FRANCISCAN MEDICAL STAFF BYLAWS

St. Anne Hospital, St. Anthony Hospital,
St. Clare Hospital, St. Elizabeth Hospital,
St. Francis Hospital, St. Joseph Medical Center

Effective November 26, 2024

FRANCISCAN
MEDICAL STAFF BYLAWS

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PREAMBLE

WHEREAS, Virginia Mason Franciscan Health is a non-profit corporation organized under the laws of the state of Washington that operates the Franciscan Health System (the "Health System"); and

WHEREAS, Virginia Mason Franciscan Health's purpose is to serve as a health system providing patient care, education, and research consistent with the Mission Statement of Virginia Mason Franciscan Health and CommonSpirit Health; and

WHEREAS, To accomplish the mission, the Medical Staff has established the following goals:

a. To self-govern according to democratic principles, encouraging participation by all and giving each member the opportunity to be heard and represented. Decision making will respect and show consideration to those with minority opinions.

b. To provide the highest quality, appropriate, and timely care for every patient admitted to or treated in any of the Hospitals, Departments, or services of the System, and cared for by the Medical Staff and the associates who assist in patient care.

c. To aspire to standards of excellence in continuous professional and personal development for all Members of the Medical Staff and those that assist them.

d. To foster an inclusive, collegial, transparent and communicative culture in support of the Medical Staff Compact amongst the Medical Staff, Administration, the Board, and all individuals that bear responsibility for and assist in patient care.

e. To undertake ethical governance of the Medical Staff in a manner that prepares it to meet existing and future challenges promptly and effectively.

f. To support an environment of sound scientific standards that is conducive to teaching, research, and other aspects of the medical sciences.

WHEREAS, it is recognized that the Medical Staff wants to provide a structure to maintain and improve quality medical care within the Health System and must accept and discharge this responsibility, as delegated by and subject to the ultimate authority of the Board, and that the cooperative efforts of the Medical Staff, the Health System's management and the Board are necessary to fulfill the Health System's obligation to its patients;

THEREFORE, the Medical Staff adopts these Bylaws, subject to approval by the Board.

DEFINITIONS

1. "ACGME General Competencies" means the areas of general competencies developed by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

2. "Administration" means the executives of the Health System or a Hospital engaged to fulfill leadership and operational responsibilities of the Health System or Hospital including, the Chief Executive Officer, the Chief Medical Officer, the Chief Nursing Officer, the Chief Operations Officer, or their respective designees

3. "Adverse Actions" are limited to the following actions or recommendations:

    a. Recommended denial of initial appointment to the Medical Staff;

    b. Recommended denial of reappointment to the Medical Staff;

    c. Recommended revocation of Medical Staff Membership;

    d. Recommended denial of an initial or reappointment request for some or all Privileges;

    e. Recommended revocation, restriction or reduction of some or all Privileges;

    f. Reduction of Privileges for a period in excess of thirty (30) days;

    g. Recommended suspension of Privileges for more than thirty (30) days;

    h. Recommendation for involuntary imposition of a mandatory concurrent consultation requirement that restricts the Practitioner's, or Physician Assistant's Privileges (i.e., based on the Practitioner's, or Physician Assistant's professional competence, the consultant or proctor must approve a course of treatment recommended by the Practitioner, or Physician Assistant in advance, a proctor must be present and observe procedures, or a proctor may direct care or intervene with or stop a procedure) for longer than thirty (30) days;

    i. Summary suspension or restriction of Medical Staff Membership and/or Privileges for longer than thirty (30) days;

    j. Limitation of the right to admit patients for more than thirty (30) days, unless based upon a reduction of Medical Staff category not related to an adverse determination as to a Practitioner's competence or professional conduct;

    k. Immediate imposition of a mandatory proctoring requirement, for a period for more than thirty (30) days, which materially restricts the Practitioner's or Physician Assistant's Privileges;

    l. Immediate imposition of a mandatory concurrent consultation requirement for more than thirty (30) days that restricts the Practitioner's or Physician Assistant's Privileges (i.e., based on the Practitioner's or Physician Assistant's professional

competence, the consultant or proctor must approve a course of treatment recommended by the Practitioner or Physician Assistant in advance, a proctor must be present and observe procedures, or a proctor may direct care or intervene with or stop a procedure);

m. Suspension or revocation of all or some of a Practitioner's or Physician Assistant's Temporary Privileges for more than thirty (30) days;

n. Recommendation to suspend or revoke all or some of a Practitioner's or Physician Assistant's Temporary Privileges for more than thirty (30) days;

o. Recommendation to deny a Practitioner's or Physician Assistant's request for reinstatement following a leave of absence; and/or

p. Any other Adverse Action that must by law be reported by the Hospital to the National Practitioner Data Bank, regardless of whether the Practitioner or any other individual or entity may have a separate reporting obligation.

4. "Allied Health Professional" (AHP) means an individual (other than a Physician (M.D. or D.O.), Dentist (D.D.S. or D.M.D.), or Podiatrist (D.P.M.)) who is licensed or certified to practice a health care profession and may be credentialed pursuant to these Bylaws and the Credentials Manual, but is not eligible for Medical Staff Membership or entitled to certain rights granted Medical Staff Members pursuant to these Bylaws.

5. "Anesthesia Services" means services that involve the administration of a medication to produce a blunting or loss of: pain perception (analgesia); voluntary and involuntary movements; autonomic function; and loss of memory and/or consciousness. "Anesthesia" does not include: (1) analgesia, use of a medication to provide relief of pain through the blocking of pain receptors in the peripheral and/or central nervous system where the patient does not perceive pain to the extent that may otherwise prevail, but the patient does not lose consciousness; (2) topical anesthesia; or (3) local anesthesia.

6. "Approval Date" means the date these Bylaws are approved by the voting Members of the Medical Staff and approved by the Board.

7. "Attending Provider" means the Practitioner or Independent AHP granted admitting Privileges who is the patient's primary treating provider and who shall be responsible for the oversight the patient's overall medical care at the Hospital during the patient's inpatient or outpatient admission, including without limitation granting approval of an inpatient Hospital stay and coordination of consultations and diagnostic services.

8. "Basic Qualifications" means the minimum qualifications that a Practitioner or Physician Assistant must demonstrate in order to have an application for Medical Staff Membership and/or Privileges accepted for review, and to maintain Medical Staff Membership and Privileges.

9. "Board" means the Health System's Board of Directors.

10. "Campus" denotes the sites that include the licensed Hospitals operated by Franciscan Health System known as St. Anne Hospital, St. Anthony Hospital, St. Clare Hospital, St. Elizabeth Hospital (a Critical Access Hospital), St. Francis Hospital, and St. Joseph Medical Center.

11. “Campus Chief of Staff” means the chief elected officer of the Campus Medical Staff or the Campus Chief of Staff’s designee. The Campus Chief of Staff’s designees shall include the Campus Chief of Staff-Elect, the Campus Secretary/Treasurer, the immediate Past Campus Chief of Staff, the Campus Member At Large, or if the listed designees are unavailable then other such Medical Staff Members designated by the Medical Staff President and Chief Medical Officer.

12. “Campus Chief of Staff-Elect” means the elected successor to the Campus Chief of Staff of the Campus Medical Staff or the Campus Chief of Staff Elect’s designee.

13. “Chief Executive Officer” or “CEO” means the individual appointed by the Board to act on its behalf in the overall administrative management of the Health System, or the Chief Executive Officer’s designee. The Chief Executive Officer’s designees shall include the Chief Medical Officer, or other such persons designated by the Chief Executive Officer.

14. “Chief Medical Officer” or “CMO” means the Practitioner appointed by the Health System to provide administrative support and leadership for the Medical Staff, and serve as a liaison among the Administration, the Medical Staff Officers, and the Medical Staff, or the Chief Medical Officer’s designee. The Chief Medical Officer’s designees include the Hospital Chief Medical Officers, or other such Medical Staff Members designated by the Chief Medical Officer.

15. “Clinical Privileges” or “Privileges” refers to permission granted by the Board, acting upon Medical Executive Committee recommendations, to Practitioners, Independent AHPs and Physician Assistants to render specific types of care to inpatients and outpatients, with reasonable access to and use of Hospital equipment, facilities, and Hospital personnel necessary to effectively exercise such Privileges, at Hospital facilities.

16. “Credentials Manual” means the Health System policy adopted in accordance with these Bylaws, which outlines the uniform credentialing process for individual Practitioners and Allied Health Professionals.

17. “Credentialing” means a Peer Review process that includes obtaining and verifying the contents of a completed initial application for Medical Staff Membership and Privileges or designation as an AHP through the Medical Staff process. Re-Credentialing is the process of obtaining and verifying the contents of a completed reappointment application for Medical Staff Membership and Privileges, or designation through the Medical Staff process as an Independent AHP or Dependent AHP. Contents that were verified initially and are static, such as education, will not be re-verified.

18. “Critical Access Hospital” means a hospital that meets the definition of “critical access hospital” set forth at section 1820(c)(2) of the Social Security Act and is certified as a critical access hospital by the Centers for Medicare & Medicaid Services.

19. “Date of Receipt” means the date any Notice, Special Notice or other communication was delivered personally or electronically; or if such Notice, Special Notice or communication was sent by mail, it shall mean 72 hours after the Notice, Special Notice or communication was deposited, postage prepaid, in the United States mail. (See also, the definitions of “Notice” and “Special Notice” below).

20. “Department” means a subunit of a Division, composed of at least 10 Practitioners in the Division practicing in the same or similar specialty at a Hospital, as approved by the Campus

Medical Staff Leadership Council, the Division Chair, and the Medical Executive Committee.

21. "Department Head" means the principal elected officer of the Department, or the Department Head's designee. The Department Head's designees shall include the Department Vice-Head (if applicable), or if the listed designees are unavailable then other such Medical Staff Members designated by the Medical Staff President and Chief Medical Officer.

22. "Dependent Allied Health Professional" or "Dependent AHP" means an individual who is not a Licensed Independent Practitioner who is appropriately licensed or trained to practice a health care profession and has been given permission by the Health System to provide specific patient care services, under the supervision of, or at the request of, the Practitioner who is responsible for both the patient's care and supervision of the Dependent AHP. A Dependent AHP may be credentialed pursuant to these Bylaws and the Credentials Manual, but is not eligible for Medical Staff Membership or entitled to certain rights granted to Medical Staff Members pursuant to these Bylaws. Dependent AHPs categories are defined in the Credentials Manual, and include Physician Assistants.

23. "Distant-Site Ambulatory Care Organization" means a Medicare-participating or Joint Commission accredited entity that is not a hospital but furnishes Virtual Health Services as a Distant-Site, such as an imaging center, urgent care center, or medical practice.

24. "Distant Site Hospital" means a Medicare-participating or Joint Commission accredited hospital.

25. "Division" means any structural unit of the Medical Staff in which the Division Chair is responsible for recommending Privileges for Practitioners, Independent AHPs, and Physician Assistants in the Division to the Medical Executive Committee. The Divisions of the Franciscan Medical Staff include: Medicine, Surgery, and Women & Children.

26. "Division Chair" means the principal elected officer of the Division, or the Division Chair's designee. The Division Chair's designees shall include the Department Heads, Campus Chief of Staff, or if the listed designees are unavailable then other such Medical Staff Members designated by the Medical Staff President and Chief Medical Officer.

27. "Effective Date" means the date these Bylaws become effective, at least two (2) months after the Approval Date, and following the election or selection of the Medical Staff Officers, Medical Staff leaders, and Medical Staff committee chairs who serve on the Medical Executive Committee, in accordance with these Bylaws.

28. "Electronic Signature" or "E-Signature" means a digital or electronic signature ("e-signature"), which evidences an intent to be bound, whether transmitted by fax machine, in the form of an electronically scanned image (e.g. in pdf form), by e-mail, or by other means of e-signature technology approved by the Health System.

29. "Ex Officio" means service on a committee or in a Medical Staff leadership role by virtue of office or position held. An *Ex Officio* appointment is without a vote unless specified otherwise.

30. "Focused Professional Practice Evaluation" or "FPPE" means the time-limited evaluation of a Practitioner's or Physician Assistant's competence in performing a specific Privilege.

31. "For Cause FPPE" means FPPE that is implemented whenever a question arises regarding

a Practitioner's or Physician Assistant's medical or clinical knowledge, ability to provide safe, high-quality patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, or systems-based practice.

32. "General Qualifications" means the deliberative qualifications a Practitioner or Physician Assistant must demonstrate in order to have and to maintain Medical Staff Membership and/or Privileges as defined in Article I Section 3.

33. "Good Standing" means the individual is not the subject of a current corrective action investigation, is not the subject of a pending recommendation for adverse action by the Medical Executive Committee, and does not have the individual's Privileges voluntarily resigned or limited while under investigation, or involuntarily limited, restricted, suspended or otherwise encumbered for disciplinary cause or reason.

34. "Health System" or "System" refers to the Franciscan Health System, operated by Virginia Mason Franciscan Health, a member of CommonSpirit Health.

35. "Hospital" denotes the licensed hospital of each of the six Campus sites, including St. Anne Hospital, St. Anthony Hospital, St. Clare Hospital, St. Elizabeth Hospital, St. Francis Hospital, and St. Joseph Medical Center.

36. "Independent Allied Health Professional" or "Independent AHP" means a Licensed Independent Practitioner other than a Physician (M.D. or D.O.), Dentist (D.D.S. or D.M.D.), or Podiatrist. An Independent AHP practices within the scope of their license, consistent with individually granted Clinical Privileges. An Independent AHP may be credentialed pursuant to these Bylaws and the Credentials Manual, but is not eligible for Medical Staff Membership or entitled to certain rights granted to Medical Staff Members pursuant to these Bylaws. Independent AHPs include but are not limited to Advanced Registered Nurse Practitioners (ARNP), and Clinical Psychologists. Residents are not Independent AHPs.

37. "Initial FPPE" means FPPE that is implemented for all initial appointments and newly requested Privileges.

38. "Investigating Committee" means the individual, or standing or ad hoc committee, including the Medical Executive Committee or Professional Performance Committee, designated or appointed to conduct an Investigation.

39. "Investigation" or "Formal Investigation" means the Peer Review process of gathering and reviewing information related to a concern regarding the competence, professional conduct, or quality and appropriateness of care provided by a Practitioner or Physician Assistant, which is undertaken after approval by the Medical Executive Committee or Board to initiate an Investigation.

40. "Joint Conference" means a meeting between representatives of the Medical Staff and the Medical Executive Committee or between representatives of the Medical Executive Committee and the Board to address and resolve conflicts.

41. "Licensed Independent Practitioner" means an individual permitted by law and by the Health System to provide care, treatment, and services without direction or supervision. A Licensed Independent Practitioner practices within the scope of their license, consistent with individually granted Privileges. Residents are not Licensed Independent Practitioners.

42. “Medical Executive Committee” means the committee composed of selected or elected representatives from each Campus, as set forth in Article VI, Section 2, who are authorized to act on behalf of the Medical Staff, as set forth in these Bylaws.

43. “Medical Staff” means the Franciscan Health Medical Staff, which is a self-governing body, accountable to the Board, that operates under these Bylaws, the Policies and Manuals. The Medical Staff is composed of Practitioners, recommended by the Medical Staff (through the Medical Executive Committee) and approved by the Board.

44. “Medical Staff Compact” means the document approved by the Medical Executive Committee and each Campus Medical Staff Leadership Council that sets out the goals and responsibilities of the System and the Medical Staff, and is included in the application for initial appointment and reappointment.

45. “Medical Staff President” means the person elected to serve as the lead administrator for the Medical Staff, or the Medical Staff President’s designee. The Medical Staff President’s designees shall include the Medical Staff Vice-President, the Immediate Past Medical Staff President, or other such Medical Staff Officers designated by the Medical Staff President.

46. “Medical Staff Secretary/Treasurer” means the individual appointed by the Medical Executive Committee, or the Medical Staff Secretary/Treasurer’s designee. The Medical Staff Secretary/Treasurer’s designees include the Campus Secretary/Treasurers, or if the listed designees are unavailable then other such Medical Staff Members designated by the Medical Staff President and Chief Medical Officer.

47. “Medical Staff Self-Governance Contact” means attendance at 50% or more of the Department meetings in a Medical Staff Year.

48. “Medical Staff Services Office” or “MSSO” means the Health System’s department that provides administrative and technical support for the Medical Staff. All notices to or from the Regional Credentials Committee, Professional Performance Committee, Medical Executive Committee, or other Medical Staff committees may be submitted to or by the Medical Staff Services Office on behalf of the committee.

49. “Medical Staff Treasury” means a line of accounting maintained by the Health System for each Campus Medical Staff, which is funded through application fees for the Campus.

50. “Medical Staff Year” means the period from July 1 through June 30.

51. “Member” means any Practitioner, other than an Independent AHP, who has been appointed to the Medical Staff.

52. “Membership” means having the duly appointed status of being a Member of the Medical Staff.

53. “Mentor” means a Medical Staff Member assigned by the Department Head to a new Medical Staff Member upon initial appointment to facilitate the welcome and orientation of the new Medical Staff Member.

54. “Military Status” a Medical Staff Member who is an active duty physician, dentist, or podiatrist at a military facility with which the Health System has a Resource Sharing Agreement to provide services to patients within the jurisdiction of the military facility. Military

Status does not apply to Off Duty Civilian Employment. See Article II Section 5.

55. “Notice” means a written communication delivered personally to the addressee or sent by United States mail, postage prepaid, or by facsimile or by electronic transmission addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the System. (See also, the definitions of “Date of Receipt” above and “Special Notice” below).

56. “Ongoing Professional Practice Evaluation (OPPE)” means the summary of routine and ongoing data collected for the purpose of assessing a Practitioner’s, Independent AHP’s or Physician Assistant’s clinical competence and professional behavior. The information gathered during the OPPE process is factored into decisions to maintain, revise, or revoke existing Clinical Privileges prior to or at the end of the reappointment cycle.

57. “Past Campus Chief of Staff” means the immediate past chief elected officer of the Campus Medical Staff.

58. “Patient Contact” means an admission, an on-site consultation (including radiology or pathology consultations), or a surgery or procedure furnished at one or more of the Hospitals. A Medical Staff Self-Governance Contact is also counted as a Patient Contact, except as noted below for Affiliate Staff Category. A Virtual Health Service is not counted as a Patient Contact.

59. “Peer Review” or “Professional Review” means the entire process to evaluate the competence, professional conduct of, or the quality and appropriateness of care provided by Practitioners and AHPs, including Credentialing, Privileging, Focused Professional Practice Evaluation (FPPE), Ongoing Professional Practice Evaluation (OPPE), and actions relating to the authorization to provide patient care in the Hospital.

60. “Policies and Manuals” means the Rules and Regulations, the Credentials Manual, the Organizational Manual, and any other rules that are determined necessary by the Medical Executive Committee to further define the general policies contained in these Bylaws.

61. “Practitioner” means, unless otherwise expressly limited, any currently licensed Physician (M.D. or D.O.), Dentist (D.D.S. or D. M.D.), Podiatrist (D.P.M.), or Independent AHP.

62. “Primary Campus” means the Campus where a Practitioner or AHP has or will: (i) focus the Practitioner’s or AHP’s practice, which may be evidenced by the Campus where the Practitioner or AHP has the most Patient Contacts, (ii) engage in Medical Staff and Department activities, and exercise prerogatives appropriate to the Practitioner’s Medical Staff Category (including for Active and Associate Medical Staff Members, the eligibility to vote for Campus-based elections and eligibility to serve as a Medical Staff leader for the Campus), and (iii) participate in on-call schedules for the Campus, as required under these Bylaws.

63. “Privileging” means a Peer Review process that includes evaluating and assessing the initial request for Privileges or the request for modification of Privileges for Medical Staff Members, Independent AHPs, and Physician Assistants through the Medical Staff process. Re-Privileging is the process of re-evaluating and re-assessing the request for Privileges for Medical Staff Members, Independent AHPs, and Physician Assistants through the Medical Staff process at reappointment.

64. “Proctor” means a Practitioner, ARNP, or PA subject to appropriate Physician supervision who is responsible for the assessment of the skills and knowledge of the Practitioner or Physician Assistant being observed and who meets the qualifications for a Proctor as set forth in the Credentials Manual. The Proctor must be approved in advance by the Department Head. If the observation is being conducted at a Health System Hospital, the Proctor must have Clinical Privileges in the specialty area being proctored. If the observation is conducted outside of a Health System facility, then the Proctor must hold privileges in the specialty area being proctored at the Proctor’s own health care facility. The subject Practitioner or Physician Assistant is solely responsible for all arrangements for the Proctor.

65. “Region or Regional” means the geographic and operational regions of the Health System and the Medical Staff, with the associated Campuses, as set forth in the Credentials Manual.

66. “Scope of Practice” means the permission granted to a Dependent AHP, other than Physician Assistants, by the Medical Executive Committee and the Board to engage in a specific practice at the Hospital under appropriate supervision by a credentialed Active or Associate Medical Staff Member.

67. “Significant Misrepresentation” means a misrepresentation or omission on an application which, if known to the Medical Staff committee, Medical Staff Officer or other Medical Staff leader, may have altered the Credentialing or Privileging review process or outcome.

68. “Special Notice” means a Notice delivered personally to the addressee or sent by certified or registered mail, return receipt requested, or if there is any impediment to the U.S. Postal Service, the Chief Executive Officer, in their sole discretion, have Notice delivered by electronic transmission addressed to the addressee at the last email address provided to the Medical Staff Services Office in accordance with Article I Section 2.1. (See also, the definitions of “Date of Receipt” and “Notice” above).

69. “Sponsor” means the Medical Staff Member in Good Standing identified in a delegation, supervision, or collaboration agreement as providing primary clinical and administrative oversight for a Dependent AHP.

70. “Supervising Practitioner” means one or more Medical Staff Members in Good Standing responsible for the patient’s care and providing clinical supervision of a Dependent AHP. A Supervising Practitioner must have current Medical Staff Membership and/or Privileges to practice in the same Department as the Dependent AHP.

71. “Temporary Privileges” means those Clinical Privileges granted to a Practitioner or AHP for a specified period of time, not to exceed one hundred-twenty (120) days, and under prescribed circumstances. See Article IV Section 2.

72. “Virtual Health Services” is the provision of clinical services to patients by Practitioners from a distance via electronic communication including but not limited to telemedicine and telehealth services.

ARTICLE I. QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP

SECTION 1. NATURE OF MEDICAL STAFF MEMBERSHIP

1.1. Membership on the Medical Staff and Privileges are a privilege and not a right, and may be extended only to those professionally competent Practitioners, except for Independent AHPs, who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the Policies and Manuals. Appointment to the Medical Staff shall confer only such Privileges and prerogatives as have been granted by the Board in accordance with these Bylaws. Independent AHPs are not eligible for Medical Staff Membership.

SECTION 2. BASIC QUALIFICATIONS FOR MEMBERSHIP

2.1. A Practitioner must demonstrate continuous compliance with each of the Basic Qualifications set forth in this section in order to have an application for Medical Staff Membership and/or Privileges accepted for review, and to maintain Medical Staff Membership and Privileges, except for the Honorary Staff category, as noted below. The Practitioner must continuously:

2.1.1. Possess a current and unrestricted Washington State license, except for Practitioners with Military Status.

2.1.2. Possess a current Federal Drug Enforcement Agency (DEA) number applicable to the location with a Washington State address, if practicing medicine, dentistry, or podiatry and the requested Clinical Privileges contemplate prescribing controlled substances.

2.1.3. Demonstrate proof of graduation from an appropriately accredited professional school and completion of an Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), American Dental Association (ADA), or American Podiatric Medical Association (APMA) approved residency program.

2.1.4. Be currently certified and maintain certification by a professional board recognized by the American Board of Medical specialties (ABMS), the AOA, the American Council of Certified Podiatric Physicians & Surgeons (ACCPPS), the American Board of Podiatric Medicine (ABPM), or the American Board of Oral and Maxillofacial Surgeons (ABOMS) or other dental specialty board as required in the applicable Privileges form in the clinical specialty for which Privileges are requested.

a. If not board certified at the time of initial appointment, board certification must be achieved within the timeframe established by the Practitioner's specialty board, or within five (5) years of initial appointment, whichever is shorter.

b. Practitioners may be exempt from the board certification requirements based on continuous Medical Staff Membership as set forth below:

i. Practitioners who were granted Medical Staff Membership at a Campus on or before March 1, 2005, and have continuously

maintained Medical Staff Membership shall be exempt from the board certification requirement.

c. Board certification requirements do not apply to Dentists (other than oral and maxillofacial surgeons) or Honorary Staff.

2.1.5. Have and continuously maintain professional liability insurance coverage, including prior acts coverage for claims made policies that meet the criteria specified by the Board. Minimum professional liability insurance coverage requirements are one million ($1,000,000) per occurrence, and three million ($3,000,000) annual aggregate for each Practitioner. Practitioners with Military Status are exempt from this Section 2.1.5.

2.1.6. Not have been convicted of, or entered a plea of guilty or no contest to any felony within the past ten (10) years.

2.1.7. Not have been convicted of, or entered a plea of guilty or no contest to any misdemeanor involving (a) insurance or health care fraud or abuse, (b) violence, physical abuse or exploitation directed at a person, or (c) violation of law pertaining to controlled substances or illegal drugs, unless the Applicant is enrolled and satisfactorily participating in, or has successfully completed, a program supervised by the Washington Physician Health Program (WPHP), or other program approved by the Medical Executive Committee, within the past ten (10) years.

2.1.8. Attest to reading and agrees to comply with the Disruptive Behavior Policy.

2.1.9. Attest to reading and agrees to comply with the Standards and Expectations for Medical Staff Communication Policy.

2.1.10. Attest to reading and agrees to comply with the Medical Staff Compact.

2.1.11. Be a Member, employee, or subcontractor of the group or person that holds an exclusive or semi-exclusive contract or participates in a closed panel, if requesting Privileges in a Department or service line operated under an exclusive or semi-exclusive contract or a closed panel approved by the Board.

2.1.12. Not be currently excluded or suspended from participation in any federal health care program, including the Medicare, Medicaid, and Tricare programs.

2.1.13. Participate in any vaccination, screening, or personal protective equipment requirements in accordance with Hospital licensure requirements, CMS requirements, accreditation standards, and Health System policy based on the above requirements or standards approved by the Board, unless the Practitioner limits their practice to Virtual Health Services and does not furnish services on-site at the Campuses.

2.1.14. Not have been involuntarily dismissed, terminated or summarily suspended from any medical staff or had Privileges involuntarily terminated, restricted or summarily suspended by any health facility (including any Health System Campus) for reasons of clinical competence or professional conduct, which action was upheld following waiver or exhaustion of any procedural remedies which was reported to the NPDB within the past five (5) years.

2.1.15. Not have voluntarily resigned or surrendered Medical Staff Membership or Clinical Privileges, or failed to renew Membership or Clinical Privileges while under investigation or to avoid investigation or other Peer Review activity by any health facility (including any Health System Campus), which was reported to the NPDB within the past five (5) years.

2.1.16. Provide and maintain a valid physical address, email address, and cell phone number that will be used as a primary methods of communication.

2.2. A Practitioner who does not meet these Basic Qualifications is ineligible to apply for Medical Staff Membership, and the application shall not be accepted for review, except for applicants for the Honorary Staff. If it is determined during the processing that an applicant does not meet all of the Basic Qualifications, the review of the application shall be discontinued. An applicant who does not meet the Basic Qualifications is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific standards that adversely affected such Practitioner. Those comments and requests shall be reviewed by the Medical Executive Committee and the Board, which shall have sole discretion to decide whether to consider any changes in the Basic Qualifications or to grant a waiver as allowed by Section 4 below.

SECTION 3. GENERAL QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP

3.1. In addition to the Basic Qualifications under Section 2, the Practitioner must:

3.1.1. Document the Practitioner's (i) adequate experience, education, and training in the requested Privileges; (ii) current professional competence; (iii) good judgment; and (iv) adequate physical and mental health status (subject to any legally required reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that the Practitioner is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized high professional level of quality of care for this community; and

3.1.2. Be determined (i) to adhere to the lawful ethics of the Practitioner's profession; (ii) to be capable of consistently working in a professional, collaborative, and cooperative manner with others in a hospital setting and refraining from harassment of others so as not to adversely affect patient care or Hospital operations; and (iii) to be willing to participate in and properly discharge Medical Staff responsibilities.

SECTION 4. WAIVER OF QUALIFICATIONS

4.1. The Board has the discretion to deem a Practitioner to have satisfied board certification under Section 2.1.4 above only in the following situations and only as it relates to the following specified areas of Privileges or Membership. The Board has discretion to waive the board certification qualification, following receipt of recommendations from the Professional Performance Committee, and the Medical Executive Committee, if the Board first determines:

4.1.1. The Practitioner has the burden and has demonstrated by clear and convincing evidence that the Practitioner has substantially comparable qualifications;

4.1.2. Waiving the qualification is not inconsistent with applicable laws and accreditation standards;

4.1.3. Waiving the qualification is necessary to serve the best interests of the patients and the System; and

4.1.4. Waiving the qualification fulfills an important patient care need, treatment or service.

4.2. There is no obligation to grant any such waiver, and Practitioners have no right to have a waiver considered and/or granted. A Practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws. The waiver, if granted, may set a waiver period and/or any additional conditions associated with such waiver. If the waiver is granted and the Practitioner does not meet any of the conditions associated with the waiver by any time period/deadline, then Practitioner's Privileges shall be automatically suspended as of the date the Practitioner fails to meet such condition(s)

SECTION 5. NONDISCRIMINATION

5.1. The Health System will not discriminate in granting Medical Staff Membership or Privileges on the basis of any protected class as defined by federal, state, or municipal law, including but not limited to on the basis of race, color, ethnicity, national origin, citizenship, sex, age, disability, religion, creed, veteran's status, sexual orientation, gender identity or gender expression, or other criterion so long as such criterion is unrelated to the delivery of quality and safe patient care or to professional competence or conduct.

