NORTHWEST HOSPITAL & MEDICAL CENTER

Seattle, Washington

BYLAWS OF
NORTHWEST HOSPITAL MEDICAL STAFF

Effective Date:

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OF

NORTHWEST HOSPITAL MEDICAL STAFF

ARTICLE I: NAME

The name of this organization is Northwest Hospital & Medical Center Medical Staff.

ARTICLE II: DEFINITIONS

A. The term "Medical Staff" means this organization and all individuals who are members thereof.

B. The term "Hospital" means Northwest Hospital & Medical Center.

C. The term "Governing Board" means the governing body of the Hospital or designated persons so functioning on its behalf and holding responsibility for Medical Staff matters.

D. The term "Medical Executive Committee" ("MEC") means the Executive Committee of the Medical Staff unless specific reference is made to the executive committee of the Governing Board.

E. The term "Executive Director" means the individual appointed by the Governing Board, or his/her designee, to act in its behalf in the overall management of the Hospital.

F. The term "Physician" means Doctors of Medicine and Doctors of Osteopathy.

G. The term "Consultant" means a member of the Physician Active Staff, Affiliate Active Staff, Provisional Staff or Courtesy Staff who may be asked to advise in his/her specialty concerning a patient in the Hospital.

H. The term "Medical Staff Year" means a twelve-month period ending on the 31st day of December in each year.

I. The term "Elected Medical Staff Leadership" shall mean the Chief of Staff, the Chief of Staff Elect and the Secretary/Treasurer of the Medical Staff.

J. The term "Vice President-Medical" shall mean the physician appointed by the Executive Director.

ARTICLE III: PURPOSES AND FUNCTIONS OF THE MEDICAL STAFF

The Medical Staff recognizes that the Governing Board has ultimate responsibility and authority concerning all activities in the Hospital, including medical activities, and that the Governing Board has delegated to the Medical Staff the duty of establishing and controlling the quality of medical care in the Hospital. To fulfill that duty, which the Medical Staff assumes, the purposes and functions of the Medical Staff are:

A. To establish standards of medical care and professional conduct for the Medical Staff; to strive that those standards be in compliance with selected national accrediting organizations;

B. Regularly to review, analyze and supervise the professional conduct and the quality of medical care in the Hospital, giving precedence at all times to the interests and safety of the patients;

C. To establish and maintain a formal medical educational program to help accomplish the foregoing;

D. To exercise necessary discipline within the limitations of authority delegated by the Governing Board over members of the Medical Staff for violations of these Bylaws, the rules and regulations of the Medical Staff, the policies and procedures of the Hospital applicable to the Medical Staff and decisions of the Governing Board and the Hospital administration;

E. To report and make recommendations to the Governing Board at regular intervals as to: the quality of medical care in the Hospital; the establishment, maintenance and enforcement of professional standards; all matters relating to the Medical Staff and applications therefore; all alterations of staff status; the grant, denial, modification and limitation of clinical privileges of members of the Medical Staff; disciplinary actions; and such specific matters as may be referred to the Medical Staff by the Governing Board or the Executive Committee of the Governing Board; and

F. To assist the Governing Board and Executive Director in planning Hospital goals to meet community needs.

G. To establish qualifications for appointment, privileges, and terms of appointment for each category of the Medical Staff, as set forth in the Medical Staff Bylaws.

H. To communicate all official Medical Staff transactions in writing, unless otherwise specified herein.

ARTICLE IV: MEMBERSHIP

A. Categories of Membership. The Medical Staff shall be divided into the following categories:

1 Provisional Staff
2. Physician Staff: Active, Provisional, Courtesy
3. ARNP Staff: Active, Provisional, Courtesy
4. Affiliate Staff: Active, Provisional, Courtesy
5. Associate Physician Staff
6. Inactive
7. Emeritus

1. Provisional Staff.

a. Qualifications. The Provisional Staff shall consist of newly appointed members of the Medical Staff, whose qualifications and professional activities shall be observed and examined by the Medical Staff for a period of one year. Provisional Staff members shall be appointed to a specific Division and as appropriate Sub-specialty, and normally the Chief of the Division or his/her representative shall perform such observation.

b. Rights and Responsibilities. Provisional Staff Members shall not be eligible to vote or to hold office on the Medical Staff. They shall assume and perform all other duties and obligations of members of the Medical Staff.

2. Physician Active Staff.

a. Qualifications. The Physician Active Staff shall consist of Doctors of Medicine and Doctors of Osteopathy who have at least twenty (20) patient contacts per year, or who have the majority of their patient contacts at Northwest Hospital.

b. Rights and Responsibilities. Physician Active Staff members shall have the right to admit patients to the Hospital subject to limitations regarding availability of facility space and equipment. Physician Active Staff members shall assume and perform all duties and obligations of membership on the Physician Active Staff, including attendance at such Medical Staff meetings as provided for in these Bylaws and its Rules and Regulations, and performance, as appropriate, of emergency service care and consultation requests. Physician Active Staff members shall be appointed to specific Sections and Divisions as defined in these Bylaws and shall be eligible to vote and hold office on the Medical Staff and serve on its committees.

3. ARNP Active Staff.

a. Qualifications. The ARNP Staff shall consist of Advanced Registered Nurse Practitioners who work with physician members of the Medical Staff or whose offices are appropriately available for patient care to the Hospital and who have at least twenty (20) patient contacts per year, or who have the majority of their patient contacts at Northwest Hospital.

b. Rights and Responsibilities. ARNP Staff members are individuals who may participate directly in the medical management of patients, but only under the supervision of an Active member of the Medical Staff accorded clinical privileges under these Bylaws, and who shall have ultimate responsibility for the patient's care. The ARNP shall have a written agreement for supervision by the Active Medical Staff member.

ARNP Staff members shall be appointed to a specific Division and Sub-specialty. They shall be eligible to vote and to hold office on the Medical Staff, may serve on its Divisional and sub-specialty committees as voting members, and shall assume and perform all other duties and obligations of the Physician Active Staff.

4. Affiliate Active Staff.

a. Qualifications. Affiliate Active Staff shall meet all criteria and conditions as may from time to time be established by the MEC and approved by the Governing Board and shall consist of Dentists, Podiatrists, Clinical Psychologists and Certified Nurse Midwives.

An Affiliate Active Staff member shall have at least twenty (20) patient contacts per year, or have the majority of his/her patient contacts at Northwest Hospital, and shall have offices appropriately available for patient care to the Hospital.

b. Rights and Responsibilities. Affiliate Active Staff members may

admit patients to the Hospital within the scope of privileges granted to them at Northwest Hospital & Medical Center. Consultation must be obtained for clinical problems outside of the Affiliate member's area of limited licensure, which may be present or may arise during the hospitalization. Procedures performed by Affiliate Active Staff shall be under the overall supervision of the Chairman of the Division to which they are assigned. Affiliate Active Staff members shall be eligible to vote and to hold office on the Medical Staff, may serve on its Divisional and sub-specialty committees as voting members, and shall assume and perform all other duties and obligations of the Physician Active Staff.

5. Courtesy Staff.

a. Qualifications. The Courtesy Staff shall consist of individuals eligible for Physician Active Staff, ARNP Active Staff or Affiliate Active Staff membership, who are given privileges to admit or attend an occasional patient in the Hospital as delineated by their privileges and pursuant to the Bylaws, Rules and Regulations. Courtesy Staff must hold Physician Active Staff Membership, ARNP Active Staff Membership, Affiliate Active Staff Membership or other comparable Medical Staff membership in another hospital in the community. On a case-by-case basis, as special circumstances may warrant, the Governing Board may appoint individuals to the Courtesy Staff who are not members of the active or comparable medical staff of another hospital in the community. The individual will be encouraged to join a hospital active staff and until so done, exceptions may be made on a case-by-case basis. Those Courtesy Staff members having more than twenty (20) patient contacts a year, or having the majority of their patient contacts at Northwest Hospital, shall be required to seek membership on Physician Active Staff, ARNP Active Staff or Affiliate Active Staff as may be appropriate.

b. Rights and Responsibilities. Courtesy Staff members shall be appointed to a specific Division and Sub-specialty. They shall not be eligible to hold office or vote on the Medical Staff matters, but may serve on its Divisional and sub-specialty committees as non-voting members.

6. Associate Staff.

a. Qualifications. The Associate Staff shall consist of individuals who have an M.D. or D.O. degree and have sponsorship for application from a member in good standing of the Active Medical Staff and shall be approved by the Governing Board. The Governing Board may withhold approval of an applicant's appointment if the Board concludes appointment does not advance the mission of the Hospital. Initial appointments will be for a period not to exceed one year. Applicants need not meet the residency training requirement.

b. Rights and Responsibilities. Associate Staff members shall not be eligible to vote or hold office on the Medical Staff; nor shall they have right to due process. They will not have admitting privileges nor be allowed to write orders. If an Associate Staff member needs to admit a patient to Northwest Hospital, the physician will be required to make arrangements with a physician-member of the Medical Staff who has admitting privileges. Those physicians who come to the Hospital for a specific purpose (e.g. surgical assist) would have no responsibility or authority before or after patient contact. Those physicians in the Associate Staff category who practice exclusively in their offices, who wish an affiliation with Northwest Hospital, may refer patients to the Hospital but will have no patient (clinical) responsibility in the

Hospital.

7. Inactive Staff and Leave of Absence.

a. Inactive Staff Qualifications. The Inactive Staff shall consist of Members of the Medical Staff who by reason of prolonged absence from the medical community shall be granted Inactive status for a period not to exceed three years. Application for reinstatement must be made in writing. The Credentials Committee will review the requests prior to recommendation to the MEC.

b. Inactive Staff Rights and Responsibilities. Inactive Medical Staff members shall not be eligible to attend patients, vote or hold office on the Medical Staff or to serve on its committees.

c. Voluntary Leave of Absence. A Member of the Medical Staff may request a voluntary leave of absence for personal or health related reasons by submitting a written request to the Chief of Staff addressed to the Medical Staff Office. The request shall indicate the reason for the leave of absence and the anticipated length of the leave of absence. The Chief of Staff may consult with the Elected Medical Staff Leadership, the MEC, the relevant division and/or the Division Chief when evaluating the request.

d. Automatic Leave of Absence. If a Member of the Medical Staff is away from the Medical Staff or patient care responsibilities for greater than 30 days due to the member's physical or mental health or other reasons that affect their ability to care for patients safely and competently and the Member has not voluntarily requested a leave of absence, then upon becoming aware of such circumstances, the Chief of Staff in consultation with the Executive Director may place the member on an automatic medical leave of absence.

e. Rights and Responsibilities During Leave of Absence. During a leave of absence, the member will not exercise any clinical privileges and will be excused from Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations). The obligation to pay any applicable dues will continue during a leave of absence except that a Member granted a leave of absence for U.S. military service will be exempt from this obligation.

f. Reinstatement Following Personal Leave of Absence. Members requesting reinstatement will submit a written summary of activities during the leave and any other information that may be requested by the Hospital or the Chief of Staff. Requests for reinstatement will then be reviewed by the relevant Division Chief, Chief of Staff and the MEC, in consultation with the Vice President-Medical and the Executive Director.

g. Reinstatement Following Medical Leave of Absence. If the leave of absence was for health reasons (except for maternity leave), the Member shall be evaluated by the Practitioner Health Committee pursuant to the Hospital's Practitioner Health Issues Policy to determine if the Member is capable of resuming a hospital practice and safely exercising the clinical privileges requested. Following the Practitioner Health Committee's evaluation, it shall make a recommendation to the MEC regarding the Member's reinstatement to the Medical Staff. The MEC shall consider the matter and make a recommendation to the Governing Board for a final determination on the reinstatement request.

h. Expiration of Appointment During Leave of Absence. If a Member's current appointment is due to expire during the leave of absence, the Member's appointment and clinical privileges will expire at the end of the appointment period, and the individual will be required to apply for reappointment.

8. Emeritus Medical Staff.

a. Qualifications. The Emeritus Medical Staff shall consist of individuals who have formerly served on the Physician Active Staff, in good standing, for more than ten years, have retired from the private practice of medicine, and who have been nominated by the Credentials Committee for this status. Others may be appointed who are deemed worthy of such appointment by majority vote of the MEC.

b. Rights and Responsibilities. The Emeritus Medical Staff members shall not be eligible to admit patients, to vote or hold office on the Medical Staff. They shall be invited to participate in educational and social Medical Staff events with waiver of any fees for Medical Staff events and shall be invited guests to the annual staff dinner. They shall be allowed to serve as non-voting members of committees.

9. Fellows.

Fellows must be enrolled in an ACGME (Accreditation Council on Graduate Medical Education), AOA (American Osteopathic Association) or ADA's Commission on Dental Accreditation approved fellowship training program. Fellows must be eligible to apply for Medical Staff membership, be granted appointment and be assigned clinical privileges to the extent needed to fulfill their additional educational requirements and as permitted by law, these Bylaws and the Medical Staff Rules & Regulations. Fellows are assigned to a specific specialty within one of the Divisions. Fellows must work under the supervision of a member of the Medical Staff when managing clinical problems for which the Fellow has not been granted clinical privileges. The supervising Medical Staff member must be granted the specific privileges for any clinical problem they supervise.

10. Physicians in Training.

Physicians in Training are medical students, interns and residents who are sponsored and supervised by an Active Medical Staff Member for a clinical experience at Northwest Hospital and approved by their institution for the specific clinical experience at Northwest Hospital. They must be in training at an institution with which the Hospital has an affiliation agreement for educational purposes. Scope of clinical activities and the degree of supervision are established by the appropriate Division of the Medical Staff and approved by the Governing Board. Policies and procedures governing the Hospital's relationship with the Physician in Training are defined by Hospital Administration. Supervision of Physicians in Training shall be performed in accordance with Hospital and Medical Staff policies and procedures. The supervising Active Medical Staff Member has ultimate responsibility for the patient. Physicians in Training are not members of the Medical Staff and therefore are not granted the rights and privileges afforded members of the Hospital's Medical Staff.

B. Appointments and Privileges.

1. Grant and Revocation. Each appointment and reappointment to the Medical Staff shall be made to one or more specific Divisions or Sections and to a specific

category of membership, and shall limit the exercise of clinical and other privileges to those specifically granted. Individuals shall have the burden of establishing their qualifications for appointment, reappointment and privileges, including submission of all documents, references and other evidence material to proper evaluation of their qualifications. Each appointment, reappointment, termination of appointment, and each grant, limitation and termination of privileges shall be made by the Governing Board after receipt and review of recommendations from the MEC or Hearing Committee. The Governing Board may at any time impose conditions on, suspend, limit or terminate any appointment, privilege or privileges, change any category of membership, or take other corrective action in its discretion whenever it determines an individual does not meet the qualifications for appointment or privileges described below in Article IV, B. 3 and 4, or whenever it determines the personal or professional conduct of an individual is lower than the standards of the Medical Staff, disruptive of the operations of the Hospital, or impairs the quality of patient care or the safety or interests of any patient.

2. Release and Immunity from Liability. The following are express conditions applicable to any applicant and to any person appointed to the Medical Staff and to anyone having or seeking privileges or status as a Registered Health Professional and to anyone, having or seeking the privilege to practice that person's profession in the Hospital. In addition, by applying for appointment, reappointment or clinical privileges the applicant expressly accepts these conditions during the processing and consideration of the applicant's application, regardless of whether or not the applicant is granted appointment or clinical privileges. These conditions shall also apply during all periods of appointment and reappointment;

a. To the fullest extent permitted by law, the applicant or appointee extends absolute immunity to, and releases from liability, the Hospital and its representatives and any third party with respect to any and all civil liability which might arise from any acts, communications, reports, recommendations, or disclosures involving an applicant or appointee, performed, made, requested or received by the Hospital and its representatives, to, from, or by any third party including other appointees to the Medical Staff concerning activities relating, but not limited, to:

(i) Applications for appointment or clinical privileges;

(ii) Periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;

(iii) Proceedings for reduction or suspension of clinical privileges or revocation of Medical Staff appointment, or any other disciplinary sanction;

(iv) Summary suspension;

(v) Hearings and appellate reviews;

(vi) Medical care evaluations;

(vii) Utilization reviews;

(viii) Other Hospital and Medical Staff, division, section, sub-specialty or committee activities relating to the quality of patient care or the professional conduct of an applicant or appointee to the Medical Staff or of any individual granted privileges to practice in the Hospital, and concerning matters or inquiries relating to an applicant's or

appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter that might directly or indirectly have an effect on the individual's competence, or on patient care, or on the orderly operation of this Hospital or any other hospital or health care facility including otherwise privileged or confidential information.

b. Any act, communication, report, recommendation or disclosure, with respect to any such applicant or appointee, made in good faith and at the request of an authorized representative of the Hospital or any other hospital or health care facility, anywhere at any time, for the purposes set forth in (a) above, shall be privileged to the fullest extent permitted by law. Such privileges shall extend to employees of the Hospital and its authorized representatives, and to any third parties who either supply or are supplied information and to any of the foregoing authorized to receive, release or act upon the same.

c. The Hospital and its authorized representatives are specifically authorized to consult with the appointees to the medical staffs of other hospitals or health care facilities or the management of such hospitals or facilities where the applicant or appointee is or has been associated, and with others who may have information bearing on the applicant's or appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter, as well as to inspect all records and documents that may be material to such questions. The applicant or appointee grants immunity to any and all hospitals, health care facilities, individuals, institutions, organizations and their representatives who in good faith supply oral or written information, records or documents to the Hospital in response to any inquiry emanating from the Hospital or its authorized representatives.

d. The applicant or appointee specifically releases from any liability all representatives of the Hospital, including all appointees to its Medical Staff, for investigations requested, statements made, materials provided or acts performed in good faith in evaluating the applicant or appointee for any of the purposes or reasons set forth in this section.

e. As used in this section the term "Hospital and its representatives" means the Hospital, the corporate member(s), the members of its Board and their appointed representatives, officers, the Executive Director and his or her subordinates or designees, employees, consultants to the Hospital, the Hospital's attorneys and their partners, assistants or designees, and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating the applicant's or appointee's credentials and/or acting upon the application or conduct in the Hospital.

f. As used in this section, the term "third parties" means all individuals or government agencies, organizations, associations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives.

3. Qualifications for Appointment.

a. Nature of Medical Staff Membership. Membership on the Medical Staff is a privilege extended only to professionally competent individuals who continuously comply with the Rules and Regulations of the Medical Staff and the requirements of these Bylaws and the Bylaws of the Hospital, as amended from time to time. Appointment to the Medical Staff shall confer only such clinical privileges as are granted by the Governing Board in

accordance with these Bylaws. Appointment to the Medical Staff shall be made pursuant to the following criteria uniformly applied to all applicants for appointment and privileges.

b. Basic Criteria for Membership. All applicants for initial appointment to the Medical Staff shall meet the following criteria, which shall be verified by the Hospital from the primary source whenever feasible:

(i) Applicants must be appropriately licensed to practice in their profession in the State of Washington; document their background, experience, training and competence, professional behavior, their good reputation and their ability to work with others sufficiently to satisfy the Medical Staff and Governing Board that they will provide efficient, high quality medical care in the Hospital; this shall include information on voluntary and involuntary relinquishment of membership, licensure, and privileges.

(ii) Physician applicants must have completed a residency as required for Board Certification in the appropriate specialty for which privileges are requested.

(iii) Applicants to the Affiliate Staff must have completed a residency, if applicable, in the appropriate specialty for which privileges are requested. The residency requirement may be waived by the Governing Board after considering the special competence and experience of the applicant.

(iv) All applicants must provide current evidence of professional liability insurance which meets criteria for such insurance as established by the Hospital;

(v) Initial physician applicants to the Medical Staff must provide documentation of current certification by a national specialty board approved by the American Board of Medical Specialties or American Osteopathic Association. Initial non-physician applicants to the Medical staff must provide documentation of certification from such nationally recognized specialty board or organization which provides certification in the non-physician applicant's profession and, if applicable, certification in the specialty within the non-physician's profession. Physicians desiring Hospital medical staff membership who have successfully completed a residency and/or fellowship must provide documentation of board certification within five (5) years of the date they were first eligible for board admission if they wish to remain eligible for staff privileges. Board Certification must be in the specialty for which privileges are requested. Physician members of the Medical Staff are required to maintain ABMS or AOA Board Certification, as defined by their certifying board, in their primary specialty. Non-physician members of the Medical Staff are required to maintain board, as defined by their certifying board, in their professional category and any specialty. In exceptional circumstances, the Governing Board may grant waivers.

(vi) Applicants must have evidence of reasonable ability to perform privileges requested at a level of competency which consistently meets or exceeds the standard of care acknowledged in the course of peer review.

(vii) The application form for membership shall provide information regarding demographic data (location, phone, birth date, and citizenship), education (premedical, medical/ professional education, residencies, fellowships and other postgraduate education), history of membership or affiliation at other health care facilities, teaching appointments, publications or major professional meetings (either as attendee or speaker, etc.),

specialty board status, membership in professional societies, licensure, DEA No. or statement of exception, state licensure(s) held, DSHS, Medicare Provider No., liability insurance, NPI, practice history, information on adverse actions or pending actions with regard to staff membership, privileges, licensure, and certification, legal or professional liability matters, and ability to perform privileges requested. In addition, a photo and application fee shall be submitted as well as a list of privileges requested. A completed application packet will also contain a list of three physicians, including a member of the Northwest Hospital Active Medical Staff, as references from present and past affiliations as well as information from the National Practitioner Data Bank, and Washington State Patrol.

(viii) Applicants for Medical Staff membership must submit documentation of back-up coverage as part of their application. Back up coverage must be a physician Medical Staff member with privileges in the same specialty. The MEC may grant exceptions.

c. Institutional Criteria. Basic Qualifications shall also include a determination as may be made from time to time by the Governing Board as to:

(i) The ability of the Hospital to provide adequate facilities and supportive services for the applicant and his/her patients; and

(ii) The patient care needs of the Hospital for additional staff members with the applicant's skills and training.

d. Miscellaneous.

(i) No license, training, privilege, or membership at in another hospital or any other factor, as such, shall entitle any individual to privileges or Membership on the Medical Staff.

(ii) Medical Staff Membership shall not be denied on the basis of sex, sexual orientation, race, creed, color or national origin.

(iii) The Hospital and the Medical Staff may determine there are clinical services to be delivered through telemedicine, according to commonly accepted quality standards. Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. If a telemedicine practitioner prescribes, renders a diagnosis or otherwise provides clinical treatment to a patient, the telemedicine practitioner shall be credentialed and privileged through the Medical Staff mechanisms set forth in these Bylaws or credentialing and privileging decisions of the distant site will be accepted if the distant site is a Joint Commission accredited organization and a contract exists between the Hospital and the distant site.

(iv) Acceptance on the Medical Staff shall constitute that member's agreement to comply with and be bound by all provisions of these Bylaws and the Bylaws of the Hospital as amended from time to time, all rules, regulations, and policies governing membership on the Medical Staff and practice at the Hospital, and all applicable principals of professional ethics.

(v) It is the further responsibility of all Medical Staff members and Registered Health Professionals to report to the Chief of Staff or designee the following:

- within (30) days of any judgment or arbitration award or any financial payment to settle a claim involving professional liability that such judgment, award or payment occurred and the details surrounding such action, and;

- immediately upon revocation, suspension, challenge, or voluntary relinquishment of a license to practice medicine or other health care profession or narcotics license.

- immediately upon voluntary or involuntary termination of Medical Staff Membership, limitation, reduction, or loss of clinical privileges at another hospital or healthcare facility.

Failure to report as required may result in suspension of clinical privileges or other corrective action.

(vi) At its discretion, the MEC may request any applicant for appointment to appear for an in person interview with one or more of its members.

4. Qualifications for Privileges.

a. Each application by an individual for clinical privileges or a modification of clinical privileges must be specific as to the clinical privileges requested.

b. Criteria for Privileges. In addition to the criteria set forth in Article IV.B.3. - Qualification for Appointment, requests for clinical privileges shall be evaluated in light of clinical performance, the documented results of patient care audits and other quality review activities and information concerning clinical performance obtained from other institutions and health care settings where the applicant provides or has provided clinical services. Such a determination shall also include consideration of the individual's physical and mental ability to perform at the level of requested privileges, and shall be in accordance with the policies for delineation of privileges established by each Division and Sub-specialty with the approval of the MEC and the Governing Board. Any applicant must submit evidence of current health status if requested by the Credentials Committee and/or the MEC of the Medical Staff. A separate record shall be maintained for each individual who requests individual clinical privileges.

5. Initial Appointments. In order to observe the qualifications of the applicant, initial appointment to membership shall be made only to the Provisional Medical Staff for a period of twelve months. On or before the end of this appointment period, the member shall be:

a. appointed to the appropriate Medical Staff category;

b. reappointed to the Provisional Medical Staff for a period not exceeding twelve months for additional observation; or

c. not appointed.

6. Reappointments.

a. On or before the end of each appointment period, the member

shall either be reappointed to the same or another category of membership or removed from the Medical Staff. Reappointment will be for a term of not more than two years.

The application forms for reappointment shall include documentation of present affiliations, special education, training or awards, ability to perform privileges requested, professional liability claims and coverage, legal, and adverse action information, and request for privileges. A completed application packet will also include reference letters from outside institutions addressing the physician's ability to practice as requested as well as information from the National Practitioner Data Bank.

b. If after a two-year interval a Medical Staff member has had no patient contacts at the Hospital, he or she may, in the sole discretion of the Governing Board, be administratively removed from the Medical Staff. Such administrative removal from the Medical staff under this section shall not entitle the Medical Staff member to a hearing under Article V of these Bylaws.

c. Reappointment criteria are an extension of initial appointment criteria and include review of Physician Quality Summary, assessment of new or ongoing privilege requests, evidence of ability to perform privileges requested, and evidence of relevant training, clinical competence and peer recommendations, to support the physician's request for privileges.

7. Temporary Privileges. Temporary privileges may be granted to a non-staff physician in the following circumstances:

a. New Applicant with a Complete Application. Temporary privileges for a new applicant to the Medical Staff may be granted by the Executive Director or authorized designee upon the recommendation of the Chief of Staff or authorized designee consisting of the Chief of Staff elect, Chief of the Division affected, or the Vice President-Medical of the Hospital, when a complete application which raises no concerns is awaiting review and approval by the Board or its delegated Board committee, and verification of the following has been obtained by the MEC:

- current licensure;
- relevant training or experience, current competence;
- ability to perform the privileges requested;
- a query and evaluation of the National Practitioner Data Bank;
- a complete application;
- no current or previously successful challenge to licensure or registration;
- no subjection to involuntary termination of medical staff membership at another organization;
- no subjection to involuntary limitation, reduction, denial or loss of clinical privileges at any hospital or healthcare facility, and
- proof of current professional liability insurance acceptable to the Hospital.

For new applicants meeting the criteria set forth above, temporary privileges shall be granted for a period not to exceed 120 consecutive days.

b. Important Patient Care Need. Temporary privileges may also be granted to an applicant by the Executive Director or authorized designee upon the recommendation of the Chief of Staff or authorized designee consisting of the Chief of Staff elect, Chief of the Division affected, or the Vice President-Medical, when there is an important patient care, treatment or service need such as the following:

i. the care of a specific patient; or
ii. when necessary to prevent a lack or lapse of services in a needed patient care area.

When temporary privileges are granted to meet an important patient care need, evidence of the following is required: current Washington state licensure, current competence, acceptable malpractice history, DEA number, acceptable results of a query to the National Practitioner Data Bank, and proof of current professional liability insurance acceptable to the Hospital. Temporary privileges granted to meet an important patient care need shall not exceed a period of 120 days, except in extraordinary circumstances the time period may be extended as determined by the Executive Director or authorized designee, in consultation with the Vice President-Medical, the Chief of the Division affected, or the Chief of Staff (or the Chief of Staff Elect in the absence of the Chief of Staff).

8. Locum Tenens. The Executive Director or authorized designee may grant temporary admitting and clinical privileges to a physician serving as a locum tenens for a member of the Medical Staff. The criteria set forth above for temporary privileges granted for a new applicant with a complete application [Section 7(a)] must be met. During any 12-month period, an individual serving as a locum tenens may exercise privileges for a maximum of 60 days, except where hardship caused by incapacitating illness or similar special circumstance of the staff member makes this impractical, privileges in such event may be granted for a period not to exceed 120 days.

9. Compliance with Bylaws and Policies. Prior to any temporary or locum tenens privileges being granted, the physician must agree to be bound by the Bylaws, rules and regulations, policies, procedures, and protocols of the Medical Staff and the Hospital.

10. Emergency Disaster Privileges. In any emergency, any member of the Medical Staff, to the degree permitted by his license and regardless of Privileges, Division, Sub-specialty, or Medical Staff status or lack of it, shall be permitted and assisted to use every facility of the Hospital and to do everything possible to treat the patient. For the purpose of this section, an "emergency" is defined as a condition in which immediate treatment is necessary to prevent serious permanent harm to a patient, to preserve the life of a patient or to prevent serious deterioration or aggravation of a patient's condition.

In case of an emergency/disaster, any licensed independent practitioner shall be given privileges by the then ranking administrative or Medical Staff authority of the Hospital. When the emergency/disaster situation no longer exists the "Emergent Privilege Status" will be terminated and further privileging will be through the established protocols.

11. Termination of Temporary and Similar Privileges. Privileges that are temporary, locum tenens, or emergency disaster are granted as a courtesy and may be terminated, all or partially, immediately and without cause, by the Executive Director or authorized designee, Vice President-Medical, or Chief of Staff. If privileges are terminated by one of the referenced persons, notice will be provided to the other individuals designated with

authority to terminate privileges, including the Chief of the Division or Sub-specialty in which that physician was granted privileges. Privileges so terminated do not entitle the physician to a hearing and appeal rights unless a professional review action is taken based upon professional competence or conduct and the action is reportable to the National Practitioner Data Bank.

12. Emergency Call. All members of the Active, Courtesy and Provisional staff shall, upon request of the applicable Division Chief, share Emergency Room Call with other members from his/her Division until he/she attains the age of 60. Any exceptions to this must be approved by the Chief of his/her respective Division and the Chief of Staff. Service on the Emergency Call Schedule at the Hospital is an obligation of membership for those who are requested to serve on the Call Schedule but is not a right, privilege or other entitlement for any member of the Medical Staff whether or not the individual has regularly served on the Call Schedule or has been requested to serve on the Call Schedule in the past. Criteria for participation in Emergency Room Call shall be specified in Divisional Rules and Regulations.

13. Medical Staff Dues and Budget. The Medical Staff, through its MEC has the right to establish and collect Medical Staff dues, and disburse Medical Staff funds. Approval of the annual budget is by the Medical Staff. Proposed dues and budget will be submitted by the Secretary/Treasurer to the Medical Staff at least thirty days prior to the budget year for adoption. Dues will be billed to the Medical Staff membership before December 31st of each year. Failure to pay dues within 6 months will result in suspension of privileges.

C. Procedure Concerning Appointments and Privileges.

1. Applications. Each individual must apply in writing to the Medical Staff Office for initial appointment, for initial or additional privileges and for change in category of membership.

a. Application for Initial Appointment. The initial application must be in writing, signed by the applicant, and submitted on the Medical Staff Application form, and shall be accompanied by such other documents and references as may be required therein.

b. Application for Reappointment. A completed reappointment packet designed to update the applicant's qualifications shall be submitted to the Medical Staff Office.

The Medical Staff Office shall collect such additional references and other materials as may be deemed pertinent by the Vice President -Medical or any Medical Staff committee or Chief of the Division or sub-specialty taking part in evaluation of the application for initial appointment or reappointment and shall transmit them with the application, documents and references to the MEC within thirty days after receipt of the application and all documents and references as may be required therein.

2. Evaluation of Applications. The MEC shall coordinate the investigation and the evaluation of all applications. The applicable Division Chief will review the application and may, as necessary, consult with or request other Members in the applicant’s specialty to review some or all portions of the application and provide the Division Chief with feedback and a recommendation if requested. At its next regular meeting or at a special meeting after receipt of such report, the MEC may review all of the foregoing and determine its own recommendations and appropriate action based upon its evaluation of the applicant's qualifications for appointment and privileges. Failure of a Division Chief, or others requested by the Division Chief to review

the application, to meet the time goals referenced shall not be a violation of these Bylaws nor provide to the applicant any right to damages or other remedy. The MEC will make a recommendation to the Governing Board which shall make a final determination on the application.

3. An application will not be considered complete until all required and pertinent information is received and verified through the Medical Staff Office. If an applicant fails to provide all information needed for a complete application within six (6) months after the Medical Staff Office has submitted written documentation to the applicant outlining the outstanding information, the application will be closed and filed as incomplete and no further action will be taken to complete the application. Anyone having an application filed as incomplete will not be eligible to apply for medical staff membership and privileges again for twelve (12) months from the date upon which the application is filed as incomplete.

D. Provision of Care

1. Medical History and Physical Exam. Hospitalized patients must have a written or dictated medical history and physical examination no more than 30 days prior to, or within 24 hours after initial hospitalization, but prior to surgery or a procedure requiring anesthesia service. For a medical history and physical examination that was completed within 30 days prior to hospitalization, an update documenting any changes in the patient's condition is completed within 24 hours after admission, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination is completed by a physician, or other practitioner in accordance with the Rules and Regulations. Additional requirements concerning medical history and physician exam are defined in the Rules and Regulations.

2. Surgical Assisting. All members of the Medical Staff, in addition to other clinical privileges which may be requested and may be granted, have privileges to function as a surgical assistant.

ARTICLE V: CORRECTIVE ACTION AND SUMMARY SUSPENSION

A. Corrective Action. Whenever the competence or professional conduct of any member with clinical privileges affects or could affect adversely the health or welfare of a patient or patients, or is considered to be lower than the established standards or contrary to the aims of the Medical Staff, or to be disruptive to the operations of the Hospital, corrective action against such Member may be requested by any officer of the Medical Staff, any Chief of Division or Sub-specialty or the Chairperson of any Inter-Divisional committee of the Medical Staff, the Chief Executive Officer, the Vice President-Medical or the Governing Board. Each request for corrective action shall be in writing, delivered to the Chief of Staff, and shall delineate the specific facts which constitute one or more of the grounds for the request as stated above in Article IV, B.1, 3, and 4 or as otherwise referenced in these Bylaws. A copy of this request shall be sent to the Member involved.

B. Summary Suspension of Clinical Privileges.

1. Whenever a Member disregards the requirements of these Bylaws or Hospital policies relating to patient care; or whenever a Member's conduct raises a reasonable and good faith belief that abuse of, or impairment due to alcohol or other drugs or a Member's

physical or mental health status might adversely impact patient care or materially disrupt the operations of the Hospital; or whenever a Member's conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patients, Medical Staff members, employees or other persons present in the Hospital, any one of the following: the Chairperson of the Governing Board, the Executive Director, the Chief of the Medical Staff or the Vice President-Medical shall have the authority to summarily suspend the Medical Staff membership status and/or suspend all or any portion of the admitting and/or clinical privileges of such Member, and such summary suspension shall become effective immediately upon imposition.

2. The person(s) imposing the suspension shall, within seventy-two (72) hours of the suspension, issue written notice of the suspension to the Member advising him/her of the reasons for the suspension. The person(s) imposing the suspension shall likewise give immediate written notice of the suspension to all other persons authorized under this subsection to impose summary suspensions and to appropriate Hospital Divisions and Medical Staff Officers.

3. A summary suspension shall also constitute a request for corrective action, and shall be processed in accordance with this Article and Article VI.

4. Immediately upon the imposition of a summary suspension, the Chief of the Medical Staff or responsible Division chairperson shall have the authority to provide for alternative medical coverage for the patients of the Member impacted by the suspension remaining in the Hospital at the time of the suspension. The wishes of the affected patients shall be considered in the selection of such alternative practitioner

C. Evaluation of Corrective Action Request.

1. Conciliation. Whenever the corrective action could result in a reduction, restriction, suspension, revocation, denial or failure to renew clinical privileges or membership on the Hospital's Medical Staff (an "Adverse Action"), the Chief of Staff shall refer the matter to the Chief of the applicable Division or Sub-specialty. One or more of either the Chief of the affected Division (or Sub-specialty), the Chief of Staff, the Chief of Staff Elect or the Vice President-Medical shall then arrange a personal or telephone conference or conferences with the Member to discuss the matter in an effort to conciliate and resolve the matter without any further proceedings. At his or her discretion, the individual(s) initiating the personal or telephone conference, may request participation/attendance of the Chief of Staff, the Chief of the affected Division (or Sub-specialty, the Elected Medical Staff Leadership and/or the Vice President-Medical at these conferences. It is expected that efforts at conciliation will be fully resolved within thirty (30) days from initiation by the Division Chief. A stenographic record, not verbatim, of the conference shall be made by or at the direction of the Division Chief.

2. Investigative Subcommittee.

i. If such conciliation efforts as described in Section C.1. above fail, an evaluation and investigation of the matter shall be conducted by a subcommittee of at least three members of the Division or Sub-specialty

which shall be appointed by the Division Chief (the "Investigative Subcommittee").

ii. The Investigative Subcommittee shall not include any individual who:

- Is in direct economic competition with the Member being investigated;
- is professionally associated with, a relative of, or involved in a referral relationship with, the individual being investigated;
- has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially consider the matter; or
- was actively involved in the matter at any previous level.

iii. The Investigative Subcommittee shall give notice to the Member, informing the Member of the request and charges, and requesting the Member to appear before it at a stated place at one of two (2) times at least six (6) days apart. The notice shall state the times and place the Member may inspect evidence relative to the charges prior to the appearance.

iv. During his/her appearance, the Member shall be asked to discuss, explain or refute the charges and evidence and may be accompanied by any member(s) of the Active Medical Staff the Member chooses to assist and speak on the Member's behalf.

v. A stenographic record, not verbatim, of the proceedings shall be made by the Investigative Subcommittee. The Member shall fully and timely cooperate with all provisions of this Article V including, but not limited to, responding to questions and providing documentation, whether from office records or elsewhere. The proceedings of the Investigative Committee do not constitute a hearing, and none of the procedural rules for hearings will apply.

3. Investigative Committee Report. The Investigative Subcommittee shall evaluate the evidence and shall submit the evidence and record of the proceedings to the MEC with its report setting forth its findings, conclusions and recommendations.

4. MEC Review and Recommendation. At a special meeting or at latest at its next regular meeting after receipt of such report, the MEC shall review all of the foregoing and determine its own recommendations. The Chief of Staff may, at his/her option, invite the Member to appear at such MEC meeting. Such appearance shall not constitute a hearing and no procedural rules shall apply. If the Member appears, a stenographic record, not verbatim, of the proceedings shall be made by the MEC, and the Member shall be asked to discuss, explain or refute the charges and evidence. The MEC shall submit a recommendation to the Governing Board regarding the corrective action request along with the Investigative Subcommittee's Report and records of proceedings.

5. Governing Board Review. If the recommendation of the MEC upon evaluation of the corrective action request and the Investigative Subcommittee report would not result in a

an Adverse Action, the MEC recommendation and all of the evidence and materials forwarded by the Investigative Subcommittee to the MEC shall be submitted to the Governing Board at its next regular meeting. The Governing Board shall act on the matter at that meeting.

ARTICLE VI. HEARING AND APPEALS

A. Grounds for Hearing. For the purpose of this Article IV, the term Member shall mean a Medical Staff Member or applicant to the Medical Staff for membership and/or clinical privileges.

1. The Member shall be entitled to the hearing and procedural rights under these bylaws upon occurrence of the following:

   i. A recommendation of the MEC for an Adverse Action, as defined in Article V.A.1., against the Member after evaluation of an application for appointment/reappointment or a request for corrective action.

   ii. A recommendation by the Governing Board for an Adverse Action against a Member or without prior Adverse Action recommendation by the MEC.

2. No other recommendations of the MEC or the Governing Board shall entitle the Member to a hearing.

B. Notice of Adverse Action and Right to Request Hearing. The Chief of Staff shall provide the affected Member with written notice of the proposed Adverse Action entitling a Member to a hearing by certified mail, return receipt requested. Such written notice shall include a copy of the Medical Staff Bylaws and shall state:

1. It has been proposed that an adverse recommendation or decision be taken against the Member or applicant and the reasons for such recommendation or decision;
2. That the Member or applicant has the right to request a hearing on the proposed action within thirty (30) days following the date of receipt of such notice;
3. That any request for the hearing must be made in writing, addressed to the Chief of Staff and include the name, address and telephone number of counsel, if any, for the Member or applicant.

C. Request for Hearing and Waiver of Right to Hearing. The affected Member has thirty (30) days following receipt of the notice of the proposed Adverse Action to request a hearing. The request must be in writing and addressed to the Chief of Staff. Failure to submit a timely written request for hearing or a failure without good cause to appear at all times at the hearing shall be deemed a waiver of the Member's right to a hearing. All rights to further hearing and all appellate rights of the Member are waived. In the event of such waiver, the MEC recommendations shall be submitted to the Governing Board for a final determination.

D. Notice of Hearing. The Chairman of the Hearing Committee or a person designated by the chair shall notify the affected Member by certified mail, return receipt requested, of the date of the hearing. The notice shall also state:

1. The place, time and date of the hearing which date shall not be less than thirty (30) days after the date of the notice;

2. A proposed list of witnesses (if any) expected to testify at the hearing on behalf of the MEC and a brief summary of the anticipated testimony

3. The names of the Hearing Panel members and Presiding Officer, if known;

4. A statement of the specific reasons for the Adverse Action recommendation and, if applicable, a list of patient records and other information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity to review and respond with additional information.

E. Composition of Hearing Committee. Upon receiving the Member's request for hearing, the Chief of Staff shall recommend for appointment by the MEC a Hearing Committee, consisting of not less than three individuals, one of whom shall be designated chairman. No member of the MEC shall be eligible for appointment to the Hearing Committee, nor shall any person who instigated or participated in the action concerning the immediate facts giving rise to the action pending be eligible for appointment to the Hearing Committee. No person in direct economic competition with the Member or applicant shall be eligible for appointment to the Hearing Committee. Knowledge of the matter involved or having participated previously in other adverse matters involving the Member or applicant shall not preclude a person from serving on the Hearing Committee.

F. Presiding Officer. The Chief of Staff shall appoint a Presiding Officer, who shall be an attorney, to preside at the hearing. The Presiding Officer must not act as a prosecuting officer or as an advocate for the Member, the Governing Board or the MEC. The Presiding Officer may participate in the private deliberations of the Hearing Committee and serve as an advisor to the Hearing Committee regarding the hearing procedure, but shall not be entitled to vote on the Hearing Committee recommendations. The Presiding Officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, and that decorum is maintained throughout the hearing. The Presiding Officer shall determine the order of procedure of the hearing and shall have the authority and discretion to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence. In all instances Presiding Officer shall act in such a way that all information relevant to the subject matter of the hearing is considered by the Hearing Committee in formulating its recommendations.

G. Objections to Hearing Panel/Presiding Officer. Any objection to any member of the Hearing Panel or to the Presiding Officer must be made in writing, within ten (10) days of receipt of notice, to the Executive Director. The objection must include reasons to support it. A copy of the objection will be provided to the Chief of Staff. The Chief of Staff will be given a reasonable opportunity to comment. The Executive Director will rule on the objection and give notice to the parties. The Executive Director may request that the Presiding Officer, make a recommendation as to the validity of the objection unless the Presiding Officer is the subject of the objection.

H. Pre-Hearing Procedures.

1. The affected Member shall have the right to representation by an attorney or other person of the Member's choice

2. The MEC shall appoint one of its members, another Medical Staff member, or an attorney to represent it at the hearing and thereafter may, if requested, continue to advise the Governing Board on the matter.

3. At least fourteen (14) days before the hearing, the Member or applicant requesting the hearing shall provide a written list of the names of witnesses expected to testify on the Member or applicant's behalf.

4. The Presiding Officer shall require the Member or a representative (who may be counsel) for the Member and for the Medical Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross examination. It is expected that the hearing shall last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

5. The parties and counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which in-person testimony at the hearing is reasonably required.

6. The following documents shall be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre hearing conference (without the need for authentication); and (c) stipulations agreed to by the parties.

I. Hearing Procedure

1. The hearing shall be conducted in the presence of the entire Hearing Committee and the affected Member. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

2. The hearing shall not be bound by the rules of law relating to the examination of witnesses or presentation and exclusion of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered.

3. A verbatim record of the hearing shall be kept. The cost of the stenographic reporter shall be borne by the Hospital. The cost of a hearing transcript shall be available at the Member's expense.

4. The representative of the MEC and the Member, or his/her representative, shall have the right to call, examine and cross-examine witnesses, to introduce evidence determined to be relevant by the Presiding Officer regardless of its admissibility in a court of law, and to rebut evidence adduced by the other party. If the affected Member does not testify on

his/her behalf, he/she may be called and examined by the MEC representative as if under cross-examination.

5. The members of the Hearing Committee may question the witnesses, call additional witnesses, or request additional evidence as they deem appropriate.

6. New or additional reasons for a proposed adverse recommendation, not raised or presented in the original notice, may be introduced at the hearing if permitted by the Hearing Committee. The Hearing Committee, in its sole discretion, shall determine whether additional reasons for a proposed adverse recommendation shall be considered. If considered, the party against whom the evidence is presented shall be provided a reasonable opportunity to respond before the Hearing Committee.

7. Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the Executive Director on a showing of good cause.

8. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee shall thereupon conduct its deliberations outside the presence of the parties. All issues shall be determined by majority vote.

J. Basis of Decision. The decision of the Hearing Committee shall be based on the evidence admitted at the hearing. This evidence may consist of the following:

1. oral testimony of witnesses;

2. documents and exhibits;

3. memoranda of points and authorities submitted by the parties;

4. any material contained in the Hospital's files and prepared as part of the activities of the Hospital including, but not limited to, patient care records of the Member, credentialing, quality assurance, peer review, patient statements and other input/statements regarding the Member who requested the hearing;

5. any and all applications, references, written statements of individuals and accompanying documents;

6. all officially noticed matters;

7. any other evidence admitted by the Presiding Officer.

K. Burden of Proof. At any hearing it shall be incumbent on the Member who requested the hearing to come forward with more convincing evidence to prove that the Adverse Action recommendation which prompted the hearing was unreasonable, not sustained by the evidence or otherwise unfounded.

L. Hearing Committee Decision. After all the evidence has been submitted by both parties, the Hearing Committee shall recommend confirmation of the recommendation of the MEC unless it finds the person who requested the hearing has proved by more convincing evidence that the recommendation which prompted the hearing was unreasonable, not sustained by the evidence, or

otherwise unfounded. The Hearing Committee may recommend either increasing or decreasing the severity of the Adverse Action recommended by the MEC.

M. Hearing Committee Report. A report should be made containing written findings of the Hearing Committee's decision and its recommendation for appropriate action. The report shall be forwarded to the Executive Director. A copy of the report shall be sent to the Chief of Staff and by certified mail, return receipt requested or by personal delivery to the affected Member. The MEC's recommendation, together with the Hearing Committee's recommendation and report shall be submitted to the Governing Board. The Governing Board shall make a final determination on the matter.

N. Right to Appeal. Within thirty (30) days after the Member and the MEC are notified of the recommendation of the Hearing Committee, the Member or the MEC may request an appellate review by the Governing Board. The request shall be in writing, shall be delivered to the Executive Director, either in person or by certified mail, and shall include a brief statement of the reasons for the appeal. If appellate review is not requested within 30 days of receipt of the recommendation of the Hearing Committee as provided herein, the Member and the MEC shall be deemed to have accepted the recommendation of the Hearing Committee and the recommendation of the Hearing Committee shall be submitted to the Governing Board for final action on the matter.

O. Grounds for Appeal. The grounds for appealing an adverse decision shall be that:

1. there was substantial failure to comply with the Hospital or Medical Staff Bylaws in the conduct of the review or hearing so as to deny due process or a fair hearing; or

2. the decision was not supported by the evidence.

P. Conduct of Appeal. The appealing party shall provide a record of the proceedings before the Hearing Committee, at the appealing party's own expense, to the Governing Board. The appealing party must arrange for the record to be transcribed and submitted to the Governing Board within thirty (30) days of the appealing party's receipt of notice of the Hearing Committee's decision or as soon thereafter as the record can be completed, otherwise the appeal shall be dismissed. If the appeal is successful as determined by the Governing Board, the Hospital shall reimburse the appealing party for the cost of transcribing the record of the Hearing Committee proceedings. Each party shall have the right to present a written statement to the Governing Board and, in its sole discretion, the Governing Board may allow each party or its representative to appear personally and make oral argument. Except in extraordinary situations, the Governing Board will not accept additional oral or written evidence. If, in its discretion, the Governing Board determines to accept additional evidence, it shall do so on such conditions as it may determine, considering the rights of cross-examination and confrontation as provided before the Hearing Committee. After the conclusion of the appellate proceedings before the Governing Board, the Governing Board shall render a final decision in writing and shall deliver copies thereof to the Member by certified mail, return receipt requested and to the MEC. A copy will be provided to the Executive Director.

Q. Recesses and Amendments to Time Schedules. Notwithstanding anything in these Bylaws to the contrary, any time period for notice, hearing, report or other matter provided in these Bylaws may, to the extent permitted by law, be accelerated or postponed, and any hearing or appearance may be recessed and reconvened by the Hospital or committee involved, without

special notice, for good cause such as, for example, to obtain additional information, or to receive written evaluation by a lower level committee.

R. Notices. All notices provided for in these Bylaws shall be in writing and shall be deemed given only when delivered in person to the addressee, or when mailed by certified mail, postage prepaid, to the home or office address of the addressee.

S. Privileged Communications - Release from Liability. Each report, information, complaint or accusation made, and evidence given, and each recommendation under Articles IV, V or VI of these Bylaws shall be deemed a privileged communication pursuant to applicable state or federal law. Each applicant to and member of the Medical Staff waives and releases all rights of personal redress against the Medical Staff, the MEC, the Governing Board and each person and entity thereon or involved with disciplinary or evaluation action taken under Articles IV, V and VI of these Bylaws, and each Person and entity providing information in connection therewith to the fullest extent permitted by law. The release here referenced is a supplement to and does not limit the release and immunity from liability referenced in Article IV, B.2.

T. Right to One Hearing and One Appeal Only. No applicant or Medical Staff member shall be entitled as a matter of right to more than one hearing or appeal to the Governing Board on any single matter which may be the subject of a hearing.

U. Exhausting of Due Process Rights. A Member must exhaust all review remedies afforded by these Bylaws before resorting to legal action.

ARTICLE VII: MEDICAL STAFF OFFICERS

A. Officers-Term of Office. The elected officers of the Medical Staff shall be the Chief of Staff, Chief of Staff Elect and Secretary-Treasurer nominated with the advice and consent of the Governing Board. Elections will be held every two (2) years at the annual meeting of the Medical Staff. Vacancies for any unexpired term shall be filled by election as defined in Article X. Section I. (Action without Meeting). Any officer may be re-elected without restriction on the number of terms, except the Chief of Staff, who may not be re-elected consecutively. Newly elected officers shall assume their offices at the next regular MEC meeting following approval of the election by the Governing Board.

B. Qualification. A person elected to the position of Secretary-Treasurer must have been a member in good standing of the Physician Active Staff, ARNP Active Staff or Affiliate-Active Staff for the previous year. For the Chief of Staff Elect position, the individual elected must have been a member in good standing of the Physician Active Staff, ARNP Active Staff or Affiliate-Active Staff for the previous two years. The individual elected to Chief of Staff will meet the same qualifications of the Chief of Staff-Elect position. Failure to maintain Physician Active Staff, ARNP Active Staff or Affiliate-Active Staff shall immediately create a vacancy in the office.

C. Nominations. A Nominating Committee appointed by the MEC shall make nominations. The MEC, at its discretion may serve as the Nominating Committee. The Nominating Committee shall meet at least sixty (60) days prior to the meeting of the Medical Staff at which an election is to be held and cause copies of the list of nominees to be mailed to all members of the Physician

Active Staff, ARNP Active Staff and Affiliate Active Staff at their office addresses at least fifty (50) days prior to that meeting. Nominations may also be made by petition to the Nominating Committee naming the position and nominee and signed by at least five (5) Physician Active Staff, ARNP Active Staff or Affiliate Active Staff members. These petitions shall be submitted to the Chairman of the Nominating Committee at least twenty (20) days prior to the election date and shall be mailed to the Membership at least ten (10) days prior to the Election. Nominations may be made thereafter, until the time of the elections, by a petition of at least five (5) Physician Active Staff, ARNP Active Staff or Affiliate Active Staff members with concurrence of the Nominee. If additional nominations are made in sufficient time prior to the ballot being printed, no distinction shall be made between nominations of the Committee and nominations from petition of five Physician Active Staff, ARNP Active Staff or Affiliate Active Staff members. However, nominations made later than twenty (20) days prior to the Election will not be published prior to the Election date. All nominees shall meet the qualifications listed in Article VI, B.

D. Duties of Officers.

1. Chief of Staff. The Chief of Staff is authorized and responsible for managing the Medical Staff in accordance with these Bylaws, the Hospital Bylaws, and the Statement of Functions and Responsibilities for Medical Staff Officers. The Chief of Staff is responsible for establishing and maintaining the Statement of Functions and Responsibilities for Medical Staff Officers subject to the approval of the MEC.

2. Chief of Staff Elect. The Chief of Staff Elect is authorized and responsible to assist the Chief of Staff in accordance with these Bylaws, the Hospital Bylaws, and the Statement of Functions and Responsibilities for Medical Staff Officers. The Chief of Staff Elect shall assume the authority and responsibilities of the Chief of Staff in the absence of the Chief of Staff.

3. Secretary-Treasurer. The Secretary-Treasurer is responsible for oversight of Medical Staff meetings minutes in accordance with these Bylaws, the Hospital Bylaws, and the Statement of Functions and Responsibilities for Medical Staff Officers. The Secretary-Treasurer shall assume the authority and responsibilities of the Chief of Staff or Chief of Staff Elect in their absence.

E. Removal from Office. Any elected Medical Staff Officer may be removed from office by vote of two-thirds of the voting members of the Medical Staff present at a regular or special meeting at which a quorum is present (or two-thirds of those voting in the case of action without a meeting under Article XI., I) if notice of the proposed action is mailed with the notice of the meeting or with the ballots, as the case may be. Removal shall be for failure to conduct those responsibilities as described herein.

F. Vice President-Medical. The person holding the position known as the Vice President-Medical, as appointed by the Executive Director, shall be an ex officio non-voting member of all committees of the Medical Staff including, but not limited to, all Divisional and Inter-Divisional committees.

ARTICLE VIII: PEER REVIEW PRIVILEGE

The Performance Improvement and Safety Oversight Committee and other Committees, including but not limited to, all Divisional and Inter-Divisional Committees, involved with quality assurance and peer review are regularly constituted review and quality improvement committees pursuant to RCW 4.24.250, RCW 70.41.200, and the Health Care Quality Improvement Act of 1986, and as each may be amended.

ARTICLE IX: DIVISIONS OF THE MEDICAL STAFF

A. Divisions and Sections.

1. General.

a. Divisions. The Medical Staff shall be organized into the Division of Surgery and the Division of Medicine. All members of the Medical Staff shall be deemed to fall under the jurisdiction of a Division. Additional Divisions may be created by the mutual decision of the Hospital and the MEC. Each Division shall have a Division Chief with overall responsibility for the supervision and satisfactory discharge of the functions of the Division.

b. Sections. Each Division may be further subdivided into Sections by the mutual decision of the Division Chief and the MEC. Each Section shall have a Section Head with responsibility for the supervision and satisfactory discharge of the functions of the Section.

B. Functions and Responsibilities of Divisions

1. Each Division shall be responsible for the regular review and evaluation of the quality of patient care and the competence and qualifications of its members. The review shall include consideration of deaths, unimproved patients, infections, complications, errors in diagnosis and treatment, pathology reports, medical records, utilization of facilities, nursing and therapeutic resources of the Hospital, and such other reports as may be felt necessary for adequate medical care evaluation.

2. Each Division shall be responsible for the establishment of criteria for the granting of clinical and other privileges to Provisional Staff, Physician Active Staff, ARNP Active Staff, Affiliate Active Staff and Courtesy Staff within its respective Division and make recommendations for appointment and reappointment to the Medical Staff which are based in part on peer recommendations. The granting, renewal, or revision of privileges shall be related to findings of regular and ongoing medical audit, as outlined above, as well as other considerations and criteria established in these Bylaws, and in Division Rules and Regulations.

3. Each Division shall establish Rules and Regulations as needed. All Division Rules and Regulations will be forwarded to the MEC for review and recommendation for approval to the Governing Board prior to implementation.

4. The Division Chief may delegate Division functions and responsibilities to Sections and/or to other committees established by the Division Chief at his/her discretion.

C. Division Chiefs.

1. Qualifications and Selection. Each Division shall be headed by a Division Chief who shall be nominated by the Chief of Staff and the Hospital, subject to the approval of a majority of the members of the Division who vote. Each Division Chief shall be a member of the Physician Active Staff, willing and able to serve in this capacity and who can devote the necessary time to the office. The term of this office is four (4) years and may be renewed. Unexpected vacancies shall be filled by the mechanism as outlined above.

2. Responsibilities. Each Division Chief shall report and be accountable to the Chief of Staff and the Vice President-Medical or his/her designee for all professional and Medical Staff activities in the respective Division in accordance with these Bylaws, the Hospital Bylaws, and the Statement of Functions and Responsibilities of Medical Staff Officers.

3. Removal from Office. A Division Chief may be removed from office:

a. At a regular Division meeting, or a special Division meeting by a two-thirds majority of the members of the Division. Notification of a special meeting shall be given at least twenty (20) days prior to the meeting and contain a description of the proposed action.

b. By the Chief of Staff and/or the Hospital Chief Quality Officer upon written notification for failure to conduct those responsibilities described herein.

D. Functions and Responsibilities of Sections. Each Section shall be responsible for carrying out such functions delegated to it by the Division. Such functions may include the establishment of criteria for the granting of clinical and other privileges to Provisional Staff, Physician Active Staff, ARNP Active Staff, Affiliate Active Staff and Courtesy Staff within its respective Section as well as establishment of clinical guidelines and other systems for the improvement of the quality of patient care.

E. Section Heads.

1. Qualifications and Selection. Each Section shall be headed by a Section Head who shall be nominated by the Division Chief and MEC, subject to the approval of a majority of the members of the Section who vote. Each Section Head shall be a member of the Division, willing and able to serve in the capacity and who can devote the necessary time to the position. The term of this position is for a period of two (2) years which may be renewed.

2. Responsibilities. Each Section Head shall report and be accountable to the Division Chief, the Chief of Staff and the Vice President, Medical or his/her designee, for all professional and Medical Staff activities in the respective Sections in accordance with these Bylaws, the Hospital Bylaws, and the Statement of Functions and Responsibilities of Medical Officers.

3. Removal from Office. A Section Head may be removed from office by the Division Chief, and/or the Chief of Staff upon written notification for failure to conduct those responsibilities described herein.

F. Audit Committees.

1. Division Audit Committees. Each Division Chief shall establish Division or Section Audit Committees, as necessary, to review the quality of patient care provided by members of the Division or Section as contemplated by RCW 70.41.200 and RCW 4.24.250 as amended. Audit Committee members shall be appointed by the Division Chief or Section Head, as appropriate, from the Division and may include voting *ad hoc* members from other Divisions or Sections. Each Audit Committee shall have at least four (4) members.

2. Ex Officio Audit Committee Members. Each Division Audit Committee may appoint qualified physicians or medical experts who are not members of the Medical Staff as ex officio members of the Committee. These ex officio members shall be appointed for terms designated by each Audit Committee. Ex officio members shall assist the Audit Committee to carry out its duties by issuing reports and recommendations to the Committee. All members of an Audit Committee, including ex officio members, shall be considered members of a medical malpractice prevention program, for purposes of RCW 70.41.200 as amended.

ARTICLE X: INTERDIVISIONAL COMMITTEES

A. Medical Executive Committee (MEC)

1. Composition. The MEC shall be comprised of the following voting members: Chief of Staff, Chief of Staff Elect, Secretary-Treasurer, immediate past Chief of Staff (if a member in good standing of the Active Medical Staff and he or she chooses to fill the position) and each of the Division Chiefs. The Committee may also identify members of the Active Medical Staff, ARNP Active Staff or RHP staff to serve as ad hoc voting members as may be needed to fulfill the functions and responsibilities of the Committee. Ad hoc members may be removed with a fifty percent (50%) vote of the Committee. There shall not be more than five (5) ad hoc members serving on the Committee. The Executive Director (or designee), the Vice President-Medical , the Chief Medical Information Officer and the Medical Director of Ambulatory Clinics will also serve on the Committee as ex-officio non-voting member. The Chief of Staff shall be the chair of the MEC.

2. Functions and Responsibilities.

a. To represent and to act on behalf of the Medical Staff under such limitations as may be imposed by these Bylaws and the Governing Board.

b. To coordinate activities and general policies of the Divisions and Section and any other committees of the Medical Staff.

c. To receive and act upon reports of the Division Chiefs, Section Heads and the other committees of the Medical Staff.

d. To consider and recommend action to the Executive Director on all matters of medical-administrative nature.

e. To fulfill the Medical Staff's accountability to the Governing Board for the quality of medical care rendered to the patients in the Hospital.

f. To keep the Medical Staff abreast of the accreditation program and informed of the accreditation status of the Hospital.

g. To create such committees as may be necessary to the proper functioning of the Medical Staff and otherwise to be responsible for the performance of all functions of the Medical Staff set forth in Article III.

h. To assess dues as may be necessary to carry out the functions of the Medical Staff.

i. To serve as the Credentials Committee in the review of all applications for appointment and reappointment to the Medical Staff. When acting as the Credentials Committee, the MEC shall also review all other matters received from the Divisions, including but not limited to all credentialing criteria as well as criteria for new or special procedures established by Divisions and/or Sections.

j. To serve as the Medical Education/Library Committee in the planning and coordination of overall CME programs for physicians, and supervision of the activities of the Medical Library.

k. To serve as the Professional and Graduate Medical Education Committee to oversee all professional and graduate medical education activities in accordance with Hospital Policies and Procedures.

B. Performance Improvement and Safety Oversight Committee.

1. Composition. The Committee shall be comprised of members appointed by the Chief of Staff, that are representative of the Medical Staff, and representatives from the Hospital, including but not limited to representatives from Administration, Clinical Services, Operations and Medical Staff. Chief of Staff Elect shall chair the Committee. Medical Staff and Elected Medical Staff Leadership function as an integral part of the Hospital's Performance Improvement and Safety program. They incorporate Performance Improvement into Medical Staff functions.

2. Functions and Responsibilities. The Performance Improvement Committee is responsible for interdisciplinary systems to improve quality of care, to include but not limited to:

a. Implementation of standards of care.

b. Reduction in variation.

c. Outcomes analysis. Outcomes analysis may include clinical outcomes, functional outcomes, cost effectiveness, resource utilization, and patient satisfaction.

d. Implementation of the clinical component of the Hospital information system.

e. Establishment of annual goals to achieve the Committee's performance improvement mandate.

C. Infection Control Committee. The Infection Control Committee shall be comprised of members of the Medical Staff appointed by the Chief of Staff and shall include such necessary participation by Nursing, Administration, and ancillary services as is appropriate to perform the Committee's function of regular Hospital-wide surveillance of all infections processes, which can be controlled by in-Hospital efforts. The Chairman of the Infection Control Committee shall have the authority to institute appropriate measures such as isolation or culturing when necessary.

D. Committee on Cancer.

1. Composition. The Committee on Cancer shall be comprised of members appointed by the Chief of Staff, that are board certified/eligible representatives of the Medical Staff from all medical specialties involved in the care of cancer patients within the limits of those disciplines available at the Hospital, including but not limited to: surgery, primary care, medical oncology, gynecology, diagnostic imaging, radiation oncology, pathology, pain management/palliative care, and a designated physician liaison to American College of Surgeons. The Committee should also have members from administration, nursing, care-management/social services, cancer registry, quality assurance/quality improvement and other representation as appropriate.

2. Functions and Responsibilities. The Committee on Cancer is responsible to plan, initiate, promote and assess the results of cancer care in the Hospital. The Committee on Cancer shall be concerned with the entire spectrum of care for cancer patients admitted to the institution. The Committee on Cancer shall be a regularly constituted review committee pursuant to RCW 4.24.250 and RCW 70.41.200 as amended. The minimal required duties of the Committee on Cancer include the following:

a. To organize, publicize, implement, and evaluate regular educational and consultative cancer conferences (including Tumor Board) that are multidisciplinary, Hospital-wide, and patient oriented.

b. To assure that consultative services in the major disciplines are available to cancer patients in the institution.

c. To assure that cancer rehabilitation services are available and are being used.

d. To develop and review support care systems for the patient with end stage cancer.

e. In accordance with the Hospital's quality assurance/quality improvement plan pursuant to RCW Chapter 70.41 to perform an audit role regarding patient care, either directly or by review of audit data supplied by other committees.

f. To plan and implement a minimum of two (2) patient-care evaluation studies annually, one (1) short-term (process) and one (1) long-term (outcome).

g. To coordinate audit activities with appropriate Medical Staff Divisions, Sections or other committees in accordance with the Hospital quality assurance/quality improvement plan.

h. To actively supervise the cancer database or registry for quality control of abstraction, staging and reporting.

3. Meetings, Reports, and Recommendations.

a. The Committee on Cancer shall meet at least quarterly as an entity separate from conferences or tumor boards, and document its activities and attendance.

The Committee on Cancer shall prepare an annual report to the community and to physicians on the Cancer Program's goals and the actions taken to meet those goals.

ARTICLE XI: MEETINGS OF THE MEDICAL STAFF AND COMMITTEES

A. The Annual Meeting of Active Staff. An Annual Meeting of the Active Staff shall be held in the spring. Notice thereof will be mailed to each member of the Physician Active Staff, ARNP Active Staff and Affiliate Active Staff at least twenty-one (21) days before the meeting. At this meeting, any retiring officers and committees shall make such reports as may be desirable and officers for the ensuing year shall be elected.

B. Regular Meetings. In addition to the Annual Meeting of the Active Staff, the Chief of Staff may elect to convene meetings of the Active Staff as needed for purposes of providing on-going communication and information to the Medical Staff. Official Medical Staff business may be conducted at these meetings when notification requirements as defined in these bylaws are met and a quorum of voting members of the Medical Staff, also as defined in these bylaws, is present at the meeting. Ongoing communication will be accomplished through other means which may include, but are not limited to, mailings, surveys, forums, e-mail and communication from the Medical Staff Leadership to Division and Section Chiefs.

C. Special Meetings. Special Meetings of the Medical Staff may be called at any time by the Chief of Staff. A Special Meeting may be called by the Chief of Staff to manage conflict between the organized Medical Staff and the MEC. The Chief of Staff shall call a Special Meeting within twenty (20) days after a request by the Governing Board, the MEC, the Executive Director or any five members of the Active Staff. Notice thereof shall be mailed to each member of the Physician Active Staff, ARNP Active Staff and Affiliate Active Staff at least ten (10) days before the meeting. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting.

D. Medical Staff Participation. All Members of the Medical Staff are expected to attend and participate in meetings and educational conferences at the Hospital.

E. Quorum. Twenty-five percent (25%) of the total Physician Active Staff, ARNP Active Staff and Affiliate Active Staff members shall constitute a quorum at any meeting of the Medical Staff. A quorum once present at a meeting shall be considered to remain present even if members thereafter withdraw from the meeting prior to adjournment leaving less than twenty-five percent (25%) of such total present. A quorum in the case of action without a meeting under Article X. I. shall be those voting and no minimum number of votes is required.

F. Voting. Only members of the Physician Active Staff, ARNP Active Staff and Affiliate Active Staff may vote on matters before the Medical Staff. Except as otherwise expressly provided in the Bylaws, a majority vote of Physician Active Staff, ARNP Active Staff and Affiliate Active Staff members present at a meeting at which a quorum is present (or a majority

of those voting in the case of action without a meeting under Article X.I.) shall be sufficient to approve any act of the Medical Staff.

G. Agenda. The preparation of the agenda for all meetings of the Medical Staff shall be the responsibility of the Chief of Staff. Preparation of the agenda for all Divisional educational conferences shall be the responsibility of the Chief of the affected Division or Sub-specialty.

H. Committee Meetings. Except as may be otherwise expressly provided in these Bylaws, all meetings of each committee of the Medical Staff shall be on reasonable notice to each member by the Chairman of the Committee. Committee action shall be by vote of a majority of the voting members attending a meeting at which a quorum is present. Fifty percent (50%) or 3 (three) of the voting members of a committee shall constitute a quorum. A quorum, once present at a meeting, shall be considered to remain present even if members thereafter withdraw from the meeting prior to adjournment leaving less than fifty percent (50%), or 3 (three) of such voting members present. Each committee chairman shall be considered a voting member. Committee members will be expected to attend at least seventy-five percent (75%) of the meetings. All Inter-Divisional Committees shall report to the MEC at the request of the Chief of Staff.

I. Action Without a Meeting. Subject to the quorum requirements for Medical Staff meetings, any action or election required by these Bylaws to be taken at a meeting of the Medical Staff may, at the sole discretion of the MEC, be taken by ballot without a meeting. In the case of elections, the ballots shall be mailed (with a list of all nominees and positions for which nominated) to the voting members on or before the date a list of any nominees by petition must otherwise have been mailed, and in all other cases shall be mailed with the notice of the proposed action. Each ballot shall set forth a date fixed by the MEC (which shall be not less than twenty (20) days after mailing) by which the ballot must be received by the Medical Staff Office in order to be valid and counted. Two (2) envelopes shall be enclosed with the ballot, an inner one and an outer one, for use in voting the ballot. The outer envelope shall be addressed to the Medical Staff Office and shall have a line on its exterior for the signature of the voting member. To vote, the member shall mark the ballot and seal it in the inner envelope. He shall then seal the inner envelope in the outer envelope and sign the latter. The ballot shall then be mailed or delivered so as to be received by the Medical Staff Office by the date fixed as above provided. The Medical Staff Office may substitute an email ballot and voting process in lieu of the envelope and mailing process set forth above.

ARTICLE XII: REGISTERED HEALTH PROFESSIONALS

A. Registered Health Professionals (RHP's) may include, but are not limited to, Physician Assistants (PA), Perfusionists, Audiologists, Acupuncturists, and Surgical Assistants (SA). All applicants must meet institutional criteria, eligibility and qualification requirements and be approved by the Governing Board or its designee. Licensure alone in the State of Washington does not permit a health care professional access to Hospital facilities.

B. RHP's are individuals who may participate directly in the medical management of patients, but only under the supervision of a current Member of the Medical Staff ("Supervising Member") accorded clinical privileges under these Bylaws, and who shall have ultimate responsibility for the patient's care. The RHP shall have a written agreement for supervision by the Supervising Member. RHP's are not eligible for attendant rights.

C. Applications for practice privileges as an RHP shall be processed in accordance with policies and procedures as established by the MEC and approved by the Governing Board.

D. The Supervising Member shall:

1. Propose candidacy of an RHP;

2. Provide upon request the written agreement defining terms of employment and/or supervision to the MEC or the Governing Board;

3. Agree to assume clinical responsibility and supervision of the candidate.

E. The Physician Active Staff member's Division shall:

1. Define the roles and limitations of practice of the RHP;

2. Review the candidate's application for completeness and training appropriate to the requested privileges.

F. The MEC in its capacity to oversee credentials shall:

1. Establish procedures for review of application for practice privileges as an RHP, review of quality of care provided by the RHP, and renewal of appointment;

2. Establish criteria for practice privileges in each category of RHP;

3. Review and make recommendations to the Board regarding individual applications for practice privileges and reappointment; and

4. Review and make recommendations to the Board regarding requests for suspension, limitation or revocation of an RHP's practice privileges.

G. The Board or its delegated committee shall:

1. Approve an application for practice privileges as an RHP, upon receipt of appropriate recommendations from the Medical Staff. The appointment shall not exceed two years;

2. Hold authority to suspend, limit or revoke any RHP's practice privileges subject to the RHP's right to a meeting and appeal as described herein, without recourse to the distinctive process rights described in these Bylaws for Members of the Medical Staff;

3. In consultation with the MEC of the Medical Staff determine the institutional need for RHP's;

4. Reserve the right to modify the clinical roles and limitations of RHP's previously determined by Divisions.

H. Summary Suspension

1. Whenever an RHP disregards the requirements of these Bylaws or Hospital policies relating to patient care; or whenever an RHP's conduct raises a reasonable and

good faith belief that abuse of, or impairment due to alcohol or other drugs might adversely impact patient care; or whenever an RHP's conduct or clinical competence requires that immediate action be taken to protect patient(s) or to reduce the threat of injury or damage to the health or safety of any patients, Medical Staff members, employees or other persons present in the Hospital, any one of the following: -- the Chairperson of the Governing Board, Chief Executive Officer, the Chief of the Medical Staff or the Vice President-Medical, shall have the authority to summarily suspend the RHP and/or all or any portion of the clinical privileges of such RHP, and such summary suspension shall become effective immediately upon imposition.

2. The MEC of the Medical Staff may suspend, limit or revoke an RHP's practice privileges at the Hospital by giving the RHP written notice of the action, a description of the reasons for the action, and a description of the RHP's right to a meeting and appeal of the action.

3. Within thirty (30) days of the date of the written notice, the RHP may request a meeting with the MEC or its designee to discuss the action. The RHP may fully participate at the meeting and explain why he or she believes the action is inappropriate. The RHP may not invite witnesses or an advocate to this meeting without prior approval of the MEC. The Committee or its designee may interview other individuals with knowledge of the facts if, in the Committee's discretion, good cause is shown for conducting additional interviews. The MEC of the Medical Staff will approve recommendations and notify the RHP of its decision.

4. The RHP may appeal the decision of the MEC of the Medical Staff by writing a letter to the Chief of Staff describing why the RHP believes the decision of the MEC is inappropriate. The Chief of Staff will present the letter to the Board, or such committee as may be designated by the Board for such a purpose, who shall review the appeal on the basis of the letter and the record developed by the MEC of the Medical Staff and the Credentials Committee. The Board or its Committee may at its sole discretion admit additional evidence and permit oral argument or take such action as it deems appropriate. The decision of the Board or its designated committee shall be final.

I. Temporary privileges may be granted to a Registered Health Professional to assist in the management of a specific patient. Temporary privileges shall be upon approval of the Executive Director or designee.

1. The Applicant shall be required to:

    - Have a sponsoring physician on the Active Medical Staff, and;
    - Provide documentation of current applicable state licensure, DEA license, if applicable, and malpractice insurance, and;
    - Define in writing the scope of services expected to be provided; and
    - Comply with all applicable rules and regulations of the Medical Staff as well as policies and procedures of the hospital.

2. The sponsoring physician shall:

- Submit in writing to the Medical Staff Office verification of the qualifications of the applicant and the scope and duration of expected involvement of the RHP,

- Provide direct supervision of the RHP during the duration of the encounter.

J. Temporary privileges will be limited to two requests per twelve month period. After the second request, the applicant will be required to apply for provisional RHP privileges at Hospital.

K. Temporary privileges may be granted to an RHP whose application for privileges is complete and pending final approval. Temporary privileges shall be limited to standard "roles and limitations" for the designated RHP category as defined by the applicable Division or Sub-Specialty of the Medical Staff. Temporary privileges shall be granted with the approval of the Chief of the Division or Sub-specialty in which that RHP will practice or by the Chief of Staff, Chief of Staff Elect or Vice President-Medical. The sponsoring physician is responsible to provide supervision of and to be accountable for the practice of the RHP.

ARTICLE XIII: RULES AND REGULATIONS AND POLICIES

Some requirements of the Bylaws may have associated details which reside in the Rules and Regulations and Policies of the Medical Staff. The Rules and Regulations and Policies of the Medical Staff define operational guidelines for the Medical Staff that promote excellence and continuity of patient care and high standards for record keeping consistent with legal and regulatory requirements. Divisions or Sections may maintain supplemental Rules and Regulations.

The Rules and Regulations and Policies of the Medical Staff in effect at the date of adoption of these Bylaws shall continue in effect until amended as provided for in this Article XII. Such Rules and Regulations may be amended at any regular meeting of the MEC. The Medical Staff will be notified of the proposed revision. Such amendments shall then become effective when and if approved by the Governing Board. The Medical Staff will be notified when and if amendments are approved by the Governing Board. In cases of a documented need for an urgent amendment to Rules and Regulations and Policies necessary to comply with law or regulation, the MEC may provisionally adopt and the Governing Board may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff will be immediately notified by the MEC. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment stands. If there is conflict over the provisional amendment, A Special Meeting, pursuant to Article X, Section C, may be called by the Chief of Staff. The Medical Staff may adopt Rules and Regulations and Policies and amendments thereto, and propose them directly to the Governing Board. In addition to all of the rights and remedies of the Medical Staff set forth in Article IV, noncompliance with Rules and Regulations may lead to temporary suspension of privileges, until such noncompliance has been corrected.

ARTICLE XIV: AMENDMENTS TO BYLAWS

These Bylaws may be amended at any regular or special meeting of the Medical Staff if the notice of the meeting sets forth the proposed amendment. These Bylaws may also be amended by mail by signed ballot by the Medical Staff. For adoption, amendments so adopted shall become effective when and if approved by the Governing Board. Proposed amendments shall require a

two-thirds majority of those voting. Once proposed, an amendment to the Bylaws must receive final approval by the Governing Board within three (3) months. Neither the Medical Staff nor the Governing Board may unilaterally amend the Medical Staff Bylaws, Rules and Regulations. The Medical Staff may adopt Bylaws and amendments thereto, and propose them directly to the Governing Board.

ARTICLE XV: ADOPTION

These Bylaws shall replace and supersede all previous Bylaws and shall control all Rules and Regulations of the Medical Staff and its Divisions.

ADOPTED March 29, 1988, by the Medical Staff, and APPROVED by the Governing Board April 19, 1988.

Amended:

April l4, l989	May 21, 1993	November 20, 1998	May 3, 2011
July 11, l989	July 16, 1993	January 5, 1999	September 20, 2011
October l3, 1989	November 15, 1993	July 13, 1999	October 19, 2012
January 12, 1990	February 18, 1994	March 7, 2000	June 7, 2016
April l3, l990	July 15, 1994	May 15, 2001	
September 10, 1990	October 21, 1994	April 1, 2002	
April 12, 1991	November 18, 1994	April 22, 2003	
October 11, 1991	April 21, 1995	May 21, 2004	
April 10, 1992	January 19, 1996	October 19, 2007	
December 18, 1992	May 17,1996	May 16, 2008	

NORTHWEST HOSPITAL & MEDICAL CENTER

Seattle, Washington

ADDENDUM I:

MEDICAL STAFF
RULES AND REGULATIONS

Effective Date:

January 9, 2015

NORTHWEST HOSPITAL & MEDICAL CENTER
MEDICAL STAFF ORGANIZATION
RULES AND REGULATIONS

Rules and Regulations are required by Medical Staff Bylaws and are periodically reviewed and approved by the Medical Executive Committee and Governing Board or its designee. They define operational guidelines for Medical Staff that promote excellence and continuity of patient care and high standards for record keeping consistent with legal and regulatory requirements. Divisions or sections may maintain supplemental Rules and Regulations.

Medical staff must provide continuous care for their patients whether they are in or out of the hospital.

Medical Staff will exhibit professional behavior when interfacing with patients and families, clinic and hospital staff and other professional colleagues, in compliance with Federal, Washington State and NWHMC guidelines for Respect in the Workplace and NWHMC Disruptive Practitioner policy.

Emergency Care

1. ED On-Call schedules are maintained for all specialties and On-Call physicians are continuously available. In the event an ED physician determines a patient requires hospitalization but the On-Call physician is not available, the patient will be stabilized and transferred to another area facility. Patients presenting to the Emergency Department or Child Birth Center requesting medical treatment will be provided a medical screening exam by a practitioner privileged to perform such an exam, including practitioners privileged in Emergency Medicine and Obstetrics. The hospital recognizes EMTALA defined exceptions to required availability:
   - No Active, Courtesy or Provisional Medical Staff member appointments in specialty;
   - On-Call physician is simultaneously on call at another facility and is actively responding to an emergency at that site;
   - An On-Call surgeon is in the OR performing surgery;
   - Other emergent or urgent circumstances prevent the On-Call physician from responding in a timely manner.

2. Emergency Department Call
   a. Physicians in each specialty shall share equally in ED call coverage if requested.
   b. Call schedules will be submitted to the Medical Staff Office at least one month prior to commencement. Section heads are responsible for ensuring call schedules are submitted in a timely fashion.
   c. If a physician cannot take call after the schedule has been published, it is the responsibility of the assigned physician to arrange an acceptable substitute.
   d. It is the responsibility of the physician initiating a switch to contact the Medical Staff Office with this change so it may be disseminated to the Emergency Department and other necessary areas.

3. Members of the medical staff must respond to calls from the Emergency Department (ED) or nursing units in a timely manner. Pages or telephone calls from the ED must be answered within 30 minutes. Trauma Team members and Cardiac Cath Lab Team members must be

present in the ED within 30 minutes of the time their presence is requested by the ED physician. Urgent calls from any nursing unit must be answered within 30 minutes.

4. When patients presenting to the ED require consultation or hospitalization, the patient's physician must promptly assume responsibility for care. This may be delegated by the patient's physician to a consultant or hospital based physician.

5. In the ED, a doctor-patient relationship is as identified by the patient unless the patient has not seen that physician for two or more years or the physician terminated their relationship according to procedures accepted in the community. A mentally competent patient may disclaim association with any doctor and request another. Patients described by these exceptions or those not established with a NWHMC physician are designated "unassigned".

6. Care of unassigned inpatients or those with a disputed physician-patient relationship is provided by doctors on the primary care or specialty ED on-call lists or by a hospital based physician. Disputes are resolved later by the VPMQ (Vice President Medical Quality).

7. Following ED discharge, a patient's established physician provides necessary follow up care. ED staff will notify the appropriate doctor's office of needed follow up. When an unassigned patient agrees to have required follow up care, the appropriate physician on ED call for unassigned patients will either provide the care or information about available alternatives. ED patient is responsible to initiate follow up in a timely manner.

<u>In-Patient Care</u>

8. Patients are admitted for observation or in-patient care only to NWH Medical Staff members with hospital admitting privileges. An admitting Medical Staff member is the "attending" unless otherwise indicated.

9. All ICU status patients will be managed or co-managed by a critical care physician for the duration of their ICU status admission. Evidence of management or co-management by the critical care physician will be in the form of a daily progress note.

10. Code status (including orders to not resuscitate) must be determined by the attending NWH Medical Staff member, ARNP, PA or resident and recorded at the time of admission.

11. Newly admitted patients are assessed by the attending NWH Medical Staff member, ARNP, PA or resident in a timely manner depending on a patient's condition. This will be within 8 hours of admission to the ICU/CCU or within 18 hours of admission to other clinical units. Upon request of the charge nurse, patients in the ICU/CCU are to be seen within 30 minutes.

12. Hospitalized patients are seen daily by their attending NWH Medical Staff member, ARNP, PA or resident, and actively involved consultants. Dated and timed progress notes must be recorded and signed after each visit.

13. ARNP, PA or resident visits and charting may substitute for visits or charting of the supervising NWH physician if the following conditions are met:

a. ARNP or PA-C is a fully credentialed member of the NWHMC Registered Health Professional Staff. Residents must be working at NWHMC in the context of affiliation agreements between NWHMC and resident training program and a

scope of practice must be on file that includes rounding and associated documentation.

b. For PA-Cs – copies of approved Washington State Physician Assistant ("PA") practice plans are on file with the Medical Staff Office. Standard Washington State PA plans require the sponsoring physician to see patients every two working days. It is the responsibility of the PA and the sponsoring physician to request an exemption to this rule from the Department of Health and submit the approved written exemption when they provide the practice plan to the Medical Staff Office.

c. The supervising physician will continue to oversee and monitor all work performed by the ARNP, PA or resident. The supervising physician must remain immediately available to address changes in clinical course.

Coverage of Established Patients – In or Out of Hospital

14. A physician unavailable for patient inquiries or care or who is unable to make daily patient hospital rounds must provide coverage by a qualified member of the medical staff. Signing out to the Emergency Department is not acceptable. If a physician is not available, a medical staff division chief or Chief of Staff may designate a doctor to provide temporary coverage.

Consultations

15. A physician requesting consultative help must personally contact the consultant and is responsible for timeliness of the consultant's response.

16. Any consultation requested will be performed by the physician of whom the request is made or by another physician, with privileges in the same specialty, who is covering for the physician of whom the request is made.

17. Consultations must be completed and dictated or electronically generated for the patient record within 24 hours after requested or sooner depending on clinical urgency.

18. It is good medical practice that consultative help be obtained:

a. when diagnosis is obscure or treatment is not producing expected results;
b. when best therapy is uncertain;
c. for major surgical cases in which the patient is a poor surgical risk;
d. for the critically ill as defined by ICU/CCU admission regulations; or
e. for obstetrical cases defined by Family Practice and OB/GYN regulations.

19. In situations of clinical urgency or when consultations are required by hospital policy but not obtained by the attending physician, consultative assistance may be ordered by any medical staff officer, VPMQ or hospital Chief Executive Officer.

20. If more than one physician is involved in a patient's care, the attending must clearly define both nature and duration of each consultant's responsibility. This information must be documented in the patient's chart. Unless specified otherwise, the attending is responsible for total management of care.

Discharge or Transfer

21. Patients are discharged only by order of the attending NWH Medical Staff member or ARNP, PA or resident, by signing out against medical advice (AMA) or after absence without leave (AWOL). Administrative policy defines procedures for AMA and AWOL.

22. Transfers may occur because NWHMC cannot provide needed care or because a patient requests transfer. Transfer procedures to other acute care facilities are regulated by hospital patient transfer protocols and those of EMTALA (Emergency Medical Treatment and Active Labor Act):

a. Consent for transfer must be signed by the patient or patient's representative;
b. A physician at the receiving facility must agree to accept the patient in transfer;
c. Prior to transfer, a patient with an emergent medical condition or who is in active labor must have a medical screening examination to determine if they are medically stable. If not stable, NWHMC must provide whatever additional evaluation and treatment may be required to stabilize before transfer;
d. For pregnancy with contractions, NWHMC must deliver the baby and placenta except when the benefits of transfer appear to outweigh risks that could arise from or during transfer.

The Medical Record

23. Patients of Northwest Hospital & Medical Center must have a legible, readily available medical record that contains sufficient information to support diagnosis, justify administered treatment and document a patient's course in the hospital. Whenever possible, use of electronic documentation of component portions of the medical record is preferred to written or paper formats.

24. Upon readmission, a patient's record of prior hospitalizations is to be provided for the attending physician and stored on the nursing unit until discharge, for those records which are still paper documents. Access to medical records in electronic format when available, constitute the legal medical record and knowledge of how to access is expected of the Medical Staff.

25. Medical records are hospital property and may not be removed from NWHMC campus except with court order, subpoena or by statute. Diagnostic images, tracings and their folders are hospital property but may be signed out by physicians for continued patient care. Loaned materials should be promptly returned. For those records available electronically, and if printing of these documents is required, the expectation is the Medical Staff member will handle these documents in keeping with HIPAA guidelines, as they constitute protected patient information.

26. Abbreviations. Symbols and abbreviations may be used only when they have been approved by appropriate committees. An official record of approved and disallowed abbreviations is kept on file in Medical Records Department.

27. Hand-written entries in the medical record, including but not limited to progress notes and orders, must show the date and time of charting and must be signed by the author. Entries may not be backdated. Electronic entries will have the necessary date and time stamp.

28. Confidentiality. The medical staff is responsible for protecting patient privacy and the confidentiality of patient information, in conversation, the medical record or on computer.

29. Release of information. Written consent of the patient is required for release of medical record information to persons not otherwise authorized to receive this information. Disclosure of medical information must comply with Washington State law and NWHMC policies that protect patient confidentiality and right to privacy.

30. Attending NWH Medical Staff members or ARNP, PA or resident are responsible for completing several components of the medical record: history and physical examination, provisional diagnosis, planned course of action, diagnostic and therapeutic orders, daily progress notes, final diagnosis and discharge summary. Documentation by an ARNP, PA or resident can be used to establish diagnosis.

31. Hospital based physicians are responsible for charted reports from their respective services (Anesthesiology, Diagnostic Imaging, Emergency Department, Inpatient Team, Laboratory and Pathology).

Orders

32. Orders for treatment of patients of Northwest Hospital & Medical Center are communicated by providers qualified according to state license and prescriptive authority and with hospital privileges granted by the Medical Staff Organization. Orders may be written, verbal or faxed when computer provider order entry (CPOE) is not available. Otherwise it is the expectation that CPOE will be utilized for order entry unless it is not feasible. Examples include but are not limited to when in the midst of surgical or invasive procedures, when a computer or other electronic device is not available, such as while driving a vehicle. Chemotherapy orders will not be accepted as verbal orders. Handwritten medication orders must be entirely printed. Medication orders handwritten in cursive are considered illegible.

33. Physician in Training Staff (interns, residents and 3rd & 4th year medical students) may write orders if they are working at NWHMC in the context of affiliation agreements between NWHMC and resident training programs. Medical student orders will be implemented only after being approved and cosigned by a supervising physician.

34. A verbal or faxed order for treatment shall be treated as being in writing if given by a practitioner within the scope of their licensure. Orders may be recorded only by those disciplines as allowed by state law. All verbal orders will be taken from these individuals, entered electronically and read back to the provider. Signature of those orders will be accomplished within 48 hours of the order.

35. The elements of a complete medication order will include: patient's name, date, time, name and amount of drug, route and frequency of administration, and name of prescribing practitioner.

36. Abbreviations, acronyms, and symbols which may increase risk of medication errors will be avoided. A "Do Not Use" list is approved and published by the Executive Committee of the Medical Staff and is updated periodically to be consistent with regulatory recommendations.

37. PRN orders for medications should specify indication(s) for use. When more than one agent is ordered and can be used for a given indication, the order should clarify which agent to use under what circumstances.

38. "Resume orders" is not acceptable as a blanket reinstatement of previous orders for medications. Pre-operative medication orders are discontinued at the time of the operation or procedure and need to be regenerated following the operation. An order stating, "Resume medications" will be acceptable only when reconciled with the patient's list of previous medications and reviewed by the prescribing practitioner. Documentation of all the required elements of a complete medication order must be included.

39. Orders for procedures or diagnostic tests include, by inference, all necessary standard preparations unless specified differently by the ordering physician.

40. Pre-established order sets may be used if approved by the Medical Staff Organization and Hospital.

Restraints

41. Although use of restraints is generally discouraged, they may be ordered for either medical immobilization or behavioral management. Regulatory and hospital requirements as well as Medical Staff policy set forth here mandate a restrained patient be evaluated by a licensed independent practitioner and orders cosigned in a timely manner.

- Medical Immobilization: Initial orders for medical immobilization must be cosigned within 24 hours and reordered every 24 hours as long as the patient requires restraint.
- Behavioral Management: Within one hour of restraining a patient for behavioral management, a licensed independent practitioner must perform a face-to-face evaluation and cosign the order. As long as restraint for behavioral management is required, renewal orders must be rewritten every 4 hours.

Procedure for Delinquent Restraint Orders

42. If a patient is restrained but not evaluated or orders not cosigned within the time constraints described above, a QA memo shall be initiated and a certified letter sent from the Chief of Staff to the responsible physician reiterating this policy. If there is a second infraction for the same physician, a second certified letter shall be sent. It will indicate that in the event of a third occurrence the physician's medical staff privileges may immediately be suspended. Before consideration is given to reinstate privileges, physician must first appear before the Medical Executive Committee and remit payment of a $500.00 fine to the Medical Staff Office with a letter that requests reinstatement and outlines plans for ensuring compliance. Any subsequent occurrence may result in immediate termination of medical staff privileges, an event reportable to the National Practitioners Data Bank.

Medical History and Physical Examination

43. Basic requirements for a medical history and physical examination (H&P) are addressed in Article IV, Section D of the Bylaws. Further requirements are specified as follows:

a) An H&P cannot be performed more than 30 days prior to admission.
b) An H&P performed more than seven days prior to admission must have an interval update.
c) All surgical or invasive procedures, in-patient or outpatient, require an H&P in the chart prior to performing the procedure. If a typed, dictated or electronically generated history and physical is not in the medical record prior to surgery, a pre-operative note may be hand written. Hand written note must also include diagnosis, the intended procedure/surgery and information pertinent to the surgery or anesthesia Elective surgeries/procedures may be delayed or canceled if either a typed H&P or hand-written note is not in the patient's chart prior to starting.
d) Outside records must be in a form acceptable to the hospital and compatible with its medical record system. .
e) For pediatric patients, H&P must include immunization status and assessment of developmental age.
f) An ED physician report for the current hospitalization can be used as the patient's H&P if it meets criteria as outlined in item #44 of this document. H&P's from physicians who

are not privileged at Northwest Hospital may be used only when verified and cosigned by the attending Northwest Hospital physician.

g) H&P's completed by an ARNP, PA or resident must be cosigned by the attending physician.

44. A complete H&P must include reason for admission, present illness, significant past medical history, relevant family history, substance use, medications, allergies and review of systems and pertinent physical findings concerning the admitting diagnosis or procedure.

45. Podiatric Pre-Operative History and Physical. Podiatrists may perform pre-operative H&P's on their patients of surgical risk ASA I or II. These must meet all standards defined in Item 44.

46. Operative and Other Procedures in the Ambulatory Care Setting. An H&P is required when procedures have inherent risk, involve puncture or incision of the skin for insertion of an instrument or foreign material into the body. These include, but are not limited to: percutaneous aspiration or biopsy, invasive diagnostic and therapeutic cardiovascular procedures, diagnostic and therapeutic fiberscopic procedures, device implantation and interventional radiological procedures. Excluded are venipuncture and intramuscular injections. Exceptions should be known to have minimal risk. Scope of the required H&P depends on risk of the procedure and anesthesia. Minimum requirements:

History

- Symptoms and indication for procedure or IV infusion
- History of the illness or injury
- Relevant past medical history
- Allergies and current medications
- Results of tests relating to the problem

Physical Examination (varies with type of anesthesia)

- With regional, local, topical, or no anesthesia: exam should be specific to the procedure
- With IV or oral sedation: above plus auscultation of heart and lungs
- With epidural, spinal or general anesthesia: above plus a written or dictated assessment of the patient's general condition.

For series patients, the H&P must be no more than one year old and the problem list must be updated upon each admission.

Other Chart Notes

47. Operative or Procedure Note (hand written). Must be written in progress notes immediately following completion of an operation or procedure. It must contain pre-op and post-op diagnoses, procedure, surgeon, assistant, anesthesiologist, type of anesthesia, estimated fluid lost and replaced, drains in place, complications and length of procedure.

48. Operative or Procedure Report (dictated or electronically generated). Immediately following any out-patient or in-patient procedure, an operative report must be dictated or electronically generated using the standard format and must be completed within 24 hours of the procedure. The typed or electronically generated report then must be reviewed and signed by the dictating physician within 30 days.

49. Progress Notes. Daily (or more frequent) progress notes must be dated, timed and recorded after each patient contact. When possible, each current problem should be identified and correlated with specific orders, and test or treatment results.

50. Discharge Summary. A written note and dictated or electronically generated discharge summary are required for all patients hospitalized more than 48 hours and must be completed within 24 hours of discharge. A discharge summary must include: reason for hospitalization, procedures performed, the care, treatment and services provided, condition and disposition at discharge, provisions for follow-up care, and information provided to the patient and family. Normal obstetrical deliveries and normal newborn infants admitted to the hospital less than 48 hours require only a summation progress note and completed discharge order form. Discharge summaries completed by an ARNP, PA or resident must be cosigned by the attending physician.

51. Emergency Department Report. The emergency department report must be completed within 48 hours of the patient's visit.

Completion and Authentication of the Medical Record - Practitioner's Responsibility

52. Dictated or electronically generated reports, including, but not limited to H&P, operative and procedure reports, consultations, pathology reports, discharge summaries and ED reports, must be reviewed and authenticated by the dictating practitioner using one of the following methods:

- Sign each report
- Authenticate electronically

Documentation Deadlines

53. Dictated or electronically generated H&P and Operative Reports (24 hours). Medical Records will notify the responsible physician if routine H&P's or Operative Reports are not completed within 24 hours after admission or performance of a procedure, respectively. Late dictation will be monitored and reported quarterly to the Medical Executive Committee.

54. Inpatient Hospital Record (at time of discharge). Medical record of a hospitalization must be complete at the time of discharge. The attending physician is responsible for completed and signed H&P, progress notes, final diagnosis, and written discharge summary.

55. Inpatient Hospital Record (30 days after discharge). The responsible physician will be notified by Medical Records Department if a discharged patient's chart is missing required reports, authentication or signature, or specific documentation required to support timely hospital billing. The entire record, including authenticated dictation of H&P, operative reports and discharge summary must be complete within 30 days after discharge or it will be considered "delinquent" and processed in the manner described below. Exception to this delinquency procedure occurs if an attending physician's absence of 30 days or more coincides with a delinquency deadline and the Medical Records Department is notified before the absence is to occur.

Procedure for Delinquent Charts – Suspended Privileges

56. If a record remains incomplete 15 calendar days after discharge, Chief of Staff, by letter, e-mail or fax, will caution the attending. If a record still remains incomplete 21 days after discharge, Chief of Staff, by additional letter, e-mail or fax, will caution the attending: unless the record is complete in 9 calendar days, the Medical Executive Committee will be informed and, without further notice, the Chief of Staff or Division Chief may suspend all elective admitting, operating room and other clinical privileges. The physician is responsible for notifying patients whose cases are canceled.

57. A physician incurring six automatic suspensions in a 12-month period will be removed from the medical staff in what will be classified a "voluntary, not in good standing" resignation.

Application for staff membership and clinical privileges will require a new application with fees and will be considered only after all dictation is complete.

58. Suspended privileges because of medical record delinquency is not reportable to the National Practitioner Data Bank but may be communicated in letters of reference and will be considered at the time of review for reappointment to Medical Staff.

59. Practitioners who depart from the Medical Staff with incomplete medical records will be notified and provided two weeks to complete their records. If their records remain incomplete after the two week period, the practitioner may be deemed by the Medical Executive Committee to have left the Medical Staff "not in good standing" and this status may be communicated in letters of reference. Such standing is not reportable to the National Practitioner Data Bank.

Informed Consent

60. Patient Consent for Procedure or Treatment. Except for extreme emergencies, procedures or treatment are performed only after consent by the patient or appropriate representative. Consent may be as designated in hospital admission documents or on hospital forms provided for selected procedures or treatments. Medical staff must adhere to the principles of informed consent in accordance with hospital policy and Washington State law.

HIPAA

61. HIPAA regulations take effect April 14, 2003 and as of this date, they require all providers to distribute a Notice of Privacy Practices to patients on the first patient encounter. The Notice of Privacy Practices is a relatively standardized document that explains in simple language a patient's rights to access and to request amendment to their medical information. It also explains how the provider will use and disclose information about the patient. The notice includes instructions on how a patient may file a complaint regarding the privacy of their health information. HIPAA allows large organizations with multiple providers practicing together to set up an Organized Health Care Arrangement (OHCA). This arrangement allows the providers to share one joint Notice of Privacy Practices rather than each handing a slightly different notice to the patient during the course of the patient's hospital care. NWHMC has formed an OHCA and created the Notice of Privacy Practices all practitioners will use when treating patients at the hospital (this notice will also be used in NWHMC owned clinics). In order for this OHCA to be viable, the hospital must include language in its Notice of Privacy practices explaining the OHCA as well as update these Rules and Regulations (see Addendum III of the Medical Staff Bylaws).

62. Physicians should be familiar with the NWHMC Notice of Privacy Practices and should be prepared to deal with patient questions regarding their rights. The registration points at the hospital will hand this notice to each patient the first time they register on or after April 14, 2003. A copy of this document is posted on the Intranet (see links from the Physician site or go directly to the NWHMC HIPAA site).

63. HIPAA Policies: NWHMC has several policies mandated by HIPAA. Copies of the policies are available on the NWHMC Intranet. Physicians should be familiar with each:

- Privacy & Confidentiality
    - Incidental Use & Disclosure
    - Violation exemptions
    - Alternative communication of Protected Health Information (PHI)
    - Privacy Officer role
    - Safeguards for PHI

    - Complaint process
    - Sanctions for violations
    - Mitigation of harm
- Release of Protected Health Information
    - With authorizations
    - Without authorizations
    - Who can request
- Amendment to Protected Health Information
    - Patients may request to amend their health information;
    - Requests must be in writing to H.I.M. (Medical Records)
    - Denials, Appeals—requests can be denied but due process must be followed. In the end, the patient can appeal and the appeal must become part of the patient's record.
- Designated Record Set
    - specifies exactly which records we consider to be part of our DRS
    - reduces the reach of a request to see "all" records.
- Research Requirements
    - Authorizations are required to access patient data for research purposes. Some exceptions to this are:
        - IRB Waivers
        - Research Preparation
        - Research on Decedents
        - Data Use Agreement
        - De-identified data
- Accounting of Disclosures
    - We are required to keep a list of disclosures of PHI made outside of normal treatment, payment or operations, including mandatory disclosures
    - Mandatory disclosures includes, but is not limited to public health, surveillance and statistics reporting
    - Patient requests for this list must be in writing to H.I.M. (Medical Records)

Surgical Specimens

64. Tissue specimens collected from procedures are usually submitted to pathology for examination necessary to determine tissue diagnosis. Pathologists dictate a final report for the hospital record. Exceptions to the policy of submitting all tissue are outlined in Departments of Surgery and Pathology policies and relevant Operating Room protocol.

Disaster Preparedness

65. Patient care policies during a disaster are the joint responsibility of the Medical Emergency Disaster Coordinator (a physician) and the senior hospital administrator on duty. Patient evacuation from a portion of the hospital or from hospital grounds is directed jointly by the Disaster Coordinator, administrator on duty and the nursing supervisor. In case of a disaster, physicians may be required to defer certain patient care decisions to the Disaster Coordinator.

66. Scope and severity of a disaster will determine staff physician response. Should additional doctors be needed at the hospital, those on the daily ED call list will be notified first. Medical Staff Office maintains the list and a copy is on file in the ED.

67. Physicians responding to a disaster call or returning to the hospital in the event of a widespread disaster must report for assignment to the Emergency Command Center.

Infection Control

68. Infection Control Committee establishes policy for reporting and managing communicable diseases, protocols for blood borne pathogens and for required TB testing. Infection control policies apply to all physicians, registered health professionals, hospital staff and students.

New Procedures

69. A physician or hospital agent may introduce a new procedure into the hospital only according to policies of the New Procedures Committee (ad hoc from the Executive/Credentials Committee). A new procedure must be approved by the appropriate audit committee and defined as a unique procedure not considered a routine extension of a physician's current privileges and presently not performed at the hospital.

Research

70. Research that may involve Northwest Hospital patients, medical records, or staff must be approved by the Research Committee, which is an administrative committee of the Governing Board. The Research Committee is not a substitute for the IRB functions required by regulatory agencies. No research project may proceed without approval by the Research Committee as well as continuous approval and surveillance by an authorized IRB.

Pharmacy

71. Drugs acceptable for use in the hospital are listed in the hospital formulary. Exceptions, including drugs used in clinical trials, must be approved by the Research Committee and/or Pharmacy, Therapeutics, and Blood Utilization Committee.

Autopsies

72. Attending physicians are encouraged to request autopsies when diagnoses are uncertain or clinical questions are likely to be resolved by autopsy findings. This may include deaths associated with unexplained or unanticipated complications, infectious diseases, obstetric or neonatal complications, and occupational or environmental hazards.

73. King County Medical Examiner must be notified of death in the following circumstances: occurs in less than 24 hours after admission, death with no diagnosis, intraoperative or unexplained postoperative death, unanticipated death, death incident to pregnancy or death due to medical misadventure. In these situations, autopsy may be required by the Medical Examiner.

74. A requesting physician should consult with Pathology to define the scope of an autopsy.

75. Autopsy requires signed consent and is performed by a hospital pathologist or designee.

76. The attending physician will be notified when an autopsy is to be performed.

77. Divisions of the Medical Staff regularly review and discuss autopsy information.

78. Pronouncement of death will be done in accordance with hospital policies and procedures.

Approvals:

Executive Committee Governance:	March 1, 1999
Quality Standards:	April 2, 1999

Implementation Date:	September 1, 1999
Revised:	January 2000
Approval-January 2000 Revisions:	
Executive Committee – Governance:	February 7, 2000
Quality Standards:	February 11, 2000
Implementation Date for January 2000 Revisions:	March 7, 2000
Revised:	February 2001
Approvals-February 2001 Revisions:	
Executive Committee – Governance:	February 26, 2001
Quality Standards:	March 16, 2001
Implementation Date for February 2001 Revisions:	April 17, 2001
Revised:	March 2002
Approvals – March 2002 Revisions:	
Executive Committee – Governance:	March 11, 2002
Quality Standards:	March 15, 2002
Implementation Date for March 2002 Revisions:	April 1, 2002
Revised:	February 2003
Approvals – February 2003 Revisions:	
Executive Committee – Governance:	March 3, 2003
Quality Standards:	March 21, 2003
Implementation Date for February 2003 Revisions:	March 21, 2003
Revised:	October 2003
Approvals – October 2003 Revisions:	
Executive Committee – Governance:	November 3, 2003
Quality Standards:	January 16, 2004
Implementation Date for October 2003 Revisions:	January 16, 2004
Revised:	May 2005
Approvals – May 2005 Revisions:	
Executive Committee – Governance:	June 6, 2005
Quality Standards:	June 17, 2005
Implementation Date for May 2005 Revisions:	September 1, 2005
Revised:	May 2006
Approvals – May 2006 Revisions:	
Executive Committee – Governance:	May 1, 2006
Quality Standards:	May 19, 2006
Implementation Date for May 2006 Revisions:	September 1, 2006

Revised:	March 2007
Approvals – March 2007 Revisions:	
Executive Committee – Credentials:	March 12, 2007
Quality Standards	March 16, 2007
Implementation Date for March 2007 Revisions:	March 16, 2007
Revised:	June 2007
Approvals – June 2007 Revisions:	
Executive Committee – Governance:	July 9, 2007
Quality Standards:	August 17, 2007
Implementation Date for June 2007 Revisions:	August 17, 2007
Revised:	October 2007
Approvals – October 2007 Revisions:	
Executive Committee – Governance:	October 8, 2007
Quality Standards:	October 19, 2007
Implementation Date for October 2007 Revisions:	October 19, 2007
Revised:	December 2007
Approvals – December 2007 Revisions:	
Executive Committee – Governance:	December 3, 2007
Quality Standards:	December 21, 2007
Implementation Date for December 2007 Revisions:	December 21, 2007
Revised:	June 2008
Approvals – June 2008 Revisions:	
Executive Committee – Governance:	June 2, 2008
Quality Standards:	June 20, 2008
Implementation Date for June 2008 Revisions:	June 20, 2008
Revised:	January 2010
Approvals – January 2010 Revisions:	
Executive Committee – Governance:	December 7, 2009
Quality Standards:	January 15, 2010
Implementation Date for January 2010 Revisions:	January 15, 2010
Revised:	April 2010
Approvals – April 2010 Revisions:	
Executive Committee – Governance:	April 5, 2010
NWH Board:	May 18, 2010
Implementation Date for April 2010 Revisions:	May 18, 2010
Revised:	November 2010

Approvals – November 2010 Revisions:	
Executive Committee – Governance:	November 1, 2010
NWH Board:	November 19, 2010
Implementation Date for November 2010 Revisions:	November 19, 2010
Revised:	May 2011
Approvals – May 2011 Revisions:	
Executive Committee – Governance:	March 7, 2011
NWH Board:	June 17, 2011
Implementation Date for May 2011 Revisions:	June 17, 2011
Revised:	September 2011
Approvals – September 2011 Revisions:	
Executive Committee – Governance:	July 11, 2011
NWH Board:	September 20, 2011
Implementation Date for September 2011 Revisions:	September 20, 2011
Revised:	October 2011
Approvals – October 2011 Revisions:	
Executive Committee – Governance:	October 3, 2011
NWH Board:	October 21, 2011
Implementation Date for October 2011 Revisions:	October 21, 2011
Revised:	November 2011
Approvals – November 2011 Revisions:	
Executive Committee – Governance:	November 7, 2011
NWH Board:	November 18, 2011
Implementation Date for October 2011 Revisions:	November 18, 2011
Revised:	April 2012
Approvals – April 2012 Revisions:	
Executive Committee – Governance:	April 2, 2012
NWH Board:	April 20, 2012
Implementation Date for April 2012 Revisions:	June 1, 2012
Revised:	May 2012
Approvals – May 2012 Revisions:	
Executive Committee – Governance:	June 4, 2012
NWH Board:	May 18, 2012
Implementation Date for May 2012 Revisions:	June 4, 2012
Revised:	September 2012

Approvals – September 2012 Revisions:	
Executive Committee – Governance:	June 4, 2012
NWH Board:	September 21, 2012
Implementation Date for September 2012 Revisions:	September 21, 2012
Revised:	October 2012
Approvals – October 2012 Revisions:	
Executive Committee – Governance:	October 8, 2012
NWH Board:	October 19, 2012
Implementation Date for October 2012 Revisions:	October 19, 2012
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Approvals – March 2014 Revisions:	
Executive Committee – Governance:	March 3 2014
NWH Board:	March 21, 2014
Implementation Date for March 2014 Revisions:	April 1, 2014
Revised:	
Approvals – January 2015 Revisions:	
Executive Committee – Governance:	January 9, 2015
NWH Board:	January 9, 2015
Implementation Date for January 2015 Revisions:	January 9, 2015

NORTHWEST HOSPITAL & MEDICAL CENTER

Seattle, Washington

ADDENDUM II:

STATEMENT OF FUNCTIONS & RESPONSIBILITIES

Effective Date:

September 1, 2006

STATEMENT OF FUNCTIONS AND RESPONSIBILITIES
CHIEF OF STAFF

Qualifications/Election: Chief of Staff is a member in good standing of the Active or Affiliate-Active Medical Staff (for at least the previous two years) nominated by the Medical Staff and elected by a majority of voting Medical Staff members.

Tenure : 2 years

Governance

- Medical Staff CEO with authority granted by Medical Staff Bylaws.
- Responsible for establishing and maintaining Statement of Functions and Responsibilities for Medical Staff Officers.
- Represent Medical Staff to HRNW Board as an ex officio voting member.
- Represent Medical Staff to Hospital Executive Committee as a voting member.
- Chair Medical Executive Committee on Governance and Medical Executive Committee on Credentials.
- Responsible for Medical Staff meetings (annual and special meetings).
- Responsible for Medical Staff leadership development.
- Appoint interdepartmental committees including Infection Control, Pharmacy, Therapeutics & Blood Utilization and Continuing Medical Education.
- Review reports from Division Chiefs and assume supervisory responsibilities in their absence.
- Responsible for oversight of the reporting structure of the Medical Staff Divisions and Sections.
- Oversee Medical Staff Leadership participation in strategic planning with Medical Staff and Hospital.
- Coordinate annual Performance Reviews of Division Chiefs in consultation with CEO or designee.

Performance Improvement

- Responsible for Medical Staff Performance Improvement activities.
- Responsible for corrective action hearings, appeals, and sanctions defined in Bylaws.
- Assure Medical Staff compliance with regulatory requirements, including JCAHO, State, and other accrediting agencies.

Credentials

- Responsible for establishing and maintaining current credentialing and privileging criteria.
- Oversee Credentialing and Privileging activities to ensure compliance with regulatory requirements, Northwest Hospital policies as well as Medical Staff Bylaws/Rules & Regulations.
- Make recommendations for Medical Staff appointments and reappointments and clinical privileging to the HRN Board through their Quality Standards Committee.

Medical Staff Communication

- Assure communication among Medical Staff including information sharing, opinion gathering, and consensus building by various means (newsletters, e-mail, surveys, open forums, etc.)

CHIEF OF STAFF ELECT

Qualifications/Election: Chief of Staff Elect is a member in good standing of the Active or Affiliate-Active Medical Staff (for at least the previous two years) nominated by the Medical Staff and elected by a majority of voting Medical Staff members.

Tenure: 2 years

Governance

- Assume Chief of Staff authority and responsibilities when Chief of Staff is absent.
- Responsible for maintaining Physician Health Program.
- Represent Medical Staff to HRNW Board as ex officio voting member.
- Under the direction of the Chief of Staff & CEO, participate in strategic planning for the Medical Staff and Hospital.

Credentialing

- Assumes oversight responsibility for Credentialing and Privileging activities when Chief of Staff is absent.

Performance Improvement

- Review Performance Improvement documents involving Chief of Staff in consultation with the Chief Quality Officer.
- Chair Clinical Performance Improvement Committee
- Chair Physician Order Oversight Committee

SECRETARY-TREASURER

Qualifications/Election: Secretary-Treasurer is a member in good standing of the Active or Affiliate-Active Medical Staff (for at least the previous year) nominated by the Medical Staff and elected by a majority of voting Medical Staff members.

Tenure: 2 years

Governance

- Responsible for Annual Medical Staff meeting minutes.
- Responsible for electronic maintenance of Medical Staff funds.
- Responsible for annual dues assessment with Medical Staff Office support.
- Provide annual financial report/budget to Medical Executive Committee on Governance with recommendations for changes to Medical Staff dues structure and officer stipend adjustment.
- Perform annual review of the Medical Staff Bylaws/Rules & Regulations in consultation with Medical Staff Services Supervisor.
- Ensures ongoing dissemination of information to the Medical Staff through various mediums including a quarterly Medical Staff newsletter.
- Serve as co-chair for committees chaired by Chief of Staff Elect.
- Develop and oversee Leadership Education program for Medical Staff Leadership
- Under the direction of the Chief of Staff & CEO, participate in strategic planning for the Medical Staff and Hospital.
- Assume responsibilities of Chief of Staff or Chief of Staff-Elect in their absence.

DIVISION CHIEFS

Qualifications/Election Division Chiefs are members of the Physician Active Staff nominated by Chief of Staff and Northwest Hospital CEO through the Medical Executive Committee on Governance, then approved by a simple majority of division members eligible to vote.

Tenure: Four years, renewable.

Summary of Responsibilities As directed by Medical Staff Bylaws, division chiefs are accountable to the CEO and Medical Executive Committee for professional and Medical Staff activities of their division and responsible for the following:

Governance

- Responsible for Division clinical and administrative activities.
- Chair division Audit Committee meetings.
- Identify sections and nominate section heads, in accordance with Medical Staff Bylaws.
- Delegate clinical responsibilities to section heads.
- Identify a deputy chief to serve in chief's absence.
- Appoint co-chairs of interdisciplinary quality councils.
- Represent division to Medical Executive Committee and other interdepartmental or interdisciplinary committees.
- Implement Medical Executive Committee actions affecting the division.
- Advise CEO or designee on issues relating to the division.
- Present annual report to Medical Executive Committee on division goals, accomplishments and challenges.
- Attend weekly Senior Management meeting.
- Under the direction of the Chief of Staff & CEO, participate in strategic planning for the Medical Staff and Hospital.

Credentialing

- Advise Medical Executive Committee about division clinical privileges criteria and recommend clinical privileges for each division member.
- Oversee currency of criteria for privileging with input from Sections as needed.
- Review provider credentials and QA files at time of appointment and reappointment and make recommendations to the Medical Executive Committee on Credentials.
- As designee for CEO, review and act on requests for temporary or interim privileges.

Performance Improvement

- Supervise PI activities including development of standards of care, standardized order sets, outcome measures, data collection and analysis.
- Develop and implement division policies, protocols, and other methods to pursue best clinical practice.
- Develop and implement a Peer Review program relative to clinical practice throughout the institution to oversee and ensure clinical competency of Division Medical Staff members.

- Use clinical data to assess Performance Improvement techniques for improving quality of care.
- Perform clinical performance review of division members to include: QA memos, quality of care concerns and citizenship issues.
- Perform concurrent care reviews with Care Management and authorize decertifications.
- Participate in corrective action defined in Bylaws.
- Report to Chief of Staff and Medical Executive Committee regarding division PI activities.
- Insure division compliance with Medical Staff Bylaws, Rules and Regulations.
- In conjunction with the Chief Quality Officer and other Medical Staff Officers, responsible to monitor and ensure physician compliance with clinical documentation projects that may include Interqual, DRG Assurance and DRG Transfer Rule.

SECTION HEADS

Qualifications/Election: Section Heads are members of a Division of the Medical Staff nominated by their Division Chief through the Medical Executive Committee then approved by a simple majority of section member eligible to vote.

Tenure: 2 years, renewable

Summary of Responsibilities: Section heads report and are accountable to their division chief for section professional and Medical Staff activities. Each section head is responsible for the following:

Governance

- Clinical activities of the Section.
- Where applicable, co-chair interdisciplinary Quality Council for the section.
- Provide strategic planning for the section and assist the hospital with program development.

Credentialing

- Recommend section clinical privilege criteria to division chief.

Performance Improvement

- Develop and maintain contemporary standards of care for important disease states, based upon clinical practice guidelines, evidence-based medicine, and local and national standards of care.
- Develop outcome measures with data collection and analysis for important disease states.
- Develop standardized order sets.
- Analyze and review clinical data to assess effectiveness of Performance Improvement activities.
- Monitor professional performance of members.
- Upon request of division chief, provide concurrent inpatient review in conjunction with Care Management. Identify clinical problems and provide attending physicians with concurrent consultative, educational and administrative resources.
- Report section Performance Improvement activities to division chief.
- Disseminates Performance Improvement data to section members.

Physician Education

- Identify medical education needs of section members and make recommendations for educational opportunities to the CME Committee.

APPROVALS:

Originally Drafted and Approved:	1998
Revised:	August 2006
Approvals – August 2006 Revision:	
Medical Executive Committee – Governance:	August 14, 2006
Quality Standards Committee:	August 18, 2006
Implementation Date for August 2006 Revision:	September 1, 2006

NORTHWEST HOSPITAL & MEDICAL CENTER

Seattle, Washington

ADDENDUM III:

HIPAA RESOLUTION

Effective Date:

March 21, 2003

RESOLUTION OF THE MEDICAL EXECUTIVE COMMITTEE
OF
NORTHWEST HOSPITAL & MEDICAL CENTER

The Medical Executive Committee of Northwest Hospital & Medical Center has determined that it is beneficial to revise the Medical Staff Organization Rules and Regulations in response to certain regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Therefore,

IT IS HEREBY RESOLVED that the Medical Staff Rules and Regulations shall be amended to add the following provisions:

Participation in Organized Health Care Arrangement ("OHCA")

Purpose

In order to provide quality patient care in a clinically integrated setting, Northwest Hospital & Medical Center, including its Medical Staff (collectively, "OHCA Participants") are required to share patient information for treatment purposes, as well as for a broad range of activities that support and improve their operations, including without limitation, payment and billing functions, quality improvement initiatives and operations management and planning. The OHCA described herein has been declared and established, in accordance with the HIPAA "Standards for Privacy of Individually Identifiable Health Information" ("Privacy Rules"), 45 C.F.R. Subtitle A, Subchapter C, Parts 160 and 164, and for the purpose of better serving Northwest Hospital & Medical Center patients and facilitating the exchange of "protected health information" among Northwest Hospital & Medical Center, Practitioners, RHP's and other health care professionals providing care at the Hospital.

Terms of OHCA Participation

In accordance with the obligations arising under the Medical Staff Bylaws and Rules & Regulations, the OHCA Participants shall participate in the OHCA described herein on the terms set forth in the Medical Staff Bylaws & Rules & Regulations and as set forth below.
Pursuant to the Privacy Rules, Northwest Hospital & Medical Center has developed a notice of privacy practices that will be distributed to or made available to the OHCA Participants in accordance with applicable Northwest Hospital & Medical Center policies ("Privacy Notice") that provides Northwest Hospital & Medical Center patients with information about the uses and disclosures of patient "Protected Health Information" or "PHI" at Northwest Hospital & Medical Center. The Privacy Notice indicates to patients that, among other things (i) Northwest Hospital & Medical Center and the OHCA Participants participate in an OHCA in a clinically integrated setting at the Hospital, and (ii) Northwest Hospital & Medical Center and the OHCA Participants will share PHI as necessary to carry out treatment, payment and operations relating to the OHCA in accordance with the Privacy Rules. The Privacy Notice, along with the OHCA described herein, shall become effective on the Privacy Rules compliance deadline of April 14, 2003.

The Privacy Notice includes a "joint notice" provision that generally describes the class of separate covered entities to which the Privacy Notice applies for health care delivered at Northwest Hospital & Medical Center facilities, which class included the OHCA Participants. Northwest Hospital & Medical Center and OHCA Participants acknowledge and agree to abide by the terms of the Privacy Notice in connection with the use and disclosure of PHI related to

care or other services provided at the Hospital. Through the execution of the appointment and reappointment application form OHCA Participants agree with Northwest Hospital & Medical Center to abide by the terms of the Privacy Notice, as it may be revised from time to time by Northwest Hospital & Medical Center in accordance with these Rules with respect to PHI created or received by them as part of their participation in the OHCA described herein.

Northwest Hospital & Medical Center may from time to time (prior to and following the Privacy Rules compliance deadline) amend or revise the Privacy Notice. Northwest Hospital & Medical Center will notify OHCA Participants of any revisions to the Privacy Notice in accordance with applicable Northwest Hospital & Medical Center policies and such revisions shall be binding on OHCA Participants without further action by Northwest Hospital & Medical Center or any OHCA Participant.

An OHCA Participant's participation in the OHCA described herein shall terminate automatically to the extent that an OHCA Participant's Privileges at the Hospital are terminated or suspended. Except as described below, no OHCA Participant shall be entitled to voluntarily withdraw from the OHCA described herein while maintaining Privileges at the Hospital. Northwest Hospital & Medical Center, by amendment to the Bylaws and Rules, reserves the right in its sole discretion to withdraw from and terminate the OHCA described herein.

The OHCA described herein has been established for the sole and limited purpose of meeting the OHCA requirements set forth in the Privacy Rules. OHCA Participants shall exercise medical judgment free of any direction or control by Northwest Hospital & Medical Center within the areas of such participant's professional competence and the limits established by the Bylaws, and the terms of any employment relationship between Northwest Hospital & Medical Center and an OHCA Participant or other agreement between an OHCA Participant and Northwest Hospital & Medical Center. The OHCA described herein shall not be construed to (i) constitute Northwest Hospital & Medical Center or any independent OHCA Participant as partner, joint venturers, co-workers, or otherwise as participants in a joint or common undertaking of any kind whatsoever, or (ii) allow either party to create or assume any obligation on behalf of the other party for any purpose whatsoever. To this end, OHCA Participants shall not be permitted to act on behalf of Northwest Hospital & Medical Center with respect to Northwest Hospital & Medical Center's compliance obligations under the Privacy Rules or any other similar law or regulations, including without limitation, the right to (i) agree to restrictions regarding the use PHI or (ii) agree to amend PHI or records about an individual maintained by Northwest Hospital & Medical Center.

OHCA Participants shall be responsible for their respective compliance obligations under the Privacy Rules, the HIPAA "Administrative Simplification" regulations or any other applicable law or regulation including without limitation the obligation to prepare and use, if applicable, separate notices of privacy practices for medical practices in offices or facilities separate from Northwest Hospital & Medical Center. Other than as to the limited responsibilities as participants in the OHCA described herein, neither Northwest Hospital & Medical Center nor any OHCA Participant is undertaking any responsibility whatsoever in relation to compliance obligations of any other covered entity or OHCA Participant under the Privacy Rules or other HIPAA Administrative Simplification regulations.

In accordance with the definition of "business associate" found in 45 C.F.R. § 103 of the Privacy Rules, no participant in the OHCA described herein shall become a "business associate" of any other OHCA participant solely through the performance of any function or activity described in such definition on behalf of the OHCA described herein.

Northwest Hospital & Medical Center and OHCA Participants shall comply with all applicable laws and regulations, including without limitation, state and federal laws and regulations related to health information privacy, security, confidentiality, consent, access and disclosure, including the Privacy Rules and Washington Uniform Health Information Act RCW ch 70 02.

Passed and approved by majority vote, and adopted by the Northwest Hospital & Medical Center Executive Committee on Governance on March 3, 2003

Approvals:

Executive Committee-Governance:	March 3, 2003
Quality Standards:	March 21, 2003