1of MSP#001 in connection with the initial application. As with the initial application, the staff member shall bear the burden of completing the reinstatement application form and producing all information requested. The reinstatement application will be processed in the same manner as noted above in Section 1 – Procedure for Reappointment.

Section 3 - Approval

1. No later than one month prior to the end of the current appointment period, Medical Staff Services, shall bring to the attention of the Chair of each clinical department the completed, verified application, and each applicants' current peer review file.

2. No later than 15 days after receipt of the completed application the department Chair shall provide the Credentials Committee with a completed "Reapplication Assessment" form for each individual seeking reappointment. The Chair shall include in each assessment when applicable, the reasons for any changes recommended in staff category, in clinical privileges, or for non-reappointment for those who applied for changes and for those who did not. The Chair of the department concerned shall be available to the Credentials Committee to answer any questions that may be raised with respect to any such report.

3. The Credentials Committee, or designee, after receiving the reports from each clinical department Chair, shall review all pertinent information available, including all information provided from other committees of the Medical Staff and from hospital management, for the purpose of determining its recommendations for staff reappointment, for change in staff
4. As part of the process of making its recommendation, the Credentials Committee may require that an individual currently seeking reappointment procure a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee either as part of the reapplication process or during the appointment period to aid it in determining whether clinical privileges should be granted or continued. The results of such examination shall be available for the Credentials Committee's consideration. Failure of an individual seeking reappointment to procure such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary relinquishment of all clinical privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon. The Credentials Committee shall have the right to require the appointee to meet with the committee to discuss any aspect of the individual's reappointment application, qualifications, or clinical privileges requested. The Credentials Committee may use the expertise of the department Chair, or any member of the department, or an outside consultant, if additional research is required into the appointee's qualifications for reappointment.

5. Executive Committee Procedure. The Credentials Committee shall forward written findings and recommendations to the Executive Committee in time for the Executive Committee to consider the individual's reappointment at its regularly scheduled meeting before the expiration of the applicant's appointment period. Where non-reappointment, non-promotion of an eligible current appointee, or a change in clinical privileges is recommended, the reason for such shall be stated. The Chairperson of the Credentials Committee, or his/her designee shall be available to the Executive Committee (or to the Governing Body) to answer any questions that may be raised with respect to the recommendation.

6. Basis of Recommendations. Each recommendation concerning reappointment of a person currently appointed to the Medical Staff or a change in staff category, where applicable, shall be based upon a consideration of the following information:

a. Such appointee's professional ethics, competence, and clinical judgment in the treatment of patients and his/her physical and mental capacity to treat patients;

b. His/her compliance with the hospital bylaws and policies and the Medical Staff Bylaws, Credentialing Procedural Policies and Rules and Regulations;

c. His/her behavior and cooperation with hospital personnel;

d. His/her cooperation and relations with other practitioners, and his/her general attitude toward patients, the hospital and the public;

e. His/her physical or mental health;

f. Satisfactory completion of CME as required by Washington State licensing
requirements.

g. The individual's clinical and/or technical skills as indicated in part by the results of performance improvement, or other monitoring activities;

h. Previously successful and currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration;

i. Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;

j. Other reasonable indicators of continuing qualifications including information found in the individual's file.

k. Current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments and settlements;

l. Courtesy Staff members who have had no or minimal activity at PHSW, and no or minimal activity at other hospital affiliations will be required to provide; a) two (2) peer references attesting to their professional qualifications and competence, ethical character, physical and mental health and ability to work with peers; and b) documentation of continued training and/or experience of privileges being requested.

7. At least 10 days prior to the final scheduled Governing Body meeting in the reappointment cycle, the Executive Committee shall transmit its written reports and recommendations concerning the reappointment, clinical privileges and, where applicable, change in staff category, of each person currently holding a Medical Staff appointment, to the Governing Body (or its committee) through the Chief Executive Officer or his/her designee, in time for the Governing Body (or its committee) to consider reappointments at its final scheduled meeting in each reappointment cycle.

Where non-reappointment or non-promotion of an eligible current appointee, or a further limitation in clinical privileges is recommended, the reason for such recommendation shall be stated, and the report shall not be transmitted to the Governing Body until the affected staff appointee has exercised or has waived the right to a Hearing as provided in this policy. The Chairperson of the Executive Committee, or his/her designee, shall be available to the Governing Body to answer any questions that may be raised with respect to the recommendations.

8. If the Executive Committee has determined to make a recommendation contrary to the recommendation of the Credentials Committee, the Executive Committee shall either:

a. Remand the matter to the Credentials Committee for its further investigation and preparation of responses to specific questions raised by the Executive Committee prior to its final recommendation; or
b. Set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation, and forwards its recommendation, together with the Credentials Committee's findings and recommendation, to the Governing Body through the Chief Executive Officer or his/her designee.

9. Any recommendation by the Executive Committee that would entitle the affected individual to the procedural rights provided in MSP#019 of the Credentialing Procedural Policies shall be forwarded to the Chief Executive Officer who shall promptly notify the affected individual by certified mail, return receipt requested. The Chief Executive Officer shall then hold the recommendation until after the individual has exercised or has waived the right to a Hearing as provided in this policy. At that time, the Chief Executive Officer shall forward the recommendation of the Executive Committee, together with all supporting information, to the Governing Body. The Chairperson of the Executive Committee, or his/her designee, shall be available to the Governing Body to answer any questions that may be raised with respect to the recommendation.

In the event the Governing Body determines to consider modification of the action of the Executive Committee and such modification would entitle the individual to a Hearing in accordance with, MSP#019, Section I, Paragraph a., it shall so notify the affected individual, through the Chief Executive Officer, and shall take no final action thereon until the individual has exercised or has waived the procedural rights so provided.

