# BYLAWS OF THE MEDICAL PROFESSIONAL STAFF
## OF SWEDISH HEALTH SERVICES

## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREAMBLE</strong></td>
<td>5</td>
</tr>
<tr>
<td><strong>ARTICLE I: STATEMENT OF THE PURPOSES OF THE MEDICAL PROFESSIONAL STAFF</strong></td>
<td>6</td>
</tr>
<tr>
<td>1.1 Name</td>
<td>6</td>
</tr>
<tr>
<td>1.2 Purposes</td>
<td>6</td>
</tr>
<tr>
<td>1.3 The Applicability of the Bylaws to Multiple Campuses</td>
<td>6</td>
</tr>
<tr>
<td>1.4 Definitions</td>
<td>6</td>
</tr>
<tr>
<td>1.5 Titles, Headings and Captions</td>
<td>10</td>
</tr>
<tr>
<td>1.6 Severability</td>
<td>10</td>
</tr>
<tr>
<td><strong>ARTICLE II: MEDICAL PROFESSIONAL STAFF ORGANIZATION AND GOVERNANCE</strong></td>
<td>10</td>
</tr>
<tr>
<td>2.1 Medical Professional Staff Organization</td>
<td>10</td>
</tr>
<tr>
<td>2.2 Medical Professional Staff Officers</td>
<td>11</td>
</tr>
<tr>
<td>2.3 Immediate Past System Chief of Staff</td>
<td>14</td>
</tr>
<tr>
<td>2.4 Treasurer</td>
<td>15</td>
</tr>
<tr>
<td>2.5 Finances</td>
<td>16</td>
</tr>
<tr>
<td>2.6 Campus Medical Professional Staff Officers</td>
<td>17</td>
</tr>
<tr>
<td>2.7 Immediate Past Campus Chief of Staff</td>
<td>19</td>
</tr>
<tr>
<td><strong>ARTICLE III: DEPARTMENTS OF THE MEDICAL PROFESSIONAL STAFF</strong></td>
<td>20</td>
</tr>
<tr>
<td>3.1 Department Function</td>
<td>20</td>
</tr>
<tr>
<td>3.1.3 Enhance the professional development of member clinicians</td>
<td>21</td>
</tr>
<tr>
<td>3.2 Organization of Departments</td>
<td>21</td>
</tr>
<tr>
<td>3.3 Department Functions</td>
<td>21</td>
</tr>
<tr>
<td>3.4 Department Chiefs</td>
<td>22</td>
</tr>
<tr>
<td>3.5 Advisory Positions</td>
<td>25</td>
</tr>
<tr>
<td>3.7 Department Meetings</td>
<td>25</td>
</tr>
<tr>
<td>3.8 Department Sections</td>
<td>26</td>
</tr>
<tr>
<td><strong>ARTICLE IV: MEDICAL PROFESSIONAL STAFF COMMITTEES</strong></td>
<td>27</td>
</tr>
<tr>
<td>4.1 Medical Professional Leadership Council</td>
<td>27</td>
</tr>
<tr>
<td>4.3 Professional Review Oversight Committee (PROC)</td>
<td>30</td>
</tr>
<tr>
<td>4.4 Professional Peer Review Committees</td>
<td>32</td>
</tr>
<tr>
<td>4.5 Credentials Committee</td>
<td>33</td>
</tr>
<tr>
<td>4.6 Bylaws Committee</td>
<td>34</td>
</tr>
<tr>
<td>4.7 MPLC/Medical Professional Staff Relations Committee</td>
<td>35</td>
</tr>
<tr>
<td>4.8 Campus Executive Committees</td>
<td>36</td>
</tr>
<tr>
<td>4.9 Campus Quality Councils</td>
<td>37</td>
</tr>
</tbody>
</table>
ARTICLE V: PARLIAMENTARY PROVISIONS RELATING TO GENERAL MEDICAL PROFESSIONAL STAFF MEETINGS, AS WELL AS DEPARTMENTAL AND COMMITTEE MEETINGS .................................................. 38
5.1 Regular Medical Professional Staff Meetings .......................................................... 38
5.2 Special Medical Professional Staff Meetings ......................................................... 38
5.3 Quorum for Medical Professional Staff Meetings ................................................ 38
5.4 Mail or Electronic Ballot for Medical Professional Staff Actions ............................. 38
5.5 Attendance Requirements ..................................................................................... 39
5.6 Minutes and Reports; Confidentiality .................................................................... 39
5.7 Department/Standing Committee Reports ......................................................... 39
5.8 Quorum for Department/Standing Committee Meetings .................................... 39
5.9 Rules of Order ........................................................................................................ 39
5.10 Voting .................................................................................................................... 39
5.11 Approval of Bylaws ............................................................................................... 39
5.12 Amendment of Bylaws ......................................................................................... 40
5.13 Adoption of Bylaws .............................................................................................. 41

ARTICLE VI: MEDICAL PROFESSIONAL STAFF RULES AND REGULATIONS AND POLICIES .................................................................................................................. 41
6.1 Medical Professional Staff Rules and Regulations and Policies ............................. 41
6.2 Consistency ............................................................................................................. 42
6.3 Accessibility ............................................................................................................ 42

ARTICLE VII: MEDICAL PROFESSIONAL STAFF MEMBERSHIP AND PRIVILEGES .... 42
7.1 Nature of Medical Professional Staff Membership .............................................. 42
7.2 Qualifications .......................................................................................................... 42
7.3 Clinical and Other Privileges ................................................................................ 44
7.4 Nondiscrimination .................................................................................................. 48
7.5 Allied Health Professionals .................................................................................... 48
7.6 Procedures Relating to Medical Professional Staff Membership and Privileges ...... 53
7.7 Review by Outside Consultants ............................................................................. 62

ARTICLE VIII: CATEGORIES OF THE MEDICAL PROFESSIONAL STAFF ...................... 63
8.1 Membership Categories ......................................................................................... 63
8.2 Active Category ...................................................................................................... 63
8.3 APC Category ......................................................................................................... 64
8.4 Courtesy Category .................................................................................................. 64
8.5 Administrative Category ......................................................................................... 65
8.6 Honorary Category ................................................................................................. 65
8.7 Residents and Fellows ............................................................................................ 66

ARTICLE IX: MEMBER RIGHTS ................................................................................ 66
9.1 Member Rights ........................................................................................................ 66

ARTICLE X: QUALITY IMPROVEMENT ...................................................................... 68
10.1 Performance Improvement .................................................................................... 68
10.2 Organization ........................................................................................................... 70
10.3 Policies and Procedures of the Quality Improvement Program ............................. 70
## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.4 Peer Review</td>
<td>72</td>
</tr>
<tr>
<td>10.5 Focused Professional Practice Evaluation</td>
<td>74</td>
</tr>
<tr>
<td>10.6 Review Period</td>
<td>75</td>
</tr>
<tr>
<td>10.7 External Peer Review</td>
<td>75</td>
</tr>
<tr>
<td>10.8 Conclusions</td>
<td>76</td>
</tr>
<tr>
<td>10.9 Proctoring</td>
<td>77</td>
</tr>
<tr>
<td><strong>ARTICLE XI: DISCIPLINARY AND REVIEW HEARING</strong></td>
<td>77</td>
</tr>
<tr>
<td>11.1 Right to Review Hearing</td>
<td>77</td>
</tr>
<tr>
<td>11.2 Limitation on Review Hearings</td>
<td>77</td>
</tr>
<tr>
<td>11.3 Non-Adverse Actions</td>
<td>77</td>
</tr>
<tr>
<td>11.4 Disciplinary Action</td>
<td>79</td>
</tr>
<tr>
<td>11.5 Review Hearing Procedures</td>
<td>87</td>
</tr>
<tr>
<td><strong>ARTICLE XII: LEGAL PROTECTIONS AND CONFLICTS OF INTEREST</strong></td>
<td>92</td>
</tr>
<tr>
<td>12.1 Legal Protections</td>
<td>92</td>
</tr>
<tr>
<td>12.2 Authorization and Release</td>
<td>92</td>
</tr>
<tr>
<td>12.3 Acknowledgments</td>
<td>93</td>
</tr>
<tr>
<td>12.4 Participation in Professional Review</td>
<td>93</td>
</tr>
<tr>
<td>12.5 Use of Information</td>
<td>93</td>
</tr>
<tr>
<td>12.6 Interpretation</td>
<td>93</td>
</tr>
<tr>
<td>12.7 Conflicts of Interest</td>
<td>93</td>
</tr>
<tr>
<td><strong>ARTICLE XIII: HISTORY AND PHYSICALS</strong></td>
<td>94</td>
</tr>
<tr>
<td>13.1 Requirements</td>
<td>94</td>
</tr>
<tr>
<td>13.2 Performance and Authentication</td>
<td>94</td>
</tr>
<tr>
<td>13.3 Interval Note</td>
<td>95</td>
</tr>
<tr>
<td>13.4 Documentation</td>
<td>95</td>
</tr>
</tbody>
</table>
PREAMBLE

The Swedish Medical Professional Staff advances the mission of Swedish Health Services “to improve the health and well-being of each person we serve” by providing content expertise, advanced technical skills and clinical leadership that promotes the health and wellness of our patients, our staff and our communities. Those in our care will experience the joy of birth and healing as well as the despair of disease, illness, suffering, and the mysteries of life and death. We are committed in our professionalism and humanity to care for all with skill, compassion and empathy, making best use of our human, professional and technical resources for the benefit of all who we serve.

The Swedish Medical Professional Staff is collectively responsible for assuring the quality of clinical care, promoting continuous quality improvement and the efficient use of resources, assuring ethical behavior, and promoting continuing education in best medical practices.

In pursuit of these goals the Swedish Medical Professional Staff adopts the following Bylaws:
ARTICLE I: STATEMENT OF THE PURPOSES OF THE MEDICAL PROFESSIONAL STAFF

1.1 Name
The name of this organization shall be the Medical Professional Staff of Swedish Health Services (hereafter “Medical Professional Staff”).

1.2 Purposes
The purposes of the Medical professional staff are to:

1.2.1 Promote quality care for all patients admitted or treated in any of the facilities, institutes, programs or departments of the Hospital, toward which end the Medical Professional Staff will abide by and perform in an official capacity for Swedish.

1.2.2 Strive for quality professional performance by all Practitioners authorized to practice in or on behalf of the Hospital through the appropriate delineation of the Privileges that each Practitioner may exercise in the Hospital and through ongoing review and evaluation of each Practitioner’s performance, and in so doing act in an official capacity for and at the direction of Swedish pursuant to these Bylaws.

1.2.3 Provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill.

1.2.4 Initiate and maintain rules and regulations for the governance of the Medical Professional Staff and provide a means whereby issues concerning the Medical Professional Staff and the Hospital may be discussed by the Medical Professional Staff with the Board and the CE.

1.3 The Applicability of the Bylaws to Multiple Campuses
To the extent that Swedish Health Services operates multiple campuses under one hospital license or operates as a regional healthcare system, these Bylaws shall presumptively cover all hospital campuses.

1.4 Definitions
For the purposes of these Bylaws and unless stated otherwise, the following definitions apply.

1.4.1 ADVANCED PRACTICE CLINICIAN or APC means a Practitioner credentialed by the Medical Professional Staff as an ARNP, CNM, CRNA, or PA-C.

1.4.2 ADVERSE ACTION means any action that requires a Practitioner to exercise or waive his/her right to a Review Hearing (Medical Professional Staff member) or Review Procedure (AHP).

1.4.3 ALLIED HEALTH PROFESSIONAL or AHP means an individual who is qualified by training, experience and current competence in a discipline which the Board, with the MPLC’s recommendation, has determined by policy to allow to practice in the Hospital and who is credentialed by the MPLC and Board of Trustees, but who is not a Medical Professional Staff member.

1.4.4 BALLARD CAMPUS means the Hospital's facilities located in the Ballard area of Seattle at NW Market and Barnes.
1.4.5 **BOARD** means the Board of Trustees of Swedish Health Services.

1.4.6 **CAMPUS** means any one or more of the Hospital facilities identified as a campus in these Bylaws.

1.4.7 **CAMPUS APC STAFF** means the APC staff with a common Primary Campus designation.

1.4.8 **CAMPUS CHIEF OF STAFF** means the Medical Professional Staff leader of a campus elected or appointed pursuant to these Bylaws.

1.4.9 **CAMPUS CHIEF OF STAFF-ELECT** means the Medical Professional Staff leader-elect of a campus elected or appointed pursuant to these Bylaws.

1.4.10 **CAMPUS EXECUTIVE COMMITTEE (CEC)** means the Campus-based group of Active and APC members of the Medical Professional Staff responsible for representing the unique circumstances, needs, and challenges of their Campus to the MPLC.

1.4.11 **CAMPUS MEDICAL PROFESSIONAL STAFF** means the group of Medical Professional Staff members with a common Primary Campus designation.

1.4.12 **CHERRY HILL CAMPUS** means the Hospital's facilities located at and adjacent to 500 17th Avenue, Seattle, Washington.

1.4.13 **CHIEF EXECUTIVE (CE)** means Swedish’s Chief Executive.

1.4.14 **CLINICAL INFORMATION SYSTEM (CIS)** means the enterprise-wide electronic application, such as Epic, that supports the functions of patient care. These may include registration, scheduling, clinical documentation, orders, results viewing, interaction checking (such as allergy, medication-medication, laboratory-medication, weight-dose, etc.), and medication reconciliation.

1.4.15 **DAYS** means calendar days.

1.4.16 **DEPARTMENT** means a system-wide clinical organizational unit of the Medical Professional Staff generally organized along specialty lines. The MPLC must approve the formation of a department.

1.4.17 **DEPARTMENT CHIEF** means the Medical Professional Staff member duly appointed or elected in accordance with these Bylaws to serve as the head of a Department.

1.4.18 **DEPARTMENT SECTION or SECTION** means the subset of a clinical Department of the Medical Professional Staff organized at a Campus.

1.4.19 **DIVISION** means a system-wide subset of a clinical Department of the Medical Professional Staff, organized along specific specialty lines.

1.4.20 **EDMONDS** means Swedish/Edmonds, a general acute care hospital owned by Verdant Health Commission and operated by Swedish/Edmonds, a Washington non-profit corporation, located at 21601 76th Avenue West, Edmonds, WA 98026.

1.4.21 **EMERGENCY MEDICAL CONDITION** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or, with regard to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
- Serious impairment to any bodily function, or
- Serious dysfunction of any bodily part, or
• Death

1.4.22 **EX-OFFICIO** means service as an appointee of a body by virtue of an office or position held. Unless otherwise expressly provided, Ex-Officio means without voting rights.

1.4.23 **FIRST HILL CAMPUS** means the Hospital's facilities located at 747 Broadway in the First Hill area of Seattle, Washington.

1.4.24 **FITNESS FOR DUTY** means the Practitioner does not have an impairment and is able to exercise privileges with reasonable skill and safety and without compromise, loss of cognitive or motor skills essential to perform granted privileges.

1.4.25 **HOSPITAL** refers to any one or more of the acute care facilities operated by Swedish Health Services including Swedish Medical Center/First Hill, Swedish Medical Center/Ballard, Swedish Medical Center/Cherry Hill, and Swedish/Issaquah. As of the effective date of these Bylaws, Swedish Medical Center/First Hill and Swedish Medical Center/Ballard are operated under a single hospital license. Swedish Medical Center/Cherry Hill, and Swedish/Issaquah are each operated under a separate license.

1.4.26 **IMMEDIATE PAST CAMPUS CHIEF OF STAFF** means the leader who most recently completed tenure as Campus Chief of Staff.

1.4.27 **IMMEDIATE PAST SYSTEM CHIEF OF STAFF** means the leader who most recently completed tenure as System Chief of Staff.

1.4.28 **IMPAIRMENT** means the inability of a Practitioner to exercise privileges with reasonable skill and safety because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or the use or abuse of drugs (psychoactive substances) including alcohol.

1.4.29 **INTEGRATED COMMITTEE** means a standing committee led by the Medical Professional Staff and which includes non-Medical Professional Staff members to address issues related to clinical practice.

1.4.30 **INVESTIGATION** means a formal investigation that begins after the appointment of an investigatory body after the submission of a Request for Corrective Action or Summary Suspension.

1.4.31 **ISSAQUAH** means Swedish/Issaquah, a general acute care hospital owned and operated by Swedish Health Services, a Washington non-profit corporation, located at 751 N.E. Blakely Drive, Issaquah, WA 98029.

1.4.32 **MEDICAL ADMINISTRATOR** means the senior physician leader in Swedish Administration who provides overall direction for the functions of the Medical Professional Staff. May be the Chief Medical Officer or the Senior Medical Director.

1.4.33 **MEDICAL PROFESSIONAL LEADERSHIP COUNCIL (MPLC)** means the group of Active and APC members of the Medical Professional Staff empowered to act for the Medical Professional Staff between meetings of the organized Medical Professional Staff.

1.4.34 **MEDICAL PROFESSIONAL STAFF** means the Physicians, Dentists, Oral and Maxillofacial Surgeons, and APCs who are members according to criteria set forth in these Bylaws at Swedish Medical Center/First Hill, Swedish Medical Center/Ballard, Swedish Medical Center/Cherry Hill, and Swedish Medical Center/Issaquah (jointly referred to herein as Hospital, in accordance with Section 1.4.16 of these Bylaws). Privileges to admit and treat patients at the Hospital may be accorded to members according to the additional criteria set forth in these Bylaws. Does not include Allied Health Professionals or other persons holding licenses.
1.4.35 **MEDICAL PROFESSIONAL STAFF BYLAWS** or **BYLAWS** means these Bylaws which shall provide for the organization and governance of the Medical Professional Staff and establish the procedures applicable to the granting, delineation, reduction and exercise of Privileges, appointment and reappointment to Medical Professional Staff membership, and the suspension and termination of such Privileges and membership at the Hospital.

1.4.36 **MEDICAL PROFESSIONAL STAFF UNIT** means the subset of Practitioners whose Primary Campus together with other campuses operates under one hospital license.

1.4.37 **MEDICAL PROFESSIONAL STAFF YEAR** means the period from January 1 to December 31 of the same calendar year.

1.4.38 **ORAL AND MAXILLOFACIAL SURGEON** means a licensed Dentist qualified for Board Certification by the American Board of Oral and Maxillofacial Surgery.

1.4.39 **PEER REVIEW** means the protected, confidential process in which members of the Medical Professional Staff evaluate professional behavior, patient management, and documentation of one Practitioner in one case or multiple cases, or of a group of Practitioners in a sample or population of patients, based on reports of selected quality indicators or other data.

1.4.40 **PHYSICIAN** means a licensed doctor of medicine or osteopathy or a podiatrist.

1.4.41 **PODIATRIST** means a licensed podiatric physician and surgeon.

1.4.42 **PRACTITIONER** means member of the Medical Professional Staff or privileged Allied Health Professional staff.

1.4.43 **PRIMARY CAMPUS** means the Campus identified by a Practitioner as the Campus at which they primarily exercise their Medical Professional Staff privileges.

1.4.44 **PRIVILEGES** means the clinical privileges granted to a Practitioner to provide specifically delineated diagnostic or therapeutic medical, surgical, or dental services in the Hospital.

1.4.45 **RESIDENT OR FELLOW** means a Physician who is receiving post-graduate training in a residency or fellowship program in the Hospital.

1.4.46 **REVIEW HEARING** means a proceeding conducted for a Medical Professional Staff member in accordance with Article XI of these Bylaws.

1.4.47 **REVIEW PROCEDURE** means a procedure conducted for an Allied Health Professional in accordance with Section 7.5.5 of these Bylaws.

1.4.48 **STANDARDS** means Swedish’s policies, procedures, protocols, guidelines, and clinical forms.

1.4.49 **SWEDISH** means **SWEDISH HEALTH SERVICES**, as the corporation that conducts business as Swedish Medical Center and operates health care facilities at various locations.

1.4.50 **SYSTEM CHIEF OF STAFF** means the elected or appointed system-wide leader of the Swedish Medical Professional Staff.

1.4.51 **SYSTEM CHIEF OF STAFF-ELECT** means the elected or appointed system-wide leader-elect of the Swedish Medical Professional Staff.

1.4.52 **TREASURER** means **TREASURER OF THE MEDICAL PROFESSIONAL STAFF** who is the person elected by the Medical Professional Staff to serve as the treasurer.
1.4.53 **VOTE DATE** means the date on which voting closes in a Medical Professional Staff election.

1.4.54 **WRITTEN NOTICE** means either (a) written notification sent by certified mail, return receipt requested (notification is considered received five days after being posted) or (b) written notification personally delivered, with delivery verified by a receipt of delivery or an affidavit of the deliverer. Notification is considered received when delivered.

1.5 **Titles, Headings and Captions**
The titles, headings and captions appearing in these Bylaws are used and intended for convenience of description or reference only and shall not be construed or interpreted to limit, restrict or define the scope or effect of any provision.

1.6 **Severability**
If any provision of these Bylaws or its applications to any person or circumstance is held invalid by a court of competent jurisdiction, the remainder of these Bylaws or the application of the provision of other persons or circumstances shall not be affected.

**ARTICLE II: MEDICAL PROFESSIONAL STAFF ORGANIZATION AND GOVERNANCE**

2.1 **Medical Professional Staff Organization**

2.1.1 **Right of the Medical Professional Staff to determine organization**
Swedish consists of several health care facilities and multiple licenses. Each Swedish Medical Professional Staff Unit has the right to vote to join other Swedish Medical Professional Staff Units to operate as a united medical staff. A Swedish medical staff that is unified has the right to elect to discontinue such a unification arrangement as permitted by law. Medical Professional Staff members shall be informed of these rights in writing at the time of initial application and at the time of each reappointment.

2.1.2 **Methods for determining medical staff organization**
The question of medical staff organization under this subsection may be put before the Medical Professional Staff Units by either one of the following two methods:

(a) A resolution adopted by majority vote of the MPLC at any regular or special meeting;

(b) Upon receipt by the MPLC of a petition signed by at least 25 Active and/or APC members of a Medical Professional Staff Unit. The petition is considered received on the date of the last regular MPLC meeting that occurs in the month immediately following the month in which the petition is received in the Medical Professional Staff Office.

2.1.3 **Composition of ballot question**
The MPLC shall draft any ballot question put to the Medical Professional Staff under this section. The MPLC has the authority to determine the question that will appear on a ballot in an election held pursuant to 2.1.2(b) in a manner it deems consistent with the intentions expressed in a petition.
2.1.4 Timing of vote
Except as constrained by 2.1.5, the MPLC shall fix a Vote Date for a Medical Professional Staff election that is no sooner than 45 days and no later than 90 days following the date of the meeting at which the MPLC adopts a resolution under 2.1.2(a), or following the date of receipt of the petition under 2.1.2(b), whichever is applicable.

2.1.5 Frequency of votes
Medical Professional Staff votes under this section shall occur no more frequently than once every 24 months.

2.1.6 Method of voting
The MPLC shall determine the method of voting which shall be by mail or electronic ballot or by vote of the Medical Professional Staff at any regular or special meeting of the Medical Professional Staff.

In order to be adopted at a Medical Professional Staff meeting, the same notice provisions of subsection 5.2 regarding special meetings must be provided and the question must receive a two-thirds affirmative vote.

In order to be adopted by a mail or electronic ballot, the question must be voted upon by not less than 10 percent of the Active and APC Medical Professional Staff members and receive a two-thirds affirmative vote. The ballot must be distributed to each Active and APC Medical Professional Staff member not later than two weeks before the Vote Date.

Each Active and APC member may cast no more than one vote in each Medical Professional Staff election in which they are eligible to vote. The unification will be effective only in those Medical Professional Staff Units which adopt the measure.

2.1.7 Special provisions for Medical Professional Staff Vote to Discontinue a Unified Medical Professional Staff
In addition to the requirements in 2.1.1 through 2.1.6, a Medical Professional Staff vote in an election on the question of discontinuing a unified medical staff is subject to the following conditions:

(a) Each Active and APC member may cast no more than one vote, which shall be counted as a vote with the member’s Primary Campus Medical Professional Staff Unit;

(b) The ballot question must provide an effective date of the discontinuance, which shall be a date not less than 60 days and not more than 180 days from the date of the election;

(c) Any Medical Professional Staff Unit which adopts a measure to discontinue a unification arrangement shall cease being a part of the Medical Professional Staff on the effective date provided for in the ballot.

