MEDICAL STAFF BYLAWS
OF
PROVIDENCE HOLY FAMILY HOSPITAL
2010

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Annual Approval/Medical Executive Committee
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**ARTICLE I. MEDICAL STAFF MEMBERSHIP**

SECTION 1. NATURE OF MEDICAL STAFF MEMBERSHIP
Membership on the Medical Staff of Holy Family Hospital (HFH) is a privilege, which shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated policies of the Medical Staff and Holy Family Hospital. The Medical Staff of HFH shall have overall responsibility for the quality of services provided by individuals with clinical privileges, as well as the responsibility of accounting therefore to the Board of Directors.

SECTION 2. QUALIFICATIONS FOR MEMBERSHIP
A. Doctors of Medicine, Doctors of Osteopathy, dentists (DDS, DMD), podiatrists (DPM), psychologists (PhD), and other allied health professionals holding a license to practice in the State of Washington must provide documentation as follows to assure the Medical Staff and Board of Directors that any patient treated by them will be given a high quality of medical or dental care:
   1. Background, experience, training, judgment
   2. Demonstrated character
   3. Demonstrated competence, physical and mental capabilities
   4. Adherence to the ethics of their profession
   5. Ability to work with others

No individuals shall be entitled to membership on the Staff or to the exercise of particular clinical privileges merely by virtue of licensure to practice in this or in any other state, or of membership in any professional organization, or of privileges at another hospital. Applicants for membership must be in practice or in process of establishing a practice in the community or referral area to be considered for membership.

B. Doctors of Medicine, Doctors of Osteopathy and Doctors of Podiatric Medicine are required to show documentation of completion of an Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), or American Podiatric Medical Association (APMA) approved residency, or their equivalent.

SECTION 3. NONDISCRIMINATION
The Hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of ancestry, race, gender, religion, or age.

SECTION 4. CONDITIONS AND DURATION OF APPOINTMENT
A. Initial appointment and reappointment to the Staff shall be made by the Board of Directors or a designated subcommittee of the Board. The Board shall act on appointments and reappointment only after there has been a recommendation from the Credentials Committee to the Medical Executive Committee (MEC) in accordance with the provisions of these bylaws.

B. Appointments to the staff will be for no more than twenty-four calendar months.

C. Clinical privileges shall be granted in accordance with Appendix H.

SECTION 5. DUES
A. Annual staff dues shall be governed by the most recent action of the MEC. The Medical Staff Office shall notify each staff member in writing of any contemplated change in staff
dues at least 21 days before the meeting at which voting on such proposed change is to take place.

B. Active, Associate, Affiliate and Allied Health Professional Staff are required to pay dues. In extraordinary circumstances, exceptions to this requirement may be granted by the MEC.

C. Dues shall be due and payable upon request. Failure to pay dues shall be construed as a voluntary resignation from the staff.

SECTION 6. ETHICAL REQUIREMENTS
A person who accepts membership on the staff agrees to act in an ethical, professional, and courteous manner in accordance with the mission and philosophy of the Hospital. Each member shall be dedicated to providing a high quality of medical care, demonstrating compassion and respect for human dignity, safeguarding patient confidences, and dealing honestly with patients, families and colleagues.

It is the policy of Holy Family Hospital to provide all patients, visitors and providers with an environment free of all forms of unlawful discrimination or harassment. Harassment is the verbal or physical conduct that denigrates or shows hostility or aversion toward an individual because of ancestry, religion, gender, age or disability, or that has the purpose or effect of creating an intimidating, hostile, or offensive working environment or of unreasonably interfering with an individual’s work performance.

SECTION 7. RESPONSIBILITIES OF MEMBERSHIP
A. Each staff member will direct, coordinate and be responsible only for the care of his/her patients. She/He is also responsible for the actions of other staff members under his/her supervision.

B. Each staff member must provide for continuous care to his/her patients. Inpatients must be rounded upon daily by the admitting physician or his/her designee, with appropriate notation in the patient record.

C. All practitioners shall maintain formal coverage arrangements to assure that any patient under the care and supervision of such practitioner will receive continuous care consistent with their expected needs, especially in the case of emergencies.

D. Each staff member must abide by the bylaws, policies and procedures of the Staff.

E. Each staff member accepts the obligation to promptly notify the Medical Staff Office of 1) any substantive changes in the medical staff member’s physical or mental health as it may affect the ability to practice medicine, 2) malpractice claims paid or changes in coverage, 3) any sanctions or restrictions of privileges imposed by any other health care institution, or 4) formal investigation, sanction, restriction, action, or stipulation from any licensing agency.

F. Each staff member agrees to maintain on file in the Medical Staff Office at all times a current copy of professional license/s, DEA registration (as needed according to scope of practice), and malpractice coverage. Failure to provide these documents shall be considered an administrative relinquishment of applicable privileges until the documents are provided. The Medical Staff Office may impose a fine not to exceed $100 for practitioners who do not provide these documents in a timely manner.
G. All active staff members must serve and actively participate in peer review activities as requested by their department/section chair.

SECTION 8. STAFF MEMBER RIGHTS

A. In the event that a staff member is unable to resolve a difficulty working with his/her respective department chair, that staff member may, upon presentation of a written notice, meet with the MEC within a reasonable length of time or at the next scheduled MEC meeting to discuss the issue.

B. Any staff member has the right to initiate a recall election of a member officer and/or department chair. A petition for such recall must be presented, signed by at least fifty (50%) percent of the members of the Active Staff. Upon presentation of such valid petition, the MEC will schedule a special general staff meeting at which time the issues will be discussed and followed by a vote for or against recall. If the result of the vote is to recall the President of the Medical Staff, the President-elect shall immediately take office as President.

C. Any staff member may initiate a call for a general staff meeting. Upon presentation of a petition signed by twenty five (25%) percent of the members of the Active Staff, the MEC will schedule a general staff meeting for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted.

D. In the event a rule, regulation or policy is felt to be inappropriate, any staff member may submit a petition signed by twenty-five (25%) percent members of the Active Staff. When such petition has been received, the MEC will then vote on whether to maintain, alter, or eliminate the rule or policy in question.

E. Any section/subspecialist group may request a department meeting when a majority of the members/subspecialist group believes that the department has not acted in an appropriate manner.

F. For physician health issues, HFH participates in a program which is separate from the disciplinary process. Information regarding accessing the program is on file in the Medical Staff Office and regularly provided to the physician staff members.

G. For issues involving disciplinary action, denial of requests for appointment, clinical privileges, or any other matter relating to individual credentialing actions, refer to Section 7, and the Fair Hearing Plan (Appendix A) to provide recourse in these matters.

H. All individuals covered by these bylaws have a right to a hearing/appeal pursuant to the institution’s fair hearing plan in the event any of the following actions are taken or recommended (see Appendix A).

1. Denial of initial staff appointment;
2. Denial of reappointment;
3. Revocation of staff appointment;
4. Denial or restriction of requested clinical privileges;
5. Reduction in clinical privileges;
6. Revocation of clinical privileges;
7. Individual application of, or individual changes in, mandatory concurring consultation requirements; and
8. Suspension of staff appointment or clinical privileges if such suspension is for more than 14 days.
**ARTICLE II. CATEGORIES OF THE STAFF**

**SECTION 1. PROVISIONAL CATEGORY**

All initial appointments to the Medical Staff shall be provisional for a minimum period of six (6) months. Initial appointments to the Allied Health Professional Staff are provisional for a minimum of three (3) months; this applies also to physician extenders moving between the Departments of Surgery and Medicine. Appointments to provisional membership may not exceed two (2) full years, at which time the failure to advance an appointee from Provisional to full Active, Associate, Affiliate or Allied Health Professional Staff shall be deemed a termination of his or her respective appointment. Failure to exercise the privileges granted, failure to cooperate in the peer review process, failure to comply with policies on completion of medical records, or failure to adhere with Holy Family Hospital’s Code of Ethical Behavior policy may be considered an automatic relinquishment. Automatic relinquishment due to a failure to exercise the privileges granted is not an adverse action to restrict or revoke professional privileges, therefore, reporting to the National Practitioner Data Bank under the Health Care Quality Improvement Act of 1986 may not be required. A Provisional appointee whose membership is terminated shall have the rights accorded by these bylaws to a member of the Medical Staff who has failed to be reappointed.

Provisional Staff members shall be assigned to a clinical department where their performance shall be reviewed by that department’s chairperson, or his or her representative, to determine the eligibility of the Provisional member for full membership and for exercising the clinical privileges provisionally granted to them.

To be transferred from provisional staff to full medical staff membership, a member must have provided care to an adequate number of patients, so that his/her clinical competence can be thoroughly evaluated. The review may consist of records from Holy Family Hospital or other area hospitals or at least three (3) references from practitioners that are personally knowledgeable of the practitioner’s competency.

Members of the Provisional Staff shall not be eligible to vote, make nominations for, or hold elective office. Such members may serve on committees. Requests for new privileges will not be granted to provisional staff members.

**SECTION 2. ACTIVE CATEGORY**

Qualifications: Appointees to the category must:

Admit or otherwise be involved in a minimum of 25 patient encounters (or 50/year for a group of four or more physicians) at the hospital per Patient encounter is defined as admission, emergency center patient, short stay patient, ambulatory surgery patient, or consultation. This does not include activity as result of covering for an on call active member.

In the event an appointee to the Active category does not meet the qualifications for reappointment to the Active category, and if the appointee is otherwise abiding by all bylaws, rules, regulations, and policies of the Staff, the appointee may be appointed to the Associate category.

Prerogative: Appointees to the Active category may:

A. Exercise clinical privileges without limitation, except as otherwise provided in these Bylaws and Medical Staff policies, or by specific restriction.

B. Vote on all matters presented at general and special meetings of the Staff, and of the appropriate department and committee of which he/she is a member.
C. Hold office and sit on or be the chairperson of any committee, unless otherwise specified elsewhere in these Bylaws.

**Responsibilities:** Appointees to the Active category must:

A. Pay all dues and assessments promptly.
B. Contribute to the organizational and administrative affairs of the Staff.
C. Actively participate in recognized functions of Staff appointment including quality improvement, monitoring activities, clinical privilege development, and other staff functions as may be required.
D. Participate in the emergency room and other specialty coverage responsibilities unless exempted by the MEC individually or by policy (Refer also to Appendix C).

**SECTION 3 COMMUNITY BASED PHYSICIANS**

Community based is reserved for those physicians who have turned their care over to the Hospitalist service. Members in the category maintain all the rights and responsibilities associated with the active category except that they are excused of their responsibility for ED call by the virtue of their contractual relationship with the Hospitalist service. Members of community based-active category are required to provide care upon discharge to those patients who were managed by the Hospitalist service. The community based-active category may assist the attending physician in the care of patients, to include making social rounds. Should there be a termination in the contract with the Hospitalist Service; members in this category will be required to cover their emergency call.

**SECTION 4. ASSOCIATE CATEGORY**

**Qualifications:** Those practitioners who are otherwise qualified for active staff membership, but who are involved in less than 25 patient encounters per year (or 50/year for a group of four or more physicians) will be appointed to the Associate Category. Patient encounter is defined as admission, EC patient, short stay patient, ambulatory surgery patient, recurring outpatient, or consultation. Members of this category can verify that they are in good standing and using their admission and clinical privileges at another facility within the community.

**Prerogatives:** Appointees to this category may:

A. Exercise those privileges as granted by the Board, which will include admission of patients to the hospital unless otherwise specified.
B. Attend meetings as a non-voting member of the staff and department of which he/she is an appointee, and any staff or Hospital education programs.

**Responsibilities:** Appointees to this category must:

A. Participate in the on-call coverage of the Emergency Department as determined by the MEC. (Refer also to Appendix C).
B. Participate, if assigned, as a member of staff committees, and in quality assessment review activities upon request by the respective clinical departments.

**SECTION 5. AFFILIATE CATEGORY**

**Qualifications:** The Affiliate Staff shall consist of independent practitioners including dentists, podiatrists and psychologists, who actively participate in the rendering of care to hospital patients.

**Prerogatives:** Appointees to this category may:

A. Exercise those privileges as granted by the Board
B. Attend staff meetings as a non-voting member, and any staff or Hospital educational programs.
C. Admit and manage patient if so designated on the practitioner’s privilege list.
Responsibilities:
A. Pay all dues and assessments promptly
B. Participate in department or committee meetings, if requested by the MEC and/or department chairpersons
C. Participate in quality assessment review activities as requested by the respective clinical departments.

SECTION 6. MEMBERSHIP WITH LIMITED PRIVILEGES

SECTION 6A. HONORARY CATEGORY
Honorary category is restricted to those individuals the staff wishes to honor. Such staff appointees are not eligible for clinical privileges and are not required to pay dues. They may, however, attend medical staff and department meetings.

SECTION 6B. MEDICO-ADMINISTRATIVE
The Medico-Administrative Staff consists of Medical staff members who hold administrative positions in the Hospital and whose primary responsibility is non-clinical in nature. They may be granted specific clinical privileges. They may not vote, hold office or serve on Medical Staff committees. They may attend section, department meetings and educational programs. They are not required to participate in Emergency Department call. They may be exempted from the requirement of malpractice insurance depending on the scope of their practice.

SECTION 6C. ALLIED HEALTH PROFESSIONAL CATEGORY
This category includes, but is not limited to, CRNA’s, Physician Assistants, Nurse Practitioners, private surgical techs, and similar practitioners. With the exception of the hospital-employed CRNA’s, AHPS shall be directly employed and supervised by a member of the medical staff in good standing. The Hospital-employed CRNA’s will be supervised by a medical staff Anesthesiologist in good standing or other member of the medical staff with anesthesia privileges. All AHP’s are appointed through the medical staff credentialing system. Specifically, they do not have privileges to vote, and do not have committee responsibility.