SECTION 6. ETHICAL REQUIREMENTS

6.1. A Practitioner accepting Membership on the Medical Staff and Clinical Privileges at any Hospital agrees to comply with Health System and Hospital Policies. As a condition of Medical Staff Membership and Clinical Privileges, each Practitioner agrees that the Practitioner shall not engage in any practice in a Health System facility that causes the Health System or its affiliates to fall out of compliance with the United States Conference of Catholic Bishops' Ethical and Religious Directives for Catholic Health Care Services, (the "Directives") available at http://www.usccb.org/, or cause the Health System or its affiliates to violate any policy or any terms related to the Directives in any agreement applicable to the Health System or its affiliates.

6.2. It is not considered a violation of the Directives if a physician treats a patient in the physician's private practice or informs a patient or patient representative of all their medical options in a care plan, including those medical options that may not be performed in Health System facilities or cause the Health System or its affiliates to fall out of compliance or violate any policy or terms related to said Directives.

SECTION 7. RESPONSIBILITIES OF MEMBERSHIP

7.1. Subject to any other provision of these Bylaws and the Policies and Manuals, Medical Staff Members with appropriate Privileges shall manage and coordinate the patient's care, treatment and services. The Medical Staff Member is not responsible for the actions of other Practitioners, Allied Health Professionals or Health System employees, unless such person is acting under the Medical Staff Member's supervision or sponsorship.

7.2. Each Medical Staff Member must abide by these Bylaws, the Policies and Manuals, Standards of Conduct Policy, Medical Staff Compact, and other policies and procedures of the Health System.

7.3. Each Medical Staff Member granted Privileges to furnish a history and physical examination shall record an appropriate history and physical examination as delineated in the Medical Staff Rules and Regulations. Specifically, a medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon, a podiatrist, or other qualified licensed individual who is granted Privileges to perform a history and physical in accordance with state law and the Rules and Regulations. A history and physical prepared by another qualified licensed individual shall be countersigned by the Attending Provider, podiatrist, or oral and maxillofacial surgeon.

When the medical history and physical examination is completed within thirty (30) days before admission or registration, the Medical Staff Member must complete and document an updated examination of the patient within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition must be completed and documented by a physician, an oral and maxillofacial surgeon, a podiatrist, or other qualified licensed individual in accordance with state law and the Rules and Regulations. The updated examination documented by another qualified licensed individual shall be countersigned by the Attending Provider, podiatrist or oral and maxillofacial surgeon.

7.4. Each Medical Staff Member and Practitioner granted Clinical Privileges shall notify the Chief Medical Officer through the Medical Staff Services Office immediately (no later than the end of the next business day, unless otherwise stated below) when it relates to any of the following:

7.4.1. Loss of a current and unrestricted Washington State license, except for Practitioners with Military Status.

7.4.2. Professional liability judgments or settlements;

7.4.3. Reports made to the National Practitioner Data Bank;

7.4.4. Changes in malpractice liability insurance coverage

7.4.5. Voluntary or involuntary denial, limitation, suspension, revocation, non-renewal, or probationary conditions for membership at any hospital or health care facility/organization;

7.4.6. Voluntarily or involuntarily denial, limitation, suspension, revocation, non-renewal, or probationary conditions for Clinical Privileges at any hospital or health care facility/organization.

7.4.7. Any investigation or proceeding (hearing or appeal) is initiated by any hospital or health care facility/organization or its medical staff relating to professional conduct, competence or quality of care.

7.4.8. Any investigation, revocation, probation, limitation or other sanction relating to the Practitioner's license by the professional licensing agency for the Medical Staff Member's discipline.

7.4.9. Any investigation, revocation, probation, limitation or other sanction relating to the Practitioner's DEA certification, if applicable.

7.4.10. Loss or lapse of board certification for any reason, or expiration of board admissibility without obtaining board certification, unless exempted under Article I, Sections 2.1.4 or 4. .

7.4.11. Any criminal indictment, criminal conviction, or plea bargain related to any felony.

7.4.12. Any criminal indictment, criminal conviction, or plea bargain related to any misdemeanor involving (a) insurance or health care fraud or abuse, (b) violence, physical abuse or exploitation directed at a person, or (c) violation of law pertaining to controlled substances or illegal drugs, including whether the Practitioner is enrolled and satisfactorily participating in, or has successfully completed, a program supervised by the Washington Physician Health Program (WPHP), or other program approved by the Medical Executive Committee.

7.4.13. Any investigation, exclusion, or suspension from any Federal health care program, including Medicare, Medicaid, and TriCare.

7.4.14. Any change to the Practitioner's physical address, email address, cell phone number, fax number, or other contact information as defined in the Credentials Manual, as applicable, that will be used as the primary methods of communication within 30 days of any changes.

7.5. Current contact information is important for continuity of care and patient safety. Failure to timely update any of the information required under Section 7.4 above may result in an Investigation and/or corrective action.

7.6. Any Medical Staff committee, at its discretion, may require the appearance of a Practitioner during a review or investigation of the clinical course of treatment of a patient or the Practitioner's professional conduct (a "Special Appearance"). If possible, the chair of the meeting should give the Practitioner at least ten (10) days' advance written notice of the time and place of the Special Appearance. In addition, whenever a Special Appearance is requested because of an apparent or suspected deviation from standard clinical practice, notice shall be given by Special Notice, and shall include a statement of the issue involved and that the Practitioner's appearance is mandatory. Failure of a Practitioner to appear at any meeting with respect to which the Practitioner was given notice of a Special Appearance shall (unless excused by such committee chair or the Medical Executive Committee upon a showing of good cause) result in an automatic suspension of the Practitioner's Privileges until the required Special Appearance is made or other action is taken by the Medical Executive Committee. The Practitioner shall not be entitled to the procedural rights described in these Bylaws for an automatic suspension based on failure to attend a Special Appearance under this Section 7.7.

7.7. Each Practitioner and Physician Assistant granted Clinical Privileges shall, at the request of the Professional Performance Committee, Medical Executive Committee, or other individual or committee designated by the Medical Executive Committee will undergo an

examination or assessment by a health care professional(s) acceptable to the requesting committee when questions arise concerning the Practitioner's or Physician Assistant's physical or mental well-being that may affect the safe and competent delivery of care to patients in accordance with the Health System Well-Being Policy. The Practitioner or Physician Assistant will execute a release allowing the requesting individual or committee to discuss with the health care professional(s) the reasons for the examination or assessment, and allowing the health care professional(s) to discuss and report the results of the examination or assessment to the requesting individual or committee.

SECTION 8. MEETING ATTENDANCE

8.1. Each Active and Associate Medical Staff Member is encouraged to attend at least fifty percent (50%) in aggregate of the Medical Staff, Campus Medical Staff, and Department meetings each Medical Staff Year.

8.2. Each Active and Associate Medical Staff Member appointed or elected to serve as a voting Member of a Medical Staff committee is responsible to attend at least fifty percent (50%) of the Medical Staff committee meetings each Medical Staff Year.

8.3. An Active or Associate Medical Staff Member who cannot attend a meeting may request an excused absence for good cause shown, which may be excused in the discretion of the Medical Staff President, Department Head, or committee chair, as applicable.

8.4. Meeting attendance reports will be reviewed with each Medical Staff Member's reappointment.

ARTICLE II. MEDICAL STAFF CATEGORIES

Each Medical Staff Member shall be assigned to a Medical Staff category based upon the qualifications defined in these Bylaws. Medical Staff categories include Active, Associate, Affiliate and Honorary. Each Medical Staff Member shall be assigned a Primary Campus upon appointment. Each Practitioner applying for Medical Staff Membership must meet the Privilege criteria defined by the Credentials Committee for each Privilege requested under the process defined in Article III and the Credentials Manual.

Medical Staff Members with Military Status are subject to the exceptions and responsibilities under Article II Section 5.

SECTION 1. THE ACTIVE STAFF CATEGORY

1.1. Qualifications: In addition to the Basic Qualifications under Article I Section 2, each applicant for the Active Staff Category must meet the following qualifications:

1.1.1. Furnish twelve (12) or more Patient Contacts in each Medical Staff Year, as determined each Medical Staff Year following initial appointment.

1.1.2. Practice in sufficient proximity to the Primary Campus as determined by the Primary Campus Medical Staff Leadership Council to ensure that any patient under the care and supervision of such Practitioner will receive continuous care consistent with their expected needs, particularly in the case of emergencies.

1.1.3. The Primary Campus Medical Staff Leadership Council may make exceptions to the requirement for proximity to the Primary Campus for certain categories of Practitioners who do not have patients under their care and supervision, except for during times when the Practitioner is on the Hospital premises, and who do not maintain a practice outside the Hospital.

1.2. Prerogatives: Appointees to the Active Staff Category have the following prerogatives:

1.2.1. Exercise Clinical Privileges approved by the Board, including admitting Privileges.

1.2.2. Attend Medical Staff meetings, Division and Department meetings, and CME events.

1.2.3. Vote on all matters presented at general and special meetings or for electronic voting of the Medical Staff, and on all matters presented for vote of the Division or Department, or any Medical Staff committee of which they are a Member.

1.2.4. Be nominated for, elected or appointed, and serve as a Medical Staff Officer in accordance with these Bylaws.

1.2.5. Sit on or be the chairperson of any Medical Staff committees if appointed or elected to such committee or position, unless otherwise specified elsewhere in these Bylaws.

1.2.6. Any Active Medical Staff Member has the right to an audience with the Medical Executive Committee, not more than once each Medical Staff Year, to address any difficulty collaborating with, or unresolved issues with, the Active Medical Staff Member's respective Division Chair or Department Head. The audience with the Medical Executive Committee may not be for the purpose of Peer Review, including OPPE and FPPE, which are addressed elsewhere in these Bylaws. The Active Medical Staff Member will submit a Notice to the Medical Executive Committee that describes the issue to be discussed. The Medical Executive Committee may decline the audience if, in the Medical Executive Committee's sole discretion, the issue described in the Notice from the Medical Staff Member has already been addressed. The Medical Executive Committee will provide Notice of the date, time and location of the audience with the Medical Executive Committee to the requesting Active Medical Staff Member and the involved Division Chair or Department Head. An audience with the Medical Executive Committee under this Section 1.2.6 shall not constitute a "hearing" as that term is used in these Bylaws, nor shall the hearing and appeal procedures apply, and the Active Medical Staff Member is not entitled to have an attorney participate in the audience with the Medical Executive Committee.

1.3. Responsibilities: Appointees to the Active Staff Category have the following responsibilities:

1.3.1. Attest to the appropriate Primary Campus where the Active Staff appointee will exercise voting rights and participate in on-call coverage programs, subject to possible reassignment to another Primary Campus by the Campus Medical Staff Leadership Council(s) or the Medical Executive Committee, as set forth in Article VIII Section 1.1.4.

1.3.2. Participate in on-call coverage for the Primary Campus in accordance with the EMTALA Examination, Treatment and Transfer of Individuals in Need of Emergency Services Policy (the "EMTALA Policy") and other specialty coverage programs at the Primary Campus, unless exempted by the Primary Campus Medical Staff Leadership Council. The responsibilities are further defined in the EMTALA Policy and the Rules and Regulations.

1.3.3. Fulfill the basic responsibilities of Medical Staff Membership as set forth in Article I Section 7 of these Bylaws.

SECTION 2. THE ASSOCIATE CATEGORY

2.1. Qualifications: In addition to the Basic Qualifications under Article I Section 2, each applicant for the Associate Staff Category must meet the following qualifications:

2.1.1. Furnish between one (1) and twelve (12) Patient Contacts (provided that the Patient Contacts are not exclusively Medical Staff Self-Governance Contacts) in each Medical Staff Year, as determined each Medical Staff Year following initial appointment.

2.1.2. Practice in sufficient proximity to the Primary Campus as determined by the Primary Campus Medical Staff Leadership Council to ensure that any patient under the care and supervision of such Practitioner will receive continuous care consistent with their expected needs, particularly in the case of emergencies.

2.1.3. The Primary Campus Medical Staff Leadership Council may make exceptions to the practice location for certain categories of Practitioners who do not have patients under their care and supervision, except for during times when the Practitioner is on the Hospital premises.

2.1.4. Provide any information requested by Medical Staff committees to confirm continuous competence and quality, including Healthcare Effectiveness Data and Information Set (HEDIS).

2.2. Prerogatives: Appointees to the Associate Staff Category have the following prerogatives:

2.2.1. Exercise Clinical Privileges approved by the Board, including admitting Privileges.

2.2.2. Attend Medical Staff meetings, Division and Department meetings, and CME events.

2.2.3. Vote on all matters presented at general and special meetings or for electronic voting of the Medical Staff, and on all matters presented for vote of the Division or Department, or any Medical Staff committees of which they are a Member.

2.2.4. Be nominated for, elected or appointed, and serve as Secretary/Treasurer or Campus Member At-Large of the Medical Executive Committee, in accordance with these Bylaws.

2.2.5. Sit on any Medical Staff committees if appointed or elected to sit on such committee, unless otherwise specified elsewhere in these Bylaws.

2.2.6. Be nominated for, and elected to serve as Division Chairs and Department Heads in accordance with these Bylaws.

2.2.7. Associate Staff appointees are not eligible to chair any Medical Staff committee, to be nominated for, elected or appointed, or serve as a Medical Staff President, Medical Staff Vice President, Campus Chief of Staff, or Campus Chief of Staff-Elect.

2.2.8. Any Associate Medical Staff Member has the right to one audience with the Medical Executive Committee each Medical Staff Year to address any difficulty collaborating with, or unresolved issues with, the Associate Medical Staff Member's respective Division Chair or Department Head. The audience with the Medical Executive Committee may not be for the purpose of Peer Review, including OPPE and FPPE, which are addressed elsewhere in these Bylaws. The Associate Medical Staff Member will submit a Notice to the Medical Executive Committee that describes the issue to be discussed. The Medical Executive Committee may decline the audience if, in the Medical Executive Committee's sole discretion, the issue described in the Notice from the Medical Staff Member has already been addressed. The Medical Executive Committee will provide Notice of the date, time and location of the audience with the Medical Executive Committee to the requesting Active Medical Staff Member and the involved Division Chair or Department Head. An audience with the Medical Executive Committee under this Section 2.2.8 shall not constitute a "hearing" as that term is used in these Bylaws, nor shall the hearing and appeal procedures apply, and the Associate Medical Staff Member is not entitled to have an attorney participate in the audience with the Medical Executive Committee.

2.3. Responsibilities: Appointees to the Associate Staff Category have the following responsibilities:

2.3.1. Attest to the appropriate Primary Campus where the Associate Staff appointee will exercise voting rights and participate in coverage programs, subject to possible reassignment to another Primary Campus by the Campus Medical Staff Leadership Council(s) or the Medical Executive Committee, as set forth in Article VIII Section 1.1.4.

2.3.2. If the Primary Campus Medical Staff Leadership Council or Medical Executive Committee determines there is a need for Associate Staff appointees to participate in on-call coverage for the Primary Campus in accordance with the EMTALA - Examination, Treatment and Transfer of Individuals in Need of Emergency Services Policy and other specialty coverage programs at the Primary Campus, unless exempted by the Primary Campus Medical Staff Leadership Council. The responsibilities are further defined in the [EMTALA Policy] and the Rules and Regulations.

2.3.3. Fulfill the basic responsibilities of Medical Staff Membership as set forth in Article I Section 7 of these Bylaws

SECTION 3. THE AFFILIATE CATEGORY

3.1. Qualifications: In addition to the Basic Qualifications under Article I Section 2, each applicant for the Affiliate Staff Category must meet one or more of the following qualifications:

3.1.1. Do not furnish Patient Contacts in the Medical Staff Year other than Medical Staff Self-Governance Contacts, as determined each Medical Staff Year following initial appointment, or

3.1.2. Request only Virtual Health Services Privileges and not have a Medical Staff Self-Governance Contact, or

3.1.3. Maintain a practice located in the service area of the Campus where the Practitioner is seeking Affiliate Staff Category appointment and request permission to follow patients referred to Active or Associate Medical Staff appointees for services furnished at the Hospital, or receive referrals of patients after the patient receives Hospital services and the Practitioner needs access to patient information to promote continuity of care.

3.2. Prerogatives: Appointees to the Affiliate Staff Category have the following prerogatives:

3.2.1. Exercise Clinical Privileges requested and approved by the Board, which are limited Virtual Care Privileges.

3.2.2. Attend Medical Staff meetings, Division and Department meetings, and CME events.

3.2.3. For Affiliate Staff appointees who are granted permission follow their patients, review their own patient's medical record, but not make any entries, write orders, record progress notes or request consultations.

3.2.4. Sit on any Medical Staff committees if appointed or elected to sit on such committee, except for the Medical Executive Committee, the Regional Credentials Committee, the Regional Peer Review Committee, or the Professional Performance Committee.

3.2.5. Affiliate Staff appointees are not eligible to vote on Medical Staff matters, to chair any Medical Staff committee, to be nominated for, elected or appointed, or serve as a Medical Staff President, Medical Staff Vice President, Campus Chief of Staff, Campus Chief of Staff-Elect, Division Chair or Department Head, Secretary/Treasurer, or At-Large Member of the Medical Executive Committee.

3.2.6. Appointees to the Affiliate Staff will be assigned to a Primary Campus upon appointment to the Medical Staff.

3.3. Responsibilities: Appointees to the Affiliate Staff category must fulfill the basic responsibilities of Medical Staff Membership as set forth in Article I Section 7 of these Bylaws, as applicable to any Privileges granted.

SECTION 4. THE HONORARY CATEGORY

4.1. Qualifications: Each applicant to the Honorary Staff Category must meet the following qualifications:

4.1.1. Be selected by the Medical Executive Committee as an individual that the Medical Executive Committee wishes to honor due to a history of sustained professional excellence and leadership within the Medical Staff.

4.1.2. Have been a Medical Staff Member in good standing for at least ten (10) consecutive years at one of the Campuses.

4.2. Prerogatives: Appointees to the Honorary Staff Category have the following prerogatives:

4.2.1. Attend Medical Staff meetings, Division and Department meetings, and CME events.

4.2.2. Attend any Medical Staff committee meetings if requested, appointed or elected to sit on such committee, as a guest or non-voting Member, except for the Medical Executive Committee, the Regional Credentials Committee, the Regional Peer Review Committee, or the Professional Performance Committee.

4.2.3. Honorary Staff appointees are not eligible for Privileges, to vote on Medical Staff matters, to chair any Medical Staff committee, to be nominated for, elected or appointed, or serve as a Medical Staff Officer.

4.2.4. Appointees to the Honorary Staff will be assigned to a Primary Campus upon appointment to the Medical Staff.

4.3. Responsibilities: Appointees to the Honorary Staff Category do not have responsibilities, except for any committee obligations.

SECTION 5. MILITARY STATUS

5.1. A Medical Staff Member in any Medical Staff category under Sections 1 through 3 above with Military Status is: (i) exempt from Washington State medical license requirements under Article I Section 2.1.1, (ii) exempt from professional liability insurance requirements under Article I Section 2.1.5, (iii) exempt from on-call coverage services, and (iv) entitled to expedited leave of absence for any required military service in accordance with Article II Section 3 of the Credentials Manual.

5.2. A Medical Staff Member with Military Status will have a pre-arranged plan of coverage for patients who are hospitalized, but for whom the Medical Staff Member may no longer be available to provide continued care because of a military obligation to ensure that hospitalized patients will have continuous coverage in the event the Medical Staff Member with Military Status has a military assignment, transfer, or deployment with minimal notice. Such arrangement may be made with another Medical Staff Member with Military Status with the same Clinical Privileges who is covered under the Resource Sharing Agreement or a Member of the Active Staff with the same Clinical Privileges. The plan of coverage will be updated to reflect any changes from time to time. The plan of coverage and any updates will be submitted to the CMO and filed in the Medical Staff Member's credentials file

ARTICLE III. CREDENTIALING AND PRIVILEGING

SECTION 1. CLINICAL PRIVILEGES

1.1. The Board shall appoint and reappoint applicants to the Medical Staff and grant initial, renewed, or revised Privileges, considering the Medical Executive Committee's recommendations, in accordance with these Bylaws, and the Credentials Manual, and policies of the Medical Staff as they are established and amended by the Medical Executive Committee with the approval of the Board.

1.2. Appointment to the Medical Staff is granted after a review of the application and all documents related to the applicant. For applicants who meet all of the Basic Qualifications under Article I Section 2, and General Qualifications under Article 1 Section 3.

1.3. Criteria for Privileges are developed by the Regional Credentials Committees, recommended to the Professional Performance Committee, and are subject to approval of the Medical Executive Committee and the Board. Criteria for Privileges are uniformly applied to all applicants, and constitute the basis for granting Medical Staff appointment and Privileges.

1.4. The Medical Staff, through the Division Chair or Department Head, Regional Credentials Committee, Professional Performance Committee, and Medical Executive Committee, shall consider the verified contents of the completed application for appointment and reappointment and the request for Privileges through the basic steps of the processes described in this Article and the associated details forth in these Bylaws and the Credentials Manual.

1.5. The Division Chair or Department Head, Regional Credentials Committee, the Professional Performance Committee, and the Medical Executive Committee shall evaluate the verified contents of the completed application for appointment and reappointment and the request for Privileges before recommending action to the Board.

1.6. The Clinical Privileges recommended by the Medical Executive Committee to the Board shall be based upon the applicant’s education, training, experience, demonstrated competence and judgment, professional conduct, references, and other relevant information for the Privileges requested.

1.7. Any Member of the Medical Staff who wishes to augment or otherwise modify such Member’s Clinical Privileges may be granted such augmentation or modification upon such Member’s demonstration that such Member possesses the requisite training, skill, and experience necessary to competently exercise the Clinical Privileges sought. The procedure for modification of Clinical Privileges shall be that described in the Credentials Manual as established and amended by the Medical Executive Committee with the approval of the Board.

1.8. Appointments and subsequent reappointments, and granting, renewing, or revising Privileges shall be for a period of not more than two (2) years.

1.9. Upon appointment to the Medical Staff each Member will be assigned to a Division, a Primary Campus, and Department, and will be assigned a Mentor by the Department Head to facilitate the welcome, orientation, and development of the new Medical Staff Member.

SECTION 2. APPLICANT’S BURDEN

2.1. The applicant shall have the burden of producing adequate information for a proper evaluation of such applicant’s competence, character, ethics, and other qualifications and

of resolving any doubts about such qualifications. The applicant shall have the burden of providing evidence, if challenged, that all of the statements made and the information given on such applicant's application are factual and true.

SECTION 3. ADMINISTRATIVE REJECTION OF APPLICATION OR REQUEST FORM

3.1. If, at any time, the information received indicates that the applicant does not meet the Basic Qualifications for Membership set forth in Article I Section 2 of these, or the objective eligibility requirements for Privileges requested as set forth in the appropriate application forms (such as completing a fellowship or performing a minimum number of specialized procedures), the application or request will not be processed.

3.2. An application or request for Privileges that contains a Significant Misrepresentation will not be processed.

3.3. An application submitted without the application fee will not be included in the written report from the Division Chair or Department Head to the Regional Credentials Committee under Article III Section 4.5.2 below. The application will be considered incomplete and will be returned to the applicant for submission of the application fee. The applicant will have thirty (30) days from the date the application was returned to submit the application fee.

3.3.1. If the application is for initial Medical Staff appointment or Clinical Privileges, and the application fee is not received within thirty (30) days from the date the application was returned, the application will be considered withdrawn, and the applicant will be so notified.

3.3.2. If the application is for reappointment, and the application fee is not received within thirty (30) days from the date the application was returned, the Medical Staff Services Office will notify the applicant by Special Notice that the applicant's failure to submit the application fee in accordance with these Bylaws shall result in the applicant being deemed to have voluntarily resigned from the Medical Staff and to have relinquished the applicant's Privileges on the date the applicant's then-current appointment and Privileges expire.

3.4. The applicant will be notified in writing that the applicant is not eligible to apply for Medical Staff Membership or to request Privileges, as appropriate, that the applicant's application or request will not be processed, the basis for the administrative rejection, and that the applicant is not entitled to a hearing or appeal under these Bylaws.

SECTION 4. INITIAL APPOINTMENT

4.1. The initial application to the Medical Staff shall be in writing or via electronic application, signed by the applicant, and submitted on a form specified by the Health System. The Health System may accept electronic signature through the approved electronic application.

4.2. The completed application, in accordance with the Credentials Manual, shall be returned to the Medical Staff Services Office within thirty (30) days from the date of issue. Incomplete applications will not be processed and shall be returned to the applicant for completion. The applicant has thirty (30) days to resubmit the completed application. If the

completed application is not received within that time, the application is considered withdrawn, and the applicant will be so notified.

4.3. The Medical Staff, directly or through the Medical Staff Services Office, shall verify from primary sources the information provided by the applicant and collect additional information wherever necessary.

4.4. The completed initial application shall include a minimum of two (2) references from professional peers who have personal knowledge of and are directly familiar with the applicant's professional competency. The reference letter may incorporate the ACGME General Competencies in the professional peer's review of the applicant's request for Privileges and/or appointment to the Medical Staff.

4.5. Division Chair or Department Head

4.5.1. Upon completion of the application, verification of its contents, and receipt of additional information, the credentials file with all related materials will be forwarded to the appropriate Division Chair or Department Head for evaluation, as applicable.

4.5.2. The Division Chair or Department Head shall review the applicant's application, credentials file, and all other relevant information, and shall provide a summary of the review and recommendations to the Regional Credentials Committee. The Division Chair or Department Head shall determine if the education, training, experience, demonstrated competence, health status, and all other information in the credentials file supports the applicant's request for Privileges and/or appointment to the Medical Staff. The Division Chair or Department Head's review of the applicant's request for appointment to the Medical Staff and/or Privileges may incorporate the ACGME General Competencies. The Division Chair or Department Head's comments and recommendations will be documented in the applicant's credentials file.

4.5.3. A list of the Division Chair or Department Head's recommendations with any comments will be forwarded to the applicable Campus Medical Staff Leadership Council of all applications for appointment, reappointment, or Privileges for the applicable Campus for informational purposes. The Campus Medical Staff Leadership Council may, but is not required to, provide comments to the Regional Credentials Committee regarding any applicant.

4.5.4. All applications submitted without the application fee will be addressed in accordance with Section 3.3 above.

4.6. Regional Credentials Committee

4.6.1. The Regional Credentials Committee will receive the summary and recommendation from the Division Chair or Department Head and comments, if any, from the Campus Medical Staff Leadership Council.

4.6.2. Based on the information in the applicant's credentials file and the Division Chair or Department Head's summary and recommendation, the Regional Credentials Committee may:

a. Recommend approval of appointment to the Medical Staff and all requested Privileges;

b. Recommend denial of Medical Staff Membership and/or all or some of the requested Privileges;

c. Recommend mandatory Initial FPPE for initial appointments and new Clinical Privilege requests;

d. Recommend For Cause FPPE related to initial appointments and new Clinical Privilege requests in addition to mandatory Initial FPPE, if deemed appropriate; or

e. Request any additional information to assist in its deliberations, and/or request an interview with the applicant.

4.6.3. Within thirty (30) days of receipt of completed summary and recommendation from the Division Chair or Department Head, the Regional Credentials Committee shall provide a written report of the review and recommendation to the Professional Performance Committee. If the report is adverse to the Practitioner, the report shall include the reasons for such adverse report.

4.7. Professional Performance Committee

4.7.1. The Professional Performance Committee will review the report and recommendation from the Regional Credentials Committee, and may take the following actions:

a. Recommend appointment to the Medical Staff and all requested Privileges, and assignment to a Division and Department, in accordance with the recommendation of the Regional Credentials Committee;

b. Recommend denial of Medical Staff Membership and/or all or some of the requested Privileges;

c. Amend the recommendation of the Regional Credentials Committee; or

d. Request any additional information to assist in its deliberations, refer a matter back to the Regional Credentials Committee, or take other action as allowed in the Credentials Manual.

4.7.2. Within thirty (30) days of receipt of written report of the review from the Regional Credentials Committee, the Professional Performance Committee shall provide a written report to the Medical Executive Committee for all applications for which the application fee has been submitted. If the report is adverse to the practitioner, the report shall include the reasons for such adverse report.

4.8. Medical Executive Committee

4.8.1. The Medical Executive Committee at its next regularly scheduled meeting, will consider the written report and recommendations of the Professional Performance Committee. Based upon the report the Medical Executive Committee may:

a. Recommend approval of appointment to the Medical Staff and all requested Privileges.

b. Recommend denial of Medical Staff Membership and/or all or some the requested Privileges; or

c. Request any additional information to assist in its deliberations, refer a matter back to the Professional Performance Committee, or take other action as allowed in the Credentials Manual.

4.8.2. Within thirty (30) days of receipt of written report of the review from the Professional Performance Committee, the Medical Executive Committee will provide a written report and recommendation (with or without comment) to the Board.

4.8.3. If the recommendation is adverse to the applicant, the Medical Staff President shall promptly notify the applicant by Special Notice of the decision and the reasons for the recommendation, and inform the applicant of their right to hearing and appeal under Article XII of these Bylaws. The Board shall be generally informed of, but shall not receive detailed information and shall not take action on, the pending adverse recommendation until the applicant has exhausted or waived the applicant's procedural rights under these Bylaws.