10. PHSW Medical Staff will not discriminate against sex, age, race, creed, mental or physical disability, religion, sexual orientation and/or national origin in making decisions regarding the granting or denying of medical staff membership or clinical privileges. To ensure that all applications are handled in a non discriminatory manner, the following processes are in place:
   • Any practitioner complaints alleging discrimination will be evaluated and follow-up will be documented by the Credentials Committee
   • All new applicant and reappointment denials will be reviewed annually by the Credentials Committee. Meeting minutes will provide documentation of the reason for any denials
   • Upon appointment to the Credentials Committee all members will be asked to sign an affirmation statement to make decisions in a nondiscriminatory manner

REVIEW & APPROVAL:
Credentials Committee: 1/11/05, 9/05 Bylaws Committee: 1/13/09
Executive Committee: 12/99, 3/00, 4/01, 9/03, 11/4/03, 2/1/05, 10/4/05, 2/3/09, 12/1/09, 7/6/10
Board of Directors Approval: 5/00, 11/19/03, 2/16/05, 10/22/05, 2/18/09, 12/16/09, 7/21/10 moved to Bylaws
Every practitioner practicing at this hospital by virtue of Medical Staff membership or otherwise, in connection with such practice, or in administrative position, shall be entitled to exercise those clinical privileges specifically granted to him/her by the Governing Body, except as provided in Section 2 of this Policy. Evaluation of clinical privilege requests is based on the findings of the Medical Staff assessment process relevant to the individual’s performance. All privileges granted, renewed or revised will not exceed a period of two years.

PROCEDURE:

Section 1 - Clinical Privileges

a. Every initial application for staff appointment must contain the specific privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's current licensure, education, training, experience, demonstrated competence, references, the individual’s documented experience in categories of treatment areas or procedures, the conclusions drawn from organization performance improvement activities, continuing education and other relevant information. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges being requested.

b. Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, peer review or the ongoing evaluation of the practitioner’s competence, review of the records of patients treated in this or other hospitals, review of the records of the Medical Staff which document the evaluation of the members participation in the delivery of medical care, verification of current licensure and evidence that the applicant is eligible for the clinical privileges being requested.

c. For any privileges which require resuscitation certification (ACLS, ATLS, PALS, NRP) a 6-month grace period will be extended to allow a practitioner to complete recertification. If current certification is not provided to the Medical Staff Office at the end of the 6-month grace period, the practitioner will not be eligible to continue to exercise the specific privilege(s) requiring certification until proof of current certification is provided. This grace period applies to current members of the medical staff and to new applicants to the medical staff, who have held the required certification within the last six months.

d. The delineation of clinical privileges will be determined by the Executive Committee in consultation with the department committees. In order to obtain additional privileges, a practitioner must make written application on the prescribed form, which must state the type of clinical privileges desired and recent special training and experience. Such application should be processed in the same manner as an initial application as noted in MSP #001. The exercise of clinical privileges within any clinical department is subject to the Rules and Regulations of that department and to the authority of the department’s Chair.
e. To view or access a practitioner’s privileges, all hospital staff and credentialed practitioners may contact the Medical Staff Office during regular business hours or view privileges online at the hospital via the MIDAS+Seeker Privilege Inquiry program at any time. If computer access is not available, the Nursing Supervisor may be consulted to access the physician’s file when the medical staff office is closed.

f. Resources are evaluated, when indicated, for all new privileges. Resources, equipment and personnel to support the requested privilege are evaluated in collaboration with PHSW’s Planning Services.

g. Privileges – Dentists and Podiatrists: Privileges granted to dentists and podiatrists shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist and podiatrist may perform shall be within their scope of licensure and specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the chair of the Department of Surgery. All dental and podiatry patients shall receive the same basic medical assessment by an individual with privileges to perform the medical assessment.

h. Allied Health Professionals may be approved by the Governing Body upon the recommendation of the Executive Committee of the Medical Staff and may render services to hospital patients as set forth in MSP#008.

Section 2 - Clinical Privileges for Dentists

a. Surgical procedures performed by dentists shall be under the overall supervision of the Chair of the Department of Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician who holds an appointment to the Medical Staff before dental surgery shall be scheduled for performance, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization. Dentists are responsible for the part of their patients’ history and physical examination that relates to dentistry.

b. The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. Dentists may write orders within the scope of their license and consistent with the Medical Staff rules and regulations and in compliance with the hospital and Medical Staff bylaws.

Section 3 – Oral Surgeons

a. Oral surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified by privileging to do so by the Credentials Committee. "Oral surgeons" is defined as licensed dentists who have successfully completed a post-graduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education.
Section 4 - Clinical Privileges for Podiatrists

a. Surgical procedures performed by podiatrists shall be under the overall supervision of the chair of the Department of Surgery. A medical history and physical examination of each patient shall have taken place and been recorded in the medical record by a physician who holds an appointment to the Medical Staff before podiatry surgery shall be performed, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

b. History and Physical examination privileges may be granted to podiatrists who have demonstrated the necessary qualifications, appropriate training and experience. Such privileges will be limited to patients whose medical condition is classified within the American Society of Anesthesiologists (ASA) Category I and II only;

c. The podiatrist shall be responsible for the podiatry care of the patient, including the podiatry history and podiatry physical examination as well as all appropriate elements of the patient's record. Podiatrists may write orders, which are within the scope of their license, consistent with the Medical Staff Rules and Regulations, and in compliance with Medical Staff Bylaws.
ARTICLE XVI

TEMPORARY PRIVILEGES

Section 1 - Temporary Interim Privileges – Initial Appointments

The CEO, or his/her designee, may grant temporary interim admitting and clinical privileges to an applicant for an initial period of one hundred twenty (120) days, provided the following criteria are met and verified from primary sources:

The applicant must have:

- Submitted a completed application to the medical staff;
- Current Washington State License;
- Current DEA registration;
- Liability insurance coverage as specified in the Medical Staff Bylaws;
- Favorable peer references, attesting to competence, citizenship, and health status;
- Letters of reference from the most recently completed residency training program and past hospital affiliations attesting to relevant training and experience;
- Reliable information attesting to competence, ability to perform the privileges requested, and ethical behavior;
- Signed acknowledgment of receipt of copies of the Medical Staff Bylaws, Credentialing Policies, and Rules and Regulations, and agreed to be bound by their terms; and
- Fulfilled any other criteria required by the medical Staff Bylaws and Credentialing Procedural Policies.