Qualifications/Responsibilities:
A. Provide certification and/or licensure as applicable and proof of adequate malpractice insurance.
B. Have scope of service specified with corresponding level of supervision.
C. Must be employees of the hospital or of a credentialed and privileged medical staff member.
D. Provide a signed sponsorship agreement by his/her physician employer/sponsor of the medical staff.
   NOTE: The AHP’s membership and scope of services expire automatically upon the termination of employment with the hospital or with the sponsoring physician, and/or termination of the sponsoring physician’s Medical Staff membership and/or privileges.
E. Undergo review and supervision by the medical staff department in which the sponsor is a member to include: review of credentials file and quality improvement activity initially and at least every two years thereafter.
F. Pay all dues and assessments promptly.

SECTION 7. LEAVE OF ABSENCE
1. An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the Credentials Committee. The request must state the beginning and ending dates of the leave, which shall not exceed twenty-four (24) months, and the reasons for the leave.
2. The Credentials Committee will determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the President of the Medical Staff shall consult with the Credentials Committee and the relevant Department Chair and consider both the reason given for the requested leave and the level of activity. Practitioners moving from the hospital’s patient catchment area are not normally granted a leave of absence or retained on staff.

3. No later than 30 days prior to the conclusion of the leave of absence, the individual shall request reinstatement by providing to the Credentials Committee a written summary of professional activities during the leave of absence. The Credentials Committee shall refer the matter to the Medical Executive Committee for a recommendation. The individual bears the burden of providing information sufficient to demonstrate current competence and all other applicable qualifications.

4. If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual’s physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

5. The Board shall consider the recommendations of the Medical Executive Committee and may approve reinstatement to the same or a different staff category and may limit or modify the individual’s clinical privileges. In the event the Board determines to take action that would entitle the individual to request a hearing, the individual shall be given special notice.

6. Absence for longer than twenty-four (24) months shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Chief Executive Officer. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

7. Leaves of absences and reinstatement are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

** ARTICLE III. OFFICERS**

SECTION 1. OFFICERS OF THE STAFF
The officers of the Staff shall be:
A. President
B. President Elect
C. Medicine Department Chair
D. Surgery Department Chair

SECTION 2. QUALIFICATIONS OF OFFICERS
Officers must be members of the Active category at the time of nomination and election and must remain members in good standing during their terms of office. Officers may not simultaneously hold leadership positions on another hospital’s medical staff. Officers shall be Board Certified or demonstrate comparable competence.
SECTION 3. ELECTION OF OFFICERS

**Refer to Appendix G, Nominating Committee**

A. President Elect shall be elected at the annual meeting of the Staff. Only members of the Active Staff shall be eligible to vote.

B. A nominating committee shall consist of three or more members of the Active Staff (see Appendix G). This committee shall offer one or more nominees for the office of President Elect. Nominations must be announced, and the names of the nominees distributed to all members of the Active Staff at least 30 days prior to the annual staff meeting.

C. Nominations may also be made by petition signed by at least 15% of the appointees of the Active Staff. Such petition must be submitted at least 14 days prior to the annual staff meeting.

SECTION 4. TERM OF OFFICE

All officers serve a term of two years. Officers shall take office on the first day following the annual staff meeting held in January.

SECTION 5. VACANCIES IN OFFICE

Vacancies in office during the year, except the office of the President, shall be filled by the MEC. If there is a vacancy in the office of the President, the President Elect shall serve the remainder of the term.

SECTION 6. DUTIES OF OFFICERS

A. **President** – The President shall serve as the chief medical-administrative officer of the Hospital and will oversee and coordinate those duties specified in the Duties of the MEC (Article 5, Section 2).

B. **President Elect** – In the absence of the President, the President Elect shall assume all the duties and have the authority of the President. He/She shall perform such further duties to assist the President as requested. He/She shall also be a member of the Credentials Committee. He/She will see to the safeguarding of staff funds, the administration of staff expenditures, the collection of dues, and make appropriate periodic reports of status of same to the staff.

C. **Medicine and Surgery Department Chairs**

Medicine and Surgery Department Chairs have the following roles and responsibilities:

1. Oversee the professional performance of credentialed individuals within the Department, including review and recommendations regarding initial appointments and reappointments
2. Participate in development of clinical privilege criteria for the credentialed members within the Department
3. Participate in the administrative activities of the Department when needed, such as recommendation of off-site sources for services not provided by the Hospital Policy review staffing recommendations Space, equipment, and other resources Orientation and education of staff New services and programs to be added
4. Together with hospital managers and leadership, oversee the quality of clinical care provided in the Department, and regularly attend and report this to the Medical Executive Committee
5. Chair the regular and special meetings of the department, and communicate issues as needed with members of the department

D. **Committee/Section Chairs:**

1. Oversee a function of the medical staff/hospital such as Credentialing, Ethics etc., or a specific clinical area such as Cardiac Services, Stroke Services, etc.
2. Participate in the administrative activities such as:
   a). Recommendation of off site sources for services not provided by the Hospital
   b). Policy review
   c) Staffing recommendations
   d) Space, equipment and other resources
   e) Orientation and education of staff
   f) New services and programs to be added
   g) Make recommendations for with respect to ongoing and reappointment activities
3. Together with hospital managers and leadership, oversee the quality of clinical care provided in the service areas and regularly attend and report this to the Medical Executive Committee Chairs.
4. Chair the regular and special meetings of the department, and communicate issues as needed with members of the department.

SECTION 7. REMOVAL FROM OFFICE
The Staff may remove from office any officer for failure to fulfill the specifications as outlined in the job description, by petition of fifty percent (50%) of the Active staff members and a subsequent two-thirds vote by ballot of the Active Staff.

**ARTICLE IV. DEPARTMENTS**

SECTION 1. ORGANIZATION OF DEPARTMENTS
The staff shall be organized into two departments, Medicine and Surgery. Each department shall have a chairperson with overall responsibility for the supervision and satisfactory discharge of assigned functions of the department.

Optional Sections:
Recognized sections are those listed in Appendix B. Additional groups wishing to organize into an official section and obtain a vote at the MEC shall propose this as an amendment to the bylaws.

Organized sections will regularly report at their respective Department meetings. Special section meetings may be scheduled for a specified purpose. Such special meetings must be preceded by at least two weeks prior notification to the members of the section. Sections are responsible to select their chairs by vote or rotation.

Sections may perform any of the following activities:
A. Continuing education
B. Grand rounds
C. Discussion of policies
D. Discussion of equipment needs
E. Participation in the development of criteria for clinical privileges when required by the department chair
F. Discuss a specific issue at the special request of a department chairperson or the MEC

SECTION 2. QUALIFICATIONS, SELECTION, TENURE AND REMOVAL OF DEPARTMENT CHAIRPERSONS
A. Each chairperson shall be a board certified (or be considered equivalently qualified by the MEC through the credentialing process) member of the Active Staff;
B. Department chairpersons will be appointed by the President
C. Department chairpersons may be removed from office for failure to fulfill the duties as outlined in the job description, after a two-thirds vote of the MEC. For the purpose of
removal, two-thirds of the departmental members must be in agreement (absentee ballots will be permitted).

SECTION 3. FUNCTIONS OF DEPARTMENT CHAIRPERSONS
Each Chairperson shall perform those functions specified in Article III, Officers, above.

SECTION 4. FUNCTIONS OF DEPARTMENTS
A. Each department shall assist in development of criteria, consistent with the policies of the Medical Staff and of the Boards for the granting of clinical privileges.
B. Each department shall participate in the quality monitoring and improvement programs of the hospital.

SECTION 5. ASSIGNMENT TO DEPARTMENTS
The MEC will, after consideration of the recommendations of the chairperson of the clinical departments as transmitted through the Credentials Committee, recommend department assignments for all members in accordance with their qualifications. Individuals will ordinarily be assigned to only one department.

**ARTICLE V. COMMITTEES**

SECTION 1. DESIGNATION AND SUBSTITUTION
There shall be a Medical Executive Committee (MEC) and such other standing and special committees of the staff responsible to the MEC as may from time to time be necessary and desirable to perform the staff functions listed in these Bylaws.

SECTION 2. MEDICAL EXECUTIVE COMMITTEE (MEC)
COMPOSITION: The MEC is composed of Active Staff members as listed in Appendix B. The HFH President (or his/her designee), the HFH Director of Patient Care Services, and Chief Medical Officer (CMO) shall be ex-officio members without vote. The Chairperson will be the President of the Staff.

DUTIES: The duties of the MEC shall be to:
A. Receive or act upon reports and recommendations concerning patient care quality, appropriateness reviews, evaluation and monitoring functions, and recommend to the Board specific programs and systems to implement these functions.
B. Create a formal liaison between the Medical Staff, the President, and the Board of Directors.
C. Submit recommendations to the Board concerning matters relating to appointments, reappointment, staff category, department assignments, clinical privileges and corrective action.
D. Account to the Board and to the Staff for the overall quality and efficiency of patient care in the Hospital.
E. Take reasonable steps to encourage ethical and professional conduct and competent clinical performance on the part of staff appointees including initiating investigations and initiating and pursuing corrective action, when warranted.
F. Discharge their delegated administrative responsibilities and make recommendations on medical-administrative and Hospital management matters, including performance improvement.
G. Keep the medical staff up-to-date concerning the licensure and accreditation status of the Hospital.
H. Follow the hospital’s mission and philosophy; participate in identifying community health needs, set Hospital goals, and implement programs.

I. Represent and act on behalf of the staff, subject to such limitations as may be imposed by these Bylaws; and

J. Formulate rules and regulations, subject to Board approval.

K. Assess and recommend to the Board off-site sources for needed patient care services not provided by the hospital.

L. Act on behalf of the organized medical staff between medical staff meetings.

**MEETINGS:** The MEC shall meet at least ten (10) times per year and maintain a permanent record of its proceedings and actions. The MEC may choose to meet in executive session with only the voting members and those specifically invited in attendance.

**SECTION 3. EXTERNAL COMMITTEES**
The Medical Executive Committee may authorize members of the Medical Staff to serve on committees external to the Hospital which coordinate specific medical staff functions among the local health care organizations. Such committees (e.g., City-Wide Pharmacy and Therapeutics; City-Wide Infection Control) may perform activities on behalf of the Medical Staff, but shall not engage in any activity which would be confidential or protected from discovery if conducted by a committee comprised only of members of the Medical Staff and/or persons appointed by the Hospital.

**SECTION 4. STAFF FUNCTIONS**
The MEC may assign the following responsibilities to departments or sections. Additionally the MEC may establish committees, workgroups, or individuals to fulfill these responsibilities.

A. Monitor and evaluate care provided in and develop clinical policy for special care areas (such as intensive or coronary care units), patient care support services (such as emergency, outpatient, home care and other ambulatory care services).

B. Conduct or coordinate quality, appropriateness, and improvement activities, including invasive procedures, blood usage reviews, medical record and other reviews.

C. Conduct or coordinate utilization review activities.

D. Conduct or coordinate credentials investigations regarding staff membership and granting of clinical privileges.

E. Provide continuing education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments and other perceived needs.

F. Investigate and control nosocomial infections and monitor the Hospital’s infection control program.

G. Plan for response to fire and other disasters, for the Hospital’s growth and development and for the provision of services required to meet the needs of the community.

H. Direct staff organizational activities, including staff Bylaws, review and revision, staff officer and committee nominations, liaison with the MEC and Hospital administration, and review and assist in achieving Hospital accreditation.

I. Coordinate the care provided by members of the staff with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services.

J. Engage in other functions reasonably requested by the MEC and Board.

**ARTICLE VI. STAFF MEETINGS**

**SECTION 1. ANNUAL STAFF MEETING**
A. An annual meeting of the Staff shall be held during the month of January each year. Written notice of the meeting shall be sent to all staff members and conspicuously
posted 30 days in advance. The agenda of the meeting may include reports on review
and evaluation of the work done in departments, election of President Elect and the
conduct of other staff business.

B. The primary objective of the meetings shall be to report on the activities of the staff and
to conduct other business as may be on the agenda. Written minutes of all meetings
shall be prepared and recorded.

SECTION 2. SPECIAL STAFF MEETINGS
A. The President may call a special meeting of the staff at any time. The President shall
call a special meeting within 30 days after receipt of a written request, therefore, signed
by not less than one-fourth of the Active Staff, or upon a resolution by the MEC. Such
request or resolution shall state the purpose of the meeting. The President shall
designate the time and place of any special meeting.

B. Written or printed notice stating the time place and purposes of any special meeting of
the Staff shall be conspicuously posted and shall be sent to each member of the Staff at
least 7 days before the date of such meeting. The attendance of the Staff at a meeting
shall constitute a waiver of notice of such meeting. No business shall be transacted at
any special meeting, except that stated in the notice of such meeting.

SECTION 3. REGULAR MEETINGS
Committees may, by resolution, provide the time for holding regular meetings without notice
other than such resolution. Departments shall hold a minimum of quarterly meetings to review
the findings from quality improvement activities and to carry on department business.

SECTION 4. SPECIAL MEETINGS
A special meeting of any committee or department may be called by or at the request of the
chairperson or director thereof or by the President.

SECTION 5. QUORUM
Staff Meetings: Those present and voting.
MEC Meetings: Fifty percent (50%) of the voting members of the committee or 70% of
the Officers and Department/Committee Chairs
Committee/Department/Section Meetings: Those present and voting.

SECTION 6. ATTENDANCE REQUIREMENTS
Members of the Staff are encouraged to attend meetings of the Medical Staff.

MEC and Credentials Committee Meetings: Members of the MEC and Credentials
Committee are expected to attend at least fifty percent (50%) of the meetings held.