4.9. The Board

4.9.1. The Board, at its next regularly scheduled meeting, shall review the report from the Medical Executive Committee regarding applications for appointment or reappointment and initial granting, revisions or revocation of Clinical Privileges, except for those Practitioners who have an adverse recommendation who are entitled to hearing and appeal under Article XII.

4.9.2. The Board makes the final decision on all Medical Staff applications for appointments and reappointments, and the granting, revision, or denial of Clinical Privileges. The Board is not bound by the recommendations of the Medical Executive Committee.

4.9.3. Within fifteen (15) days of the final decision of the Board, the Chief Executive Officer, or a representative of the Board, shall inform the applicant in writing of the Board's decision.

4.9.4. If the recommendation of the Board is adverse to the applicant, following a favorable recommendation from the MEC, the Chief Executive Officer or Board Chair or designee shall promptly notify the applicant by Special Notice of the decision and the reasons for the recommendation, and inform the applicant of their right to hearing and appeal under Article XII of these Bylaws.

SECTION 5. REAPPOINTMENT

5.1. Reappointment to the Medical Staff shall be made by the Board. The Board shall act on the reappointment application upon receipt of a recommendation from the Medical Executive Committee.

5.2. Reappointment to the Medical Staff, or renewal or revisions of Clinical Privileges, shall be required on at least a biennial basis.

5.3. The Medical Staff Services Office will initiate the reappointment process at least six (6) months prior to the expiration of the current appointment.

5.4. The procedure for reappointment to the Medical Staff shall be that described in the Credentials Manual as established and amended by the Medical Executive Committee with the approval of the Board.

5.5. The Member applying for reappointment shall have the burden of providing adequate information for a proper evaluation of such Member's competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications. Such Member shall have the burden of providing evidence, if challenged, that all of the statements made and the information given on such Member's application for reappointment are factual and true. Each recommendation concerning reappointment of a Member to the Medical Staff shall be based upon the standards set forth in these Bylaws, and the Credentials Manual, including:

5.5.1. The Member's professional ethics, competence, and clinical judgment in the treatment of patients as indicated by the Member's practice at the Health System, information obtained from other hospitals, health care facilities, and health plans, and updated information with respect to such Member's professional liability experience.

5.5.2. The Member's physical and mental capacity to treat patients.

5.5.3. The Member's compliance with these Bylaws and other Medical Staff documents.

5.5.4. The Member's use of the Health System's facilities for such Member's patients, such Member's cooperation and relations with other practitioners, and such Member's general attitude toward patients, the Health System and the public.

5.5.5. The Member's meeting attendance in accordance with Article I Section 8.

5.6. Timely Applications for Reappointment

5.6.1. The completed application for reappointment shall be returned to the Medical Staff Services Office within thirty (30) days from the date of issue under Section 5.3 above. Incomplete reappointment applications will not be processed and shall be returned to the applicant for completion. The applicant has thirty (30) days from the date the application was returned to resubmit the completed application for reappointment.

5.6.2. If a completed application for reappointment is not returned within sixty (60) days of the date of issue under Section 5.3 above, the Medical Staff Services Office will notify the applicant by Special Notice that the applicant's failure to return the completed application for reappointment in accordance with these Bylaws shall result in the applicant being deemed to have voluntarily resigned from the Medical Staff and to have relinquished the applicant's Privileges on the date the applicant's then-current appointment and Privileges expire.

5.6.3. If a Medical Staff Member submits a completed application for reappointment, which is received less than ninety (90) days before the first day of the month the then-current appointment and Privileges expire, the application for reappointment will not be processed due to insufficient time to obtain required verifications and documentation necessary for the Division Chair or Department Head, Regional Credentials Committee, Professional Performance Committee, Medical Executive Committee, and Board to review. The Medical Staff Member shall be deemed to have voluntarily resigned from the Medical Staff and to have relinquished the Medical Staff Member's Privileges on the date the Member's then-current appointment and Privileges expired. The former Medical Staff Member's application will be processed as a new applicant without seniority.

5.6.4. If a Member is deemed to have voluntarily resigned or relinquished Privileges under this Section 5.6 of these Bylaws, the Member shall not be entitled to any Automatic Actions, Hearings and Appeals under Article XII of these Bylaws.

5.7. The Medical Staff Services Office will forward the timely, complete reappointment application, and accompanying documents for evaluation and review by the Division Chair or Department Head, as applicable.

5.8. Review by the Division Chair or Department Head, Campus Medical Staff Leadership Council, Regional Credentials Committee, Professional Performance Committee, Medical Executive Committee, and approval by the Board will follow the same procedure outlined in Article III, Sections 4.5 through 4.9 above.

5.9. All applications for reappointment submitted without the application fee will be addressed in accordance with Article III Section 3.3 above.

5.10. Reappointment Recommendations

5.10.1. The reappointment recommendation shall be written or electronically entered and shall specify whether the applicant's appointment should be renewed; renewed with modified Membership category, Department affiliation, and/or Privileges; or terminated. The Medical Staff may require additional proctoring as Initial FPPE of any Privileges that are used so infrequently as to make it difficult or unreliable to assess current competency. If such proctoring requirements are imposed solely for lack of activity, the initial proctoring requirement itself is not reportable to the National Practitioner Data Bank and shall not result in any hearing or appeal rights under Article XII of these Bylaws.

5.10.2. If the recommendation is adverse to the applicant, the Chief Executive Officer or Board Chair or designee shall promptly notify the applicant by Special Notice of the decision and the reasons for the recommendation, and inform the applicant of their right to hearing and appeal under Article XII of these Bylaws.

SECTION 6. CLOSED PANEL, EXCLUSIVE AND SEMI-EXCLUSIVE CONTRACTS

6.1. To promote quality care, patient safety, efficiency, adequate coverage, or compliance with accreditation standards, the Health System or a Hospital may elect to close a service line or program as "closed panel" or enter into exclusive or semi-exclusive contracts with groups or individual practitioners to provide professional services in the service line or program on an exclusive basis.

6.2. Through a closed panel arrangement, the Health System or Hospital may close the service line or program and limit the grant and exercise of Clinical Privileges in the service line or program to those practitioners who meet certain objective qualifications or comply with objective requirements for accreditation or staffing under the closed panel requirements, as adopted and amended from time to time. Examples of a closed panel include Hospital programs that are seeking or have been awarded status as a "Center of Excellence" ("COE") in accordance with nationally recognized standards, where the COE status requires that all practitioners meet certain objective qualifications (such as subspecialty board certification) or comply with objective COE requirements (such as documentation or response times).

6.3. To be eligible to apply for or exercise Clinical Privileges in a program or service line operated as a closed panel, a practitioner must continuously meet the objective qualifications and comply with the closed panel requirements. See Article I, Section 2, Basic Qualifications and Article XI, Section 3, Automatic Suspension and Termination. If a Medical Staff Member fails to maintain the objective qualifications or to comply with the closed panel requirements, the Medical Staff Member's ability to exercise Clinical Privileges in the closed panel will be automatically suspended in accordance with Article XI, Section 3, Automatic Suspension and Termination.

6.4. The Health System or Hospital may enter into a contract with group or individual practitioners to provide professional services in a service line or program on an exclusive or semi-exclusive basis. "Semi-exclusive" contracts may be used to arrange for more than one group or individual provider to be the exclusive providers of professional services in a service line or program.

6.5. To be eligible to apply for or exercise Clinical Privileges in a service line or program operated under an exclusive or semi-exclusive contract, the practitioner must be and remain a Member, employee, or subcontractor of the group or person that holds the exclusive or semi-exclusive contract for a service line or program. See Article I, Section 2, Basic Qualifications and Article XI, Section 3, Automatic Suspension and Termination. If a Medical Staff Member fails to maintain the Member's status as a Member, employee, or subcontractor of the group or person that holds the exclusive or semi-exclusive contract for a service line or program, the Member's ability to exercise Clinical Privileges in the service line or program will be automatically suspended in accordance with Article XI, Section 3, Automatic Suspension and Termination.

6.6. The Medical Executive Committee, upon reasonable request of the Hospital or Health System Administration or the Board of Directors, will provide recommendations regarding appropriate qualifications, clinical standards for quality care, patient safety, efficiency, adequate coverage, or compliance with accreditation standards for an initial closed panel or exclusive or semi-exclusive contract or the renewal of a closed panel or exclusive or semi-exclusive contract.

SECTION 7. REMOTE PROVIDER AND VIRTUAL HEALTH SERVICES PRIVILEGES.

7.1. In order to meet patient care needs, the Health System or a Hospital may enter into agreements with practitioners, hospitals, or other health care entities to provide clinical services (including but not limited to interpretive and, diagnostic, or consultant services) through remote providers using Virtual Health Services technology. In such instances, the individual practitioners must be granted appropriate Clinical Privileges by the Health System, but they are not required to be Members of the Medical Staff.

7.2. Specific Clinical Privileges for the diagnosis and treatment of patients at the Hospitals through Virtual Health Services must be developed and delineated based upon commonly accepted quality standards.

7.3. If the agreement for Virtual Health Services is with an individual Practitioner, the Practitioner must apply for and be granted Clinical Privileges in the manner outlined for Members of the Medical Staff in Article III, Section 4 above.

7.4. Reliance on Distant-Site Credentialing Information

7.4.1. If the agreement for Virtual Health Services is with a Distant-Site Hospital or Distant-Site Ambulatory Care Organization, the Health System may rely on the Credentialing information furnished by the Distant-Site Hospital or Distant-Site Ambulatory Care Organization with whom the Health System has an agreement for Virtual Health Services.

7.4.2. Applicants based at a Distant-Site Hospital or Distant-Site Ambulatory Care Organization who intend to provide Virtual Health Services under a written agreement with the Health System under this Article III Section 7 must submit an application as directed by the Medical Staff Services Office.

7.4.3. The Health System will query the National Practitioner Data Bank.

7.4.4. The Health System will obtain a Washington State Patrol background check.

7.5. In all cases, the Practitioner must hold a license to practice in the state of Washington.

7.6. In all cases review of the application by the Division Chair or Department Head, Campus Medical Staff Leadership Council, Regional Credentials Committee, Professional Performance Committee, Medical Executive Committee, and approval by the Board will follow the same procedure outlined in Article III Sections 4.5 through 4.9 above.

7.7. If the Health System has not entered into a written agreement for Virtual Health Services with a Distant-Site Hospital or Distant-Site Ambulatory Care Organization, but the Health System has a pressing clinical need for Virtual Health Services and a Distant-Site Practitioner can supply such services via a Virtual Health Services link, the Distant-Site Practitioner may be granted Temporary Privileges to provide Virtual Health Services for a limited time in accordance with Article IV Section 2 of these Bylaws.

SECTION 8. TIME PERIOD FOR PROCESSING

8.1. The time periods in this Article III are guidelines and are not directives that create any rights for an applicant to have an application processed within these precise periods. The processing may be delayed or discontinued in the event of an incomplete application, as noted above. If action at a particular step in the process is delayed without good cause, the next higher authority may immediately proceed to consider the application upon its own initiative or at the direction of the Chief of Staff or the Chief Medical Officer.

ARTICLE IV. CLINICAL PRIVILEGES

SECTION 1. GENERAL

1.1. The Clinical Privileges recommended to the Board shall be based upon the applicant's education, training, experience, demonstrated competence and judgment, references, and other relevant information.

1.2. The procedure for assignment and modification of Clinical Privileges shall be that described in the Credentials Manual as they are established and amended by the Medical Executive Committee with the approval of the Board.

1.3. Any Member of the Medical Staff who wishes to augment or otherwise modify such Member's Clinical Privileges may be granted such augmentation or modification upon such Member's demonstration that such Member possesses the requisite training, skill, and experience necessary to competently exercise the Clinical Privileges sought. The procedure for modification of Clinical Privileges shall be that described in the Credentials Manual and these Bylaws.

SECTION 2. TEMPORARY CLINICAL PRIVILEGES

2.1. Under certain circumstances, Temporary Privileges may be granted for a limited period of time. The Medical Staff must review the qualifications of any Practitioner or AHP who requests Temporary Privileges and assure that the available information supports the granting of the Temporary Privileges. The nature of the Medical Staff review of an application for Temporary Privileges may vary, depending upon the reason for Temporary Privileges and the specific Privileges the Practitioner or AHP requests. Temporary Privileges may be granted under the following circumstances:

2.1.1. To fulfill an important patient care, treatment, or service need ("Patient Need"). This may include, but is not limited to, providing care, treatment, and services for up to five (5) patients in any twelve (12) month period. Such Temporary Privileges shall automatically expire at the earlier of the conclusion of the important patient care need (such as the patient's discharge), or ninety (90) days from the date the Temporary Privileges were granted; or

2.1.2. When an applicant for new Privileges, including an application for initial Medical Staff Membership or AHP status and a request for new Privileges from an existing member of the Medical Staff or AHP, with a completed application that raises no concerns, has been reviewed by the Regional Credentials Committee, and is awaiting review and approval by the Medical Executive Committee and the Board ("Completed Application").

2.2. Minimum requirements

2.2.1. A Practitioner or AHP who requests Temporary Privileges to fulfill an important Patient Need under Section 2.1.1 above, must satisfy the following qualifications and requirements:

a. Complete an Application for Temporary Privileges documenting the important patient care, treatment and service need, and provide information regarding the applicant's qualifications and certify the applicant's agreement to abide by these Bylaws. The application fee will not be charged for those applicants seeking Temporary Privileges to fulfill an important patient care need.

b. Possess a current and unrestricted Washington State license, except for Practitioners with Military Status.

c. Have and continuously maintain professional liability insurance coverage, including prior acts coverage for claims made policies that meet the criteria specified by the Board. Minimum professional liability insurance coverage requirements are one million ($1,000,000) per occurrence, and three million ($3,000,000) annual aggregate for each Practitioner. Practitioners with Military Status are exempt from this Section 2.2.1.c

d. Possess a current Federal Drug Enforcement Agency (DEA) number if practicing medicine, dentistry, or podiatry and the requested Temporary Privileges contemplate prescribing controlled substances.

e. Not have been involuntarily dismissed, terminated or summarily suspended from any medical staff or had Privileges involuntarily terminated, restricted or summarily suspended by any health facility (including any Health System Campus) for reasons of clinical competence or professional conduct, which action was upheld following waiver or exhaustion of any procedural remedies which was reported to the NPDB within the past five (5) years.

f. Not have voluntarily resigned or surrendered medical staff membership or Clinical Privileges, or failed to renew membership or Clinical Privileges while under investigation or to avoid investigation or other Peer Review activity by any health facility (including any Health System Campus), which was reported to the NPDB within the past five (5) years.

g. Not be currently excluded or suspended from participation in any federal health care program, including the Medicare, Medicaid, and Tricare programs.

h. Provide a minimum of one (1) reference from either:

   i. a professional peer who has personal knowledge of and is directly familiar with the applicant's professional competency; or

   ii. One or more hospitals where the applicant primarily practices or has recently practiced. The Medical Staff Services Office will communicate with the equivalent of the Medical Staff Services Office at the provided hospitals to verify affiliation.

i. Be currently certified and maintain certification in the clinical specialty for which the Temporary Privileges are requested by a professional board in accordance with Article I Section 2.1.4, or of the Temporary Privileges are to fulfil a Patient Need possess and maintain the equivalent designation conferred by the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.

2.2.2. A Practitioner or AHP who requests Temporary Privileges for Completed Application while awaiting review and approval of a completed application for new Privileges by the Medical Executive Committee and the Board under Article III

Section 4.9 above, and must satisfy the qualifications and requirements set forth in Section 2.2.1 above and the following qualifications and requirements:

a. A request for Temporary Privileges under Section 2.1.2 above may be considered only when the application for new Privileges is complete, all required documentation has been received and verified, and there are no significant questions or unfavorable action concerning the applicant's qualifications.

b. For Practitioners, demonstrate proof of graduation from an appropriately accredited professional school and completion of an Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), American Dental Association, or American Podiatric Medical Association (APMA) approved residency program.

c. Not have been convicted of, or entered a plea of guilty or no contest to any felony.

d. Not have been convicted of, or entered a plea of guilty or no contest to any misdemeanor involving (a) insurance or health care fraud or abuse, (b) violence, physical abuse, or exploitation directed at a person, or (c) violation of law pertaining to controlled substances or illegal drugs, unless the Applicant is enrolled and satisfactorily participating in, or has successfully completed, a program supervised by the Washington Physician Health Program (WPHP), or other program approved by the Medical Executive Committee.

e. Not have been subject to a successful challenge to their licensure or registration.

2.3. Granting Temporary Privileges.

2.3.1. Temporary Privileges for Patient Needs or Completed Application may be granted by the Board on the recommendation of the Medical Staff President.

2.3.2. Temporary Privileges shall automatically terminate at the end of the designated period or service, not to exceed ninety (90) days, unless earlier terminated.

2.3.3. A Practitioner or AHP whose Medical Staff Membership or Privileges were automatically terminated for a failure to complete medical records shall not be eligible for Temporary Privileges.

2.3.4. Granting of Temporary Privileges shall have no bearing on final acceptance or rejection of a Practitioner’s or AHP’s Completed Application for Medical Staff Membership or Privileges, as applicable.

2.4. Denial or Expiration

2.4.1. There is no right to Temporary Privileges. Temporary Privileges are granted as a courtesy. Temporary Privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting Practitioner’s or AHP’s qualifications, ability, and

judgment to exercise the Privileges requested in accordance with these Bylaws, and only after the appropriate level of review under this Article IV Section 2.

2.4.2. Should Temporary Privileges be denied, or modified, the Practitioner or AHP will not be entitled to any of the corrective action and due process rights under these Bylaws.

a. The rejection or modification of a request for Temporary Privileges does not prohibit the Practitioner from applying for Privileges in accordance with Article III Section 1, or an AHP from applying for Privileges in accordance with Article V Section 2.

2.4.3. Temporary Privileges may be automatically terminated, suspended, or adversely affected in accordance with these Bylaws.

2.4.4. A Practitioner or AHP whose Temporary Privileges expire is not entitled to any rights under these Bylaws.

2.4.5. When a Practitioner's or AHP's Temporary Privileges are suspended, terminated, revoked, or expire, the appropriate Division Chair, or in the Division Chair's absence the Campus Chief of Staff shall assign another Member of the Medical Staff with appropriate Privileges to assume responsibility for the care of the Practitioner's patient(s). The wishes of the patient and affected Practitioner shall be considered in the choice of a replacement Member.

2.5. General Considerations

2.5.1. A Practitioner or Physician Assistant granted Temporary Privileges shall be subject to FPPE, OPPE and other applicable Peer Review or quality review. Dependent AHPs shall be subject to evaluation in accordance with Article IV Section 4 of the Credentials Manual.

2.5.2. A Practitioner or Physician Assistant granted Temporary Privileges is entitled to procedural rights afforded by these Bylaws only as set forth in Article XII Section 1. A Dependent AHP is entitled to procedural rights only as set forth in Article IV Section 3 of the Credentials Manual. A Practitioner or Physician Assistant shall not be entitled to more than one hearing on any matter.

2.5.3. Practitioners and Physician Assistants requesting or receiving Temporary Privileges shall be bound by these Bylaws.

SECTION 3. DISASTER PRIVILEGES

3.1. In the event of a disaster, defined as circumstances under which the Health System's Emergency Management (Disaster) Plan is implemented, Practitioners and Physician Assistants who volunteer to assist the Health System may be granted Privileges in accordance with the Emergency Management Disaster Credentialing Procedure on an emergency basis, and as needed to care for the Hospital's patients ("Volunteer Practitioners").

3.2. In the event of a community wide disaster the Chief Medical Officer has the authority to grant disaster Privileges to appropriate Volunteer Practitioners to the degree permitted by

the Volunteer Practitioner's license. The decision to grant disaster Privileges to a Volunteer Practitioner is to be made in accordance with the needs of the Hospital and its patients, and consistent with the qualifications of the volunteer.

3.3. Volunteers considered eligible to act as Volunteer Practitioners must at a minimum present a valid government–issue photo identification issued by a state or federal agency and at least one of the following:

3.3.1. A current picture Hospital ID card,

3.3.2. A current license to practice,

3.3.3. Primary source verification of the license,

3.3.4. Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups,

3.3.5. Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances, such authority having been granted by a federal, state, or municipal entity, or

3.3.6. Identification by current Hospital or Medical Staff Member(s) with personal knowledge regarding the Practitioner's or Physician Assistant's identity.

3.3.7. The Hospital will query the National Practitioner Data Bank.

3.4. The verification process is a high priority and as time, power, and technology permits, the Medical Staff Services Office will obtain primary source verification of the Volunteer Practitioner's licensure as soon as the immediate situation is under control, not to exceed 72 hours from the time the Volunteer Practitioner has been granted disaster Privileges.

3.4.1. In the event primary source verification cannot be completed in 72 hours (e.g. no means of communication or lack of resources) primary source verification will be completed as soon as possible.

3.4.2. In the event primary source verification cannot be completed in 72 hours, there must be documentation of why it could not be performed in the required timeframe, evidence of a demonstrated ability to continue to provide adequate care and evidence of the Hospital's attempts to perform primary source verification as soon as possible.

3.5. A log will be maintained recording the volunteer's ability to act as a Volunteer Practitioner during a disaster.

3.6. An ID badge will be issued to each emergently privileged Volunteer Practitioner.

3.7. The Volunteer Practitioner will be assigned in accordance with the Hospital's Emergency Management Disaster Credentialing Procedure. Whenever possible, the Volunteer Practitioner will be paired with a currently privileged Member of the Medical Staff or a credentialed Independent AHP or Physician Assistant who has similar credentials or

licensure. Whenever possible, the Volunteer Practitioner granted disaster Privileges should act only under the direct supervision and mentoring of a Medical Staff Member or Independent AHP with like credentials. If a Member of the Medical Staff or Independent AHP with like credentials is not available to be paired with the Volunteer Practitioner, another Member of the Medical Staff or Independent AHP will perform direct observation and mentoring of the Volunteer Practitioner.

3.8. The Medical Staff President shall make a decision regarding continuation of the disaster Privileges granted within 72 hours of the initial granting of disaster Privileges and at least once each week until the disaster Privileges expire or are terminated. This determination shall be based upon the oversight of the Volunteer Practitioner and information obtained regarding the professional practice of the Volunteer Practitioner.

3.9. Termination of Disaster Privileges

3.9.1. Disaster Privileges may be terminated at any time for any reason or cause.

3.9.2. A Volunteer Practitioner's disaster Privileges will be immediately rescinded by the Medical Staff President in the event any information is received that suggests the Volunteer Practitioner is not capable of rendering services in an emergency.

3.9.3. Disaster Privileges will automatically terminate when they are determined to no longer be necessary by the Medical Staff President in accordance with Emergency Management Disaster Credentialing Procedure.

3.9.4. ID badges previously issued to the Volunteer Practitioner will be collected upon termination. The Volunteer Practitioner staff Member should be debriefed as time permits.

3.10. There will be no appeal or procedural rights under these Bylaws in the event a Volunteer Practitioner's disaster Privileges are denied or terminated, regardless of the reason for action.

SECTION 4. EMERGENCY PRIVILEGES

4.1. For the purposes 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.

4.2. In the case of an emergency, any Member of the Medical Staff or Physician Assistant, to the degree permitted by the Practitioner's or Physician Assistant's license, 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 or Physician Assistant must relinquish care of the patient if not already privileged to continue care. The wishes of the patient shall be considered where feasible in the selection of a Medical Staff Member to continue care.

4.3. If there is a need for emergency, specialized care not normally available at the Hospital, any Practitioner or Physician Assistant who is not credentialed but possesses skills and expertise to administer such treatment for a patient in immediate danger may request to do everything possible to save the life of a patient.

4.4. The Chief Medical Officer shall review the Practitioner's or Physician Assistant's credentials and Privileges from the facility where the Practitioner or Physician Assistant practices and make a recommendation.

SECTION 5. DISASTER MANAGEMENT

5.1. In the event of a disaster, Emergency Management Disaster Plans and Procedures are implemented (Refer to #504.00, 504.20, 504.60 and 504.70).

5.2. The Chief Medical Officer has authority for Medical Staff activities when the plan is implemented. If the emergency situation requires, this authority includes changing or overruling the orders of primary physicians, discharging patients to other facilities (or other locations), and whatever else may be medically required in the Chief Medical Officer's professional opinion.

ARTICLE V. ALLIED HEALTH PROFESSIONALS

SECTION 1. OVERVIEW

1.1. Allied Health Professionals are not Members of the Medical Staff, and are not eligible to apply for or be granted Medical Staff Membership. Accordingly, AHPs are not entitled to serve as Medical Staff Officers, Division Chairs, Department Heads or Medical Staff committee chairs. Except as otherwise permitted in these Bylaws, AHPs are not entitled to vote on Medical Staff matters.

1.2. Independent AHPs and Physician Assistants will be eligible to be appointed to and serve as voting Members of the Regional Credentials Committees, Regional Peer Review Committees, and the Professional Performance Committee in accordance with Article VII Sections 3, 4, and 6 respectively.

1.3. Each Department of the organized Medical Staff will develop credentialing criteria for the granting of Clinical Privileges to Independent AHPs and Physician Assistants, and Scope of Practice for Dependent AHPs. The classifications, Basic Qualifications, and Practitioner Sponsor and Supervising Practitioner requirements for Dependent AHPs will be set forth in the Credentials Manual and Scope of Practice forms.

1.4. The Privileges, Scope of Practice, credentialing criteria of classifications of AHPs working within each Department must be approved by the Regional Credentials Committee, Professional Performance Committee, Medical Executive Committee, and the Board initially, and reviewed periodically to ensure the credentialing criteria and delineation of Privileges and Scope of Practice are reflective of desired clinical practice in the Hospitals.

1.5. Upon granting of Privileges or Scope of Practice, as applicable, each AHP will be assigned to a Primary Campus, Division, and Department as appropriate to the AHP's education, occupational or professional training, and experience.

1.6. Practitioners who desire to serve as Sponsor or Supervising Practitioner, or to supervise or direct, or work in consultation or collaboration with AHPs, as applicable, must have current Medical Staff Membership and/or Privileges to practice in at least one of the same Department(s) as the AHP. The Practitioner's supervision will be carried out in accordance with applicable state and federal laws, these Bylaws, and applicable Policies and Manuals, and the AHPs applicable Privilege or Scope of Practice delineations.

1.7. These Bylaws, including without limitation, ethical requirements, responsibilities, summary suspensions, automatic suspensions and terminations, confidentiality, immunities, and the Policies and Manuals will apply to AHPs, as modified to reflect the more limited practice and procedural rights of AHPs, except to the extent specified in these Bylaws. Where these Bylaws and Policies and Manuals provisions apply to AHPs, references to a "Medical Staff Member", "Member" or "Practitioner" will mean an AHP, and references to "Privileges" will mean Privileges or Scope of Practice, as applicable.

SECTION 2. PRIVILEGES AND SCOPE OF PRACTICE

2.1. Categories of AHPs Eligible to Apply for Privileges or Scope of Practice

2.1.1. The categories of AHPs allowed to practice within the Hospitals, and their Privileges or Scope of Practice, as applicable, are subject to approval by the Board. The Board may, at its discretion, request the Medical Executive Committee study and make recommendations regarding the categories of AHPs that should be permitted to practice in each Hospital, and the Privileges or Scope of Practice, prerogatives, and responsibilities to be assigned to the category. Prior to making any proposed changes, the Board will consider input from the relevant Division Chair or Department Head, Regional Credentials Committee(s), and the Medical Executive Committee.

2.1.2. The categories of Independent AHPs are set forth in these Bylaws (See, Definitions). The categories of Dependent AHPs are set forth in the Credentials Manual.

2.1.3. AHPs will not be eligible to apply to practice at a Hospital until the category of AHP and applicable Privileges or Scope of Practice have been recommended by the Medical Executive Committee and approved by the Board.

2.2. Independent AHPs and Physician Assistants must meet the same Basic Qualifications and General Qualifications for Medical Staff Membership set forth in Article 1 Sections 2 & 3, as modified to reflect the more limited practice, license and certification, and Privileges, as applicable, of the AHP.

2.3. Dependent AHPs must meet the basic qualifications for Dependent AHPs set forth in the Credentials Manual, and the same General Qualifications for Medical Staff Membership set forth in Article 1, Section 3.

2.4. Applications for initial or renewed appointment for AHPs, including requests for Privileges or Scope of Practice, will be submitted and processed in a manner parallel to that specified for Medical Staff applicants in Article III (Credentialing and Privileging), and Article IV (Clinical Privileges), except as set forth in this Article V. Dependent AHPs, except Physician Assistants, are not required to submit an application fee.

2.5. The specific Clinical Privileges or Scope of Practice granted and degree of supervision/collaboration required, if any, will be defined in the delineation of Privileges or Scope of Practice and, in the case of Physician Assistants, in the practice plan as well.

2.6. Independent AHP and Physician Assistant Privileges

2.6.1. Independent AHPs and Physician Assistants may exercise only the Privileges specifically granted them by the Board. The Privileges for which each Independent AHP or Physician Assistant may apply and any special limitations or conditions to the exercise of such Privileges will be based on recommendations of the Regional Credentials Committee, Professional Performance Committee, and Medical Executive Committee, and are subject to the approval of the Board.

2.6.2. Independent AHPs and Physician Assistants are credentialed in the same manner as Practitioners in accordance with Article III, except as set forth in this Article V and the applicable Privilege forms.

2.6.3. Independent AHPs and Physician Assistants must assure that records are signed or countersigned as required under these Bylaws and the Policies and Manuals, and consistent with the Independent AHP's or Physician Assistant's license, certificate, or other legal credentials, and the Privileges approved by the Board.