Written unlimited approval for the granting of temporary privileges is required from the:

- Appropriate Department Chair;
- Credentials Committee Chair; and
- Chair of the Executive Committee.

Temporary privileges will not be granted in the event of:

- A current or previously successful challenge of license or DEA registration;
- Prior involuntary termination of medical staff membership at any institution;
- Prior involuntary limitation, reduction, denial or loss of clinical privileges at any institution; or
- Prior voluntary resignation of staff membership or limitation of clinical privileges at any institution while under investigation

The staff member with temporary privileges shall act under the oversight of the Chair of the clinical department in which the privileges are exercised.

Section 2 - Care of Specific Patient

a. Temporary clinical privileges may be granted by the CEO, or his/her designee, for the care of a specific patient to a practitioner who is not an applicant for membership, provided that there
shall first be obtained such practitioner's signed acknowledgment that he/she has received copies of the Medical Staff's Bylaws, Credentialing Procedural Policies and Rules and Regulations and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary clinical privileges. Documents required include:

1. Completion of Temporary Privilege Application
2. Verification of State Licensure
3. Current DEA registration
4. Amount and term of professional liability insurance coverage
5. Receipt and evaluation of results from the National Practitioner’s Data Bank
6. Verification of having successfully completed residency training; and
7. Confirmation of good standing in hospital affiliation where the practitioner is actively practicing with no clinical competency concerns
8. Written concurrence of the Department Chair

Such temporary privileges shall be restricted to the treatment of not more than four patients in any one (1) year by any practitioner, after which such practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients.

Section 3 – Specialty Care Situations
Temporary clinical privileges may be granted by the CEO, or his/her designee, to a practitioner who is not an applicant for membership, in order to provide expert proctoring for specialty procedures provided that there shall first be obtained such practitioner's signed acknowledgment that he/she has received copies of the Medical Staff's Bylaws, Credentialing Procedural Policies and Rules and Regulations and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary clinical privileges.

To be eligible to apply for temporary privileges, the applicant must be a member of the Active Staff or equivalent of another hospital where they actively participate in a continuous quality improvement program and other quality review evaluation and monitoring activities similar to those required of the Active Staff of this hospital. Patients must be admitted by a member of the PHSW medical staff. The attending physician has the ultimate responsibility for the patient's general medical condition throughout the hospitalization. Documents required from the applicant include:

- Completion of temporary privilege application.
- Verification of current state licensure (Any state license accepted).
- Current DEA registration.
- Amount and term of professional liability insurance coverage.
- Receipt and evaluation of results from the National Practitioner’s Data Bank
- Verification of having successfully completed residency training.
- Confirmation of good standing in hospital affiliation where the practitioner is actively practicing with no clinical competency concerns.
- Written concurrence of the department chair.
Section 3 – Locum Tenens

The CEO, or his/her designee, with concurrence of the Chairs of the Executive Committee, Credentials Committee, and the appropriate clinical Department, may grant temporary privileges to a physician serving in locum tenens for a member of the Medical Staff for a period of not to exceed one hundred and twenty (120) days. Applicants for locum tenens privileges shall follow the procedure set forth in Section 1 of this policy (Initial Temporary Interim Privileges).

At the expiration of the locum tenens term, locum tenens privileges may be reapplied for, and will require review and approval by the Department Chair, Executive Committee Chair, and the CEO, or his/her designee. Documentation required is the same as specified in Section 1 of this policy.

Section 4 – Temporary Privileges in Event of a Disaster

- During a disaster in which the emergency management plan has been activated and PHSW is unable to handle the immediate patient needs, the CEO or his/her designee, or the Medical Staff President or his/her designee, may grant temporary clinical privileges on a case by case basis upon presentation of photo ID card issued by a state, federal or regulatory agency; and any of the following:
  - A current picture hospital or healthcare ID card that identifies professional designation;
  - Current U.S. or Canadian licensure to practice;
  - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT);
  - Identification indicating that the individual has been granted authority to render patient care in emergency circumstances. Such authority having been granted by a federal, state or municipal entity; or
  - Presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner’s identity and qualifications
  - Primary source verification of the license

Information regarding current malpractice insurance carrier shall also be provided.

Verification of the credentials and privileges of individuals who receive disaster privileges will be given high priority. Medical Staff Services will verify current licensure, malpractice insurance and hospital status (telephone verifications are acceptable) as soon as the immediate situation is under control. The verification will be completed within 72 hours from the time that the practitioner presents to the organization and a decision will be made regarding the continuation of disaster responsibilities for each practitioner. In special circumstances, when primary source verification cannot be completed within 72 hours, documentation of why primary source could not be performed in the required time frame will be documented. In this case, verification will be performed as soon as possible. Medical Staff Services will permanently maintain a file for each practitioner who has provided emergency disaster medical treatment.

The Emergency Medical Director or designee will orient the practitioner and provide oversight while the hospital disaster operation is in progress.
Practitioners granted privileges during a disaster will be given special identification. This may include a photocopy of the identification document or a name tag.