SECTION 7. SPECIAL MEETING REQUIREMENTS
Whenever a pattern of suspected deviation from standard clinical or professional practice is
identified, the President, or the applicable department chairperson, may require the staff
member to confer with him/her or with a standing or ad hoc committee that is considering the
matter. The staff member will be given a written notice with return receipt requested of the
conference at least five (5) days prior to the conference, including the date, time and place, and
a statement of the issue involved. The staff member’s appearance is mandatory at the
conference. Failure of the staff member to appear at any such conference, unless excused by
the MEC upon showing good cause, will result in an automatic suspension of all or such portion
of the staff member’s clinical privileges as the MEC may direct. A suspension under this
Section will remain in effect until the matter is resolved by subsequent action of the MEC and the Board of Directors. Such resolution shall be made in a timely manner in concurrence with the Fair Hearing Plan.

SECTION 8. PARTICIPATION BY CHIEF EXECUTIVE OFFICER
The Hospital President and any representative assigned by him/her may attend any committee, department, or section meeting, unless the meeting is an executive session.

SECTION 9. ROBERT’S RULE OF ORDER
The latest edition of “Robert’s Rule of Order” shall prevail at all meetings of the General Staff, MEC and departmental meetings unless waived, except that the chairperson of any meeting may vote.

SECTION 10. NOTICE OF MEETINGS
Written notice stating the place, day and hour of any called meeting shall be delivered or sent to each member of the committee or department not less than three days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

SECTION 11. ACTION OF COMMITTEE/DEPARTMENT
The action of a majority of its members present at a meeting shall be the action of a committee or department.

SECTION 12. RIGHTS OF EX OFFICIO MEMBERS
Except as otherwise provided in these Bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members thereof, except they shall not vote.

SECTION 13. MINUTES
Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. Each committee and department shall maintain a file of the minutes of each meeting, according to the Providence Health Care retention schedule.

**ARTICLE VII. REVIEW, REVISION, ADOPTION AND AMENDMENT**

SECTION 1. STAFF RESPONSIBILITY
The Staff shall have the responsibility to formulate, review annually, adopt and recommend to the Board, medical staff bylaws, appendices, rules and regulations, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable and timely manner. This applies as well to the review, adoption and amendment of the related rules, policies and protocols developed to implement various sections of these Bylaws and appendices.

SECTION 2. BYLAWS REVIEW
A Medical Staff Bylaws Committee as a subcommittee of the MEC shall be convened as needed for the purpose of reviewing and, as felt appropriate by the committee, recommending amendments to the Bylaws or any of the supporting documents identified above.
A. The Bylaws Committee shall be the Medical Staff President, President Elect, Surgery and Medicine Department Chairmen.
B. The President Elect shall chair.
C. The committee may request consultative support from other medical staff members, hospital staff, or outside sources, including legal advice, as it deems necessary. Such consultants will serve without vote.

D. The Bylaws Committee shall meet no later than seventy-five (75) days prior to the end of each calendar year and as frequently thereafter as shall be required.

SECTION 3. METHODS OF ADOPTION AND AMENDMENT

An amendment of these bylaws may be initiated by a member of the Executive Committee, the Governing Body, or by 10% of the Active staff. Amendments may be proposed at any regular or special meeting of the Executive Committee, but may not be voted upon until a subsequent meeting of the Executive Committee at least two weeks after the amendment has been proposed. If approved by a majority vote of the Executive Committee, a proposed amendment shall be circulated to the Active staff within two weeks of the date of the Executive Committee approval. If fewer than 5% of the Active staff object to the proposed amendment (objections must be returned to Medical Staff Office within 30 days of the date of circulation), the Executive Committee shall forward to the Governing Board their recommendation. If greater than 5% of Active Staff object to the proposed amendment, a meeting of the Medical Staff will be convened as per Article VI, Section 2. A revote on such an amendment proposal may be cast by a signed written ballot (for those members unable to attend the special meeting) submitted to Medical Staff Office. To be approved, such amendment will require two thirds affirmative vote of the votes cast at the special meeting including the signed, written ballots received prior to the meeting. The Executive Committee may, by majority vote, make changes in the Bylaws specifically required by law, state regulation or JCAHO standards. Any amendments enacted by the Executive Committee or by the Active staff shall be effective only when approved by the Governing Board. Neither the Medical Staff nor the Governing Board can unilaterally amend the Medical Staff Bylaws.

Significant changes to the bylaws will be communicated to the medical and AHP staffs either by a direct mailing or in the physician newsletter.

SECTION 4. RULES AND REGULATIONS.

The MEC shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. These Rules and Regulations shall be subject to the Board of Directors’ annual approval. New policies, rules, and regulations and significant changes to existing documents shall be distributed in writing to the staff.

ADMITTED by the Medical Staff on

Keith Kadel, M.D.
President, Medical Staff

APPROVED by the Board of Directors on 3/3/2010
1. The term “Medical Staff” or “Staff” is defined as all medical and osteopathic physicians, dentists, podiatrists, psychologists holding licenses who are privileged to attend patients at Holy Family Hospital.

2. “Joint Conference” is defined as a meeting between representatives of the Board and the physician members of the MEC.
APPENDIX A FAIR HEARING PLAN

ARTICLE 1

1.A. COLLEGIAL INTERVENTION

(1) This Plan encourages collegial and educational efforts by Medical Staff leaders and Hospital administration, to address questions relating to the clinical practice and/or professional conduct of members of the Medical Staff and Allied Health Professional Staff. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

(2) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

(3) All collegial intervention efforts by Medical Staff leaders and Hospital administration are part of the Hospital’s performance improvement and professional and peer review activities.

(4) The relevant Medical Staff leader shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual’s confidential file. If documentation is included in an individual’s file, the individual will have an opportunity to review it and respond in writing. The response shall be maintained in that individual’s file along with the original documentation.

(5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

(6) The President of the Medical Staff in conjunction with the Vice President Medical Affairs or Chief Executive Officer shall consider the question and determine whether to direct it to be handled in accordance with other hospital policies or to direct it to the Executive Committee for further consideration.

1.B. INITIAL REVIEW

(1) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue, regarding:

(A) the clinical competence or clinical practice of any member of the Medical Staff or Allied Health Professional Staff, including the care, treatment or management of a patient or patients;
(B) the known or suspected violation by any member of the Medical Staff or Allied Health Professional Staff of applicable ethical standards or the Bylaws, Rules or Regulations, or policies of the Hospital or the Medical Staff.

These matters may be referred to the President of the Medical Staff, the chair of the department, the chair of any standing committee, the Chief Executive Officer or designee, or the Chairperson of the Board.

(2) The person to whom the matter is referred shall make sufficient inquiry to satisfy him or herself that the question raised is credible and, if so, shall forward it in writing to the Executive Committee.

(3) Whenever the conduct or professional behavior of any member of the Medical Staff or Allied Health Professional Staff is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others, the relevant hospital or medical staff policy will apply.

(4) No action taken pursuant to this Section shall constitute an investigation.

1.C. INVESTIGATIONS:

1.C.1. Initiation of Investigation

(1) When a question involving clinical competence or professional conduct is referred to, or raised by, the Executive Committee, the Committee shall review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to the Bylaws or other hospital policies. In making this determination, the Executive Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Executive Committee to do so.

(2) The Executive Committee shall inform the individual that an investigation has begun. If the individual is a dependent Allied Health Professional Staff member, the supervising physician shall be notified as well. Notification may be delayed if, in the Committee’s judgment, informing the individual would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

(3) The President of the Medical Staff shall keep the Chief Executive Officer fully informed of all action taken in connection with an investigation.

1.C.2. Investigative Procedure:

(1) Once a determination has been made to begin an investigation, the Executive Committee shall either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an individual or ad hoc committee to conduct the investigation. Any ad hoc committee shall not include
partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical or Allied Health Professional Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., another individual of similar licensure category).

(2) The committee conducting the investigation (“investigating committee”) shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital, the Medical Executive Committee, or the investigating committee to do so, such as when:

(A) the clinical expertise needed to conduct the review is not available on the Medical or Allied Health Professional Staff; or

(B) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical or Allied Health Professional Staff; or

(C) the individuals with the necessary clinical expertise on the Medical or Allied Health Professional Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

(3) The investigating committee may require a physical and mental examination of the individual by health care professional(s) acceptable to it. The results of such examination shall be made available for consideration by the investigating committee.

(4) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.

(5) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside
review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 60 to 90 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

(6) At the conclusion of the investigation, the investigating committee shall submit a written report to the MEC with its findings, conclusions and recommendations.

(7) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the orderly operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

(A) relevant literature and clinical practice guidelines, as appropriate;
(B) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);
(C) any information or explanations provided by the individual under review.

1.C.3. Recommendation:

(1) The Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Executive Committee may:

(A) determine that no action is justified;
(B) issue a letter of guidance, warning, or reprimand;
(C) impose conditions for continued appointment;
(D) impose a requirement for monitoring or consultation;
(E) recommend additional training or education;
(F) recommend reduction of clinical privileges;
(G) recommend suspension of clinical privileges for a term;
(H) recommend revocation of appointment and/or clinical privileges; or
(I) make any other recommendation that it deems necessary or appropriate.

(2) A recommendation by the Executive Committee that would entitle the individual to request a hearing shall be forwarded to the Chief Executive Officer who shall
promptly inform the individual, by special notice. If the individual is a dependent Allied Health Professional Staff member, the supervising physician shall be informed of the Executive Committee’s recommendation. The Chief Executive Officer shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

(3) If the Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board. Every adverse action taken by one PHC hospital against a practitioner shall have the same adverse effect at all other PHC hospitals if applicable.

(4) In the event the Board considers a modification to the recommendation of the Executive Committee that would entitle the individual to request a hearing, the Chief Executive Officer shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(5) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders at each PHC hospital where the practitioner has been granted privileges on an ongoing basis through the Hospital’s performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

1.D. SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

(1) Any member of the Executive Committee or the Board shall have the authority whenever action must be taken immediately to prevent danger to the health or welfare of any individual in the Hospital, to summarily suspend all or any portion of the clinical privileges of a practitioner. Such summary suspension shall be deemed the action of the Executive Committee or the Board, whichever the case may be, and such summary suspension shall become effective immediately upon imposition and the summary suspension shall be effective immediately at each PHC hospital where the practitioner has been granted similar privileges.

(2) Each summary suspension must be reported to and reviewed by the Executive Committee in the PHC hospital where the incident occurred within ten days of the action. The Executive Committee will review the summary suspension and may modify, continue or terminate the terms of the suspension.
(3) The chair of the department or a designee shall have the authority to provide alternative coverage for any patient of the suspended practitioner hospitalized in a PHC hospital at the time of suspension. The wishes of the patient shall be considered in the selection of an alternate practitioner.

1.E. ACTION BY GOVERNMENT AGENCY OR INSURER:

(1) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below must be promptly reported to the Medical Staff Office.

(2) An individual’s clinical privileges shall be automatically relinquished (or restricted as stated) at all of the PHC hospitals where the individual has been granted staff membership, and the individual will be precluded from applying at any other PHC hospital if any of the following occur and only if the action will affect hospital privileges or activity:

(A) **Licensure**: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual’s license.

(B) **Certification**: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual’s certification that is required by the Hospital for the privileges delineated.

(C) **Controlled Substance Authorization**: Revocation, suspension or the placement of conditions or restrictions on an individual’s DEA or state controlled substance authorization. Failure to obtain or renew a DEA certificate shall not, however, be cause for automatic relinquishment of privileges if not required for the privileges granted.

(D) **Insurance Coverage**: Termination or lapse of an individual’s professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.

(E) **Medicare and Medicaid Participation**: Termination, exclusion, or preclusion by government action from participation in the Medicare or Medicaid programs.

(F) **Criminal Activity**: Indictment, conviction, or a plea of guilty or *nolo contendere* pertaining to any felony, or any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance fraud or abuse; or (iv) violence against another.

1.F. FAILURE TO PROVIDE REQUESTED INFORMATION:
Failure to provide information pertaining to an individual’s qualifications for appointment, reappointment or clinical privileges, in response to a written request from the Executive Committee, the Credentials Committee, the Chief Executive Officer or any other committee authorized to request such information, shall result in automatic relinquishment or denial of all clinical privileges at all of the PHC hospitals to which the individual has applied or may apply thereafter until the information is provided.

1.G ACTIONS NOT GROUNDS FOR HEARING:

After a thorough investigation by the Executive Committee of the appropriate PHC hospital, none of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

(1) issuance of a letter of guidance, warning, or reprimand;
(2) imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
(3) termination of temporary privileges;
(4) failure to complete medical records;
(5) imposition of a requirement for additional training or continuing education;
(6) denial of a request for leave of absence, or for an extension of a leave;
(7) determination that an application is incomplete;
(8) determination that an application will not be processed due to a misstatement or omission;
(9) determination of ineligibility based on a failure to meet threshold criteria;
(10) determination of ineligibility due to the lack of need or resources
(11) determination of ineligibility due to the existence of an exclusive contract.
(12) termination of membership and privileges of a dependent Allied Health Professional Staff member solely because the individual is no longer employed by an Active Medical Staff member or by a corporation, limited liability corporation, partnership, or similar entity that is owned by at least one Active Medical Staff member or by the Hospital.
(13) Suspension of clinical privileges for less than 30 days.
(14) Failure to achieve Board certification or recertification as may be required by bylaws or privileging criteria.
ARTICLE 2 - HEARING AND APPEAL PROCEDURES

2.A. INITIATION OF HEARING

2.A.1. Grounds for Hearing:

(1) An individual is entitled to request a hearing whenever the Executive Committee makes one of the following recommendations:
   (A) denial of initial appointment to the Medical or Allied Health Professional Staff (hereinafter referred to as “Staff”);
   (B) denial of reappointment to the Staff;
   (C) termination of Staff membership;
   (D) denial of requested clinical privileges (except for the reason that privileging threshold criteria is not met);
   (E) revocation of clinical privileges;
   (F) suspension of clinical privileges for more than 30 days;
   (G) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance).