2.6.4. An Independent AHP or Physician Assistant requesting Privileges to prescribe controlled substances must have prescriptive authority and possess a current Federal Drug Enforcement Agency (DEA) number.

2.6.5. Independent AHPs with admitting Privileges must follow the requirements of these Bylaws, the Policies and Manuals, any guidelines outlined by state licensing board, and the Privilege delineations. A patient's general medical condition is managed by a Physician with appropriate Privileges for any patient needs that are outside the Privileges of the admitting Independent AHPs.

a. A patient's psychiatric problem that is not specifically within the Privileges of the Independent AHP will be managed and coordinated by a credentialed Physician with appropriate Privileges.

2.6.6. Independent AHPs with admitting Privileges are required to obtain and document clinical guidance from an appropriately credentialed Medical Staff Member prior to major diagnostic or therapeutic interventions or within twenty-four (24) hours of admission, whichever comes first, except in the case of uncomplicated labor and delivery. Medical Staff consultation is required prior to transfer of a newborn or other patient to another facility.

2.6.7. Independent AHPs with admitting Privileges must identify one or more Independent AHPs or Practitioners with comparable Privileges to provide 24-hour, 7 day a week coverage in their absence.

2.6.8. Independent AHPs with admitting Privileges who admit a Medicare beneficiary must identify a Physician who will assume responsibility for the Medicare beneficiary being "under the care of" the Physician.

2.7. Dependent AHP Scope of Practice

2.7.1. Dependent AHPs (other than Physician Assistants) may exercise only the Scope of Practice specifically granted by the Board. The Scope of Practice for which each Dependent AHP may apply and any special limitations or conditions to the exercise of such Scope of Practice will be based on recommendations of the Regional Credentials Committee, Professional Performance Committee, and Medical

Executive Committee, and are subject to the approval of the Board. Dependent AHPs are not entitled to apply for, or be granted, Privileges.

2.7.2. Dependent AHPs practice under the supervision and direction of a Practitioner who meets the requirements set forth in Section 1.6 above.

a. A Dependent AHP may provide only those services that are within the Scope of Practice and the supervising Practitioner's own Privileges, and the applicable practice agreement between the Dependent AHP and supervising Physician.

b. The supervising Practitioner of a Dependent AHP will assume full responsibility, and be fully accountable for the conduct of the Dependent AHP within the Hospital.

c. Any concerns regarding the supervision of the Dependent AHP by the Supervising Practitioner will be referred to the Professional Performance Committee for review in accordance with Article XI Section 8.

2.7.3. Dependent AHPs (other than Physician Assistants) are credentialed in the same manner as Practitioners in accordance with Article III, except as set forth in this Article V and the applicable Scope of Practice forms.

2.7.4. Dependent AHPs must assure that records are countersigned as follows:

a. The supervising Practitioner will countersign all entries except routine progress notes.

b. Unless otherwise specified in these Bylaws, or the Policies and Manuals, prerogatives, Scope of Practice, or specific supervision protocols, all record entries that require countersignatures must be countersigned as soon as possible but in no event later than twenty-four (24) hours, after the entry is made.

2.8. Appointment or reappointment to the AHP staff and the initial or renewed grant of Privileges or Scope of Practice will not exceed two (2) years.

2.9. The initial grant of Privileges for Independent AHPs and Physician Assistants will be subject to Initial FPPE in the same manner as a Practitioner granted Privileges.

SECTION 3. PREROGATIVES

3.1. The prerogatives that may be extended to an AHP may include:

3.1.1. Provision of specified patient care services consistent with the Privileges or Scope of Practice approved for the AHP, as applicable, and within the scope of the AHP's licensure or certification.

3.1.2. Service on the Medical Staff committees, Department committees, and Hospital committees, as requested in accordance with the description of the committee composition set forth in these Bylaws, the committee policy, or committee charter, as applicable.

3.1.3. Attendance at the meetings of the Department(s) to which the AHP is assigned, as permitted by the Medical Staff or Department Rules, and attendance at Hospital education programs in the AHP's field of practice.

SECTION 4. BASIC RESPONSIBILITIES

4.1. Each AHP will continuously meet all of the following responsibilities

4.1.1. Fulfill the same basic responsibilities for Medical Staff Membership set forth in Article I Section 7, as modified to reflect the more limited practice, procedural rights, license and certification, and Privileges or Scope of Practice of the AHP, as applicable.

4.1.2. Participate directly in the management of patients, retain appropriate clinical responsibility, and exercise independent judgment within the AHP's area of professional competence for the care and supervision of each patient for whom the AHP is providing services. For Dependent AHPs and Independent AHPs who are not granted admitting Privileges, a Medical Staff Member who has appropriate Privileges will supervise, direct, and retain the ultimate responsibility for each patient's care in accordance with applicable state and federal laws, and the Dependent AHP's Scope of Practice and the Independent AHPs Privileges, as applicable.

4.1.3. Record reports and progress notes on patient records and write orders for treatments to the extent authorized by these Bylaws, and the Policies and Manuals provided that such orders are consistent with applicable state and federal laws, and within the scope of the AHPs license, certificate, or other legal credentials, and granted Privileges or Scope of Practice, as applicable.

SECTION 5. PEER REVIEW, CORRECTIVE ACTION, AND SUSPENSIONS

5.1. Independent AHP and Physician Assistant Hearing & Appeals

5.1.1. Independent AHPs and Physician Assistants are subject to the same Peer Review, Investigations, and summary suspensions or restrictions and corrective actions as Practitioners, as set forth in Article XI of these Bylaws.

5.1.2. Independent AHPs and Physician Assistants may invoke the same hearing and appeal procedures as Practitioners, set forth in Article XII of these Bylaws, provided however, the Hearing Panel will include at least one (1) Independent AHP in the same licensure category as the affected individual, or one (1) Physician Assistant if the Physician Assistant is the affected individual, as applicable.

5.2. Dependent AHP Grievance Procedures

5.2.1. Dependent AHPs are not entitled to the hearing and appeal procedures applicable to Practitioners, Independent AHPs, and Physician Assistants under these Bylaws. Nothing contained in these Bylaws will be interpreted to grant Dependent AHPs the procedural rights set forth in these Bylaws, including Article VIII.

5.2.2. Dependent AHPs (other than Physician Assistants) who are subject to an Adverse Action as defined in these Bylaws may request a grievance, as set forth in the Credentials Manual.

5.3. Automatic Suspension and Termination

5.3.1. An Independent AHP's or Physician Assistant's Privileges may be automatically suspended, limited, or terminated for failure to maintain the Basic Qualifications in accordance with Article I, Section 2, and Article V Section 2, following the same process applicable to Practitioners and Medical Staff Members set forth in Article XI Section 3.

5.3.2. A Dependent AHP's Scope of Practice may be automatically suspended, limited, or terminated for failure to maintain the basic qualifications set forth in the Credentials Manual, following the same process applicable to Practitioners and Medical Staff Members set forth in Article XI Section 3.

5.3.3. An AHP's Privileges or Scope of Practice, as applicable, may be automatically suspended, limited, or terminated on the same grounds applicable to Medical Staff Members set forth in Article XI Section 4 (Other Automatic Suspensions and Terminations).

5.3.4. Additionally, an AHP's Privileges or Scope of Practice, as applicable, will be automatically suspended if:

a. The AHP's Sponsor, or supervising or collaborating/consulting Practitioner's Medical Staff Membership or relevant Privileges are suspended, restricted or terminated, for any reason; or

b. The AHP's Sponsor, or supervising or collaborating/consulting Practitioner no longer agrees to act as supervising or collaborating/consulting Practitioner for any reason.

c. The AHP's automatic suspension will end under Section (a) when the AHP submits written notification to the Medical Staff Services Office of a change in Sponsor, or supervising or collaborating/consulting Practitioner, signed by the Practitioner.

5.3.5. The AHP's automatic suspension under Section (b) will end when the Sponsor, supervising or collaborating/consulting Practitioner's Medical Staff Membership and/or Privileges are fully reinstated. An AHP who is subject to automatic suspension or automatic termination of Privileges or Scope of Practice is not entitled to any procedural rights, including any hearing or appeal under Article XII, or grievance process under the Credentials Manual.

5.3.6. An AHP subject to an automatic suspension or termination will be provided a Notice of the automatic suspension or termination in accordance with Article XI Section 6 (Notifications and Patient Continuity of Care).

5.3.7. Patients affected by an automatic suspension, termination, or expiration of an AHP's Privileges or Scope of Practice will be assigned to another AHP or Medical Staff Member with comparable Privileges by the Division Chair or Campus Chief

of Staff. The wishes of the patient and supervising or collaborating/consulting Practitioner will be considered, when feasible, in choosing a substitute AHP or Medical Staff Member.

ARTICLE VI. MEDICAL STAFF OFFICERS AND LEADERS

SECTION 1. MEDICAL STAFF OFFICERS

1.1. The officers of the Medical Staff (collectively, the "Medical Staff Officers") shall be:

1.1.1. Medical Staff President;

1.1.2. Medical Staff Vice President;

1.1.3. One Campus Chief of Staff from each Campus;

1.1.4. One Campus Chief of Staff-Elect from each Campus;

1.1.5. Secretary/Treasurer of the Medical Staff;

1.1.6. One Campus Secretary/Treasurer for each Campus; and

1.1.7. Immediate Past Medical Staff President.

SECTION 2. QUALIFICATIONS FOR MEDICAL STAFF OFFICERS AND LEADERS

2.1. Only a qualified Practitioner who continuously satisfies the following criteria shall be eligible to serve as a Medical Staff Officer, Medical Staff leader, or committee chairperson. A qualified Practitioner:

2.1.1. Is licensed as a physician, dentist, or podiatrist.

2.1.2. Is appointed to, and remains in Good Standing, on the Active Medical Staff.

2.1.3. Demonstrates involvement in maintaining quality medical care at the Campus or the System.

2.1.4. Constructively participates in Medical Staff affairs, including Peer Review activities.

2.1.5. Is willing to discharge faithfully the duties and responsibilities of the position to which the individual is selected, elected, or appointed.

2.1.6. Is knowledgeable concerning the duties of the position.

2.1.7. Is in compliance with the Health System Governance Policy, Corporate Responsibility G-001 Conflicts of Interest, in connection with their role as a Medical Staff Officer, Medical Staff leader, or committee chairperson.

2.2. All Medical Staff Officers, Medical Staff leaders, and committee chairpersons must possess at least the above qualifications to be nominated and elected, and must maintain such qualifications throughout the term of their office or position. Any Medical Staff Officer,

Medical Staff leader, or committee chairperson who fails to continuously satisfy the above qualifications will promptly report the change in qualification to the Medical Staff President (or if the affected individual is the Medical Staff President, to the Medical Staff Vice President).

2.3. If a Medical Staff Officer, leader or committee chairperson fails to continuously possess the above qualifications, they shall be automatically removed from their office or position, creating an automatic vacancy. Elections shall be held as soon as possible to fill the vacancy.

2.4. Each Medical Staff Officer, Medical Staff leader, or committee member or nominee for such office or position shall submit a completed conflicts of interest disclosure questionnaire to the Medical Executive Committee in advance of nomination, election, or appointment, and if elected or appointed, annually thereafter or as requested by the Medical Executive Committee.

SECTION 3. SELECTION OF OFFICERS OF THE MEDICAL STAFF

3.1. Transition Process

3.1.1. Between the Adoption Date of these Bylaws in accordance with Article XV, and the Effective Date, the selection of Officers of the Medical Staff shall be administered in accordance with the transition election process set forth in Addendum A. After the Effective Date, the selection of Officers of the Medical Staff shall be administered in accordance with Article VI, Sections 3.2 through 3.7 below.

3.2. Medical Staff President

3.2.1. The Medical Executive Committee or a subcommittee shall serve as nominating committee to develop a slate of one or more candidate(s) meeting the qualifications described in Section 2 above for the office of Medical Staff President.

3.2.2. If the Medical Executive Committee appoints a nominations subcommittee, the subcommittee will include at least three (3) Medical Executive Committee members, with one Campus Chief of Staff and one Member-At-Large, each from different Campuses.

3.2.3. The slate of candidate(s) shall be developed and either included in the Medical Staff newsletter, posted or sent by electronic communication or mail to Active and Associate Medical Staff Members in advance of the election.

3.2.4. Elections shall be held at least two (2) months before the end of the Medical Staff Year in which the term of office expires.

3.2.5. The election shall be by mail or electronic ballot. A mail or electronic ballot shall be sent to Active and Associate Medical Staff Members.

3.2.6. Active and Associate Medical Staff Members may vote for a write-in candidate, provided, however, that if elected, the write-in candidate must meet the qualifications of office described in Section 2 above, and agree in writing to accept the obligations of office of Medical Staff President.

3.2.7. The outcome of the election shall be determined by a plurality of the votes cast by Active and Associate Medical Staff Members through mail or electronic ballots that are returned to Medical Staff Services Office within 15 days after the ballots were mailed or electronically transmitted to the Active and Associate Medical Staff Members.

3.2.8. In case of a tie, the Medical Executive Committee shall appoint the Medical Staff President from among the candidates receiving the tie vote.

3.3. Medical Staff Vice President

3.3.1. The Medical Staff Vice President will be selected by majority vote of the Medical Executive Committee from among the Campus Chiefs of Staff and Members-at-Large of the Medical Executive Committee. The Medical Staff Vice President may serve concurrently as Medical Staff Vice President and either Campus Chief of Staff or Member-At-Large, subject to the limitation on voting under Section 3.8 below.

3.3.2. The Medical Executive Committee vote shall be held at least two (2) months before the end of the Medical Staff Year in which the term of office expires.

3.4. Secretary/Treasurer of the Medical Staff

3.4.1. The Secretary/Treasurer will be selected by majority vote of the Medical Executive Committee from among the Campus Chiefs of Staff and Members-at-Large of the Medical Executive Committee. The Secretary/Treasurer of the Medical Staff may serve concurrently as Secretary /Treasurer of the Medical Staff and either Campus Chief of Staff or Member-At-Large, subject to the limitation on voting under Section 3.8 below.

3.4.2. The Medical Executive Committee vote shall be held at least two (2) months before the end of the Medical Staff Year in which the term of office expires.

3.5. Campus Secretary/Treasurer

3.5.1. The Campus Secretary/Treasurer will be selected by majority vote of the Campus Medical Staff Leadership Council from among the Campus Medical Staff Leadership Council members. The Campus Secretary/Treasurer may serve concurrently as Campus Secretary/Treasurer and either Campus Chief of Staff or Member-At-Large, subject to the limitation on voting under Section 3.8 below.

3.5.2. The Campus Medical Staff Leadership Council vote shall be held at least two (2) months before the end of the Medical Staff Year in which the term of office expires.

3.6. Immediate Past President

3.6.1. The Immediate Past President will serve in this office by virtue of past service as Medical Staff President.

3.7. Campus Chiefs of Staff and Campus Chiefs of Staff-Elect

3.7.1. The Medical Executive Committee shall assign for each Campus an even year or odd year schedule for elections for the offices of the Campus Chief of Staff and Campus Chief of Staff-Elect.

3.7.2. The Campus Medical Staff Leadership Council or a subcommittee shall serve as nominating committee for the offices of the Campus Chief of Staff and Campus Chief of Staff-Elect.

3.7.3. The Campus Medical Staff Leadership Council or a subcommittee shall develop a slate of one or more candidate(s) for whom the Campus is their Primary Campus in accordance with the Credentials Manual, and who meet the qualifications described in Section 2 above.

3.7.4. The slate of candidate(s) shall be either included in the Medical Staff newsletter, posted or sent by electronic communication or mail to Active and Associate Medical Staff Members from the Campus in advance of the election.

3.7.5. Elections for Campus Chief of Staff and Campus Chief of Staff-Elect shall be held at each Campus at least two (2) months before the end of the Medical Staff Year in which term of office expires.

3.7.6. The election shall be by in-person vote at the Annual Campus Medical Staff meeting, by mail ballot, and/or by electronic ballot, as determined by the Campus Medical Staff Leadership Council.

3.7.7. If the election is by electronic ballot or by mail ballot, the ballot shall be sent to the Active and Associate Medical Staff Members from the Campus at the Member's last known address or most recent email provided to the Medical Staff Services Office.

3.7.8. If the Campus Medical Staff Leadership Council will allow both electronic ballot and in-person vote at the Annual Campus Medical Staff meeting, the electronic ballots will close on the day of the Annual Campus Medical Staff meeting.

3.7.9. Active and Associate Medical Staff Members from the Campus may vote for a write-in candidate, provided, however, that if elected, the write-in candidate must meet the qualifications of office described in Section 2 above, and agree in writing to accept the obligations of office.

3.7.10. The outcome of the election shall be determined by a plurality of the votes cast in-person, or by mail or electronic ballots that are returned to Medical Staff Services Office within 15 days after the ballots were mailed to the Active and Associate Medical Staff Members from the Campus.

3.7.11. In case of a tie, the Campus Medical Staff Leadership Council shall appoint the position from among the candidates receiving the tie vote.

3.8. One Vote. Any voting Member of a medical staff committee who holds more than one office or position as a Medical Staff Officer, Medical Staff leader, committee chairperson or committee member shall have only one (1) vote on any matter before the Medical Staff or a Medical Staff committee.

SECTION 4. TERM OF OFFICE

4.1. All Medical Staff Officers shall serve a two (2) year term, except the offices of Campus Chief of Staff and Campus Chief of Staff-Elect, which will each serve a two (2) year term for a total combined term of four (4) years. Officers shall take office on the first day of the Medical Staff Year following their election or selection.

4.2. A Medical Staff Officer selected or elected may continue to serve in the same office as Medical Staff Officers for a period of up to four (4) years.

4.3. Prior service as an interim Medical Staff Officer or interim Medical Staff leader in accordance with Addendum A, or prior service as a Medical Staff Officer or Medical Staff leader at any Campus prior to the Effective Date of these Bylaws will not be counted toward the applicable term limits under Section 4.

SECTION 5. VACANCIES IN OFFICE

5.1. Vacancies created by resignation, removal (automatic or by vote), or death of a Medical Staff Officer shall be filled as follows:

5.1.1. Vacancies for the Medical Staff President, the Medical Staff Vice President or the Secretary/Treasurer shall be filled by the Medical Executive Committee for the balance of the unexpired term.

5.1.2. Vacancies for a Campus Chief of Staff or Campus Chief of Staff-Elect during the Medical Staff year shall be filled by the Campus Medical Staff Leadership Council of the Campus from which the vacancy developed for the balance of the unexpired term.

5.1.3. A vacancy in the office of Immediate Past President will not be filled.

5.2. Medical Staff Officers who fill a vacancy are eligible for subsequent election or appointment, without regard to term limits

SECTION 6. DUTIES OF OFFICERS

6.1. Medical Staff President: The Medical Staff President shall serve as the chief elected officer of the Medical Staff, shall chair the Medical Executive Committee, shall serve as an *ex officio* Member of all other Medical Staff committees without a vote, shall consult with the Board as requested, shall appoint and remove chairs of designated Medical Staff committees, and shall fulfill those additional duties specified in the Organizational Manual.

6.2. Medical Staff Vice President: In the absence of the Medical Staff President, the Vice President shall chair the Medical Executive Committee and shall assume all other duties and have the authority of the Medical Staff President. When assuming the duties of the Medical Staff President the Medical Staff Vice President shall refrain from voting, except when necessary to break a tie vote.

6.3. Campus Chief of Staff: Each Campus Chief of Staff shall serve as a voting Member of the Medical Executive Committee. The Campus Chief of Staff shall serve as chair of the Campus Medical Staff Leadership Council of their Primary Campus, and shall fulfill those duties specified in the Organizational Manual.

6.4. Campus Chief of Staff-Elect: Each Campus Chief of Staff-Elect shall serve as a non-voting, ex officio Member of the Medical Executive Committee. In the absence of the Campus Chief of Staff, the Campus Chief of Staff-Elect of the same Primary Campus shall chair the Campus's Medical Staff Leadership Council, shall attend Medical Executive Committee meetings as a voting Member, and shall assume all other duties and have the authority of the Campus Chief of Staff. In the absence of the Campus Member At-Large the Campus Chief of Staff-Elect shall attend Medical Executive Committee meetings as a voting Member as the Campus Member At-Large's designee.

6.5. Secretary/Treasurer of the Medical Staff: The Secretary/Treasurer shall serve as a voting Member of the Medical Executive Committee. The Secretary/Treasurer shall be responsible for use of the Medical Staff Fund and shall fulfill those additional duties specified in the Organizational Manual.

6.6. Immediate Past Medical Staff President: The Immediate Past President shall serve as advisor to the Medical Staff President and a non-voting, ex officio Member of the Medical Executive Committee.

6.7. Each Medical Staff Officer shall perform such further duties as the Medical Staff President or the Medical Executive Committee may from time to time request.

SECTION 7. REMOVAL FROM OFFICE

7.1. The Medical Staff may remove from office the Medical Staff President, the Medical Staff Vice President, or the Secretary/Treasurer of the Medical Staff by petition of ten percent (10%) of the Active and Associate Staff Members and a subsequent two-thirds (2/3) majority of ballots cast by the Active and Associate Staff Members and returned within fourteen (14) days of mailing.

7.2. The Campus Medical Staff may remove from office Campus Chief of Staff or the Campus Chief of Staff-Elect by petition of ten percent (10%) of the Active and Associate Staff Members from the Campus and a subsequent two-thirds (2/3) majority of ballots cast by the Active and Associate Staff Members from the Campus and returned within fourteen (14) days of mailing.

7.3. Removal from Medical Staff Office shall be for any valid cause, including failure to conduct those responsibilities assigned within these Bylaws or other policies and procedures of the Medical Staff.

7.4. Voting on removal shall be by mailed or electronically transmitted secret ballot. A ballot shall be mailed or electronically transmitted to each Active and Associate Staff Member who is eligible to vote on the removal, and have a return date that is at least 15 days after the date the ballot was mailed or electronically transmitted. The ballots shall be counted by the Medical Staff President (unless the Medical Staff President is the subject of the recall effort) and Chief Medical Officer.

7.5. A Medical Staff Officer is removed automatically if they fail to continuously meet the qualifications for office under Section 2 above.

SECTION 8. DIVISION CHAIRS

8.1. Each Division will have one (1) Division Chair.

8.2. Qualifications: Each Division Chair must meet the qualifications for Medical Staff leaders set forth in Article III, Section 2 of these Bylaws, except that a Division Chair may be an Associate Staff appointee.

8.3. The Division Chair shall also be certified by an appropriate specialty board or possess comparable competence affirmatively established through the credentialing process.

8.4. The Division Chair should also have prior Medical Staff leadership experience and training, for example, prior services as a Department Head or comparable position, participation in Medical Staff leadership training, service as Peer Review or Credentials Committee chair, or comparable position as determined by the Medical Executive Committee.

8.5. Election:

8.5.1. Division Chairs for the Divisions of the Medical Staff shall be elected by majority vote of the Medical Executive Committee. Elections for Division Chairs shall be held at least two (2) months before the end of the Medical Staff Year in which term of office expires.

8.5.2. The Medical Executive Committee shall assign for each Campus an even year or odd year schedule for elections for Division Chairs.

8.6. Duties: The duties and responsibilities of the Division Chairs may include the following:

8.6.1. Clinically related activities of the Division across the System;

8.6.2. Administratively related activities of the Division, unless otherwise provided by the relevant Hospital;

8.6.3. Serve as Medical Staff liaison between the System, the Medical Executive Committee, and the Campuses for clinically related activities of the Division;

8.6.4. Continuing surveillance of the professional performance of all individuals in the Division who have delineated Clinical Privileges;

8.6.5. Recommending to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the Division;

8.6.6. Recommending Clinical Privileges for each Member of the Division;

8.6.7. Assessing and recommending to the relevant Hospital or Health System authority off-site sources for needed patient care, treatment, and services not provided by the Division or the Hospital;

8.6.8. The integration of the Division into the primary functions of the Health System;

8.6.9. The coordination and integration of interdivisional and intradivisional services;

8.6.10. The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;

8.6.11. The recommendation for a sufficient number of qualified and competent persons to provide care, treatment, and services;

8.6.12. The determination of the qualifications and competence of Division or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

8.6.13. The continuous assessment and improvement of the quality of care, treatment, and services;

8.6.14. The maintenance of quality control programs, as appropriate;

8.6.15. The orientation and continuing education of all persons in the Division;

8.6.16. Recommendations for space and other resources needed by the Division;

8.6.17. Serve as an *ex officio* Member of the Medical Executive Committee, without a vote.

8.7. Term: Division Chairs shall serve an initial two (2) year term. Division Chairs shall take office on the first day of the Medical Staff Year following their election. Division Chairs may serve successive two (2) year terms for up to three (3) consecutive terms.

8.8. Removal: Division Chairs may be removed by two-thirds (2/3) vote of the Medical Executive Committee or two-thirds (2/3) vote of the voting Members of the Division.

8.9. Designees: Division Chairs may delegate duties to Department Heads from time to time.

SECTION 9. DEPARTMENT HEADS

9.1. Each Department on each Campus will have one (1) Department Head or two (2) Co-Department Heads. All references to Department Heads in these Bylaws apply to Co-Department Heads.

9.2. Qualifications: Each Department Head must meet the qualifications for Medical Staff leaders set forth in Article VI Section 2 of these Bylaws, except that a Department Head may be an Associate Staff appointee.

9.3. Election: Department Heads shall be elected by plurality vote of the Active and Associate Staff Members from the applicable Campuses and in the Department.

9.3.1. Two (2) or more Active or Associate Staff Members from the Campus and in the Department may nominate a Department Head.

9.3.2. Elections for Department Heads shall be held at each Campus at least two (2) months before the end of the Medical Staff Year in which the term of office expires.

9.3.3. The election shall be by in-person vote at the Annual Campus Medical Staff meeting, Division meeting or Department meeting (provided that only Active and Associate Members in attendance at the meeting from the same Department may vote for the Department Head), or by mail ballot, and/or by electronic ballot, as determined by the Campus Medical Staff Leadership Council.

9.3.4. If the election is by electronic ballot or by mail ballot, the ballot shall be sent to the Active and Associate Medical Staff Members from the Campus and in the Department at the Member's last known address or most recent email provided to the Medical Staff Services Office.

9.3.5. If the Campus Medical Staff Leadership Council will allow both electronic ballot and in-person vote at the Annual Campus Medical Staff meeting, Division meeting or Department meeting, the electronic ballots will close on the day of the meeting.

9.3.6. Active and Associate Medical Staff Members from the Campus and in the Department may vote for a write-in candidate, provided, however, that if elected, the write-in candidate must meet the qualifications of office described in Article VI Section 2 above, and agree in writing to accept the obligations of office.

9.3.7. The outcome of the election shall be determined by a plurality of the votes cast in-person, or by mail or electronic ballots that are returned to Medical Staff Services Office within 15 days after the ballots were mailed to the Active and Associate Medical Staff Members from the Campus in the Department.

9.3.8. In case of a tie, the Campus Medical Staff Leadership Council shall appoint the position from among the candidates receiving the tie vote.

9.4. Duties:

The duties and responsibilities of the Department Head may include the following

9.4.1. Serve as an *ex officio* Member of the Campus Medical Staff Leadership Council, with a vote.

9.4.2. Serve as liaison between the Department and the Division Chair for clinically related activities of the Department.

9.4.3. Perform such duties delegated by the Division Chair, including by way of example and not limitation, (i) evaluating applications for appointment and reappointment and Clinical Privileges on behalf of the Division Chair to facilitate the recommendation for Practitioners in the Department, (ii) performing Focused Professional Practice Evaluations of new Medical Staff Members or current Members with new Privileges in the Department, including proctoring, (iii) serving as a mentor for new Medical Staff Members in the Department, and (vi) performing Focused Professional Practice Evaluations for Medical Staff Members in the Department.

9.5. Term. Department Heads shall serve an initial two (2) year term. Department Heads shall take office on the first day of the Medical Staff Year following their election. Department Heads may serve successive two (2) year terms for up to three (3) consecutive terms.

9.6. Removal: Department Heads may be removed by two-thirds (2/3) vote of the Active and Associate Staff Members in the Department or a two-thirds (2/3) vote of the Campus Medical Staff Leadership Council.

ARTICLE VII. COMMITTEES

SECTION 1. DESIGNATION AND SUBSTITUTION

1.1. There shall be a Medical Executive Committee, and such other standing and special committees of the Medical Staff responsible to the Medical Executive Committee as may from time to time be necessary and desirable to perform the Medical Staff functions listed in these Bylaws. Those functions requiring participation of, rather than direct oversight by, the Medical Staff may be discharged by the Medical Staff representation on such Health System committees as are established to perform such functions.

1.2. Whenever these Bylaws require that a function be performed by, or that a report or recommendation be submitted to the Medical Executive Committee, but a standing or special committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it by the Medical Executive Committee. All such committee actions are subject to review by the Medical Executive Committee. Notwithstanding the foregoing, if a standing or special committee becomes aware of any quality or behavior concerns regarding an individual Practitioner or Allied Health Professional that is outside the scope of the authority expressly delegated to the committee by the Medical Executive Committee under these Bylaws and Rules and Regulations, the committee is authorized to review the facts, and report or refer the matter to the Medical Executive Committee, or other appropriate standing or special committee, for further review and action.

SECTION 2. MEDICAL EXECUTIVE COMMITTEE

2.1. Confidentiality and Immunity:

The Medical Executive Committee is deemed to be a regularly constituted quality improvement committee pursuant to RCW 4.24.250, and RCW 70.41.200, as well as a professional review body as defined in the Health Care Quality Improvement Act of 1986. All minutes, reports, recommendations, communications, and actions made or taken by a Medical Executive Committee are covered by the provisions of the Health Care Quality Improvement Act of 1986, RCW 4.24.250, and RCW 70.41.200 or the corresponding provisions of any subsequent state or federal statute providing immunity or confidentiality for quality improvement, Peer Review, or related activities.