Disaster privileges may be terminated at any time during the verification process if areas of concern are identified. Disaster privileges shall immediately terminate once the disaster has ended, as determined by the hospital administration.

Practitioners granted disaster privileges are not subject to the provisions of the Fair Hearing Plan.

Section 5 – Special Conditions

The departmental Chair may impose special requirements of supervision and reporting for any practitioner granted temporary privileges. The CEO, or his/her designee, shall immediately terminate temporary privileges for failure to comply with special requirements.

Section 6 – Termination of Privileges

The CEO, or his/her designee, may at any time, upon the recommendation of the Chair of either the Executive Committee or the department concerned, terminate a practitioner’s temporary privileges effective as of the discharge from the hospital of the practitioner’s patient(s) then under his/her care in the hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination shall be immediately effective and the departmental Chair or, in his absence, the Chair of the Executive Committee, shall assign a member of the Medical Staff to assume responsibility for the care of such patient(s) until discharge from the hospital. The wishes of the patient(s) shall be considered in the selection of such substitute practitioner.

Section 7 – Denial of Temporary Privileges

The CEO or his/her designee may deny temporary privileges with no rights to a Hearing under MSP#019 of the Credentialing Procedural Policies. Failure to receive temporary privileges shall not prevent an applicant from requesting privileges under MSP#001 and MSP#003 of the Credentialing Procedural Policies.

Section 8 - Emergency Privileges

In the case of emergency, any physician member of the Medical Staff, to the degree permitted by his license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he/she does not desire to request privileges, the patient shall choose or be assigned to an appropriate member of the Medical Staff. For the purpose of this section, an "emergency" is defined as a condition which would result in serious permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.
Section 9 – Residents

a. Residents from outside programs will be granted temporary privileges to attend to patients for a period not to exceed ninety (90) days when the following criteria have been met:
   1. Verification of current state license;
   2. Verification of malpractice insurance in the minimum amount of $1/3 million; verification of a Graduate Medical Education (GME) agreement between PHSW and the sponsoring training program;
   3. Receipt of signed statement from staff physician who is assuming responsibility for the resident;
   4. Obtain approval by Chair of the department in which the resident will function, the President of the Medical Staff, and the hospital CEO or his/her designee;

   Resident must wear a name tag identifying him/her as a resident.

Bylaws Committee: 5/4/09
Executive Review & Approval: 12/99, 3/00, 4/01, 9/03 & 4/6/04, 12/6/05, 5/2/06, 3/08, 6/2/09, 7/6/10
BOD Review & Approval: 12/99, 5/00, 7/01, 9/03 & 4/21/04, 11/18/06, 5/17/06, 3/19/08, 6/17/09, 7/21/10 moved to Bylaws
ARTICLE XVII

PRECAUTIONARY SUSPENSION

Section 1 – Service of Notice or Documents

a. Any notice or document required to be provided to a Medical Staff member, by any Provision of this Policy, shall be delivered to such individual by:

1. Documented personal service to include the date, time and signature of the person making such service; or
2. Certified mail, return receipt requested.

Section 2 - Grounds for Precautionary Suspension

e. The President of the Medical Staff, the Chief Medical Officer, the Chairperson of the practitioner’s clinical department, the Chairperson of the Credentials Committee, the Chief Executive Officer, or the Chairperson of the Governing Body shall each have the authority to suspend all or any portion of the clinical privileges of a Medical Staff member whenever there is reasonable basis to believe that failure to take such action may result in danger to the health and/or safety of any individual or there is reasonable basis to believe that failure to do so may interfere with the orderly operation of the hospital. The involved Medical Staff member shall be notified promptly in writing of the precautionary suspension and the reasons therefore.

b. When possible, the involved Medical Staff member will be given the opportunity to voluntarily refrain from exercising privileges pending an investigation of the concerns raised. Such voluntary agreement shall not be deemed a precautionary suspension.

c. A precautionary suspension or a voluntary agreement to refrain from exercising privileges is not a complete professional review activity by a professional review body of the hospital. It shall not imply any final finding of responsibility for the situation that caused the precautionary suspension or the voluntary agreement to refrain from exercising privileges.

d. Preliminary review of the precautionary suspension or voluntary agreement not to exercise privileges shall be performed by the Credentials Committee to determine whether there is sufficient evidence to continue the precautionary suspension or the voluntary agreement not to exercise privileges, or whether to withdraw the precautionary suspension or voluntary agreement not to exercise privileges. Notwithstanding a withdrawal, the Credentials Committee may still proceed under its investigative procedure. The preliminary review by the Credentials Committee shall be completed within twenty (20) days of the precautionary suspension or voluntary agreement not to exercise privileges. If the preliminary review cannot be completed within twenty (20) of the precautionary suspension or voluntary agreement not to exercise privileges, the reasons for the delay shall be transmitted to the Executive Committee so that it may consider whether the precautionary suspension should be lifted or continued. The Executive Committee shall render a decision on whether to lift or continue the
precautionary suspension within thirty (30) days of receipt of the reasons for delay. Any
decision on the matter by the Executive Committee shall be provided to the involved
Medical Staff member.

e. Once a Precautionary Suspension or a voluntary agreement to refrain from exercising
privileges has been reviewed and upheld by the Credentials Committee, the precautionary
suspension or voluntary agreement to refrain from exercising privileges shall be deemed
to have commenced on the date the Credentials Committee issues its written opinion
upholding the precautionary suspension or the voluntary agreement to refrain from
exercising privileges. Such action by the Credentials Committee is data bank reportable
if it is for the time period and reasons requiring reporting.

f. The upholding by the Credentials Committee of any such suspension or voluntary
agreement to refrain from exercising privileges shall immediately be reported in writing
to the Chief Executive Officer, the Chief Medical Officer, and the President of the
Medical Staff, and to the involved Medical Staff member. Any such decision shall
remain in effect unless or until modified by the Credentials Committee or the Governing
Body. If modified, notification of such modification shall be given to the involved
Medical Staff member.