2.2 Medical Professional Staff Officers

2.2.1 The officers of the Medical Professional Staff shall be System Chief of Staff and System Chief of Staff-Elect.
2.2.2 Qualifications of Officers
Each person nominated for Medical Professional Staff office must be a Physician, Dentist, or Oral and Maxillofacial surgeon who at the time of nomination, election, and during the term of office is an Active Medical Professional Staff member. Failure to continuously maintain such status shall immediately create a vacancy in such office. No person shall serve in System and Campus officer positions concurrently.

2.2.3 Nominations and Elections

System Chief of Staff-Elect

(a) The nomination and election process shall be as follows:
A nominating committee consisting of each Campus Chief of Staff, Campus Chief of Staff-Elect, and Campus Immediate Past Chief of Staff may submit nominees for the office of System Chief of Staff-Elect to the MPLC in July.

(b) These names shall be announced at the Medical Professional Staff annual meeting. Nominees may provide a brief statement of qualifications to the Medical Professional Staff. Nominations may also be accepted from the floor.

(c) No person shall be nominated by the nominating committee or from the floor without the nominee’s consent. The final list of qualified nominees shall be submitted to the Active and APC Medical Professional Staff members for a vote by mail or electronic ballot by October 31. The nominee receiving the most votes shall be elected.

2.2.4 Term of Office
The System Chief of Staff and System Chief of Staff-Elect are each elected for a two year term and shall take office starting January first following the election.

2.2.5 Removal from Office

(a) Possible reasons for removal from office include:

(1) Failure to maintain Active staff status;

(2) Failure to maintain uninterrupted Medical Professional Staff privileges;

(3) Failure to carry out the duties of office to the satisfaction of the MPLC and/or members of the Medical Professional Staff;

(4) Denial, restriction, suspension, termination, revocation, or non-renewal of Medical Professional Staff membership and/or privileges;

(5) Any physical or mental disability that impairs or could impair the Physician's ability to carry out his/her professional obligations in a manner that meets the standard of care in the community, Hospital Standards, and the Medical Professional Staff Bylaws, Rules and Regulations, and policies; or
(6) Automatic relinquishment of privileges for failure to comply with Medical Professional Staff Bylaws, Rules and Regulations, or policies or with Hospital Standards.

(b) Process for Removal from Office. One-third of the MPLC or 100 members of the Active and APC Medical Professional Staff may by resolution call for the removal of any system officer. A meeting of the MPLC shall be called to consider such resolution. Written Notice of such meeting must be given to such officer at least 10 days prior to the date of the meeting. The officer shall be afforded the opportunity to speak in his/her own behalf prior to the MPLC taking any vote on such resolution. For the removal to be effective, it must thereafter be approved by an affirmative vote of two-thirds of the MPLC.

2.2.6 Vacancies in Office

(a) System Chief of Staff. If there is a vacancy in the office of System Chief of Staff prior to the expiration of the System Chief of Staff term, the System Chief of Staff-Elect shall assume the duties and authority of the System Chief of Staff for the remainder of the unexpired term.

(b) System Chief of Staff-Elect. If there is a vacancy in the office of System Chief of Staff-Elect prior to the expiration of the System Chief of Staff-Elect term, the MPLC shall appoint a new Acting System Chief of Staff-Elect. An Acting COSE shall not assume the office of COS without having been elected by the Medical Professional Staff.

2.2.7 Duties of Officers

(a) Duties of the System Chief of Staff. The System Chief of Staff serves as the chief administrative officer of the Medical Professional Staff to:

(1) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Professional Staff;

(2) Serve as the Chair of the MPLC;

(3) Serve as chair of the planning committee for and preside at the annual Medical Professional Staff leadership retreat;

(4) Serve as an Ex-Officio member of all other system-wide Medical Professional Staff committees;

(5) Attend the meetings of the Board;

(6) Communicate the views, policies, needs, and grievances of the Medical Professional Staff and report on its medical activities to the Board and the CE;

(7) Provide day-to-day liaison on medical matters with the CE and the Board;
(8) Receive and interpret the policies of the Board to the Medical Professional Staff and report to the Board on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Professional Staff to oversee the provision of quality medical care;

(9) Serves as chair of the System Quality Council;

(10) Appoint the Chair of each system-wide Medical Professional Staff standing committee unless otherwise specified in these Bylaws;

(11) Be the spokesperson for the Medical Professional Staff in Hospital deliberations and in external professional and public relations;

(12) Be responsible for the Medical Professional Staff’s input into the Hospital's accreditation process;

(13) Interpret and enforce these Bylaws, Rules and Regulations, and policies;

(14) Implement sanctions where indicated and comply with procedural safeguards in all instances where corrective action has been requested affecting a Practitioner; and

(15) Become the Immediate Past System Chief of Staff upon completion of his/her tenure as System Chief of Staff.

(b) Duties of the System Chief of Staff-Elect. The System Chief of Staff-Elect:

(1) Serves as a member of the MPLC;

(2) Performs such duties as may be assigned to him/her by the System Chief of Staff;

(3) Serves as Chair of the PROC;

(4) Becomes the System Chief of Staff upon completion of his/her tenure as System Chief of Staff-Elect; and

(5) Assumes all the duties and has the authority of the System Chief of Staff in the event of the System Chief of Staff’s inability to perform due to illness, absence from the community, or unavailability for any other reason.

2.3 Immediate Past System Chief of Staff

2.3.1 Term of Office. The Immediate Past System Chief of Staff shall serve a two-year term.

2.3.2 Vacancy in Office. In the event of a vacancy in the office of the Immediate Past System Chief of Staff, the most recent-serving Immediate Past System Chief of Staff eligible to serve may be appointed at the discretion of the System Chief of Staff. If no past chief is able to serve, the System Chief of Staff shall appoint a member of the Active staff, with
ratification by the MPLC, to discharge the duties of the Immediate Past System Chief of Staff for the remainder of the term.

2.3.3 Duties. The Immediate Past System Chief of Staff shall:

(a) Advise the System Chief of Staff in matters as requested;
(b) Lead an effort to recruit new leaders from within the Medical Professional Staff;
(c) Aid in the enforcement of the Medical Professional Staff Bylaws, Rules and Regulations, and policies, as requested by the System Chief of Staff;
(d) Serve as vice chair of the Professional Review Oversight Committee;
(e) Serve as a member of the MPLC;
(f) Serve as a member of the Credentials Committee;
(g) Attend the annual Medical Professional Staff leadership retreat; and
(h) Attend the annual Board of Trustees retreat.

2.4 Treasurer

2.4.1 Qualifications of the Treasurer
The Treasurer must at the time of appointment, nomination, election and during the term of office be an Active or APC Medical Professional Staff member of any Swedish medical staff. Failure to continuously maintain such status shall immediately create a vacancy in the office.

2.4.2 Nominations and Elections

(a) Nominations and elections shall be as follows: The Medical Professional Staff Financial Advisory Committee shall nominate and present to each CEC the names of two candidates in July of the year in which the election is held.
(b) These names shall be announced at the next meeting of each Campus Medical Professional Staff. Nominees may provide a brief statement of qualifications at each meeting. Nominations may also be accepted from the floor.
(c) No person shall be nominated by the nominating committee or from the floor without the nominee’s consent. The final list of qualified nominees shall be submitted to the Active and APC Medical Professional Staff members for a vote by mail or electronic ballot by October 31. The nominee receiving the most votes shall be elected.

2.4.3 Term of Office
The Treasurer is elected for two-year term and shall take office starting January first following the election. A person who serves as Treasurer for two consecutive terms is not eligible for re-election as Treasurer until at least two years have elapsed.
2.4.4 Duties of the Treasurer

(a) Call, preside at and be responsible for the agenda of the meetings of the Medical Professional Staff Financial Advisory Committee.

(b) Provide to the MPLC, every two months, a financial report, including the year-to-date funds, spending and investment portfolio.

(c) Serve as an Ex-Officio member of MPLC.

(d) Meet with the financial advisor and/or accountant to review reports and statements of accounts and balances of the Medical Professional Staff funds.

(e) Become the Immediate Past Treasurer upon completion of term as Treasurer.

(f) Be responsible for the Medical Professional Staff’s input to the Medical Professional Staff Financial Advisory Committee.

2.5 Finances

2.5.1 Application Fees
The MPLC establishes and determines the amount of application fees.

2.5.2 Membership Dues
The MPLC establishes the amount of annual dues to be paid by each member of the Medical Professional Staff and Allied Health Professional Staff within parameters set by action of the Medical Professional Staff.

The following are exempt from dues assessments:

(a) Practitioners on leave of absence
(b) Practitioners serving as active duty military personnel
(c) Honorary members
(d) Practitioners who hold Medical Professional Staff membership and exercise privileges solely for purposes of participating in Hospital-sponsored charitable care.

Practitioners whose initial appointment occurs in the final quarter of the fiscal year shall not be assessed dues for that year. There shall be no other exemptions from dues assessment other than by action of the MPLC. The Medical Professional Staff membership and all of the privileges of any Practitioner whose dues are in arrears shall be automatically and finally terminated without a Review Hearing or any of the procedural rights provided in these Bylaws.

2.5.3 Use
Application fees and dues as well as income earned thereon shall be expended for such purposes consistent with legal requirements for not-for-profit Washington corporations as authorized or approved by the MPLC, which shall also establish such organization and/or process as it deems appropriate to administer such funds.
2.6 Campus Medical Professional Staff Officers

2.6.1 The officers of the Campus Medical Professional Staff shall be the Campus Chief of Staff and Campus Chief of Staff-Elect.

2.6.2 Qualifications of Officers
Each person nominated for Campus Medical Professional Staff office must be a Physician, Dentist, or Oral and Maxillofacial surgeon who at the time of nomination, election, and during the term of office is an Active Medical Professional Staff member whose Primary Campus is the Campus in which the office is organized.

2.6.3 Nominations and Elections
Campus Chief of Staff-Elect
(a) The nomination and election process shall be as follows:
A nominating committee consisting of at least one past Campus Chief of Staff shall draft nominees for the office of Campus Chief of Staff-Elect to the CEC in July.

(b) These names shall be announced to the Campus Medical Professional Staff. Nominees may provide a brief statement of qualifications to the Medical Professional Staff. Nominations may also be accepted from Active and APC Primary Campus members.

(c) No person shall be nominated by the nominating committee or from the members without the nominee’s consent. The final list of qualified nominees shall be submitted to the Active and APC Campus Medical Professional Staff members for a vote by mail or electronic ballot by October 31. The nominee receiving the most votes shall be elected.

2.6.4 Term of Office
The Campus Chief of Staff and Campus Chief of Staff-Elect are each elected for a two-year term and shall take office starting January first following the election.

2.6.5 Removal from Office
(a) Possible reasons for removal from office include:

(1) Failure to maintain Active, Primary Campus staff status;

(2) Failure to maintain uninterrupted Medical Professional Staff privileges;

(3) Failure to carry out the duties of office to the satisfaction of the CEC and/or Primary Campus members of the Medical Professional Staff;

(4) Denial, restriction, suspension, termination, revocation, surrender, or non-renewal of Medical Professional Staff membership and/or privileges;
(5) Any physical or mental disability that impairs or could impair the Physician's ability to carry out his/her professional obligations in a manner that meets the standard of care in the community, Hospital Standards, and the Medical Professional Staff Bylaws, Rules and Regulations, and policies; or

(6) Automatic relinquishment of privileges for failure to comply with Medical Professional Staff Bylaws, Rules and Regulations, or policies or with Hospital Standards.

(b) Process for Removal from Office. One-third of the CEC or 25 members of the Active and APC Campus Medical Professional Staff may by resolution call for the removal of any campus officer. A meeting of the CEC shall be called to consider such resolution. Written Notice of such meeting must be given to such officer at least 10 days prior to the date of the meeting. The officer shall be afforded the opportunity to speak in his/her own behalf prior to the CEC taking any vote on such resolution. For the removal to be effective, it must thereafter be approved by an affirmative vote of two-thirds of the CEC.

2.6.6 Vacancies in Office

(a) Campus Chief of Staff. If there is a vacancy in the office of Campus Chief of Staff prior to the expiration of the Campus Chief of Staff term, the Campus Chief of Staff-Elect shall assume the duties and authority of the Campus Chief of Staff for the remainder of the unexpired term.

(b) Campus Chief of Staff-Elect. If there is a vacancy in the office of Campus Chief of Staff-Elect prior to the expiration of the Campus Chief of Staff-Elect term, the CEC shall appoint a new Acting Campus Chief of Staff-Elect. An Acting Campus Chief of Staff-Elect shall not assume the office of Chief of Staff without having been elected by the Medical Professional Staff.

2.6.7 Duties of Officers

(a) Duties of the Campus Chief of Staff. The Campus Chief of Staff serves as the Campus chief administrative officer of the Campus Medical Professional Staff to:

(1) Call, preside at, and be responsible for the agenda of all general meetings of the Campus Medical Professional Staff;

(2) Serve as Chair of the CEC;

(3) Serve as an Ex-Officio member of all other Campus Medical Professional Staff committees;

(4) Serve as a member of the Medical Professional Leadership Council;

(5) Serve as a member of the Campus Quality Council;
(6) Serve as a member of the planning committee for the annual Medical Professional Staff leadership retreat;

(7) Communicate the views, policies, needs, and grievances of the Campus Medical Professional Staff and report on its medical activities to the MPLC and System Chief of Staff;

(8) Provide day-to-day liaison on medical matters with the System Chief of Staff;

(9) Receive and interpret the policies of the Board to the Campus Medical Professional Staff and report to the MPLC on the performance and maintenance of quality with respect to the delegated responsibility of the Campus Medical Professional Staff to oversee the provision of quality medical care;

(10) Appoint the Chair of each Campus Medical Professional Staff committee unless otherwise specified in these Bylaws;

(11) Be the spokesperson for the Campus Medical Professional Staff in Hospital deliberations and in external professional and public relations;

(12) Be responsible for the Campus Medical Professional Staff's input into the Hospital's accreditation process;

(13) Interpret and enforce these Bylaws, Rules and Regulations, and policies;

(14) Implement sanctions where indicated and comply with procedural safeguards in all instances where corrective action has been requested affecting a Practitioner; and

(15) Become the Immediate Past Campus Chief of Staff upon completion of his/her tenure as Campus Chief of Staff.

(b) Duties of the Campus Chief of Staff-Elect. The Campus Chief of Staff-Elect:

(1) Serves as a member of the MPLC and the CEC;

(2) Performs such duties as may be assigned to him/her by the Campus Chief of Staff;

(3) Becomes the Campus Chief of Staff upon completion of his/her tenure as Campus Chief of Staff-Elect; and

(4) Assumes all the duties and has the authority of the Campus Chief of Staff in the event of the Campus Chief of Staff’s inability to perform due to illness, absence from the community, or unavailability for any other reason.

2.7 Immediate Past Campus Chief of Staff
2.7.1 Term of Office. The Immediate Past Campus Chief of Staff shall serve a two-year term.

2.7.2 Vacancy in Office. In the event of a vacancy in the office of the Immediate Past Campus Chief of Staff, the most recent-serving Immediate Past Campus Chief of Staff eligible to serve may be appointed at the discretion of the Campus Chief of Staff. If no past chief is able to serve, the Campus Chief of Staff shall appoint a member of the Active staff, with ratification by the CEC, to discharge the duties of the Immediate Past Campus Chief of Staff for the remainder of the term.

2.7.3 Duties. The Immediate Past Campus Chief of Staff shall:

(a) Advise the Campus Chief of Staff in matters as requested;

(b) Lead an effort to recruit new leaders from within the Campus Medical Professional Staff;

(c) Chair the nominating committee for the election of the Campus Chief of Staff-Elect;

(d) Aid in the enforcement of the Medical Professional Staff Bylaws, Rules and Regulations, and policies, as requested by the Campus Chief of Staff;

(e) Serve as a member of the Campus Quality Council;

(f) Serve as a member of the CEC;

(h) Attend the annual Medical Professional Staff leadership retreat; and

ARTICLE III: DEPARTMENTS OF THE MEDICAL PROFESSIONAL STAFF

3.1 Department Function
Departments shall serve as the organizing framework that assists and coordinates the efforts of Medical Professional Staff members of the same or related specialties to deliver safe, high quality, effective medical and surgical care. There is a large and growing number of medical and surgical specialties and subspecialties and that limits the organization’s ability to staff and support all possible specialty and subspecialty groups; therefore the number of supported Departments shall be limited to 12. Departments may be created or eliminated by vote of the Medical Professional Staff upon recommendation of the Medical Professional Leadership Council provided the number of Departments does not exceed the maximum number of 12. Departments shall:

3.1.1 Facilitate coordinated, collaborative, effective and efficient practice and care delivery by its specialists.

3.1.2 Facilitate the recognition, implementation and dissemination of best medical and surgical practice.
3.1.3 Enhance the professional development of member clinicians.

3.2 Organization of Departments
The Medical Professional Staff is organized into 11 system-wide Departments with Sections established by the Campus as applicable to accomplish the Department’s responsibilities. These Departments may include a number of Divisions as appropriate to accomplish their responsibilities. Each member of the Medical Professional Staff shall be assigned to an appropriate Department and to Sections at each applicable Campus. The Departments are organized as follows:

3.2.1 Anesthesiology and Pain Management; including Acupuncture

3.2.2 Emergency Medicine and Critical Care

3.2.3 Family Medicine; including Addiction Medicine, General Practice, Family Medicine Geriatrics, and Sports Medicine

3.2.4 Imaging and Diagnostic Services; including Pathology, Diagnostic Radiology, Interventional Radiology, Neuroradiology, Nuclear Medicine, Ultrasound

3.2.5 Medicine; including Allergy/Immunology, Audiology, Cardiology, Dermatology, Dermatopathology, Endocrinology/Metabolism, Epidemiology, Gastroenterology, Geriatric Psychiatry, Hematology, Hospital Medicine, Infectious Disease, Internal Medicine, Internal Medicine Geriatrics, Medical Oncology, Nephrology, Neurology, Neurophysiology, Occupational/Environmental Medicine, Palliative Care Medicine, Physiatry, Psychiatry, Psychology, Pulmonary Disease, Radiation Oncology, Radiation Therapy, Rheumatology, and Sleep Medicine

3.2.6 Obstetrics, Gynecology, and Perinatology; including Gynecological Oncology, Gynecological Surgery, Midwifery, Infertility, and Reproductive Endocrinology

3.2.7 Orthopedics; including Podiatry

3.2.8 Pediatrics; including Neonatology

3.2.9 Psychiatry [or Behavioral Medicine]


3.2.11 Urology

3.3 Department Functions

3.3.1 Establish Privileges Criteria
Each Department shall recommend threshold criteria for granting and changing of Privileges consistent with these Bylaws, Rules and Regulations, and policies of the Medical Professional Staff and Hospital Standards. The criteria shall be submitted to the Credentials Committee for review and recommendation. If the Credentials Committee
recommendation is different than that of the Department, the matter shall be referred back to the Department for further consideration. If an agreement cannot be reached, the Credentials Committee shall make recommendations to the MPLC as well as provide the departmental recommendations if different and the MPLC shall make a final recommendation for approval by the Board. Following approval by the Board, the criteria shall be made available to applicants for appointment and reappointment and to Medical Professional Staff members assigned to each Department.

3.3.2 Establishment of a Specialty Advisory Division
Each Department may establish specialty advisory Divisions as needed to assist in carrying out its responsibilities. Divisions shall be led by an Active or APC member elected by the Active and APC members of the Division. Criteria for membership in a Division shall be Board Certification in a specialty Board as described in these Bylaws or by other specialty training criteria when such a Board does not exist. A Division is not required under these Bylaws to hold meetings or record minutes of meetings. A Division, if formed, may meet on an as needed basis.

3.3.3 Review of Aggregate Data
Each Department shall review and evaluate, using aggregate data derived from care pathways and department-determined indicators, the quality and appropriateness of patient care. When variation from agreed upon standards of performance and clinical outcome occurs, each Department shall institute performance improvement plans on a departmental basis.

3.3.4 Conduct Departmental Business
Each Department shall meet as necessary to conduct departmental business.

3.4 Department Chiefs

3.4.1 Qualifications. Each Chief must be an Active or APC Medical Professional Staff Member, well qualified by training and experience, with demonstrated leadership ability.

3.4.2 Nominations, Elections and Tenure
Any Active or APC Department member may nominate a qualified individual to serve as chief. Nominations for office must be submitted no later than November 1. Elections must be held by November 30 by vote of the Active and APC Medical Professional Staff members by mail or electronic ballot of the Active and APC Department members. See Article V of these Bylaws for voting qualifications. The term of office shall begin January 1.

The Chief of each clinical Department shall be elected or re-elected by the Active and APC membership of the Department for a two-year term. Any person who serves as Chief of a clinical Department for three consecutive terms is not eligible for re-election as Chief of that Department until at least two years have elapsed following the end of such third term. The terms of Chiefs of clinical Departments shall be determined in accordance with procedures adopted by The MPLC so that, as nearly as possible, the terms of one-half of the total number of such Department Chiefs will commence in an even-numbered year and the other one-half in an odd-numbered year.

3.4.3 Removal from Office
Possible reasons for removal from office include:

1. Failure to maintain Active or APC staff status;

2. Failure to maintain uninterrupted Medical Professional Staff Privileges;

3. Failure to carry out the duties of office to the satisfaction of the MPLC and/or members of the Department in accordance with the procedure as outlined in these Bylaws;

4. Denial, restriction, revocation, or non-renewal of Medical Professional Staff membership and/or Privileges;

5. Any physical or mental disability that impairs or could impair the Physician’s ability to carry out his/her professional obligations in a manner that meets the standards of care in the community, Hospital Standards, and the Medical Professional Staff Bylaws, Rules and Regulations, and policies; or

6. Automatic relinquishment of Privileges for failure to comply with Hospital Standards, Medical Professional Staff Bylaws, Rules and Regulations, or policies.

Process for Removal from Office

1. Removal may be initiated by petition of three voting members of the MPLC or the lesser of 25 members or 10 percent of the Active and APC Medical Professional Staff members of the Department.

2. Removal of a Chief of a clinical Department prior to the normal expiration of his/her term of office may be accomplished by affirmative action of a two-thirds majority of all Active and APC Medical Professional Staff members assigned to such Department or by two-thirds majority vote of the members of the MPLC.

Vacancy in Office
Should a vacancy occur prior to the expiration of the term, the Chief of Staff shall appoint an interim Chief to serve out the unexpired term. The Active and APC Medical Professional Staff members of the Department shall ratify such appointment at the next regular meeting; if not ratified, the members shall elect another member Department Chief at the same meeting.

Duties of Department Chief. The Chief of each Department:

(a) Oversees the clinical activities and performance within the Department;

(b) Participates in the administrative activities within the Department;

(c) Establishes departmental committees and appoints committee members;
(d) Gives guidance on the overall medical policies of the Hospital and campuses and makes specific recommendations and suggestions regarding such Department in order to promote quality and appropriate patient care;

(e) Administers these Bylaws, Rules and Regulations, and policies of the Medical Professional Staff and the Hospital within the Department, including assuring compliance with patient care review requirements and implementation of MPLC actions affecting such Department;

(f) Promotes the teaching, education, and research programs of the Department;

(g) Supports the orientation program for new members;

(h) Participates in the administration of the Department through cooperation with the nursing service and the Hospital administration in matters affecting patient care, including but not limited to personnel, supplies, equipment, space and other resources, regulations, standing orders and techniques, procedures, and protocols;

(i) Assists in the preparation of reports pertaining to the Department, including annual budgetary plans as may be required by the MPLC, the CE, or the Board;

(j) Carries out education and Corrective Action for individual Department members whose practice fails to meet standards with the assistance of the Chief of Staff, Chief Medical Officer, and other appropriately designated individuals;

(k) Transmits to the Credentials Committee the Department's recommendations concerning applications for membership and membership category, reappointment, and delineation of privileges for all individuals in the Department. Such recommendations shall include the results of quality management and peer review activities;

(l) Recommends criteria for delineation of privileges;

(m) Assesses and recommends to the relevant Hospital authority off-site sources for needed patient care services not provided by the Department or Hospital;

(n) Communicates the Board's mission, vision, and goals to Department membership;

(o) Assures that important processes and activities are measured, assessed, and improved systematically and fosters communication and collaboration among Departments;

(p) Participates in interdisciplinary and interdepartmental performance-improvement activities;

(q) Communicates relevant organizational issues, regulatory requirements, and quality initiatives to the Department;

(r) Routinely communicates activities and concerns of Department members to the Chief of Staff.
3.5 Advisory Positions
The Chief of a Department may appoint other members of his/her Department to advisory positions to provide assistance to him/her in fulfilling the Chief's duties and responsibilities.