2.2. Composition:

2.2.1. The Medical Executive Committee may include Medical Staff Members and other practitioners and individuals determined by the Medical Staff.

2.2.2. The Medical Executive Committee shall consist of the following voting Members:

a. Medical Staff President;

b. Medical Staff Vice President;

c. The Campus Chief of Staff from each Campus;

d. Secretary/Treasurer of the Medical Staff;

e. A Member At-Large from each Campus;

f. The Chair of the System Professional Performance Committee appointed by the Medical Executive Committee; and

g. The Chair of the System Medical Staff Bylaws Committee.

2.2.3. The Medical Executive Committee shall include the following *ex officio*, non-voting Members:

a. A Campus Chief of Staff-Elect from each Campus;

b. The Division Chairs;

c. The Chief Medical Officer and Hospital Chief Medical Officers;

d. The System CEO or COO;

e. The System CNO;

f. The System Vice President of Quality; and

g. The Immediate Past Medical Staff President

2.3. Selection and Removal of Medical Executive Committee members:

2.3.1. Medical Staff Officers who serve on the Medical Executive Committee are selected and removed in accordance with Article VI Section 7.

2.3.2. The Members-at-Large who serve on the Medical Executive Committee are selected and removed in accordance with Section 2.4 below.

2.3.3. Division Chairs who serve on the Medical Executive Committee are selected and removed in accordance with Article VI Section 8.

2.3.4. The Chair of the Professional Performance Committee who serves on the Medical Executive Committee is selected and removed by the Medical Executive Committee from among the Members of the Professional Performance Committee.

2.3.5. Other administrative *ex officio* Members of the Medical Executive Committee not addressed in this Section 2.2 are selected and removed by the Board or the CEO.

2.4. Selection and Removal of Members At-Large:

2.4.1. The Medical Executive Committee shall assign for each Campus an even year or odd year schedule for elections for the Members At-Large.

2.4.2. The Members At-Large will be selected by majority vote of the Campus Medical Staff Leadership Council from among Members in Good Standing on the Active or Associate Medical Staff with the Campus as the Member's Primary Campus.

2.4.3. The Medical Executive Committee vote shall be held at least two (2) months before the end of the Medical Staff Year in which the term of the Member At-Large position expires.

2.4.4. The Members At-Large shall serve an initial two (2) year term, and may be selected for successive terms up to three (3) consecutive terms.

2.4.5. The Campus Medical Staff Leadership Council may remove any Member At-Large upon 2/3 majority vote of the Committee. Removal of a Member At-Large shall be for any valid cause, including failure to conduct those responsibilities assigned within these Bylaws or other policies and procedures of the Medical Staff.

2.4.6. A Member At-Large is automatically removed, creating an automatic vacancy, if the Member At-Large fails to continuously possess the qualifications under Section 2.4.2 above, or changes the Member's Primary Campus.

2.5. Duties:

The Medical Staff delegates to the Medical Executive Committee the authority to carry out certain Medical Staff responsibilities. The Medical Executive Committee shall carry out its work within the context of the Health System functions of governance, leadership and performance improvement. The Medical Executive Committee has the primary authority for activities relating to Medical Staff self-governance and performance improvement of Practitioners and AHPs with Privileges or AHPs with Scope of Practice.

The Medical Executive Committee shall act on behalf of the Medical Staff between meetings of the Medical Staff. With assistance of the Chief Medical Officer, the Medical Executive Committee is delegated to perform the following duties:

2.5.1. Oversee the development of Medical Staff Bylaws, Policies and Manuals, recommend approval, amendment, or disapproval of all such Medical Staff Bylaws, Policies and Manuals, and oversee the implementation of all such Medical Staff Bylaws, Policies and Manuals in accordance with Article XV of these Bylaws.

2.5.2. Recommend Bylaws and amendments to these Bylaws to the voting Members of the Medical Staff for approval in accordance with Article XV Section 2 of these Bylaws.

2.5.3. Recommend Medical Staff Policies and Manuals and amendments to the Medical Staff Policies and Manuals in accordance with Article XV Section 3 of these Bylaws, including any details associated with the processes contained in these Bylaws.

2.5.4. Adopt any urgent Medical Staff Rules or Policies and Manuals to comply with law or regulation in accordance with Article XV Section 3.7 of these Bylaws.

2.5.5. Supervise, report to, and be accountable to the Board, as appropriate, regarding the performance of all Medical Staff functions, which shall include but not be limited to:

a. Requiring and acting on regular reports and recommendations from the Medical Staff Officers, Division Chairs, Department Heads, and Medical Staff committees concerning the discharge of their respective assigned functions;

b. Issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and

c. Following up with Medical Staff Officers, Division Chairs, Department Heads, and Medical Staff committees to ensure implementation of all directives.

2.5.6. Coordinate the activities of the Medical Staff committees, Division Chairs, and Department Heads.

2.5.7. Based upon input from Division Chair or Department Heads, Regional Credentials Committees, and Professional Performance Committee, review and make recommendations to the Board regarding all applications for Medical Staff Membership and AHP appointment, reappointment, and the delineation of Privileges or Scope of Practice, as applicable, in accordance with the processes in these Bylaws and the Credentials Manual.

2.5.8. Request routine Peer Review or collegial intervention of Practitioners and AHPs in accordance with the processes in these Bylaws in instances where there is doubt about an applicant's ability to perform the Privileges or Scope of Practice requested.

2.5.9. When indicated, approve Investigations and corrective actions affecting Medical Staff Members and AHPs.

2.5.10. Make recommendations to the Board regarding Medical Staff matters including without limitation:

a. The structure of the Medical Staff;

b. The process used to review credentials and to delineate individual Privileges or Scope of Practice;

c. The organization of the quality assessment and improvement activities of the Medical Staff and the mechanism used to conduct, evaluate, and revise such activities;

d. The mechanism by which Membership on the Medical Staff may be terminated; and

e. The mechanism for hearing and appeal procedures.

The Medical Executive Committee duties set forth in this Section 2.5 may be satisfied by way of recommending the processes in these Bylaws and Policies and Manuals addressing the applicable duties.

2.5.11. Make recommendations to the Board for the termination, summary suspension, or restriction of Medical Staff Membership or Clinical Privileges in accordance with Article XI of these Bylaws.

2.5.12. With the assistance of the Medical Staff President and Chief Medical Officer, supervise the Medical Staff's compliance with:

a. The Medical Staff Bylaws, and Policies and Manuals;

b. The Health System's and Hospital's bylaws, and policies and procedures;

c. State and federal laws and regulations; and

d. The standards of the applicable Medicare accreditation entity.

2.5.13. Participate in the review of Health System policies and procedures that relate to the Medical Staff, and promote compliance with the approved policies of the Health System.

2.5.14. With the Division Chairs, set objectives for establishing, maintaining, and enforcing professional and clinical standards within the Hospitals and the Health System, and for the continuing improvement of the quality of care rendered in the Hospitals, and assist in developing quality improvement programs to achieve these objectives.

2.5.15. Report and make recommendations to the Board through the Medical Staff President on at least the following:

a. The outcomes of quality improvement programs with sufficient background and detail to assure the Board that quality of care is consistent with professional standards; and

b. The general status of any Medical Staff Member or AHP disciplinary or corrective actions in progress.

2.5.16. Review and make recommendations to the Chief Medical Officer regarding the quality of care by Practitioners under exclusive contract arrangements for professional services at the Health System or a Hospital.

2.5.17. Upon reasonable request of the Health System or Hospital Administration or the Board, provide recommendations to the Chief Medical Officer regarding appropriate qualifications, clinical standards for quality care, patient safety, efficiency, adequate coverage, or compliance with accreditation standards for an initial closed panel or exclusive or semi-exclusive contract or the renewal of a closed panel or exclusive or semi-exclusive contract.

2.5.18. Establish, as necessary, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the Medical Executive Committee.

2.5.19. Establish the date, time, place, and agenda of any meetings of the Medical Staff.

2.5.20. Perform such other duties set forth in these Bylaws.

2.6. The Medical Staff may revoke or change any authority delegated to the Medical Executive Committee through amendment of these Bylaws in accordance with Article XV Section 2 of these Bylaws.

2.7. The Medical Executive Committee shall meet at least ten (10) times per year and maintain a permanent record of its proceedings and actions.

2.8. A quorum for the Medical Executive Committee is fifty percent (50%) of the voting Members. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of voting Members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be required by these Bylaws.

2.9. The action of a majority of the voting Members at a meeting at which a quorum is present shall be the action of the Medical Executive Committee, unless a greater number is required by these Bylaws. The Medical Staff President shall refrain from voting, except when necessary to break a tie vote.

SECTION 3. REGIONAL CREDENTIALS COMMITTEES

3.1. Establishment:

There shall be two (2) or more Regional Credentials Committees established by the Medical Executive Committee.

3.2. Confidentiality and Immunity:

Each Regional Credentials Committee is deemed to be a regularly constituted quality improvement committee pursuant to RCW 4.24.250, and RCW 70.41.200, as well as a professional review body as defined in the Health Care Quality Improvement Act of 1986. All minutes, reports, recommendations, communications, and actions made or taken by a Regional Credentials Committee are covered by the provisions of the Health Care Quality Improvement Act of 1986, RCW 4.24.250, and RCW 70.41.200 or the corresponding provisions of any subsequent state or federal statute providing immunity or confidentiality for quality improvement, Peer Review, or related activities.

3.3. Composition:

3.3.1. Each Regional Credentials Committee shall consist of between three (3) and five (5) Members of the Medical Staff and one (1) Independent AHP or Physician Assistant from each Campus selected by the Campus Medical Staff Leadership Council of that Campus and appointed by the Medical Executive Committee. The Campus representative of the Regional Credentials Committee shall be a voting Member of the Campus Medical Staff Leadership Council in accordance with Article VIII Section 1.1.3.

3.3.2. The Chair of each Regional Credentials Committee shall be appointed by the Medical Staff President from the Members of the Committee.

3.3.3. Members will serve for a period of two (2) years and may be reappointed for successive terms.

3.3.4. The Medical Staff President, Medical Staff President Elect, Chiefs of Staff for the affiliated Campuses, Hospital Chief Medical Officers, and the Chief Medical Officer may serve as ex-officio members, without vote.

3.4. Duties:

3.4.1. Each Regional Credentials Committee will carry out the duties set forth in the Credentials Manual.

3.4.2. Each Regional Credentials Committee will receive reports from the associated Division Chair or Department Heads on applications for Medical Staff and Allied Health Professionals appointment, reappointment and privilege requests for the affiliated Campuses.

3.4.3. Each Regional Credentials Committee will carry out Ongoing Professional Practice Evaluation (OPPE) as set forth by the Medical Staff Ongoing Professional Practice Evaluation Policy, which may consist of:

a. Ongoing review of cases, by volume, outcome, complication rates, returns to the hospital, average length of stay, average cost by case, post discharge surveillance data- all compared to peer group comparisons, and adjusted where possible for acuity

b. Review of participants Peer Review experience, grievances, incident reports, litigation/claims, patient satisfaction data, and CMS Core Metric report cards.

c. OPPE may be performed concurrent with the reappointment cycle but must meet the timelines as set forth by the Medical Staff Ongoing Professional Practice Evaluation Policy. The data used is presented to the Division Chair or Department Head, the Chief Medical Officer, and the Regional Credentials Committee in advance of reappointments and renewal of Privileges.

3.4.4. Each Regional Credentials Committee will review the (OPPE) reports for applicants for reappointment and renewed Privileges requests in advance of the reappointment date.

3.4.5. Each Regional Credentials Committee will make recommendations to the Professional Performance Committee regarding all applications for Medical Staff and Allied Health Professionals appointment, reappointment and Privilege requests within the Region, subject to Medical Executive Committee recommendation and final Board approval.

3.4.6. Each Regional Credentials Committee will make recommendations to the Professional Performance Committee regarding Initial Focused Professional Practice Evaluations related to initial appointments and new Clinical Privilege requests within the Region.

3.4.7. Following final Board approval, the Regional Credentials Committee will provide each campus Medical Staff Leadership Council with a list of site-specific Medical Staff and Allied Health Professional appointments, reappointments and Privileges for informational purposes.

3.4.8. Each Regional Credentials Committee will evaluate and/or seek resolution of unresolved or repeated Practitioner or Allied Health Professional behavior concerns referred by the Campus Medical Staff Leadership Council(s) in accordance with the Credentials Manual and associated policies. The Regional Credentials Committee may refer unresolved, repeated or egregious behavior concerns, including any recommendations for FPPE, to the Professional Performance Committee for further review and action.

3.4.9. Records will be maintained of all Regional Credentials Committee activities and shall be confidential in accordance with these Bylaws, and are afforded all protections pursuant to RCW 4.24.240-250 and RCW 70.41.200.

3.4.10. Each Regional Credentials Committee will meet at least monthly.

3.4.11. Each Regional Credentials Committee will collaborate with the other Regional Credentials Committees to develop professional criteria for Clinical Privileges for all Practitioners and Allied Health Professionals in the Health System. The Regional Credentials Committees will make recommendations to the Professional Performance Committee, subject to approval of the Medical Executive Committee and the Board.

3.4.12. The Regional Credentials Committees will collaborate to address the definition of procedure specific privileging criteria for new or unusual treatments in accordance with the Policy for Developing Privileges for New Technology, following recommendation of the Division(s). The Regional Credentials Committees will recommend privileging criteria to the Professional Performance Committee, subject to approval of the Medical Executive Committee and the Board.

SECTION 4. REGIONAL PEER REVIEW COMMITTEES

4.1. Establishment:

There shall be two (2) or more Regional Peer Review Committees established by the Medical Executive Committee and operated in accordance with the Regional Peer Review Committee charters. See Peer Review Policy.

4.2. Confidentiality and Immunity:

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

4.3. Composition:

4.3.1. Each Regional Peer Review Committee shall consist of at least ten (10) established Medical Staff leaders from a broad variety of specialists and two (2) Independent AHPs or Physician Assistants from the Region with representation from each affiliated Campus selected by the Campus Medical Staff Leadership Councils of that Region and appointed by the Medical Executive Committee.

4.3.2. The Chair of each Regional Peer Review Committee shall be appointed by the Medical Staff President from the Members of the Committee, and shall report to the Professional Performance Committee.

4.3.3. Membership will be reviewed and approved by the Medical Executive Committee.

4.3.4. Members will serve for a period of two (2) years and may serve for successive terms.

4.3.5. The Medical Staff President, Medical Staff President Elect, Chiefs of Staff for the affiliated Campuses, Hospital Chief Medical Officers, and the Chief Medical Officer may serve as an ex-officio member, without vote.

4.4. Duties:

4.4.1. Establish, maintain and ensure a consistent, timely, defensible, balanced, useful and ongoing Peer Review process.

4.4.2. Review data derived from the Peer Review process to identify and address organizational trends and Practitioner or Allied Health Professional-specific issues.

4.4.3. Determine whether the Peer Review process is operating as it should and take appropriate or necessary action to ensure that the process meets the above criteria.

4.4.4. Function on an ad hoc basis to review individual, potentially problematic cases and/or Practitioners or Allied Health Professionals.

4.4.5. Make recommendations to the Professional Performance Committee for FPPE or other actions.

4.5. Meetings:

Each Regional Peer Review Committee shall meet on an ad hoc basis, as needed, but at least one (1) time each Medical Staff Year.

SECTION 5. MEDICAL STAFF BYLAWS COMMITTEE

5.1. Establishment

A Medical Staff Bylaws Committee will be convened at least every other year or more frequently as requested by the Regional Credentials Committees, the Campus Medical Staff Leadership Councils, or the Medical Executive Committee, or as called by the chair of the Medical Staff Bylaws Committee for the purpose of reviewing and, as deemed appropriate by the Medical Staff

Bylaws Committee, recommending amendments to these Bylaws or any of the Policies and Manuals.

5.2. Composition

5.2.1. The Medical Staff Bylaws Committee will be appointed by the Medical Staff President and approved by majority vote of the Medical Executive Committee.

5.2.2. The Medical Staff Bylaws Committee shall be composed of at least one (1) Medical Staff Member in Good Standing from each Campus selected by the Campus Medical Staff Leadership Council of that Campus and at least one (1) Independent AHP or Physician Assistant, each approved by the Medical Executive Committee, and the past Medical Staff President, if the past Medical Staff President is available and willing to serve.

5.2.3. The Chief Medical Officer will serve on the Medical Staff Bylaws Committee, as an *ex officio* Member without a vote.

5.2.4. The Medical Staff Bylaws Committee will choose a chairperson from among its Active Medical Staff Members.

5.2.5. The Medical Staff Bylaws Committee may request consultative support from other Medical Staff Members, the Hospital System administrative staff, or outside sources, including legal advice, as it deems necessary. Such consultants will not be Members of the Medical Staff Bylaws Committee, and will not have a vote.

5.2.6. Medical Staff Bylaws Committee members will serve a two (2) year term, and may serve up to five (5) consecutive two (2) year terms.

5.2.7. A recording secretary and technical support will be provided by the Health System.

SECTION 6. PROFESSIONAL PERFORMANCE COMMITTEE

6.1. Establishment

There shall be a Professional Performance Committee established by the Medical Executive Committee and operated in accordance with the Professional Performance Committee charter. See Peer Review Policy.

6.2. Confidentiality and Immunity

The Professional Performance Committee is deemed to be a regularly constituted quality improvement committee pursuant to RCW 4.24.250, and RCW 70.41.200, as well as a professional review body as defined in the Health Care Quality Improvement Act of 1986. All minutes, reports, recommendations, communications, and actions made or taken by a Regional Peer Review Committee are covered by the provisions of the Health Care Quality Improvement Act of 1986, RCW 4.24.250, and RCW 70.41.200 or the corresponding provisions of any subsequent state or federal statute providing immunity or confidentiality for quality improvement, Peer Review, or related activities.

6.3. Composition

6.3.1. The Professional Performance Committee shall be composed of one (1) Independent AHP or Physician Assistant, and at least one (1) established Medical Staff leader from each Campus selected by the Campus Medical Staff Leadership Council of that Campus and approved by the Medical Executive Committee.

6.3.2. The Chair of the Professional Performance Committee shall be appointed by the Medical Executive Committee.

6.3.3. Members will serve for a period of two (2) years and may serve for successive terms.

6.3.4. The Medical Staff President, Medical Staff President Elect, Chiefs of Staff for the affiliated Campuses, the Chairs the Regional Credentials Committees, the Chairs of the Regional Peer Review Committees, the Hospital Chief Medical Officers, and the Chief Medical Officer may serve as *ex-officio* members, without vote.

6.4. Duties

6.4.1. The Professional Performance Committee will perform such duties set forth in the Professional Practice Evaluation Policies, and as delegated by the Medical Executive Committee. The Medical Executive Committee will not delegate to the Professional Performance Committee the authority to make a recommendation to the Board to grant, deny, restrict, suspend or revoke Medical Staff Membership or Clinical Privileges of any individual.

6.4.2. The Professional Performance Committee will carry out the duties set forth in the Credentials Manual.

6.4.3. The Professional Performance Committee will receive reports and recommendations from the Regional Credentials Committees regarding all applications for Medical Staff and Allied Health Professionals appointment, reappointment and Privilege requests within the System, and may take the following actions:

a. Recommend to the Medical Executive Committee appointment or reappointment to the Medical Staff, grant or renewal of Clinical Privileges, and assignment to a Division, including any special conditions, in accordance with the recommendation of the Regional Credentials Committee.

b. Amend the recommendation of the Regional Credentials Committee.

c. Request any additional information to assist in its deliberations, refer a matter back to the Regional Credentials Committee, or take other action as allowed in the Credentials Manual.

6.4.4. The Professional Performance Committee will make recommendations to the Medical Executive Committee regarding all applications for Medical Staff and Allied Health Professional appointment, reappointment and Privilege requests within the System.

6.4.5. The Professional Performance Committee will receive and act on recommendations from the Regional Credentials Committees for Initial FPPE for initial appointments and new Clinical Privileges.

6.4.6. The Professional Performance Committee will receive reports from the Regional Peer Review Committees regarding all data derived from the OPPE and Peer Review process and recommendations from the Regional Peer Review Committees of further evaluations, such as a FPPE.

6.4.7. The Professional Performance Committee will evaluate and/or seek resolution of unresolved or repeated Practitioner or Allied Health Professional behavior concerns referred by the Regional Credentials Committee and egregious behavior concern. The Professional Performance Committee may conduct FPPE and/or make recommendations to the Medical Executive Committee for further action in accordance with the Focused Professional Practice Evaluation Policy.

6.4.8. The Professional Performance Committee will carry out FPPE as set forth by the Focused Professional Practice Evaluation Policy, which may consist of:

a. Conduct FPPE or receive and act on recommendations from the Regional Peer Review Committees for For Cause FPPE when questions arise regarding a Practitioner's or Allied Health Professional's ability to provide safe and highly quality care.

b. Conduct For Cause FPPE, other than an Initial FPPE for initial appointment or new Privileges, in accordance with the Medical Staff Focused Professional Practice Evaluation Policy for Practitioners with potential behavioral issues or clinical performance that may affect the Practitioner or Allied Health Professional's ability to provide safe and high quality care.

c. Monitor and oversee FPPE in accordance with the Medical Staff Focused Professional Practice Evaluation Policy.

d. Receive regular reports of FPPE status and/or actions related to the provider performance summaries.

e. Report findings and conclusions of the FPPE process, and make recommendations to continue FPPE, move to OPPE, or initiate a formal Investigation, to the Medical Executive Committee.

6.4.9. The Professional Performance Committee may conduct a formal Investigation of any Practitioner or Allied Health Professional as requested by the Medical Executive Committee, and make a written report of the results of the investigation to the Medical Executive Committee, including an in-person presentation to the Medical Executive Committee, if requested. The Professional Performance Committee may delegate the Investigation to a subcommittee or ad hoc committee to serve as the Investigating Committee.

6.5. Meetings

6.5.1. The Professional Performance Committee shall meet at least monthly.

SECTION 7. STANDING AND AD HOC MEDICAL STAFF COMMITTEES

7.1. The Medical Staff will discharge its additional duties through standing and ad hoc Medical Staff Committees.

7.2. The purposes, membership and duties of additional standing Medical Staff committees will be further defined in charters recommended by the Medical Executive Committee and approved by the Board, and as amended from time to time. The Medical Staff committee charters are incorporated into these Bylaws by reference. The Medical Executive Committee may establish additional standing Medical Staff committees, with approval of the Board.

7.3. The Medical Executive Committee may, by resolution, establish ad hoc Medical Staff committees from time to time to carry out the Medical Staff duties under these Bylaws, including without limitation, nomination committees in accordance with Article VI, Investigating Committees in accordance with Article XI, and such other committees as the Medical Executive Committee deems appropriate to fulfill the Medical Staff's duties and responsibilities and ensure the effective Medical Staff self-governance.

7.4. The Medical Staff will participate in any other committees of the Health System or Hospitals as requested by the Board.

SECTION 8. COMMITTEE MEETINGS

8.1. Quorum:

8.1.1. A quorum of a committee is fifty percent (50%) of the voting Members, unless otherwise defined in the applicable committee charter.

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

8.2. Action of a Medical Staff Committee: The action of a majority of the voting Members at a meeting at which a quorum is present shall be the action of the Medical Staff committee, unless a greater number is required by these Bylaws. The Medical Staff President shall refrain from voting at meetings of the Medical Staff committee, except when necessary to break a tie vote

8.3. Electronic Meetings: At the discretion of the Medical Staff committee chair, a Medical Staff committee meeting may be conducted by telephone conference or other confidential, secure, electronic means, which shall be deemed to constitute a meeting of the Medical Staff committee for the matters discussed and action taken during such conference.

8.4. Electronic Action Without a Meeting: At the discretion of the Medical Staff committee chair, action may be taken without a meeting of a Medical Staff committee, and such action is valid if it is acknowledged in writing, in a secure electronic or facsimile means, setting forth the action so taken which is signed by at least two-thirds (2/3) majority of the voting Members of the Medical Staff committee.

8.5. Proxy Voting: Voting by proxy will not be permitted in any vote of the Medical Staff or a Medical Staff committee.

8.6. Conflict of Interest: Any committee member who has a conflict of interest, either personal, professional or financial, or was an active participant in the matter before the committee at any previous level, that may affect the committee member's ability to make a fair and impartial decision on a matter before the committee, or the safety or quality of care, treatment and services, will disclose the conflict to the committee chair. Other committee members may also present the question of a conflict of interest on a matter for any other committee member. The committee chair will make the final determination whether a committee member does or does not have a conflict of interest for the matter before the committee. If the committee chair determines that the committee member has a conflict of interest in the matter, the committee member may provide any relevant factual information on the matter before the committee, but will recuse themselves (and leave the room) during deliberations and vote on the matter.

ARTICLE VIII. CAMPUS ORGANIZATION

SECTION 1. ORGANIZATION OF CAMPUSES

The Medical Staff will be organized into six Campuses which are located at St. Anne Hospital, St. Anthony Hospital, St. Clare Hospital, St. Elizabeth Hospital, St. Francis Hospital, and St. Joseph Medical Center.

1.1. Campus Medical Staff Leadership Council

1.1.1. Establishment:

Each Campus will establish a Campus Medical Staff Leadership Council. The Campus Chief of Staff will chair the Campus Medical Staff Leadership Council.

1.1.2. Confidentiality and Immunity:

Each Campus Medical Staff Leadership Council is deemed to be a regularly constituted quality improvement committee pursuant to RCW 4.24.250, and RCW 70.41.200, as well as a professional review body as defined in the Health Care Quality Improvement Act of 1986. All minutes, reports, recommendations, communications, and actions made or taken by a Campus Medical Staff Leadership Council are covered by the provisions of the Health Care Quality Improvement Act of 1986, RCW 4.24.250, and RCW 70.41.200 or the corresponding provisions of any subsequent state or federal statute providing immunity or confidentiality for quality improvement, Peer Review, or related activities.

1.1.3. Composition:

a. The Campus Medical Staff Leadership Council shall consist of the following voting Members: the Campus Chief of Staff, the Campus Chief of Staff-Elect, the Campus Member At-Large of the Medical Executive Committee, the Campus representative on the Regional Credentials Committee, the Campus Department Heads, and one (1) Independent AHP or Physician Assistant appointed by the Campus Chief of Staff. The Campus Chief of Staff shall refrain from voting, except when necessary to break a tie vote.

b. The Campus Medical Staff Leadership Council shall consist of the following *ex officio* Members, without a vote: the Hospital Chief Operations Officer, Chief Medical Officer, Hospital Chief Medical Officer, Chief Nursing Officer, Immediate Past Campus Chief of Staff, Campus Secretary/Treasurer, Quality Program Manager, other Members of Hospital Administration designated by the Chief of Staff, or their respective designees.

1.1.4. Duties:

The Campus Medical Staff Leadership Council duties will include the following:

a. Facilitate communications and serve as a liaison among the Campus Medical Staffs, the Medical Executive Committee, and Administration for matters concerning the Medical Staff.

b. Receive recommendations from Division Chairs or Department Heads for applicants to the Medical Staff for initial appointments, reappointments and Clinical Privileges where the Campus is designated as the applicant's Primary Campus. A recommendation from the Campus Medical Staff Leadership Council is not required. The Campus Medical Staff Leadership Council may, but is not required to, provide comments to the Regional Credentials Committee regarding the following:

i. Any questions regarding the applicant's Primary Campus designation,

ii. Any concerns whether the Campus has resources to support the Clinical Privileges requested by the applicant, and

iii. Any comments regarding the professional conduct or competence of the applicant for consideration by the Regional Credentials Committee in accordance with the Credentials Manual, as amended from time to time.

c. Address call coverage in accordance with the Policies and Manuals and the EMTALA - Examination, Treatment and Transfer of Individuals in Need of Emergency Services Policy, and make recommendations to the Medical Executive Committee regarding the need for Members of the Associate Medical Staff to participate in on-call coverage.

d. Advise the Medical Executive Committee regarding the Campus' unique circumstances and any significant difference in the Campus patient population and services offered at the Campus.

e. Make recommendations to the Medical Executive Committee and assist in establishing and implementing policies and procedures addressing the needs and concerns of the Members of its Campus Medical Staff.

f. Advise the Medical Executive Committee on issues localized to the Campus.

g. Assist in the monitoring and improvement of patient care.

h. Fulfill such other responsibilities delegated to it by the Medical Executive Committee.

1.1.5. Meetings:

Each Campus Medical Staff Leadership Council will meet at least six (6) times per year. The Campus Medical Staff Leadership Council meetings are subject to the same standards and requirements as a Medical Staff committee as set forth in Article VII, Section 8 above.

ARTICLE IX. UNIFIED MEDICAL STAFF

SECTION 1. FRANCISCAN HEALTH MEDICAL STAFF UNIFICATION

1.1. The Franciscan Medical Staff can elect to be unified with, or opt-out of unification with, the medical staffs of other hospitals in the Health System that share the same Board, according to the following processes. The resulting unified medical staff will be referred to as the "Franciscan Medical Staff".

1.2. Unification Process

1.2.1. The Board determines that a unified and integrated medical staff is permissible and votes in favor of a resolution to support unification of the Medical Staff.

1.2.2. As soon as unification is under consideration by the Board, but no later than six (6) months before submission for a Medical Staff vote under these Bylaws, the Campus will send written notice of proposed unification of medical staffs to the voting Members of the Medical Staff.