g. If deemed appropriate by the Credentials Committee, a full investigation of the
issue may be initiated as defined in MSP#017. If an investigation is commenced, notice
of such action will be transmitted to the Chief Executive Officer, the Chief Medical
Officer, and the President of the Medical Staff and to the involved Medical Staff member.

h. Immediately upon the imposition of a precautionary suspension or voluntary agreement
not to exercise privileges, the appropriate department chair, or if unavailable, the
President of the Medical Staff, or designee, shall assign to another Medical Staff member
with appropriate clinical privileges, responsibility for care of the suspended member’s
patients still in the hospital. The wishes of the patient shall be considered in the selection
of any newly assigned Medical Staff member.

i. It shall be the duty of all of the Medical Staff appointees to cooperate with the President
of the Medical Staff, the Chief Medical Officer, the department Chair concerned, the
Credentials Committee, and the Chief Executive Officer in enforcing all suspensions or
voluntary agreement not to exercise privileges.

Section 3 - Automatic Suspension of Privileges for Conviction of Medicare/Medicaid Fraud
Which Results in Exclusion from Participation

a. Medical staff members who are convicted of Medicare/Medicaid fraud and who are
suspended from participation in Medicare/Medicaid programs will be automatically
suspended from the Medical Staff, without right of appeal. The involved Medical Staff
member shall be given notice by the CEO of the automatic suspension. When and if the
exclusion from participation expires, the former Medical Staff member may reapply for
Medical Staff membership and appropriate privileges.
Section 4 – Automatic Loss of Privileges or Part Thereof

a. Action by the Washington State licensing Body or agency revoking or suspending an involved Medical Staff member’s professional license, or it’s loss or lapse for any reason, shall result in automatic relinquishment of all hospital clinical privileges and Medical Staff membership as of that date, until the matter is resolved to the satisfaction of the Credentials Committee. In the event the involved Medical Staff member’s license is only partially restricted, the clinical privileges that would be affected by the license restriction shall be similarly restricted at the hospital. Partial restriction of a Medical Staff member’s license, however, may prompt an investigation.

Section 5 – Voluntary Relinquishment of Privileges for Failure to Provide Necessary Information

a. If at any time a Medical Staff member fails to timely provide necessary information pursuant to a reasonable written request by the Credentials Committee, the Executive Committee, or the Chief Executive Officer, the Medical Staff member’s clinical privileges shall be deemed to be voluntarily relinquished until the requested necessary information is provided to the reasonable satisfaction of the requesting party. For purposes of this section, "necessary information" shall refer to;

(1) Requested physical or mental examination reports as specified elsewhere in this policy, or
(2) Requested information necessary to explain an investigation at another facility, professional review action, or resignation from another health care facility or agency.

Section 6 - Confidentiality and Reporting

Actions taken and recommendations made pursuant to the Bylaws and Policies shall be treated as confidential in accordance with such Bylaws and Policies and all applicable laws. In addition, the CEO shall make reports of actions taken pursuant to these Bylaws or Policies in compliance with applicable laws. Copies of any such reports by the CEO shall be provided to the involved Medical Staff Member when permitted by law.
ARTICLE XVIII
FAIR HEARING PLAN

Section 1 - Initiation of Hearing

a. Grounds for Hearing. Except as otherwise provided in these bylaws and procedural policies, the following recommendations or actions with respect to an individual practitioner, if deemed adverse under Section 1, Part b. below, are grounds for a Hearing upon timely and proper request by the practitioner:

1. Denial of initial staff appointment;
2. Denial of staff reappointment;
3. Suspension of staff membership;
4. Revocation of staff membership;
5. Denial of appointment or appointment in requested staff classification or failure to advance;
6. Reduction in staff classification;
7. Suspension or limitation of the right to admit patients;
8. Denial or restriction of requested clinical privileges;
9. Reduction in clinical privileges;
10. Suspension of clinical privileges;
11. Revocation of clinical privileges;
12. Application of a mandatory consultation or supervision requirement other than at the time of initial reappointment or at the time of a request for additional privileges.

Voluntary relinquishment of privileges for failure to provide necessary information, as defined in MSP#018, Section 5, is not grounds for a hearing.

Automatic relinquishments are not grounds for a Hearing.

b. When Deemed Adverse. A recommendation or action listed in Section 1, Part a. above is adverse when it has been:

1. Recommended or approved for forwarding to the governing body as provided in the appointment, reappointment, corrective action or Hearing provisions of these procedural policies by the Executive Committee;
2. Taken by the governing body under circumstances in which no prior right to request a Hearing existed;
3. Based directly upon the acts, omissions or other conduct of the affected practitioner.

c. Notice of Adverse Recommendation or Action. When a recommendation is made which,
according to the bylaws and procedural policies, entitles an individual to a Hearing prior to a final decision on that recommendation, the applicant or member, as the case may be, shall promptly be given notice by the Chief Executive Officer, by certified mail, return receipt requested, or by personal delivery.

This notice shall:

1. Advise the practitioner of the recommendation or action, the reasons therefor, and his/her right to request a Hearing pursuant to the bylaws and procedural policies;
2. Summarize the rights of the practitioner in the Hearing;
3. Specify that the practitioner has thirty (30) days after receiving the notice within which to submit a request for a Hearing and that the request must satisfy the condition of part d., Section 1, below;
4. State that failure to request a Hearing within the specified time period and in the proper manner will result in loss of all rights to any Hearing on the matter that is the subject of the notice and that the practitioner will be deemed to have accepted the action taken;
5. State that upon receipt of the practitioner's Hearing request, the CEO will notify the practitioner of the date, time and place of the Hearing.

d. Request for Hearing. The practitioner shall have thirty (30) days after receiving a notice under part c. of Section 1, above, to file a written request for a Hearing. The request must be delivered to the CEO either in person or by certified mail, return receipt requested.