3.6 Division Chief
A Chief for a Division within a Department may be elected or, if none has been elected, may be appointed by a Department Chief. The nominations and elections for the chief will be by the Active and APC members of the Division in accordance with the nominations and elections process for the Department Chief.

3.6.1 Responsibilities
The Division chief shall assist the Department Chief with credentialing or other functions as determined by the Department and at the request of the chair.

3.6.2 Removal from Office
(a) Possible Reasons for Removal from Office. The possible reasons for removal from office of Division Chiefs are the same as for the Department Chiefs.

(b) Process for Removal from Office. The process for removal from office of a Division Chief is the same as for the Department Chief.

3.7 Department Meetings

3.7.1 Departments
Departments shall meet as necessary to conduct business and evaluate the clinical work of Practitioners with Privileges in the Department. Departmental business shall include, but not be limited to, review of committee reports; planning and implementation of departmental educational programs; formulation of departmental policies, and allocation of responsibilities necessary for the efficient operation of the Department. Department policies shall take effect only after approval by the MPLC. Regular reports of department activities and initiatives may be presented at the regular Medical Professional Leadership Council meetings.

3.7.2 Special Meetings
A special meeting of any Department may be called by or at the request of the Chief thereof, the Chief of Staff, or one-third of the Department's members at the time, but not less than three members.

3.7.3 Notice of Meetings
Written or electronic notice stating the place, day, and hour of any special or any regular meeting not held pursuant to resolution shall be given to each member of such Department not less than 10 days before the time of such meeting by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail and addressed to the member at his/her address as it appears on the records of the Medical Professional Staff Services Department. Notice by email address shall be deemed delivered when sent if sent to the Practitioner’s email address currently on file with the Medical Professional Staff Services office. It is the responsibility of the Practitioner to notify the Medical Professional Staff Services Department of any changes to his or her email address. No
business shall be transacted at any special meeting except that business stated in the notice of the meeting.

3.7.4 Manner of Action
The action of a Department shall be defined as the action taken by the majority of the members present at a meeting at which a quorum is present. Action may be taken without a meeting by unanimous consent in writing signed by each member entitled to vote.

3.8 Department Sections

3.8.1 Organization of Sections
Departments are organized into Sections at each applicable Campus. Each Department member shall be assigned to Sections wherever applicable.

3.8.2 Section Functions
Each Section shall assist the Department in fulfilling Departmental duties.

3.8.3 Section Chiefs
Each Section may elect a Section Chief for a two-year term. The nominations and elections for the Section Chief will be by the Active and APC members of the Section, in accordance with the nominations and elections process for the Department Chief.

(a) Qualifications
Each Section Chief must be an Active or APC Department member, well qualified by training and experience, with demonstrated leadership ability.

(b) Nominations, Elections, and Tenure
Each Section shall, by November 30, elect a Chief by mail or electronic ballot to a two-year term commencing the following January 1. Any person who serves as a Section Chief for three consecutive terms is not eligible for re-election until at least two years have elapsed following the end of such third term. Terms of Section Chiefs shall coincide with the term of the respective Department Chief.

(c) Removal from Office
The possible reasons for removal from office and the process for removal shall be the same as for those of a Department Chief enumerated in subsection 3.3.3(a) and (b) but applied to a Section.

(d) Vacancy in Office
A vacancy occurring prior to the expiration of a Section Chief term shall be filled by the Department Chief subject to ratification of Section members at the next meeting of the Section. If the appointment is not ratified the Section shall elect another qualified member to complete the unexpired term.

(e) Duties
The duties of the Section Chief are to assist the Department Chief in completing his/her duties as they apply to the Campus assume the Campus responsibilities of the Department Chief when the Chief is unable or unavailable to perform these duties, and assist the Department Chief with Campus credentialing or other functions as determined by the Department and at the request of the chief.
(f) Section Meetings
A Section shall establish its own schedule of meetings. A Section is not required under these Bylaws to hold meetings or record minutes of meetings. A Section may meet on an as-needed basis.

(g) Creation and Dissolution of a Section
A Section is created and dissolved only by action of the MPLC in the creation and dissolution of a Department and the approval or discontinuance of Departmental services at a Campus.

ARTICLE IV: MEDICAL PROFESSIONAL STAFF COMMITTEES

4.1 Medical Professional Leadership Council

4.1.1 Composition
The majority of voting members of the MPLC shall be Active Medical Professional Staff Members. The MPLC shall consist of:

(a) the System Chief of Staff;
(b) the Immediate Past System Chief of Staff;
(c) the System Chief of Staff-Elect;
(d) each Campus Chief of Staff and Chief of Staff-Elect;
(e) one Advanced Practice Clinician member elected by APCs as provided in §4.1.2;
(f) the following non-voting members:

(1) the CE of Swedish, or designee,
(2) the Chair of the Credentials Committee,
(3) the Chair of the Bylaws Committee,
(4) the Chief Medical Officer,
(5) the Treasurer;
(6) the Administrative Director of Medical Professional Staff Services, or designee
(7) the Chief Nursing Officer, or designee, and
(8) other qualified individuals who may be invited at the discretion of the System Chief of Staff.
4.1.2 Nominations, Elections, Tenure and Vacancy

(a) The nomination and election process for members identified in §4.1.1(e) shall be as follows:

(1) Nominations will be sought from organized groups of Campus APC Staff recognized by the MPLC. Each APC member must be given an opportunity, whether through a recognized APC group or individually, to nominate an eligible member.

(2) These nominees shall be announced at the Medical Professional Staff annual meeting and nominees may provide a brief statement of qualifications.

(3) The final list of nominees shall be submitted to APC members for a vote by mail or electronic ballot consistent with the procedures for Medical Professional Staff elections by October 31. The individual receiving the most votes shall be elected.

(b) Tenure

(1) All terms are two years.

(2) Members may not serve more than three terms in the same office consecutively. An unexpired term shall not be counted toward this limit.

(c) Vacancy
A vacancy for any reason shall be filled by appointment of an Acting member by the System Chief of Staff after consultation with all recognized APC groups. The Acting member shall hold the seat until a successor is seated following a special election. The special election shall include an opportunity for nomination by each APC member and a mail or electronic ballot submitted to each APC member. The individual receiving the most votes shall be elected.

4.1.3 Qualifications
A member appointed pursuant to Sections 4.1.1(f)(8) may be any Medical Professional Staff or APC member.

4.1.4 Duties of the MPLC
The MPLC:

(a) Is responsible to the Medical Professional Staff and Board for the duties of the organized Medical Professional Staff as established by these Bylaws, Rules and Regulations, and policies;

(b) Promotes professionally ethical conduct and competent clinical performance on the part of all members of the Medical Professional Staff, including the initiation of and/or participation in corrective measures when warranted;
(c) Assists with the establishment and proper operation of a medical care quality management/peer review program providing for systematic review and evaluation of the quality and appropriateness of patient care;

(d) Reviews the results of quality management, performance improvement and peer review activities, as they relate to the performance and clinical competence of Medical Professional Staff members and others granted privileges, and reviews credentials of all applicants and makes recommendations to the Board for appointment, advancement, reappointment, additional Privileges, or changes in Privileges and assignment to a Department;

(e) Represents and acts on behalf of the Medical Professional Staff, subject to any limitations that may be imposed by these Bylaws and the Board;

(f) Implements policies of the Medical Professional Staff or delegates responsibility for implementation to a Department, council, medical director, or individual member of the Medical Professional Staff;

(g) Receive reports and recommendations from Campus Executive Committees regarding the unique circumstances, needs, and challenges of each campus;

(h) Acts as a liaison between the Medical Professional Staff, the CE and the Board and conveys issues of importance from the Medical Professional Staff;

(i) Adopts and amends all Rules and Regulations, subject to Board approval as provided in these Bylaws;

(j) Adopts and amends such policies as it deems necessary. Such policies shall not be in conflict with these Bylaws or Rules and Regulations; and

(k) Provides oversight in the process of analyzing and improving patient satisfaction.

4.1.5 Duties of MPLC Members
The MPLC members:

(a) Attend the meetings of the MPLC and the Medical Professional Staff;

(b) Serve on the QSC, PROC, or other committees as designated by the System Chief of Staff.

4.1.6 Removal from Office:

(a) Possible reasons for removal from office include:

(1) Failure to maintain uninterrupted Hospital privileges;

(2) Failure to carry out the duties of office to the satisfaction of the Medical Professional Staff;

(3) Denial, restriction, suspension, termination, revocation, or non-renewal of Medical Professional Staff membership and/or Privileges;
(4) Any physical or mental disability that impairs or could impair the
member’s ability to carry out his/her professional obligations in a manner
that meets the standard of care in the community, Hospital Standards,
and the Medical Professional Staff Bylaws, Rules and Regulations, and
policies.

(5) Automatic relinquishment of Privileges for failure to comply with
Medical Professional Staff Bylaws, Rules and Regulations, or policies or
with Hospital Standards.

(b) Process for Removal from Office. One of two methods may be used to remove a
voting member who is not a system or campus officer from the MPLC:

(1) The member may be removed by an affirmative vote of at least 80
percent of MPLC members voting at a regular or special meeting. The
member shall be afforded the opportunity to speak in his/her own behalf
prior to any vote on such resolution.

(2) One hundred members of the Active and APC Medical Professional Staff
may by resolution call for the removal of any voting MPLC member. A
meeting of the Medical Professional Staff shall be called to consider such
resolution. Written Notice of such meeting must be given to such
member at least 10 days prior to the date of the meeting. The member
shall be afforded the opportunity to speak in his/her own behalf prior to
any vote on such resolution. For the removal to be effective, it must
thereafter be approved by an affirmative vote of at least two-thirds of
Active and APC Medical Professional Staff members voting.

4.1.8 Meetings
The MPLC shall meet monthly (at least 10 times in each Medical Professional Staff year)
and maintain a permanent record of its proceedings and actions.

[This will be moved to the O&F.]

4.3 Professional Review Oversight Committee (PROC)
The PROC is authorized to provide system-wide oversight of the Medical Professional Staff
Performance Improvement function, peer review, and focused peer review activities. The PROC
reports to the MPLC. The PROC reviews individual and system-wide performance measures in
order to provide consistent and highly reliable quality care through standardization.

4.3.1 Composition
The PROC is comprised of:

(a) System Chief of Staff-Elect, who serves as chair;

(b) Chair or designee from each professional peer review committee;

(c) Immediate Past System Chief of Staff, who serves as vice chair and acts in the
absence or at the request of the chair; and
(d) Members appointed by the System Chief of Staff-Elect to provide representation and balance from each campus and a broad range of specialties.

(e) Swedish CMO and/or VPMAs; non-voting.

(f) Chief of the Medical Professional Staff; non-voting.

(g) Director of Medical Professional Staff Services, or designee; non-voting.

(h) A representative of Risk Management; non-voting.

(i) Vice President of Quality and Patient Safety; non-voting.

(j) Chief Nursing Officer or designee; non-voting.

4.3.2 Term
The length of term for each appointed member will be two years. Such terms will be staggered to allow for continuity of membership. Members may serve no more than three consecutive terms, after which the member may be reappointed following an absence of at least one year.

4.3.3 Duties
The PROC:

(a) Reviews and evaluates the quality of patient care provided by Practitioner through identifying performance data to be measured, assuring appropriate collection of data, assessment of data collected, and conclusions related to findings and assessment.

(b) Investigates matters referred to the committee and reports findings and recommendations to the MPLC.

(c) Maintains confidentiality of all proceedings, reports, and written documents of committee meetings, keeping these totally separate and apart from all other committee records and Hospital records, releasing them only in accordance with an appropriate order or as permitted by applicable law.

(d) Approves the formation of specific professional peer review committees and related subcommittees to review applicable performance data, report conclusions, and make recommendations to the PROC. The professional peer review committees assure completion of individual and focused review of Practitioner performance and recommend action.

(e) Recommends actions to the MPLC and Board.

(f) Has responsibility for the overall review of the quality review program including responsibility for ensuring compliance in the measurement and monitoring of quality indicators by the Medical Professional Staff Departments and for the Peer Review process.
(g) Receives and reviews aggregate data when concerns are identified.

(h) Facilitates analysis of quality data to determine if the established expectations have been met. If variances are found, the committee determines if such variances are systemic and/or attributable to an individual Practitioner, with the intent of addressing all issues to assure performance improvement. This includes education and monitoring activities.

4.3.4 Frequency of Meetings
The committee will meet monthly, except that meetings will not be held in August and December unless called by the chair.

4.4 Professional Peer Review Committees

4.4.1 Organization

(a) Appointment and Term of Chairs
The PPRC chairs are selected by and serve at the pleasure of the PROC chair. The chairs are appointed for a two-year term and may serve no more than three consecutive terms.

(b) Membership Selection and Term

(1) Member Selection. The members of each PPRC will be appointed by the chair after consultation with the PROC chair and respective Department chiefs. Each committee will include representation from each applicable Campus. In addition to the membership requirements the chair may appoint voting and non-voting members from among the AHP staff privileged within the PPRC’s field.

(2) Term. The length of term for each regular, voting member will be two years. Terms will be staggered to allow for continuity of membership. A member may serve no more than three consecutive terms except when requested at the discretion of the chair to serve one additional year. After the maximum of seven years, a member may be reappointed following an absence of at least one year.

(c) Quorum
A quorum consists of at least three members. The chair may delay action on case reviews with potential evaluation categories of determination of significant improvement opportunities to a future meeting at which a majority of voting members are present.

(d) Frequency of Meetings
Each PPRC will meet monthly, except in August and December. Additional meetings may be called by the chair as necessary.

(e) Guests
The PPRC chair may determine when an observer or guest may be invited to attend. The observer shall have no voting rights and must sign the confidentiality attestation.
4.4.2 Professional Peer Review Committees
Professional peer review committee composition and case review assignment shall be as provided in the Organization and Functions policy.

4.4.4 Ad Hoc Committees
An ad hoc PPRC may be appointed by the PROC when needed to review multidisciplinary cases, clinical practices, clinical procedures, or in the event of that conflict of interest preclude consideration by a PPRC. The membership of such committee will include one or more peer representatives of the Practitioner(s) involved in the care provided. The reviewer will present the case review at the next PPRC meeting. Ad hoc committee reviewers must complete a Confidentiality Agreement and Conflict of Interest Disclosure.

4.5 Credentials Committee

4.5.1 Composition
The Credentials Committee shall consist of an Active or APC Medical Professional Staff member appointed by the System Chief of Staff who shall serve as Chair, the Immediate Past System Chief of Staff, and at least two Primary Campus representatives from each Campus appointed by the Chair in consultation with the respective Campus Chiefs of Staff. The Medical Administrator and a representative of Medical Professional Staff Services shall serve as Ex-Officio members of the committee.

4.5.2 Duties
(a) Chair. The Chair:
(1) Is responsible for the oversight of the credentialing process;
(2) Serves as an Ex-Officio member of the MPLC and reports activities/recommendations of the Credential Committee to this body monthly.
(3) Appoints members to the Credentials Committee consistent with the provisions of Section 4.4.1.

(b) The Credentials Committee:
(1) Reviews and verifies the credentials of all applicants for Medical Professional Staff and Allied Health Professional staff membership and submits a report to the MPLC on each applicant for membership or Privileges, giving specific consideration to the recommendations from Departments in which such applicant is assigned;
(2) Reviews each Medical Professional Staff and Allied Health Professional staff member authorized to provide services at the Hospital for renewal
of such Privileges every two years for reappointment and renewal of Privileges and submits recommendations regarding membership and delineation of Privileges to the MPLC;

(3) Reviews and evaluates information regarding the competence of Medical Professional Staff members and other individuals referred to it, and based upon such reviews, makes recommendations for appointments, reappointments, terminations, and the granting and changing of Privileges and assignment to a Department;

(4) Reviews individual credentials that are referred by the MPLC, PROC, professional peer review committees or the System Chief of Staff;

(5) Evaluates clinical and professional performance, technical skills, and judgment based on the results of Department and Hospital-wide quality management, performance improvement, and peer review activities;

(6) Evaluates and makes recommendations concerning threshold criteria, as recommended by Departments for Privileges;

(7) Makes preliminary recommendations concerning new procedures. When a Practitioner proposes to offer a significantly new procedure at the Hospital, the Credentials Committee and the MPLC shall make a preliminary recommendation about whether the new procedure should be offered, including consideration of the required Hospital's capabilities to do so. Before a decision is made to offer the new procedure, the Credentials Committee, with expert consultation as necessary, shall develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate. The Credentials Committee shall forward its recommendations to the MPLC which shall review the matter and forward its recommendations to the Board for final action.

4.5.3 Meetings
The Credentials Committee shall meet not less than 10 times per year and shall maintain a permanent record of its proceedings and actions.

4.6 Bylaws Committee

4.6.1 Composition
The Bylaws Committee shall consist of an Active or APC Medical Professional Staff member appointed by the System Chief of Staff who shall serve as Chair. In addition, members shall be appointed by the Chair from among the Active and APC Medical Professional Staff with proportionate representation of Campuses and consideration given to specialty representation. The System Chief of Staff, Medical Administrator, and the Director of Medical Professional Staff Services, and others designated by the Chair, shall serve in an Ex-Officio capacity.
4.6.2 Duties

(a) Chair. The Chair:

(1) Is responsible for the oversight of the committee’s duties;

(2) Serves as an Ex-Officio member of the MPLC and reports activities/recommendations of the Bylaws Committee to this body monthly;

(3) Appoints members to the Bylaws Committee consistent with the provisions of Section 4.6.1.

(b) The Bylaws Committee:

(1) Is responsible for receiving all Medical Professional Staff Bylaws, Rules and Regulations, and policy amendments proposed by any Active or APC Medical Professional Staff member, Department, or committee;

(2) Considers amendments to the Medical Professional Staff Bylaws, Rules and Regulations, and policies which are referred to the committee or proposed by members of the committee or any member of the Active or APC staff;

(3) Reviews newly proposed department, committee, Medical Professional Staff, and Hospital Standards for composition and compliance with the Medical Professional Staff Bylaws, Rules and Regulations, and policy at the request of the System Chief of Staff or MPLC;

(4) Reviews and evaluates the continued adequacy and appropriateness of the Medical Professional Staff Bylaws, Rules and Regulations, and policy and submits a report to the MPLC as appropriate.

4.6.3 Meetings
The Bylaws Committee shall meet as needed.

4.7 MPLC/Medical Professional Staff Relations Committee

4.7.1 Composition
The MPLC/Medical Professional Staff Relations Committee shall be an ad hoc committee consisting of the System Chief of Staff, System Chief of Staff-Elect, Chief Medical Officer, and other qualified individuals as invited by the System Chief of Staff. The chair of the Bylaws Committee and the Administrative Director of Medical Education and Medical Professional Staff Services shall serve as non-voting members of the committee.

4.7.2 Duties
The MPLC/Medical Professional Staff Relations Committee provides a forum for Medical Professional Staff members to review issues and manage conflict between the Medical Professional Staff and the MPLC including but not limited to proposals to adopt a rule, regulation, or policy, or an amendment thereto. Conflicts which cannot be resolved
at this level will be presented to representatives of the Board for consideration and settlement. This committee shall meet within 30 days after receipt of a written request signed by not less than 25 members of the Medical Professional Staff.

4.8 Campus Executive Committees

4.8.1 Membership
The majority of voting members of the CEC shall be Active or APC Medical Professional Staff members. The voting members of each CEC shall consist of the Campus Chief of Staff, Campus Chief of Staff-Elect, and other designated members as selected by the Campus. The Vice President of Medical Affairs and the Campus chief executive shall be non-voting members. Voting members may invite non-voting and Ex Officio members. The Campus Chief of Staff shall serve as chairperson of the CEC. Additional members may be appointed to the CEC, with or without a vote and to a term, as specified in the Policies.

4.8.2 Duties
The Campus Executive Committee (CEC) is a Campus-based group of Active and/or APC members of the Medical Professional Staff responsible for representing the unique circumstances, needs, and challenges of their Campus to the MPLC.

The duties of each CEC shall be to carry out the functions delegated by the Professional Staff and MPLC to:

(a) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of the members, including initiating investigations and initiating and pursuing corrective action, when warranted.

(b) Make recommendations on clinical and Hospital management matters.

(c) Inform the Campus Medical Professional Staff of the accreditation program and the accreditation status of the Hospital.

(d) Establish other committees and task forces as necessary to carry out the Hospital-specific Medical Professional Staff obligations and responsibilities.

(e) Cooperate with the MPLC and the Campus Chief Executive in securing compliance with these bylaws and the Policies.

4.8.3 Removal from office
One of two methods may be used to remove a non-officer, voting member from the CEC:

(a) The member may be removed by an affirmative vote of at least 80 percent of CEC members voting at a regular or special meeting. The member shall be afforded the opportunity to speak in his/her own behalf prior to any vote on such resolution.

(b) One hundred members of the Active or APC Medical Professional Staff may by resolution call for the removal of any voting CEC member. A meeting of the Campus Medical Professional Staff shall be called to consider such resolution.
Written Notice of such meeting must be given to such member at least 10 days prior to the date of the meeting. The member shall be afforded the opportunity to speak in his/her own behalf prior to any vote on such resolution. For the removal to be effective, it must thereafter be approved by an affirmative vote of at least two-thirds of Active and APC Campus Medical Professional Staff members voting.

4.9 Campus Quality Councils
Each Campus Quality Council is a multi-disciplinary standing committee that oversees and provides leadership for Campus clinical quality and safety in key programs/service areas and is accountable to the MPLC and the system-wide Quality and Safety Committee (QSC). The Quality Council sets Campus priorities for performance improvement and provides oversight for implementation of the quality and safety activities on an annual basis.

4.9.1 Composition
Each Campus Quality Council membership includes all members of the Campus Executive Committee, the Medical Director of Quality & Patient Safety or designee, the Vice President of Operations and Integration or designee, the Campus Nurse Executive, the Directors of Nursing, the Manager of Quality Management, the Patient Safety Officer and other members appointed by the Chair, who is the Campus Chief of Staff.

4.9.2 Duties
The Campus Quality Council:

(a) Carry out policies of the system QSC.

(b) Is a multidisciplinary team that oversees and provides leadership for Campus quality initiatives as defined by the Board Quality Committee via the Quality and Safety Council.

(c) Has Campus-level responsibility for oversight and improvement of the standard of care in inpatient and outpatient settings.

(d) Provides both an operational and a strategic focus to assist Swedish to achieve exemplary levels of performance in clinical service areas.

(e) Oversees the prioritization and selection of Campus-level clinical performance improvement projects.

(f) Compares clinical outcomes and performance of key programs and services against local, system and national benchmarks, reviews strategic measures and oversees follow-up plans.

(g) Assists with and supports implementation of safety and clinical quality projects on a campus level.

4.9.2 Meetings
This committee shall meet monthly and will maintain a permanent record of its proceedings and activities which are forwarded to the MPLC and the system-wide Quality and Safety Committee.
ARTICLE V: PARLIAMENTARY PROVISIONS RELATING TO GENERAL MEDICAL PROFESSIONAL STAFF MEETINGS, AS WELL AS DEPARTMENTAL AND COMMITTEE MEETINGS

5.1 Regular Medical Professional Staff Meetings
The MPLC shall establish by resolution a schedule of regular meetings of the Medical Professional Staff. Notice of the schedule of such meetings shall be given when such schedule is established; thereafter, meetings provided for in that schedule may be held without further notice except as otherwise provided in these Bylaws. One regular meeting shall be designated as the annual meeting of the Medical Professional Staff and AHP staff to which all credentialed Practitioners are invited. At such meeting, candidates for election to leadership positions shall be announced.

