BYLAWS OF THE MEDICAL STAFF
OF SWEDISH HEALTH SERVICES
EDMONDS

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SWEDISH
Edmonds
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ARTICLE I: STATEMENT OF THE PURPOSES OF THE MEDICAL STAFF

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

1.2 Purposes
The purposes of the Medical Staff are to:

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

1.2.2 Strive for quality professional performance by all Practitioners authorized to practice in 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 Edmonds 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 Staff and provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Board and the CEO.

1.3 [This Section is intentionally omitted.]

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

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

1.4.2 ADVERSE ACTION means any action that requires a Practitioner to exercise or waive his/her right to a Review Hearing (Medical 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 MEC’s recommendation, has determined by policy to allow to practice in the Hospital.

1.4.4 BOARD means the Board of Trustees of Swedish Edmonds.

1.4.5 CHIEF EXECUTIVE OFFICER (CEO) means Swedish Edmonds’ Chief Executive Officer.
1.4.6 **CHIEF OF SERVICE** or **CHIEF** means the Medical Staff member duly appointed or elected in accordance with these Bylaws to serves as the head of a given Service and its respected Service Committee.

1.4.7 **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.

1.4.8 **COUNCIL OF MEDICAL EXECUTIVE COMMITTEES** means the committee that assures uniform practices for bylaws, credentialing and peer review for every medical staff of the Swedish Health Services system.

1.4.9 **DAYS** means calendar days.

1.4.10 **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

1.4.11 **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.

1.4.12 **HOSPITAL** means Swedish Edmonds, a general acute care hospital operated by Swedish Edmonds, a Washington non-profit corporation, located at 21601 – 76th Avenue West, Edmonds, WA 98026.

1.4.13 **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.

1.4.14 **MEDICAL EXECUTIVE COMMITTEE** (MEC) means the group of Active members of the Medical Staff empowered to act for the Medical Staff between meetings of the organized Medical Staff.

1.4.15 **MEDICAL STAFF** means the Physicians, Dentists, Podiatrists and Oral and Maxillofacial Surgeons who are members according to criteria set forth in these Bylaws at Swedish Edmonds. 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.

1.4.16 **MEDICAL STAFF BYLAWS** or **BYLAWS** means these Bylaws which shall provide for the organization and governance of the Medical Staff and establish the procedures applicable to the granting, delineation, reduction and exercise of Privileges, appointment and reappointment to Medical Staff membership, and the suspension and termination of such Privileges and membership at the Hospital.

1.4.17 **MEDICAL STAFF YEAR** means the period from January 1 through December 31 of the same calendar year.
1.4.18 **ORAL AND MAXILLOFACIAL SURGEON** means a licensed Dentist qualified for Board Certification by the American Board of Oral and Maxillofacial Surgery.

1.4.19 **PEER REVIEW** means the process of evaluating 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.

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

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

1.4.33 **POLICIES** means Swedish’s policies, procedures, protocols, guidelines, and clinical forms.

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

1.4.23 **PRESIDENT** means President of the Medical Staff.

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

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

1.4.26 **REVIEW HEARING** means a proceeding conducted for a Medical Staff Member in accordance with Article XI of these Bylaws.

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

1.4.28 **SERVICE** means that group of Practitioners who have Privileges in or have been assigned to one of the general areas of medicine, surgery and obstetrics, pediatrics, psychiatry, ancillary service, emergency service and family practice in accordance with their professional interests pursuant to and for the purposes of these Bylaws.

1.4.29 **SERVICE COMMITTEE** means that functional division of the Medical Staff responsible for the quality of care delivered in each respective Service.

1.4.30 **SWEDISH EDMONDS** is a Washington state non-profit corporation, wholly-owned by Swedish Health Services, that operates the Hospital and is the employer of all Hospital employees.

1.4.31 **SWEDISH HEALTH SERVICES** is a Washington state non-profit corporation that wholly-owns Swedish Edmonds.

1.4.32 **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 STAFF ORGANIZATION AND GOVERNANCE

2.1 Finances

2.1.1 Application Fees
The MEC establishes and determines the amount of application fees.

2.1.2 Membership Dues
The MEC establishes the amount of annual dues to be paid by each member of the Medical Staff and Allied Health Professional Staff within parameters set by action of the Medical Staff. Practitioners on leave of absence or serving as active duty military personnel, and Honorary Medical Staff members are exempt from dues assessments. There shall be no other exemptions from dues assessment other than by action of the MEC. The Medical 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.

2.1.3 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 MEC, which shall also establish such organization and/or process as it deems appropriate to administer such funds.

2.2 Medical Staff Leadership

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

2.2.2 Qualifications of Officers
Each person nominated for Medical Staff office must be a Physician who at the time of nomination, election, and during the term of office is an Active Medical Staff member and either a medical physician or osteopathic physician. Failure to continuously maintain such status shall immediately create a vacancy in such office.

2.2.3 Nominations and Elections

(a) The nominating committee shall consist of members of the Active Medical Staff appointed by the President at least 30 days before the October Medical Staff meeting. This committee shall offer one or more nominees for each office and submit the nominees by mail to the Active staff on or before October 1. Nominations may also be made by an Active Medical Staff member by submitting nominee or nominees in writing to the nominating committee on or before September 15. Nominations from Active medical staff members may also be accepted from the floor. No person shall be nominated without the nominee’s consent.
(b) The officers shall be elected on the date of the annual meeting of the Medical Staff. Only members of the Active staff shall be eligible to vote. If a quorum is not present at the annual meeting, voting shall be by mail or electronic ballot. Ballots shall be sent to the Active staff a minimum of 14 days prior to the deadline for the return of the ballots.

(c) To be elected, a minimum of 50 percent of the total number of Active staff must vote in the election, and if by mail or electronic ballot, the ballot must be returned by the voting deadline and the nominee must be approved by a majority of the total number of Active staff who return their ballots. Should the situation arise where there are three or more candidates and no candidate receives a majority, the name of the candidate receiving the fewest votes shall be omitted from each successive ballot until a majority vote is obtained by one candidate.

2.2.4 Term of Office
All officers shall serve a two-year term commencing on the first day of the year following the year in which they are elected in the cases of the President-Elect and the Secretary-Treasurer. The regular term of the President shall commence on the first day of the third year following the year in which the person is elected to the office of President-Elect.

2.2.5 Removal from Office
Any officer of the Medical Staff may be removed from office in the manner hereinafter provided.

(a) Initiation of Action: A recall action may be initiated by a petition therefor naming the affected officer, signed by at least 40 percent of the total number of members of the Active staff filed with the Secretary-Treasurer. No cause need be stated nor shown. Should the subject of the petition for recall be the Secretary-Treasurer, this process shall be delegated to the President of the Medical Staff.

(b) Notification Procedure: Immediately upon the filing of such a petition, the Secretary-Treasurer shall furnish the affected officer a true and complete copy thereof by Special Notice, and promptly thereafter shall mail a true and complete copy of the same to each member of the Active staff together with a mail ballot.

(c) Balloting Procedure: The mail ballot must be sent to each member of the Active staff at least 10 days prior to the deadline for the return of the ballot. The sole question presented by the ballot shall be whether the affected officer should be recalled.

(d) Result: The concurrence of 60 percent of the total number of Active staff shall be required to recall the affected officer. The President shall designate three tellers to supervise the receiving and counting of the ballots and they shall forthwith certify the result which shall be recorded in the records of the Medical Staff. The recall of an affected officer shall be effective immediately, and a vacancy created by recall shall be filled in the manner provided in Section 2.2.6.
2.2.6 Vacancies in Office

(a) If there is a vacancy in the office of Secretary-Treasurer, it shall be filled by a qualified member of the Medical Staff appointed by the MEC.

(b) If there is a vacancy in the office of the President, the President-Elect shall serve out the remaining term before commencing the regular, full two-year term as President that follows.