(2) No other recommendations shall entitle an individual to a hearing.

(3) The hearing shall be conducted in as informal and collegial a manner as possible.

(4) In the event that the Board determined to commence the investigation which resulted in any of these recommendations, all references in this Article to the Executive Committee shall mean the Board.

2.B. THE HEARING

2.B.1. Notice of Recommendation:

The Chief Executive Officer shall promptly give special notice of a recommendation that entitles an individual to request a hearing. This notice shall contain:

(1) a statement of the recommendation and the general reasons for it;
(2) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
(3) a copy of this Fair Hearing Plan

2.B.3. Request for Hearing:

An individual has thirty days following receipt of the notice to request a hearing. The request shall be in writing to the Chief Executive Officer. Failure to request a hearing
shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

2.B.4. Appointment of the Hearing Panel

The CEO and the Medical Staff President or Chief of Staff at the PHC hospital where the incident or problem occurred shall appoint a Hearing Panel composed of not less than three members, one of whom shall be designated as Chair. The Hearing Panel shall be composed of members of the Medical or Allied Health Professional Staff from any of the PHC hospitals where the individual who is subject of the hearing was granted privileges, who did not actively participate in the matter at any previous level, or practitioners, physicians or laypersons affiliated or not affiliated with the PHC hospitals.

2.B.5. Notice of Hearing and Statement of Reasons:

(1) If a hearing is timely requested, the Chief Executive Officer shall schedule the hearing and provide, by special notice, the following:
   (A) the time, place, and date of the hearing;
   (B) the names and specialty of the Hearing Panel members and the Hearing Officer if known; and
   (C) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual’s qualifications.

(2) The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

2.B.6. Witness List:

(1) At least fifteen days before a pre-hearing conference is scheduled, the MEC and individual requesting the hearing shall each provide a written list of the names of witnesses expected to offer testimony on their behalf.

(2) The witness lists shall include a brief summary of the anticipated testimony.

(3) The witness list of either party may, in the discretion of the Hearing Panel Chair, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.
2.B.7. Hearing Panel, Hearing Panel Chair, and Hearing Officer:

1. Hearing Panel:
   (A) The Hearing Panel shall not include anyone who is in direct economic competition with, or professionally associated with the individual requesting the hearing.

2. Hearing Panel Chair
   (A) The Hearing Panel Chair shall not act as an advocate for either side at the hearing.
   (B) The Hearing Panel Chair shall serve as the Presiding Officer and shall be entitled to one vote.
   (C) The Hearing Panel Chair shall:
      (i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
      (ii) prohibit conduct or presentation of evidence that is redundant, excessive, irrelevant or abusive or that causes undue delay;
      (iii) maintain decorum throughout the hearing;
      (iv) determine the order of procedure;
      (v) rule on all matters of procedure and the admissibility of evidence;
      (vi) and may consult with a Hearing Officer, if one is used, on any of these matters.

3. Hearing Officer:
   (A) A Hearing Officer may also be appointed to serve as advisor to the Hearing Panel chair and members. This person may be an attorney. When used in these advisory circumstances, the Hearing Officer is not entitled to vote. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing. He may participate in the deliberations of the Hearing Panel, but is not entitled to vote on the matter before the Hearing Panel.

4. Objections
   Any objection to any member of the Hearing Panel or the Hearing Officer shall be made in writing to the Chief Executive Officer within ten days of receipt of notice, who shall have sole discretion to resolve the objection. Failure by any party to object within this timeframe shall constitute a waiver.

2.C. PRE-HEARING AND HEARING PROCEDURE

2.C.1. Pre-Hearing Conference:
   The Hearing Panel Chair shall require a representative (who may be counsel) for the individual and for the Executive Committee to participate in a pre-hearing conference. At
the pre-hearing conference the Hearing Panel Chair in consultation with the Hearing Officer, if one is used, shall resolve all procedural questions, including any objections to exhibits or witnesses, and the time to be allotted to each witness’s testimony and cross-examination.

2.C.2. Provision of Relevant Information:

(1) The individual requesting the hearing is entitled to the following, subject to the condition that all documents and information be maintained as confidential and not disclosed or used for any purpose outside of the hearing:

(A) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual’s expense;

(B) reports of experts relied upon by the Executive Committee, and

(C) copies of any other documents relied upon by the Executive Committee.

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

(2) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners.

(3) Prior to the hearing, on dates set by the Hearing Panel Chair or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Hearing Panel Chair shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(4) Evidence unrelated to the reasons for the recommendation or to the individual’s qualifications for appointment or the relevant clinical privileges shall be excluded.

(5) Neither the individual, nor his or her attorney, nor any other person acting on behalf of the individual shall contact Hospital employees appearing on the Executive Committee’s witness list concerning the subject matter of the hearing, unless specifically agreed upon by the Chief Executive Officer.

2.C.3. Failure to Appear:

Failure by the individual or his representative, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

2.C.4. Record of Hearing:
A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

2.C.5. Rights of Both Sides and the Hearing Panel at the Hearing:

(1) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Hearing Panel Chair:
   (A) to call and examine witnesses, to the extent they are available and willing to testify;
   (B) to introduce exhibits;
   (C) to cross-examine any witness on any matter relevant to the issues;
   (D) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and
   (E) to submit a written statement at the close of the hearing.

(2) If the individual who requested the hearing does not testify in his or her own behalf, he or she may be called and questioned by the MEC or by the panel.

(3) The MEC is to be represented by an individual or individuals chosen by the Medical Staff President to serve in this capacity.

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

2.C.6. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment, membership and clinical privileges.

2.C.7. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

2.C.8. Persons to be Present:
The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Chief Executive Officer or Medical Staff President.

2.C.9. Postponements and Extensions:
Postponements and extensions of time may be requested by anyone, but shall only be permitted by the Hearing Panel Chair or the Chief Executive Officer on a showing of good cause.

2.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

2.D.1. Order of Presentation:
The Executive Committee shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

2.D.2. Basis of Hearing Panel Recommendation:
Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the Executive Committee unless it finds that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

2.D.3. Deliberations and Recommendation of the Hearing Panel:
Within fourteen days after the close of the hearing, as determined by the Hearing Panel, the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Hearing Officer and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

The Hearing Panel shall deliver its report to the Chief Executive Officer who shall send by special notice a copy of the report to the individual who requested the hearing. The Chief Executive Officer shall also provide a copy of the report to the Executive Committee.
2.D.5. Board Action After A Fair Hearing

A. If an appeal is not requested pursuant to 2.E.1., an appeal is deemed to be waived, and the Hearing Panel’s report and recommendation shall be forwarded to the Board for final action. The Board shall have thirty days after receipt of the Hearing Panel’s report to render a final decision in writing, including specific reasons, and shall send special notice thereof to the individual. If the individual is a dependent Allied Health Professional Staff member, the supervising physician shall be notified as well. The Board may affirm, modify, or reverse the recommendation of the Hearing Panel, or in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board’s ultimate legal responsibility to grant appointment and clinical privileges. A copy of the Board’s decision shall also be provided to the Executive Committee and all other PHC hospitals.

2.E. APPEAL PROCEDURE

2.E.1. Time for Appeal:

Within ten days after notice of the Hearing Panel’s recommendation, either party may request an appeal. The request shall be in writing, delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within ten days, an appeal is deemed to be waived and the Hearing Panel’s report and recommendation shall be forwarded to the Board for final action.

2.E.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(1) there was substantial failure to comply with this Policy and/or the Bylaws of the Hospital or Medical Staff during or prior to the hearing, so as to deny a fair hearing; and/or

(2) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.
2.E.3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding Sections, the Chairperson of the Board shall schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

2.E.4. Nature of Appellate Review:

(1) The Chairperson of the Board shall appoint an appellate review panel composed of not less than three persons; either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made, or the Board may consider the appeal as a whole body. Knowledge of the matter involved shall not preclude any person from serving as a member of the appellate review panel so long as that person is not in direct economic competition with the practitioner and did not take part in the investigation or a prior hearing on the same matter.

(2) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the appellate review panel (or Board) may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(3) The appellate review panel (or Board) may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the appellate review panel (or Board).

(5) The appellate review panel shall recommend final action to the Board.

2.E.5. Board Action After An Appeal:

Within thirty days after receipt of the appellate review panel’s recommendation, the Board shall render a final decision in writing, including specific reasons, and shall send special notice thereof to the individual. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further
review and recommendation, or make its own decision based upon the Board’s ultimate legal responsibility to grant appointment and clinical privileges. A copy shall also be provided to the Executive Committee of each PHC hospital.

2.E.6. Further Review:
Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall in no event exceed thirty days except as the parties may otherwise agree.

2.E.7. Right to One Hearing and One Appeal Only:
No applicant or member of the Staff shall be entitled to more than one hearing and one appellate review on any matter.

ARTICLE 3
ARTICLE 3 - CONFIDENTIALITY, PEER REVIEW PROTECTION, NOTICES AND REPORTING REQUIREMENTS

3.A. CONFIDENTIALITY:
(1) Actions taken and recommendations made pursuant to this Policy shall be strictly confidential. Individuals participating in peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:
(A) when the disclosures are to another authorized member of the Staff or authorized Hospital employee and are for the purpose of conducting legitimate peer review activities; or
(B) when the disclosures are authorized, in writing, by the Chief Executive Officer or by legal counsel to the Hospital.
Any breach of confidentiality may result in a professional review action and/or appropriate legal action.
(2) All peer review activities pursuant to this document and related Medical Staff documents shall be performed by "Professional Review Committees" in...
accordance with Washington Rev. Code § 4.24.240. Professional Review Committees include, but are not limited to:

(A) all committees;
(B) all departments and service lines;
(C) the Board and its committees; and
(D) any individual acting for or on behalf of any such entity, including but not limited to department chairs, service line chairs, committee chairs and members, officers of the Medical Staff, the VPMA and experts or consultants retained to assist in peer review activities.

All reports, recommendations, actions, and minutes made or taken by Professional Review Committees are confidential and covered by the provisions of applicable state law. All Professional Review Committees shall also be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 et seq

(3) Notices

All notices set forth in this Fair Hearing Plan shall be in writing and sent via first class mail or hand delivered to the recipient unless specified otherwise... If sent via first class mail from Spokane County, WA notices shall be deemed received three days after deposited with the United States Postal Service, postage prepaid. In all other cases, the period for calculating time under this Fair Hearing Plan will be from the date of actual receipt by the recipient.

(4) Reporting Requirements

A professional review action that is based on professional competence or conduct and that adversely affects the clinical privileges of a practitioner lasting more than thirty days, or a surrender of privileges while under formal investigation for incompetence or professional conduct to avoid adverse action, will be reported to the National Practitioner Data Bank as required by law. All PHC hospitals will report adverse actions in accordance with definitions and time frames required by federal, state and local statutes.

Fair Hearing Plan Approved January 2002
Revised 2005, 5/07
The following individuals comprise the Medical Executive Committee (MEC).

- President
- President-Elect (Chair of Finance Committee)
- Past President
- Cancer Committee Chairperson
- Cardiac Committee Chairperson
- Credentials Committee Chairperson
- Ethics Committee Chairperson
- ICU Committee Chairperson
- Medicine Department Chairperson
- Stroke Committee Chairperson
- Surgery Department Chairperson
- Trauma Committee Chairperson
- Utilization Management Chairperson

**Section Representatives**
- Anesthesia Representative
- Emergency Services Representative
- Family Practice Representative
- Hospitalist Representative
- Internal Medicine Representative
- Obstetrics/Gynecology Representative
- Orthopedic Representative
- Pathology Representative
- Pediatric Representative
- Radiology Representative
APPENDIX C   EMERGENCY CARE

Any person seeking evaluation and treatment in the Emergency Center (EC) is entitled to a medical screening exam. Someone acting on the person’s behalf may also request medical care. The medical screening exam may only be performed by an emergency physician, emergency physician assistant, an ARNP, or an attending physician credentialed through the medical staff. Additionally, for purposes of the Obstetrical Service the qualified medical personnel able to perform the medical screening exam may be a designated and trained Labor and Delivery Registered Nurse.

The purpose of the on-call list is to ensure that the EC is prospectively aware of which physicians are available to provide further treatment necessary to stabilize individuals with emergency medical conditions. If physicians regularly provide a service to the public, the service should be available through on-call coverage.

Active staff members of those specialties determined by the MEC are required to participate in the EC call rotation. It is expected that members of any given specialty will divide that responsibility in a fair and equitable fashion. Individual specialties or call groups may elect to cover a senior physician’s call responsibilities. In instances where adequate call coverage cannot be achieved by mutual consent among members of a specialty, or there are not enough specialists to adequately cover call, the MEC shall determine and impose a reasonable call schedule. If for any reason a physician is unable to fulfill on-call duties, it is that physician’s responsibility to arrange for an alternate physician and to notify the EC.

EC pages should be returned as soon as possible. 20 minutes is the ideal time for response. If calls are not returned after 30 minutes (emergent) or 60 minutes (non-emergent), EC staff will contact the following in order: partner, Section or Department Chair, President of the Medical Staff.

The expected response time for the on-call physician to be physically present in the EC is proportional to the stability of the patient’s condition. The on-call physician is obligated to provide or arrange for provision of the care directly related to the EC event and upon completion thereof has fulfilled the obligation.

A. The Emergency Center physician may call the on-call specialist in to the EC to evaluate/treat the emergent patient. This does obligate the specialist to come to the Emergency Center.

B. The Emergency Center physician may call the on-call specialist and mutually arrange to have the patient with an urgent health care need seen in his/her private office within a medically reasonable time period. This commits the specialist to see the patient, but is dependent upon the patient making appropriate contact as well. (Note that patients’ health plans may redirect a non-emergent patient to another in-network health care provider.)