5.2 Special Medical Professional Staff Meetings
Special Medical Professional Staff meetings may be called at any time by the System Chief of Staff, the Board, or the MPLC. In addition, the System Chief of Staff shall call a special meeting within 30 days after receipt of a written request signed by not less than 25 members of the Active and APC Medical Professional Staff. Written or electronic notice, stating the place, day, hour, and purpose of any special meeting, shall be given to each member of the Medical Professional Staff not less than 10 days nor more than 30 days prior to such meeting. If mailed, the notice shall be deemed given when deposited, postage prepaid, in the United States mail and addressed to the Medical Professional Staff member at his/her address as it appears on the records of the Medical Professional Staff Services Department. Notice by email address shall be deemed delivered when sent if sent to the Medical Professional Staff member’s email address currently on file with the Medical Professional Staff Services office. It is the responsibility of the Medical Professional Staff member to notify the Medical Professional Staff Services Department of any changes to his or her email address. The attendance of a member of the Medical Professional Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that business stated in the notice of the meeting.

5.3 Quorum for Medical Professional Staff Meetings
A quorum consists of 10 percent or 50 members, whichever is less, of the total membership of the Active and APC Medical Professional Staff. When transacting business that requires action by only those Active and APC Primary Campus Medical Professional Staff members, a quorum shall be 10 percent or 25 members, whichever is less, of the Active and APC Primary Campus Medical Professional Staff members. There shall be no voting by proxy.

5.4 Mail or Electronic Ballot for Medical Professional Staff Actions
Any action that can be taken by the Medical Professional Staff at a meeting (either by the entire Medical Professional Staff or by those Practitioners who practice at a given campus) may be taken by mail or electronic ballot if the MPLC so directs. Such ballot must (1) state the Vote Date by which it must be received by the System Chief of Staff in order to be counted, (2) describe the proposed action to be taken, and (3) specify a date, time, and location prior to the Vote Date for Medical Professional Staff members who desire to meet informally to discuss such issue. The ballot must be distributed to each Active and APC Medical Professional Staff member not later than two weeks before the Vote Date. To be effective, 10 percent of the Active and APC Medical Professional Staff members must vote on the matter and it must receive the affirmative vote of
greater than one-half of votes cast (or a greater majority if required for such matter by provisions of these Bylaws). The MPLC or System Chief of Staff may authorize an extension of the voting period of up to 14 days beyond the original Vote Date if the minimum voting threshold is not reached.

5.5 Attendance Requirements
Medical Professional Staff members are advised to attend Medical Professional Staff meetings and Department meetings for their own benefit and to contribute to the Medical Professional Staff decision making process, but attendance shall not be required.

5.6 Minutes and Reports; Confidentiality
A record shall be promptly prepared and permanently maintained for each regularly scheduled Medical Professional Staff, Department or committee meeting. Minutes shall include a list of persons attending, matters discussed, and actions taken. Confidential copies of minutes shall be promptly furnished to the Office of Medical Professional Staff Services to be preserved as the official record.

Minutes and reports shall be distributed (even in draft form) only to Department or committee members, the MPLC, the CE, the Medical Administrator, the Board, and those agents and employees who work to assist them. Minutes and reports, or those portions of minutes and reports dealing with quality improvement, performance improvement, peer review, and disciplinary action, shall be maintained in a secure manner, so that only those individuals described in the preceding sentence shall have access to them. They shall be kept confidential.

5.7 Department/Standing Committee Reports
The minutes shall be forwarded to the MPLC and maintained in the Department of Medical Professional Staff Services.

5.8 Quorum for Department/Standing Committee Meetings
A quorum consists of at least three Active and APC staff members or a majority, whichever is less.

5.9 Rules of Order
All matters of procedure shall be governed by Robert's Rules of Order, Newly Revised. These Bylaws shall prevail when there is a conflict.

5.10 Voting
Voting by proxy (wherein one individual who is present purports to cast a vote on behalf of an individual who is absent) shall not be allowed. However, absentee ballots (wherein the absent member casts his/her own vote) may be permitted at the sole discretion of the MPLC for votes in which the issue has been fixed at a preceding meeting and a vote is being taken at a subsequent meeting, such as election or removal of officers and amendment of these Bylaws.

5.11 Approval of Bylaws

5.11.1 Approval Process for Bylaws

(a) The MPLC shall recommend for review and approval by the Active and APC Medical Professional Staff and the Board such Bylaws as deemed necessary. Voting shall be in accordance with voting methods stated in these Bylaws, Rules and Regulations, and policies.
Notwithstanding Section 5.12 below, the organized Medical Professional Staff has the ability to adopt Medical Professional Staff Bylaws, and amendments thereto, and to propose them directly to the Board. Prior to a vote for adoption by the Medical Professional Staff the proposal is presented for informational purposes to the MPLC in writing and signed by not less than 25 members. The proposal is then voted upon by the Medical Professional Staff with the same process as Bylaws amendments recommended by the MPLC (Section 5.12). Such votes may occur no more frequently than every six months. If adopted, the proposal is then presented to the Board for its consideration and approval.

5.12 Amendment of Bylaws

5.12.1 Process
These Bylaws may be amended only by mail or electronic ballot or by vote of the Active and APC Medical Professional Staff members at any special meeting called for that purpose or at any regular meeting of the entire Medical Professional Staff, for which meetings, prior notice must be provided.

(a) In order to be adopted at a Medical Professional Staff meeting, a proposed amendment must receive an affirmative vote by two-thirds of the Active and APC Medical Professional Staff members present at a meeting at which a quorum is in attendance.

(b) In order to be adopted by a mail or electronic ballot, a proposed amendment must be voted upon by not less than 10 percent of the Active and APC Medical Professional Staff members and receive an affirmative vote of two-thirds of such members voting.

(c) The report and recommendations of the Bylaws Committee, with respect to any proposed amendment to these Bylaws, shall first be submitted to the MPLC for approval prior to submission to the Active and APC Medical Professional Staff members:

1. If the vote occurs at a Medical Professional Staff meeting, then the proposed amendment shall be distributed to Active and APC Medical Professional Staff members no less than two weeks prior to the date of such meeting;

2. If the vote occurs by mail or electronic ballot, then it shall be submitted to Active and APC Medical Professional Staff members in the manner provided in these Bylaws for mail or electronic ballots;

(d) The MPLC shall have the authority to amend the Bylaws in non-substantive issues, including but not limited to spelling and grammatical corrections as well as the updating of titles without a vote by the Active and APC Medical Professional Staff members.

5.12.2 Approval by Board
An amendment so adopted by the Active and APC Medical Professional Staff members shall become effective when approved by the Board.
5.13 Adoption of Bylaws
These Bylaws shall not be in conflict with the Board Bylaws and may not be unilaterally amended or approved by either entity.

ARTICLE VI: MEDICAL PROFESSIONAL STAFF RULES AND REGULATIONS AND POLICIES

6.1 Medical Professional Staff Rules and Regulations and Policies
The Medical Professional Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Board.

6.1.1 Approval Process for Rules and Regulations and Policies

(a) MPLC proposals

(1) The authority to propose to adopt a rule, regulation, policy, or an amendment thereto is granted to the MPLC by vote of the organized Medical Professional Staff and approval by the Board. This authority must be affirmed by such a vote at least every two years. The process of the vote will be as outlined in Section 5.12.

(2) With this authority, the MPLC shall propose for approval by the Board such Rules and Regulations and policies as it deems necessary. Prior to submission to the Board, such proposals shall be promptly communicated to the Medical Professional Staff for review and comment period of 14 days. If there is conflict between the organized Medical Professional Staff and MPLC about a proposal the issue may be brought by interested representatives of the Ad Hoc Committee on MPLC/Medical Professional Staff Relations prior to submission to the Board.

(3) The MPLC shall have the authority to amend a rule, regulation, or policy in non-substantive issues, including but not limited to spelling and grammatical corrections as well as the updating of titles without the requirement of a Medical Professional Staff review and comment period.

(b) Emergency Rulemaking
In the case of a documented need for an urgent amendment necessary to comply with law or regulation, the MPLC and Board may provisionally adopt amendments without prior notification of the Medical Professional Staff. This delegated authority for the MPLC must be affirmed by a vote of the Medical Professional Staff at least every two years. The process for this vote will be as outlined in Section 5.12. In the case of an urgently adopted provisional amendment, the Medical Professional Staff will be notified about the amendment and will have 30 days for retrospective review and comment. If there is no conflict between the organized Medical Professional Staff and the MPLC, the provisional amendment will stand. If there is conflict, as expressed in writing and signed by not less than
25 members of the organized Medical Professional Staff, the issue will be brought to the Ad Hoc Committee on MPLC/Medical Professional Staff Relations for discussion and resolution. If necessary, a revised amendment will then be submitted to the Board for action.

(c) Medical Professional Staff Proposals

The Medical Professional Staff may recommend Rules and Regulations and policies for approval by the Board of Trustees. Prior to a vote for adoption by the Medical Professional Staff the proposal shall be presented for informational purposes to the MPLC in writing and signed by not less than 25 members. The proposal is then voted upon by the Medical Professional Staff with the same process as Bylaws amendments recommended by the MPLC (Section 5.12). Such votes may occur no more frequently than every six months. If adopted, the proposal is then presented to the Board for its consideration and approval.

6.2 Consistency
The Rules and Regulations and policies shall not conflict with these Bylaws.

6.3 Accessibility
When approved by the Board, the Rules and Regulations and policies shall be made accessible to all Practitioners along with other pertinent Medical Professional Staff and Hospital policies.

ARTICLE VII: MEDICAL PROFESSIONAL STAFF MEMBERSHIP AND PRIVILEGES

7.1 Nature of Medical Professional Staff Membership

Membership on the Medical Professional Staff is a privilege that shall be extended only to professionally competent Physicians, Dentists, Oral and Maxillofacial Surgeons and APCs who continuously meet the qualifications, standards, and requirements set forth in these Bylaws.

The Medical Professional Staff is a part of the legally constituted Hospital Corporation created by the Board. The Medical Professional Staff serves as an extension of the Board when carrying out credentialing, privileging, and quality control functions.

7.2 Qualifications

Individuals qualified for membership on the Medical Professional Staff shall be only those Physicians and Practitioners who continuously demonstrate, to the satisfaction of the Medical Professional Staff and the Board, the following qualifications:

7.2.1 Current license to practice in the State of Washington.

7.2.2 Evidence of graduation from an approved school of medicine, osteopathy, dentistry, or podiatry.

7.2.3 Documented background, education, relevant training, recent experience, demonstrated current competence and judgment, adherence to the ethics of their profession, good reputation and character, satisfactory current physical and mental condition, and ability to work harmoniously with others, sufficient to ensure the Medical Professional Staff and the Board that any patient treated by them in the Hospital will receive quality care and
that the Hospital and the Medical Professional Staff will be able to operate in an orderly manner.

7.2.4 Current Drug Enforcement Administration (DEA) prescription authority, if applicable.

7.2.5 Current and valid professional liability insurance coverage issued by a company that is licensed or approved by the State of Washington and acceptable to the Board, in the form of deductibles and amounts to be determined by the Board from time to time, unless otherwise stated in the Bylaws.

7.2.6 Applicant is not excluded from participation in the Medicare program, any state Medicaid program, or from any other governmental healthcare payment program.

7.2.7 Requisite Training and Board Certification

(a) Successful completion of an approved, prerequisite residency training program with the Accreditation Council of Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), the Council of Podiatric Medical Education (CPME), or the Council of Dental Accreditation (CDA) as well as subsequent compliance with Section 7.2.7(b).

(b) Board Certification by a specialty Board recognized and approved by the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Podiatric Surgery, or the American Dental Association (or an equivalent Canadian Board Certification). The MPLC may determine equivalency of a foreign board’s certification to that of a corresponding American board for the purpose of credentialing and privileges. Exemptions to specialty board certification as a requirement for credentialing and privileges may be granted by the MPLC on a case-by-case basis.

If not Board Certified, the applicant must be Board Admissible and attain Board Certification within five years of completing one’s residency or fellowship training, or, for those whose board allows eligibility beyond five years, the Practitioner must attain initial certification within the timeframe allowed by the applicable board.

Applicant shall maintain such certification as stipulated by their certifying bodies so long as the applicant is a member of the Medical Professional Staff. Maintenance of such certification may be accepted on a case by case basis after consideration by the Credentials Committee and MPLC. The applicant will attest to his/her status of certification at the time of initial application and every reappointment.

The applicant’s Board Certification must be in a specialty for which the applicant is applying for Privileges. However, requests for Privileges outside the specialty for which the applicant has board certification will be considered if (a) certification for the specialty is not available from one of the organizations listed above; (b) the applicant provides evidence satisfactory to the Credentials Committee and MPLC of additional training, education, experience to support such request (which may include certification by a board other than one of those identified); and (c) the applicant meets all other requirements for Medical
Professional Staff membership and Privileges. The Board shall determine the Department(s) to which various Board specialties and individual applicants are assigned.

7.2.8 The requirements of Section 7.2.7 do not apply to the following:

(a) Dentists

(b) Current members of the Medical Professional Staff who were members as of 1992 and who continue to maintain membership status through consecutive, uninterrupted reappointments to the Medical Professional Staff.

(c) Practitioners in practice prior to 1992 who, at the time of appointment to the Medical Professional Staff, are Active Staff members of another hospital accredited by The Joint Commission and approved by the Board.

(d) Practitioners who are members in good standing of the health care organization at the time of a merger or affiliation with Swedish. If, at the time of a merger or affiliation, there are Practitioners who left one of the healthcare organizations under adverse conditions, or who may have withdrawn an application prior to a hospital taking final action, or who may be under focused review or investigation, these Practitioners shall be considered for membership on a case-by-case basis.

7.2.9 Continuing Medical Education (CME) Requirements. CME requirements adopted by the State of Washington to maintain licensure provided that at least 20 percent of said CME is in applicant's specialty or subspecialty.

7.3 Clinical and Other Privileges

7.3.1 Privileges

Every Practitioner practicing at the Hospital (by virtue of Medical Professional Staff membership or otherwise) shall, in connection with such practice, be entitled to exercise only those Privileges specifically granted to him/her by the Board, whether for inpatient or outpatient services at Swedish. In order to exercise Privileges, demonstrated understanding of the culture of patient safety and demonstrated proficiency with the Practitioner’s role in patient safety will be a condition of appointment and reappointment to the Medical Professional Staff. The Hospital shall make available to the Medical Professional Staff educational resources to assist members in meeting this requirement. Demonstrated competency in the Clinical Information System is also a requirement for Privileges. The Hospital will provide training and technical support to enable Practitioners to achieve this competency.

(a) Initial Determination

Every initial application for Privileges must contain a request for the specific Privileges desired by the applicant. Privileges granted by the Board shall be based on the recommendations of the MPLC following its consideration of the recommendations by the Departments as reviewed by the Credentials Committee. The applicable Department Chief or designee shall review and make recommendations on the request for privileges.
(b) Basis for Determination
The initial determination as to Privileges shall be based upon the applicant's education and training, recent experience, demonstrated competence and judgment, physical and mental health status, character, professional ethics, reputation, references, and any other factors relevant to the furtherance of the purpose of the Hospital and community healthcare, including peer input, the results of inquiry to the National Practitioner Data Bank, and an evaluation by the clinical Department or Departments in which Privileges are sought. Any relevant information relating to the applicant's qualifications may be considered by the applicable Departments, the Credentials Committee, the MPLC, and the Board. Professional performance from Performance Improvement activities, including substantive, Practitioner-specific information, shall consider the following:

(1) Nonuse of Privileges for a high-risk procedure or treatment over the previous two years;

(2) Emergence of new technologies; and

(3) Comparison to aggregate information.

(c) Applicant’s Burden of Proof
The applicant shall bear the burden of establishing his/her qualifications and competence to exercise the Privileges sought.

(d) Focused Professional Practice Evaluation for New Medical Professional Staff Members
During the first year of Medical Professional Staff membership, focused case review is routinely carried out by the Department chair or his or her designee. This may include, but is not limited to, chart review, clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient (e.g., consulting Physicians, assistants at surgery, nursing or administrative personnel).

(e) Proctoring
Proctoring is an objective evaluation of a Practitioner’s clinical competence by a proctor who represents, and is responsible to, the Medical Professional Staff. Initial applicants seeking Privileges are proctored while providing the services for which Privileges are requested. In most instances, a proctor acts only as a monitor to evaluate technical and cognitive skills of another Practitioner. For detailed information on Proctoring, see Section 10.9 of these Bylaws.

(f) Failure to Provide Requested Information
If at any time an appointee fails to provide required information pursuant to a formal request by the Credentials Committee, the MPLC, or the CE, then the appointee's Privileges shall be automatically relinquished until the required information is provided to the satisfaction of the requesting party. For purposes of this section, "required information" shall refer to (1) physical or mental examinations as may be requested pursuant to these Bylaws/policies, (2) information necessary to explain an investigation, professional review action, or resignation from another facility or agency, (3) information pertaining to professional liability actions involving the appointee, or (4) any information
relative to past or present practices or (5) past or present DEA registrations or state licenses. Whenever an application remains incomplete for a period of greater than one hundred eighty (180) days from date of signature, it shall automatically be administratively withdrawn. The appointee may reapply in accordance to policy regarding reapplication.

(g) Consultation with Other Departments
When any Privileges sought by an applicant are subject to the jurisdiction of Departments other than the Department to which the applicant is requesting assignment, the Department to which assignment is sought, after making an initial decision to recommend any such Privileges, shall review the application and consult with other such Departments before making a final recommendation to the Credentials Committee. After the Credentials Committee completes its review, it shall transmit its recommendations to the MPLC. If any other such Department objects to the recommendation of any such Privileges by the Department(s) to which assignment is sought, then it may file such objections in writing with the MPLC, which shall refer the matter back to the Credentials Committee.

(h) Scope and Extent of Services for Dentists
Surgical services that each Dentist may perform shall be specifically delineated and granted in the same manner as all other Privileges. The Dentist shall be responsible for admitting such patient completing and recording a history and physical examination prior to scheduling the performance of dental surgery for the care of any medical problem that may be present at the time of admission or that may arise during the period of hospitalization, appropriate consult will be requested.

(i) Scope and Extent of Privileges for Fellows
The medical and surgical Privileges provided by each Fellow shall be performed in accordance with the provisions of the fellowship program and with the approval of the Swedish Graduate Medical Education Committee and Director of Medical Education. The credentialing mechanism is set forth in these Bylaws.

7.3.2 Temporary Privileges
Applicants for privileges in Sections 7.3.2(a) – (b) shall be required to meet the minimum criteria as stated in the Bylaws, Section 7.2.

(a) Temporary Privileges
Temporary Privileges are not granted except to address an important patient care need or a condition that mandates the professional services of a Practitioner with expertise not currently possessed by an available member of the Medical Professional Staff; or to facilitate the role of a proctor; or to allow participation in a limited training course. In these cases, and upon recommendation of the System Chief of Staff or designee, temporary Privileges are granted for a specific limited period of time by the CEO or designee. These Privileges are determined on a case by case basis and may be granted only two times per calendar year per Practitioner. The individual must apply for Medical Professional Staff membership if required more frequently. Temporary Privileges for new applicants shall not be granted for a period greater than 120 days.
(b) Specific Patient Privileges
These Privileges are granted by the CE or designee for the purpose of allowing a Practitioner to see a specific patient at the request of the patient and/or the patient’s attending Physician. These Privileges may be granted only two times per calendar year. The individual must apply for Medical Professional Staff membership if required more frequently.

(c) Interim Privileges
These privileges may be granted by the CE or designee after completion of the application, including recommendation by the Credentials Committee or its designee, and may remain in effect up to 60 days until recommendation is made by the MPLC and final action by the Board.

The policy on interim Privileges does not apply to the Privileges as described in the above Sections 7.3.2(a) – (b). The Privileges described in Sections 7.3.2(a) – (b) are time-limited and granted only at the discretion of the CE or designee in compliance with those sections of the Bylaws and may be denied, restricted, limited, suspended, or revoked at any time with or without cause. Such action shall not give rise to any Review Hearing (Medical Professional Staff member) or Review Procedure (AHP) rights.

The applicable Department Chief may impose special requirements of supervision and reporting on any Practitioner granted the Privileges above.

The Privileges above shall be immediately terminated by the CE or designee upon notice of failure by the Practitioner to comply with any conditions under which such privileges were granted.

7.3.3 Emergency Privileges
In the case of Emergency Medical Condition, any Practitioner, to the degree permitted by his/her license and regardless of service or staff status or lack thereof, shall be permitted and assisted by Hospital personnel to give appropriate medical care, using every facility of the Hospital necessary, until relieved by a Practitioner who holds appropriate Privileges to provide such care. Any Practitioner who assists in connection with an Emergency Medical Condition for which he/she has not been granted specific Privileges shall make every reasonable effort to call for appropriate consultation or assistance reasonably available under the circumstances and shall arrange for subsequent care by a Practitioner holding appropriate Privileges.

7.3.4 Disaster Privileges
Upon implementation of the emergency management plan and in the event the Hospital is unable to meet immediate patient needs, the Hospital may grant disaster Privileges using a modified credentialing and privileging process for eligible volunteer practitioners. This process must, at a minimum, provide for verification of licensure, and oversight by the Medical Professional Staff of the care, treatment, and services provided. The decision to grant disaster Privileges is made on a case-by-case basis in accordance with the needs of the Hospital and it patients, and on the qualifications of the volunteer practitioner.

The following individuals and their designees are authorized to grant disaster privileges: the President, the CE, the System Chief of Staff, the Medical Administrator, the Hospital
Administrative/Nursing Supervisor, and the Incident Commander. These Privileges may be granted only for the purpose of providing care, treatment, and services during an official emergency. When the emergency situation no longer exists, the disaster Privileges shall be automatically terminated.

7.3.5 Telemedicine Credentialing and Privileging
Licensed independent Practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging process of Swedish.

7.4 Nondiscrimination
Medical Professional Staff membership, Privileges, and the exercise of Privileges shall not be denied any applicant or member in a manner prohibited by applicable accreditation standards, or state or federal nondiscrimination law. Additionally, membership, Privileges, and the exercise of Privileges shall not be denied based on a Practitioner’s type of specialty, or type of patient treated.

In consideration for Medical Professional Staff membership or Privileges within the scope of the applicant's respective licenses, no applicant shall be discriminated against solely on the basis of whether such applicant is licensed as an MD, DO, or DPM.

7.5 Allied Health Professionals
Allied Health Professionals (“AHP”) authorized to provide services in the Hospital shall be limited to the categories of Independent AHP and Supervised AHP. All AHPs shall be governed in accordance with the Medical Professional Staff Bylaws, Rules and Regulations, and all Medical Professional Staff and Hospital Standards and policies, and provider service forms. The Board may, from time to time, review and modify the categories or types of AHPs authorized to function in the Hospital, upon the recommendation of the MPLC. Each AHP shall be assigned to a clinical Department.

The policy of the Hospital is to permit Supervised AHPs and Independent AHPs to provide authorized health care services to Hospital patients subject to any described limitations and procedures. Supervised AHPs will not have independent admitting or discharge Privileges unless otherwise stated on the Privilege form.

7.5.1 Authority to Provide Services in the Hospital

(a) Nature of the Authority
Authority to provide health care services in the Hospital is a privilege, not a matter of right, which shall be extended only to professionally competent AHPs who continuously meet the qualifications, standards and requirements as set forth by the Hospital.

(b) Qualifications
Every AHP providing health care services in the Hospital must, at the time of application, initial approval and continuously thereafter:

(1) Be either a Hospital employee or employed or sponsored by a member in good standing of the Medical Professional Staff of the Hospital.
(2) Verification must be provided which will document an acceptable level of quality and efficiency as is required by the Hospital.

(3) Demonstrate ability to work with and relate to Hospital staff members, members of all health disciplines, Hospital management and employees, the Board, visitors and community in general in a cooperative, professional manner that is essential for maintaining an environment appropriate to quality and efficient patient care.

(4) Be free of or have under adequate control of any physical or mental health impairment, and to be free from abuse of any type of substance or chemical that affects cognitive, motor or communication ability in a manner that interferes with, or presents, a reasonable probability of interfering with the general qualifications.