(c) If there is a vacancy in the office of President-Elect, a nominating committee to be constituted in the manner provided in Section 2.2.3, shall be promptly appointed by the President. Such committee shall offer one or more nominees for the office of President-Elect in its report submitted to the Medical Staff at a special meeting of the Medical Staff called in accordance with Section 5.2.1. Nominations may also be made from the floor at that Medical Staff meeting following presentation of the nominating committee report. When nominations are closed an election for the office of President-Elect shall be conducted at such meeting in the manner provided in Section 2.2.3. No person shall be nominated by the committee or from the floor without that person’s consent.

2.2.7 Duties of Officers

(a) President: The President shall serve as the chief administrative officer of the Medical Staff to:

(1) Act in coordination and cooperation with the CEO in all matters of mutual concern within the Hospital;

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

(3) Serve as a member of the Council of Medical Executive Committees;

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

(5) Be responsible for the enforcement of the Medical Staff Bylaws, and rules and regulations, for implementation of sanctions where these are indicated, and for the Medical Staff’s compliance with procedural safeguards in all instances where corrective action has been requested affecting a Practitioner;

(6) Appoint committee members to applicable standing, special and multidisciplinary Medical Staff committees except the MEC;

(7) Represent the views, policies, needs and grievances of the Medical Staff to the Board and to the CEO;

(8) Receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with
respect to the Medical Staff’s delegated responsibility to provide quality medical care as chairperson of the Quality Council;

(9) Be responsible for the educational activities of the Medical Staff; and

(10) Be the spokesperson for the Medical Staff in its external professional and public relations.

(b) President-Elect: In the absence of the President, the President-Elect shall temporarily assume all the duties and the authority of the President. The President-Elect shall be a member of the MEC of the Medical Staff. The President-Elect may succeed the President as provided in Section 2.2.6 when a vacancy occurs in that office.

(c) Secretary-Treasurer: The Secretary-Treasurer shall be a member of the MEC of the Medical Staff. The Secretary-Treasurer shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the President, attend to all correspondence, be in the custody and control of the membership dues and provide an accounting for such dues at least annually and whenever requested by the President or the Board, and perform such other duties as ordinarily pertain to that office.

2.3 Immediate Past President

2.3.1 Term of Office. The Immediate Past President 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 President, the most recent-serving Immediate Past President eligible to serve may be appointed at the discretion of the President. If no past president is able to serve, the President shall appoint a member of the Active staff, with ratification by the MEC, to discharge the duties of the Immediate Past President for the remainder of the term.

2.3.3 Duties. The Immediate Past President of Staff shall:

(a) Advise the President in matters as requested;

(b) Aid in the enforcement of the Medical Staff Bylaws, Rules and Regulations, and policies, as requested by the President; and

(c) Serve as a member of the MEC.

2.4 Support Services to the Medical Staff

2.4.1 Secretarial/Treasury Services
The CEO shall arrange for the provision of secretarial and treasury services to the Medical Staff for the purpose of keeping minutes of meetings, sending notices, attending to correspondence, maintaining funds, bank accounts and financial records, and performing other such duties as may be appropriate.
ARTICLE III: SERVICES AND DIVISIONS OF THE MEDICAL STAFF

3.1 Organization of Services
The Medical Staff is organized into eight Services, which shall have Service Committees responsible for establishing standards for the granting and exercise of Privileges in their respective areas of practice applicable to all Practitioners. Each Service shall be headed by a Chief of Service and shall function under its respective Service Committee and the MEC. Each member of the Medical Staff shall be assigned to an appropriate Service. The Services are organized as follows:

3.1.1 Medicine to include communicable diseases, cardiology, diseases of the lungs, gastroenterology, endocrinology, neurology, dermatology, physical medicine, oncology, hematology, rheumatology and other medicine specialties.

3.1.2 Surgery to include neurological surgery, proctology, urology, thoracic surgery, orthopedic surgery, plastic surgery, traumatic surgery, neoplastic surgery, ophthalmology, otolaryngology, gynecology, oral surgery, podiatric surgery, dentistry, general surgery and other surgical specialties.

3.1.3 Obstetrics

3.1.4 Pediatrics

3.1.5 Psychiatry

3.1.6 Critical Care

3.1.7 Ancillary Service to include anesthesia, pathology and radiology.

3.1.8 Emergency Service to include work performed in the emergency room and by emergency room physicians. Members of the Medical Staff may treat patients in the emergency room as appropriate in accordance with their general Hospital Privileges.

3.1.9 Family Medicine, of which its Service Committee shall be responsible for establishing, in conjunction with the other Service Committees, such standards applicable to family and general Practitioners.

3.2 Composition and Service Committee Functions

3.2.1 Establish Privileges Criteria
Each Service shall recommend threshold criteria for granting and changing of Privileges consistent with these Bylaws, Rules and Regulations, and policies of the Medical Staff. In conjunction with the Credentials Committee, and the MEC, the Service Committees shall evaluate the competency and qualifications of Practitioners and AHPs for the purpose of assuring that the extent of practice of such persons at the Hospital is limited to the exercise of Privileges for which they are qualified on the basis of their education, training, experience, demonstrated personal and professional competence and judgment, references and other relevant information. Problems arising in the exercise of Privileges by a Practitioner in a particular Service shall be evaluated by the committee for the purpose of improving patient care.
3.2.2 Establish Subcommittees
Service Chiefs or the President may establish subcommittees by appointing Practitioners assigned to given Services, and such other Practitioners as may be deemed necessary or desirable, to assist in performing the duties and discharging the functions prescribed in this Section 3.2.

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

Such reviews shall include a consideration of all deaths, of patients with infections, complications, errors in diagnosis and treatment, of patients currently in the Hospital with unsolved clinical problems, of proper utilization of Hospital facilities and Services, and of other significant patient care matters. The review of surgical matters shall also include a monthly comprehensive tissue review for justification of all surgery performed, whether tissue was removed or not, for acceptability of the procedure chosen, and for agreement or disagreement between the preoperative and pathological diagnoses.

3.2.4 Conduct Service Business
Each Service shall meet as necessary to conduct Service business.

3.3 Service Chiefs

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

3.3.2 Nominations, Elections and Tenure
Each Chief shall serve for a two-year term following nomination and election in the manner provided for in Section 2.2.3 for officers of the Medical Staff. The Chiefs of family practice, obstetrics, and ancillary Services shall be elected in odd years, while the Chiefs of surgery, medicine, pediatrics, psychiatry and emergency Services shall be elected in even years.

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

(1) Failure to maintain Active staff status;

(2) Failure to maintain uninterrupted Medical Staff Privileges;

(3) Failure to carry out the duties of office to the satisfaction of the MEC and/or members of the Service in accordance with the procedure as outlined in these Bylaws;
(4) Denial, restriction, revocation, or non-renewal of Medical 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, Policies, and the Medical Staff Bylaws, Rules and Regulations, and policies; or

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

(b) Removal of a Chief may be accomplished by a two-thirds majority vote of the MEC.

3.3.4 Vacancy in Office
Should a vacancy occur prior to the expiration of the term, the MEC at its next meeting shall appoint a successor to serve out the remaining term.