C. The Emergency Center physician may give the patient a list of specialists to contact. This does not obligate any specialist on the list to see the patient.

The emergency physician or physician assistant relationship with the patient terminates when the patient’s care and treatment has been assumed by another physician. The transfer of care and treatment responsibility is presumed when the attending or on-call physician either
exercises control over treatment of the patient (for example, first visits the patient or issues orders) or when the physician agrees in person or by phone to assume control and responsibility for the patient’s care.

If there is a disagreement between the emergency physician and the attending (or on call) physician about the disposition of a patient, it is the attending (or on call) physician’s responsibility to examine the patient in the EC in a timely manner (typically 30 minutes) and assume responsibility for the care, treatment, and disposition of the patient.
APPENDIX D  SURGICAL CARE

GENERAL INFORMATION

Scheduling:
1. Surgeons will schedule procedures according to their respective privileges. If more than one procedure is contemplated, all procedures should be listed at the time they are scheduled.

2. If infection is suspected, this should be noted at the time of scheduling.

3. If pathology consultation is desired, this should be noted at the time of scheduling.

4. Emergency cases are to be determined by the surgeon and scheduled at his discretion. Emergency cases may take priority over scheduled cases and substituted, if necessary. It is the responsibility of the attending surgeon of an emergency case to contact the surgeon of an elective case if the emergency case needs to be done as a priority.

Pre-operative Assessment:
Appropriate pre-operative assessment by the Medical Staff is defined as follows:
1. The decision to perform surgery considers:
   a. the patient’s medical, anesthetic and drug history
   b. the patient’s physical status
   c. diagnostic data
   d. the risks/benefits of the procedure
   e. the need to administer blood or blood components

2. The risks/benefits associated with a procedure are discussed with the patient, as are alternative to the procedure, the risk of blood transfusion and anesthesia options.

3. The pre-operative diagnosis is documented.

4. The pre-anesthesia patient assessment includes data collected during the assessment process and provides information needed to plan anesthesia.

5. The plan of care is formulated for all patients undergoing anesthesia.

6. The plans for the post-procedure technical and nursing care are developed for each patient, based on condition and assessed needs.

7. The availability of blood or blood components is determined before initiating anesthesia.

8. The following are assessed before surgery.
   a. the needs for additional diagnostic data
   b. the patient’s physical and psychological needs
   c. Pre-operative laboratory work and the pre-surgical assessment and case management program is completed and recorded in the patient’s record.

9. Surgery is performed only after a history, physical examination and the pre-operative diagnosis have been completed and recorded in the patient’s medical record and any indicated diagnostic tests have been completed and reported in the medical record. In unusual emergency situations in which there is inadequate time to record the history and physical examination before surgery, a brief note, including the pre-operative diagnosis, will be recorded before surgery.

10. The pre-operative diagnosis and required laboratory tests must be recorded in the patient’s medical record prior to any surgical procedure. If not recorded, the surgery will be postponed or delayed until such information is recorded.
cases, determined by the practitioner to be emergent, the practitioner will make a comprehensive note regarding the patient’s condition and a statement as to the reasons the cases should not be delayed.

11. If photographs are contemplated, then written consents must be obtained preoperatively. However, the surgeon may have photographs taken during surgery in any case where he/she deems it necessary for medical purposes. In such a case, the written proposal or ratification must be obtained after the surgery from the patient, if the patient is identifiable by photograph.

12. Blood transfusions should be recorded at the time of infusion, and appropriate orders written and remarks made in the progress notes to justify the transfusions. If blood is given by the anesthesiologists, it shall be noted by them on the anesthesia records. All other transfusions should be noted on the orders and signed by the operating surgeon.

**Surgeons Conduct:**
Surgeons will comply with all hospital policies regarding site marking, patient identification, proper attire, visitors in the OR, and surgery scheduling.
APPENDIX E MEDICAL RECORDS

A History and Physical must be completed and documented for each patient no more than 30 days prior to or 24 hours after hospital or registration but prior to surgery or a procedure requiring anesthesia services. An updated medical entry must be completed and documented in the patient’s record within 24 hours after admission. For those patients having surgery, the anesthesia assessment will suffice as the update.

In all cases, the updated H&P must take place prior to surgery or a procedure requiring anesthesia services. The update must document an examination for any changes in the patient’s condition since the patient’s H&P was performed that might be significant for the planned course of treatment. The physician or qualified licensed individual uses clinical judgment and assessment of the patient’s condition and co-morbidities, if any, in relation to the patient’s planned course of treatment to decide the extent of the update assessment needed as well as the information to be included in the update note in the patient’s medical record.

If the practitioner finds the H&P is incomplete, inaccurate, or otherwise unacceptable, the practitioner reviewing the H&P may disregard and complete a new H&P within 24 hours of admission or registration but prior to surgery or a procedure requiring anesthesia.

The H&P must be completed and documented by physician (as defined in section 1861(r) of the Social Security Act), oromaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy.

In accordance with the Medical Staff Bylaws, Rules and Regulations, suspension in the form of an automatic transfer from Active or Associate staff status to an inactive status will occur whenever medical records remain incomplete for more than 31 days after the chart is available to the physician for completion. Dictations are considered delinquent if not completed within 30 days of discharge.

Incomplete records include all dictated reports, all documents requiring final diagnoses and all documents that require signatures

An automatic transfer to an inactive status will have the effect of suspending the practitioner’s elective admissions or scheduling of surgical cases until such time as medical records have been brought up to date. A physician who in this way has privileges suspended may complete previously scheduled surgeries, but is responsible for arranging for immediate coverage for his/her hospitalized patients and for arranging coverage for the E.R. on-call schedule if that physician has been assigned call any time during the period of the suspension. Physicians with attending responsibilities to the teaching services will not be permitted to continue that responsibility during the duration of the suspension. Alternate coverage for the supervision of house staff must be arranged by the attending physician.

Physicians on the delinquent list more than three times in a 12 month period will be suspended from the medical staff and will have to reapply for privileges.

When all delinquent records have been completed, the physician will be automatically returned to the status that was in effect prior to the suspension and all privileges (admitting and clinical) will be reinstated.

Repeat offenders (anyone who is suspended two or more consecutive months) will receive a certified mail notification from the Medical Executive Committee requiring immediate completion of
records. If the physician does not complete their delinquent records in the timeframe indicated by the MEC, previously scheduled surgeries will be cancelled and corrective action may be pursued through the Fair Hearing process as outlined in the Bylaws (appendix A, Fair hearing Plan).

A 24-hour exemption from this full suspension of privileges will be granted to a physician who is managing an emergency situation. The exemption will be for the emergency situation only and will not extend to other hospitalized, scheduled or non-emergent patients. The physician is responsible to obtain authorization for the emergency exemption from the Surgery Department Chair (or designee), the Medical Staff President (or designee) or the Chief Medical Officer.

Physicians who are on an unexpected extended leave for illness or personal business may be temporarily excused from medical recordkeeping responsibilities by notifying Patient Information Management. All delinquent medical records then must be completed within one week of return to practice.

APPENDIX F CONSULTATION

When a physician seeks consultation of another physician relative to a patient’s medical treatment and/or condition, that physician shall have the direct responsibility to contact the consultant personally. Physician-to-physician contact is considered to be a professional courtesy. The hospital personnel will not notify physicians when their consultation is needed except as to facilitate direct physician-to-physician communication.
APPENDIX G COMMITTEES

CANCER COMMITTEE
The Cancer Committee shall consist of one representative from each of the following medical specialties and departments: Medical Oncology, Radiation Oncology, Surgery, Pathology, Family Practice, and Urology, as well as representatives from the Tumor Registry, Performance Improvement, Nursing, and hospital Administration. Other representatives may be added to the committee from time to time as the committee determines. The Chair is appointed by mutual agreement of the Medical Staff President and Hospital President.

The Cancer Committee shall:
- Plan, initiate, stimulate, and assess the results of cancer activities in the hospital.
- Organize, publicize, implement, and evaluate regular educational and consultative cancer conferences.
- Assure that consultative services and rehabilitation services in the major disciplines are available to cancer patients.
- Plan and implement long-term and short-term patient care evaluation studies.
- Encourage the development of a support care system for the patient dying from cancer.
- Oversee the activities of the tumor registry.
- Assign a chairperson for the Tumor Board conference.

Meetings, Reports and Recommendations:
The Cancer Committee shall meet at least quarterly, or as often as necessary, and shall maintain a permanent record of its proceedings and shall report to the Executive Committee on a scheduled basis.

CARDIAC COMMITTEE
The Cardiac Committee shall consist of the chairman and the representatives from each active staff cardiologists, as well as family practice, internal medicine, radiology, emergency medicine, pharmacy, nursing, cardiovascular and cardiopulmonary technicians and administration. The Chair is appointed by mutual agreement of the Medical Staff President and Hospital President.

The Cardiac Committee shall:
- Oversee the efficiency of the care rendered to patients with cardiovascular disease at Holy Family Hospital.
- Evaluate the data collection efforts and analyze the reports generated for submission internally (to MEC and Board) and externally as quality assurance and performance improvement activities.
- Review and recommend medical and hospital staff performance improvement activities for cardiovascular services.
- Assist with criteria for privileging.

Meetings, Reports and Recommendations:
The Cardiac Committee shall meet at least quarterly, or as often as necessary, and shall maintain a permanent record of its proceedings and shall report to the Executive Committee on a scheduled basis.

MEDICAL EXECUTIVE COMMITTEE
The Medical Executive Committee shall consist of the chairman, medical staff president, president elect, and three (3) additional Active staff members shall be appointed by the chairman for terms of two (2) years each and confirmed by the MEC. The Chairman shall be
appointed by the Medical Staff President. Service on this committee shall be considered as the primary medical staff obligation of each member of the committee and other medical staff duties shall not interfere. If at any time the continued workability of the committee is threatened by the inability or unwillingness of any of the committee members to serve, the President of the Staff shall appoint up to five (5) additional members to the committee for terms of one year each.

CREDENTIAL COMMITTEE:
The Credentials Committee shall:

a) Review the credentials of all applicants for medical staff appointment, reappointment, and clinical privileges, to make inquiries of and interview such applicants as may be necessary, and to make a report of its findings and recommendations.

b) Review the credentials of all applicants who request to practice at the hospital as allied health professionals, to make inquiries of and interview such applicants as may be necessary, and to make a report of its findings and recommendations.

c) Arbitrate conflicting privileging recommendations from clinical departments, and following such arbitration to make a report of its findings and recommendations.

d) Review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the medical staff and of those practicing as allied health professionals and, as a result of such review, to make a report of its findings and recommendations.

e) Annually review and recommend amendments to the appointment, reappointment and the clinical privileging criteria and procedures.

Meetings, Reports and Recommendations
The Credentials Committee shall meet monthly, or as often as necessary, to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Executive Committee, the Chief Executive Officer of the Board. The Chairperson of the Credentials Committee shall be available to meet with the Board, or its applicable committee, on all recommendations that the Credentials Committee may make.

INTENSIVE CARE UNIT COMMITTEE (ICU)
The ICU Committee shall consist of representatives from pulmonary medicine, internal medicine, cardiology, neurosurgery, administration, and others as deemed appropriate by the Committee Chairman. The Chairman shall be a pulmonologist appointed by mutual agreement by the Medical Staff President and Hospital President.

The ICU Committee shall:

a) Oversee the efficiency and effectiveness of care rendered to patients within the ICU.

b) Review and approve ICU policies, procedures, and protocols necessary for ongoing ICU care.

c) Formulate performance improvement monitoring and reviews as required.

d) Provide specific recommendations to related medical staff departments/committees to improve ICU care.

e) Assist in criteria development for privileging.

Meetings, Reports and Recommendations
The ICU Committee shall meet as often as necessary. Minutes shall be kept and a report of activities submitted to the Executive Committee on a scheduled basis

STROKE COMMITTEE
The Stroke Committee shall consist of the chairman and representatives from neurology as well as other practitioners involved in the diagnosis and treatment of patients with the diagnosis of stroke. Support staff involved in care will also serve on the committee. The Chairman of the Stroke Committee shall be an actively practicing neurologist, and will be appointed by mutual agreement of the Medical Staff President and Hospital President.

The Stroke Committee shall:

a) Oversee the efficiency of care rendered to patients with the diagnosis of stroke at Holy Family Hospital.

b) Evaluate data collection efforts and analyze the reports generated for submission internally to (MEC and Board) and externally as quality assurance and performance improvement activities.

c) Review and recommend medical and hospital staff performance improvement activities for stroke program services.

Meetings, Reports and Recommendations:
The Stroke Committee shall meet at least quarterly or as often as necessary and shall maintain a permanent record of its proceedings and shall report to the Executive Committee on a scheduled basis.

TRAUMA COMMITTEE
The Trauma Committee shall consist of representatives of emergency medicine, neurosurgery, general surgery, orthopedics, anesthesia, trauma coordinator, emergency department RN, administration and others as deemed appropriate by the committee chairman. The Chairman of the Trauma Committee shall be an actively practicing general surgeon, and will be appointed by mutual agreement of the Medical Staff President and Hospital President.

The Trauma Committee shall:

a) Review and approve trauma policies, procedures, and protocols necessary for ongoing trauma care per proposed guidelines for statewide designation.

b) Formulate performance improvement monitoring and reviews as required.

c) Provide specific recommendations to related medical staff departments-committees to improve trauma care and coordination.

d) Review and disseminate hospital specific data and regional data from the trauma registry.

e) Assist in criteria development for privileging.

Meetings, Reports and Recommendations
The Trauma Committee shall meet as often as necessary. Minutes shall be kept and a report of activities submitted to the Executive Committee on a scheduled basis.