(c) Supervised AHPs
All Supervised AHPs providing care in the Hospital are required to have a documented continuous supervising relationship with a Physician with appropriate Privileges. The supervising Physician is responsible for the care provided. A supervising Physician must be available at all times for consultation with the Supervised AHP on patient care issues and must review and co-sign history and physicals, consultations, operative notes, and discharge summaries. Peer review may include both the supervising Physician and the Supervised AHP.

(d) Independent AHPs

(1) Psychologists are considered to be independent Practitioners who shall have authority to provide consultation services upon request of a member of the Medical Professional Staff.

(2) Certified Nurse Midwives are required to have Physician back-up but shall have authority to admit, treat, consult, perform procedures, give orders and discharge patients in accordance with the Privileges authorized.

(e) Liability Insurance Coverage
AHPs shall have professional liability insurance coverage with a qualified carrier and in an amount acceptable to the Board. Such AHPs will provide the Hospital with satisfactory evidence of such insurance no less than annually or upon request.

(f) Notice of Suit
In the event an AHP is served a summons and complaint issued from any court of any jurisdiction arising from an incident alleged to have arisen out of health care services provided by the AHP, the AHP shall immediately notify the Office of Medical Professional Staff Services and provide a copy of the summons and complaint.

(g) Notice of Practice Change
In the event an AHP changes his/her employment arrangement and/or specialty, he/she is to notify the Office of Medical Professional Staff Services immediately (within five days) and must provide adequate documentation of training and experience as appropriate to the new practice. This may include a new practice plan filed with the State of Washington. Failure of notification may result in an automatic termination of Medical Professional Staff membership and Privileges.

7.5.2 AHP Application

(a) Written Application and Information
All AHPs shall complete a pre-application initially to determine eligibility. All applications by AHPs for initial authorization and for renewal of authorization to provide health care services in the Hospital shall be in writing, signed by the applicant and the applicant's supervising and/or sponsoring Physician(s) and submitted on a form provided by the Hospital in accordance with the procedure following this policy. The application shall indicate the health care services which the AHP is requesting to be authorized to perform. The applicant shall provide detailed information documenting his/her professional and personal qualifications, including current competency to support granting of the Privileges requested. This information shall include at least the following:

(1) A criminal history background check;
(2) Status of the applicant's ability to provide the services/Privileges requested with reasonable skill and safety;
(3) Education, training and current competency information;
(4) Adequate information for a proper evaluation of moral and ethical character, personality, and ability to get along with others;
(5) Current licensure or certification and DEA registration, if applicable; and
(6) Privileges will be automatically terminated in the event the AHP is excluded from participating in the Medicare/Medicaid programs or any other governmental program.

The burden of proof shall be upon the applicant to provide all requisite documentation. Further, an application shall be accompanied by a processing fee in an amount to be determined by the Hospital and the Medical Professional Staff.

Dues shall be assessed annually in January of each year in an amount to be determined by the Hospital and Medical Professional Staff. Dues cannot be waived and shall not be pro-rated.

(b) AHP Authorization/Release
By applying for authorization to provide health care services in the Hospital each applicant thereby signifies his/her willingness to appear for interviews in regard to his/her application; authorizes the Hospital to consult with other hospitals in which the applicant has provided health care services and with others who may
have information bearing on the applicant's competency, character, health status, personal and ethical qualifications; consents to the Hospital's inspection of all records and documents that may be material to an evaluation of the applicant's professional and personal qualifications and competency to provide the health care services which the applicant has requested; releases absolutely from any liability all representatives of the governing body, the Hospital and/or the Hospital's designee and the Medical Professional Staff for their acts performed in connection with evaluating the applicant and the applicant's credentials; and releases absolutely from any liability all individuals and organizations who in good faith provide information to the Hospital concerning the applicant's competency, ethics, character, health status and other qualifications to provide requested health care services in the Hospital, including otherwise privileged or confidential information.

(c) Submission of AHP Application
Applications shall be submitted to the Hospital's Medical Professional Staff Office. The Department Chief, or designee, of the Medical Professional Staff Department to which the AHP's primary supervising and/or sponsoring Physician(s) has/have been assigned, or, in cases of an independent AHP, the Chief, or designee, of the appropriate service area will review the application and comment on any concerns as to privileges requested. The Credentials Committee will review the application and, based on Hospital Standards and Medical Professional Staff policies and guidelines, make a recommendation on Privileges requested. This recommendation will be forwarded to the MPLC for review.

The report of the Department Chief and the recommendations of the Credentials Committee and MPLC will then be presented to the Board. Exception: If an Adverse Action is recommended for reasons other than misrepresentation or inability to meet threshold criteria, the AHP shall be afforded due process rights as stated in Section 7.5.5 of these Bylaws.

Following Board action the applicant, as well as the supervising Physician (if applicable), will be sent written notification of same.

(d) Nondiscrimination
Privileges, and the exercise of Privileges shall not be denied any applicant or Practitioner in a manner prohibited by applicable state or federal nondiscrimination law. Additionally, Privileges and the exercise of Privileges shall not be denied based on a Practitioner’s type of specialty, or type of patient treated.

7.5.3 Health Care Services

(a) Term
Authorization upon approval of initial application or upon renewal shall be for a period not to exceed two calendar years. However, R-5 Radiology residents shall only be granted Privileges for a period of one year up to the end of their residency.

Licensure, registration or certification, when applicable, must be confirmed annually at a time consistent with the state required re-licensure.
(b) Provision of Services
Supervised AHPs shall not be authorized to independently admit or discharge patients to/from the Hospital.

(c) Limitation/Automatic Termination

(1) All Privileges automatically terminate when an AHP’s certificate or license expires or is revoked or suspended. An AHP’s Privileges may also be terminated for cause by the System Chief of Staff or by the Chair of the Department to which the AHP is assigned.

(2) A Supervised AHP’s Privileges automatically terminate when:

(i) The Medical Professional Staff membership or applicable Privileges of the supervising Physician are terminated, whether voluntary or involuntary;

(ii) The supervising Physician no longer agrees to act as the supervising Physician, regardless of the reason;

(iii) The relationship between the AHP and the supervising Physician is otherwise terminated, regardless of the reason; or

(iv) The AHP no longer meets the membership requirements.

In these circumstances, there is no Review Procedure pursuant to Section 7.5.5 of these Bylaws.

7.5.4 Prerogatives
AHPs may serve on committees as requested.

7.5.5 Peer Review and Hearing Procedure for Allied Health Professionals
The quality and efficiency of the care provided by AHPs shall be monitored and reviewed as part of the Medical Professional Staff performance improvement structure and activities. If the performance review process results in an Adverse Recommendation from the MPLC, the AHP shall have the right to challenge the finding as outlined in the Hearing Procedure below.

(a) Hearing Procedure
An AHP may file a written grievance with the MPLC within 15 days after the date of receipt of a notice of a proposed Adverse Action.

Upon receipt of the grievance, the MPLC shall afford the AHP an opportunity for an interview concerning the grievance. The interview does not constitute a “Review Hearing,” as established by the Bylaws or any rights applicable to a Review Hearing. Before the interview, the AHP must be informed of the nature of the circumstances giving rise to the action and may present relevant information at the interview. A record of the interview and the decision on the action must be made by the MPLC.

(b) Action of the Board
The Board shall consider the recommendation of the MPLC and make a written final decision. The Board’s decision shall be final, binding and conclusive.

(c) Sole Remedy
The procedure as outlined in subsection (1) above is the sole and exclusive remedy available to an AHP who is the subject of an Adverse Recommendation or who has his or her Privileges limited or terminated. Nothing in these Bylaws may be interpreted to entitle an AHP to the Review Hearing provisions applicable to the Medical Professional Staff. Notwithstanding the preceding sentence, the MPLC or the Board, as the case may be, may, in its sole discretion, apply all or part of such provisions as it deems necessary or appropriate under the circumstances.

(d) Disciplinary Action for Allied Health Professionals – Notification and Reporting

The CE or an authorized designee shall notify the National Practitioner Data Bank, the State Medical Quality Assurance Commission, and other organizations that may require notification by law, concerning final determinations that reduce, restrict, suspend, terminate, revoke, or deny Privileges or surrender of Privileges while under investigation or to prevent an investigation. Restrictions, revocations, reductions, non-renewals, or denials of Privileges that occur solely because the AHP does not meet the established threshold eligibility criteria for a particular Privilege shall not be reported in accordance with NPDB policy.

The CE or an authorized designee of the Hospital shall report to the Washington State Department of Health when the practice of an AHP is restricted, suspended, limited, or terminated based upon a conviction, determination, or finding by the Hospital as defined in RCW 18.130.180 (and as amended) within 15 days of conviction, determination, or finding, or of a voluntary resignation while the AHP is under investigation.

7.6 Procedures Relating to Medical Professional Staff Membership and Privileges

7.6.1 Pre-Application

(a) A pre-application for appointment to the Medical Professional Staff shall be sent only upon request to those individuals to determine whether they are eligible for appointment and privileges because they meet the threshold criteria for appointment and privileges consideration; (ii) who desire to provide care and treatment to patients for conditions and diseases for which the Hospital has facilities and personnel; and (iii) who indicate an intention to utilize the Hospital as required by the staff category to which they desire appointment.

(b) An individual requesting a pre-application for appointment shall initially be sent (i) a letter that outlines the threshold criteria for appointment and the privileges consideration and explains the review process, and (ii) a pre-application form that requests proof that the threshold criteria for appointment and the privileges consideration can be met by the individual.

(c) Those individuals who meet the threshold criteria for consideration for appointment to the Medical Professional Staff and privileges shall be given an
application. Individuals who fail to meet these criteria shall not be given an application and shall be so notified. The determination that an applicant is not eligible for membership or privileges is an administrative determination and shall not entitle the applicant to a hearing under the provisions of these Bylaws.

The Pre-Application must be accompanied by payment of such application fee as may be specified in accordance with these Bylaws. The application fee shall be returned if the applicant does not meet criteria for receiving an application.

7.6.2 Application for Appointment
Application for Medical Professional Staff membership must be typewritten or legibly handwritten in ink, signed by the applicant, submitted on a form (or forms) prescribed by the MPLC, and approved by the Board.

7.6.3 Application Content

(a) Every application shall contain the applicant's specific acknowledgment of a Medical Professional Staff member's obligations to provide continuous care of his/her patients, abide by the Medical Professional Staff Bylaws, Rules and Regulations, and policies, and accept committee and consultation assignments as required of members in the Medical Professional Staff category to which the applicant is requesting appointment.

(b) The application shall require detailed information concerning the applicant's character, professional qualifications, and physical and mental health status, and shall include the names of four Practitioners (at least one of whom must not have a current or currently-contemplated medical practice affiliation with the applicant) who have had sufficient recent experience in observing and working with the applicant to enable them to render an opinion on his/her professional competence and who can provide adequate information pertaining to the applicant's professional competence, character, and professional ethics, which may include an assessment of the following areas:

(1) Patient care. Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

(2) Medical/clinical knowledge. Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.

(3) Practice-based learning and improvement. Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

(4) Interpersonal and communication skills. Practitioners are expected to demonstrate interpersonal and communications skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
(5) Professionalism. Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity and a responsible attitude towards their patients, their profession, and society.

(6) Systems-based practice. Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve, coordinate, and optimize health care in various delivery systems.

(c) The application shall include the name(s) of all healthcare entities to which the applicant has applied or has had or currently has an association, employment, privileges, or practice, and if discontinued, the reasons for such discontinuation, including the withdrawal of an application and reasons for such withdrawal.

(d) The application shall include proof of current licensure. Primary source verification of licensure is done at appointment, reappointment, renewal, or revision of privileges and at time of licensure expiration.

(e) The application shall include proof of current professional liability insurance coverage.

(1) Each Practitioner will maintain professional liability insurance coverage for all services provided by the Practitioner during the period that the Practitioner is a member of the Medical Professional Staff. Except as otherwise provided in Section 7.6.3(e)(8), such insurance shall be issued by a company that is licensed or approved by the State of Washington.

(2) The liability limits of Practitioner's insurance coverage will not be less than $1 million per occurrence/$3 million aggregate. These are minimum requirements for coverage. These minimum limits may be changed by the Board. Each Practitioner should consult regularly with his or her insurance carrier and/or professional associations and maintain coverage with liability limits consistent with that maintained by other Practitioners in the same specialty.

(3) If a Practitioner's coverage includes a deductible greater than $25,000 per claim, the Practitioner shall provide evidence that such insurance is a "pay on behalf of policy." This means that the insurance company is responsible for paying all costs and expenses and then recouping the amount of the deductible from the Practitioner.

(4) The Practitioner will provide the Hospital with a certificate of insurance evidencing this insurance coverage as required in connection with the initial application process and annually thereafter.

(5) The Practitioner will immediately notify the Hospital of any lapse, discontinuation or other material change in the scope of insurance coverage.
(6) If the insurance maintained by the Practitioner is on a claims made as opposed to an occurrence basis, the Practitioner will obtain and maintain "tail coverage" if the Practitioner's coverage lapses or is discontinued for any reason.

(7) The Practitioner's obligation to maintain professional liability insurance, and tail coverage, as described above, continues even after the Practitioner is no longer a member of the Medical Professional Staff.

(8) A Practitioner may participate in an approved program of self-insurance, risk retention group or other alternative risk financing vehicle if the following requirements are met:

(i) The arrangement must be evidenced by a formal trust, risk retention group or other formal document that provides for the same/equivalent levels of coverage for the Practitioner as described above. This document shall be reviewed by Swedish's Risk Management Department for appropriate minimum coverage and funding terms.

(ii) The self-funding level must be determined by recognized actuaries with experience in health care liability projections. The funding level shall be at least at a 75 percent confidence level.

(iii) The Practitioner shall provide at least 30 days advance Written Notice of his/her intent to withdraw from the self-insured program, or its impending discontinuation, or funding confidence level shortfall (under 75 percent confidence level). In such event, Practitioner shall also promptly provide evidence satisfactory to Swedish of Practitioner's purchase of additional insurance (e.g. tail) or Practitioner’s funding of a commercially reasonable mechanism for continued coverage of any and all claims (including without limitation, any known or unknown claims and any reported or unreported claims wholly or partially covered under said self insured program.) In the event additional insurance for continued coverage of such claims is obtained by Practitioner pursuant to the foregoing, such insurance must satisfy all of the criteria described in Section 7.6.3(e) (1) through (5) above. In the event Practitioner provides funding for continued coverage of such claims pursuant to the foregoing, the funding level shall be at least at a 75 percent confidence level.

(f) The application shall include information regarding (i) any involvement of the applicant in any previous or current professional liability actions, final judgments, or settlements; (ii) challenges to or voluntary or involuntary relinquishment of any license, certification, or registration; (iii) whether the applicant's Medical Professional Staff membership and/or privileges have ever been revoked, suspended, voluntarily or involuntarily limited, reduced, terminated, or not renewed at any other hospital or institution; (iv) whether the applicant has ever withdrawn an application for Medical Professional Staff membership during an investigation process or applied for privileges at another
hospital and not appointed to staff for any reason; and (v) whether his/her membership in local, state, or national medical societies, his/her license to practice any profession in any jurisdiction, his/her Medicare or Medicaid provider status in any state or Office of the Inspector General Medicare/Medicaid sanction status, or his/her Drug Enforcement Administration (DEA) license has ever been suspended, modified, surrendered, terminated, or not renewed.

(g) The application shall contain a request for the privileges desired by the applicant, if applicable.

(h) The application shall contain a provision that the applicant agrees to continuously and voluntarily, without being asked, update his/her application at any time during the process when new or updated information becomes available, including immediate notification to Swedish in the event of exclusion from Medicare/Medicaid programs.

(i) The application shall include a statement that the applicant has had an opportunity to access and review the Bylaws, Rules and Regulations, and policies of the Medical Professional Staff and the Hospital Standards and that he/she agrees to be bound by the provisions thereof.

(j) The application shall include an agreement that if any Adverse Action is taken with respect to the Practitioner's application for Medical Professional Staff membership or clinical and/or admitting privileges, either initially or during the course of his/her practice if he/she has been granted Medical Professional Staff membership, then the Practitioner will fully exhaust his/her administrative remedies under these Bylaws, which shall be the exclusive, binding, and conclusive remedy to the fullest extent permitted by law.

(k) The application shall also include any other information that the Hospital deems relevant or that is required by law, regulation, or accreditation standard to obtain.

(l) The application shall include an agreement by the applicant that any misrepresentation, misstatement, or omission from the application, whether intentional or not, may result in immediate denial or future revocation of Medical Professional Staff membership and clinical and admitting privileges.

(m) An application shall be considered to be administratively withdrawn if not complete within 180 days from date of signature. The applicant shall have no rights to a hearing or appellate review due to an incomplete application. The applicant may reapply; the application fee must be paid again in order to reapply.

7.6.4 Applicant’s Agreement
By applying for appointment to the Medical Professional Staff, each applicant thereby signifies his/her willingness to appear for interviews in regard to the application; authorizes the Hospital and the Medical Professional Staff to consult with administrative and Medical Professional Staff members of other health care entities with which the applicant has been associated and with others who may have information bearing on his/her competence, character, health status, professional ethics, and other qualifications; and authorizes such Hospital's inspection of all records and documents that may be material to such an evaluation.
The applicant further agrees to be governed by the Medical Professional Staff Bylaws, Rules and Regulations, and policies, as well as the Swedish policies, as such now exist or may hereafter be amended.

7.6.5 Applicant’s Release
By applying for such appointment, each applicant thereby releases from any liability all representatives of the Hospital and its Medical Professional Staff for their acts in connection with evaluating the applicant and his/her credentials and releases from any liability all individuals and organizations who provide information to the Hospital concerning the applicant's competence, character, health status, professional ethics, and other qualifications. The applicant specifically understands and agrees that credentialing and peer review information is exchanged and shared by and among the campuses and programs and services operated by Swedish and authorizes and consents to the sharing and exchange of such information. The applicant further understands and agrees that credentialing and peer review information may be exchanged and shared by Swedish with other coordinated performance improvement programs as permitted by applicable laws and regulations.

7.6.6 Verification of Information
Verification of an applicant's credentials, including but not limited to requesting information from the National Practitioner Data Bank (NPDB), is the responsibility of the Medical Professional Staff's Credentials Committee and the Hospital. The applicant shall bear the burden of producing adequate documentation and information for proper evaluation and verification of his/her competence, character, health status, professional ethics, and other qualifications. The application is considered complete when all required documentation has been received and verified. An application must be completed within 180 days from date of signature or it will be administratively withdrawn.

7.6.7 Submission Process
The completed application and all supporting materials shall be submitted to the Chief or designee of the Department based on practitioner specialty training. The Chief of the applicable Department shall review the application and request for privileges and transmit them, together with departmental recommendations, to the Credentials Committee for consideration at its next regular meeting or submit them to the Credentials Committee Chair or designee pursuant to the expedited credentialing process.

7.6.8 Appointment Process
(a) The Credentials Committee shall report its recommendations to the MPLC within 30 days after receipt of the completed application for membership. Prior to making its report, the Credentials Committee and the Chiefs or designee of the applicable Department shall examine the evidence of the professional competence, character, health status, professional ethics, and other qualifications of the applicant and shall determine whether the applicant meets all the necessary qualifications for the category of Medical Professional Staff membership and the privileges requested by him/her. This determination shall be based on information contained in references given by the applicant and from other sources available to them, which may include a personal interview with the applicant if deemed appropriate by the Credentials Committee. The reports of the
departmental Chiefs shall include specific written recommendations for delineating the applicant's privileges in the respective Departments.

(b) The Credentials Committee shall submit to the MPLC the completed application together with its recommendation that (a) the applicant be provisionally and/or conditionally appointed to the Medical Professional Staff with or without delineated privileges, or (b) the applicant be rejected for Medical Professional Staff membership, or (c) the applicant's application be deferred for further consideration.

(c) At its next regular meeting, after receipt of the application and the Credential Committee's recommendation, the MPLC shall decide (a) to recommend to the Board that the applicant be provisionally appointed to the Medical Professional Staff, (b) to recommend that he/she be rejected for Medical Professional Staff membership, or (c) to recommend that his/her application be deferred for further consideration. All recommendations to appoint must also specifically recommend the privileges to be granted, if applicable. These recommendations may be qualified by probationary conditions relating to such privileges.

(d) When the MPLC's recommendation is to defer the application for further consideration, the MPLC must submit, within 60 days thereafter, a subsequent recommendation to the Board for provisional appointment with specified privileges or for rejection for Medical Professional Staff membership and privileges.

(e) The MPLC’s recommendation together with all supporting documentation must be promptly forwarded to the Board.

(f) The Board shall act on the matter at its next regular meeting after receipt of a favorable recommendation from the MPLC. If the MPLC's decision is adverse to the applicant in respect to either appointment or privileges, the CE or designee shall give the applicant written Notice of such adverse recommendation within five days. Notification by the CE or designee shall include notice of the applicant's right to a hearing unless otherwise stated in these Bylaws. Such adverse recommendation shall be held in abeyance until the applicant has exercised his/her rights or has waived his/her rights under these Bylaws. The fact that the adverse recommendation is held in abeyance does not allow privileges to be conferred where none previously existed.

(g) The Board shall act in the matter at the earlier of (a) its next regular meeting after all of the applicant's rights have been exhausted or waived or (b) as provided in these Bylaws. The Board's decision (or that of the Appeals Committee acting in its behalf) shall be conclusive. Prior to finalizing a decision that is contrary to an MPLC recommendation, representatives of the Board shall consult with the MPLC and the Chair of the Credentials Committee. All decisions to appoint shall include a delineation of the privileges, if any, which the applicant may exercise.

(h) Applicants shall be notified of favorable membership and privilege decisions of the Board by mail. Notification shall include a delineation of the privileges which the applicant may exercise. In addition, all decisions to grant, deny, revise, or revoke privileges is made available in writing or in electronic format to all
internal and external entities required to administer membership and privileging information.

(i) In the case of an adverse decision, the Board shall send notice through the CE or designee to the System Chief of Staff and Chief of the applicable Department and, by certified mail, return receipt requested, give notice to the applicant, including the reason for the decision.

7.6.9 Reappointment Process

(a) Periodic re-determination of membership and privileges if applicable shall occur at least once every two years and shall be based upon any relevant information that documents the evaluation of the Practitioner's participation in the delivery of medical care. This information may include the direct observation of care being provided, review of the records of patients treated, and review of the records of the Medical Professional Staff and/or Hospital. This review shall be carried out by the Chief of the respective Department or designee, who shall make recommendations as appropriate to the Credentials Committee.

(b) Each recommendation concerning reappointment to the Medical Professional Staff and the privileges to be granted upon reappointment shall be based upon such member’s continuing to possess all qualifications for Medical Professional Staff membership and privileges pursuant to these Bylaws and the category of membership pursuant to these Bylaws.

(c) Each Practitioner shall be scheduled for periodic reappraisal, which is accomplished biennially. The MPLC shall make written recommendations to the Board, through the System Chief of Staff, concerning the reappointment including any exceptions/notations, conditional reappointments, non-renewals, and/or granting of specific privileges. Thereafter, the procedures provided in these Bylaws relating to recommendations on applications for initial appointments shall be followed.

(d) Reclassification of Medical Professional Staff membership categories may be made at any time upon review of membership criteria. Such action will not be subject to due process hearing as provided in these Bylaws.

(e) Reappointment is a performance-based reappraisal process contingent upon satisfactory quality assessment activities. The member shall permit access to confidential peer review, performance improvement, and care management information from all other hospitals at which he/she has privileges.

(f) The reappointment process must be accomplished within the same time frame as is described for initial applications.

(g) When a Practitioner scheduled for periodic reappraisal is unable to be contacted at the time of reappointment because he/she is serving active military duty, the recredentialing process will resume upon the Practitioner's return.

7.6.10 Reapplication
An individual may not ask for a Pre-Application Questionnaire for three years after any of the following events:

(a) The individual has been the subject of a final adverse action;

(b) The individual's membership or privileges have been revoked, resigned, or relinquished during an investigation;

(c) The individual withdraws his/her request for membership and/or privileges during an investigation after an interview with the Credentials Committee;

(d) The MPLC has recommended adverse action on a previous application;

(e) After the applicant has unsuccessfully applied for staff two times, even if the application is administratively withdrawn as incomplete after 180 days in accordance with these Bylaws.