3.3.5 Duties of Service Chief. The Chief of each Service shall:

(a) Be accountable for overseeing all professional and administrative activities within the particular Service, including the integration of the Service into the primary functions of the organization;
(b) Be responsible for the coordination and integration of Services;
(c) Be responsible for the development and implementation of policies and procedures that guide and support the provision of services;
(d) Make recommendations for a sufficient number of qualified and competent persons to provide care for the Service;
(e) Provide continuing surveillance of the professional performance of all individuals who have delineated Privileges in the Service;
(f) Assess and recommend to the relevant Hospital authority off-site sources for needed patient care, treatment and services not provided by the Service;
(g) Recommend space and other resources needed by the Service;
(h) Recommend to the Medical Staff the criteria for Privileges with the Service;
(i) Recommend Privileges for each member of the Service;
(j) Participate in the determination of the qualifications and competence of Service personnel who are not licensed independent Practitioners and who provide patient care services;
(k) Assist in the continuous assessment and improvement of the quality of care and of services provided;
(l) Assist in the maintenance of quality control programs as appropriate;
(m) Assist in the orientation and continuing education of all persons in the Service;
(n) Be a member of the MEC, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding the particular Service in order to promote quality patient care;
(o) Maintain continuing review of the professional performance of all Practitioners with Privileges in the particular Service, report regularly thereon to the MEC, and initiate corrective action wherever appropriate;

(p) With the Service Committee of the particular Service, conduct patient care review required by these Bylaws and perform the other functions delineated in these Bylaws;

(q) Be responsible for enforcement of these Medical Staff Bylaws and rules and regulations within the particular Service;

(r) Be responsible for implementation within the particular Service of actions taken by the MEC of the Medical Staff;

(s) Transmit to the Credentials Committee and MEC the particular Service Committee's recommendations concerning the staff classification, the appointment and reappointment, and the delineation of Privileges for all Practitioners in the particular Service;

(t) Be responsible for the teaching, education and research program in the particular Service;

(u) Participate in every phase of administration of the particular Service through cooperation with the nursing service and the Hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques;

(v) Assist in the preparation of such annual reports, including budgetary and long range planning, pertaining to the particular Service as may be required by the MEC, the CEO or the Board; and

(w) Attend and preside at the committee meetings of the particular Service.

3.4 Advisory Positions
The Service Chief may appoint other members of his/her Service to advisory positions to provide assistance to him/her in fulfilling the Chief's duties and responsibilities.

3.5 Assistant Chief of Services
Each Service may elect an Assistant Chief for a two-year term. The nominations and elections for the Service Assistant Chief will be in accordance with the nominations and elections process for the Service Chief.

3.5.1 Responsibilities

(a) The Assistant Chief shall assume the responsibilities of the Service Chief when the Chief is unable or unavailable to perform these duties;

(b) The Assistant Chief shall assist the Service Chief with functions as determined by the Service and at the request of the Service Chief.

3.5.2 Removal from Office

(a) Possible Reasons for Removal from Office. The possible reasons for removal from office of an Assistant Chief are the same as for the Service Chiefs.

(b) Process for Removal from Office. The process for removal from office of an Assistant Chief is the same as for the Service Chief.
3.6 Service Committee Meetings

3.6.1 Service Committees
Service Committees shall meet as necessary to conduct business and evaluate the clinical work of Practitioners with Privileges in the Service. At least annually, each Service shall submit a written report to the MEC. Service business shall include, but not be limited to, planning and budgeting for the acquisition of equipment to be used in the Hospital by the affected Service Committee members; review of committee reports; planning and implementation of Service educational programs; formulation of Service policies, and allocation of responsibilities necessary for the efficient operation of the Service. Service policies shall take effect only after approval by the MEC.

3.6.2 Special Meetings
A special meeting of any Service may be called by or at the request of the Chief thereof, the President, or one-third of the Service's members at the time, but not less than three members, if applicable.

3.6.3 Notice of Meetings
Written or electronic notice stating the place, date, and hour of any meeting not held pursuant to resolution shall be given to each member of such Service 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 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 Staff Services office. It is the responsibility of the Practitioner to notify the Medical 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.

3.6.4 Manner of Action
The action of a Service Committee 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.

3.7 Creation and Dissolution of a Service

3.7.1 Creation of a Service
A group of Physicians in a specialty may petition the MEC in writing to become a Service if the following criteria are met:

(a) The specialty must have a minimum of five members on the Active staff with privileges in the specialty; and

(b) The MEC must approve the creation of the Service by a two-thirds majority vote with endorsement by the Board.
3.7.2 Dissolution of a Service
A Service may be dissolved by a two-thirds majority vote of the MEC and endorsement by the Board.

ARTICLE IV: MEDICAL STAFF COMMITTEES

4.1 Medical Executive Committee (MEC)

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

(a) the President;
(b) the President-Elect;
(c) the Secretary-Treasurer;
(d) the Immediate Past President;
(e) the Chief of each Service;
(f) the chair of the Credentials Committee;
(g) the chair of the Medical Records and Utilization Review Committee; and
(h) the chair of the Critical Care Committee.

(i) the following ex-officio members (without vote):
   (1) the CEO of Swedish Edmonds;
   (2) the Administrator;
   (3) the Chief Nursing Executive or designee; and
   (4) other individuals who may be invited at the discretion of the President.

4.1.2 [This section is intentionally omitted.]

4.1.3 [This section is intentionally omitted.]

4.1.4 Duties of the MEC
The duties of the MEC include:

(a) Is responsible to the Medical Staff and Board for the duties of the organized Medical 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 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 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 Service;

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

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

(g) Sends reports and/or recommendations to the Council of Medical Executive Committees;

(h) Acts as a liaison between the Medical Staff and the CEO and the Board and conveys issues of importance from the Medical 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 MEC Members
The duties of MEC members include:

(a) Attend the meetings of the MEC;

(b) Serve on the MSQOC, or other committees as designated by the President.

4.1.6 [This section is intentionally omitted.]

4.1.7 [This section is intentionally omitted.]
4.1.8 Meetings
The MEC shall meet at such intervals as the MEC deems necessary to perform its duties and specially when called by the President. It shall maintain a permanent record of its proceedings and actions.

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

4.2.1 Composition
The MSQOC is comprised of:

(a) the President, who serves as chair;
(b) the President-Elect;
(c) the Secretary-Treasurer;
(d) the Immediate Past-President;
(e) Administrator;
(f) Chairperson of the Bylaws Committee;
(g) Chairperson of the Credentials Committee;
(h) appropriate Service Chiefs;
(i) Others as determined by the President;
(j) Medical Director of Quality and Patient Safety, Ex-Officio; and
(k) Representative from Quality Assurance, Ex-Officio.

4.2.2 [This section is intentionally omitted.]

4.2.3 Duties
The MSQOC:

(a) Oversees functions related to Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation review;
(b) Oversees assessment of general medical staff performance; and
(c) Oversees physician quality-related activities, i.e., core measure compliance, complaints regarding conduct of practitioners.
4.2.4 Frequency of Meetings
The committee will meet monthly, and on an as-needed basis as called by the Chair or other members to address matters brought to the MSQOC’s attention.

4.3 Peer Review Functions of Service Committees
There is a Service Committee for each of the following – Medicine, Surgery, Obstetrics, Pediatrics, Psychiatry, Emergency Medicine, Ancillary Services and Family Medicine. These are the same Service Committees discussed in Article III of these Bylaws.

As it relates to peer review, the duties of the Service Committees shall be:

(a) Assure that performance improvement and peer review activities and functions are carried out in a timely and responsible manner.

(b) Identification of data to be measured.

(c) Assuring appropriate collection of data.

(d) Assessing the data collected.

(e) Making recommendations related to their findings and assessment.

(f) Carrying out the peer review function.

(g) Reporting findings for inclusion in an individual Practitioner’s profile to be used for the purposes of credentialing and related activities.

(h) Reporting findings and recommendations to the MSQOC and MEC.

(i) Forwarding requests/recommendations for systems and process improvement initiatives to MSQOC and MEC.

4.3.1 [This section is intentionally omitted.]

4.3.2 [This section is intentionally omitted.]

4.3.3 [This section is intentionally omitted.]

4.3.4 [This section is intentionally omitted.]

4.3.5 [This section is intentionally omitted.]

4.4 Credentials Committee

4.4.1 Composition
The Credentials Committee shall consist of at least four representatives from the Medical Staff who shall be appointed annually by the President, and a chairperson, who shall be elected in the manner provided in Section 2.2.3. The CEO or designee and the
Administrator shall serve as Ex-Officio members of the committee. The Chair may also appoint Allied Health Professionals credentialed by Swedish Edmonds to serve as ad hoc, non-voting members of the committee. In addition, for applicants who are being considered for employed positions within Swedish Edmonds, the Medical Director responsible for hiring the applicant may serve as an ad-hoc non-voting member of the committee with regard to review of the applicant.

4.4.2 Duties

(a) Chair.