Waiver by Failure to Request a Hearing. A practitioner who fails to request a Hearing within the time and in the manner specified in Part d, Section 1, above, will be deemed to have waived his/her right to such Hearing and to have accepted the action involved and such action shall thereupon become effective immediately following Governing Body action. The CEO shall promptly send the practitioner special notice of each action taken under any of the following sections and shall notify the president of each action.

Section 2 - Hearing Prerequisites

a. Hearing Committee. Upon receipt of the Hearing request, the President of the Medical Staff, shall appoint a Hearing Committee composed of not less than three (3) members. The majority of the hearing committee members shall be active members of the medical staff. Persons selected shall not have previously actively participated in the consideration of the immediate facts that may have resulted in this adverse action or be in direct economic competition with the practitioner, one of whom shall be appointed as Chair. Knowledge of the matter involved and/or prior involvement in an adverse action involving the practitioner shall not preclude a member of the Active Staff from serving as a member of the Hearing Committee. The Hearing Committee, immediately upon appointment, shall be entitled to independent legal counsel paid by the hospital. Counsel shall advise the Hearing Committee concerning all phases of the Hearing process. Counsel shall have no right to vote.

b. Notice and Time and Place of the Hearing. The Medical Staff President or his designee
shall within ten (10) working days after the appointment of the Hearing Committee, schedule a Hearing, and notify the applicant or member by special notice of the time, place and date. A Hearing shall be scheduled on a date not less than thirty (30) days from the date appearing on the face of the notice of Hearing.

c. **Content of Hearing Notice.** The notice of Hearing shall be prepared by the President of the Medical Staff or his designee and shall state in concise language:

1. The criteria, bylaws, procedural policies or other requirements relied on in the adverse recommendation, decision or act;
2. The composition of the Hearing Committee;
3. The time, place and date of the Hearing;
4. Notification that the right to the Hearing may be forfeited if the practitioner fails without good cause to appear;
5. Notification that, in the Hearing, the practitioner involved has the right to representation by an attorney or other person of the practitioner's choice at the practitioner's expense;
6. Notification that the practitioner has the right to have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof;
7. Notification that the practitioner has the right to call, examine and cross-examine witnesses;
8. Notification that the practitioner has the right to present evidence determined to be relevant by the Chair of the Hearing Committee;
9. Notification that the practitioner has the right to submit a written statement at the close of the Hearing;
10. Notification that upon completion of the Hearing the practitioner involved has the right to receive the written recommendation of the Hearing Committee, including a statement of the basis of the recommendation and shall receive a written decision of the governing body, including a statement of the basis of the decision;
11. The name of the person to contact for access to the record on which the adverse event was based;
12. The names and addresses of witnesses then contemplated, if any; and
13. The name of any person(s) appointed to present the evidence in support of the adverse action.

d. **List of Witnesses.** The Governing Body or Executive Committee may, by notice received at least 12 days before the Hearing by the affected person, request a list of witnesses. Such a list shall be provided in writing, with the names and addresses of the individuals who will give testimony or evidence in support of the affected person at the Hearing, within ten (10) days of such request.

**Section 3 - Hearing Procedure**

a. **Personal Presence.** Failure, without good cause, of the practitioner to appear at the Hearing shall constitute a waiver of the right to a Hearing and a voluntary acceptance of the recommendations or actions pending, which shall then become final and effective immediately following Governing Body action.
b. **Representation.** The person requesting the Hearing shall have the right to be represented at the Hearing at his expense by an attorney or physician of his choice. He shall inform the Chief Executive Officer in writing of the name of that person at least ten days prior to the date of the Hearing. The Executive Committee or the Chief Executive Officer shall appoint a representative, who may be an attorney, to present its recommendations and to examine witnesses.

c. **Chair of Hearing Committee.** The Chair of the Hearing Committee shall preside over the Hearing. He/she shall act to ensure that decorum is maintained, and that all persons who participate in the Hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence. He shall have the authority and discretion to make rulings on all questions, which pertain to matters of procedure, and to the admissibility of evidence, upon which he may be advised by legal counsel. In all instances he shall act in such a way that the Hearing Committee in formulating its recommendations considers all information relevant to the continued appointment or clinical privileges of the person requesting the Hearing. The Chair may select an impartial individual, not affiliated with the hospital, to act as presiding officer, at his/her discretion.

d. **Rights of Parties.** The parties to the Hearing shall have the right to:

1. Call and examine witnesses;
2. Present evidence;
3. Cross-examine. If the practitioner does not testify on his own behalf, he/she may be called and examined as if under cross-examination.
4. Obtain a copy of the Hearing record upon payment of any reasonable charges associated with the preparation thereof.

e. **Procedure and Evidence.** The Hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons might customarily rely in the conduct of serious affairs may be considered regardless of the admissibility of such evidence in a court of law. The members of the Hearing Committee may interrogate the witnesses, call additional witnesses or request additional evidence, as they deem appropriate. At the close of the Hearing, each party shall be entitled to submit memoranda concerning any issue of law or fact, and those memoranda shall become part of the Hearing record. Oral evidence shall be taken only on oath or affirmation.

f. **Official Notice.** In reaching a decision, the Hearing Committee may take official notice, either before or after submission of the matter for decision, or any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the state where the Hearing is held. Parties present at the Hearing must be informed of the matters to be noticed, and those matters must be noted in the Hearing record. Any party shall be given an opportunity, on timely request, to request that a matter be officially noticed by evidence or by written or oral presentation of authority, in a manner to be determined by the Hearing Committee.
g. **Basis of Decision.** The decision of the Hearing Committee shall be based on the evidence produced at the Hearing. This evidence may consist of the following:

1. Oral testimony of witnesses;
2. Memorandum of points and authorities in connection with the Hearing;
3. Any material regarding the person who requested the Hearing contained in the hospital's files and prepared as part of the activities of the hospital provided the person who requested the Hearing has had the opportunity to comment on and, by other evidence, refute it;
4. Any and all applications, references, and accompanying documents;
5. All officially noticed matters;
6. Any other evidence admitted by the committee.

h. **Burden of Proof.** The Governing Body or the Executive Committee, depending on whose recommendation prompted the Hearing initially, shall first come forward with evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the Hearing to come forward with evidence. After all the evidence has been submitted by both sides, the Hearing Panel shall recommend in favor of the Executive Committee, and/or the Governing Body unless it finds that the individual who requested the Hearing has proved that the recommendation that prompted the Hearing was not supported by substantial evidence.

i. **Hearing Record.** An accurate record of the Hearing must be kept. The Hearing Committee may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. If the Hearing Committee does not elect to do so, the practitioner may arrange for a public court reporter at his own expense, but shall consent to the hospital's right of access to any such transcription with the hospital to bear one-half the cost of producing the record and the entire cost of copying the hospital's copy. The Hearing record shall also contain all exhibits or other documentation considered, written statements submitted by the parties, and correspondence between the parties or between the Hearing Committee and the parties, if any, during the Hearing process.

j. **Postponements and Extensions.** Requests for postponements or extensions of time beyond times expressly permitted in this Fair Hearing Plan, may be granted by the Chair of the Hearing Committee only upon showing of good cause and only if the request is made as soon as is reasonably practical.

k. **Presence of Hearing Committee Members and Vote.** A majority of the Hearing Committee members must be present throughout the Hearing and deliberations. If any committee member is absent from any part of the proceedings, he shall not be permitted to participate in the deliberations or the decision. The adoption of the Hearing Committee's report and decision shall be by majority vote.

h. **Recesses and Adjournment.** The Chair of the Hearing Committee 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. Upon conclusion of presentation of oral and written evidence and argument, the Hearing shall be closed. The Hearing
Committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the Hearing shall be adjourned.

Section 4 - Hearing Committee Report and Further Action.

a. Deliberations and Recommendation of Hearing Committee. After final adjournment of the Hearing, the Hearing Committee shall render a decision, accompanied by a report, which shall contain a concise statement of the reasons justifying the decision made and shall deliver such decision and report to the Medical Staff President. The report may recommend confirmation, modification, or withdrawal of the original recommendation of the Executive Committee. The report, together with the Hearing exhibits, shall be forwarded to the Executive Committee.

b. Disposition of Hearing Committee Report. Upon its receipt, the Medical Staff President or his/her designee, shall send a copy of the report and decision by certified mail, return receipt requested or by personal delivery, to the person who requested the Hearing.

c. Final Action by Executive Committee. After receiving the Hearing Committee's report, the Executive Committee shall confirm, modify or withdraw its own original recommendation. Notice of the Executive Committee's action, and a statement of the basis for the decision, shall be sent to the affected member by certified mail, return receipt requested or by personal delivery. The Executive Committee's recommendation shall be transmitted to the Governing Body.

d. Unless the affected member exercises the right to appeal, the Governing Body shall make a final decision upon the Executive Committee's recommendation.

e. If the written decision of the Governing Body modifies changes or reverses the Executive Committee’s recommendation, the matter may be referred to a Joint Conference Committee, as defined in MSP/#033.

Section 5 – Joint Conference Committee

a. Within seven (7) days following receipt of the written decision of the Governing Body, the CEO shall, after consultation with the President of the Medical Staff and Chair of the Governing Body, refer the matter to the Joint Conference Committee for review. The Joint Conference Committee shall consist of:

- Chair of the Governing Body, or designee;
- Chief Medical Officer;
- Chair of the Credentials Committee, if the adverse recommendation and/or action was that of the Credentials Committee, or alternatively
- President of the Medical Staff, if the adverse recommendation and/or action was that of the Executive Committee; and
- President-Elect of the Medical Staff

b. Responsibility & Special Notice – The responsibility of the Joint Conference Committee
is to review the hearing record and the written decision of the Governing Body modifying
or reversing the most recent adverse recommendation and/or action of the Executive
Committee or Credentials Committee, and the reasons of the Governing Body therefore,
and to prepare a written report of the Committee’s recommendations to the Governing
Body, which shall be delivered to the Chair of the Governing Body, with a copy to the
CEO, within thirty (30) days after the Joint Conference Committee was convened.

Within seven (7) days after receipt by the Joint Conference Committee’s
recommendations to the Governing Body, the CEO shall mail Special Notice to the
practitioner, which shall include:

1. An enclosed copy of the Joint Conference Committee’s written recommendations;
2. The date on which the Joint Conference Committee was convened, and the names of
   the members of the Joint Conference Committee;
3. A statement that the practitioner does not have a right to object to any member of the
   Joint Conference Committee;
4. A statement that the Governing Body shall take final action and prepare its written
decision within twenty (20) days after receipt of the Joint Conference Committee’s
written recommendations;
5. The date on which the Governing Body received the Joint Conference Committee’s
   written recommendations; and
6. The date on which the CEO received the Joint Conference Committee’s written
   recommendations.