UTILIZATION MANAGEMENT COMMITTEE
The purpose of the Utilization Management Committee is to assure appropriate allocation of Holy Family Hospital resources by striving to maintain and promote high quality patient care in the most cost-effective manner through analysis, review and evaluation of clinical practice. A formal UR structure and function is a mandated component of participation in federal programs. The Chairman will be appointed by mutual agreement of the Medical Staff President and Hospital President.

The Utilization Management Committee shall:
a) Oversee necessity and appropriateness of admissions as defined by severity of illness and intensity of service criteria; appropriateness of continued hospital stay; timely, appropriate and effective discharge planning.
b) Conduct chart reviews, as appropriate, and communicate findings to individual physician.
c) Identify patterns and/or trends regarding utilization of resources.
d) Provide written reports and recommendations to the Medical Staff and Administration on Committee findings.
e) Inform Medical Staff members and Administration of Federal/State/ and other regulatory agency requirements.
f) Confidently report comparative data on physician resource consumption to the physicians as appropriate.
g) Evaluate and recommend alternative levels of care when appropriate.
h) Monitor denials to evaluate financial impact of identified trends.

Meetings, Reports and Recommendations
The UR Committee shall meet quarterly or as often as necessary, to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report on a scheduled basis its recommendations to the MEC

SPECIAL SUB-COMMITTEES OF THE MEDICAL EXECUTIVE COMMITTEE

BYLAWS COMMITTEE — See description under Article VII, Section 2

FINANCE COMMITTEE
The purpose of the Finance Committee is to assure appropriate investment and allocation of the Holy Family Hospital Medical Staff Dues Account. The Finance Committee consists of the President-Elect, the Past President, the Director of the Medical Staff Office, and the VP-Finance. The President-Elect will serve as Chair. The Finance Committee will meet twice yearly or as needed, with reports to the MEC.

NOMINATING COMMITTEE
(Refer to Article III, Section 3, pg.7, Election of Officers)
At least thirty (30) days prior to the next Annual meeting, the Nominating Committee shall nominate the President-Elect.

The Nominating Committee shall consist of 1) President Elect, who will serve as chairman of this committee; 2) Medical Staff President, and 3) Surgery and Medicine Department Chairmen. Other members may be appointed by the chairperson or the Medical Staff President.

Elections shall be by a majority of votes of the Active staff members present and voting. Voting shall be by ballot, voice or hand vote. When there are three or more candidates and no candidate receives a majority of the votes, there shall be a second balloting for the two candidates with the highest number of votes.

Department chairmen shall be appointed by the Medical Staff President.
PHYSICIAN COMPLIANCE AND OVERSIGHT COMMITTEE

The Physician Compliance and Oversight Committee shall consist of the President, President Elect, Credential Committee Chair and applicable Department Chair. The purpose of the committee is to review valid behavioral issues and or identified patterns of inappropriate behavior and make recommendations to the Medical Executive Committee for follow up of the practitioner.

MULTIDISCIPLINARY PEER REVIEW COMMITTEE

The multidisciplinary peer review committee shall consist of representatives of the primary sections within the hospital. The purpose of this committee is to conduct peer review from a multidisciplinary focus.

APPENDIX H CREDENTIALING PROCEDURES

Section 1. Qualifications for membership

A. Only individuals licensed to practice medicine, osteopathy, dentistry or podiatry in the State of Washington and who can document education, training, experience, competence, ethical standards, ability to work with others, and health status to meet the standards of the Hospital may be considered for admission to the Medical Staff.

B. Other health care practitioners for whom privileges or scopes of service have been approved by the Board and who can document education, training, experience competence, ethical standards, ability to work with others, and health status to meet the standards of the Hospital may be considered for admission to the Staff.

C. All applicants must sign and agree to follow the Code of Conduct, as adopted by the MEC.

D. Appointment to the staff and the granting of clinical privileges shall not be denied on the basis of sex, age, race, creed, religion, color or national origin.

E. Appointment to the staff or the granting of clinical privileges shall not be granted solely by virtue of licensure, membership in a professional organization or appointment to the staff of another healthcare facility.

F. Applicants for Medical Staff membership after August 1, 2007 from Doctors of Medicine, Doctors of Osteopathy, and Doctors of Podiatric Medicine must have completed a residency approved by one of the following: Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), or American Podiatric Medical Association (APMA), or the equivalent. Sacred Heart Hospital only: This requirement does not apply to 3rd, 4th, and 5th year psychiatry residents who provide short-term care for assigned patients for weekends, holidays, or brief staff vacations under the supervision of a psychiatrist who is an Active Staff member.

H. The Board makes the final determination regarding membership and privileges.

Section 2. Responsibilities of Applicants, Staff Members and the Hospital

A. Responsibilities of Applicants:
1. Applicants for staff membership must furnish the documents specified in Appendix B (Credentialing Procedures) and authorize the release to the Medical Staff of information relevant to the applicant's education, training, experience, competence, ethical standards, ability to work with others, and health status. By applying for appointment to the staff, each member thereby signifies his agreement that all application documentation, including but not limited to application forms, peer references, competency verifications, performance improvement information, and procedures lists may be shared within PHC organizations. The authorization will release from liability the Hospital and all individuals and organizations providing information to the Hospital in good faith and without malice.

2. Applicants have the burden of producing information which the Medical Staff deems adequate to properly evaluate the applicant's education, training, experience, competence, ethical standards, ability to work with others, and health status. Applicants must update their applications with current information when it is available. Failure to update is grounds for rejecting an application.

3. Applications will be reviewed for completeness and accuracy. An application containing false or misleading information will be rejected and not processed. Incomplete applications will be rejected and not processed unless the missing information is provided within 180 days of the initial submission of the application.

4. Applicants may request clinical privileges in addition to membership on the staff. Application for clinical privileges is described in Appendix C.

B. Responsibilities of Staff Members

1. Staff members agree to abide by these Bylaws, the rules, regulations and policies, adopted pursuant to these Bylaws as well as the policies and procedures of the Hospital.

2. Staff members must promptly notify the Medical Staff Office of
   a. Any substantive changes in their physical or mental health that may affect their ability to practice medicine
   b. Malpractice claims paid on their behalf, whether by settlement or judgment, and changes in their professional liability insurance coverage
   c. Sanctions or restrictions of privileges imposed on them by any other health care institution, and
   d. Sanctions, restrictions, or revocations of any license to practice medicine from any licensing agency

C. Responsibilities of the Hospital

Within 90 days of receipt of a complete and accurate application, all required supporting documentation, and all primary source verifications, the MEC will make its recommendation to the Board and the Board will make its decision regarding the application for staff membership and/or clinical privileges.
Section 3. Initial Appointment Requirements and Process

All applicants to the staff must meet minimum established membership and credentialing criteria, including sufficient activity to assess current clinical competence, to be considered for appointment. If an application does not meet established criteria, the individual will be notified, with no rights to the Fair Hearing process. By applying to the staff, the applicant agrees to adhere to Medical Staff Bylaws, Rules and Regulations, Code of Conduct, and Ethical and Religious Directives for Catholic Healthcare Facilities.

A. Only members of the staff shall be entitled to obtain clinical privileges, except as otherwise provided herein. When applicants apply to the Staff, the hospital will provide the applicant with a description of the appointment and privileging process.

B. Application for appropriate staff membership and clinical privileges shall be made on forms prescribed by the Board. The application shall include the applicant’s professional education and qualifications, special training, all former staff appointments, all former clinical privileges obtained, history and disposition of any disciplinary actions, and physical and mental conditions adversely affecting the applicant’s competence, including, but not limited to, drug and alcohol abuse, and such other information as may be required by the Board. For both membership and privileging considerations, the application shall include information as to whether there have been any challenges to any licensure or registration; voluntary and involuntary relinquishment of any license or registration; voluntary and involuntary termination of medical staff membership; voluntary and involuntary limitation, reduction, or loss of clinical privileges; all professional liability actions resulting in a final judgment against the applicant; documentation as to the applicant’s health, relevant practitioner-specific data as compared to aggregate data (as available); and morbidity and mortality data (as available). Only a completed application qualifies for consideration. Any information during the credentialing process that is found to be false shall void the application. Each applicant shall furnish the following.

1. Primary source verification of the applicant’s medical school, verifying the applicant’s attendance and graduation.

2. Primary source verification of completion of residency program and fellowship program (if applicable). If a recent graduate, the confirmation should include an evaluation according to the Accreditation Council on Graduate Medical Education Core Competencies.

3. Letters of good standing from a representative of each hospital with which the applicant is or has been affiliated for a minimum of the past ten years.

4. Three (3) peer reference forms which cover the following core competencies. A minimum of two references must attest to current competency for the specific requested procedures. When possible, one of the competency references should be from a practitioner in the same specialty as the practitioner requesting privileges.
   a. Patient care
   b. Medical/clinical knowledge
   c. Practice-based learning and improvement
   d. Interpersonal and communication skills
   e. Professionalism
   f. Systems-based practice

5. Additional documentation and verification of current competency when deemed necessary for specific privileges, to include work and military history.
6. Primary source evidence of current Washington state license/registrations/s as required for scope of practice.
7. Evidence of a DEA certificate, if applicable.
8. Evidence of other certificates as applicable to privileges requested.
9. Specification of clinical privileges held in the past, currently performing and for which the applicant is applying. Data from prior organizations’ professional practice reviews will be obtained if available.
10. Statement of present physical and mental health status as it may limit or impair the applicant's ability to satisfactorily perform the privileges being requested.
11. Written evidence that the applicant carries at least the minimum amount of professional liability insurance as required by the Board; information on all malpractice claims and a consent to the release of information by present and past malpractice insurance carriers.
12. Copy of government issued photo ID (verified by Medical Staff Office prior to beginning practice).
13. NPI (National Practitioner Identifier) number (unless exempted).
14. For physician applicants, Federation of State Medical Boards (FSMB) or American Medical Association (AMA) profile to confirm license status in other states.

C. The National Practitioner Data Bank will be queried regarding any information relative to the applicant.

D. The Washington State Patrol and other contracted agencies, as applicable, will be queried for criminal history information.

E. The Department of Health and Human Services/Office of the Inspector General and the General Services Administration/Excluded Parties Listing System will be checked to confirm no exclusions exist.

F. The applicant shall have the burden of producing adequate information for a proper evaluation of his or her competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

G. Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of receipt of a copy of the current bylaws, appendices, and agrees to abide by the terms of the bylaws, appendices, and policies and procedures. Each applicant shall include a signed pledge to provide continuous care for his/her patients and acknowledgment of the bylaws process regarding release of information and immunity from civil liability.

H. If any material information provided by the applicant is found to be false or misleading, the application shall automatically be voided, and will not be processed further. An applicant whose application has been voided shall not be eligible to reapply for staff membership or to reapply for clinical privileges for a period of at least 24 months from the date the application was voided. If the applicant chooses to reapply at the end of this period, the reapplication will not be considered unless the applicant meets his/her burden of producing adequate information of his/her integrity. As stated in Appendix A, Section 6, such determination that an application will not be processed due to a misstatement or omission is not grounds for a hearing.

I. By applying for appointment to the staff, each applicant thereby signifies his or her willingness to appear for interviews in regard to his or her application, authorizes the
hospital to consult with members of the medical staffs of other hospitals with which the applicant has been associated, and with other qualified persons who may have reliable information bearing on the applicant’s competence, character, ethical qualifications, and ability to perform the privileges requested, and consents to the hospital’s inspection of all records and documents which may be material to an evaluation of his or her professional qualifications, competence, and ability to carry out the clinical privileges requested. This may include a physical or mental health evaluation provided by a mutually-agreed upon internal and/or external health care professional/s.

J. All completed applications will be forwarded to the chairman of the appropriate clinical department or departments and appropriate privileging committee or committees for recommendations regarding membership and clinical privileges. A report of the clinical department chairman’s recommendations, specifically delineating the applicant’s recommended clinical privileges, shall be forwarded to the Credentials Committee.

K. The Credentials Committee shall review the applicant’s qualifications for membership and clinical privileges and shall review the recommendation(s) from the clinical department chairman. If the application for membership and clinical privileges is satisfactory, and if the department chairman recommends approval, the Credentials Committee shall forward the application with its recommendations to the Executive Committee. If the Credentials Committee recommendation does not concur with the department chairman’s recommendation, the application may be referred back to that chairman for further discussion and action, or the application may be forwarded to the Executive Committee for discussion of the conflicting recommendations at the Executive Committee level. When privileges are requested from more than one clinical department, the Credentials Committee will arbitrate and resolve any conflicting recommendations from the department chairmen and send a final recommendation to the Executive Committee, or will consult the clinical department chairman for further discussion and action.

L. After receipt of the application and the report and recommendation of the appropriate clinical department chairman, and the recommendation of the Credentials Committee, the Executive Committee shall determine whether to recommend that the applicant be provisionally appointed to the Staff, that the applicant be rejected for staff membership, or that the application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted. Such clinical privileges may be qualified by probationary conditions. Only the Medical Staff President, Hospital President or Chair of the Board, or their designees, shall be authorized to report to an applicant the status of his or her application and the decision of the Staff and the Board.

M. If the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed up within sixty (60) days with a subsequent recommendation for provisional appointment with specified clinical privileges, or for rejection for staff membership.

N. The Medical Staff President/Hospital President shall forward the Executive Committee’s recommendation, together with all supporting documentation, to the next meeting of the Board and/or Board Subcommittee. Within ten working days of action by the Board, the decision shall be provided from the Medical Staff President/Hospital President to the applicant and to the appropriate hospital and clinical departments.

O. If an adverse recommendation is made to either a new applicant applying for privileges or membership, or to a current staff member applying for additional privileges by the clinical
department, the applicant shall be informed of the reason for denial and shall be entitled to and be informed of the rights provided in the hearing and appellate review procedures contained in the Fair Hearing Plan. Adverse recommendations may be reportable to the appropriate State licensing agency and the National Practitioner Data Bank.