(1) The chairperson of the committee shall serve for a two-year term following nomination and election in the manner provided in Section 2.2.3, for officers of the Medical Staff. The chairperson shall be a member of the Active staff. The chairperson shall be elected in odd years.

(2) Removal of a chairperson during the chairperson’s term of office may be accomplished by a two-thirds majority vote of the MEC, a simple majority of which immediately thereafter shall appoint a successor to serve out the remaining term.

(3) Similarly, in the event of a vacancy in the position of chairperson for any reason other than removal, the MEC at its next meeting shall appoint a successor to serve out the remaining term.

(b) Duties

(1) To review the credentials of all applicants and to make recommendations for Staff membership, Service assignment and delineation of Privileges in compliance with these Bylaws;

(2) To make a report to the MEC regarding each applicant for Medical Staff membership or Privileges, including specific consideration of the recommendations from the Services in which such applicant requests Privileges;

(3) To review periodically information available regarding the competence of staff members and as a result of such reviews to make recommendations for the granting of Privileges and reappointments;

(4) To investigate any breach of ethics that is reported to it; and

(5) To review reports that are referred by the Medical Executive, Medical Record and Utilization Review Committees, or by any other committees provided for in these Bylaws, and by the President.
4.4.3 Meetings
The Credentials Committee shall meet at such intervals as the Committee deems necessary to perform its duties and specially when called by its chairperson, and shall maintain a permanent record of its proceedings and actions.

4.5 Bylaws Committee

4.5.1 Composition
The Bylaws Committee shall consist of an Active Medical Staff member appointed by the President who shall serve as Chair. In addition, members shall be appointed by the Chair from among the Active Medical Staff with consideration given to geographic and specialty representation. The President, the Administrator, and the Director of Medical Staff Services, and others designated by the Chair, shall serve in an Ex-Officio capacity.

4.5.2 Duties
The Bylaws Committee:

(a) Considers amendments to the Medical 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 staff; and

(b) Reviews newly proposed Service, committee, medical staff, and Policies for composition and compliance with the Medical Staff Bylaws, Rules and Regulations, and policy at the request of the President or MEC;

4.5.3 Meetings
The Bylaws Committee shall meet as needed, but no less than annually.

4.6 MEC/Medical Staff Relations Committee

4.6.1 Composition
The MEC/Medical Staff Relations Committee shall be an ad hoc committee consisting of the President, President-Elect, Chief Medical Officer, and other qualified individuals as invited by the President. The chair of the Bylaws Committee and the Administrative Director of Medical Education and Medical Staff Services shall serve as Ex Officio members of the committee.

4.6.2 Duties
The MEC/Medical Staff Relations Committee provides a forum for medical staff members to review issues and manage conflict between the Medical Staff and the MEC 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 Staff.

4.7 Other Committees
The President or MEC may establish or dissolve integrated committees or ad hoc committees, which shall then be identified in the Organization and Functions Policy.
ARTICLE V: PARLIAMENTARY PROVISIONS RELATING TO GENERAL MEDICAL STAFF MEETINGS, AS WELL AS SERVICE AND COMMITTEE MEETINGS

5.1 Annual Medical Staff Meeting
The annual meeting of the Medical Staff shall be held in the month of October.

5.2 Other Medical Staff Meetings

5.2.1 Special Meetings
Special Medical Staff meetings may be called at any time by the President, the Board, or the MEC. In addition, the President shall call a special meeting within 30 days after receipt of a written request signed by not less than 25 members of the Active Medical 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 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 Staff member at his/her address as it appears on the records of the Medical Staff Services Service. Notice by email address shall be deemed delivered when sent if sent to the Medical Staff member’s email address currently on file with the Medical Staff Services office. It is the responsibility of the Medical Staff member to notify the Medical Staff Services Service of any changes to his or her email address. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that business stated in the notice of the meeting.

5.2.2 Other Meetings
The MEC may establish by resolution a schedule of additional regular meetings of the Medical Staff. Notice of the schedule of such regular meetings shall be given when such schedule is established; thereafter, regular meetings provided for in that schedule may be held without further notice for the purposes of reviewing and evaluating Service and committee reports and recommendations. Business to be transacted at such meetings shall be limited to matters that require action only by Active Medical Staff members.

5.3 Quorum for Medical Staff Meetings
A quorum consists of 20 percent of the total membership of the Active Medical Staff. There shall be no voting by proxy.

5.4 Mail or Electronic Ballot for Medical Staff Actions
Any action that can be taken by the Medical Staff at a meeting may be taken by mail or electronic ballot if the MEC so directs. Such ballot must (1) state the date ("the Vote Date") by which it must be received by the President 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 Staff members who desire to meet informally to discuss such issue. The ballot must be distributed to each Active Medical Staff member not later than two weeks before the Vote Date. To be effective, 20 percent of the Active Medical 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).
5.5 Order of Business for Medical Staff Meetings

5.5.1 The order of business at any regular Medical Staff meeting is as follows at the discretion of the presiding Medical Staff Officer:

(a) Call to order;
(b) Acceptance of the minutes of the last regular Medical Staff meeting (or campus meeting as appropriate) and all such intervening special meetings;
(c) Special Reports;
(d) Standing Committee Reports;
(e) Report from CEO or designee of Hospital;
(f) Report from the Chief Medical Officer or his/her designee;
(g) Report from the presiding officer;
(h) Old business;
(i) New business;
(j) Election of Officers (if applicable);
(k) Discussion and recommendations for improvement of the professional work of the Hospital;
(l) Announcements;
(m) Adjournment.

5.5.2 The order of business at special Medical Staff is as follows:

(a) Reading of the notice calling the meeting;
(b) Transaction of the business for which the meeting was called;
(c) Adjournment.

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

5.7 Minutes and Reports; Confidentiality
A record shall be promptly prepared and permanently maintained for each regularly scheduled Medical Staff, Service 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 Staff Services to be preserved as the official record.

Minutes and reports shall be distributed (even in draft form) only to Service or committee members, the MEC, the CEO, the 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.

5.8 Service/Standing Committee Reports
The minutes shall be maintained in the Office of Medical Staff Services.

5.9 Quorum for Service/Standing Committee Meetings
A quorum consists of those Active staff members present, but not less than three members or majority.

5.10 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.

5.11 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 MEC 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.

5.12 Review of Bylaws, Rules and Regulations and Policies
These Bylaws, Rules and Regulations and policies shall be reviewed at least every two years and revised as needed.

5.13 Approval of Bylaws

5.13.1 Approval Process for Bylaws

(a) The MEC shall recommend for review and approval by the Active Medical 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.

(b) Notwithstanding Section 5.14 below, the organized Medical Staff has the ability to adopt Medical Staff Bylaws, and amendments thereto, and to propose them directly to the Board. Prior to a vote for adoption by the Medical Staff the proposal is presented for informational purposes to the MEC in writing and signed by not less than 25 members. The proposal is then voted upon by the Medical Staff with the same process as Bylaws amendments recommended by the MEC (Section 5.14). 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.

5.14 Amendment of Bylaws

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

(a) In order to be adopted at a Medical Staff meeting, a proposed amendment must receive an affirmative vote by two-thirds of the Active Medical 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 20 percent of the Active Medical 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 MEC for approval prior to submission to the Active Medical Staff members:

(1) If the vote occurs at a Medical Staff meeting, then the proposed amendment shall be distributed to Active Medical 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 Medical Staff members in the manner provided in these Bylaws for mail or electronic ballots;

(d) The MEC shall have the authority to amend the Bylaws in non-substantive issues, including spelling and grammatical corrections as well as the updating of titles without a vote by the Active Medical Staff members.

(e) Bylaws ballots shall allow for approval of the Bylaws recommendation in total, a vote to disapprove in total, or a line item veto.

5.14.2 Approval by Board
An amendment so adopted by the Active Medical Staff members shall become effective when approved by the Board.

5.15 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 STAFF RULES AND REGULATIONS AND POLICIES

6.1 Medical Staff Rules and Regulations and Policies
The Medical 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) MEC proposals

(1) The authority to propose to adopt a rule, regulation, policy, or an amendment thereto is granted to the MEC by vote of the organized medical 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 5.14.