7.6.11 Other Licenses or Membership
No individual shall be entitled to appointment to the Medical Professional Staff or to the exercise of privileges merely because (i) he/she is licensed to practice any profession in this or any other state, (ii) he/she is a member of any particular professional organization, or (iii) he/she has in the past had Medical Professional Staff membership or privileges at this or any other hospital. Existing Medical Professional Staff membership and privileges shall not entitle the member to automatic reappointment or continuation of privileges.

7.6.12 Member’s Agreement
Acceptance of membership on the Medical Professional Staff or of privileges constitutes the Practitioner's agreement to strictly abide by the ethics of his/her profession, the Medical Professional Staff Bylaws, Rules and Regulations, policies, and all Hospital Standards; and to immediately report to the System Chief of Staff or CE any voluntary or involuntary reduction, suspension, non-renewal, denial, or revocation of his/her privileges at any other hospital or healthcare facility and any denial, revocation, termination, suspension, restriction, reduction, limitation, sanction, probation, non-renewal, monitoring, relinquishment, withdrawal of any healthcare-related license.

7.6.13 Conditions and Duration of Appointment

(a) Authority of the Board
The Board shall make initial appointments and reappointments to the Medical Professional Staff. The Board shall act on appointments, reappointments, terminations, revocations, suspensions, reductions, or non-renewals of appointment only after there has been a recommendation from the Medical Professional Staff as provided in these Bylaws. In the event of unwarranted delay on the part of the Medical Professional Staff, the Board may act without such recommendation on the basis of documented evidence of the individual's qualifications as provided above. This evidence shall be obtained from reliable sources other than the Medical Professional Staff.

(b) Provisional Appointment and Privileges
All initial appointments to the Medical Professional Staff and all granting of privileges shall be provisional for a period of one year provisional membership.
may be extended for one additional year. The failure to advance from provisional status after two full years shall be deemed a termination of Medical Professional Staff membership and privileges. A provisional appointee whose membership is so terminated shall have the rights accorded by these Bylaws.

(c) Duration of Reappointment
Reappointment to all staff categories will be for a period not to exceed two years. Practitioners who have reached age 70 will be reappointed for one year.

(d) Limitation of Privileges
Appointment to the Medical Professional Staff shall confer on the appointee the exercise of only such privileges as granted by the Board in accordance with these Bylaws.

(e) Leave of Absence
Members of the Medical Professional Staff and the Allied Health Professional Staff may request a leave of absence subject to approval by the MPLC and the Board, for a period not to exceed 12 consecutive months. Upon return to practice, the practitioner shall provide documentation regarding relevant activities during the absence, valid practice affiliation information, evidence of professional liability insurance, and other information required for credentialing purposes. The application for reinstatement takes effect only after approval by the Department Chair or designee, Credentials Committee, MPLC and by the Board.

(f) Serious or Disabling Illness
Any member of the Medical Professional Staff or Allied Health Professional Staff who has suffered a serious or disabling illness may be requested by the Department Chief, Credentials Committee Chair, or Chief Medical Officer or his/her designee to have a medical or psychiatric evaluation prior to providing patient care. A member's health status must not impede his or her ability to care for patients. Members of the Medical Professional Staff shall not render care to any patient when the member is impaired either by the effects of medication or substance abuse or by physical or mental illness.

7.6.14 Resignation
A Practitioner who withdraws from membership in the Medical Professional Staff shall be deemed to have resigned in good standing, provided that such Practitioner has performed all Medical Professional Staff obligations, including completion of medical records.

7.7 Review by Outside Consultants

The Executive Committee, the Chief Medical Officer or designee and the Chief of the Medical Professional Staff may, through the Medical Professional Staff Administrator, obtain the services of a qualified consultant or consultants to review all or part of any application for appointment or reappointment to the Medical Professional Staff or perform all or part of any peer review or Performance Improvement activity as deemed appropriate.

Such review shall be advisory and the MPLC shall retain the responsibility for making appointment, reappointment, peer review or Performance Improvement recommendations as set.
forth in these Bylaws. The consultant or consultant activities shall be confidential and protected
to the same extent as if performed by the Medical Professional Staff.

ARTICLE VIII: CATEGORIES OF THE MEDICAL PROFESSIONAL STAFF

8.1 Membership Categories
The Medical Professional Staff is divided into five categories: Active, APC, Courtesy,
Administrative and Honorary. Staff membership is independent of privileging. Each member of the
Medical Professional Staff must identify a Primary Campus which will determine voting rights for
the member. This designation shall be made at the time of initial application and thereafter may be
revised no more than once per calendar year. Primary Campus designations revised after July 1 will
not take effect until December 31.

8.2 Active Category
Appointees to this category are Physicians, Dentists, Podiatrists or Oral and Maxillofacial Surgeons
who may or may not provide care for patients admitted to the Hospital and who assume all of the
prerogatives, functions, and responsibilities of this category. Although many primary care
Practitioners are performing little or no inpatient care, and subspecialists perform procedures in the
outpatient setting in offices or ambulatory centers versus Hospital, they are committed to the
mission of Swedish. This may be evidenced by fulfillment of at least two of the following five
criteria:

(a) Provision of patient care services (SMC is the primary facility for patient care)
   • admissions, consultations, referrals to SMC;

(b) Practice affiliation (groups with state-approved quality review plans);

(c) Attend 50 percent of Department meetings per calendar year;

(d) Serve on at least one Hospital committee (by definition, this requires 50 percent attendance
    for said committee) or on the Board of Governors;

(e) Maintained Active staff membership at Swedish for five consecutive years.

Active members are:

8.2.1 Eligible to vote in and hold office at the system and Primary Campus levels, and serve on
Medical Professional Staff committees;

8.2.2 Eligible to be included in Swedish physician referral programs;

8.2.3 Assigned to one specific Department;

8.2.4 Required to attend meetings as outlined in these Bylaws;

8.2.5 Required to provide emergency care and accept consultation assignments where
appropriate for those Practitioners with Privileges as described in Rules and Regulations;
8.2.6 Required to support and participate in the Medical Professional Staff’s continuing medical education, graduate medical education, and community health education programs;

8.2.7 Required to participate in quality management, performance improvement, peer review, care management, and other Medical Professional Staff peer assessment activities as required;

8.2.8 Required to pay dues established pursuant to these Bylaws; and

8.2.9 Required to carry professional liability insurance coverage.

8.3 APC Category
Appointees to this category are APCs who may or may not provide care for patients admitted to the Hospital and who assume all of the prerogatives, functions, and responsibilities of this category. APC members must be recommended by an Active Medical Professional Staff member.

APC members are:

8.3.1 Eligible to vote in and hold office at the system and Primary Campus levels, and serve on Medical Professional Staff committees as permitted by these Bylaws;

8.3.2 Eligible to be included in Swedish physician referral programs;

8.3.3 Assigned to the APC Department and one specific specialty Department;

8.3.4 Required to attend meetings as outlined in these Bylaws;

8.3.5 Required to provide emergency care and accept consultation assignments where appropriate for those Practitioners with Privileges as described in Rules and Regulations;

8.3.6 Required to support and participate in the Medical Professional Staff’s continuing medical education, graduate medical education, and community health education programs;

8.3.7 Required to participate in quality management, performance improvement, peer review, care management, and other Medical Professional Staff peer assessment activities as required;

8.3.8 Required to pay dues established pursuant to these Bylaws; and

8.3.9 Required to carry professional liability insurance coverage.

8.4 Courtesy Category
Appointees to this category are Practitioners who may or may not provide care for patients admitted to the Hospital and who assume all of the prerogatives, functions, and responsibilities of this category. They do not have to satisfy the other membership criteria as enumerated above for Active members. In order to qualify for this category, Practitioners must maintain Active membership status in the Medical Professional Staff of another hospital approved by the Board or, for those Practitioners whose specialty practice is primarily outpatient, be recommended by four peers, at least one of whom is an Active Staff member who can attest to the Practitioner’s quality of care. Exceptions to this policy are those Practitioners who were members prior to 1992 and who have
maintained continued membership through consecutive, uninterrupted reappointments. Courtesy members are:

8.4.1 Assigned to one specific Department;

8.4.2 Eligible to serve on Departmental and/or Medical Professional Staff Campus committees without the right to vote, unless otherwise specified in these Bylaws;

8.4.3 Not eligible to serve as a system-wide or Campus officer of the Medical Professional Staff or vote on matters before the Medical Professional Staff or Campus Medical Professional Staff;

8.4.4 Required to pay dues established pursuant to these Bylaws;

8.4.5 Required to carry professional liability insurance coverage;

8.4.6 Required to provide emergency care and accept consultation assignments where appropriate for those practitioners with privileges as described in Rules and Regulations;

8.5 Administrative Category
Appointees to this category are Practitioners who have full-time positions as administrators or academicians. Members in this category are:

8.5.1 Assigned to one specific Department, but have no privileges;

8.5.2 Not allowed to consult, treat, or admit patients and may not document in patient records;

8.5.3 Eligible to serve on Departmental and/or Medical Professional Staff committees in an Ex-Officio capacity;

8.5.4 Permitted to participate in investigative and/or research activities;

8.5.5 Not eligible to serve as a system-wide or Campus officer of the Medical Professional Staff or vote on matters before the Medical Professional Staff or Campus Medical Professional Staff;

8.5.6 Required to pay dues as established pursuant to these Bylaws;

8.5.7 Required to carry professional liability insurance coverage unless not engaged in clinical practice.

8.6 Honorary Category
Appointees to this category are retired Medical Professional Staff members who have either served at least 20 years on the Active or APC staff or who have otherwise distinguished themselves as outstanding Practitioners, educators, researchers, or administrators. Honorary members are:

8.6.1 Appointed by the Board on recommendation of the MPLC;

8.6.2 To have no required duties or Privileges;
8.6.3 Not allowed to consult, treat, admit patients, or assist in surgery and may not write in patient records;

8.6.4 Not eligible to hold office in the Medical Professional Staff;

8.6.5 Eligible to sit in an Ex-Officio capacity on Medical Professional Staff committees unless otherwise stated;

8.6.6 Not required to pay dues; and

8.7 Residents and Fellows
Swedish Medical Professional Staff participate in postgraduate medical education training for residents and fellows through formal programs sponsored by Swedish Medical Center and affiliated programs from other institutions. All fellowship and residency training is overseen by the Graduate Medical Education Committee. The Program, Fellowship, or Training Director for each approved area of training must be an Active staff member of the Medical Professional Staff.

Residents and Fellows have no Medical Professional Staff rights or Privileges unless qualified through application to Medical Professional Staff membership with specific Privileges based on meeting specialty qualification from prior training (Medical Professional Staff Fellows). Residents and Fellows are subject to the GME Appeal Process and shall have no Review Hearing rights.

The attending supervising Physician has responsibility for patient care (See Rules and Regulations, Sec. XVIII). The trainee may enter information into the medical record. Documentation completion is the responsibility of the Medical Professional Staff member.

ARTICLE IX: MEMBER RIGHTS

9.1 Member Rights
The rights of each member of the Medical Professional Staff include, but are not limited to the following:

9.1.1 Right to Meet with Medical Professional Staff Leadership
A Medical Professional Staff member has the right to meet with Medical Professional Staff Officers and/or Department leadership. If the issue or concern cannot be resolved, the member may meet with the MPLC upon written request to the System Chief of Staff.

9.1.2 Right to Initiate a Petition
An Active and/or APC Medical Professional Staff member has the right to initiate a petition to:

(a) Recall his/her Department Chair;

(b) Recall a Medical Professional Staff Officer;

(c) Establish, modify, or delete any rule, regulation, or policy;

(d) Submit a proposed amendment to the Bylaws;
(e) Call for a special meeting of the Medical Professional Staff;

(f) Call for a special meeting of the member’s Department or Division;

(g) Recall any action of the MPLC, except those relating to Department and committee reports and relating to Privileges.

(h) Call an election of the Medical Professional Staff on the question of unification of Swedish medical staffs or the dissolution of an existing unified Medical Professional Staff, as permitted by law.

9.1.3 Right to Communicate with the Board
A Medical Professional Staff member may communicate with the Board on a rule, regulation or policy adopted by the organized Medical Professional Staff or the MPLC. This may be initiated by a written request to the Board chair who will determine the method of communication.

9.1.4 Petition
A petition requires the signatures of 25 members of the Active and APC Medical Professional Staff, except petitions to recall a Department or Division chief, which requires the signatures of 10 percent of the Department or Division or 25 Active and/or APC members, whichever is less. The petition may be submitted to the MPLC for consideration at their next meeting. In a case in which there is a Department or Division Chief recall, the petition must be submitted to the MPLC.

9.1.5 Right to a Review Hearing
The right to a Review Hearing and appeal in accordance with these Bylaws in the event of the following actions or recommendations by the MPLC:

(a) Denial, restriction, suspension, termination, revocation, or non-renewal of Medical Professional Staff membership and/or Privileges due to an investigation;

(b) Failure to advance a Medical Professional Staff member from Provisional status to full Courtesy, APC or Active membership status after 24 months;

(c) Reduction of an Active Medical Professional Staff member to the Courtesy category, unless reduction is a result of the member’s failure to meet the requirements of Section 8.2;

(d) Imposition of mandated additional training that causes interruption in the Medical Professional Staff member’s practice of greater than 30 days.

9.1.6 Right to Representation
The Medical Professional Staff shall be represented in any Hospital deliberation affecting the discharge of Medical Professional Staff responsibilities.
ARTICLE X: QUALITY IMPROVEMENT

10.1 Performance Improvement

10.1.1 Purpose
The Medical Professional Staff of Swedish supports the provision of quality clinical services through review of the ongoing performance improvement activities. These activities include results, findings, and conclusions of the individual peer review cases, focused peer review for a group of cases, and department or system performance improvement activities. Peer review and performance improvement findings are considered in performance evaluation, credentialing, and privileging.

The Medical Professional Staff has a leadership role in the organization’s performance improvement activities. When the performance of a process is dependent on the activities of one or more individuals with Privileges, the Medical Professional Staff provides leadership for the process measurement, assessment and improvement activities.

These processes include, but are not limited to, assessment and treatment of patients, education of patients and family, and coordination of care; medication management oversight; infection control oversight; blood and blood components; operative and other procedures; medical record review for timely, accurate and legible entries; autopsy assessment; significant departures from established patterns of practice; tissue review; utilization review; and quality management system.

Individual cases or concerns are reviewed as needed based on incident or variance reporting. Should there be a need to assess the performance or competency of an individual, a focused review of Practitioner performance will be initiated. For broader issues, evaluation and improvement of processes and outcomes will be used to impact performance improvement.

10.1.2 Authority
The Board delegates authority to the MPLC for the administration and oversight of the performance improvement processes and activities of Practitioners. Authority for directing activities and participation in the Peer Review and Performance Improvement activities is delegated to the PROC. The PROC is authorized to provide oversight of the performance improvement function and focused review activities as outlined in these Bylaws. Reports and recommendations from these activities shall be prepared and shared with the MPLC and the Board.

10.1.3 Ongoing Performance Improvement Data
Practitioner specific performance data is collected and compared to peer or national data available. This information is provided in regular reports to the Medical Professional Staff member and is used as part of the reappointment process. Variations are reviewed for statistical significance. Areas to be measured include, but are not limited to:

(a) Blood Use: AABB transfusion criteria;
(b) Prescribing of Medications: Prescribing errors and appropriateness of prescribing for Drug Use Evaluations;
(c) Surgical Case Review: appropriateness and outcomes for selected high-risk procedures;
(d) Specific Department/peer review indicators that have been defined by the Medical Professional Staff;
(e) Moderate Sedation Outcomes;
(f) Appropriateness of care for non-invasive specialties;
(g) Utilization Data;
(h) Significant deviations from established standards of practice; and
(i) Timely and legible completion of patients’ medical records.

10.1.4 Performance Indicators for Case Review
In addition to cases or concerns identified through the reviews discussed in Section 10.1.3, the Medical Professional Staff Departments and PPRCs will identify indicators and criteria for review of patient care activities.

10.1.5 Scope
All Practitioners will be subject to the requirements outlined in these Bylaws for peer review, focused peer review, and monitoring of Practitioner performance.

10.1.6 Regulation
It is desirable that quality concerns are resolved within the Medical Professional Staff and that Practitioners at the Hospital work through the established quality committee structures. However, any Practitioner who has concerns about accreditation issues or the safety or quality of care provided in the Hospital may report these concerns to applicable regulatory or accreditation agencies and will not be subject to disciplinary action for making such a report. Additionally, any Practitioner who in good faith communicates a complaint or information alleging quality of care concerns to the Washington State Department of Health in accordance with state law will not be subject to reprisal or retaliatory action.

10.1.7 Reporting
The PROC will provide an annual report to the MPLC, Quality and Safety Committee and Board Quality Committee on the professional peer review committees’ activities including case volumes, categories, behavioral concerns and indicators.

10.1.8 Quality and Safety Committee
When issues are identified that involve systems-oriented quality concerns and require multidisciplinary input, the PROC may recommend that the issue be brought to the Quality and Safety Committee for discussion. The Quality and Safety Committee may opt to sponsor a multi-disciplinary quality improvement effort to address the issue.
10.2 Organization

10.2.1 Professional Peer Review Committees
Quality review activities are performed by the professional peer review committees identified in the Organization and Functions policy. Ad hoc committees may be designated by the MPLC as needed.

10.2.2 Responsibilities

(a) System Chief of Staff: The System Chief of Staff is responsible for ensuring that the Practitioners meet their requirement in peer review and performance improvement activities.

(b) MPLC: The MPLC is responsible for performance improvement of the professional services provided by all Practitioners. The MPLC is responsible for action or recommendations for action based upon the findings and conclusions of the PROC.

(c) Professional Review Oversight Committee (PROC): The PROC functions as the quality sub-committee of MPLC and assures that performance improvement and focused review activities and functions are carried out in a timely and responsible manner and in compliance with requirements as outlined in the Medical Professional Staff Rules and Regulations and policies and the most current standards of applicable regulatory or accreditation agencies. System issues are referred to the Quality and Safety Committee for resolution with responsibility for reporting to the PROC.

(d) Professional Peer Review Committees: The professional peer review committees (PPRCs) conduct peer review and focused review, review applicable performance data, report conclusions, and make recommendations to the PROC. Professional peer review committees assure completion of individual and focused review of Practitioner performance and recommend action to the PROC.

10.3 Policies and Procedures of the Quality Improvement Program

10.3.1 Conflict of Interest
A Practitioner may not be involved in the determination of appropriate care when that individual’s patient case or cases are under review. Any member of the PROC or PPRC must be recused during any review of care in which the Practitioner was involved.

Peer review may result in Practitioners reviewing care provided by their practice partners or relatives. These relationships do not necessarily require a committee member to recuse him/herself from participation in the review. It is the obligation of committee members to act in an unbiased manner. However, in order to avoid actual or perceived conflicts of interest, a committee member must disclose to the committee chair if a Practitioner under review is a relative or practice partner of the committee member. The chair of the committee will review the facts and may excuse a committee member from participation in the review.

10.3.2 Confidentiality of Information

Bylaws 70
Swedish Medical Professional Staff
All files, information, materials, documentation and discussions related to review activities are privileged and confidential in accordance with applicable federal and state law, including the Health Care Quality Improvement Act of 1986. Confidentiality is essential to the effective functioning of peer review and quality improvement activities. Candid participation by Practitioners is required. The proceedings, reports and written records of professional peer review committees and other committees that evaluate professional competency or review the quality of patient care, together with the records pertaining to such matters of Swedish Health Services and of those employees of Swedish Health Services who serve such committees and panels as staff persons, shall be in the possession and control of the CE or designee.

The CE or designee shall preserve, to the fullest extent permitted by law, the confidentiality of all such information and material which shall be used and released only in the manner and for the purposes described in these Bylaws to evaluate professional competency and qualifications, including limiting the extent of practice of persons in the Hospital, and to review and evaluate the quality of patient care. Unauthorized release or disclosure of such information and materials by a Practitioner shall be grounds for corrective action.

In addition, and not by way of limitation, it is intended that all information and documents, including complaints and incident reports, created, collected and maintained about health care providers arising out of matters that are subject to evaluation by any review committee conducting quality reviews shall be maintained and protected from unauthorized disclosure as provided in this subsection to the fullest extent permitted by law.

10.3.3 Access to Quality/Peer Review Information

Peer review and individual performance improvement information is confidential and available only to authorized individuals who have a legitimate need to access such information; and only the extent necessary to conduct their assigned responsibilities.

(a) Notwithstanding Article XI of these Bylaws, a Practitioner may review his/her Quality/Peer Review Information, redacted version (if applicable), in the presence of Medical Professional Staff Office personnel; provided that, the Practitioner may not take the Quality/Peer Review Information outside of the Medical Professional Staff Office nor may the Practitioner make photos or copies of such information.

10.3.4 Record Retention

Retention of peer and focused review information will be in compliance with state and federal requirements and consistent with established policies. Information is archived in a secure manner for the duration of the Practitioner’s membership and/or credentialled period plus 50 years.

10.3.5 Individual Confidentiality Requirement

All those involved in peer review, focused review and evaluation of performance will hold information in strict confidence and make no voluntary disclosures of such information. Each person will sign a confidentiality statement agreeing to abide by Medical Professional Staff Bylaws, Rules and Regulations, policies, and Hospital Standards.
10.4 Peer Review

10.4.1 Medical Professional Staff Performance Improvement Staff Role
Swedish provides staffing to support the Medical Professional Staff committees conducting peer reviews and focused reviews through the quality review committees. Referrals are forwarded to Medical Professional Staff performance improvement coordinators in the office of Medical Professional Staff Services. The coordinator is responsible for initial research and collection of information for the appropriate QRC.

10.4.2 Quality Variance Report

(a) A possible or potential problem with individual Practitioner performance may be identified and referred for peer review through identification of:

(1) A significant departure from established patterns of practice.

(2) A sentinel event as defined by applicable regulatory or accreditation agencies.

(3) A reviewable event or reportable event as outlined by Hospital Standards in accordance with regulatory requirements.

(4) A potential risk management issue relating to Practitioner performance.

(5) A concern or issue related to performance of quality care identified by a department chair, MPLC, System Chief of Staff, or the CE. Any Practitioner may refer a case through a department chair, the CE, or the System Chief of Staff.

(6) Care which may be non-compliant with expected standards of care as identified by failure to pass defined clinical indicators.

(7) Any concerned individual.

(b) The source of the Quality Variance Report is not disclosed to the Practitioner being reviewed.

10.4.3 Documentation
All cases referred for peer review are documented on the Referral Case Review / Focused Review Summary Form by the Medical Staff Performance Improvement Department coordinator prior to inclusion on the MPSQOC agenda. Completed reviews are filed in the Practitioner’s quality/peer review file.

10.4.4 Case Review Preparation
Before each QRC Meeting, the following steps will happen for each case referred to the Medical Staff Performance Improvement Office.

(a) PI coordinator prepares the initial Peer Review Referral Form and contacts the appropriate QRC chair to assign a reviewer.
(b) The QRC chair may determine that an issue does not have a quality concern which merits review by the QRC or the chair may send a letter identifying improvement opportunities to the Practitioner without review by the QRC. All of the chair’s out-of-committee determinations will be reported at the next QRC meeting.

(c) QRC chair or designee reviews case and develops questions for the Practitioner(s). A letter of inquiry (LOI) is sent to the Practitioner with these questions. The Practitioner is given 10 working days to respond to the LOI.

(d) If a Root Cause Analysis has been conducted, the reviewer includes this information for consideration.

(e) PI coordinator schedules the case review for the next QRC meeting.

(f) All determinations will be reported to the MSQOC.

10.4.5 QRC Meeting Review

The initial QRC meeting is held and the case is reviewed by the committee as a whole. The reviewer presents findings to QRC using a generic reference in lieu of the individual Practitioner’s name.

(a) The case is presented to the QRC by the reviewer. The blinded letter of inquiry (with the reviewer’s questions) and the Practitioner’s response letters are provided to the QRC for review. If the QRC is satisfied it has enough information to make a decision, the QRC makes a final determination at the first QRC meeting. If the QRC has additional questions, a second letter of inquiry is sent to the Practitioner.