1.2.3. The notice will include at least the following information: the Health System Campus(s) and medical staff(s) involved in the proposed unification, any risks and benefits, and schedule, plans and prospects for the Franciscan Medical Staff.

1.2.4. The Medical Executive Committee will review the proposal and share with all Medical Staff Members its analysis of the proposed unification, based on its assessment of the immediate and long-term effects of unification three (3) months prior to the Medical Staff vote on unification.

1.2.5. The Medical Staff will vote on whether to unify at a special meeting called for that purpose or by electronic ballot. A majority of Medical Staff Members who hold Privileges at the Campus and have the right to vote must cast votes in favor of unification or to opt-out of unification subject to the quorum requirements under Article XIV Section 6.

1.2.6. If the Medical Staff votes to accept unification, such unification will proceed only for those medical staff(s) of the other Health System Campuses that similarly vote in favor of a unified medical staff.

1.2.7. If the Medical Staff votes to accept unification, these Bylaws remain in effect until these Bylaws are amended or new Medical Staff Bylaws for the Franciscan Medical Staff are adopted pursuant to the terms of these Bylaws.

1.2.8. The Franciscan Medical Staff will establish and implement policies and procedures in accordance with applicable state and Federal laws, and Joint Commission standards.

1.3. Opt-Out Process

1.3.1. One (1) year after initial acceptance of the Unified Medical Staff, and every two (2) years thereafter, the Medical Staff at a Campus may vote on whether to opt-out of the Franciscan Medical Staff at a special meeting called for that purpose or by electronic ballot.

1.3.2. A majority of Medical Staff Members who hold Privileges at the Campus (other than telemedicine Privileges) and have the right to vote must cast votes in favor of opting-out of the Franciscan Medical Staff to unwind unification.

1.3.3. Upon voting to opt-out of the Franciscan Medical Staff, the Medical Staff remains unified, and these Bylaws remain in effect until:

a. New Medical Staff Bylaws for the separate and distinct medical staff are adopted by the separate and distinct medical staff and approved by the Board; and

b. A special election has been held and Medical Staff Officers and other leaders have been elected for the separate and distinct medical staff.

1.3.4. Upon the effective date of the opt-out from the Franciscan Medical Staff:

a. Each Member of the Franciscan Medical Staff with Privileges at the Campus will be a Member of the separate and distinct Medical Staff.

b. All Peer Review information developed by the Franciscan Medical Staff for those Members who have Privileges at the Campus (including without limitation, any credentialing, privileging, OPPE, FPPE, and investigation information) will be made available to the separate and distinct Medical Staff.

c. Any Peer Review matters that are in progress for those Members who have Privileges at the Campus as of the effective date of the opt-out will be continued by the separate and distinct Medical Staff.

ARTICLE X. STRUCTURE AND FUNCTIONS OF THE MEDICAL STAFF

SECTION 1. MEDICAL STAFF FUNCTIONS

The functions of the Medical Staff shall be as set out in these Bylaws, the Policies and Manuals, and/or by resolution of the Medical Executive Committee, subject to approval by the Board. The Medical Staff's functions and responsibilities include without limitation:

1.1. Be accountable to the Board for the quality of medical care in the Hospitals furnished by Medical Staff Members, Practitioners and AHPs with Privileges or Scope of Practice, as applicable.

1.2. Provide for an organizational structure, through which the Medical Staff carries out its functions.

1.3. Provide for self-governance, including selection and removal of Medical Staff Officers and other Medical Staff leaders.

1.4. Initiate, develop, adopt, amend, uphold, and maintain Medical Staff Bylaws and Policies and Manuals for the Medical Staff to carry out its responsibilities, which shall be compatible with the Health System's Bylaws, Health System policies, and compliant with applicable laws, regulations, and accreditation standards, and subject to approval of the Board.

1.5. Recommend to the Board any Medical Staff Bylaws and Policies and Manuals, and any amendments thereto in accordance with Article XV of these Bylaws.

1.6. Provide a means for the Medical Staff to discuss issues of mutual concern with the Board, and Administration.

1.7. Provide oversight of quality of care, treatment, and services provided by Practitioners and AHPs with Privileges or Scope of Practice, as applicable, to patients of the Health System, including through delegation of such oversight responsibilities to certain designated committees or Members of the Medical Staff.

1.8. Provide organizational structure to promote collaboration across the Health System to create a uniform quality of patient care, treatment, and services.

1.9. Monitor, evaluate, and develop clinical policies for care provided in special care areas and patient care support services;

1.10. Engage in performance improvement activities for the Health System, and provide oversight for analyzing and improving patient safety and satisfaction, including investigating and monitoring nosocomial infections by working with the Health System's infection control program.

1.11. Provide for a level of professional performance that is consistent with generally accepted standards attainable within the Health System's means and circumstances.

1.12. Establish standards for Medical Staff Membership, and examine and make recommendations to the Board regarding all applications for Medical Staff Membership and AHP appointment, reappointment, and the delineation of Privileges or Scope of Practice, as applicable

1.13. Periodically conduct appraisals of Medical Staff Members, Practitioners and AHPs with Privileges or Scope of Practice, as applicable.

1.14. Organize and support professional education and community health education and support services.

1.15. Participate in planning for the Health System's growth and development, response to disasters, and the provision of services required to meet the needs of the community;

1.16. Review and assist Administration in achieving and maintaining Health System and Hospital accreditation.

1.17. Comply with and enforce these Bylaws and the Policies and Manuals by recommending action to the Board in certain circumstances and taking action in others pursuant to these Bylaws, and the Policies and Manuals.

1.18. Engage in other functions reasonably requested by the Medical Executive Committee or the Board.

SECTION 2. DIVISIONS

2.1. The Medical Staff shall include such Divisions listed below. Each Division shall be organized as an integral unit of the Medical Staff and have one (1) Division Chair who is selected and has the authority, duties, and responsibilities specified in Article VI Section 8 of these Bylaws.

2.2. The Medical Executive Committee will periodically review the Medical Staff structure and designation of the Divisions and may recommend to the Medical Staff and the Board the creation, elimination, or merger of Divisions for better organizational efficiency and improved patient care.

2.3. Each Practitioner will be assigned to a Division upon appointment to the Medical Staff or grant of Privileges, and each AHP will be assigned to a Division upon grant of Privileges or Scope of Practice.

2.4. The current Divisions are:

2.4.1. Medicine,

2.4.2. Surgery, and

2.4.3. Women & Children

2.5. Each Division may include Departments in accordance with Section 3 below.

2.6. The Divisions shall fulfill the Peer Review, clinical, administrative, safety, quality assurance, risk management, and collegial and educational functions described in these Bylaws and the Policies and Manuals, including without limitation:

2.6.1. Serve as a forum for the exchange of clinical information regarding services provided by Members assigned to the Division.

2.6.2. Monitor and review the patient care provided by the Division for the purpose of analyzing and evaluating the quality, safety, and efficacy of care and treatment provided by the Division. Patient care reviews shall include all clinical work performed under the jurisdiction of the Division, regardless of whether the Member whose work is subject to such review is a Member of the Division.

a. The number and extent of such reviews to be conducted during a Medical Staff Year shall be determined by the Division Chair in consultation with the Medical Executive Committee and in accordance with the Medical Staff Ongoing Professional Practice Evaluation Policy.

2.6.3. Routinely collect and assess information about patient care provided in the Division, and develop objective criteria for use in evaluating patient care.

2.6.4. Develop and participate in patient care quality and performance improvement initiatives.

2.6.5. Develop and/or provide orientation and continuing medical education opportunities and grand rounds in collaboration with other Medical Staff committees responsive to quality review findings, new developments, and other needs relevant to the Division.

2.6.6. Provide recommendations to the Division Chair or Medical Executive Committee regarding the development of clinical policy and practice guidelines related to patient care and treatment provided by the Division.

2.6.7. Participate in the development of criteria for Clinical Privileges that are relevant to the care provided in the Division.

2.6.8. Participate in the development of criteria and procedures for the monitoring and supervision of AHPs, as appropriate.

2.6.9. Provide information and recommendations regarding the personnel, space, equipment, and other resource needs of the Division.

2.6.10. Provide information and recommendations regarding a specific issue at the request of a Division Chair, Medical Staff Leadership Council, or the Medical Executive Committee.

2.6.11. Perform any other such functions as may be delegated by the Medical Executive Committee or as required in these Bylaws and the Policies and Manuals.

2.7. The Divisions will perform the functions in this Section 2 in these Bylaws in collaboration with the Departments and the Department Heads and any ad hoc committees as established by the Division Chair.

2.8. The Division Chair may delegate functions to the Department Heads and Departments from time to time.

SECTION 3. DEPARTMENTS

3.1. The Medical Staff shall include Departments composed of at least ten (10) Practitioners in a Division practicing in the same or similar specialty at one or more Campuses, and approved by the applicable Campus Medical Staff Leadership Council(s), the Division Chair, and the Medical Executive Committee. Departments may be added, deleted, or consolidated as approved by the applicable Campus Medical Staff Leadership Council(s), the Division Chair, and the Medical Executive Committee.

3.2. Each Department shall be organized as an integral unit of the Medical Staff and have one (1) Department Head or two (2) Co-Department Heads who are selected and have the authority, duties, and responsibilities specified in Article VI Section 9 of these Bylaws.

3.3. The Campus Medical Staff Leadership Council will periodically review the Medical Staff structure and designation of the Departments and may recommend to the Medical Executive Committee the creation, elimination, or merger of Departments for better organizational efficiency and improved patient care.

3.4. Each Practitioner will be assigned to a Department upon appointment to the Medical Staff or grant of Privileges, and each AHP will be assigned to a Department upon grant of Privileges or Scope of Practice.

3.5. Departments shall perform such functions as delegated by the Division Chair or Medical Executive Committee, including without limitation any of the following activities on behalf of the Department or in collaboration with other Departments:

3.5.1. Report and be accountable to the Division Chair.

3.5.2. Serve as a forum for the exchange of clinical information regarding services provided by Members assigned to the Department.

3.5.3. Provide recommendations to the Division Chair regarding continuing medical education and grand rounds related to patient care quality, new developments, and other needs relevant to the Department.

3.5.4. Provide recommendations, in collaboration with other Departments, Campus Medical Staff Leadership Councils, or committees across Campuses, to the Department Head, Division Chair, or Medical Executive Committee regarding the development of clinical policy and practice guidelines related to patient care and treatment provided by the Department.

3.5.5. Participate in the development of criteria for Clinical Privileges, in collaboration with other Departments or committees across Campuses, which are relevant to the care provided in the Department.

3.5.6. Participate in the development of criteria and procedures, in collaboration with other Departments or committees across Campuses, for the monitoring and supervision of AHPs, as appropriate.

3.5.7. Provide information and recommendations to the Division Chair, Campus Medical Staff Leadership Council, or Medical Executive Committee, as applicable, regarding the personnel, space, equipment, and other resource needs of the Department.

3.5.8. Provide information and recommendations regarding a specific issue at the request of a Department Head, Division Chair, Medical Staff Leadership Council, or the Medical Executive Committee.

3.5.9. Perform any other such functions as may be delegated by the Division Chair or as required in these Bylaws and the Policies and Manuals.

SECTION 4. APPLICATION FEES

4.1. The application fees for each application for initial appointment and reappointment will be established by the Medical Executive Committee, subject to approval by the Board. The application fees may be revised from time to time.

4.2. The application fees will be credited into the Medical Staff Treasury for the applicable Primary Campus.

SECTION 5. MEDICAL STAFF TREASURY

5.1. Each Campus Medical Staff Leadership Council will establish a budget for the Campus Medical Staff, subject to approval of the Medical Executive Committee.

5.2. The Medical Staff Treasury for each Campus will be monitored by the Campus Secretary/Treasurer, subject to oversight of the Medical Staff Secretary/Treasurer.

5.2.1. The Campus Secretary/Treasurer will report to the Campus Medical Staff Leadership Council on the income, disbursements, and balance of the Medical Staff Treasury, and any variance from the budget, at each Campus Medical Staff Leadership Council meeting.

5.2.2. The Medical Staff Secretary/Treasurer will report to the MEC on the income, disbursements and balance of each Medical Staff Treasury and any variance from the budgets, at each MEC meeting.

5.3. The Medical Staff Treasury funds will be used to exclusively advance the purposes of the Medical Staff and/or health care in the community. The Health System and the Hospitals do not have authority to use Medical Staff Treasury funds for any other purposes.

5.4. Expenditures from the Medical Staff Treasury less than or equal to $10,000 require approval of the Campus Secretary/Treasurer, the Campus Medical Staff Leadership Council, and the CEO.

5.5. Expenditures from the Medical Staff Treasury greater than $10,000 require approval of the Campus Secretary/Treasurer, the Campus Medical Staff Leadership Council, the Medical Staff Secretary/Treasurer, the Medical Executive Committee, and the CEO.

5.6. In the event of a disagreement among the Campus Secretary/Treasurer, the Medical Staff Secretary/Treasurer, or the Campus Medical Staff Leadership Council with regard to approval of a proposed expenditure, the conflict may be submitted to the Medical Executive Committee for final approval on behalf of the Medical Staff, subject to approval of the CEO.

5.7. The authority of the CEO to approve or withhold approval of expenditures from the Medical Staff Treasury is limited to a determination whether such expenditure is consistent with applicable state and Federal laws governing fraud and abuse and nonprofit organizations

ARTICLE XI. COLLEGIAL INTERVENTION, SUMMARY SUSPENSION, AUTOMATIC ACTIONS AND CORRECTIVE ACTION INVESTIGATIONS

SECTION 1. CORRECTIVE ACTION

1.1. Corrective action may be considered whenever reliable information indicates a Practitioner or Physician Assistant may have exhibited acts, demeanor, or conduct, either within or outside of a Hospital, that are reasonably likely to be detrimental to patient safety or to the delivery of quality patient care; including without limitation professional conduct or professional practice that is or may be: (a) unethical; (b) contrary to Health System or Medical Staff Bylaws, or Policies or Manuals; (c) below applicable professional standards; (d) disruptive of Medical Staff, Health System, or Hospital operations; (e) improper use of Hospital resources; (f) in violation of accreditation standards applicable to the Hospital; or (g) in violation of laws relating to the delivery of health care services.

1.2. Corrective action taken by the Medical Staff leaders or committees or the Board may include Adverse Actions as provided elsewhere in these Bylaws. If corrective action taken by the Medical Staff leaders or committees, or the Board constitute Adverse Actions, the Practitioner or Physician Assistant is entitled to procedural rights, including a hearing and appeal, in accordance with Article XII of these Bylaws.

1.3. Certain corrective actions taken by Medical Staff leaders, committees, or the Board are not Adverse Actions as defined in these Bylaws, and do not entitle a Practitioner or Physician Assistant to any procedural rights, including any hearing or appeals under these Bylaws. The types of corrective actions that are not Adverse Actions include without limitation:

1.3.1. Voluntary participation in remediation following Collegial Intervention under Article XI Section 7.

1.3.2. Summary suspension or restriction of Medical Staff Membership or Privileges in accordance with Article XI Section 2 for thirty (30) or fewer days.

1.3.3. Participation in clinical training or education, such as a CME requirement, so long as such participation does not result in restriction of Privileges for longer than thirty (30) days;

1.3.4. Issuance of a letter of warning, admonition, or counsel to the Practitioner or Physician Assistant;

1.3.5. Participation in counseling for disruptive behavior or harassment;

1.3.6. Participation in health screenings, health monitoring, and reporting in accordance with Health System Well-Being Policy;

1.3.7. Imposition of For Cause FPPE;

1.3.8. Removal of a Practitioner from the call roster or on-call schedule; and

1.3.9. Any other corrective action that does not restrict Privileges for longer than thirty (30) days.

SECTION 2. SUMMARY SUSPENSION OR RESTRICTION

2.1. Criteria for Initiation

2.1.1. The Medical Staff President, the Medical Staff Vice President, the Chief Medical Officer, the Hospital Chief Medical Officer, and the Chief Executive Officer shall each have the authority to summarily suspend or restrict the Medical Staff Membership or all or any portion of the Privileges of a Practitioner whenever the failure to take such action may result in imminent danger to the health and/or safety of any individual. If a summary suspension or restriction is imposed by the Chief Executive Officer, the Chief Medical Officer, or the Hospital Chief Medical Officer, prompt notice of the summary suspension or restriction will be provided to the Medical Staff President or the Medical Staff Vice President.

2.1.2. When consistent with safety, the person authorized to impose a summary suspension or restriction may make reasonable efforts to interview the Practitioner before or at the time the summary suspension or restriction is being imposed. Such person shall document the interview in the Practitioner's quality file. The interview shall not constitute a "hearing" as that term is used in these Bylaws, nor shall the hearing and appeal procedures apply, and the Practitioner is not entitled to have an attorney participate in the interview.

2.1.3. Unless otherwise indicated by the terms of the summary suspension or restriction, such summary suspension or restriction shall become effective immediately upon imposition.

2.1.4. Unless otherwise indicated by the terms of the summary suspension or restriction, the Practitioner's patients at the Hospital shall be promptly assigned to another Member by the Campus Chief of Staff or Department Head, with assistance of the Hospital Chief Medical Officer and considering, where feasible, the wishes of the patient and the affected Practitioner in the choice of a substitute Member.

2.1.5. Written notice of the summary suspension or restriction will be promptly given to the affected Practitioner, and the Medical Executive Committee. The written notice shall constitute a request to the Medical Executive Committee for a formal corrective action investigation.

2.1.6. The Medical Staff President, may authorize an expedited initial review of the matter on behalf of the Medical Executive Committee, to be conducted by the Professional Performance Committee.

2.1.7. As part of the expedited initial review, the Professional Performance Committee may interview the affected Practitioner. The interview shall not constitute a "hearing" as that term is used in these Bylaws, nor shall the hearing and appeal procedures apply, and the Practitioner is not entitled to have an attorney participate in the interview.

2.1.8. The Medical Staff President has the authority to lift the summary suspension or restriction before conclusion of the expedited initial review or Medical Executive Committee action under Section 2.2 below, if lifting the summary suspension or restriction is deemed appropriate. If the Medical Staff President lifts the summary suspension or restriction, the Medical Staff President must provide prompt notice to the Medical Executive Committee with a summary of the rationale for concluding that there is no longer imminent danger to the health or safety of any individual

2.2. Medical Executive Committee Action.

2.2.1. The Professional Performance Committee will report to the Medical Executive Committee on the preliminary results of the expedited initial review, if any, as soon as practical, but within twenty one (21) days of imposition of the summary suspension or at the time of the Medical Executive Committee meeting, whichever is earlier.

2.2.2. The Medical Executive Committee may terminate an expedited initial review authorized by the Medical Staff President, may initiate a formal Investigation to be conducted by the Professional Performance Committee, or may conclude that there has been a sufficient review of the facts to make a determination without a formal investigation.

2.2.3. The affected Practitioner may request an interview with the Medical Executive Committee. The interview shall be convened as soon as reasonably possible under all circumstances. The interview shall not constitute a "hearing" as that term is used in these Bylaws, nor shall the hearing and appeal procedures apply, and the Practitioner is not entitled to have an attorney participate in the interview. If the affected Practitioner does not request an interview, the Medical Executive Committee may request an interview with the affected Practitioner. A summary of the interview shall be made.

2.2.4. As soon as practicable after imposition of the summary suspension or restriction but within twenty one (21) days, the Medical Executive Committee shall be convened to review the matter that resulted in the summary suspension or restriction, review the preliminary results of the expedited initial review, and consider the action taken. The Medical Executive Committee meeting requires a quorum and may be conducted by telephone conference or other reliable electronic means.

2.2.5. After considering the matters resulting in the summary suspension or restriction and the Practitioner's interview, if any, and the expedited initial review, if any, the Medical Executive Committee shall determine whether to continue, modify or terminate the summary suspension or restriction, or make other recommendations, including further formal investigation.

2.2.6. The Medical Executive Committee will also determine whether there is sufficient information for a final recommendation, or whether to initiate or continue a formal corrective action investigation. Any formal corrective action Investigation will be conducted in accordance with the procedures set forth in Section 10. If the Medical Executive Committee continues the summary suspension or restriction, and initiates or continues a formal corrective action Investigation, the Professional Performance Committee shall make reasonable efforts to forward a written report of the Investigation as soon as practicable.

2.2.7. At any time during the summary suspension or restriction, the Medical Executive Committee may recommend or take any other action in accordance with these Bylaws.

2.2.8. If the Medical Executive Committee's action or recommendation is not an Adverse Action for the Practitioner, the Medical Executive Committee's action or recommendation will be forwarded to the Board for final action, and the Practitioner will not be entitled to the procedures under Article XII.

2.2.9. If the Medical Executive Committee's action or recommendation is adverse to the Practitioner, the Practitioner will be entitled to notice and procedures under Article XII.

2.2.10. Unless it expires by its terms or is earlier terminated by the Medical Executive Committee, the summary suspension or restriction shall continue during the pendency and completion of the formal corrective action investigation process and of any hearing and appellate procedures as set forth in these Bylaws.

2.3. Notice of Summary Suspension or Restriction and Hearing Rights.

2.3.1. A summary suspension or restriction that is for longer than thirty (30) days shall constitute an Adverse Action, which entitles the Practitioner to the procedural rights under these Bylaws, provided, however, the hearing for the summary suspension or summary restriction shall be consolidated with the hearing for any other Adverse Action.

2.3.2. If the summary restriction or suspension lasts longer than 30 days or the Medical Executive Committee recommends any Adverse Action in addition to the summary suspension or restriction that entitles the Practitioner to the procedural rights afforded by these Bylaws, the Medical Executive Committee shall promptly give Special Notice to the Practitioner, and written Notice to the Board and the System CEO.

SECTION 3. AUTOMATIC SUSPENSION AND TERMINATIONS

3.1. Failure to Maintain Basic Qualifications: A Practitioner's Medical Staff Membership and Clinical Privileges will be automatically suspended for up to ninety (90) days for failure to continuously maintain any of the Basic Qualifications for Medical Staff Membership under Article I, Section 2, and as applicable to the Practitioner's Medical Staff Category and specialty under Article II, unless previously waived by the Board, including without limitation:

3.1.1. Failure to continuously possess a current and unrestricted Washington State license.

3.1.2. Failure to continuously possess a current Federal Drug Enforcement Agency (DEA) number if practicing medicine, dentistry, or podiatry and the requested Clinical Privileges contemplate prescribing controlled substances.

3.1.3. Failure to obtain or continuously maintain board certification or board eligibility in accordance with Article I, Section 2.1.4, or as required for the clinical specialty for which Privileges have been granted, unless exempted under Article I, Sections 2.1.4 or 4.

3.1.4. Failure to continuously maintain professional liability insurance coverage, including prior acts coverage for claims made, as required under Article I, Section 2, unless exempt as a Practitioner with Military Status under Article II, Section 5.

3.1.5. Conviction of, or entering a plea of guilty or no contest to any felony.

3.1.6. Conviction of, entering a plea of guilty or no contest to any misdemeanor involving (a) insurance or health care fraud or abuse, (b) violence, physical abuse or exploitation directed at a person, or (c) violation of law pertaining to controlled substances or illegal drugs, unless the Medical Staff Member is enrolled and satisfactorily participating in, or has successfully completed, a treatment program supervised by the Washington Physician Health Program (WPHP), or other program approved by the Medical Executive Committee.

3.1.7. Failure to be a Member, employee, or subcontractor of the group or person that holds an exclusive contract or closed service arrangement if the Practitioner's Privileges are in a Division or service line operated under an exclusive or semi-exclusive contract or closed service approved by the Board, unless exempted in accordance with Section 3.5 below. The Health System or Campus may enforce such an automatic suspension even if the exclusive or semi-exclusive contract or other closed staff arrangement fails to specify this automatic suspension.

3.1.8. Exclusion or suspension from participation in any federal health care program, including Medicare, Medicaid, and TriCare.

3.1.9. Failure to comply with any vaccination, screening, or personal protective equipment requirements in accordance with policies adopted by the Health System, unless the Practitioner limits their practice to Virtual Health Services and does not furnish services on-site at the Campuses.

3.1.10. Experience involuntary dismissal, termination or summary suspension from any medical staff or have Privileges involuntarily terminated, restricted or summarily suspended by any health facility (including any Health System Campus) for reasons of clinical competence or professional conduct, which action was upheld following waiver or exhaustion of any procedural remedies which was reported to the NPDB.

3.1.11. Voluntary resignation or surrender of medical staff membership or Clinical Privileges, or failure to renew membership or Clinical Privileges while under investigation or to avoid investigation or other Peer Review activity by any health facility (including any Health System Campus), which was reported to the NPDB.

3.2. Failure to Maintain Privileges Qualifications: A Practitioner's Clinical Privileges will be automatically suspended or limited for up to ninety (90) days for failure to continuously maintain the objective qualifications for the specific Clinical Privileges, unless previously waived by the Board:

3.2.1. Failure to meet objective qualifications for Clinical Privileges under Article IV, including any case numbers or required certifications (for example, subspecialty board certification, ATLS, ACLS).

a. The automatic suspension under this Section 3.2 applies only to the specific Clinical Privileges for which the Practitioner fails to meet the objective qualifications.

b. A Practitioner will be granted a 60-day grace period before the automatic suspension becomes effective to allow the Practitioner to provide evidence of current required certification, provided the Practitioner has completed or

submitted all requirements for the certification and is only awaiting confirmation of successfully attaining the certification.

3.3. Automatic Reinstatement

A Practitioner who is subject to automatic suspension under Section 3.1 or Section 3.2 will be automatically reinstated to Medical Staff Membership and Clinical Privileges, as applicable, if, prior to expiration of the ninety (90) day period, the Practitioner furnishes documented proof of compliance with the basic qualification for Medical Staff Membership or the objective qualification for Clinical Privileges that formed the basis for the automatic suspension. The Practitioner must submit the documented proof to the Medical Staff Services Office and the Campus Chief of Staff.

3.4. Automatic Termination

If a Practitioner remains subject to an automatic suspension under this Section 3 for more than ninety (90) days, the Practitioner's Medical Staff Membership and Privileges (or the affected Privileges, if the suspension is a partial suspension) shall be automatically terminated.

3.5. Exclusive Contracts

A Practitioner who was granted Privileges in a Division or service line operated under an exclusive or semi-exclusive contract or a closed service approved by the Board will not have their Privileges automatically suspended under Section 3.1 above if the Health System or Campus enters into a exclusive or semi-exclusive contract or closed service arrangement with a new group or person, and on or before the effective date of the new exclusive or semi-exclusive contract or closed service arrangement, the Practitioner becomes a Member, employee, or subcontractor of the group or person that holds the exclusive or semi-exlusive contract or is the subject of the closed service approved by the Board.

SECTION 4. OTHER AUTOMATIC SUSPENSIONS AND TERMINATIONS

4.1. A Practitioner's Medical Staff Membership or Privileges will be automatically suspended or terminated as set forth in these Bylaws, including for any of the following:

4.1.1. Summary suspension of Privileges at another Campus, in accordance with Article XI Section 2.

4.1.2. Failure to satisfy a Special Appearance requirement in accordance with Article 1 Section 7.6, unless excused by the applicable committee chair or the Medical Executive Committee.

4.1.3. Failure to timely complete medical records in accordance with Article 1 Section 7, and the Completion and Filing Medical Records Policy of the Medical Staff Rules and Regulations.

a. A Practitioner subject to automatic suspension for failure to timely complete medical records may continue to attend patients who are admitted to the Hospital at the time of automatic suspension, provided that the Practitioner cannot schedule any surgery or procedure.

b. In the event that any Practitioner practices while suspended for delinquent medical records, the Chief Medical Officer may request corrective action from the Medical Executive Committee pursuant to Article XI.

c. This automatic suspension or termination shall be in effect until all delinquent medical records are completed.

4.1.4. Significant Misrepresentation in an Application in accordance with Article III Section 3.2 discovered after the application is processed.

4.1.5. For Members of the Active and Associate Medical Staff categories, refusal to participate in on-call coverage for the Practitioner's Primary Campus when requested in accordance with Article II, EMTALA - Examination, Treatment and Transfer of Individuals in Need of Emergency Services Policy, and other specialty coverage programs at the Primary Campus.

4.1.6. Repeated refusal or failure to respond by telephone or in-person in a timely and professional manner as required in accordance with Article II, EMTALA - Examination, Treatment and Transfer of Individuals in Need of Emergency Services Policy, and other specialty coverage programs at the Primary Campus.

4.1.7. Refusal to consent to health examination or screening when there is concern that the Practitioner cannot exercise Privileges in a safe and competent manner in accordance with Article XI Section 10.5.4, and the Health System policies on Medical Staff well-being.

4.1.8. Failure of a Practitioner to timely complete Initial FPPE in accordance with the Focused Professional Practice Evaluation Policy.

4.2. Failure of a Practitioner to timely submit a completed application for reappointment in accordance with Article III Section 5 of these Bylaws, and the Credentials Manual, will result in the automatic expiration of the Practitioner's Medical Staff Membership and Privileges on the date the Practitioner's then-current appointment and Privileges expire.

SECTION 5. PROCEDURAL RIGHTS

5.1. A Practitioner who is subject to automatic suspension, automatic termination, or automatic expiration of their Medical Staff Membership or Privileges under these Bylaws is not entitled to any procedural rights, including any hearing or appeal under Article XII of these Bylaws.

5.2. To the extent consistent with applicable law, automatic suspension, automatic termination and automatic expiration of Medical Staff Membership or Clinical Privileges are not reportable to the National Practitioner Data Bank.

5.3. The automatic suspension, termination, or expiration of Medical Staff Membership and Clinical Privileges does not prohibit a Practitioner from submitting an application for initial appointment or for new Privileges, which will be reviewed in accordance with these Bylaws.