Section 6 - Appeal

a. **Time for Appeal.** Within fifteen (15) days after the affected individual is notified of the
final decision of the Executive Committee, the affected individual may request an
appellate review. The request shall be in writing, shall be delivered to the Chief
Executive Officer either in person or by certified mail, return receipt requested, and shall
include a brief statement of the reasons for appeal. If such appellate review is not
requested within fifteen (15) days as provided herein, the affected individual shall be
deemed to have accepted the recommendation involved and it shall thereupon become
final and immediately effective upon approval of the Governing Body

b. **Grounds for Appeal.** The grounds for appeal from an adverse decision shall be that:

3. There was substantial failure to comply with the hospital or Medical Staff Bylaws
   and Credentialing Procedural Policies in the conduct of the Hearings so as to deny
due process or a fair Hearing; or
2. The decision was made arbitrarily or capriciously; or
3. The evidence did not support the decision.

c. **Time, Place and Notice.** Whenever an appeal is requested as set forth in the preceding
sections, the Chief Executive Officer shall, promptly after receipt of such request,
schedule and arrange for an appellate review by the Governing Body. The Governing
Body shall cause the affected individual to be given notice of the time, place and date of
the appellate review. The date of appellate review shall be as determined by the
Governing Body; provided that when a request for appellate review is from an appointee who is then under suspension, appellate review shall be held as soon as the arrangements may reasonably be made. The time for appellate review may be extended by the Governing Body for good cause.

f. **Nature of Appellate Review.** The President of the Governing Body shall appoint a Review Panel composed of not less than three of its own members who have not previously been directly involved in the matter, to consider the final decision of the Executive Committee. The appealing party shall provide a record of the proceedings before the Hearing Committee, at the appealing party's own expense, to the Review Panel. The appealing party must arrange for the record to be transcribed and submitted to the Review Panel within thirty (30) days of the Hearing Panel's decision or as soon thereafter as the record can be completed, otherwise the appeal shall be dismissed. If the appeal before the Review Panel is successful, the Hospital shall reimburse the appealing party for the cost of providing the record of the Hearing Panel proceedings. Except in extraordinary situations, the Review Panel will not accept additional oral or written evidence. If, in its discretion, it determines to accept additional evidence, it shall do so on such conditions as it may determine, subject to the rights of cross-examination or confrontation as provided at the Hearing Committee. Each party shall have the right to present a written statement to the Review Panel, and in its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument before the full Review Panel. The Review Panel shall recommend final action to the Governing Body. The Governing Body may affirm, modify or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation.

g. **Final Decision of the Governing Body.** After the conclusion of the proceedings before the Review Panel, the Governing Body shall render a final decision in writing and shall deliver copies thereof to the affected individual and to the Executive Committee.

h. **Further Review.** Except where the matter is referred for further action and recommendation in accordance with Letter (d) of this Section, the final decision of the Governing Body following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendations shall be promptly made to the Governing Body in accordance with the instructions given by the Governing Body.

i. **Right to One Appeal Only.** No applicant or Medical Staff member shall be entitled as a matter of right to more than one Hearing or appellate review on any single matter, which may be the subject of a Hearing. However, after the expiration of two years from the date of final action by the Hearing Committee or, in the event of an appeal, by the Governing Body, an applicant or member or former member may reapply for appointment or reappointment to the Medical Staff or for an increase in clinical privileges, unless the Hearing Committee or the Governing Body provided otherwise in its final decision.

REVIEW:

Bylaws Committee: 2/23/06, 6/09 Medical Staff vote: 2/21/11 Executive Committee: 12/99, 3/00, 4/01 10/03, 11/4/03, 5/2/06, 9/1/09, 7/6/10, 3/1/11 Board of Directors Approval: 5/00, 11/19/203, 5/17/06, 10/24/09, 7/21/10 moved to Bylaws, revised 3/16/11
ARTICLE XIX

HISTORY & PHYSICALS

1. History & Physicals

a. All patients admitted to the Medical Center must have a history and physical (H&P) examination performed by a qualified practitioner or other licensed independent practitioner permitted to provide patient care independently. The H&P shall be written or dictated by the qualified practitioner and placed on the patient's medical record by hospital personnel within twenty-four (24) hours of admission. This includes patients admitted for observation. The H&P must include an introductory statement as to the reason for admission, a complete history of the present illness, a complete past medical history, a review of systems, including pertinent negatives, and an appropriate complete physical examination.

A management plan must be included in the H&P or the admitting note.

b. Outpatients undergoing invasive procedures and/or requiring procedural sedation or anesthesia or those admitted for observation require a history and physical relevant to the procedure.

1) The history and physical for surgery/procedures form or a dictated H&P may be utilized for the history and physical with a minimum content of: indications for procedure, pertinent past history, current medications, allergies, relevant diagnostic test results, physical exam and findings relevant to the procedure and co-morbidities.

a. If a completed history and physical examination has been obtained within 30 days prior to the patient's admission to the Medical Center, a durable, legible copy of this report may be used in the patient's Medical Center medical record provided there have been no subsequent changes or the changes have been recorded at the time of admission. Office records that include the required components of a history and physical examination and have been completed up to 30 days prior to the date of admission may be used for the history and physical.

b. A consultation containing the required components may be used as a history and physical provided it has been done up to 30 days prior to the date of admission.

c. When using an H&P that has been completed within 30 days prior to the hospital admission, an update, which includes a current physical examination must be documented within 24 hours of the patient’s admission or prior to any invasive procedure. The update may be documented on the H&P, progress notes or in the pre-anesthesia assessment. The update must indicate either, the nature and extent of any changes or that there have been no changes.
d. If the H&P is greater than 30 days, the practitioner must provide a current H&P. The History & Physical for Surgery/Procedures form may be used. The presurgery/procedure admission update requirement still applies as noted above.

e. H&Ps greater than 30 days are not valid.

f. For patients admitted through the emergency department going directly for a procedure/surgery, the history and physical may be performed by the emergency physician. In an emergency in which there is inadequate time to record the history and physical examination before a procedure/surgery, a brief note by the performing provider is acceptable.