(b) The QRC may request additional information or data to be collected by the PI coordinator.

(c) If the QRC sent a second letter of inquiry, the original reviewer is contacted to review the response letter when it is received.

(d) In addition to the written response, the Practitioner(s) may request or be invited to attend the next monthly QRC meeting to discuss the case.

10.4.6 Next QRC Meeting

If the QRC sent a second Letter of Inquiry, the case is again placed on the QRC agenda. The QRC assigns the final determination and action needed after presentation of the additional information obtained in writing from the Practitioner or during the interview process at the QRC meeting. If the Practitioner declines to submit written information and/or to participate in the second QRC meeting, the committee will assign a determination based on the information available.

The actions of the QRC are reported at the next MPSQOC meeting.

10.4.7 Findings and Evaluation Categories

The QRC will reach a conclusion based upon assessment of the medical care, peer judgment, documentation and compliance with accepted medical standards and
departmental policies. Sources may include but are not limited to: published standards of care, organizational policies, regulatory requirements, and Medical Professional Staff policies. The conclusion may result in the assignment of an opportunity for improvement determination. The determination will indicate the action to be taken by the QRC. See Exhibits 1 and 2: Swedish Medical Professional Staff Opportunities for Improvement Structure.

Findings from review of performance indicators and peer review activities are included in the Practitioner quality/peer review file used in the reappointment process.

The QRC findings may result in an educational plan for performance improvement, a performance improvement plan (PIP) which requires the approval of the MSQOC. If a Practitioner has a history of failed PIPs, or if the QRC has serious concerns regarding significant improvement opportunities for the Practitioner, the case may be forwarded to the MPLC. The MPLC may recommend a privilege-related Corrective Action Plan. The MPSQOC and MPLC must review and approve the Corrective Action Plan.

10.4.8 Practitioner Appellate Process (Peer Review Evaluation and Restriction of Privilege) Performance Improvement at the QRC level is considered educational and appeals are not granted.

10.5 Focused Professional Practice Evaluation

10.5.1 Should a number of cases come before a QRC concerning a specific Practitioner, the QRC may decide to conduct a focused case review. This review would include specific types of cases to be monitored over a designated time period based on criteria established by the QRC. Information for focused case review may include, but is not limited to, chart review, clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient (e.g., consulting Physicians, assistants at surgery, nursing or administrative personnel).

10.5.2 Trigger for the focused review of an individual practitioner may include:

(a) One or more cases receiving a peer review determination of significant improvement opportunities;

(b) A sentinel event in which a significant concern about Practitioner involvement or performance is raised; or

(c) A pattern of activities or quality variance reports is brought to the Department Chief or medical director.

10.5.3 All referrals for focused review will be forwarded to the appropriate QRC with documentation to include the medical record(s) and a statement of the reason for referral.

(a) The Practitioner will not appear before the QRC at the initial review of the focused review findings.

(b) The QRC chair will send a written request for the involved Practitioner to respond within 10 days. Additional time may be granted based on the volume of cases to be reviewed.
(c) The Practitioner is invited to the QRC.

(d) The QRC will review the response and assign a determination to the cases reviewed.

(e) The QRC will recommend action based on the Opportunities for Improvement Structure to MPSQOC and the MPLC.

10.6 Review Period
Each case submitted for peer review will require approximately 90 days for review. Should there be several cases for the same Practitioner, a focused review may be established and the review period may be extended. When a focused review is established, the QRC chair will report the activity plans and status to the MPSQOC.

10.7 External Peer Review

10.7.1 Considerations
Based upon the information reviewed and/or the assigned determination, the QRC may request to the MPSQOC, System Chief of Staff, Medical Administrator or CE/designee that a case be referred for external peer review. Instances in which external peer review may be beneficial include:

(a) Review of care within a specialty when there are not a sufficient number of eligible reviewers, and in the opinion of a QRC, additional expertise is needed in order to come to a conclusion.

(b) Situations which appear to require an external opinion to ensure objectivity; or the opinion of an unbiased “expert” would be considered beneficial.

(c) Reviews in which there is a serious conflict in conclusions or lack of consensus by internal reviewers.

(d) When the Medical Professional Staff needs an expert opinion or witness as part of establishing a benchmark for quality monitoring, or participating in a corrective action investigation, or for a fair hearing and appeals process.

(e) Reviews in which no Medical Professional Staff members without a conflict of interest can be identified.

(f) When a Practitioner requests permission to use new technology or perform a procedure new to the Hospital that is a radical departure from current medical practices and the Medical Professional Staff does not have the necessary subject matter expertise to evaluate adequately the quality of care involved.

10.7.2 Actions
The MPSQOC, System Chief of Staff, Medical Administrator or CE/designee may approve the request and identify any parameters, to include budgetary limitations and time expectations, or deny the request and outline expectations for further action.
10.7.3 Selection
If approved by the MPSQOC, System Chief of Staff, Medical Administrator or CE/designee, management and oversight of the external review process will be the responsibility of the Medical Staff PI Department. Potential reviewers will be identified by, and acceptable to the chair of the involved QRC, the Chief of Staff and the Department Chief of the involved Practitioner. When identifying potential reviewers, consideration will be given to experience and knowledge of peer review process, competence in standards to include access to local, state and national information, and knowledge of statistics as appropriate. The reviewer(s) may not be a member of the Medical Professional Staff of Swedish and must state that he/she has no knowledge of or connection with, the Practitioner being reviewed. Verification should be received indicating that the reviewer(s) has training, education and experience equivalent to, or greater than, that of the involved Practitioner. The reviewer(s) must be willing to sign a confidentiality statement, provide written conclusions within a specified time frame, and agree to discuss and defend his/her conclusions should Review Hearing or litigation ensue.

10.7.4 Process
Whenever possible, the external reviewer will complete the review on site. If this is not feasible, records will be photocopied, forwarded, and returned via registered mail, or other secure method with signature required. Records to be reviewed will be identified by the chair of the involved QRC and will include, but not be limited to, an overall sample of similar cases treated by the Practitioner and specific records representative of the issue, problem, question or concern. The external reviewer will provide a written analysis marked privileged and confidential to the respective QRC and the MPSQOC.

10.7.5 Chart Completion
Following the case review by the external reviewer, the QRC will complete the evaluation process for the individual case and notify the Practitioner of the final determination assigned.

10.8 Conclusions
Each QRC will forward quarterly reports of findings and conclusions related to performance to the MPSQOC. The MPSQOC reports this information to the MPLIC which will forward appropriate information to the Board.

Action by the MPLIC may include, but not limited to:

(a) Authorizing additional investigation and/or request for external Peer Review

(b) Requiring continuing education and/or training

(c) Overseeing revision of Medical Professional Staff policy and procedure(s) authorized by the Bylaws

(d) Recommending system or process review and revision via quality review committee, ad hoc or subcommittee

(e) Approving, developing, or evaluating a corrective action plan
(f) Conducting a Review Hearing process.

Any action taken by the MPLC will be within the requirements of these Bylaws and provisions for Review Hearing. In any situation where it appears that a disciplinary proceeding may be initiated against a Practitioner that could result in the substantial loss or termination of his/her Privileges, the advice and guidance of legal counsel should be sought by those persons who are involved in this phase of the Peer Review process. Recommendations that result in an adverse action against a Practitioner will invoke Article XI of these Bylaws.

Findings and/or actions from any peer review related activities shall be included in the Practitioner’s file(s) used in the reappointment process.

10.9 Proctoring

There are four types of proctoring:

10.9.1 Prospective proctoring is a review by the proctor of either the patient’s chart or the patient personally before treatment. This type of proctoring may be used if the indications for a particular procedure are difficult to determine or if the procedure carries a high risk.

10.9.2 Concurrent proctoring is when the proctor actually observes the Practitioner’s work. This is usually used for invasive procedures so that the Medical Professional Staff has first-hand knowledge necessary to satisfy itself that the physician is competent.

10.9.3 Retrospective proctoring involves a retrospective review of patient charts by the proctoring Physician. Retrospective review is usually adequate for proctoring of noninvasive procedures.

10.9.4 Off-site Proctoring requires documented evidence of proctoring from an area hospital. This may be permitted when the skills and current competence of the practitioner in question are known to members of the Medical Professional Staff. It is up to the Department Chief to make a recommendation related to the use of off-site proctoring for a specific Practitioner situation.

ARTICLE XI: DISCIPLINARY AND REVIEW HEARING

11.1 Right to Review Hearing

When a Medical Professional Staff member receives notice of an Adverse Recommendation of the MPLC, the Medical Professional Staff member shall be entitled to a Review Hearing before a hearing committee of the Medical Professional Staff. All such Review Hearings shall be in accordance with the procedural provisions set forth in this Article XI.

11.2 Limitation on Review Hearings

Notwithstanding any other provision of these Bylaws, no Medical Professional Staff member shall be entitled as a right to more than one Review Hearing pursuant to this Article XI in connection with any matter which shall have been the subject of an Adverse Recommendation. Any such entitlement may be waived as provided in these Bylaws, and failure to accept any Special Notice prescribed in these Bylaws shall constitute receipt thereof.

11.3 Non-Adverse Actions
All recommendations by the MPLC for actions other than those defined in these Bylaws as Adverse Actions shall be Non-Adverse Actions for which the Practitioner shall have no rights to a Review Hearing (Medical Professional Staff member) or Review Procedure (AHP), unless the Board fails to sustain the MPLC’s recommendation. In such event, the Board shall send Written Notice to both the Practitioner and the MPLC.

Actions that are not grounds for a Review Hearing (Medical Professional Staff member) or Review Procedure (AHP) include, but are not limited to, the following. No suit shall ever be commenced or maintained by a Practitioner with respect to any such matter:

11.3.1 Letters of warning, admonition, censure or reprimand; the Practitioner shall have the right to have a letter of response no longer than three pages appended to the Practitioner’s file if delivered to the Chief Medical Officer within 10 days of receipt of the letter of warning, admonition, or reprimand;

11.3.2 The imposition of probation or monitoring;

11.3.3 The imposition of requirements for additional training that does not cause an interruption in the Practitioner’s practice;

11.3.4 Requirements for consultation or conditions of probation in connection with the exercise of any Privileges;

11.3.5 Automatic relinquishment of Privileges or termination of Medical Professional Staff membership as provided in these Bylaws;

11.3.6 Denial, termination or reduction of temporary or emergency Privileges;

11.3.7 Denial of transfer from provisional staff to active or courtesy staff and denial of reappointment to the Medical Professional Staff for lack of sufficient Patient Contacts;

11.3.8 Deeming an application for initial appointment to the Medical Professional Staff incomplete pursuant to Section 7.6.1 of these Bylaws;

11.3.9 Deeming a staff reappointment application incomplete because of failure to complete and timely return an application for reappointment or interval information form;

11.3.10 Denial of staff reinstatement following leave of absence because of failure to timely request reinstatement or provide a statement of activities and completed current interval information form;

11.3.11 Assignment to a specific department;

11.3.12 The imposition of a Corrective Action Plan;

11.3.13 When the Practitioner voluntarily resigns Medical Professional Staff membership and surrenders Privileges;

11.3.14 When the applicant fails to achieve eligibility for an application to the Medical Professional Staff or to meet eligibility requirements for Medical Professional Staff membership and/or Privileges.
11.4 Disciplinary Action

11.4.1 Overview
Pursuant to the Bylaws, this Section 11.4 shall set forth the methods for enforcing clinical standards of practice in the Hospital for all Practitioners. The Medical Professional Staff is expected to comply with the acceptable standards of practice.

(a) Voluntary agreement is the preferred method of resolution through professional/Peer Review under these Bylaws in such a manner that the use of procedures designed to enforce such compliance does not become necessary. Voluntary resolution may not result in affording the Practitioner any Review Hearing (Medical Professional Staff member) or Review Procedure (AHP) rights.

(b) Request for Corrective Action is appropriate for conduct requiring improvement, but not requiring immediate action due to concern for potential imminent danger to a patient or others.

(c) Summary Suspension is appropriate for conduct requiring immediate action in order to avoid potential danger to a patient or others.

(d) Precautionary Restriction of Privileges is appropriate to allow time to review and address potentially serious conduct or quality concerns.

(e) Automatic Relinquishment applies when an event in and of itself disqualifies a Practitioner from exercising Privileges. In this situation, removal of Privileges also results in automatic relinquishment of Medical Professional Staff membership.

11.4.2 Adverse Actions
Only the following actions, if recommended by the MPLC and approved by the Board, shall be defined as Adverse Actions entitling a Practitioner to exercise or waive his/her right to a Review Hearing (Medical Professional Staff member) and Review Procedure (AHP) in accordance with the applicable processes defined in these Bylaws.

(a) Denial, suspension, restriction, revocation, or non-renewal of Privileges or Medical Professional Staff membership due to an investigation;

(b) Failure to advance a Medical Professional Staff member from Provisional status to Courtesy, APC or Active membership status after 24 months;

(c) Reduction of an Active Medical Professional Staff member to the Courtesy category unless such is as a result of the member’s failure to participate in the required minimum Patient Contacts or is in response to the member’s request; or

(d) Imposition of mandated additional training that causes interruption in the Practitioner’s practice for a period of 30 days or more.

11.4.3 Request for Corrective Action
Whenever the activities or professional conduct of any Practitioner with Privileges are considered to be lower than the standards or aims of the Medical Professional Staff or that undermines a culture of safety, collegial efforts may be attempted to try to resolve
the issue. If such collegial intervention fails, the matter may be referred to an officer of the Medical Professional Staff, the Chief of any clinical Department, the Chair of any standing committee of the Medical Professional Staff, the CEO, Medical Administrator, or any member of the Board. The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and if so, shall forward it as a Request for Corrective Action in writing to the MPLC. This request shall be supported by specifying those activities or conduct that constitutes grounds for the Request.

(a) Notice to Practitioner and CEO
The MPLC shall promptly give Written Notice to the affected Practitioner and also notify the CEO in writing of all Requests for Corrective Action and keep each fully informed during the process.

(b) Investigation of a request for Corrective Action
At the next meeting of the MPLC, the System Chief of Staff will present the Request for Corrective Action. The MPLC may:

(1) Refer the matter to an ad hoc professional review committee to initiate a formal investigation in order to discover the true and accurate facts; or

(2) Refer the matter back to the Department Chief, PROC, or a professional peer review committee for further information.

In making its determination, the MPLC may discuss the matter with the affected Practitioner.

The reviewing committee to which the matter is referred shall report back to the MPLC at its next regularly scheduled meeting unless otherwise stated below.

If the recommendation for Corrective Action is referred to an ad hoc professional review committee for investigation, that committee shall forward its Written Report, findings, and recommendation to the MPLC within 45 days after receipt of the recommendation for Corrective Action. This may be postponed if mutually agreed upon by the Practitioner being investigated and the ad hoc professional review committee.

(c) Interviews
Prior to making its report to the MPLC, the reviewing committee shall afford an interview to the Practitioner for whom Corrective Action has been requested. At such interview, the Practitioner shall be informed of the nature of the charges against him/her and shall be invited to discuss, explain, or refute them. This interview shall not constitute a Review Hearing (Medical Professional Staff member) or Review Procedure (AHP), but shall be preliminary in nature and shall not be conducted according to the procedural rules provided in these Bylaws for Review Hearings; neither the Practitioner nor the reviewing committee shall be represented by an attorney at the interview. A record of the interview shall be made by the reviewing committee and included with its report to the MPLC.
(d) MPLC Action
The MPLC shall make a Written Report to the Board concerning the recommendation for Corrective Action within 30 days following receipt of the reviewing committee's investigation report. Such report may include, but shall not be limited to the following recommendations:

1. Denial of the recommendation for Corrective Action;
2. Issuance of a warning;
3. Resolution by agreement;
4. Any of the Adverse Actions defined in these Bylaws.

(e) Procedural Rights
Any recommendations by the MPLC defined under Adverse Actions in these Bylaws shall entitle the Practitioner to the Review Hearing rights (Medical Professional Staff member) or Review Procedure (AHP).

(f) Other Rights
If the MPLC’s recommended action is as provided in the above Section 11.4.3(d) (1), (2) or (3), such recommendation together with all supporting documentation shall be provided to the Board and to the Practitioner. The Practitioner shall have no Review Hearing rights (Medical Professional Staff member) or Review Procedure (AHP) rights with respect to these recommendations unless the Board disagrees with the MPLC’s recommendation, in which case, the Board may direct that there be a Review Hearing (Medical Professional Staff member) or Review Procedure (AHP).

(g) Failure to Comply
In the event a Practitioner fails to comply with a recommended Corrective Action, he/she will be placed on Automatic Relinquishment from exercising any Privileges. Any Practitioner who remains on Automatic Relinquishment for a period of greater than 30 days for noncompliance with a Corrective Action shall be terminated from the Medical Professional Staff. Such termination is reportable to the National Practitioner Data Bank (NPDB).

11.4.4 Summary Suspension Procedures

(a) Whenever action is necessary to prevent imminent danger to the health of any individual as a result of the action of a Practitioner, or in the event that a Practitioner willfully disregards the requirements of Medical Professional Staff Bylaws, Rules and Regulations, policies or other significant Hospital policies, or whenever a Practitioner's conduct requires that action be taken to reduce the substantial likelihood of injury or damage to the health or safety of any individual, the System Chief of Staff, Campus Chief of Staff, the MPLC, the Medical Administrator/designee, a Department Chief, the CE or a member of the Board, each shall have the authority to summarily suspend all or any portion of the Privileges of a Practitioner. Such Summary Suspension shall become effective immediately upon imposition. A Written Report describing with particularity the circumstances resulting in any such Summary Suspension and
the degree by which the Privileges of the affected Practitioner have been reduced shall be sent by Special Notice to the affected Practitioner and filed with the System Chief of Staff and the Medical Administrator. The emergency room and the admitting office shall be notified of any such Summary Suspension as soon as reasonably possible.

(b) Immediately upon the imposition of a Summary Suspension, the System Chief of Staff, Campus Chief of Staff, or responsible Department Chief or Section Chief shall have authority to provide for alternative medical coverage for the suspended Practitioner’s patients in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative Practitioner where feasible.

(c) Pending consideration and a recommendation by the MPLC regarding a Summary Suspension, or pending a final decision thereon, the affected Practitioner may request that the suspension be made voluntary upon such terms and conditions as may be acceptable to the System Chief of Staff. If such an agreement is reached by them, it shall be written, signed by both and become effective at once for the temporary period involved unless sooner rescinded by the System Chief of Staff as may be done at any time at the System Chief of Staff’s discretion, without cause or notice, and thereby reinstate immediately the Summary Suspension then in effect.

(d) PROC Investigation and MPLC Action
Within seven days after a Summary Suspension has been imposed, the PROC shall review and consider the suspension and decide that either (a) the suspension be removed (with or without conditions) or (b) the suspension be kept in effect during further investigation. The person who has imposed the Summary Suspension shall be advised of the PROC’s recommendation. If the Summary Suspension is removed, the PROC shall forward its Written Report of the investigation to the MPLC within 30 days of the imposition of the Summary Suspension. If the Summary Suspension remains in effect, the PROC shall forward its Written Report of the investigation to the MPLC within 14 days of the imposition of the Summary Suspension.

If the Summary Suspension remains in effect, the MPLC shall meet and take appropriate action within 30 days of the imposition of the Summary Suspension, in which case, the MPLC shall consider the matter at its next regular meeting. The MPLC may (a) terminate the Summary Suspension, (b) recommend to the Board that the Summary Suspension be modified or continued, and/or (c) recommend that Corrective Action be taken.

(e) Procedural Rights
If the MPLC recommends upholding a Summary Suspension (with or without modification) and/or recommends imposition of any of the Adverse Actions provided for in these Bylaws, the Practitioner shall be entitled to a Review Hearing (Medical Professional Staff member) or Review Procedure (AHP) and the MPLC shall provide the required Written Notice. Unless the MPLC recommends otherwise, the terms of the Summary Suspension shall remain in effect pending a final decision by the Board provided, however, that the Board
summarily require the Summary Suspension to remain in effect (with or without modification).

11.4.5 Precautionary Restriction of Privileges

(a) When a specific event, a pattern of events, or any event that may lead to a recommendation by the MPLC that would entitle the individual to request a Review Hearing (Medical Professional Staff member) or Review Procedure (AHP) arises which is/are not deemed necessarily serious enough to mandate Summary Suspension but may disrupt the orderly operation of the hospital or impact patient care with potential imminent harm, any one of the Board, the Board chair or designee, the MPLC, CE, System Chief of Staff, System Chief of Staff-Elect, Campus Chief of Staff, Department Chief, Section Chief, or the Medical Administrator/designee, may impose a precautionary restriction of any or all of the Practitioner’s privileges in order to allow time to determine whether more formal action or investigation should be undertaken. When possible, prior to the imposition of a precautionary restriction, the person(s) considering the restriction will meet with the individual and review the concerns. The Practitioner may propose ways other than precautionary restriction to protect patients, employees or the orderly operation of the hospital.

(b) A precautionary restriction will take effect immediately upon imposition and may be for a period not to exceed 14 days and will remain in effect unless modified by the CE or MPLC. Any extension of the precautionary restriction beyond 14 days must be recommended by the MPLC.

(c) There is no right to a Review Hearing (Medical Professional Staff member) or Review Procedure (AHP) based on the imposition or continuation of a precautionary restriction.

(d) A precautionary restriction does not imply any final finding on the merits of the issues.

(e) The person imposing the precautionary restriction shall immediately notify the CE, System Chief of Staff and Campus Chief of Staff who shall promptly notify the Practitioner and the respective Department Chief to which the Practitioner is assigned.

(f) A precautionary restriction is an interim step in the professional review activity and does not constitute a final professional review action in and of itself. It will not imply any final finding of responsibility for the situation that caused the restriction and is not reportable to the NPDB. Under no circumstance shall a precautionary restriction extend beyond 29 days.

(g) Investigating Body
The MPLC or System Chief of staff may conduct an investigation about the concern in question, or may assign the task to an appropriate Medical Professional Staff Committee, or outside reviewer(s). The System Chief of Staff shall determine that the individual(s) conducting the investigation is not in direct economic competition with the Practitioner under investigation.
(h) Investigation Process
The investigating body may, but is not obligated to, conduct interviews with persons involved; however, this investigation shall not constitute a Review Hearing (Medical Professional Staff member) or Review Procedure (AHP) as that term is used in these Bylaws, nor shall the procedural rules with respect to Review Hearings (Medical Professional Staff member) or Review Procedure (AHP) apply. The investigating body shall provide a written report of its investigation to the MPLC as soon as practicable. The report may include recommendations for appropriate further measures or corrective action.

(i) MPLC Authority During Investigation
Regardless of the status of any investigation, the MPLC shall retain authority and discretion at all times to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigation process, or other appropriate action.

(j) MPLC Action or Recommendation
As soon as practicable after the conclusion of the investigation, the MPLC shall take action or make recommendations, which may include without limitation:

1. Determining no corrective action is appropriate, and, if the MPLC determines there was no credible evidence for the complaint in the first instance, removing any adverse information related to the complaint from the Practitioner’s file;

2. Deferring action for a reasonable time where circumstances warrant;

3. Issuing letters of admonition, censure, reprimand, or warning. In the event such letters are issued, the affected Practitioner may make a written response which shall be placed in the Practitioner’s quality file. Nothing herein shall be deemed to preclude Department Chiefs from issuing informal written or oral warnings outside of the mechanism for corrective action;

4. Recommending the imposition of terms of probation or a special limitation upon continued Medical Professional Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions; mandatory consultation, or monitoring of clinical activity;

5. Recommending relevant continuing education;

6. Recommending reduction, modification, suspension, revocation, or termination of clinical privileges;

7. Recommending reduction of membership status or limitation of any prerogatives directly related to the Practitioner’s delivery of patient care;

8. Recommending suspension, revocation, probation, or termination of Medical Professional Staff membership; and
(9) Taking other actions deemed appropriate under the circumstances.