5.4. If a Practitioner or AHP experiences one or more automatic suspension in accordance with these Bylaws, the Rules and Regulations, or policies and procedures of the Campus

or the Medical Staff, the matter may be referred to the appropriate Medical Staff leader or committee for Peer Review at any time. Peer review may include, without limitation, collegial intervention, letters of warning, a Focused Professional Practice Evaluation, or formal investigation, and may be reviewed in conjunction with the consideration of any reappointment application or request for renewal or increase of Privileges or Scope of Practice, in accordance with these Bylaws.

SECTION 6. NOTIFICATIONS AND PATIENT CONTINUITY OF CARE

6.1. A Practitioner subject to automatic suspension or termination shall be sent Notice of such automatic suspension or termination by Special Notice. The Practitioner's actual receipt of the Special Notice is not required for the automatic suspension or termination to become effective.

6.2. A Practitioner subject to automatic expiration shall be sent Notice of such automatic expiration. The Practitioner's actual receipt of the Notice is not required for the automatic termination to become effective.

6.3. Notice of an automatic suspension, termination or expiration shall also be given to the Credentials Committee, the Medical Executive Committee, and the Board, but such Notice is not required for the suspension, termination or expiration to become effective.

6.4. Patients affected by an automatic suspension, termination, or expiration of a Practitioner's Medical Staff Membership or Clinical Privileges shall be assigned to another Medical Staff Member by the Division Chair or Campus Chief of Staff. The wishes of the patient and affected Practitioner shall be considered, when feasible, in choosing a substitute Medical Staff Member.

SECTION 7. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

7.1. When questions arise relating to a Practitioner's or Physician Assistant's qualifications, competence, professional conduct, or quality and appropriateness of care, a Medical Staff Officer, Division Chair, or a Department Head, or the Chief Medical Officer in collaboration with a Medical Staff Officer, Division Chair, or Department Head, may initiate informal, collegial Peer Review efforts. There is no obligation to initiate collegial intervention efforts, and the Practitioner or Physician Assistant has no right to have collegial intervention considered or granted.

7.2. If the questions concern clinical competence, at least one person conducting the collegial intervention or consulted regarding the collegial intervention should be a peer of the Practitioner or Physician Assistant who is the subject of the intervention. For purposes of this Section, a peer is a person in the same licensure or certification category as the subject Practitioner or Physician Assistant (e.g., a physician, dentist, podiatrist, or Independent AHP).

7.3. The use of collegial intervention efforts and voluntary progressive steps by the Medical Staff are encouraged, but are not mandatory.

7.3.1. The goal of collegial intervention efforts is to arrive at voluntary, responsive actions by the Practitioner or Physician Assistant to resolve the issue that has been raised. Collegial efforts and voluntary progressive steps may be carried out, within the discretion of the Medical Staff.

7.3.2. Collegial intervention efforts and voluntary progressive steps are part of the Medical Staff's Peer Review, and may include, but are not limited to, the following:

a. Sharing and discussing applicable policies, such as policies regarding appropriate professional conduct, emergency call obligations, and the timely and adequate completion of medical records;

b. Counseling, mentoring, monitoring, observational proctoring, consultation, and education, including formal retraining programs;

c. Sharing the results of OPPE and FPPE, comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist an individual to conform the Practitioner's or Physician Assistant's practice to appropriate norms;

d. Communicating expectations for professionalism and behaviors that promote a culture of safety;

e. Informational letters of guidance, education, or counseling; and

f. Performance improvement plans that do not restrict or limit the Practitioner's or Physician Assistant's Privileges.

7.4. The appropriate Medical Staff Officer, Division Chair, Department Head, or Chief Medical Officer will document collegial intervention efforts and the outcome in writing, and placed in the Practitioner's or Physician Assistant's quality file. The Practitioner or Physician Assistant may, but is not required to, submit a written response to the collegial intervention, which will be placed in the Practitioner's or Physician Assistant's quality file.

7.5. If collegial intervention efforts do not resolve the concern, the Medical Staff may proceed with further Peer Review as set forth in these Bylaws.

7.6. Collegial intervention shall not constitute a Formal Investigation, restriction of Privileges, or grounds for any formal hearing or appeal rights under these Bylaws.

7.7. The informal collegial intervention process described in this Section 7 is in addition to the other Peer Review processes set forth in Article XI Section 10 of these Bylaws.

SECTION 8. INITIAL INQUIRY

8.1. Any concerns relating to a Practitioner's or Physician Assistant's qualifications, competence, judgment, clinical practice, professional conduct, or wellness may be referred to a Medical Staff Officer, the Division Chair, the Campus Chief of Staff, the Department Head, the Chief Medical Officer, the chair of any standing committee, the Chief Executive Officer, or the Board Chair whenever collegial efforts have not been initiated or have not resolved the concern, or a summary suspension or restriction has been continued, regarding any of the following:

8.1.1. The clinical competence or clinical practice of a Practitioner or Physician Assistant, including patient care, treatment or management, and failure to follow adopted protocols and guidelines;

8.1.2. The known or suspected violation by a Practitioner or Physician Assistant of applicable internal and external ethical standards, or these Bylaws, the Policies and Manuals, and other adopted standards of the Health System or the Medical Staff, or any applicable laws or regulations;

8.1.3. Professional conduct that is considered lower than the established standards of the Health System, or is considered to be disruptive to the operations of the Health Systems or its Medical Staff, such that the quality or efficiency of patient care is or may be affected;

8.1.4. The ability of the Practitioner or Physician Assistant to perform, with or without reasonable accommodation, the essential functions of Medical Staff Membership and/or the granted Clinical Privileges; or

8.1.5. The Practitioner's or Physician Assistant's failure to satisfy the General Qualifications for Medical Staff Membership or the granted Clinical Privileges as set forth in Article I Sections 2 and 3.

8.2. The person or committee to whom the concern is referred will make a sufficient initial inquiry to determine whether the concern is credible and, if so, will forward it to the Medical Executive Committee.

8.3. No inquiry or other action taken pursuant to this Section 8 will constitute an Investigation.

SECTION 9. INITIATION OF INVESTIGATION

9.1. The Medical Executive Committee will review the matter in question, may discuss the matter with the Practitioner or Physician Assistant, and will determine whether to approve an Investigation or direct that the matter be handled pursuant to another process. The review and discussion with the Practitioner shall not constitute a "hearing" as that term is used in these Bylaws, nor shall the hearing and appeal procedures apply, and the Practitioner is not entitled to have an attorney participate in the discussion with the Medical Executive Committee.

9.2. The Board may approve an Investigation if the Medical Executive Committee fails to approve an Investigation.

9.3. An Investigation will commence only after approval of the Medical Executive Committee or the Board.

9.4. The Medical Executive Committee will promptly inform the Practitioner or Physician Assistant that an Investigation has begun. In rare instances, notification of the Practitioner or Physician Assistant may be delayed if, in the judgment of the Medical Executive Committee, informing the Practitioner or Physician Assistant might compromise the integrity of the Investigation or disrupt the operation of the Health System or Medical Staff.

SECTION 10. INVESTIGATIVE PROCEDURE

10.1. Once a vote has been taken to initiate an Investigation, the Medical Executive Committee will investigate the matter itself as the Investigating Committee, or will delegate the Investigation to a subcommittee of the MEC, the Professional Performance Committee, a standing or ad hoc committee, or an individual to serve as the Investigating Committee.

10.2. If the Board initiates the Investigation, the Board may delegate the Investigation to the Medical Executive Committee, a subcommittee of the Board, an ad hoc committee, or an individual to serve as the Investigating Committee.

10.3. The Investigating Committee may include individuals who are not Members of the Medical Staff and have not been granted Clinical Privileges at the Health System. The Investigating Committee will not include any individual who:

10.3.1. Is in direct economic competition with the Practitioner or Physician Assistant being investigated;

10.3.2. Is professionally associated with, a relative of, or involved in a referral relationship with, the Practitioner or Physician Assistant being investigated;

10.3.3. Has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

10.3.4. Actively participated in the matter at any previous level.

10.4. Whenever the matter raised concerns the clinical competence of the Practitioner or Physician Assistant being investigated, the Investigating Committee will include at least one (1) Member who is a peer of the Practitioner or Physician Assistant, as applicable, (e.g. a physician, dentist, podiatrist, or Allied Health Professional).

10.5. The Investigating Committee may:

10.5.1. Review relevant documents, which may include patient records, incident reports and relevant literature or guidelines;

10.5.2. Conduct interviews;

10.5.3. Use outside consultants, as needed; or

10.5.4. Require an examination or assessment by a health care professional(s) acceptable to the Investigating Committee. The Practitioner or Physician Assistant being investigated will execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results of the examination or assessment to the Investigating Committee.

10.6. As part of the Investigation, the Practitioner or Physician Assistant will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the Practitioner or Physician Assistant will be informed of the concerns being investigated and will be provided a copy of the results of any medical assessments performed in accordance with Section 10.5.4 above, if not previously provided by the assessing entity, and any other documents that the Investigating Committee determines will promote discussion with the Practitioner or Physician Assistant. The Practitioner or Physician Assistant will be invited to discuss, explain, or refute the concerns or to submit a written statement prior to, or in lieu of, the meeting. A summary of the interview will be made and included with the Investigating Committee's report. This meeting shall not constitute a "hearing" as that term is used in these Bylaws, nor shall the hearing and appeal procedures apply, and the

Practitioner or Physician Assistant is not entitled to have an attorney present in the meeting.

10.7. The Investigating Committee will make a reasonable effort to complete the Investigation and issue its report within thirty (30) Days, provided that an outside review is not necessary. When an outside review is used, the Investigating Committee will make a reasonable effort to complete the Investigation and issue its report within thirty (30) Days of receiving the results of the outside review. These time periods are guidelines and are not directives that create any right for a Practitioner or Physician Assistant to have an Investigation completed within such time periods.

10.8. At the conclusion of the Investigation, the Investigating Committee will submit a written report to the Medical Executive Committee with the Investigating Committee's findings, conclusions, and recommendations.

SECTION 11. MEC RECOMMENDATION

11.1. The Medical Executive Committee at its next regularly scheduled meeting, will consider the report and recommendations of the Investigative Committee. Based upon the report the Medical Executive Committee may take any action or make any recommendation deemed appropriate, including without limitation any of the following:

11.1.1. Actions that constitute Adverse Actions as defined in these Bylaws, if the action is based on professional competence or professional conduct and restricts Privileges for longer than thirty (30) days, including by way of example:

a. Recommend revocation of some or all Privileges;

b. Immediate imposition or continuation of a summary suspension or restriction of some or all Privileges for a total of longer than thirty (30) days;

c. Recommended restriction of some or all Privileges for longer than thirty (30) days;

d. Immediate imposition or continuation of a mandatory proctoring requirement for a period of longer than thirty (30) days;

e. Immediate imposition or continuation of a mandatory concurrent consultation requirement for longer than thirty (30) days;

f. Recommend involuntary imposition of a mandatory concurrent consultation requirement that restricts the Privileges for longer than thirty (30) days; or

g. Recommend revocation of Medical Staff Membership or status as an Independent AHP or Physician Assistant.

11.1.2. Actions that are not Adverse Actions because they do not restrict Privileges for longer than thirty (30) days, including by way of example:

a. Determine that no Corrective Action is justified;

b. Issue a letter of guidance, counsel, warning, or reprimand;

c. Require a FPPE;

d. Enter into a voluntary remediation agreement;

e. Impose conditions for continued Medical Staff Membership and Clinical Privileges;

f. Require monitoring, proctoring, or consultation that does not restrict Privileges;

g. Require monitoring, proctoring, or consultation that restricts Privileges for fewer than thirty (30) days;

h. Initiate or continue a summary suspension or restriction of the Practitioner's or Physician Assistant's Privileges for a total of fewer than thirty (30) days; or

i. Require additional training or education.

11.1.3. Make any other recommendation that the Medical Executive Committee deems necessary or appropriate.

11.2. The recommendation of the Medical Executive Committee will take effect immediately, unless the recommendation is an Adverse Action that entitles the Practitioner or Physician Assistant to a prior hearing and appeal in accordance with Article XII of these Bylaws.

11.3. If a recommendation by the Medical Executive Committee is an Adverse Action that would entitle the Practitioner or Physician Assistant to a hearing and appeal in accordance with Article XII of these Bylaws, the Medical Executive Committee will forward its recommendation to the Chief Executive Officer. The Chief Executive Officer will promptly notify the Practitioner or Physician Assistant by Special Notice of the decision and the reasons for the recommendation, and inform the Practitioner or Physician Assistant of their right to hearing and appeal under Article XII of these Bylaws.

11.4. The Medical Executive Committee will provide a written report and recommendation to the Board. If the recommendation by the Medical Executive Committee is an Adverse Action that would entitle the Practitioner or Physician Assistant to a hearing and appeal in accordance with Article XII of these Bylaws, the Board shall be generally informed of, but shall not receive detailed information and shall not take action on, the recommendation until the Practitioner or Physician Assistant has exhausted or waived the Practitioner's or Physician Assistant's procedural rights under these Bylaws.

11.5. The Board, at its next regularly scheduled meeting, will review the report and recommendations from the Medical Executive Committee. Based upon the report, the Board may accept, modify, or reject any recommendation it receives from the Medical Executive Committee.

11.6. If the Board makes a modification to the recommendation of the Medical Executive Committee that would entitle the Practitioner or Physician Assistant to a hearing and appeal in accordance with Article XII of these Bylaws, following a recommendation from the Medical Executive Committee that did not entitle the Practitioner or Physician Assistant to a hearing and appeal, the Chief Executive Officer or Board Chair or designee shall

promptly notify the Practitioner or Physician Assistant by Special Notice of the decision and the reasons for the recommendation, and inform the Practitioner or Physician Assistant of their right to hearing and appeal under Article XII of these Bylaws.

11.7. No final Adverse Action will occur until the Practitioner or Physician Assistant has exhausted or waived the Practitioner's or Physician Assistant's procedural rights under these Bylaws.

ARTICLE XII. FAIR HEARING AND APPEALS

SECTION 1. GROUNDS FOR HEARING

1.1. Except as otherwise specified in these Bylaws, a Practitioner may request a hearing when an Adverse Action is taken or recommended against the Practitioner, including those Adverse Actions based on findings made after an Investigation indicating that the Practitioner lacks qualifications, has provided substandard or inappropriate care, or has exhibited inappropriate professional conduct. Adverse Actions may be recommended or taken by the MEC or the Board, and summary suspension or restrictions as an Adverse Action may be taken by the persons and committees set forth in Article XI Section 2 (Summary Suspensions).

SECTION 2. ACTIONS NOT GROUNDS FOR HEARING

2.1. Actions that do not constitute grounds for a hearing, and shall take effect without hearing or appeal, include but are not limited to:

2.1.1. Rejection of an application for initial Medical Staff Membership based on failure to submit a completed application or failure to meet the Basic Qualifications for Medical Staff Membership under Article 1 Section 2 of these Bylaws;

2.1.2. Rejection of an application for renewed Medical Staff Membership based on failure to submit a completed application for reappointment or failure to maintain the Basic Qualifications for Medical Staff Membership under Article I Section 2 of these Bylaws;

2.1.3. Denial of requested Privileges based on failure to meet minimum qualifications or criteria for the Privileges;

2.1.4. Automatic Suspension or Termination of Medical Staff Membership or Clinical Privileges under Article XI Section 3 of these Bylaws;

2.1.5. Denial or expiration of Temporary Privileges;

2.1.6. Removal of a Practitioner from the call roster or on-call schedule;

2.1.7. Imposition of proctoring as part of a FPPE;

2.1.8. Issuance of letters of warning, admonition, reprimand, guidance or education;

2.1.9. Imposition of a request for additional education, training, a physical or mental health screening; and/or

2.1.10. Summary suspension or summary restriction of Privileges for thirty (30) or fewer days.

SECTION 3. NOTICE AND REQUESTS FOR HEARING

3.1. Special Notice of Adverse Action or Recommended Adverse Action

In all cases in which Adverse Action has been taken or a recommendation made as set forth in this Article, the Chief Executive Officer shall promptly give the Practitioner Special Notice of the Adverse Action ("Notice Letter"). The Notice Letter shall contain:

3.1.1. A statement of the Adverse Action recommended or taken;

3.1.2. A general statement of the reasons for the Adverse Action recommended or taken which may include a list of the patient charts in question that form the basis of the adverse recommendation or action;

3.1.3. A statement that the Practitioner has the right to request a hearing within thirty (30) days of receipt of the Notice Letter and that the request for a hearing must be in writing and delivered to the Medical Staff President, with a copy to the Chief Executive Officer, by certified mail, return receipt requested, by registered mail, by hand delivery or overnight courier;

3.1.4. A statement that the Practitioner has the right to:

a. Be represented by an attorney or other person of the Practitioner's choice at the hearing;

b. 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;

c. Call, examine and cross-examine witnesses at the hearing;

d. Present evidence determined to be relevant by the Hearing Officer; and

e. Submit a written statement at the close of the hearing.

3.1.5. A statement that the Practitioner has the right to receive the written recommendation of the Hearing Panel, along with the bases of the recommendation, and the final written decision of the Hospital, including a statement of the basis for the decision;

3.1.6. A statement that if the Practitioner does not request a hearing within the time and within the manner stated in the Notice Letter, the Practitioner shall have waived the hearing and any appeal and be deemed to have accepted the adverse recommendation or action taken as a final action, effective immediately upon final Board action; and

3.1.7. A copy of this Article XII, the Hearing and Appeal Procedures.

3.2. Request for Hearing

3.2.1. The Practitioner shall have 30 days following the Date of Receipt of the Notice Letter to request a hearing. The request shall be in writing addressed to the Medical Staff President with a copy to the Chief Executive Officer. The request shall include the name, address, and telephone number of any attorney or other representative retained by the Practitioner as of the date of the Practitioner's request for a hearing. In the event the Practitioner has not engaged an attorney or other representative by the date of the Practitioner's request for a hearing, the Practitioner may identify the Practitioner's attorney or other representative in accordance with Section 4.5.

3.2.2. If the Practitioner does not request a hearing within the time and in the manner described above, the Practitioner shall be deemed to have waived any right to a hearing or appeal and accepted the Adverse Action recommended or taken, subject to final action by the Board. Such final recommendation or action shall be considered by the Board within 60 days and shall be given great weight by the Board, although it is not binding on the Board. The Chief Executive Officer shall provide Practitioner Special Notice of the final Board decision within ten (10) days of the Board's decision

SECTION 4. HEARING PROCEDURE

4.1. Hearings Prompted by Board Action

If the hearing is based upon an Adverse Action by the Board, the chair of the Board shall fulfill the functions assigned in this Article XII to the Medical Staff President.

4.2. Hearing Panel

4.2.1. When a hearing is requested, the Medical Staff President, in consultation with the Chief Executive Officer, shall appoint a Hearing Panel which shall be composed of not less than three (3) active staff Members who are not in economic competition with the Practitioner, and who have not acted as accuser, investigator, witness, fact finder, initial decision maker, or other active participant in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a Member of the Medical Staff from serving as a Member of the Hearing Panel. In the event that it is not feasible to appoint a Hearing Panel from the active Medical Staff, the Medical Staff President may appoint Members from other Medical Staff categories or Practitioners who are not Medical Staff Members. Such appointment shall include designation of a chair. The Hearing Panel shall include at least one (1) Member who is a peer (for example, a physician or an Independent AHP). The Medical Staff President may appoint alternates who meet the standards described above and who can serve if a Hearing Panel Member becomes unavailable.

4.2.2. The Hearing Panel shall have such powers as are necessary to discharge its responsibilities.

4.2.3. The Practitioner shall be notified of the identity of the Members of the Hearing Panel in advance of the pre-hearing conference.

4.3. The Hearing Officer

The Medical Staff President shall appoint a Hearing Officer to preside at the hearing. The Hearing Officer shall be an attorney at law. The Hearing Officer may not act as a witness, prosecutor or advocate. The Hearing Officer shall maintain order and decorum in the proceedings and assure that all parties have a reasonable opportunity to be heard and present relevant evidence. The Hearing Officer shall apply these Bylaws and determine the order of the presentation of evidence and argument during the hearing. The Hearing Officer shall have the authority to make all rulings on disputes involving the application of these Bylaws, including challenges to the qualifications of Members of the Hearing Panel. The Hearing Officer shall insure that the hearing proceeds efficiently and expeditiously. The Hearing Officer may determine that the hearing (in total and/or in part) may proceed in person, by WebEx, another virtual electronic platform and/or telephonically as the Hearing Officer deems appropriate. The Hearing Officer may also determine whether a witness's testimony may proceed in person, by WebEx, another virtual electronic platform and/or telephonically. The Hearing Officer may participate in the deliberations of the Hearing Panel, but shall not be entitled to vote.

4.4. Special Notice of Hearing Time, Place, Hearing Panel, Witnesses and Reasons for Adverse Action

Upon receipt of a timely request for a hearing, the Medical Staff President shall promptly schedule a hearing within 60 days of receipt of the request, when feasible.

4.4.1. The Medical Staff President shall give Special Notice to the Practitioner of the time, place, and date of the hearing and whether the hearing may proceed in person, by virtual electronic platform, or telephonically ("Hearing Notice"). The date the hearing commences shall not be less than 30 days from the date of Practitioner's receipt of the Hearing Notice.

4.4.2. The Hearing Notice shall include a statement of the reasons for the Adverse Action taken or recommended, including the alleged acts or omissions by the Practitioner and a list of the patient charts in question (when applicable).

4.4.3. The Hearing Notice shall identify the witnesses (if any) expected to testify at the hearing on behalf of the body whose decision prompted the hearing and provide a general summary of their expected testimony.

4.4.4. The Hearing Notice shall identify the Members of the Hearing Panel and its chair, if known, and inform the Practitioner that the Practitioner shall have ten (10) days to submit, in writing, any objections to a Hearing Panel Member, along with the bases of the objection, to the Medical Staff President for consideration. The Medical Staff President, in consultation with the Chief Executive Officer, may sustain the objection and replace the Hearing Panel Member or overrule the objection. If the Medical Staff President identifies the Hearing Panel Members after the Hearing Notice is sent, the Hearing Officer will rule on the Practitioner's objection to a Hearing Panel Member at the pre-hearing conference. If sustained, the Medical Staff President will select another person to serve on the Hearing Panel. Supplemental Notices may be provided to the Practitioner at any time, but not less than five days before the pre-hearing conference, except for good cause, as determined by the Hearing Officer.

4.5. Representation

The Practitioner shall have the right, at the Practitioner's expense, to representation by an

attorney or by another person who is a Practitioner licensed to practice in the state of Washington. The body whose decision prompted the hearing may be represented by an attorney in the hearing. The Practitioner shall provide written Notice to the Medical Staff President of the name, address and telephone number of the Practitioner's attorney or other representative no later than five (5) days before the pre-hearing conference.

4.6. Failure to Appear or Proceed

Failure without good cause of the Practitioner to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary forfeiture of the right to a hearing and acceptance of the recommendations or actions involved.

4.7. Postponements and Extensions

After a request for hearing has been made, the Hearing Officer may, for good cause and with Notice to all parties, grant extensions of deadlines imposed by these Bylaws. For example, if an additional Adverse Action or ground for an Adverse Action is identified in writing to the Practitioner by Special Notice after a hearing is scheduled, the Hearing Officer may grant an extension of the hearing date and/or related deadlines to allow the Practitioner an opportunity to evaluate the additional Adverse Action or ground.

4.8. Pre-Hearing Conference

Unless otherwise agreed by all parties, the Hearing Officer shall schedule a pre-hearing conference at least five (5) days before the hearing. The Hearing Officer shall make all rulings and enter orders necessary for the efficient and fair presentation of evidence at the hearing. The Hearing Officer shall hear and decide all objections to exhibits or witnesses, challenges to the qualifications of the Hearing Panel Members as described herein, challenges to the qualifications of the Hearing Officer, and all other disputes arising under these Bylaws or otherwise that can reasonably be anticipated in advance of the hearing. The failure of a party to object or move for relief at the pre-hearing conference shall constitute, absent good cause shown, grounds for denying the party's objection or motion at the hearing.

4.9. Pre-Hearing Discovery

4.9.1. Rights of Inspection and Copying

The Practitioner may inspect and copy (at the Practitioner's expense) any documentary information relevant to the reasons for the adverse action recommended or taken that the Medical Staff has in its possession or under its control, other than information protected by the attorney-client privilege, and work product doctrine. The body whose decision prompted the hearing may inspect and copy (at its expense) any documentary information relevant to this matter that the Practitioner has in the Practitioner's possession or under the Practitioner's control other than information protected by the attorney client privilege and work product doctrine. The requests for discovery shall be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least five (5) days before the pre-hearing conference shall be good cause for a continuance of the hearing or such other discretionary action as may be warranted by the circumstances. All confidential documentary information disclosed shall be kept confidential and shall not be disclosed or used by the receiving party for any purpose not related to the hearing and appeal, in accordance with applicable law and any stipulation signed

by the Practitioner.

The disclosure of documentary information under these Bylaws is not intended to waive any privilege under applicable law.

4.9.2. The Practitioner, the Practitioner's attorney or other representative, or any other person acting on behalf of the Practitioner, shall not contact Hospital employees, Medical Staff leaders, Medical Staff committee members, or Board members concerning the subject matter of the hearing without prior approval of the Chief Executive Officer.

4.9.3. Limits on Discovery

The Hearing Officer shall rule on discovery disputes the parties cannot resolve. Discovery may be denied based on relevancy. Discovery may also be denied or limited if the request is unreasonable, or unduly burdensome or expensive, or when necessary to protect any applicable Privilege or based on patient privacy. Further, the right to inspect and copy by either party does not extend to confidential Peer Review information concerning specifically identified or identifiable APPs or Practitioners other than the Practitioner under review. The right to inspect and copy does not create or imply any obligation to modify or create documents.

4.9.4. Objections to Introduction of Evidence Previously Not Produced for the Medical Staff

The body whose decision prompted the hearing may object to the introduction of the evidence that was not provided during an appointment, reappointment, or Privilege application review or during corrective action after requested by or on behalf of the Medical Staff, any committee or Peer Review body. The Hearing Officer shall not admit such evidence unless the Practitioner demonstrates good cause for failing to comply with the earlier request.

4.10. Pre-Hearing Exhibit Exchange

The parties must exchange all exhibits that might be offered into evidence at least five (5) days before the pre-hearing conference. Failure to comply with this Section shall be good cause for the Hearing Officer to grant a continuance or to limit the introduction of any exhibits not provided to the other side in a timely manner. Objections and the basis for the objections to exhibits shall be submitted in writing to the Hearing Officer at or before the prehearing conference. All confidential exhibits exchanged shall be maintained as confidential and shall not be disclosed or used by the receiving party for any purpose not related to the hearing and appeal, unless otherwise in accordance with applicable laws and any stipulation signed by the Practitioner required by law. The exchange of exhibits under these Bylaws is not intended to waive any Privilege under applicable law.

4.11. Pre-Hearing Witness Lists

At least five (5) days before the pre-hearing conference, each party shall furnish to the other a written list of the names and addresses of persons, in addition to those witnesses identified in the Hearing Notice under Section 4.4, who can reasonably be anticipated to give testimony or evidence in support of that party at the hearing, along with a general summary of their anticipated testimony. Testimony of additional witnesses may be presented for purposes of rebuttal or other

good cause shown. Failure to provide the name of a witness and a summary of their anticipated testimony at least five (5) days before the prehearing conference date shall constitute good cause for the Hearing Officer to continue the hearing, exclude the witness's testimony, or take other action warranted by the circumstances.

4.12. Pre-Hearing Disputes

4.12.1. The parties shall promptly notify the Hearing Officer of any disputes involving discovery, procedure, or other matters that might be resolved before the hearing. Objections to any prehearing rulings of the Hearing Officer may be made at the hearing.

4.12.2. The parties may present any motions necessary to exercise rights created by these Bylaws. Except for good cause shown, motions shall be in writing, shall be submitted no later than 10 days before the hearing, and shall concisely state the relief requested, relevant facts, and any supporting authority. The moving party shall provide copies by hand delivery (or by such other reliable method of delivery approved by the Hearing Officer) to the Hearing Officer and the opposing party. The opposing party may serve a response within five (5) days. The Hearing Officer may hold a hearing by telephone or otherwise before ruling. Rulings on written motions shall be in writing and promptly provided to the parties. The Hearing Officer shall make all motions, responses, and rulings thereon part of the record of the proceedings.

4.13. Record of the Hearing

A court reporter shall record the hearing proceedings and retain all exhibits. Unless requested by a party, the pre-hearing conference need not be recorded. The cost of attendance of the court reporter shall be borne by the Hospital, but the cost of a copy of the transcript, if any, shall be borne by the requesting party. The Hearing Officer may require oral evidence be taken under oath.

4.14. Rights of the Parties

At the hearing, both sides shall have the following rights, subject to reasonable limits determined by the Hearing Officer:

4.14.1. To call and examine witnesses, to the extent they are available and willing to testify;

4.14.2. To offer exhibits;

4.14.3. To cross-examine or impeach any witness on any matter relevant to the issues;

4.14.4. To be represented by counsel, who may examine and cross-examine witnesses and present statements and arguments; and

4.14.5. To submit a written statement within ten (10) business days after the close of the hearing or on a later date set by the Hearing Officer. Any written memorandum submitted by the party shall be delivered by that party on the same day to the other party.

a. The Practitioner may be called by the body whose decision prompted the hearing or the Hearing Panel and examined as if under cross-examination.

b. The Hearing Panel may question witnesses or call additional witnesses as the Hearing Panel, in its discretion, deems necessary.