P. Any applicant who has received a final decision denying staff membership or all or any portion of the privileges requested, shall not be eligible to reapply for staff membership or to reapply for the denied privileges, as the case may be, for a period of sixty (60) months from the date of the final decision.

Q. A final decision as referred to in this Article means the effective date of any adverse recommendation as referred to in the Fair Hearing Plan.

R. Privileges granted to each practitioner are made available to all patient care staff of the hospital. These are updated within one week of Board decision.

S. By applying to the staff of any PHC hospital, the applicant agrees that all application information received from the applicant or gained from any source during the application process may be shared among the PHC hospitals for credentialing and privileging purposes.

T. All ARNPs and CRNAs must be approved by the Chief Nursing Officer

Section 4. Procedures For Reapplication

A. The Board makes the final determination regarding membership and privileges.

A. Any Staff member who has received a final decision denying initial staff appointment, staff reappointment, curtailing existing privileges, or denying all or a portion of new privileges requested shall not be eligible to reapply for staff reappointment or for the curtailed or denied privileges, as the case may be, for a period of 60 months (five years) from the date of the final decision.

B. A reapplication for staff membership or privileges shall be accompanied by such additional information as the Executive Committee may require to demonstrate that the basis for the original final decision no longer exists; further, a reapplication by an applicant not a member of the Staff shall be processed as an original application.

Section 5. Provisional Category

A. All initial appointments to the Medical Staff (with the exception of members with no privileges) shall be provisional for a minimum period of six (6) months. Appointments to provisional membership may not exceed two (2) full years, at which time the failure to advance an appointee from Provisional to full Active, Associate, Affiliate or Allied Health Professional Staff shall be deemed a termination of his or her respective appointment. Failure to exercise the privileges granted, failure to cooperate in the peer review process, failure to comply with policies on completion of medical records, or failure to adhere with the Code of Conduct/Professional Expectations policy may be considered an automatic relinquishment. A Provisional appointee whose membership is terminated shall have the rights accorded by these bylaws to a member of the Medical Staff who has failed to be reappointed. (Automatic relinquishment due to a failure to exercise the privileges granted is not an adverse action to restrict or revoke professional privileges,
therefore, reporting to the National Practitioner Data Bank under the Health Care Quality Improvement Act of 1986 may not be required in this case.)

B. Provisional Staff members shall be assigned to a clinical department which will be responsible to oversee a focused performance monitoring process to determine the eligibility of the Provisional member for full membership and for exercising each of the clinical privileges provisionally granted. The performance monitoring criteria will be shared with the applicant. Information during this process may be gained from chart reviews, monitoring of clinical practice patterns, simulation, proctoring/precepting, external peer review, and discussion with other individuals involved in the care of mutual patients. This provisional focused evaluation will follow the six competency areas as outlined in Initial Appointment Requirements and Process B.1, which includes a review of quality and safety of patient care by the Department Chair/Section Chair.

The Department Chair will recommend to the Credentials Committee one or more of the following:

1. Full membership and privileges requested
2. Extension of provisional membership status
3. Extension of provisional status for some of the privileges requested
4. Communication with the practitioner regarding areas for improvement
5. Denial of advancement to full membership and privileges

The Credentials Committee will review and endorse or reverse the recommendation of the Department Chair and forward their recommendation to the MEC.

If the MEC endorses action 2-4 above, the Department Chair together with the Credentials Chair will communicate the recommendation to the provisional member with an explanation of the decision.

If the MEC recommends denial of advancement to full membership and privileges for any reason other than a failure to practice within the facility during the provisional period, the provisional staff member shall have the rights accorded by these bylaws to a member of the Medical Staff who has failed to be reappointed.

G. Members of the Provisional Staff shall not be eligible to vote, make nominations for, or hold elective office. Such members may serve on committees.

Section 6. Ongoing Evaluation

A. All practitioners are subject to ongoing professional practice evaluation to allow the hospital to identify trends which may impact quality of care and patient safety. The type of data to be collected is determined by individual departments and approved by the MEC.

B. Ongoing evaluation may include the following:
   1. Compliance with established quality and safety standards of the hospital
   2. Patterns of patient and staff complaints
   3. Medical record delinquencies
   4. Resource utilization, such as blood, pharmaceuticals, tests and procedures
   5. Length of stay patterns
6. Morbidity and mortality data
7. Observation by another health care professional
8. Other relevant criteria as determined by the department or the organized medical staff

C. Ongoing practice evaluation data is reviewed by the Department Chair and shared with the practitioner. Aggregate data may be reviewed at the Department level and be integrated into performance improvement activities for the department.

D. Concerns identified during the ongoing evaluation process may result in a focused practice review or the investigative process as outlined in the Fair Hearing Plan.

Section 7. Reappointment Requirements and Process

A. After the provisional appointment, Medical Staff appointments are for up to two years. (Selected AHP’s are appointed yearly.) The reappointment process is initiated by Medical Staff Services sending a reappointment form to the practitioner at least 90 days prior to the expiration of his current appointment. The reappointment form must be completed and returned along with all requested information to Medical Staff Services within 30 days after receipt by the practitioner. Failure to timely return the completed reappointment form and requested information may be considered a resignation from the staff.

B. Reappointment applications shall include the following:
1. Evidence of current licensure/registration in the state of Washington as required for scope of practice.
2. Evidence of continuing training, current competence, education and recent experience that qualifies a staff member for the privileges sought on reappointment.
3. If there is no significant clinical activity noted within the Spokane area hospitals, a reference must be obtained from a peer who has personal and recent knowledge and can attest to the practitioner’s current competence for the privileges requested.
4. Information regarding all physical and mental conditions adversely affecting competence including, but not limited to, drug and alcohol abuse, and the individual physician’s declaration of health status. The staff member agrees, upon request of the Executive Committee or Board, to submit to a physical and/or psychiatric examination by a physician agreeable to both the MEC and the staff member to verify physical and mental fitness.
5. The name and address of any other health care organization or practice setting wherein the staff member provided clinical services during the preceding period.
6. Membership, awards or other recognition conferred or granted by any professional health care societies, institutions or organizations.
7. Sanctions of any kind imposed or pending by any other health care institution, professional health care organization, or licensing authority.
8. Evidence of malpractice insurance coverage (including cancellations, non-renewals and limits), and description of any pending malpractice actions.

9. Such other specifics about the staff member’s professional ethics, qualifications and ability requested by the Staff that may bear on the member’s ability to provide good patient care in the hospital.

10. An acknowledgment of receipt of copies of the current bylaws/appendices of the Staff and a representation that the staff member agrees to abide by the terms thereof; in addition, agreement that in the event of dispute with the Staff or with the hospital that the member will exhaust all means available to him or her of resolving the dispute prior to resorting to litigation.

11. By applying for reappointment to the staff, each member thereby signifies his willingness to appear for interviews in regard to his reapplication, authorizes the hospital to consult with members of the medical staffs of other hospitals with which the member has been associated and with other qualified persons who may have reliable information bearing on the member’s current health status, competence, character and ethical qualifications, and consents to the hospital’s inspection of all records and documents which may be material to an evaluation of his or her professional qualifications and competence to carry out the clinical privileges he or she requests.

12. By applying for reappointment to the staff, each member thereby signifies his agreement that all reappointment, peer review, and performance improvement information may be shared within the PHC hospitals.

D. Medical Staff Office personnel are responsible for reviewing the reappointment form for completeness and collecting information concerning the applicant’s volume of activity during the previous twenty-four (24) months, results from ongoing professional practice evaluations, the applicant’s participation in the functions of the medical staff, the completion of the applicant’s medical records, and recommendations from peers.

E. The Department Chair or his designee will provide initial review of the reappointment application and the supporting documentation, and provide recommendation to the Credentials Committee according to the following competencies:

1. Patient care
2. Medical/clinical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communications skills
5. Professionalism
6. System-based practice

F. The Credentials Committee reviews the file and recommendations of the Department Chair/designee. If, after review, the Credentials Committee decides that the member's privileges should be revoked or curtailed or that requested privileges should be denied, the Credentials Committee may request the member to meet with the committee. This meeting shall be informal, shall not be part of the corrective action or hearing and appellate review procedure, and shall be an opportunity for the Credentials Committee and the member to discuss the reappointment application. The Credentials Committee may recommend the practitioner with no documented activity for a period of time to be appointed to a membership category with no privileges.
The Credentials Committee shall present its findings and recommendations to the Executive Committee, which considers the recommendations of the Credentials Committee in its recommendation to the Board.

At the Board meeting, prior to the completion of the member’s biennial appointment, the Executive Committee shall present a written recommendation concerning the reappointment or non-reappointment and the modification, continuation or curtailment of clinical privileges for the ensuing year. When non-reappointment or curtailment of privileges is recommended or a requested modification in privileges is not recommended, the reasons therefore shall be stated.

An expedited process of approval by two of three designated Board members may be utilized for both initial appointment and reappointment. This process may be utilized for an application which demonstrates all of the following:

1. Application and supporting documentation are complete
2. No current or previously successful challenge to licensure or registration
3. No involuntary termination of medical staff membership at another organization
4. No involuntary limitation, reduction, denial or loss of clinical privileges
5. No unusual patterns or excessive numbers of professional liability actions resulting in judgment against the applicant
6. Applicant has been recommended by Credentials Committee and the MEC and is awaiting review at the next Board meeting

The Department Chair or the MEC may at any time recommend a focused professional practice evaluation if questions arise regarding the individual’s practice within the facility. The focused review is separate from the ad hoc committee or investigation process as outlined in the Fair Hearing Plan.

K. Providing false or misleading information is a basis for not renewing membership and/or clinical privileges.

L. Failure to return reappointment forms will be considered a resignation from staff.
APPENDIX I PRIVILEGING PROCEDURES

Section 1. Privileges

A. The types of privileges performed within the Hospital are recommended through the Medical Executive Committee for approval by the Board. These ‘privileges’ or ‘scope of service’ documents include the qualifications to apply for the specific procedure or category of procedures. Prior to approving a new procedure to be performed within the Hospital, the resources necessary to support the requested privilege are determined to be currently available, or available within a specified time frame. This includes equipment as well as the training of personnel. See also the policy ‘Privileging for New Procedures’ on file in the Medical Staff Office.

B. Members of the Staff are authorized to exercise only those clinical privileges specifically granted by the Board, with the exception of emergency situations as outlined under Section 3 of this Appendix. A practitioner’s clinical privileges may be suspended for failure to exercise only those clinical procedures specifically approved by the Board.

C. Members of the Staff may, at any time, request additional privileges or may voluntarily relinquish privileges. All requests for additional privileges must meet established criteria and be accompanied by documented evidence of current training and clinical competence to support the request. Information from ongoing professional practice evaluation data sources is considered in the decision process.

D. The hospital queries the National Practitioner Data Bank when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege is requested.

E. Voluntarily relinquishing privileges may not relieve members of the Medical Staff from call obligations, as established by each department.

F. The applicant shall have the burden of establishing his/her qualifications and competency based on his/her education, training, experience, demonstrated competence, references, ability to perform the requested privileges and other relevant information for the requested clinical privileges for physicians, and scope of services for allied health professionals. To be eligible for privileges the practitioner must provide documentation of sufficient activity to assess current clinical competence.

G. Applicants must provide a summary of procedures performed within the past two years. This may include signed procedure logs from residency and/or fellowship, letters from residency, fellowship, or department chairs and/or patient data from the most recent hospitals where the individual has practiced.

H. Experience, ability, and current competence for performing the requested privilege is verified by a minimum of two peers with knowledge of the applicant’s current professional performance. Responses will be requested following the outline of competency provided in Appendix B, Section 3.
I. When during the initial credentials review process, or any subsequent review, there is not adequate clinical data to support the decision to grant the requested privilege, a focused professional practice evaluation may be arranged for a time-limited period. This focused evaluation may also be utilized for those who have not performed the required number of specific procedures, or in response to concerns regarding the provision of safe, high quality patient care. This may include any of the following.

1. Chart review
2. Monitoring clinical practice patterns
3. Simulation
4. Proctoring
5. External peer review
6. Evaluations of consulting physicians, procedure assistants, nursing or administrative personnel

J. Evaluations from treating physicians and/or a mutually agreed-upon health professional may be requested if there is doubt regarding an applicant’s ability to perform the privileges requested.

The Credentials Committee shall make periodic re-determination (at least every two years) as to whether the Staff member’s, or allied health professional’s clinical privileges shall be continued, increased or curtailed. The re-determination shall be based on review of the member’s credentials, peer recommendation, medical records, clinical department records, quality assessment records, and information obtained from other hospitals.

The scope and extent of surgical procedures that each dentist, oral surgeon and podiatrist may perform shall be specifically delineated and granted in the same manner as surgical privileges are granted to Staff members. Surgical procedures performed by dentists, oral surgeons and podiatrists shall be under the overall supervision of the chairperson of the Surgery Department. All dental and podiatry patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. The rules and regulations further define the role of the dentist and podiatrist with the Staff.

Clinical privileges for psychologists shall be limited to the usual and customary privileges as defined under state law. Consultation to determine the existence of a psychiatric disorder and/or recommendations for the treatment or disposition of patients with psychiatric disorders must be performed by a psychiatrist, and a physician member of the Staff shall be responsible for the diagnosis and treatment of patients seen by a psychologist.

Approved current clinical privileges for each practitioner are maintained in the individual practitioner’s credentials file, as well as available electronically for reference by all clinical staff.

Section 2 – Temporary Privileges

A. The Hospital President or his designee, at the written recommendation of a Department Chair, Section Chair, Credentials Committee Chair, or Medical Staff President may, upon the basis of information then available which may reasonably be relied upon as to
the competence and ethical standing of the applicant, grant temporary admitting and/or clinical privileges to an appropriately licensed individual under one of the following categories. In the exercise of such privileges, the applicant shall be subject to the Medical Staff Bylaws, policies, and procedures. Temporary privileges shall be in effect for no longer than (120) days.