(2) With this authority, the MEC 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 Staff for review and comment for 14 days. If there is conflict between the organized Medical Staff and MEC about a proposal the issue may be brought by interested representatives of the Medical Staff to a meeting of an ad hoc committee prior to submission to the Board.

(3) The MEC shall have the authority to amend a rule, regulation, or policy in non-substantive issues, including spelling and grammatical corrections as well as the updating of titles without the requirement of a Medical 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 MEC and Board may provisionally adopt amendments without prior notification of the Medical Staff. This delegated authority for the MEC must be affirmed by a vote of the Medical Staff at least every two years. The process for this vote will be as outlined in Section 5.14. In the case of an urgently adopted provisional amendment, the Medical 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 Staff and the MEC, 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 Staff, the issue will be brought to an ad hoc committee for discussion and resolution. If necessary, a revised amendment will then be submitted to the Board for action.
Medical Staff Proposals
The Medical Staff may recommend for approval by the Board Rules and Regulations and policies. Prior to a vote for adoption by the Medical Staff the proposal is presented for informational purposes to the MEC in writing and signed by not less than 25 members. The proposal is then voted upon by the Medical Staff with the same process as Bylaws amendments recommended by the MEC (Section 5.14). 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 Staff and Hospital policies.

ARTICLE VII: MEDICAL STAFF MEMBERSHIP AND PRIVILEGES

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

The Medical Staff is a part of the legally constituted Hospital Corporation created by the Board. The Medical 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 Staff shall be only those applicants who continuously demonstrate, to the satisfaction of the Medical 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 Staff and the Board that any patient treated by them in the Hospital will receive quality care and that the Hospital and the Medical 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). Applicants from outside of the United States will be considered 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.

Applicant shall maintain such certification as stipulated by their certifying bodies so long as the applicant is a member of the Medical Staff. Maintenance of such certification may be excepted on a case by case basis after consideration by the Credentials Committee and MEC. 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 MEC 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 staff membership and privileges. The Board shall determine the Service(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 Staff who were members as of April 19, 1989 and who continue to maintain membership status through consecutive, uninterrupted reappointments to the Medical Staff.
Notwithstanding Section 7.2.7 above, only in exceptional circumstances, Practitioners in practice for at least five years immediately preceding appointment to the Medical Staff are Active Staff members of another hospital accredited by The Joint Commission and approved by the Board.

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.

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 the Physician's specialty or subspecialty.

Clinical and Other Privileges

Privileges
Every Practitioner practicing at the Hospital (by virtue of Medical 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. 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 staff. The Hospital shall make available to the medical 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.

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 MEC following its consideration of the recommendations by the Services as reviewed by the Credentials Committee.

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 Service or Services in which privileges are sought. Any relevant information relating to the applicant's qualifications may be considered by the applicable Services, the Credentials Committee, the MEC, 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;

(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 Staff Members
During the first year of medical staff membership, focused case review is routinely carried out by the Service 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 physician’s clinical competence by a proctor who represents, and is responsible to, the medical 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 physician. 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 MEC, or the CEO, 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 180 days from date of signature, it shall automatically be administratively withdrawn. The Practitioner may reapply in accordance to policy regarding reapplication.

g) Consultation with Other Services
When any privileges sought by an applicant are subject to the jurisdiction of Services other than the Service to which the applicant is requesting assignment, the Service to which assignment is sought, after making an initial decision to recommend any such privileges, shall review the application and consult with other such Services before making a final recommendation to the Credentials
Committee. After the Credentials Committee completes its review, it shall transmit its recommendations to the MEC. If any other such Service objects to the recommendation of any such privileges by the Service(s) to which assignment is sought, then it may file such objections in writing with the MEC, 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 medical history and physical examination prior to scheduling the performance of dental surgery, and 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 the Accreditation Council on Graduate Medical Education 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 when there is 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 Staff. In these cases, 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. The individual must apply for Medical 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 CEO 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 Staff membership if required more frequently.

(c) Interim Privileges
These privileges may be granted by the CEO 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 MEC 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 CEO 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 Staff member) or Review Procedure (AHP) rights.

The applicable Service 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 CEO 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 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 its patients, and on the qualifications of the volunteer Practitioner.

The following individuals and their designees are authorized to grant disaster privileges: the CEO, the President of Swedish, the 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 Edmonds.
7.4 Nondiscrimination
Medical 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 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 Staff Bylaws, Rules and Regulations, policies 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 MEC. Each AHP shall be assigned to a clinical Service.

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 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 inpatient care are required to have a documented supervising relationship with a Physician with appropriate Privileges. The supervising Physician is responsible for the care provided and must be available at all times for consultation with the Supervised AHP on patient care issues. Written entries and/or dictated documents made by Supervised AHPs do not require co-signatures by their supervising physicians.

(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 Staff.

(2) [This section is intentionally omitted.]

(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 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 Staff Services immediately (within 5 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 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 Staff.

Dues shall be assessed annually in January of each year in an amount to be determined by the Hospital and Medical 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 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.
Submission of AHP Application
Applications shall be submitted to the Hospital's Medical Staff Office. The Service Chief, or designee, of the Medical Staff Service to which the AHPs 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 and Medical Staff policies and guidelines, make a recommendation on privileges requested. This recommendation will be forwarded to the MEC for review.

The report of the Service Chief and the recommendations of the Credentials Committee and MEC 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.

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.

Licensure, registration or certification, when applicable, must be confirmed annually at a time consistent with the state required relicensure.

(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 President or by the Service Chief to which the AHP is assigned.
(2) A Supervised AHP’s Privileges automatically terminate when:

(i) The Medical 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 Staff performance improvement structure and activities. If the performance review process results in an Adverse Recommendation from the MEC, the AHP shall have the right to challenge the finding as outlined in the Hearing Procedure below.

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

Upon receipt of the grievance, the MEC 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 MEC.

(2) Action of the Board
The Board shall consider the recommendation of the MEC and make a written final decision. The Board's decision shall be final, binding and conclusive.

(3) 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 Staff. Notwithstanding the preceding sentence, the
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MEC 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.

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

The CEO 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 CEO 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 Staff Membership and Privileges

7.6.1 Pre-Application

(a) A pre-application for appointment to the Medical Staff shall be sent only upon request to: (i) 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 an 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 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 Staff membership must be typewritten or legibly handwritten in ink, signed by the applicant, submitted on a form (or forms) prescribed by the MEC, and approved by the Board.

7.6.3 Application Content

(a) Every application shall contain the applicant's specific acknowledgment of a Medical Staff member's obligations to provide continuous care of his/her patients, abide by the Medical Staff Bylaws, Rules and Regulations, and policies, and accept committee and consultation assignments as required of members in the Medical 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 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 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 Edmond's Risk Management Service 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 (e) 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 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 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 Staff and Policies 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 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 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 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 Staff, each applicant thereby signifies his/her willingness to appear for interviews in regard to the application; authorizes the Hospital and the Medical Staff to consult with administrative and Medical 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 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 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 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 Service based on practitioner specialty training. The Chief of the applicable Service shall review the application and request for privileges and transmit them, together with Service 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 MEC within 30 days after receipt of the completed application for membership. Prior to making its report, the Credentials Committee and the Chiefs of the applicable Service 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 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 Service Chiefs shall include specific written recommendations for delineating the applicant's privileges in the respective Services.

(b) The Credentials Committee shall submit to the MEC the completed application together with its recommendation that (a) the applicant be provisionally and/or
conditionally appointed to the Medical Staff with or without delineated privileges, or (b) the applicant be rejected for Medical 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 MEC shall decide (a) to recommend to the Board that the applicant be provisionally appointed to the Medical Staff, (b) to recommend that he/she be rejected for Medical 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 MEC's recommendation is to defer the application for further consideration, the MEC must submit, within 60 days thereafter, a subsequent recommendation to the Board for provisional appointment with specified privileges or for rejection for Medical Staff membership and privileges.

(e) The MEC’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 MEC. If the MEC's decision is adverse to the applicant in respect to either appointment or privileges, the CEO or designee shall give the applicant written Notice of such adverse recommendation within five days. Notification by the CEO 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 MEC recommendation, representatives of the Board shall consult with the MEC 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 CEO or designee to the President and Chief of the applicable Service 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 Staff and/or Hospital. This review shall be carried out by the Chief of the respective Service or designee, who shall make recommendations as appropriate to the Credentials Committee.

(b) Each recommendation concerning reappointment to the Medical Staff and the privileges to be granted upon reappointment shall be based upon such member’s continuing to possess all qualifications for Medical 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 MEC shall make written recommendations to the Board, through the President, 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 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 MEC 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 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 Staff membership or privileges at this or any other hospital. Existing Medical 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 Staff or of privileges constitutes the Practitioner's agreement to strictly abide by the ethics of his/her profession, the Medical Staff Bylaws, Rules and Regulations, policies, and all Policies; and to immediately report to the President or CEO 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 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 Staff as provided in these Bylaws. In the event of unwarranted delay on the part of the Medical 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 Staff.

(b) Provisional Appointment and Privileges
All initial appointments to the Medical 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 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 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 Staff and the Allied Health Professional Staff may request a leave of absence subject to approval by the MEC 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 Service Chair or designee, Credentials Committee, MEC and by the Board.

(f) Serious or Disabling Illness
Any member of the Medical Staff or an Allied Health Professional who has suffered a serious or disabling illness may be requested by the Service Chief, Credentials Committee Chair, or Administrator 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 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 Staff shall be deemed to have resigned in good standing, provided that such Practitioner has performed all Medical Staff obligations, including completion of medical records.

7.7 Review by Outside Consultants
The Executive Committee, the Administrator or designee and the Chief of the Medical Staff may, through the Medical 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 Staff or perform all or part of any peer review or Performance Improvement activity as deemed appropriate.

Such review shall be advisory and the MEC 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 Staff.
ARTICLE VIII: CATEGORIES OF THE MEDICAL STAFF

8.1 Membership Categories
The Medical Staff is divided into three categories: Active, Courtesy, and Honorary. Staff membership is independent of privileging.

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 Edmonds. This may be evidenced by fulfillment of at least two of the following five criteria:

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

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

(c) Attend 50 percent of Service 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; and

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

Active members are:

8.2.1 Eligible to vote, hold office, and serve on Medical Staff committees;

8.2.2 Eligible to be included in Swedish physician referral programs;

8.2.3 Assigned to one specific Service;

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 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 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 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 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:

8.3.1 Assigned to one specific Service;
8.3.2 Eligible to serve on Service and/or Medical Staff committees without the right to vote, unless otherwise specified in these Bylaws;
8.3.3 Not eligible to serve as an officer of the Medical Staff or vote on matters before the Medical Staff at large;
8.3.4 Required to pay dues established pursuant to these Bylaws;
8.3.5 Required to carry professional liability insurance coverage;
8.3.6 Required to provide emergency care and accept consultation assignments where appropriate for those practitioners with privileges as described in Rules and Regulations;

8.4 [This section is intentionally omitted.]

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

8.5.1 Appointed by the Board on recommendation of the MEC;
8.5.2 To have no required duties or privileges;
8.5.3 Not allowed to consult, treat, admit patients, or assist in surgery and may not write in patient records;
8.5.4 Not eligible to hold office in the Medical Staff;
8.5.5 Eligible to sit in an ex-officio capacity on Medical Staff committees unless otherwise stated;
8.5.6 Not required to pay dues;
8.5.7 Required to carry professional liability insurance coverage unless not engaged in clinical practice.

8.6 Residents and Fellows
The Medical Staff may 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 Swedish Medical Center Graduate Medical Education Committee. The Program, Fellowship, or Training Director for each approved area of training must be an Active member of the Medical Staff.

Residents and Fellows have no Medical Staff rights or Privileges unless qualified through application to Medical Staff membership with specific privileges based on meeting specialty qualification from prior training (Medical 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. The trainee may enter information into the medical record. Documentation completion is the responsibility of the Medical Staff member.

ARTICLE IX: MEMBER RIGHTS

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

9.1.1 Right to Meet with Medical Staff Leadership
A Medical Staff member has the right to meet with Medical Staff Officers and/or Service leadership. If the issue or concern cannot be resolved, the member may meet with the MEC upon written request to the President.

9.1.2 Right to Initiate a Petition
An Active staff member has the right to initiate a petition to:

(a) Recall his/her Service Chair;
(b) Recall a Medical 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 Staff;
(f) Call for a special meeting of the member's Service;
(g) Recall any action of the MEC, except those relating to Service and committee reports and relating to Privileges.
9.1.3 Right to Communicate with the Board
A Medical Staff member may communicate with the Board on a rule, regulation or policy adopted by the organized Medical Staff or the MEC. 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 Medical Staff, except petitions to recall a Service Chief, which requires the signatures of 10 percent of the Service or 25 Active members, whichever is less. The petition may be submitted to the MEC for consideration at their next meeting. In a case in which there is a Service Chief recall, the petition must be submitted to the MEC.

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 MEC:

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

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

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

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

9.1.6 Right to Representation
The Medical Staff shall be represented in any Hospital deliberation affecting the discharge of Medical Staff responsibilities.

ARTICLE X: QUALITY IMPROVEMENT

10.1 Program Description

10.1.1 Purpose
The Medical 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 Service or system performance improvement activities. Peer review and performance improvement findings are considered in performance evaluation, credentialing, and privileging.

The Medical 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 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 MEC 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 MSQOC. The MSQOC is authorized to provide oversight of the performance improvement function and focused review activities as outlined in these Bylaws. The MSQOC reports to the MEC. Quality review activities are performed by the Service Committees and/or delegated performance improvement subcommittees. Service Chiefs will triage cases to specialty subcommittees as appropriate. Specialty and ad hoc committees may be designated by the MEC as needed. Reports and recommendations from these activities shall be prepared and shared with the MEC 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 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 Service/peer review indicators that have been defined by the Medical 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 Staff Services and QRCs 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 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 MSQOC will provide an annual report to the MEC, Quality Management Committee and Board Quality Committee on the quality review committees’ activities including case volumes, categories, behavioral concerns and indicators.

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

10.2 Organization

10.2.1 Service Committees
Quality review activities are performed by the following Service Committees: Medicine; Surgery; Obstetrics; Pediatrics; Psychiatry; Emergency Medicine; Critical Care; Ancillary Services; and Family Medicine. The MEC, MSQOC and/or Service Committees may delegate quality review activities to an ad hoc or subcommittee, as appropriate.

10.2.2 Responsibilities
(a) President: The President is responsible for ensuring that the Practitioners meet their requirement in peer review and performance improvement activities.

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

(c) Medical Staff Quality Oversight Committee (MSQOC): The MSQOC functions as the quality sub-committee of MEC 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 Staff governance documents and the most current standards of applicable regulatory or accreditation agencies. System issues are referred to the Quality Management Committee for resolution with responsibility for reporting to the MSQOC.

(d) Service Committees: The Service Committees conduct peer review and focused review, review applicable performance data, report conclusions, and make recommendations to the MSQOC. Service Committees assure completion of individual and focused review of Practitioner performance and recommend action to the MSQOC.

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 MSQOC or Service Committee 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
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 quality 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 Edmonds and of those employees of Swedish Edmonds who serve such committees and panels as staff persons, shall be in the possession and control of the CEO or designee.

The CEO 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 Staff Office personnel; provided that, the Practitioner may not take the Quality/Peer Review Information outside of the Medical 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 credentialed 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 Staff Bylaws, Rules and Regulations, policies, and Policies.

10.4 Peer Review

10.4.1 Quality Management and Regulatory Compliance Role
The Quality Management and Regulatory Compliance (QMRC) Department is currently identified as the Hospital Service assigned to provide administrative support for medical staff quality, peer review and performance improvement activities.

10.4.2 Initiation of Peer Review
(a) Peer review referrals are initiated by, or forwarded to, the QMRC Service. All cases referred for peer review are documented on the Confidential Peer Review Worksheet form prior to inclusion on the medical staff service committee Quality Assessment and Improvement Report.
(b) Cases shall be directed to the service committee responsible for credentialing the involved Practitioner.

(c) Charts shall be signed out on a monthly basis and assigned as per identification of Practitioner to perform peer review. The assigned peer review Practitioner will be notified regarding the need for case review by the QMRC Service.

(d) All peer review referrals will be forwarded to the respective Service Committee with, a statement of the reason for referral, peer review evaluation with preliminary “leveling assignment” and as appropriate the response by the involved Practitioner and/or the Chief of Service or other Practitioners involved in the review. The Service Committee will review documentation and determine if the information presented is adequate and appropriate.

10.4.3 Procedure for Peer Review

(a) Identification of Practitioner to Perform Peer Review

Practitioner selection for analysis of peer review issues shall be prioritized as follows:

1. To peer member of Service Committee
2. To member of same specialty/ outside committee/ different practice group
3. To member of same specialty/ outside committee/ same practice group
4. To Chief of Service for direction
5. To external peer review at the direction of MEC.

(b) Initial Peer Review

The peer reviewer shall provide an initial analysis and recommendation based on review of the chart to be completed as soon as possible after notification. Disposition of case recommendations will be denoted in writing on the Confidential Peer Review Worksheet.

1. Cases where the peer reviewer determines a “preliminary leveling assessment” of 0 or 1 will be automatically reported to the Service Committee.
2. Cases where the peer reviewer determines a “preliminary leveling assessment” of 2 or greater and further information is necessary to complete the review, QMRC (with assistance from the Chief of Service as requested) will forward a letter of inquiry to the appropriate physician(s) for his/her response.

(c) Affected Practitioner’s Response

The Practitioner who is recipient to a peer review inquiry will respond in writing within one month of the initial inquiry. Failure to respond in writing within one...
month shall result in issuance of a Letter of 2nd Notice requiring written response within 30 days. If the Practitioner who is recipient to a peer review inquiry fails to respond to the 2nd Notice letter within 30 days, the following actions may be initiated:

1. The President will contact the Practitioner by phone, and
2. A registered letter requiring response within five days will be sent to the Practitioner.

Failure on the part of a Practitioner to respond to a peer review inquiry as outlined above may be cause for summary suspension from the Medical Staff.

(d) Disposition of Initial Peer Review Findings
The Service Committee will reach a conclusion based upon assessment of the medical care, peer judgment, documentation and compliance with accepted medical standards and Service policies. Sources may include but are not limited to: published standards of care, organizational policies, regulatory requirements, and Medical Staff policies. The conclusion may result in the assignment of a category. The assigned category will indicate the action to be taken by the QRC. See Exhibit 1: Peer Review Evaluation System.

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

(e) Additional Investigation and Review

1. Should the Service Committee determine that there is a significant issue and additional information is necessary, further inquiries may be sent directly from the Service Committee.
2. If an interview of the involved Practitioner is deemed necessary, an invitation may be extended for the next meeting (regularly scheduled or special meeting). If the Practitioner declines an invitation, the Service Committee will make recommendations to MSQOC based upon the available documentation and information. If the involved Practitioner wishes to provide direct input, his/her request will be considered.
3. The Service Committee will make a recommendation based upon an assessment of the medical care, judgment, documentation and compliance with accepted medical standards (sources may include but are not limited to: regional standard of care, Joint Commission, CMS, Medical society, AMA, specialty boards and college standards, policies and/or white papers).
4. Should additional information be required, the Service Committee will identify the information required, the person who will be responsible to obtain the information, the person or persons who will be requested to
provide information and the time frame in which the information is to be reported back to the Service Committee.

10.5 Focused Professional Practice Evaluation – as it Relates to Peer Review

10.5.1 Should a number of cases come before a Service Committee concerning a specific Practitioner, the Service Committee 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 Service Committee. 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 category of 4 or 5;

(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.

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

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

(b) The Service Committee chair will send a written request for the involved Practitioner to respond within ten days. Additional time may be granted based on the volume of cases to be reviewed.

(c) The Practitioner is invited to the Service Committee.

(d) The Service Committee will review the response and assign a category to the cases reviewed.

(e) The Service Committee will recommend action based on the Peer Review Evaluation System to MSQOC and the MEC.

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 may be extended. When a focused review is established, the Service Committee chair will report the activity plans and status to the MSQOC.
10.7 External Peer Review

10.7.1 Considerations
Based upon the information reviewed and/or the category assigned, the Service Committee may request to the MSQOC, President, Administrator or CEO/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 Service Committee, 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 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 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 Staff does not have the necessary subject matter expertise to evaluate adequately the quality of care involved.

10.7.2 Actions
The MSQOC, President, Administrator or CEO/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 MSQOC, management and oversight of the external review process will be the responsibility of the MSOC. Potential reviewers will be identified by, and acceptable to the President and the Service 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 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 Service Committee 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 Service Committee and the MSQOC.

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

10.8 Conclusions
Each Service Committee will forward quarterly reports of findings and conclusions related to performance to the MSQOC. The MSQOC reports this information to the MEC which will forward appropriate information to the Board.

Action by the MEC 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 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 Fair Hearing process.

Any action taken by the MEC will be within the requirements of these Bylaws and provisions for Fair 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 clinical 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 Staff has first-hand knowledge necessary to satisfy itself that the Practitioner is competent.

10.9.3 Retrospective proctoring involves a retrospective review of patient charts by the proctoring Practitioner. 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 Staff. It is up to the Service 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 Staff member receives notice of an Adverse Recommendation of the MEC, the Medical Staff member shall be entitled to a Review Hearing before a hearing committee of the Medical 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 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 MEC 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 Staff member) or Review Procedure (AHP), unless the Board fails to sustain the MEC’s recommendation. In such event, the Board shall send Written Notice to both the Practitioner and the MEC.

Actions that are considered Non-Adverse Actions and are not grounds for a Review Hearing (Medical 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 Administrator 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 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 Staff for lack of sufficient patient contacts;

11.3.8 Deeming an application for initial appointment to the Medical Staff incomplete pursuant to Section 7.6.6 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 Service;

11.3.12 The imposition of a Corrective Action Plan;

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

11.3.14 When the applicant fails to achieve eligibility for an application to the Medical Staff or to meet eligibility requirements for Medical 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 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 Medical Staff member any Review Hearing 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 admitting and/or clinical privileges. In this situation, removal of Privileges also results in automatic relinquishment of Medical Staff membership.

11.4.2 Adverse Actions
Only the following actions, if recommended by the MEC 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 Staff member) or Review Procedure (AHP) in accordance with the applicable processed defined in these Bylaws.

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

(b) Failure to advance a Practitioner from Provisional status to Courtesy or Active membership status after 24 months;

(c) Reduction of a Practitioner to the Courtesy category unless such is as a result of the Practitioner’s failure to participate in the required minimum patient contacts or is in response to the Practitioner’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 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 Staff, the Chief of any clinical Service, the Chair of any standing committee of the Medical Staff, the CEO, 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 MEC. This request shall be supported by specifying those activities or conduct that constitutes grounds for the Request.

(a) Notice to Practitioner and CEO
The MEC 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 MEC, the President will present the Request for Corrective Action. The MEC 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 Service Chief, MSQOC, or Service Committee for further information.

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

The reviewing committee to which the matter is referred shall report back to the MEC 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 MEC 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 MEC, 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 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 MEC.

d) MEC Action
The MEC 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 MEC defined under Adverse Actions in these Bylaws shall entitle the Practitioner to the Review Hearing rights (Medical Staff member) or Review Procedure (AHP).

(f) **Other Rights**
If the MEC’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 Staff member) or Review Procedure (AHP) rights with respect to these recommendations unless the Board disagrees with the MEC’s recommendation, in which case, the Board may direct that there be a Review Hearing (Medical 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 Staff. Such termination is reportable to the National Practitioner Data Bank (NPDB).

### 11.4.5 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 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 President, the MEC, the Administrator/designee, a Service Chief, the CEO 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 President and the 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 President or responsible Service 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 MEC 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 President. 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 President as may be done at any time at the President’s discretion, without cause or notice, and thereby reinstate immediately the Summary Suspension then in effect.

(d) MSQOC Investigation and MEC Action
Within seven days after a Summary Suspension has been imposed, the MSQOC 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 MSQOC’s recommendation. If the Summary Suspension is removed, the MSQOC shall forward its Written Report of the investigation to the MEC within 30 days of the imposition of the Summary Suspension. If the Summary Suspension remains in effect, the MSQOC shall forward its Written Report of the investigation to the MEC within 14 days of the imposition of the Summary Suspension.

(e) If the Summary Suspension remains in effect, the MEC shall meet and take appropriate action within 30 days of the imposition of the Summary Suspension, in which case, the MEC shall consider the matter at its next regular meeting. The MEC 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.

(f) Procedural Rights
If the MEC 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 Staff member) or Review Procedure (AHP) and the MEC shall provide the required Written Notice. Unless the MEC 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).

11.4.6 Precautionary Restriction of Privileges
(a) When a specific event, a pattern of events, or any event that may lead to a recommendation by the MEC that would entitle the individual to request a Review Hearing (Medical 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 MEC, CEO, President, President-Elect of Medical Staff, Service Chief, or the 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 CEO or MEC. Any extension of the precautionary restriction beyond 14 days must be recommended by the MEC.

(c) There is no right to a Review Hearing (Medical 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 CEO and the President who shall promptly notify the Practitioner and the respective Service 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 MEC or President may conduct an investigation about the concern in question, or may assign the task to an appropriate Medical Staff Committee, or outside reviewer(s). The President 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 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 Staff member) or Review Procedure (AHP) apply. The investigating body shall provide a written report of its investigation to the MEC as soon as practicable. The report may include recommendations for appropriate further measures or corrective action.

(i) MEC Authority During Investigation
Regardless of the status of any investigation, the MEC 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) MEC Action or Recommendation
As soon as practicable after the conclusion of the investigation, the MEC shall take action or make recommendations, which may include without limitation:

(1) Determining no corrective action is appropriate, and, if the MEC 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 Service 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 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 Staff membership; and

(9) Taking other actions deemed appropriate under the circumstances.

(k) Subsequent Action on MEC Recommendation
The President shall promptly inform the Practitioner who was the subject of an investigation of any action or recommendation by the MEC pursuant to subsection (8) above. The President shall also inform the Board of its recommendation. If the action or recommendation is an Adverse Action and if the Medical Staff member fails to request a Review Hearing in a timely manner, the recommendation of the MEC shall become a final recommendation and the President shall so inform the Board for its review and action.
11.4.7 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 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 (c), (d) or (e) above for a period greater than 90 days without demonstration of sufficient effort to resolve this problem, Medical 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 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 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 Staff membership and Privileges.

(k) Imposition of Automatic Relinquishment of Privileges
The CEO or designee or the President or designee shall notify the Emergency Service and all other appropriate Hospital Services and personnel and Medical 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 MEC 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 Staff Bylaws, Rules and Regulations, policies or Hospital policies shall not be reappointed until the deficiency has been rectified or a corrective action plan has been approved by the MEC. Alternatively, the Practitioner may be granted conditional reappointment, contingent upon correction of the deficiency.

(m) Notification of NPDB and Washington DOH
The CEO 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 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 CEO 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 Staff member when advised of an Adverse Action, as defined in these Bylaws. A Medical 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 MEC recommends an Adverse Action, the CEO or designee shall be responsible for giving written notice of the recommended Adverse Action to the affected Medical Staff member who is entitled to a Review Hearing informing the Medical Staff member:

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

(b) A statement that the Medical 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 Administrator within 30 days of his/her receipt of the written notice of the recommended Adverse Action; and

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

Refusal to accept such written notice shall constitute receipt thereof.

11.5.2 Waiver of Hearing
The affected Medical Staff member may waive his/her right to a hearing by (1) submitting Written Notice to the 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 Administrator shall forward all recommended Adverse Actions to the Board for final action and shall give the Medical Staff member and the MEC prompt Written Notice of decisions of the Board, which become final by virtue of the Medical 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 Staff member entitled to the same, the Administrator shall schedule the Review Hearing and shall give the Medical 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 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 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
20 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 Staff or Hospital staff to voluntarily appear at the hearing if requested to do so upon reasonable notice by the MEC, 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 CEO or designee, acting with the concurrence of the President, shall appoint a Review Hearing Committee, which shall be comprised of no fewer than three Active Medical Staff members or two Active Medical Staff members and a consulting Physician who is not on the Medical 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 Staff may be appointed to the committee, but the majority of the committee shall be Active Medical 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 Staff member’s Personal Presence
The personal presence of the Medical Staff member who requested the Review Hearing shall be required. A Medical 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 President and CEO 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 MEC and the Medical 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 MEC 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 Physician 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 Physician is entitled to be accompanied and represented by any attorney or
another person of his/her choice. The MEC shall appoint a member of the Active
Medical 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 MEC 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 MEC’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 Staff Services. A stenographic copy shall be made of the hearing with the fees paid by the Hospital. The Medical 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 Staff Services Office.

(l) 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.

(m) 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 MEC’s recommendation regarding the Adverse Action and shall provide a final recommendation to the Board for its final disposition. The Administrator shall, after receipt of the written Review Hearing report, give the Practitioner and MEC Written Notice of the recommendation of the Review Hearing Committee and a copy of the Review Hearing report.

(n) Action of the Board
Upon review of the Review Hearing report, the Board shall send Written Notice of its decision to the Medical Staff member and MEC 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
ARTICLE XII: LEGAL PROTECTIONS AND CONFLICTS OF INTEREST

12.1 Legal Protections

12.1.1 Indemnification
Medical Staff Officers, Service 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 Staff involved in review of patient care activities.

12.2 Authorization and Release
Any Practitioner who applies for or accepts privileges or Medical 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 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 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 Edmonds, the Board, and any officers, agents, representatives, and employees of Swedish Edmonds, the Hospital or said association, any advisory board and committees, and the Medical 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 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, and as amended, 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 Staff membership, privileges, or other actions taken pursuant to these Bylaws:

12.4.1 The Medical Staff, its members, Services, 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 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 Administrator and the President 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 staff matters may exist for a Practitioner or advisor to the medical 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 MEC 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 President, the CEO, the Medical Director, the Service 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
Except for routine non-invasive diagnostic outpatient procedures, a medical History and Physical performed by a member of the Medical Staff is required for all admissions. The History and Physical shall contain information sufficient for all caregivers to safely care for the patient. A complete History and Physical must contain, as appropriate:

13.1.1 Chief complaint or reason for admission;

13.1.2 Clinically relevant history including history of present illness, past history, medications, allergies, family history, social history and habits and review of systems;

13.1.3 Clinically relevant physical exam;

13.1.4 Statement of conclusions/impressions/provisional diagnosis; and

13.1.5 Treatment plan or goals.

13.2 Completion and Authentication
A History and Physical must be completed and authenticated no more than 30 days prior to or within 24 hours after inpatient admission or registration, but prior to surgery or a procedure requiring sedation or anesthesia. History and Physicals over 30 days old will not be accepted. Except in extreme emergencies, no patient will undergo surgery without a documented History and Physical examination in the patient’s medical record.

13.3 Interval Note
When a patient is readmitted within 30 days for the same or related problem, an interval History and Physical reflecting any subsequent changes may be used in the medical record, providing the original History and Physical is included in the current medical record or immediately available in the earlier medical record and located on the appropriate nursing floor.
BYLAWS

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THE MEDICAL STAFF OF SWEDISH EDMONDS

President

SWEDISH HEALTH SERVICES

Chair of the Board

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