4.15. Rules of Evidence

Judicial rules of evidence and judicial rules of procedure shall not apply to a hearing conducted under this Article XII. All relevant evidence shall be considered by the Hearing Panel, without regard to admissibility of such evidence in a court of law.

4.16. Official Notice

The Hearing Officer shall have the discretion to take official notice of any matters relating to the issues under consideration that could have been judicially noticed by the courts of the state of Washington. Participants in the hearing shall be informed of the matters to be officially noticed. The matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter.

4.17. Computation of Time

Calendar days shall be used in all computations of time made under the provisions of this Article XII; unless indicated otherwise, provided that if the last day for any Special Notice or Notice is a Saturday, Sunday, or legal holiday, the period is extended to include the next day which is not a Saturday, Sunday or legal holiday.

4.18. Practitioner's Failure To Appear At The Hearing

Failure, without good cause, of the Practitioner to appear and proceed at the hearing shall be deemed to constitute:

4.18.1. A waiver of the Practitioner's right to a hearing and appeal; and

4.18.2. A voluntary acceptance of the pending adverse recommendation or action taken as a final action, which shall be forwarded to the Board for final determination.

4.19. Burdens of Presenting Evidence and Proof

4.19.1. At the hearing, the body whose decision prompted the hearing shall have the initial burden of presenting evidence supporting its action or recommendation.

4.19.2. If the body whose decision prompted the hearing presents evidence supporting its action or recommendation, the Practitioner shall bear the burden of persuading the Hearing Panel by a preponderance of the evidence that the action or recommendation of the body whose decision prompted the hearing is arbitrary, capricious, or not supported by credible evidence.

4.19.3. If the Practitioner meets the Practitioner's burden of persuasion, the Hearing Panel shall recommend reversal or modification of the action or recommendation of the body whose decision prompted the hearing; provided, however, that the Hearing Panel may not recommend an Adverse Action that is more restrictive than the

Adverse Action recommended or taken by the body whose decision prompted the hearing.

4.19.4. If the Practitioner fails to meet the Practitioner's burden, the Hearing Panel may affirm entirely or affirm and modify the recommendation and action of the body whose decision prompted the hearing; provided, however, that the Hearing Panel may not recommend an Adverse Action that is more restrictive than the Adverse Action recommended or taken by the body whose decision prompted the hearing.

4.20. Recess and Close of Hearing

The Hearing Officer may, for good cause, recess and reconvene the hearing without Special Notice. The hearing shall be closed when the Hearing Officer declares that all evidence has been received.

4.21. Basis for Decision

The Hearing Panel's decision shall be based on the evidence introduced at the hearing, including, but not limited to, medical records, written statements, testimony and opinions, relevant literature, clinical practice guidelines, reports of any outside consultants, and any other relevant information or explanations provided by the body whose decision prompted the hearing, and all logical and reasonable inferences that may be drawn from the evidence.

4.22. Deliberations and Recommendations of the Hearing Panel

The Hearing Panel shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of the deliberations, the hearing shall be finally adjourned. Within fifteen (15) days of the final adjournment, the Hearing Panel shall render a decision by majority vote and a written report, including recommendations, which shall contain a summary of the basis for the recommendation(s) ("Hearing Report"). In the event the Hearing Panel is considering an already imposed summary suspension or restriction, including mandatory consultation or mandatory proctoring, the Hearing Panel shall render the Hearing Report within fifteen (15) days of final adjournment.

4.23. Disposition of the Hearing Report

4.23.1. A copy of the Hearing Report shall be forwarded to the Chief Executive Officer, the Medical Executive Committee, the Board, and to the Practitioner. The report shall contain the Hearing Panel's findings of fact, conclusion, recommendation(s) and a summary of the reasons for the recommendation(s). The Practitioner shall be provided a copy of this Article XII explaining the procedure for appealing an adverse decision. The decision of the Hearing Panel shall be final, subject only to such rights of appeal or Board review as described in these Bylaws.

4.23.2. If the Hearing Panel fails to render a written decision within the time allowed under this Article XII, the action or recommendation of the body whose decision prompted the hearing shall be deemed affirmed for the reasons provided by the body prompting the hearing. If the Practitioner requests an appeal in accordance with Section 5 of this Article, the Hearing Panel shall submit a written report describing the matters decided by the Hearing Panel, if any, and the matters unresolved by the Hearing Panel, including a description of the views of the Hearing Panel Members.

SECTION 5. APPEAL

5.1. Time for Appeal

Within (fifteen) 15 days of receiving the decision of the Hearing Panel, either party (the Practitioner or the body whose decision prompted the hearing) may request an appellate review. A written request for such review shall be delivered to the Medical Staff President, the Chief Executive Officer, and the other party by Special Notice. If appellate review is not requested within this period, the Practitioner and/or body whose decision prompted the hearing shall have waived any right of appeal, respectively. If there is no appeal, the recommendation of the Hearing Panel shall be the final recommendation and action of the Medical Staff, and shall be forwarded to the Board for final action. The Board shall adopt, modify or reject the Hearing Panel's recommendation within sixty (60) days. The Board's decision shall be forwarded to the Chief Executive Officer. Within ten (10) days of the Board's decision, the Chief Executive Officer shall send Notice of the Board's decision to the Practitioner by Special Notice and to the Medical Executive Committee.

5.2. Appeal Board

The Board Chair or designee may appoint an Appeal Board, which shall be composed of not less than three (3) Members of the Board or independent third parties designated by the Board. Knowledge of the matter involved shall not preclude any person from serving as a Member of the Appeal Board. No Member of the Appeal Board may be in direct economic competition with the Practitioner or have acted as accuser, investigator, witness, fact finder, initial decision maker, Member of the Hearing Panel, or active participant in the consideration of the matter prior to the appeal. The Appeal Board may select an attorney to act as an Appellate Officer and have all of the authority of and carry out all of the duties assigned to a Hearing Officer as described in this Article XII. The Appellate Officer shall not have a vote. The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

5.3. Time, Place, and Notice

If an appellate review is requested in a timely manner, the Appeal Board shall, within 30 days after receiving a Notice of Appeal, schedule a review date and cause each side to be given Special Notice of the time, place, and date of the appellate review ("Appeal Notice"). The appellate review shall commence within 60 days from the date the transcript of the hearing is available or the date of the Appeal Notice, whichever is later, provided, however, when a request for appellate review concerns a Practitioner who is under suspension which is then in effect, the appellate review should commence within 45 days from the date the Appeal Notice was received. The time for appellate review may be extended by the Appellate Officer or Appeal Board for good cause.

5.4. Appeal Procedure

5.4.1. Each party shall have the right to be represented by an attorney or other representative designated by that party in connection with the appeal. The proceeding by the Appeal Board shall be an appellate hearing based upon the record of the hearing before the Hearing Panel, the memoranda submitted by the parties, and the oral arguments of the parties. The Appellate Officer may establish reasonable deadlines for the appealing party to provide a written memorandum and for the responding party to respond. Each party shall have the right to present a written memorandum in support of the party's position on appeal, with specific reference to the hearing transcript. Each party has the right to personally appear and make an oral argument, not to exceed such time limits as may be established

by the Appellate Officer. The appeal shall be deemed submitted when oral arguments are complete. The Appeal Board may, at a time convenient to itself, deliberate outside the presence of the parties.

5.4.2. The Appeal Board may, at the Appeal Board's sole discretion, consider evidence not available at the hearing, subject to a showing that such evidence could not have been made available in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing; or the Appeal Board may remand the matter to the Hearing Panel for the taking of further evidence and for a decision.

5.5. Decision

5.5.1. The party appealing shall have the burden of showing that the Hearing Panel's recommendation(s) is arbitrary, capricious, or not supported by credible evidence. The Appeal Board may affirm, modify, reverse, or remand the matter for further review by the Hearing Panel or any other body designated by the Appeal Board; provided, however, that the Appeal Board may not take an Adverse Action that is more restrictive than the action recommended or taken by the body whose decision prompted the hearing.

5.5.2. Within 45 days after the appeal is submitted, the Appeal Board shall prepare a written decision that specifies the reasons for the decision and the findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the decision reached, if such findings and conclusions differ from those of the Hearing Panel.

5.5.3. A copy of the Appeal Board decision shall be forwarded to the Chief Executive Officer. Within ten (10) days of the Appeal Board decision, the Chief Executive Officer shall send a copy of the Appeal Board decision to the Practitioner by Special Notice and to the Medical Executive Committee and Board. The Appeal Board decision shall become the final action of the Board at the time of the Board's next meeting, unless the Board rejects, modifies or returns the matter for further action.

5.5.4. The Appeal Board may remand the matter to the Hearing Panel or any other body the Appeal Board designates for reconsideration or may refer the matter to the Board for review. If the matter is remanded for further review and recommendation, the further review shall be completed within 30 days unless the parties agree otherwise or for good cause as determined by the Appeal Board.

5.5.5. The Appellate Officer may extend the time for the Appeal Board's decision not to exceed 30 days. If the Appeal Board fails to render a written decision within the time allowed under this Article XII, the matter shall be referred to the Board for final decision, and the Appeal Board shall submit a written report describing evidence considered, the matters decided by the Appeal Board, if any, and the matters unresolved by the Appeal Board, including a description of the views of the Appeal Board members. The Board shall make a final decision in accordance with this Article XII within 45 days of receipt of the Appeal Board's written decision. Within ten (10) days of the Board's final decision, the Chief Executive Officer shall send to the Practitioner the Board's final decision by Special Notice, and the Medical Executive Committee.

5.6. Right to One Hearing and One Appellate Review

Unless otherwise ordered by the Appeal Board, no Practitioner shall be entitled to more than one (1) evidentiary hearing and one (1) appellate review on any matter, which shall have been the subject of Adverse Action or recommendation.

ARTICLE XIII. CONFIDENTIALITY OF INFORMATION AND IMMUNITY FROM LIABILITY

The confidentiality and immunity provided by this Article XIII shall be express conditions to any Practitioner's application for Medical Staff Membership and to any Practitioner's or AHP's application for, or exercise of, Clinical Privileges or Scope of Practice, as applicable, at the Health System:

SECTION 1. CONFIDENTIALITY

1.1. The confidentiality of all matters relating to Medical Staff Membership, Credentialing, Privileging, quality assurance, and risk management activities is maintained by all committees and staff involved and is protected to the fullest extent of the law (see RCW 4.24.250, RCW 70.41.200, and the Health Care Quality Improvement Act of 1986).

1.2. Any act, communication, report, recommendation, or disclosure, with respect to any such Practitioner or AHP, performed or made at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

1.3. The privilege provided by this Article XIII shall extend to information furnished by Members of the Health System's Medical Staff and its Board, other Practitioners, Chief Executive Officer, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XIII, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Board or of the Medical Staff.

1.4. Upon request of the Health System, participants in the Credentialing, Privileging, quality improvement, and Peer Review activities will execute and abide by a confidentiality agreement; however, execution of such confidentiality agreement shall not be deemed a prerequisite to the effectiveness of the privilege under applicable law or as provided under this Article XIII.

SECTION 2. IMMUNITY FROM LIABILITY AND RELEASES

2.1. To the fullest extent permitted by law pursuant to the Health Care Quality Improvement Act of 1986, RCW 4.24.250, and RCW 70.41.200 or the corresponding provisions of any subsequent state or federal statute providing immunity or confidentiality for quality improvement, Peer Review, or related activities, as a condition of applying for or maintaining Medical Staff Membership, Privileges, or AHP Scope of Practice, each Practitioner and AHP acknowledges and grants immunity to each Member or representative of the Health System's Medical Staff, the Health System, the Hospital, and all third parties from civil liability for damages or other relief arising out of:

2.1.1. Providing information to a representative of the Medical Staff, Health System, Hospital, or any other health care facility concerning an applicant, Member of the

Medical Staff, or AHP who did, or does, exercise Privileges or Scope of Practice, as applicable, or provide services to the Health System; or

2.1.2. Providing services to the Medical Staff, Health System, or Hospital, or by reason of otherwise participating in a Medical Staff or Health System Credentialing, Privileging, quality improvement, or Peer Review activity.

2.2. The immunity provided under applicable law and this Article XIII shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with the Health System's or any other health care facility's activities related to, without limitation:

2.2.1. Requests for appointment to the Medical Staff and/or Clinical Privileges or Scope of Practice;

2.2.2. Periodic reappraisals for reappointment or renewal of Clinical Privileges or Scope of Practice, as applicable;

2.2.3. Professional Review, including Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE);

2.2.4. Corrective actions, including summary suspension;

2.2.5. Hearing and appellate reviews;

2.2.6. Quality improvement reviews, including patient care audits;

2.2.7. Collegial Interventions;

2.2.8. Investigations;

2.2.9. Medical care evaluations;

2.2.10. Utilization reviews;

2.2.11. Other Health System, Hospital, Division, Department, service or Medical Staff committee activities related to quality patient care and intra-professional conduct; and

2.2.12. The exchange of Peer Review information among Health System Hospitals and other health care facilities as provided in these Bylaws, and the Policies and Manuals.

2.3. The state law immunity pursuant to RCW 4.24.250 and RCW 70.41.200, or the corresponding provisions of any subsequent state statute providing immunity for quality improvement, Peer Review, or related activities, shall apply unless the applicant, Medical Staff Member, or AHP shows by clear, cogent, and convincing evidence that the information shared was knowingly false or deliberately misleading.

2.4. The federal immunity provided by the Health Care Quality Improvement Act of 1986 shall apply if the activity meets the due process requirements of the federal law, or the

corresponding provisions of any subsequent federal statute providing immunity for quality improvement, Peer Review, or related activities.

2.5. The acts, communications, reports, recommendations, disclosures and other information referred to in this Article XIII may relate to a Practitioner's or AHP's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

2.6. Upon request of the Health System, each Practitioner and AHP shall execute general and specific releases from liability in accordance with the tenor and import of this Article XIII; however, execution of such release shall not be deemed a prerequisite to the effectiveness of the immunities granted under applicable law or as provided under this Article XIII.

2.7. The consents, authorizations, releases, rights, privileges, and immunities provided in the Policies and Manuals, including the Credentials Manual, for the protection of the Health System's Practitioners, other appropriate Health System officials and personnel, and third parties, in connection with applications for initial appointment and reappointment, shall also be fully applicable to the activities and procedures covered by these Bylaws.

2.8. Provisions in these Bylaws, the Policies and Manuals, and in the Medical Staff and AHP application forms relating to authorizations, releases, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

SECTION 3. CONFIDENTIALITY OF RECORDS, FILES, AND MINUTES

3.1. Medical Staff, Division, Department, or committee minutes, files, and records, including Credentialing files, quality files, and any information regarding any Practitioner, AHP, Member, or applicant to this Medical Staff shall be privileged and confidential to the fullest extent permitted by law and in accordance with the Health System's policies on confidentiality.

ARTICLE XIV. MEDICAL STAFF MEETINGS

SECTION 1. MEDICAL STAFF MEETINGS

1.1. The Medical Staff may meet as scheduled by the Medical Staff President.

1.2. The Medical Staff of each Campus will meet as scheduled by the Campus Chief of Staff, but at least one (1) time each Medical Staff Year.

1.3. The primary objective of the meetings shall be to report on the activities of the Medical Staff and to conduct other business as may be on the agenda.

1.4. Written minutes of all meetings shall be prepared and recorded in accordance with Section 9 below.

SECTION 2. NOTICE OF MEETINGS

2.1. Written Notice stating the date, time, and place of any annual or special Medical Staff or Campus Medical Staff meeting, or any special Division or Department meeting not held pursuant to resolution in accordance with Section 5.1 below, shall be delivered to each person entitled to be present at such meeting (including by mail, facsimile, or electronic transmission addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the Health System), and shall be conspicuously posted, at least seven (7) days before the date of such meeting. The attendance of a Member at a meeting shall constitute a waiver of Notice of such meeting.

SECTION 3. SPECIAL MEETINGS

3.1. Special meetings of the Medical Staff or a Campus Medical Staff may be called at any time by the Medical Staff President or Campus Chief of Staff, as applicable, or the Medical Executive Committee, or Board, or within twenty (20) days after the receipt of a written request signed in writing or electronically by at least twenty percent (20%) of the voting Members of the Medical Staff or the Campus Medical Staff, as applicable. Such a request shall state the purpose of the special meeting.

3.2. The Medical Staff President or Campus Chief of Staff, as applicable, shall designate the date, time, and place of any special meeting.

3.3. No business shall be transacted at any special meeting, except that stated in the Notice of such meeting.

SECTION 4. ELECTRONIC MEETINGS

4.1. A Medical Staff or Campus Medical Staff meeting may be conducted by telephone conference or other confidential, secure, electronic means at the discretion of the Medical Staff President or Campus Chief of Staff, as applicable. Such electronic meeting shall be deemed to constitute a meeting of the Medical Staff or Campus Medical Staff for the matters discussed and action taken during such electronic meeting.

4.2. A Division or Department meeting may be conducted by telephone conference or other confidential, secure, electronic means, at the discretion of the Division Chair or Department Head, respectively. Such electronic meeting shall be deemed to constitute a meeting of the Division or Department for the matters discussed and action taken during such electronic meeting.

SECTION 5. DIVISION, DEPARTMENT, AND COMMITTEE MEETINGS

5.1. Regular Meetings

5.1.1. A Division, Department, or committee may, by resolution, provide the time for holding regular meetings without Notice other than such resolution.

5.1.2. Each Division shall meet at the request of the Division Chair as necessary to review and discuss patient care activities and to fulfill other Division responsibilities.

5.1.3. Each Department shall meet at the request of the Division Chair or Department Head as necessary to review and discuss patient care activities and to fulfill other Department responsibilities.

5.2. Combined or Joint Division, Department, or Committee Meetings

5.2.1. Each Division, Department, or committee may participate in combined or joint Division, Department, or committee meetings with Members from other Divisions, Departments, or Campuses. Appropriate precautions shall be taken during such a combined or joint meeting to assure that confidential Peer Review or quality information is not inappropriately disclosed, and to assure that the Medical Staff (through its authorized representative) maintains access to, and approval authority of, all minutes prepared in conjunction with any such meetings.

5.3. Confidentiality and Immunity:

5.3.1. Each Division and Department meeting is deemed to be a regularly constituted quality improvement committee pursuant to RCW 4.24.250, and RCW 70.41.200, as well as a professional review body as defined in the Health Care Quality Improvement Act of 1986. All minutes, reports, recommendations, communications, and actions made or taken by a Division or Department are covered by the provisions of the Health Care Quality Improvement Act of 1986, RCW 4.24.250, and RCW 70.41.200 or the corresponding provisions of any subsequent state or federal statute providing immunity or confidentiality for quality improvement, Peer Review, or related activities.

SECTION 6. QUORUM

6.1. There shall be no quorum requirements for Medical Staff, Campus Medical Staff, Division, or Department meetings.

6.2. Quorum requirements for the Medical Executive Committee are set forth in Article VII Section 2.8 of these Bylaws.

6.3. Unless otherwise set forth in these Bylaws or the applicable committee charter, a quorum for committee meetings, other than the Medical Executive Committee, shall consist of three (3) voting committee members.

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

6.5. Ex-officio Members shall not be counted in determining the presence of a quorum.

SECTION 7. MANNER OF ACTION

7.1. Except as otherwise specified in these Bylaws, the action of a majority of the voting Members present at a meeting at which a quorum is present shall be the action of the Medical Staff, the Campus Medical Staff, the Division, the Department, or the committee.

7.2. Except as otherwise specified in these Bylaws, the Medical Staff President, Campus Chief of Staff, or committee chair, as applicable, shall refrain from voting except when necessary to break a tie vote at a meeting.

7.3. Each voting Member shall have only one (1) vote, notwithstanding the voting Member holding multiple offices or positions.

7.4. At the discretion of the Medical Staff President, Campus Chief of Staff, Division Chair, Department Head, or committee chair, as applicable, action may be taken without a meeting of the Medical Staff, Campus Medical Staff, Division, Department, or committee, as applicable, and such action is valid if it is acknowledged in writing, in a secure electronic or facsimile means, setting forth the action so taken which is signed by at least two-thirds (2/3) majority of the voting Members of the Medical Staff, Campus Medical Staff, Division, Department, or committee, as applicable.

7.5. Voting by proxy will not be permitted in any vote of the Medical Staff, Campus Medical Staff, Division, Department, or a Medical Staff committee.

SECTION 8. ATTENDANCE

8.1. Each Member of the Medical Staff must meet the meeting attendance requirements as set out in Article I Section 8 of these Bylaws.

8.2. The Chief Executive Officer may attend any Medical Staff, Campus Medical Staff, Division, Department, or committee meeting.

SECTION 9. MINUTES

9.1. Minutes of all meetings shall be prepared and shall include a record of attendance of Members and the vote taken on each matter. The minutes shall be signed in writing or electronically by the committee chair or the committee chair's designee, and forwarded to the Medical Executive Committee or other designated committee.

9.2. Minutes of the Medical Executive Committee will be forwarded to the Board.

9.3. Each committee shall maintain a permanent file of the minutes of each meeting, which may be maintained by any retrievable medium.

SECTION 10. ROBERT'S RULES OF ORDER

10.1. The latest edition of Robert's Rules of Order may be used to guide questions of procedure at all Medical Staff, Medical Executive Committee, Campus Medical Staff Leadership Council, Division, Department, and committee meetings. The failure to follow Robert's Rules of Order will not invalidate any action taken at such meetings.

ARTICLE XV. REVIEW, REVISION, ADOPTION, AND AMENDMENT

SECTION 1. MEDICAL STAFF RESPONSIBILITY

The Medical Staff will have the responsibility to initiate, review, adopt and amend Medical Staff Bylaws. The Medical Staff will also have the responsibility to initiate, review, adopt and amend the related Policies and Manuals. The Medical Staff's responsibility for Medical Staff Bylaws and Policies and Manuals shall be exercised in good faith and in a reasonable, responsible and timely manner. Medical Staff Bylaws and Policies and Manuals will be effective only after approval by the Board. The Medical Staff hereby delegates responsibility for the adoption and amendment of Policies and Manuals to the Medical Executive Committee.

SECTION 2. MEDICAL STAFF BYLAWS - METHODS OF ADOPTION AND AMENDMENT

2.1. Amendments to these Bylaws may be proposed by the Medical Executive Committee, or proposed directly by electronic or paper petition signed by at least twenty percent (20%) of the voting Members of the Medical Staff, with or without a prior recommendation of the Medical Staff Bylaws Committee.

2.2. Proposed amendments to these Bylaws by petition will be reviewed by the Medical Executive Committee prior to submission for a vote of the Medical Staff.

2.3. The Medical Executive Committee will submit Notice of proposed amendments to these Bylaws, including proposals by petition of voting Members of the Medical Staff, to the voting Members of the Medical Staff. The Medical Executive Committee may, in its discretion, include with the Notice a report, favorable or unfavorable, to any petition for proposed amendment to these Bylaws.

2.4. In the discretion of the Medical Executive Committee, proposed amendments to these Bylaws may be voted upon by electronic or paper ballot, returned electronically or to the Medical Staff Office by the date specified by the Medical Executive Committee, which date is no sooner than twenty-one (21) days from Notice of the proposed amendments.

2.5. Amendments to these Bylaws are approved by the affirmative vote of a majority of the voting Members of the Medical Staff who submit a timely electronic or paper ballot by the date specified by the Medical Executive Committee. There is no quorum or minimum number of ballots to be submitted by voting Members of the Medical Staff in order for a proposed amendment to be approved. The Medical Staff's approval of the amendment to these Bylaws will be forwarded to the Board as a recommendation of the Medical Staff.

2.6. The Medical Executive Committee will have the power to adopt such amendments to these Bylaws as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of these Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, or inaccurate cross-references. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, the substance of such amendments will be communicated to the Medical Staff and the Board. Such amendments will be effective immediately and will be permanent if not disapproved by the Medical Staff or the Board within ninety (90) days after adoption by the Medical Executive Committee.

2.7. Amendments to these Bylaws become effective only after approval by the Board.

2.8. Neither the Medical Staff nor the Board may unilaterally amend these Bylaws.

SECTION 3. POLICIES AND MANUALS – METHODS OF ADOPTION AND AMENDMENT

3.1. The Medical Staff hereby delegates responsibility for the review, initiation, adoption and amendment of the Policies and Manuals to the Medical Executive Committee.

3.2. The Medical Executive Committee will review, initiate, adopt, and amend such Policies and Manuals as it may deem necessary and appropriate to implement the general principles found within these Bylaws, with or without a prior recommendation by the Medical Staff Bylaws Committee. The Policies and Manuals adopted and amended in

accordance with this Article XV, Section 3 will be considered an integral part of these Bylaws.

3.3. The Medical Executive Committee will provide Notice of proposed adoption or amendment of the following Policies and Manuals to the voting Members of the Medical Staff at least twenty-one (21) days prior to the Medical Executive Committee vote: Rules & Regulations, Credentials Manual, and Organization Manual. Any voting Member of the Medical Staff may provide written comments regarding the proposed adoption or amendment of such Policies and Manuals. The Medical Executive Committee will provide prompt notice of adoption or amendment of any other Policy or Manual to the voting Members of the Medical Staff following Medical Executive Committee approval.

3.4. Policies and Manuals may be adopted or amended by majority vote of the Medical Executive Committee in accordance with Article VII Section 2.9.

3.5. Amendments to the Policies and Manuals may also be proposed directly to the Medical Staff by electronic or paper petition signed by at least twenty percent (20%) of the voting Members of the Medical Staff. Notice of such petition will be provided to the Medical Executive Committee at least thirty (30) days prior to the vote by the Medical Staff. The Medical Executive Committee may comment on the proposed amendment before it is forwarded to the voting Members of the Medical Staff by electronic or paper ballot, in accordance with the processes in Article VII Section 2.5.3.

3.6. The proposed amendments to the Policies and Manuals are approved by the affirmative vote of a majority of the voting Members of the Medical Staff who submit a timely electronic or paper ballot by the date specified by the Medical Executive Committee, which date is no sooner than twenty-one (21) days from Notice of the proposed amendments. There is no quorum or minimum number of ballots to be submitted by voting Members of the Medical Staff in order for a proposed amendment to be approved. The Medical Staff's approval of the amendments to the Policies and Manuals will be forwarded to the Board as a recommendation of the Medical Staff.

3.7. In cases of a documented need for an urgent amendment to the Policies and Manuals in order to comply with a law or regulation, the Medical Executive Committee may provisionally adopt such an amendment and forward it to the Board for approval and immediate implementation without prior notification of the voting Members of the Medical Staff. The voting Members of the Medical Staff will be notified by the Medical Executive Committee of the provisionally adopted and approved Policy or Manual as soon as feasible. The voting Members of the Medical Staff will then have the opportunity for retrospective review of and comment on the provisional amendment. The Medical Staff may, by an electronic or paper petition signed by at least twenty percent (20%) of the voting Members of the Medical Staff require that the amendment be reconsidered; provided, however, the approved amendment will remain effective until such time as a superseding amendment meeting the requirements of the law or regulation has been approved.

3.8. Adoption and amendment of Policies and Manuals become effective only after approval by the Board.

3.9. None of the Medical Executive Committee, the Medical Staff or the Board may unilaterally adopt or amend Policies and Manuals.

SECTION 4. CONFLICT MANAGEMENT PROCESS

4.1. Conflicts between the Medical Staff and the Medical Executive Committee:

4.1.1. When there is a conflict between the Medical Staff and the Medical Executive Committee regarding a proposed new Policy or Manual or amendment to an existing Policy or Manual, by electronic or paper petition signed by at least ten percent (10%) of the voting Members of the Medical Staff, the matter may be submitted for conflict management.

4.1.2. Upon receipt of such a petition, the Medical Executive Committee will meet with up to five (5) of the dissenting Members of the Medical Staff or their designated representatives and discuss the conflict in a collegial manner.

4.1.3. If a satisfactory resolution cannot be achieved during such discussion, the conflict may be submitted to the Board for final action.

4.1.4. Nothing in this section is intended to prevent any Medical Staff Member from communicating with the Board regarding any new Policy or Manual or proposed amendment to a Policy or Manual. The Board will determine the manner of communication and the Board's response.

4.1.5. This conflict management process is limited to the matters noted in this Section 4. It is not to be used to address any other issue, including any Peer Review matter.

4.2. Conflict Between the Medical Executive Committee and the Board:

4.2.1. When there is a conflict between the Medical Executive Committee and the Board with regard to a proposed new Policy or Manual or a proposed amendment to an existing Policy or Manual, either a Member of the Board or a Member of the Medical Executive Committee may submit a written request to the Chair of the Board for conflict resolution. The Joint Conference Committee will consist of:

a. Three Medical Staff Officers;

b. One other Medical Executive Committee member;

c. The chair and vice-chair of the Board, or other designees of the Board;

d. The Chief Executive Officer; and

e. The Chief Medical Officer.

4.2.2. If the matter cannot be resolved by the Joint Conference within 30 days, the Board will take final action on the matter.

4.2.3. This conflict management process is limited to the matters noted in this Section 4. It is not to be used to address any other issue, including any Peer Review matter.

SECTION 5. TIME PERIODS AS GUIDELINES

5.1. The time periods in these Bylaws are guidelines and are not directives that create any rights for a Practitioner or Dependent AHP to have application processed, Investigation completed, or any other action taken within these precise periods.

ARTICLE XVI. ADOPTION

These Bylaws shall replace any previous Bylaws at all Campuses, and shall become effective on the Effective Date, as defined.

ADOPTED by the voting members of the Medical Staff on November 14, 2024.

APPROVED by the Board on November 26, 2024.