1. Practitioner is applying for full staff status and all documentation has been received regarding the applicants training, experience, and competency. The complete application with no identified concerns is awaiting MEC and/or Board approval.

2. An important patient care need exists, which no currently credentialed staff member can meet. In this instance, licensure, training, and competency must be verified. These temporary privileges will be time and/or patient specific according to the need.

3. Practitioner has been approved by the Board and in good standing at one of the PHC hospitals and will be providing a temporary service to another hospital within the PHC system. In this instance the hospital President or Chief Medical Officer, if applicable, may approve the practitioner's privilege or privileges for a specified time. (Note that AHP’s have the same requirements for physician sponsorship at the requesting hospital; PA's must also have a Practice Plan approved by the State with a credentialed physician at the requesting hospital.)

4. Temporary privileges may be granted to locum tenens practitioners. They will be assessed a processing fee in accordance with Medical Staff Credentialing Policy. Locum tenens applicants must meet the same privileging requirements as those applying for full staff privileges; however, they are not members of the Medical Staff. The Credentials Committee Chair or Credentials Committee designee may at any time during the processing of a locum tenens application determine that a concern exists regarding competency or behavior which would preclude temporary privileges; the application process will cease at that decision and the applicant will be informed that s/he is not eligible for temporary privileges. Each appointment of a locum tenens practitioner may be for no longer than 120 days.

At a minimum, the following will be verified:

a. Washington State licensure
b. DEA Certificate, if applicable
c. Liability insurance coverage meeting required limits
d. National Practitioner Data Bank query
e. AMA profile (may be waived if repeat locum or established in the community)
f. Department of Health and Human Services/Office of the Inspector General (OIG/LEIE) and the General Services Administration/Excluded Parties Listing System (GSA/EPLS) to confirm no exclusions from eligibility for governmental payments exist.
g. Privilege request
h. Peer reference, including competency for requested procedure/s
i. Good standing at other hospital/s during the prior 10 years
j. Copy of government issued photo ID (verified by Medical Staff Office prior to beginning practice)
B. The Medical Staff President or Hospital President may at any time terminate a physician's or allied health professional's temporary privileges when it is determined that the life or health of patient(s) would be endangered by continued treatment by the physician or allied health professional; this termination may be imposed immediately by any person entitled to impose a precautionary suspension pursuant to Appendix A of these Bylaws. The appropriate department chair, or in his or her absence, the Medical Staff President, shall assign a member of the Staff to assume responsibility for the care of such patient(s) until discharge from the hospital. The wishes of the patient(s) shall be considered where feasible in selection of a substitute physician or allied health professional.

C. Special requirements of supervision and reporting may be imposed by the department chair on any physician granted temporary privileges. Temporary privileges shall be immediately terminated by the Medical Staff President or Hospital President upon notice of any failure by the physician to comply with such special conditions.

Section 3 – Emergency Privileges
A. For the purpose of this Section, an “emergency” is defined as a condition in which the life or limb of a patient is in immediate danger and in which any delay in administering treatment would increase the danger.

B. In case of emergency, any physician to the degree permitted by his/her license and regardless of privileges or staff category, shall be permitted and assigned to make every reasonable effort to save the life of a patient using available facilities of the hospital, including calling for any consultation necessary or desirable.

C. When an emergency situation no longer exists, such physician must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he/she does not desire to request privileges, the patient shall be assigned to an appropriate member of the Staff.

Section 4 – Disaster Privileging

Refer to community-wide policy regarding credentialing physicians during a community disaster when the region’s emergency management plan has been activated. The Hospital President or designee will confirm that the Hospital requires services of non-credentialed practitioners to meet immediate patient needs to activate this policy and process. The policy is on file in the Medical Staff Office, and files of physicians and AHP's so activated will be retained by the Medical Staff Office.

Section 5 – Special Privileges for a Visiting Physician/Professor

A visiting physician/professor who is a recognized expert in his/her field may be granted special privileges specifically relating to his/her visit. The purposes of the visit should be for educational or instructional reasons. The visitor must be in good standing and currently credentialed for the particular procedure at his institution of practice. Evidence of licensure and malpractice coverage will be obtained. The Hospital President or his designee, at the recommendation of the Medical Staff President or Chair of the department or service line where the privilege will be exercised, may grant special privileges as defined in this section.

Section 6 – Medical Students and Residents

All Spokane Hospitals comply with the Inland Empire Hospital Services Association/Spokane Graduate Medical Education Council (IEHSA/GMEC) policy on ‘Medical
Student Training within the Hospitals’, which is on file in the MSO. All supervision of residents is performed by licensed independent practitioners with appropriate clinical privileges, and each patient’s care, treatment, and services are the responsibility of a licensed independent practitioner with appropriate clinical privileges.

Written description of the roles, responsibilities, and patient care activities of the participants in graduate medical education are housed in the Graduate Medical Education office; approved patient care activities for each resident are available electronically to hospital personnel.

Student observers may accompany a medical staff member in good standing, and the student must complete appropriate documentation in the MSO prior to observation.
APPENDIX J. VOLUNTARY CHANGES IN MEMBERSHIP

Section 1. Voluntary Resignation of Medical Staff Membership

A Medical Staff member may resign from the Medical Staff by submitting a written resignation to the Credentials Committee specifying the date the resignation will be effective. Active Staff members are requested to provide at least 30 days advance notice of their resignation. If less than 30 days notice is given, and if the Medical Staff member has not made arrangements for other members of the Medical Staff to cover his call obligation for at least 30 days after submitting his resignation, that fact may be reflected in any references provided thereafter.

Section 2. Voluntary Request for Change in Medical Staff Membership

At any time a Medical Staff member in good standing may voluntarily request a change in staff status to another category. The request must be submitted in writing to the Credentials Committee and will be reviewed by the Department or Service Line Chair before the Credentials Committee makes a recommendation to the MEC. The MEC will approve the change if the Medical Staff member meets the criteria for the category requested. This process will take approximately 45 days. Call responsibilities will remain in effect for all published call schedules until a change is approved and the next call schedule is issued.

Section 3. Leave of Absence (LOA)

If a Medical Staff member will be absent from patient care responsibilities for more than 60 consecutive days, he must request a leave of absence from the Medical Staff. A Medical Staff member who is absent from patient care responsibilities for more than 60 consecutive days and has not requested a leave of absence shall be deemed to have voluntarily resigned from the Medical Staff, and must reapply for Medical Staff membership and clinical privileges.

A. Requests for leaves of absences must be submitted in writing to the Medical Staff and include an explanation of the reason for the leave and the anticipated length of the leave. The appropriate Department or Service Line Chair will review the request and make a recommendation whether to grant to deny the request to the Credentials Committee. The Credentials Committee will evaluate the request and the recommendation of the Department or Service Line Chair and make its recommendation to the MEC.

B. The MEC may grant or deny a leave of absence. Leaves will be considered for the following reasons for up to the following periods:
   1. Education – no longer than two years
   2. Medical or maternity leave – no longer than two years
   3. Military obligation – dependent on length of expected military service, but generally not to exceed two years
   4. For such others reasons as are acceptable to the MEC provided the leave of absence is for no more than three months.

C. Granting leaves of absence are matters of courtesy, not of right, and the determination of the MEC shall be final. There is no right to a hearing or appeal if a request for a leave of absence is denied.
D. All clinical privileges, call responsibilities and other obligations of Medical Staff membership are suspended during a leave of absence.

E. With the exception of an unanticipated medical condition or military orders that do not permit the Medical Staff member to give additional notice, Active Staff members must request a leave a minimum of 45 days prior to the leave to minimize disruption of the call schedule.

F. Request to Return from Leave of Absence
   1. A minimum of 30 days prior to when the practitioner desires to return to the Medical Staff, the practitioner must request reinstatement in writing to the Credentials Committee.
   2. All the requirements for reappointment must be satisfied prior to reinstatement.
   3. Any request for privileges the practitioner did not have at the time the LOA was granted will be considered as set forth elsewhere in these Bylaws provided the request for reinstatement is granted.
   4. The Credentials Committee will confer with the Department Chair and make recommendation to the MEC whether to grant or to deny reinstatement.
   5. The MEC will make its recommendation to the Board which retains the responsibility to approve, modify, or deny the request to reinstate membership and privileges.
APPENDIX K. TIME PERIODS

The time periods specified in these Bylaws and the Fair Hearing Plan are intended to provide guidelines for the routine processing of applications, requests for reappointment, requests for corrective action, requests for a hearing, and the conduct of meetings. Deviations from the time periods set forth herein shall not be grounds for invalidating the action taken.
APPENDIX L. PRIVILEGE, CONFIDENTIALITY, RELEASE OF INFORMATION & IMMUNITY FROM LIABILITY

As a condition of appointment and reappointment to the Medical Staff, each member agrees to the following:

Section 1. Privilege and Confidentiality

By law, any and all information, minutes, documents, proceedings, reports, or records which are collected or prepared by any regularly constituted committee of the Medical Staff or Board, whose duty is to evaluate the competency or qualifications of a Medical Staff member or applicant for Medical Staff membership or clinical privileges, or to evaluate patient care, are privileged. This privilege extends to information supplied by members of the Medical Staff, the MEC, the Board, and to third parties who supply information for the purposes set forth above. For the purposes of this Article, the term ‘third parties’ means both individuals and organized representatives of the Board or the Medical Staff, including that of any other institution or facility.

In order to protect this privilege, all communication, information, documents, proceedings, records, reports, recommendations and disclosures prepared or collected by a regularly constituted committee or board of the Medical Staff or Board whose duty is to evaluate the competency or qualifications of a Medical Staff or Allied Health Professional staff member, including applicants for membership, or to review and evaluate patient care, shall be kept strictly confidential, and shall not be used for any other purpose except as may be required by law or by these Bylaws.

Section 2. Immunity

To the fullest extent permitted by law, any member of the Medical Staff, the MEC, Board or third party who, in good faith, files charges, presents evidence, provides information or participates in a regularly constituted committee of the Medical Staff or Board, whose duty is to evaluate the competency or qualifications of Medical Staff and Allied Health Professional staff members, including applicants for membership or clinical privileges, or to review and evaluate the quality of patient care, shall be immune from civil liability arising out of such activities.

Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:

A. Applications for appointment and clinical privileges;
B. The reappointment process;
C. Corrective action, including summary suspension;
D. Hearings and appellate reviews;
E. Medical care evaluations and other peer review activities;
F. Utilization reviews; and
G. Other hospital, departmental, service, or committee activities related to quality of patient care and professional conduct.

Section 3. Authorizations and Releases
By submitting an application for appointment or reappointment to the Medical or Allied Health Professional Staff or by applying for or exercising clinical privileges, a practitioner authorizes representatives of the Medical Staff and/or Hospital to solicit, provide, and act upon information and documents bearing upon the practitioner's education, training, experience, competence, ethical standards, ability to work with others, and health status; and agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff and/or Hospital in accordance with the provisions of this Article. Consistent with the Health Insurance Portability and Accountability Act (HIPAA), any personal health information (PHI) obtained by the Hospital as part of the credentialing process is maintained as confidential and subject to the Hospital's privacy policy.

Each practitioner shall, upon request of the Medical Staff and/or Hospital, execute general and specific releases as required in these Bylaws as may be applicable under relevant Washington State Law. Execution of such releases is not a prerequisite to the effectiveness of these Bylaws. Failure to execute such releases in an application for reappointment or clinical privileges shall be deemed as a voluntary resignation of staff membership. These releases allow complete and continuous sharing of information among Providence Health Care organizations.

The authorizations and releases set forth herein are for the protection of the Hospital's practitioners, other appropriate Hospital personnel, and third parties.

All applicants for appointment and reappointment consent to the release of information for any purposes set forth in these Bylaws among the Providence Health Care organizations.

Section 4. Access to Records

Practitioners' credentials files maintained by the Medical Staff Office contain privileged and confidential information. Access to these files shall only be for the purpose of conducting the activities set forth in Section 2 above; and restricted to the following individuals:

A. Hospital President or his designee;
B. Chair of the Board or his designee;
C. President of the Medical Staff his designee;
D. Chief Medical Officer (CMO), if applicable;
E. Chair of the department to which the practitioner is assigned or his designee, if a departmentalized hospital;
F. Members of the Credentials Committee, if a separate function from the MEC;
G. Personnel in the Medical Staff Office.

A practitioner may have access to, and the right to obtain a copy of, any of the documents in his credentials file which he has submitted pertaining to his application, reappointment, or clinical privileges, or correspondence pertaining to him which was addressed to or copied to him. A practitioner shall not have access to any other documents in his credentials file unless otherwise required by law or provided in accordance with hearing and appellate review procedures set forth in the Fair Hearing Plan.

Copies of minutes of all Medical Staff committees will be kept in the Medical Staff Office. Access to these minutes is restricted to members of the respective committees, personnel of the Medical Staff Office, and individuals authorized by the Medical Staff President or Hospital President. Copies of these minutes, except for copies distributed at committee
meetings, cannot be removed from the Medical Staff Office unless expressly authorized by the President of the Medical Staff, Chief Medical Officer, if applicable, Hospital President or their designee.

APPENDIX M. RESPONSE TIME

Patients admitted to critical care units shall be seen by the attending practitioner within two (2) hours, unless a clinical department specifically exempts this policy. If the attending practitioner cannot see the patient within the two-hour limit, the attending will contact an appropriate alternate practitioner who shall assume responsibility for the patient. An allied health staff member may not substitute for the physician in this case. If the patient is not seen within the stated time period, the clinical Department Chair, CMO or administrator on call will be contacted.