(k) Subsequent Action on MPLC Recommendation
The System Chief of Staff or Campus Chief of Staff, shall promptly inform the Practitioner who was the subject of an investigation of any action or recommendation by the MPLC pursuant to subsection (8) above. The System Chief of Staff or Campus Chief of Staff, shall also inform the Board of its recommendation. If the action or recommendation is an Adverse Action and if the Medical Professional Staff member fails to request a Review Hearing in a timely manner, the recommendation of the MPLC shall become a final recommendation and the System Chief of Staff or Campus Chief of Staff, shall so inform the Board for its review and action.

11.4.6 Automatic Suspension of Privileges or Termination of Staff Membership

(a) License Revocation or Suspension
Revocation or suspension of a Practitioner's professional license or other authorization to practice shall automatically, without the need for further notice to the Practitioner, terminate Medical Professional Staff membership and all Privileges.

(b) Probation
When a Practitioner is placed on probation by the State, the probation shall cause the Practitioner to relinquish, automatically and without the need for further notice to the Practitioner, his/her right to exercise any and all Privileges in accordance with the terms of the probation.

(c) Expiration
Expiration of the Practitioner's license to practice shall automatically cause the Practitioner to relinquish all Privileges until such time as the license is renewed, at which time, the Privileges shall automatically be reinstated.

(d) DEA Prescriptive Authority
A Practitioner whose DEA registration has been revoked, suspended, or expired, in whole or in part, shall immediately and automatically relinquish his/her right to prescribe medications covered by such authority until such time as the DEA registration has been renewed or reinstated, at which time, prescriptive authority shall automatically be reinstated.

(e) Liability Insurance
A Practitioner who fails to document current coverage in accordance with these Bylaws and as required by the Board shall automatically relinquish all Privileges until such time as such coverage is documented, at which time, the Practitioner's Privileges shall automatically be reinstated.

(f) Terms of Restriction
If a Practitioner relinquishes privileges under subsections (3), (4) or (5) above for a period greater than 90 days without demonstration of sufficient effort to resolve this problem, Medical Professional Staff membership and Privileges shall automatically be administratively terminated.
(g) **Failure to Comply with Corrective Action**
A Practitioner who fails to comply with a Corrective Action shall be deemed to have automatically relinquished all Privileges.

(h) **Exclusion from Medicare of Medicaid Program**
Exclusion of a Practitioner from any Medicare/Medicaid Program, whether such Practitioner has ever been an authorized provider under such program or not, shall automatically terminate such Practitioner's Medical Professional Staff membership and Privileges. Upon reinstatement or inclusion as a provider in a Medicare/Medicaid Program, this matter shall be referred to the Credentials Committee for recommendation regarding reinstatement of Medical Professional Staff membership and Privileges.

(i) **Medical Records**
An Automatic Relinquishment of all Privileges shall, in accordance with delinquent chart guidelines in the Rules and Regulations, be imposed without the need for further action. Such Automatic Relinquishment shall remain in effect until the medical records have been properly and fully completed, at which time, the Practitioner's Privileges shall automatically be reinstated.

(j) **Conviction**
At the discretion of the Board and without the need for further notice to the Practitioner, conviction of a felony or gross misdemeanor may automatically terminate Medical Professional Staff membership and Privileges.

(k) **Imposition of Automatic Relinquishment of Privileges**
The CE or designee or the System Chief of Staff or designee shall notify the Emergency Service and all other appropriate Hospital Services and personnel and Medical Professional Staff leaders when a Practitioner's actions or failure to act results in automatic relinquishment of Privileges. The Practitioner shall also be immediately notified verbally, to the extent that circumstances permit, and the MPLC shall provide the Practitioner Written Notice of the Automatic Relinquishment as soon as possible thereafter.

(l) **Relinquishment of Privileges**
Any Practitioner who has been suspended shall automatically have his/her Privileges relinquished; any Practitioner whose Privileges have been otherwise restricted or limited for failure to comply with Medical Professional Staff Bylaws, Rules and Regulations, policies or Hospital Standards shall not be reappointed until the deficiency has been rectified or a corrective action plan has been approved by the MPLC. Alternatively, the Practitioner may be granted conditional reappointment, contingent upon correction of the deficiency.

(m) **Notification of NPDB and Washington DOH**
The CE or an authorized designee shall notify the National Practitioner Data Bank, the State Medical Quality Assurance Commission, and other organizations that may require notification by law, concerning final determinations that reduce, restrict, suspend, terminate, revoke, or deny Privileges or Medical Professional Staff membership and surrender of clinical privileges while under investigation or to prevent an investigation. Restrictions, revocations, reductions, non-renewals, or denials of Privileges that occur solely because a Practitioner does
not meet the established threshold eligibility criteria for a particular Privilege shall not be reported in accordance with NPDB policy.

The CE or designee shall report to the Washington State Department of Health when the practice of a health care Practitioner is restricted, suspended, limited, or terminated based upon a conviction, determination, or finding by the Hospital as defined in RCW 18.130.180 within 15 days of conviction, determination, or finding, or of a voluntary resignation while the Practitioner is under investigation.

11.5 Review Hearing Procedures
A Review Hearing is available to a Medical Professional Staff member when advised of an Adverse Action, as defined in these Bylaws. A Medical Professional Staff member, who receives a Non-Adverse Action recommendation, as defined in the Bylaws, is not afforded Review Hearing rights.

11.5.1 Request for Review Hearing
Within five business days after the MPLC recommends an Adverse Action, the CE or designee shall be responsible for giving Written Notice of the recommended Adverse Action to the affected Medical Professional Staff member who is entitled to a Review Hearing informing the Medical Professional Staff member:

(a) The recommendation made and the reasons for it;

(b) A statement that the Medical Professional Staff member has the right to request a Review Hearing and that the request of a Review Hearing must be made in writing to the Medical Administrator within 30 days of his/her receipt of the Written Notice of the recommended Adverse Action; and

(c) A summary of the Medical Professional Staff member's rights in the Review Hearing (which may be satisfied by furnishing the Medical Professional Staff member with a current copy of the Medical Professional Staff Bylaws).

Refusal to accept such Written Notice shall constitute receipt thereof.

11.5.2 Waiver of Hearing
The affected Medical Professional Staff member may waive his/her right to a hearing by (1) submitting Written Notice to the Medical Administrator or (2) failing to request a Review Hearing within the time and in the manner set forth in these Bylaws. Such waiver of his/her right to a Review Hearing shall make the recommended Adverse Action final and non-appealable. The Medical Administrator shall forward all recommended Adverse Actions to the Board for final action and shall give the Medical Professional Staff member and the MPLC prompt Written Notice of decisions of the Board, which become final by virtue of the Medical Professional Staff Member's waiver of hearing rights.

11.5.3 Review Committee Hearing

(a) Notice of Review Hearing
Within 45 days after receipt of a request for a Review Hearing from a Medical Professional Staff member entitled to the same, the Medical Administrator shall schedule the Review Hearing and shall give the Medical Professional Staff member Written Notice of the hearing, specifying the date, time, and place of the
Review Hearing. The Review Hearing shall begin as soon as it is practical, considering the schedules and availability of all concerned, but no sooner than 30 days after the Notice of Hearing was sent to the Medical Professional Staff member, unless an earlier date has been specifically agreed to in writing by both parties. Considering the multiple time demands and schedule requirements of the day-to-day activities of Medical Professional Staff members, such Review Hearing may be scheduled before or after normal business hours or weekends or holidays if necessary in order to accomplish a fair hearing process within the required time periods. Alternatively, the parties may mutually agree to waive and/or extend the time requirements to permit a more convenient meeting. Within twenty days after issuance of the Notice of Hearing, the parties shall provide each other with a list of the names and addresses of witnesses, as far as reasonably possible, who will testify at the Review Hearing as well as a brief summary of their testimony. Five days prior to the pre-hearing conference described below, the parties shall also furnish each other with copies of all documents/exhibits that each intends to introduce into evidence at the hearing. There shall be no right to pre-hearing depositions, and there is no right to subpoena witnesses for the Review Hearing, but it shall be the duty of each member of the Medical Professional Staff or Hospital staff to voluntarily appear at the hearing if requested to do so upon reasonable notice by the MPLC, Medical Administrator, or Physician.

(b) Pre-Hearing Conference
As soon as possible after the exchange of lists of witnesses, a pre-hearing conference shall be held, but in no event less than seven days prior to the scheduled commencement of the Review Hearing. All objections to documents or witnesses shall be presented to the Presiding Officer at the pre-hearing conference, who shall rule on the objections. The Presiding Officer may determine that a particular witness shall not testify at the hearing if the witness's testimony would be irrelevant, cumulative, or otherwise not necessary for the party to present its case. Any other procedural issues relating to the Review Hearing may be addressed at the pre-hearing conference.

(c) Appointment of Review Hearing Committee
The CE or designee, acting with the concurrence of the System Chief of Staff, shall appoint a Review Hearing Committee, which shall be comprised of no fewer than three Active and/or APC Medical Professional Staff members or two Active and/or APC Medical Professional Staff members and a consulting Physician who is not on the Medical Professional Staff and who has not actively participated in the consideration of the matter at any previous level. An outside consultant who is not a member of the Medical Professional Staff may be appointed to the committee, but the majority of the committee shall be Active and/or APC Medical Professional Staff members. The committee shall not include as a member any individual who is in direct economic competition with the Physician. Having knowledge of the matter involved shall not disqualify an individual from serving on the committee so long as he/she does not have a conflict of interest and can act in good faith. The Presiding Officer shall be Chair as stated in subsection (5) below.
(d) Medical Professional Staff member’s Personal Presence
The personal presence of the Medical Professional Staff member who requested the Review Hearing shall be required. A Medical Professional Staff member who fails to appear and proceed at a Review Hearing, without good cause, shall be deemed to have waived his/her rights.

(e) Presiding Officer
The System Chief of staff and CE shall procure an individual trained and experienced in procedural law, whose fee shall be paid by the Hospital. He/she shall be responsible for conducting the hearing, ruling on issues of order and admissibility, and arranging and conducting a pre-hearing conference if deemed advisable to establish ground rules for the hearing and to conduct oral argument on procedural objections. The Presiding Officer shall be a non-voting member of the Review Hearing Committee.

(f) Procedure and Evidence
The Review Hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or admissibility of evidence. Any relevant matter upon which responsible persons would customarily rely in the conduct of serious affairs shall be admitted into evidence regardless of the inadmissibility of such evidence in a court of law. Prior to or during the hearing, the MPLC and the Medical Professional Staff Member shall be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become a part of the hearing record. The Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath. Oaths may be administered by any person authorized to notarize documents in the State of Washington. The Physician and the MPLC shall each be given an opportunity to submit a written statement at the close of the hearing.

(g) Rights of Parties
During the Review Hearing, each party has the right to:

1. Call and examine witnesses;
2. Introduce exhibits;
3. Cross-examine any witness present at the hearing on any matter relevant to the issues.

If the Member who requested the hearing does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

(h) Representation and Right to Legal Counsel
The Member is entitled to be accompanied and represented by any attorney or another person of his/her choice. The MPLC shall appoint a member of the Active or APC Medical Professional Staff and/or an attorney to represent it at the hearing, to present the evidence in support of its recommendations, and to examine witnesses. Representation of either party by an attorney at law shall be governed by the provisions of these Bylaws.
(i) Official Notice
The Presiding Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration, if such could have been judicially noticed by the courts of the State of Washington. The Presiding Officer may also take official notice of any material on file in the Hospital and all other information that can be considered pursuant to these Bylaws in connection with applications for appointment or reappointment and for clinical and admitting privileges. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. The Physician or the MPLC shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority.

Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

(j) Burden of Proof
The Physician has the burden of proving by clear and convincing evidence that the MPLC’s recommendation of Adverse Action should not be sustained because it lacks factual basis or the conclusions drawn from the facts are arbitrary, capricious, or unreasonable.

(k) Record of Review Hearing
Copies of the materials submitted in connection with the Review Hearing shall be kept on file by Medical Professional Staff Services. A stenographic copy shall be made of the hearing with the fees paid by the Hospital. The Medical Professional Staff member shall have the right to obtain a copy of the transcript at his/her expense. The transcript shall be kept on file by the Medical Professional Staff Services Office.

(1) Hearing Duration
All parties to the Review Hearing shall prepare their presentations so that the hearing may be completed in no more than 12 hours including the presentation of all evidence and any oral comments before or after the presentation of evidence. Absent a showing of good cause for a longer period, the total hearing time shall not exceed 12 hours.

A majority of the members of the Hearing Committee must be present when the hearing takes place. Any member of the Hearing Committee who must be briefly absent shall read the transcript of the portion of the hearing missed before participating in the Hearing Committee deliberations and recommendations.

During a Review Hearing, each party shall have the right to equal portions of the hearing time not to exceed 12 hours in total during which time each party may:

(i) Make any oral presentation it deems appropriate prior to presentation of evidence;
(ii) Call and examine witnesses, provided the other parties have been notified of witness names at least 10 business days prior to the Review Hearing unless good cause for failure to notify is shown;
(iii) Introduce exhibits, provided the other parties have been furnished copies of the exhibits at least 10 business days prior to the Review Hearing unless good cause for failure to furnish is shown;
(iv) Cross-examine any witness on any matter relevant to the issue of the hearing; and
(v) Submit or make a written or oral statement at the close of the Review Hearing.

The Medical Professional Leadership Council, when its action has prompted the hearing, shall be entitled to be represented by counsel or one of its members or some other Medical Professional Staff member at the hearing to present the facts in support of its adverse recommendation and to examine witnesses. The Board, when its action has prompted the hearing, shall be entitled to be represented by counsel or one of its members to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected practitioner shall thereafter be responsible for supporting practitioner’s challenge to the adverse recommendation or decision by clear and convincing evidence that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is either arbitrary, unreasonable, or capricious.

(m) Recesses and Adjournment
The Presiding Officer may recess the hearing and reconvene it without additional notice as necessary in the best judgment of the Presiding Officer. Upon conclusion of the presentation of oral and written evidence and submission of final statements, the hearing and record of the hearing shall be closed. The Review Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of all persons who are not members of or advisors to the Review Hearing Committee. Once convened, the hearing shall be completed within 60 consecutive calendar days.

(n) Review Hearing Report and Notice to Practitioner
Within 30 days after final adjournment of the Review Hearing, the Review Hearing Committee shall make a written report of its findings and/or recommendations and forward the same, together with the hearing record and all other evidence considered by it, to the Board for actions. It is the intent of these Bylaws that the Hearing Committee resolve the issues presented for its review. The report of the Hearing Committee shall recommend acceptance, rejection, or revision of the MPLC’s recommendation regarding the Adverse Action and shall provide a final recommendation to the Board for its final disposition. The Medical Administrator shall, after receipt of the written Review Hearing report, give the Practitioner and MPLC Written Notice of the recommendation of the Review Hearing Committee and a copy of the Review Hearing report.

(o) Action of the Board
Upon review of the Review Hearing report, the Board shall send Written Notice of its decision to the Medical Professional Staff member and MPLC no later than 30 days after receipt of the Review Hearing Report. The Board's decision shall be final, binding, and conclusive.
11.5.4 Resolution by Agreement
The resolution of differences by voluntary agreement is the preferred method of resolution through professional review under these Bylaws. Accordingly, agreements need not set forth cause, fault, basis, or other consideration in order to comply with this Section of the Bylaws, but must be in writing and signed by the Practitioner and the CE or the Medical Administrator on the Board's behalf.

ARTICLE XII: LEGAL PROTECTIONS AND CONFLICTS OF INTEREST

12.1 Legal Protections

12.1.1 Indemnification
Medical Professional Staff Officers, Department Chairs, and committee members are covered by the Hospital’s professional liability insurance when acting in good faith within the scope of their responsibilities under these Bylaws.

12.1.2 Legal Protections
Peer review is confidential and shall be conducted in a formally constituted meeting, and as such, it is protected by applicable Washington State and federal peer review and quality improvement statutes. Peer Review immunity extends to members of all committees of the Medical Professional Staff involved in review of patient care activities.

12.2 Authorization and Release
Any Practitioner who applies for or accepts privileges or Medical Professional Staff membership or renewal thereof at the Hospital authorizes the following entities or individuals to furnish any and all information (including records and files, whether or not the Practitioner could otherwise claim the same as privileged) to the Hospital or provide information on behalf of the Hospital in accordance with law and these Bylaws: the Hospital, its officers, agents, representatives, persons, or any institution that the Hospital or any of the foregoing believes may possess information relevant to an evaluation of the Practitioner’s ability, character, health status, professional ethics, and other qualifications that, in the opinion of the Hospital, might have a bearing on his/her competence and ability to provide or to continue to provide quality medical care and work harmoniously with officers, personnel, and Medical Professional Staff of the Hospital. The Practitioner EXPRESSLY AGREES TO RELEASE and hereby DOES RELEASE FROM LIABILITY and COVENANTS NOT TO SUE:

12.2.1 Any person or institution (including any person associated with the Hospital, whether as an officer, agent, representative, employee, member of the Medical Professional Staff, or otherwise) for furnishing or passing on to this Hospital or to any committee or to any representative of either, any information or any opinion or views about or pertaining to such Practitioner, whether or not well founded in fact;

12.2.2 Swedish, the Board, and any officers, agents, representatives, and employees of Swedish, the Hospital or said association, any advisory board and committees, and the Medical Professional Staff and members thereof, for any act, communication, report, opinion, recommendation, or disclosure, whether or not well founded in fact or in law.
12.3 Acknowledgments
Each Practitioner acknowledges the need to exercise judgment in investigating and making recommendations or decisions concerning Medical Professional Staff membership and privileges and in otherwise regulating professional review. Each Practitioner also acknowledges the efforts of the Congress, through the Health Care Quality Improvement Act of 1986, to protect from liability those who participate in professional review for the good of the patients.

12.4 Participation in Professional Review
Each Practitioner agrees that the Hospital and all its agents (including but not limited to those listed below), while acting in good faith and without actual malice, shall, to the fullest extent allowable by law, be granted absolute immunity from civil liability alleged to have arisen out of investigation, review, furnishing of information, or making of recommendations or decisions that concern Medical Professional Staff membership, privileges, or other actions taken pursuant to these Bylaws:

12.4.1 The Medical Professional Staff, its members, Departments, committees, and agents;
12.4.2 The Board, its members, and agents;
12.4.3 The Hospital, its employees, and agents;
12.4.4 Consultants, advisors, review hearing officers, presiding officers, accountants, attorneys and agents of the above;
12.4.5 Any individuals or governmental agencies or organizations who supply records, information, or opinions, including otherwise privileged or confidential information, to any of the above;
12.4.6 Any of the above who supply records, information, or opinions to other hospitals, health care or governmental entities, or insurance carriers concerned with the quality and efficiency of patient health care.

12.5 Use of Information
Each entity or individual listed above agrees to hold information that is gained while acting as an agent of the Hospital and/or Medical Professional Staff in confidence and agrees to protect the privileges and immunities of that information from discovery, except when disclosure is required by express provision of law or court order, in which case, the Chief Medical Officer and the System Chief of Staff must be given Written Notice of the intent to disclose pursuant to law or court order and must be given a reasonable opportunity to object or seek a court order preventing disclosure.

12.6 Interpretation
This Article of the Bylaws shall be liberally interpreted to give effect to its purpose of providing the persons and entities covered by it the greatest protection legally permissible in order to encourage the provision of high quality medical care through effective professional review. If portions of the waivers or protections provided in these Bylaws are determined to be invalid or unenforceable, then the remaining portions shall be deemed separable and remain effective in all respects.

12.7 Conflicts of Interest
A conflict of interest regarding Medical Professional Staff matters may exist for a Practitioner or advisor to the Medical Professional Staff. This may occur because of direct professional or economic competition, family or business relationships, past disputes that may influence the ability to judge fairly, or otherwise. In such cases the individual must divulge the conflict of
interest to the appropriate decision-making body and refrain from the activity that produces the conflict of interest until the conflict is resolved by the MPLC or other appropriate administrative body. The Practitioner must remove himself/herself from commenting at meetings or voting on any such matter. If requested to do so by the System Chief of Staff, the CE, the Medical Director, the Department Chief, or the committee Chair, such individual may author a written report dealing with the factual matters that are independently and objectively verifiable, such as published clinical standards of practice in a particular specialty, but shall express no views as to matters of opinion or judgment.

**ARTICLE XIII: HISTORY AND PHYSICALS**

13.1 Requirements
A complete History and Physical is required for all admissions. No patient will undergo surgery without a documented History and Physical examination on the patient’s chart, except in extreme emergencies. The History and Physical may be dictated or entered directly into the electronic medical record. The History and Physical is expected to document adequate information about the current status of the patient to allow the safe transfer of care to another practitioner.

13.1.1 The Complete History and Physical note must contain the following elements:

(a) Chief complaint (reason for admission)
(b) History of present illness
(c) Medical history
(d) Surgical history
(e) Family history
(f) Review of systems
(g) Medication
(h) Allergies
(i) Immunization status (pediatric patients)
(j) Prenatal information (obstetrical patients)
(k) Clinically relevant physical examination (including cardiovascular and pulmonary examination)
(l) Overall impression and specific diagnosis
(m) Treatment plan or goals

13.2 Performance and Authentication
A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. It is the responsibility of the attending physician to either perform and document a history and physical examination or to authenticate a history and physical examination by a qualified practitioner. (See also Rules and Regulations 8.16.)

13.3 Interval Note
When the medical history and physical examination are completed within 30 days before admission or registration an updated examination of the patient, including any changes in the patient’s condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. A preoperative assessment performed by an anesthesiologist will fulfill this criterion. Any concern about the patient’s status preoperatively will be communicated to the practitioner performing the procedure. The practitioner or proceduralist may then evaluate the patient further as necessary before proceeding. In cases not involving anesthesia services, the performing or ordering practitioner is responsible for providing the interval note.

The interval note must document an examination for any changes since the history and physical was performed that might be significant for the planned course of treatment or indicate “History and physical reviewed and no change.”

13.4 Documentation
History and physical notes must be filed in the patient’s hospital chart in the encounter for the matching admission.
## Exhibit 1: Swedish Ballard, Cherry Hill, First Hill and Issaquah Medical Staff Opportunities for Improvement Structure

<table>
<thead>
<tr>
<th>Findings Best Reflect</th>
<th>Required Action</th>
<th>Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Appropriate</strong></td>
<td>Letter to Practitioner from the Chair on behalf of the QRC acknowledging appropriate care. Where possible the letter will commend positive aspects of the care delivered, seek to foster collegiality and encourage ongoing participation in quality improvement efforts.</td>
<td>Aggregate reporting to MSQOC and MEC.</td>
</tr>
<tr>
<td><strong>Improvement Opportunity</strong></td>
<td>Letter to Practitioner from the Chair on behalf of the QRC with identified concerns/expectations. In straightforward cases, it may be reviewed only by the Chair without review by the QRC. The case findings will be included in the Practitioner’s quality/peer review file. A performance improvement plan (PIP) could be considered for the Practitioner by the QRC. Where possible the Practitioner will be included in the development of any PIP. The MSQOC must approve implementation of any PIP.</td>
<td>Notification to the Practitioner, Campus VPMA, Department Chief, designated Division Chair or Medical Director as appropriate. Entry in the quality/peer review file for reappointment review; entry of finding (not Practitioner-specific) on regular summary report to MSQOC and MEC.</td>
</tr>
<tr>
<td><strong>Significant Improvement Opportunity</strong></td>
<td>Letter to Practitioner from the Chair on behalf of the QRC with identified concerns/expectations. The case will be reviewed by the QRC. The case findings will be included in the Practitioner’s quality/peer review file. A performance improvement plan (PIP) may be developed by the QRC. Where possible, the Practitioner will be included in the development of any PIP. The Department Chief or designee should help with development and implementation of the Plan. The MSQOC must approve the PIP including any recommended changes in privileges.</td>
<td>Notification to the Practitioner, Campus VPMA, Department Chief, designated Division Chair or Medical Director as appropriate. Entry in the quality/peer review file for reappointment review; entry of finding (not practitioner specific) on regular summary report to MSQOC and MEC.</td>
</tr>
</tbody>
</table>
BYLAWS

APPROVED as revised by the Medical Professional Leadership Council on
APPROVED as revised by the Board on

THE MEDICAL PROFESSIONAL STAFF OF SWEDISH HEALTH SERVICES

System Chief of Staff

SWEDISH HEALTH SERVICES

Chair of the Board

Previous edition: