Medical Staff

Bylaws
Rules and Regulations
Organization and Functions Manual
Credentialing Policy and Procedures Manual
Corrective Action and Corrective Action & Fair Hearing Plan

Revised: 12/2014

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ARTICLE I. MEDICAL STAFF MEMBERSHIP

SECTION 1. PURPOSE

The purpose of this organization is to bring the physicians, dentists, and podiatrists that practice at the hospital together into a cohesive body to promote good medical, osteopathic, podiatric and dental care. It will screen applicants for medical staff membership, review privilege requests from all licensed independent practitioners permitted to practice in Trios Health (or Hospital), scrutinize work done by the staff, educate and offer advice and input to the Administrator and the Board of Commissioners. It will provide a mechanism for accountability through defined organizational components and positions.

SECTION 2. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the medical staff is a privilege that shall be extended only to professionally competent physicians, dentists, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these bylaws and Provisional policies of the medical staff and Trios Health.

SECTION 3. QUALIFICATIONS FOR MEMBERSHIP

A. Only physicians with Doctor of Medicine/Doctor of Osteopathy degrees, dentists (DDS or DMD) or podiatrists (DPM) holding a current Washington State license, and current state and/or federal drug enforcement registration(s) who can document the following criteria will be considered for staff membership. Certified and/or qualified Allied Health Professionals (AHPs) will also be considered:

1. Experience, education, training and judgment,

2. Demonstrated clinical performance and competence,

3. Professional ethics and conduct, including malpractice history,

4. Ability to perform privileges or specified services requested/health status,

5. Communication skills and the ability to read, write and understand the English language and to prepare medical records entries and other required documentation, and

6. Professional liability insurance (issued by a recognized company) of a type and in an amount established by the Board of Commissioners.

Qualifications for membership in the medical staff and the criteria entitling a practitioner to exercise clinical privileges in the Hospital include demonstrated competence and judgment, satisfactory current physical and mental condition, and ability to work harmoniously with others, sufficient to assure the medical staff and the Hospital's Board of Commissioners that any patient treated by the practitioner in the Hospital will receive quality care and that the Hospital and the medical staff will be able to operate in an orderly manner. For those situations where this is

questioned, please refer to the "*Practitioner Health Policy*", "*Disruptive Physician Policy*", or the "*Corrective Action & Fair Hearing Plan*", dependent on the situation.

No physician, dentist, podiatrist, or AHP shall be entitled to membership on the medical staff or to exercise particular clinical privileges merely by virtue of licensure to practice in this or in any other state, or of membership in any professional organization, or of privileges at any other hospital.

B. Completion of an accredited residency programs (i.e. Accreditation Council of Graduate Medical Education, American Osteopathic Association or American Podiatric Medical Association). Dentists and oral surgeons must have graduated from an approved school of dentistry and satisfactorily completed an approved postgraduate training program of at least one year fro dentistry or oral surgery.

C. In lieu of the requirement of section B, evidence of at least five years of relevant clinical experience in a hospital approved by the Joint Commission on Accreditation of Health Care Organizations or the American Osteopathic Association may be submitted, together with documentation as to fields of work, duties, and responsibilities.

D. Exceptions to the above may be made only by the Board of Commissioners after a joint conference with the medical staff.

SECTION 4. NONDISCRIMINATION

Trios Health will not discriminate in granting staff appointment and/or clinical privileges on the basis of ancestry, race, gender, faith, or age.

SECTION 5. CONDITIONS AND DURATION OF APPOINTMENT

A. Initial appointments and re-appointments to the medical staff shall be made by the Board of Commissioners. The Board of Commissioners shall act on appointments and re-appointments only after there has been a recommendation from the Medical Executive Committee in accordance with the provisions of these bylaws and related manuals.

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

C. Appointment to the medical staff shall confer on the appointee only such clinical privileges as have been granted by the Board of Commissioners.

D. Dentists and podiatrists who are members of the medical staff may admit patients if a physician member of the medical staff agrees to conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry or podiatry). The physician member will assume responsibility for problems, present at the time of the co-admission or which may arise during hospitalization, which are outside the podiatrist's or dentist's lawful scope of practice.

SECTION 6. STAFF DUES

A. Annual medical staff dues shall be governed by the most recent action, which has been approved by the Medical Executive Committee. The medical staff office shall notify each staff member in writing of any contemplated change in medical staff dues at least twenty-one (21) days before the Medical Executive Committee meeting at which voting on such proposed changes is to take place.

B. Honorary staff members will not be required to pay dues.

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

SECTION 7. ETHICAL REQUIREMENTS

A person who accepts membership on the medical staff agrees to act in an ethical, professional, and courteous manner in accordance with the Medical Staff Bylaws, Rules & Regulations and other policies and procedures of the hospital and the medical staff. For those situations where this is questioned, please refer to the "Practitioner Health Policy" or the "Corrective Action & Fair Hearing Plan", dependent on the situation.

SECTION 8. RESPONSIBILITIES OF EACH MEMBER (APPOINTEE)

Each staff member agrees to:

A. Provide appropriate and continuous care of his patients. He or she is responsible to report to Quality Management Committee chair the inappropriate actions of other physicians, dentists, allied health professionals, hospital employees under his supervision, and licensed independent practitioners.

B. Abide by the bylaws, rules, and regulations and other policies and procedures of the hospital and the medical staff, and The Joint Commission and other pertinent regulatory bodies.

C. Disclose professional liability action, either of a finalized or pending nature including previous judgments and/or settlements, to the medical staff office of the hospital when requested.

D. Disclose immediately any successful challenges to licensure or registrations or voluntary or involuntary relinquishment of such licensure or registration to the medical staff office or administrator of the hospital.

E. Disclose immediately voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, suspension or loss of clinical privileges at another institution.

F. Disclose any current criminal charges pending, any past charges and any convictions of misdemeanors or felonies when requested.

SECTION 9. PRACTITIONER RIGHTS

A. Each MD, DO, DMD, DDS and DPM on the medical staff who is not a member of the Medical Executive Committee has a right to an audience with the Medical Executive Committee provided that:

B.

1. The issue has been discussed with the department/section chair, and;

2. The issue has been discussed with the Medical Staff President, and;

3. The issue has been discussed with the practitioner or party involved, and;

4. Copies of relevant documents are to be made available to the members of the Medical Executive Committee and those in attendance prior to discussion of the Issue.

It is the intent of these provisions that the Medical Executive Committee is determined to be the appropriate forum for such discussion and that the issue can be discussed in a rational and well thought out fashion.

C. Each MD, DO, DMD, DDS, and DPM has the right to initiate a recall election of a medical staff officer provided that twenty percent (20%) of the active staff signs the petition (see III.7 of the bylaws). Upon presentation of a valid petition, the Medical Executive Committee will schedule a special general medical staff meeting for the purposes of discussing the issue and (if appropriate) to entertain a no confidence vote which will be held by mail-in ballots, as described below.

Recall elections of medical staff officers will be held by mail-in random numbered secret ballot. In the case of mail-in ballots, the ballots will be sent to the offices of record of the members of the active staff with a stamped self-addressed envelope to return the ballot. Ballots will be tabulated by the medical staff services office and validated by the parties concerned within ten (10) days of the initial mailing.

An affirmative vote may be cast by marking the ballot "yes" and returning it to the medical staff office. A negative vote may be cast by marking the ballot "no" and returning it to the medical staff office. A change will be recommended by the active staff, for approval by the Medical Executive Committee and Board of Commissioners providing that a simple majority of active medical staff members indicate "yes" for recall on the returned ballot.

D. Any MD, DO, DMD, DDS and DPM can call a general Staff meeting, with twenty percent (20%) of the active medical staff signing the petition. The Medical Executive Committee will schedule a special general medical staff meeting for the specific purpose addressed by the petitioners. No business other than that stated in the petition may be transacted (see "Special Meetings").

E. Any practitioner has a right to a hearing/appeal pursuant to the Bylaws and "Corrective Action & Fair Hearing Plan" in the event any of the following actions are taken or recommended as the result of an investigation and corrective action (*see Credentialing Policy & Procedure Manual*).

1. Denial of initial staff appointment,

2. Denial of reappointment,

3. Suspension of appointment for more than 30 days,

4. Revocation of appointment,

5. Denial of requested appointment to, or advancement in, staff category if the denial will result in a termination or restriction of clinical privileges,

6. Special limitation on the right to admit patients,

7. Denial or restriction of requested clinical privileges,

8. Reduction or restriction of clinical privileges,

9. Suspension of clinical privileges for more than 30 days,

10. Revocation of clinical privileges,

11. Individual application of, or individual changes in, a requirement of mandatoryconcurring consultation or any significant limitation on the exercise of clinical privileges, except for a suspension or observation requirement in connection with the exercise of new privileges or reinstatement of a practitioner after a leave of absence.

12. Any other action which requires a report to be made to the Washington State Medical or Disciplinary Boards under RCW 70.41.210 or other applicable law.

Provided, however, that there shall be no right to a hearing/appeal for those matters that are specifically excluded from a hearing in these Bylaws or the Medical Staff "*Corrective Action & Fair Hearing Plan*".

F. Communications Regarding Practitioners:

1. Whenever a complaint, letter or report concerning a Trios Health practitioner is received and is deemed serious by the receiving party (CEO, any official of the Hospital or a practitioner) the complaint letter or report will remain in the Hospital and be treated as a quality assurance document until otherwise classified. Within thirty (30) days of submission, cases that are coded based on Hospital-wide Indicators is produced by the Quality Department on a monthly basis, screened and referred for clinical review.

2. All formal complaints including patient problem reports, incident reports or complaint/letter/report concerning practitioners will always require notification of the practitioner. The notice to practitioner and any response from the practitioner will be routed through normal quality assurance channels, i.e. Quality Management Committee or Department. Cases which require additional committee review or peer review will be subject to the timelines set forth in the Medical Staff Peer Review Policy.

3. All reported complaints, letters, or reports will be treated seriously and investigated under the following guidelines: All events will be kept confidential to the fullest extent possible. This means disclosure only to witnesses and others as necessary to allow investigation and response to the complaint and as may be required by law.

SECTION 10. DISCIPLINARY PROCEDURES

A. The complete procedural details related to the indications for and the process by which a **Medical Staff member's membership or clinical privileges may be terminated, suspended** or other corrective action taken are found in the Corrective Action &Fair Hearing Plan.

B. Indications for termination or suspension of Medical Staff membership may include, but **are not limited to, concerns regarding the Medical Staff member's ability to:**

1. Deliver safe, effective, quality patient care;

2. Meet the emotional, physical or behavioral requirements of membership including avoiding disruptive behavior;

3. Comply with the Medical Staff Bylaws, Policies, and Rules and Regulations or non-compliance with federal and state laws and regulations or applicable Trios policies or procedures.

C. The **process for determining if a Medical Staff member's membership should be** terminated or suspended or other corrective action taken may involve:

1. The results of ongoing professional practice evaluation (hereinafter OPPE) related to renewal of membership and clinical privileges;

2. Focused professional practice evaluation (hereinafter FPPE) related to assessment during the provisional period; or

3. A request for investigation of a Medical Staff member.

D. The disciplinary process will involve review by the Medical Executive Committee, Trios Administration and the Board and may involve review by Medical Staff officers, the applicable department, an investigating committee, or any standing committee of the Medical Staff.

ARTICLE II. CATEGORIES OF THE MEDICAL STAFF

SECTION 1. THE ACTIVE CATEGORY

QUALIFICATIONS: Appointees to the category (MD, DO, DDS, DMD, or DPM) must:

A. Admit or otherwise be involved in a minimum of 25 patient contacts at the hospital per year except as expressly waived for practitioners who document their efforts to support the hospital's patient care mission to the satisfaction of the Medical Executive Committee and Board of Commissioners. A patient "contact" includes an inpatient or outpatient activity defined as an admission, an invasive procedure or a consultation.

In the event an appointee to the active category does not meet the qualifications for reappointment to the active category, and if the appointee is otherwise abiding by all bylaws, rules, regulations and policies of the staff, the appointee will be appointed to the Courtesy category.

B. Live within 30 miles of Trios Health and be able to respond within 30 minutes when on call for ER and/or his patients.

PREROGATIVES: Appointees to this category may:

A. Exercise clinical privileges as are granted by the Board of Commissioners;

B. Vote on all matters presented by the medical staff and by the appropriate department and committee of which (s)he is a member;

C. Hold office and sit on or be the chairperson of any committee, unless otherwise specified elsewhere in these bylaws;

D. Participate in hospital and medical staff education programs as appropriate.

RESPONSIBILITIES: Appointees to this category must:

A. Contribute to the organizational and administrative affairs of the medical staff;

B. Actively participate in recognized functions of the staff appointment including quality/performance improvement, risk management and monitoring activities, including monitoring of new appointees during the Provisional period, and in discharging other staff functions as may be required from time to time;

C. Participate in the emergency service and other specialty coverage programs as determined by the department chair or by the Medical Executive Committee;

WAIVER: The appropriate department may, by a majority vote of members present, relieve members of the active staff from selected types of call when the following occurs:

- Provider submits request in writing stating one of the following reasons:
    - Age (greater then 65 years)
    - Fulfillment of call obligations are being met at another local hospital and is documented and submitted to the Medical Staff Services Office on a quarterly basis
    - Hardship/health situation.

D. Pay all medical staff dues and assessments promptly.

E. Complete the appropriate Provisional time period.

SECTION 2. THE COURTESY CATEGORY

QUALIFICATIONS:

A. The Courtesy category is reserved for practitioners (MD, DO, DDS, DMD, or DPM) who admit or otherwise are involved in a maximum of 50 patient contacts at the hospital per year except as expressly waived for practitioners who document their efforts to support the hospital's patient care mission to the satisfaction of the Medical Executive Committee and Board of Commissioners. A patient "contact" includes an inpatient or outpatient activity defined as an admission, an invasive procedure or a consultation.

In the event an appointee to the Courtesy category has more than 50 patient contacts, and if the appointee is otherwise abiding by all bylaws, rules, regulations and policies of the staff, the appointee will be appointed to the Active category.

B. Must live within 30 miles of Trios Health, and be able to respond within 30 minutes when on call for ER and /or his patients.

PREROGATIVES: Appointees to this category may:

A. Exercise clinical privileges as are granted him by the Board of Commissioners.

B. Attend meetings of the staff and department of which (s)he is an appointee and an staff or hospital education programs;

C. Not vote or hold office.

RESPONSIBILITIES: Appointees to this category must:

A. Pay all dues and assessments promptly;

B. Participate in the emergency services and other specialty coverage programs to cover the practitioners own patient panel;

C. Admit or provide services to patients in the hospital.

D. Participate in recognized medical staff functions including quality/performance improvement, risk management, and other monitoring activities including monitoring

initial appointees during the Provisional period and in discharging other staff functions as may be required from time to time.

E. Complete the appropriate Provisional time period.

SECTION 3. CONSULTING

QUALIFICATIONS: The Consulting category is reserved for specialist practitioners (MD, DO, DDS, DMD, DPM) of recognized professional ability who are ineligible for membership in other medical staff categories. This would be a practitioner with training and skill, not available locally. Eligible practitioners requesting such privileges must meet current standards for training and/or experience as established by the Medical Executive Committee. Privileges granted will be limited to those not currently provided by Active and Courtesy Trios Health medical staff members.

PREROGATIVES: Appointees to this category may:

A. Exercise clinical privileges as are granted by the Board of Commissioners.

B. Not admit patients to the hospital.

C. Not hold office or vote in medical staff affairs.

RESPONSIBILITIES: Appointees to this category must:

A. Provide service to patients as requested.

B. Limit activity to the rendering of consultations, procedures and ramifications thereof.

C. Participate in performance improvement activities when a case involving a Consulting staff member is presented for review at a general staff, department, or committee meeting and further follow-up or action is requested. The Consulting staff member involved shall be notified in writing at least one week in advance and will be required to attend.

SECTION 4. AFFILIATE STAFF CATEGORY

QUALIFICATIONS: The Affiliate Category is reserved for those practitioners who desire to be Provisional with, but do not intend to practice at the Hospital. It is a membership category with no clinical privileges being granted. The primary purpose of the Affiliate Category is to promote professional and educational opportunities, including continuing medical education collegial association and/or to establish and maintain a referral network.

PEROGATIVES: Appointees to this category may:

A. Visit hospitalized patients and review medical records but MAY NOT: admit patients, attend patients, exercise any clinical privileges, write orders or progress notes, perform consultations, assist in surgery, make notations in the medical record, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

B. Attend educational activities of the Hospital and Medical Staff.

C. Attend meetings of the Medical Staff and applicable department.

D. Not exercise a vote.

E. Not hold office.

RESPONSIBILITIES:

A. Pay all dues and assessments promptly.

SECTION 5. PROVISIONAL STAFF

QUALIFICATIONS: Membership in the Provisional category is reserved for practitioners (MD, DO, DDS, DMD, or DPM) who have applied for initial appointment to Active or Courtesy Staff. Provisional category members must meet and maintain the qualifications for the category for which they initially applied, i.e. Active or Courtesy. Provisional staff members will be monitored closely as delineated in the "Credentialing Policy and Procedure Manual", determined by the Medical Executive Committee for a period of time established by the Medical Executive Committee.

PREROGATIVES: Appointees to this category may:

A. Exercise clinical privileges as are granted by the Board of Commissioners.

B. Attend meetings of the staff and department of which s/he is an appointee and any staff or hospital education programs.

C. Not vote.

D. Not hold office.

E. Not serve on the Medical Executive Committee.

RESPONSIBILITIES: Appointees of this category must:

A. Pay all dues and assessments promptly;

B. May participate in the emergency services and other specialty coverage programs as determined by the department chair or the Medical Executive Committee;

C. Admit or provide services to patients in the Hospital in sufficient numbers for meaningful review of practitioner's patient care. Failure to do so by end of the Provisional period will result in relinquishment of privileges and/or staff membership.

D. Participate in recognized medical staff functions including quality/performance improvement, risk management, and discharging other staff functions as may be required from time to time.

E. Satisfactorily complete proctoring review as required (see the Credentialing Policy & Procedure Manual) to advance to medical staff category initially requested.

SECTION 6. ALLIED HEALTH PROFESSIONALS AND LICENSED INDEPENDENT PRACTITIONERS

There shall be additional categories of the Medical Staff consisting of individuals credentialed in their respective professions and permitted to perform specific functions within the Hospital. These categories shall consist of:

QUALIFICATIONS:

A. LICENSED INDEPENDENT PRACTITIONER ("LIP") – Those professionals who are authorized by State law and recognized by the Board of Commissioners at the recommendation of the Medical Executive Committee to provide medical care to patients without immediate supervision by a physician, to assume responsibility for care of patients, and exercise their own judgment. LIPs shall have a written agreement with physician member(s) of the medical staff listed who will provide primary back-up for those patient care situations falling outside the scope of their Hospital privileges; back-up physician(s) members are to have appropriate privileges.

B. The practitioners must live within 30 miles of Trios Health and be able to respond within 30 minutes when on call for ER and/or his patients.

PREROGATIVES:

A. These practitioners will be assigned to the department most closely related to their specialty. These practitioners are subject to the corrective action and fair-hearing procedures outlined in the medical staff documents.

B. ALLIED HEALTH PROFESSIONALS ("AHP") – Those professionals who are required by State law and/or the Hospital to provide medical care to patients under the supervision of a physician. These professionals shall be employed by and under the direct supervision of a physician staff member and will be assigned to the department of their supervising physician. AHPs are not subject to and have none of the rights available under the corrective action and fair hearing procedures outlined in the medical staff bylaws and accompanying manuals.

The initial granting of privileges to LIPs and AHPs shall be accomplished in a manner consistent with the overall procedure established for the Medical Staff as detailed in the "Credentialing

Policy and Procedure Manual" portion of these medical staff documents. Clinical privileges may be extended to LIPs and AHPs after consideration of the applicant's education, training, experience, competence, ethical standards, ability to work with others and health status.

All AHPs and LIPs are subject to re-evaluation and re-appointment on a biennial basis in a manner consistent with that detailed in the "Credentialing Policy & Procedure Manual" of these medical staff documents.

All AHPs and LIPs shall carry out their activities subject to departmental policies and procedures, and in conformity with the Medical Staff Bylaws and related documents, and other policies and procedures of the Hospital and the medical staff. No AHP or LIP shall be entitled to vote or hold office, but may serve on committees. They are required to pay dues, fees and other assessments as determined elsewhere in these medical staff documents.

SECTION 7. TELEMEDICINE PRIVILEGES

Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services.

Individuals applying for telemedicine privileges are not considered members of the medical staff and do not have the rights or benefits of membership and do not have access to the Fair Hearing process. Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

Licensed Independent Practitioners (LIP) are credentialed and privileged to perform telemedicine through one of the following mechanisms:

1) The hospital fully privileges and credentials the LIP according to the medical staff bylaws and credentialing policies, or

2) The hospital privileges the LIP using credentialing information from a CMS and The Joint Commission accredited organization and approved through the hospital process. This information shall include a list of privileges granted to the LIP and information indicating that the applicant has exercised such privileges in a competent manner.

All individuals granted telemedicine privileges will be subject to the hospital's performance improvement, OPPE, and peer review activities.

SECTION 8. RESIDENTS

The Resident Staff shall consist of those practitioners at Trios Health in the Graduate Medical Education Program. The residents will have a full or limited license from the State of Washington to practice medicine. Residents in training at Trios Health shall not hold membership on the medical staff and do not have the rights or benefits of medical staff membership and do not have access to the Fair Hearing process. Residents shall at all times, when performing duties and services related to post-graduate education, be under the supervision of an attending (supervising) physician member. The Supervising Physician shall be an appropriately credentialed and privileged member of the Medical Staff in good standing.

Residents shall be permitted to function clinically in accordance with the written training protocols developed by the residency training program with oversight by the Graduate Medical Education Committee (GMEC). The Resident Policies for Medical Staff (KGH003785) outlines residency program policies that relate to medical staff including the delineation of roles, responsibilities, and patient care activities of residents. Supervision guidelines for medical staff overseeing residents are outlined in this policy.

As per AOA requirements, Residents may be allowed to participate in hospital and medical staff committees but shall have no voting rights. Residents may not serve as Medical Staff Officers.

While Residents must first abide by AOA rules and regulations for training, unless otherwise defined by the AOA Residents shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital and Medical Staff Policies and Procedures. Residents shall be subject to limitation or termination from their ability to function as Residents at any time as per the disciplinary and remediation policies in the Resident Handbook.

The residency program leadership and/or GMEC must communicate on an annual basis or as needed, with the medical staff and hospital leaders about the performance of its residents, patient safety issues, and quality of patient care per the *Communication Between GMEC and Medical Staff Policy* (KGH003786).

SECTION 9. TEMPORARY PRIVILEGES

Temporary clinical privileges may be granted by the administrator, with written concurrence of the departmental chairperson and chairperson of Medical Executive Committee upon completion of a written application.

A signed acknowledgment will be obtained for receipt of copies of the Medical Staff Bylaws, Rules and Regulations and that he agrees to be bound by the terms thereof in all matters relating to his temporary clinical privileges.

Special requirements of supervision and reporting may be imposed by the chairperson of the department concerned on any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the administrator upon notice of any failure by the practitioner to comply with such special conditions.

The administrator may at any time, for just cause, upon the recommendation of the chairperson of the Medical Executive Committee, terminate a practitioner's temporary privileges effective as of the discharge from the Hospital of the practitioner's patient(s) then under his care in the Hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination shall be immediately effective and the chairperson of the Medical Executive Committee shall assign a member of the medical staff to assume responsibility for the care of such patient(s) until discharge from the Hospital. The wishes of the patient(s) shall be considered in the selection of such substitute practitioner. An applicant for temporary privileges shall not be entitled to the rights afforded by Article I Section 9 of these bylaws or the procedural rights afforded by the Medical Staff "Corrective Action and Corrective Action & Fair Hearing Plan".

Credentialing of Temporary Staff shall be conducted the same as for any other category, and per the "Credentialing Policy & Procedure Manual".

Types of Temporary Staff

A. Locum Tenens: Shall be granted to a practitioner serving as a Locum Tenens for a member of the medical staff, or when there is a need, to attend patients without applying for

membership on the medical staff for a period of one year, but may not work more than sixty (60) days in a calendar year. However, a Locum Tenens Radiologist may work no more than one hundred twenty (120) days in a calendar year.

B. Specified Patient Consultation: The administrator may permit a practitioner to serve as a consultant on a specified patient for a member of the medical staff, providing all of his or her credentials have been reviewed and approved by the Chair of the Medical Executive Committee.

C. Provisional/Temporary: Provisional/Temporary privileges may be granted to an applicant with a complete Type I application (see *Credentialing Policy & Procedure Manual*) following review and approval by the appropriate Department Chair, the Medical Staff President and the Administrator.

SECTION 10. DISASTER PRIVILEGES

Privileges will be granted only in the instance of which an emergency management plan is activated and the hospital is unable to meet patient's needs. Disaster privileges may be granted at the discretion of the hospital administrator, departmental chairperson, or hospital supervisor. Privileges granted should be consistent with those currently in place in the appropriate department and specialty as the physician's "home" hospital. The physician requesting disaster privileges must provide the following forms of identification.

A. A current picture identification card.

B. A current license to practice and a valid picture identification issued by the state, federal or regulatory agency.

The following information may be requested at the time of granting privileges but may not be used as a form of identification.

C. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT)

D. Presentation by current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.

Verification of the above information shall be considered a high priority and completed as soon as possible (feasible), by the Medical Staff Office. Disaster privileges will be effective immediately. A decision to continue the Disaster privileges initially granted will be determined within 72 hours. Primary source verification of licensure will be conducted through the Medical Staff Office within 72 hours of granting Disaster privileges.

Upon approval, the practitioner shall be issued appropriate identification to allow Hospital staff to readily identify the practitioner as holding disaster privileges, and shall be assigned to a Medical Staff member, in the same specialty if possible, with whom to collaborate in the care of disaster victims. Collaboration may include direct observation, mentoring, review of clinical records, or

any other method of oversight appropriate under the circumstances and approved by the person granting the disaster privileges.

SECTION 11. THE HONORARY CATEGORY

Honorary category is restricted to those individuals the staff wishes to honor. Such staff appointees are not eligible for clinical privileges. They may attend medical staff and department meetings, continuing medical education activities, and may be appointed to committees as a consultant or nonvoting member.

SECTION 12. LEAVE OF ABSENCE

A. Leave Status

B. A staff member may obtain a voluntary leave of absence not to exceed twelve (12) months by submitting written notice to the Chairperson of the Medical Executive Committee stating the exact period of time of the leave. During the period of a leave, the staff member's privileges and prerogatives shall be suspended.

C. Termination of Leave: As soon as possible prior to the termination of the leave the staff member may request reinstatement of his privileges and prerogatives by submitting a written notice to that effect to the Medical Executive Committee. The Staff member shall submit a written summary of his relevant activities during the leave.

1. The Medical Executive Committee shall make a recommendation to the Board of Commissioners concerning the reinstatement of the member's privileges and prerogatives. Failure to request reinstatement or to provide a requested summary of activities as above provided shall be deemed a voluntary withdrawal of staff membership, privileges and prerogatives by the practitioner without the right of hearing or appellate review. A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

2. A staff member placed on medical leave status shall also provide a medical clearance from his attending physician prior to return to staff privileges.

3. If a member requests leave of absence status for the purpose of obtaining further medical training in his own or another field of medical practice, reinstatement will become automatic upon request for same, with an accompanying activities summary from the program director. However, any new privileges requested will be acted upon and monitored in similar fashion as if the member were a new applicant.

4. Reinstatement will be automatic if leave of absence is for serving armed services commitment, with an accompanying summary of activities from the military.

5. If leave of absence occurs with no medical activity for the period of the leave, the Medical Executive Committee may require proof of continuing competency by

either further education (a refresher course, etc.) and/or appropriate monitoring for a period of time.

ARTICLE III. PROCESS FOR APPOINTMENT & RE-APPOINTMENT TO THE MEDICAL STAFF

SECTION 1. GENERAL

A. The complete procedural details related to the appointment and reappoint process are found in the Credentialing Policy & Procedure Manual.

B. All applications to the medical staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Board after consultation with the Credentials Committee and the Medical Executive Committee. The application shall require detailed information concerning the applicant's professional qualification, and shall request the names of at least three (3) persons who have had extensive experience in observing and working with the applicant, and who can provide adequate references pertaining to the applicant's professional competence and ethical character, and shall include information as to whether the applicant's membership status and/or clinical privileges have ever been voluntarily or involuntarily revoked, suspended, reduced or not renewed at any other hospital or institution, and as to whether his or her membership in local, state or national medical societies, or his or her license to practice any profession in any jurisdiction, has ever been, voluntarily or involuntarily, suspended or terminated. The application shall also require detailed information concerning the applicant's involvement in any professional liability action, including but not limited to any claims made by a patient and any pending or final lawsuits, settlements, or judgments including those made against the practitioner (or his/her behalf) through a professional corporation, group or employer. The application shall include information regarding the applicant's mental and physical health. The application shall require authorization including consent for release of information.

C. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her experience, professional ethics, character, background, training, demonstrated ability and current competence, and upon request of the Credentials Committee, the Medical Executive Committee, or the Board of Commissioners, physical and mental status, and of resolving any doubts about these or any of the other qualifications.

D. By applying for appointment /re-appointment to the medical staff each applicant thereby signifies his/her willingness to appear for interviews in regard to his/her application, authorizes the hospital to consult with members of medical staffs of other hospitals with which the applicant has had privileges and with others who may have information bearing on his/her competence, character, and ethical qualifications, consents to the hospital's inspection of all records and documents that may be material to an evaluation of his/her

professional qualifications and competence to carry out the clinical privileges s/he requests, as well as, of his/her moral and ethical qualifications for staff membership.

E. The application from shall include a release of liability and grant of immunity and a statement that the applicant has read the Bylaws, Rules and Regulations, Credentialing Policy & Procedure Manual, Practitioner Health Policy, Disruptive Physician Policy, Corrective Action & Fair Hearing Plan of the Medical Staff and that s/he agrees to be bound by the terms thereof if s/he is granted membership and/or clinical privileges and to be bound by the terms thereof without regard to whether or not s/he is granted membership and/or clinical privileges in all matters related to consideration to consideration of his or her application.

SECTION 2. APPOINTMENT PROCESS

A. All applications for hospital privileges shall be submitted to the hospital through the Medical Staff Office.

B. The Hospital shall query the National Practitioner Data Bank, all information reported about the applicant pursuant to the Health Care Quality Improvement Act, of 1986.

C. The Hospital shall query professional references, past department chairs and training directors for practitioner evaluations.

D. The Hospital shall query the Washington State Patrol for background inquiry as specified in the appropriate State Law(s).

E. If additional information is required before the application can be declared complete, then the applicant will be notified in writing of the need for additional information and that the application will not be further processed until that information is made available. A copy of this letter will be placed in the applicant's file.

F. When the application has been deemed complete, it is ready for processing. The application request will follow the procedure outlined in the "Credentialing Procedure Manual".

SECTION 3. RE-APPOINTMENT PROCESS

A. At the conclusion of the initial appointment period, all Medical Staff members except Honorary Staff shall undergo a biennial re-appointment. Re-appointment is an evaluation of the applicant's Medical Staff membership qualifications, as well as, the applicant's current competence to maintain the clinical privileges that have been granted.

Medical Staff re-appointments are due no greater than every twenty-four (24) months.

B. All applications for re-appointment of hospital privileges shall follow the process outlined above in Section II of this Article.

SECTION 4. CLINICAL PRIVILEGES

A. Every practitioner practicing at this hospital by virtue of medical staff membership shall, in connection with such practice, is entitled to exercise only those clinical privileges specifically granted to him or her by the Board of Commissioners.

B. Revision to clinical privileges are to be requested in writing by the practitioner, and is to be accompanied by supporting evidence to document current training, experience and competence. Information for additional privileges is to be verified, and processed similarly to any other request for clinical privileges (see Credentialing Procedure Manual).

C. Every initial application for medical staff appointment must contain a request for the specific clinical privileges desired by the applicant. The Credentials Committee and the Medical Executive Committee's evaluation of such requests shall be based on the applicant's education, training, experience, demonstrated competence, references, health status, ethical standards, ability to work with others, and other relevant information, including the appraisal by the applicable department(s).

D. Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the medical records of patients treated in this or other hospitals, and/or review of the records of the medical staff which document the evaluation of the member's participation in the delivery of medical care. In order to obtain additional privileges, a practitioner must make written application which must state the type of clinical privileges desired and be accompanied by documented evidence of current training or clinical competence to support the request. Such application should be processed in the same manner as an initial application under these Bylaws and Appointment/Re-Appointment procedures, and the applicant shall have the rights to notice of and hearings on adverse proposed recommendations as provided.

E. Privileges granted to dentists and podiatrists shall be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist and podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Surgery Department chairperson. All dental and podiatric patients shall receive the same basic medical appraisal by a physician as patients admitted to other surgical services. A physician member of the medical staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. The physical presence in the hospital of a physician staff member who will accept this responsibility is required during the administration of anesthetic, except when local is administered directly by the practitioner.

SECTION 5. CONFIDENTIAL NATURE OF PROCEEDINGS

All meetings, proceedings, and deliberations of the Board of Commissioners, the Medical Staff or their staff or agents concerning the granting, denial, revocation, restriction, or other considerations of the Status of the clinical or Staff privileges of a practitioner (as that term is defined in the

Medical Staff Bylaws) pursuant to Medical Staff Bylaws, Manuals, and Policies and Procedures of the Hospital shall be confidential and conducted in Executive Session provided, however, that any final action of the Board of Commissioners regarding the same shall be done in public session.

ARTICLE IV. OFFICERS

SECTION 1. OFFICERS OF THE MEDICAL STAFF

The officers of the medical staff shall be:

A. President

B. Vice President

C. Past President

SECTION 2. QUALIFICATIONS OF OFFICERS

Officers must have been members of the Trios Health Active category for the previous four (4) years at the time of nomination and election and must remain members of the Trios Health Active category in good standing during their terms of office. Officers may not simultaneously hold leadership positions on another hospital medical staff and shall not simultaneously hold an elected department leadership position.

SECTION 3. ELECTION OF OFFICERS

A. A nominating committee shall consist of four individuals appointed by the Medical Executive Committee. This committee shall offer one or more nominees for each office.

B. Officers shall be elected by written ballot provided they are mailed to all Active staff members with at least 50% returned, and a successful candidate is appointed by a simple majority of those returned ballots. If no simple majority is obtained, another vote will be taken at the direction of the Medical Executive Committee. Only members of the Active category shall be eligible to vote. The Board of Commissioners will confirm all officers.

C. Nominations may also be made by petition signed by at least 10% of the members of the active staff. Such petition must be submitted to Medical Executive Committee at least thirty (30) days prior to the annual medical staff meeting.

D. Nominations must be announced, and the names of the nominees distributed to all members of the active medical staff at least twenty-one (21) days prior to the annual meeting(s). Nominations will not be announced unless accepted by the nominee.

SECTION 4. TERM OF OFFICE

All officers serve a term of two (2) years. Officers shall take office on the second day of the calendar year.

SECTION 5. VACANCIES OF OFFICE

Vacancies in office during the medical staff year, except the office of the president, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of the president, the vice president shall serve the remainder of the term.

SECTION 6. DUTIES OF OFFICERS

A. President: The president shall serve as the chief medico-administrative officer of the Hospital and will fulfill duties specified in the organization and functions manual or rules and regulations.

B. Vice President: In the absence of the president, the vice president shall assume all the duties and have the authority of the president. (S)he shall perform such further duties to assist the president as the president may from time to time request. (S)he shall also chair the quality management committee. The vice president shall serve as the secretary and treasurer of the Medical Staff and in those capacities will see to the safe-guarding of staff funds, the administration of staff expenditures, the collection of dues, make appropriate periodic reports of status of same to the staff and keep the minutes of all medical staff meetings.

C. Past president: Attends the Medical Executive Committee meetings, with vote, and Serves as a consultant to the current medical staff officers.

SECTION 7. REMOVAL FROM OFFICE

Removal of an officer from their position shall be for failure to conduct those responsibilities assigned within these bylaws or other policies and procedures of the medical staff or hospital or failure to satisfy and maintain the qualifications for office. The Board of Commissioners may remove from office any officer on its own initiative, but only after a joint conference with a majority of the Medical Executive Committee representatives. The affected individual will not be present for such a joint conference. An officer may be removed from their position consistent with the process described in Article I, Section 9.b.

ARTICLE V. MEDICAL STAFF ORGANIZATION

SECTION 1. ORGANIZATION OF DEPARTMENTS

The medical staff of the hospital shall be departmentalized into a medical department and a surgical department. Each department shall be responsible for the promotion of quality care at Trios Health and for reviewing the professional performance of members rendering care at Trios

Health. Each department shall have a chair with overall responsibility for the supervision and satisfactory discharge of the functions of the department.

SECTION 2. OPTIONAL CLINICAL PRACTICE GROUP(S)

The Medical Executive Committee may recognize any group of physicians/dentists/podiatrists who have organized themselves into a clinical practice group (CPG). Any CPG, if organized, will not be required to hold regularly scheduled meetings, nor will attendance be required. CPGs are completely optional and may exist to perform any of the following activities:

A. Continuing education;

B. Grand rounds;

C. Discussion of policies;

D. Discussion of equipment needs;

E. Development of recommendations for department chairs or Medical Executive Committee;

F. Participation in the development of criteria for clinical privileges (when requested by a department chair or Medical Executive Committee);

G. Discussion of a specific issue at the request of a department chair or the executive committee; and

H. Clinical pathways

Except in extraordinary circumstances, no minutes or reports will be required reflecting the activities of the CPG. Only when CPGs are making formal recommendations to a department will a report be required to the department chair documenting the CPG specific position.

NOTE: CPG meetings will not be staffed by the representatives of the medical staff office. Attendance will not be taken.

SECTION 3. QUALIFICATIONS, SELECTION, AND TENURE OF DEPARTMENT CHAIRPERSON

A. Each chair shall be a member of the active medical staff, willing and able to discharge the functions of the office, and be either certified by an appropriate specialty board or have been determined to possess equivalent qualifications by the Medical Executive Committee.

B. Department chairs will be elected by their department to serve a 2-year term. The Board of Commissioners must approve all chairs.

C. Removal of a department chair from their position shall be for failure to conduct those responsibilities assigned within these bylaws or other policies and procedures of the

medical staff or hospital. The Board of Commissioners may remove from position any department chair on its own initiative, but only after a joint conference with a majority of the Medical Executive Committee representatives. The affected individual will not be present for such a joint conference.

Each department member has the right to initiate a recall election of a department chair provided that twenty percent (20%) of the active staff department members sign the petition. Upon presentation of valid petition, the Medical Executive Committee will schedule a special department meeting for the purposes of discussing the issue and (if appropriate) to entertain a no confidence vote which will be held by mail-in ballots, as described below.

Recall elections of department chairs will be held by mail-in random numbered secret ballot. In the case of mail-in ballots, the ballots will be sent to the offices of record for active medical staff department members with a stamped self-addressed envelope to return the ballot. Ballots will be tabulated by the medical staff services office and validated by the parties concerned within ten (10) days of the initial mailing.

An affirmative vote may be cast by marking the ballot "yes" and returning it to the medical staff office. A negative vote may be cast by marking the ballot "no" and returning it to the medical staff office. Removal will be recommended by the department, for approval by the Medical Executive Committee and Board of Commissioners providing that a simple majority of active medical staff members of the department indicated "yes" for recall on the returned ballot.

SECTION 4. FUNCTIONS OF DEPARTMENT

A. Each department, through the department chair, shall recommend criteria for the granting of clinical privileges to the Credentials Committee.

B. Each department, through the department chair, shall make recommendations for granting of clinical privileges, per the "*Credentialing Policy & Procedure Manual*".

C. Each department shall systematically evaluate the care of patients by its members.

D. Each department shall be responsible for the determination of the call schedule for emergency services and other specialty coverage for each of its members.

SECTION 5. ASSIGNMENT TO DEPARTMENTS

The Medical Executive Committee will, after consideration of the recommendations of the chair of the appropriate clinical departments and the Credentials Committee, recommend department assignments for all members in accordance with their qualifications.

SECTION 6. DUTIES OF DEPARTMENT CHAIRS

Department Chairs shall serve as the administrative officers of the Department and shall fulfill those duties specified in the Medical Staff Bylaws and Policies. Depart Chairs shall fulfill those duties specified in the Department rules and regulations. The general roles and responsibilities of Department Chairs are:

A. Oversee clinically related activities of the Department;

B. Oversee administratively related activities of the Department, unless otherwise provided by Trios;

C. Continuing surveillance of the professional performance of all individuals in the Department who have delineated clinical privileges;

D. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department;

E. Recommending clinical privileges for each member of the Department;

F. Assessing and recommending to the CEO off-site sources for needed patient care, treatment, and services not provided by the hospital;

G. Integrating the Department into the primary functions of the hospital;

H. Coordinating and integrating interdepartmental services;

I. Developing and implementing of policies and procedures that guide and support the provision of care, treatment, and services in the Department;

J. Recommending a sufficient number of qualified and competent persons to provide care, treatment, and services through the Department;

K. Determining the qualifications and competence of Non-Physician Practitioners in the Department;

L. Continually assessing and improving the quality of care, treatment, and services in the Department;

M. Maintaining quality control programs in the Department, as appropriate; and

N. Providing orientation and continuing education for all persons in the Department.

ARTICLE VI. COMMITTEES

SECTION 1. DESIGNATION AND SUBSTITUTION

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

Whenever these bylaws require that a function be performed by, or that a report or recommendation be submitted to the Medical Executive Committee or a department, but a standing or special committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

SECTION 2. MEDICAL EXECUTIVE COMMITTEE

COMPOSITION: The Medical Executive Committee shall consist of the president, past president, vice president, and chair of each department. In addition, representatives from each department shall be elected annually by their assigned department from the active medical staff as follows:

Medicine:	Internal Medicine or Medicine sub-specialty
	Emergency Medicine
	Pediatrics
	Family Medicine
Surgery:	General Surgery or Surgery sub-specialty
	Anesthesiology
	Pathology
	Obstetrics/Gynecology
	Radiology

The administrator (or his designee) and chief nurse executive shall be ex-officio members without vote. The chairperson will be the president of the medical staff. At all times, the majority of voting Medical Executive Committee members must be fully licensed doctors of medicine or osteopathy actively practicing at the Hospital.

DUTIES: The duties of the Medical Executive Committee shall be to:

A. Receive or act upon reports and recommendations concerning patient care quality and appropriateness reviews, evaluation and monitoring functions, and the discharge of their delegated administrative responsibilities; and recommend to the Board of Commissioners specific programs and systems to implement these functions;

B. Coordinate the activities of and policies adopted by the Board of Commissioners;

C. Oversee the credentialing process and submit (with or without comment) recommendations to the Board of Commissioners concerning all matters relating to

appointments, reappointments, staff category, department, assignments, clinical privileges and corrective action;

D. Account to the Board of Commissioners and to the staff for the overall quality and efficiency of patient care in the hospital and the participation of the medical staff in organization performance improvement activities;

E. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff appointees, including initiating investigations and initiating and pursuing corrective action, when warranted;

F. Make recommendations on medico-administrative and hospital management matters;

G. Keep the medical staff up-to-date concerning the licensure and accreditation status of the hospital;

H. Consistent with the mission and vision of the hospital, the Medical Executive Committee will participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;

I. Represent and act on behalf of the staff between meetings of the Medical Staff, subject to such limitations as may be imposed by these bylaws;

J. Formulate and recommend medical staff rules, policies and procedures to the Board of Commissioners;

K. Make recommendations concerning the structure of the medical staff, the mechanism by which medical staff membership may be terminated, and the mechanisms for fair hearing procedures;

L. Establish medical staff dues, fees and/or other assessments as necessary and/or appropriate; and

M. Make quarterly reports to the Board of Commissioners regarding the functions and activities of the Medical Staff.

MEETINGS: The Medical Executive Committee shall generally meet monthly but, at least ten times per year and hold special meetings whenever called by the president of the medical staff. Permanent records of its proceedings and actions will be maintained.

SECTION 3. QUALITY MANAGEMENT COMMITTEE

A. Purpose and Meetings : The Quality Management Committee:

1. Coordinates the systematic and ongoing review of the appropriateness and quality of: blood, drug use, surgery and invasive procedures, timeliness of completion of medical records, and physician related infection data;

2. Reviews and approves blood usage review plan;

3. Coordinates, prioritizes and monitors the medical staff data gathering and analysis components of the hospital's quality review program and coordinates the medical staff's activities in this area with those of the other professional and support services in the hospital.

4. Serves as a liaison for quality review issues with the medical staff, the hospital staff and the committee(s) responsible for accreditation and licensure.

5. Develops an annual strategic plan, in coordination with the director of the quality and risk management services, for the staff's performance improvement activities, and annually reviews the effectiveness and cost efficiency of the medical staff's performance improvement activities.

6. Establishes:

   (a) Formats for the aggregation, display and reporting of data and findings;

   (b) Systems for follow-up to determine that action taken results in problem resolution; and

   (c) Formats and schedules for submission of data and findings, committee minutes, and special reports.

7. Receives and synthesizes information submitted by medical staff and/or hospital departments and committees, and performance improvement teams, as appropriate.

8. Supervises the maintenance of a quality review profile on each staff member and transmits, via the quality and risk management department, the same to be used in connection with the periodic reappraisal of each staff member.

9. Implements a system for screening and evaluation of clinical risk management issues including unexpected patient care management events, morbidity concerns, analyzes aggregate data on significant high risk events by identifying possible patterns, and communicating same to the professional staff and hospital groups with related responsibilities.

10. The committee shall analyze trends of hazardous and risk management events reported, and attempt to determine effective solutions; and implement appropriate systems or suggest action to enhance the quality and safety of patient care.

11. The Quality Management Committee meets at least ten times per year and reports to the Medical Executive Committee.

The specific procedures for obtaining information to achieve the above-listed functions are outlined in other hospital and departmental policies and procedures such as hospital wide Performance Improvement (PI) Plan.

B. Composition: The Quality Management Committee includes:

1. Six physicians appointed by the President of the medical staff;

2. Vice president of the medical staff will chair and report to the Medical Executive Committee;

3. Representatives from Administration, Clinical Quality Department, Risk Management, and nursing, (ex officio), without vote; and

4. Others may be invited to report as needed.

SECTION 4. JOINT CONFERENCE COMMITTEE

A. Purpose and Meetings: The joint conference committee shall conduct itself as a forum for the discussion of matters of medical center policy and practice, especially those pertaining to peer review activities and shall act as a liaison between the medical staff, administration, and the Board of Commissioners. The joint conference committee shall meet at least annually and transmit a report of activities to the Medical Executive Committee and to the Board of Commissioners.

B. Composition: The joint conference committee shall be a duly authorized peer review and standing committee and shall be composed of the three (3) officers of the medical staff and three (3) officers of the Board of Commissioners, the hospital administrator and the assistant administrator for patient care service. The Board of Commissioners president will chair the joint conference committee.

SECTION 5. CREDENTIALS COMMITTEE

A. Composition and Term: The Credentials Committee shall be a duly authorized peer review and standing committee and shall consist of not less than three an no more than ten members of the active medical staff. The members shall consist of, but are not limited to, the Past President, Past Chairman of Medicine Department and the Past Chairman of the Surgery Department. Members shall serve a two year term or until replaced by an outgoing Department Chairman.

B. Duties : The duties of the Credentials Committee shall be:

1. to review the credentials of all applicants and to make recommendations for membership and delineation of clinical privileges in compliance with Article 1, Sections 2, 3, 4 and 5 of these bylaws;

2. to make a report to the Medical Executive Committee on each applicant for medical staff membership or clinical privileges, including specific consideration of the recommendations from the departments in which such applicant requests privileges; and

3. to review periodically all information available regarding the competence of staff members and as a result of such reviews to make recommendations for the granting of privileges, reappointments, and the assignment of physicians to the various departments or services.

C. Meetings: The Credentials Committee shall meet at least monthly and shall maintain a permanent record of its proceedings and actions.

SECTION 6. PERINATAL COMMITTEE

A. Purpose and Meetings

B. Composition: The Perinatal committee shall consist of OB/GYN physicians, Certified Nurse Midwives, Pediatricians, and Family Medicine physicians that deliver newborns.

C. Responsibilities:

1. Through the committee chair, shall recommend criteria for the granting of clinical privileges to the Surgery Department.

2. Through the committee chair, shall make recommendations for granting of clinical privileges, per the "Credentialing Policy & Procedure Manual".

3. The committee shall systematically evaluate the care of patients by its members and report this to the Surgery Department.

4. The committee shall be responsible for the determination of the call schedule for emergency services and other specialty coverage for each of its members.

SECTION 7. REMOVAL

Members of the Medical Executive Committee may be removed in the same manner as officers of the Medical Staff. Members of all other committees may be removed by an affirmative vote of the Medical Executive Committee.

SECTION 8. STAFF FUNCTIONS

Provision shall be made in these bylaws or by resolution of the Medical Executive Committee approved by the Board of Commissioners, either through assignment to the departments, to staff committees, to staff officers or officials, or to interdisciplinary hospital committees, for the effective performance of the staff functions specified in this section and described in the current organization and functions manual, and of such other staff functions as the Medical Executive Committee or the Board of Commissioners shall reasonably require. These are to:

A. Monitor and evaluate care provided in and develop clinical policy for: special care areas, such as intensive or coronary care units, and all hospital sponsored services;

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

C. Conduct or coordinate utilization review activities;

D. Conduct or coordinate credentials investigations regarding staff membership and granting and renewal of clinical privileges and specified services;

E. Provide continuing education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments and other perceived needs, and supervise the hospital's professional library services;

F. Develop and maintain surveillance over drug utilization policies and practices;

G. Investigate and control nosocomial infections, and monitor the hospital's infection control program;

H. Plan for response to fire and other disasters, for the hospital's growth and development, and for the provision of services required to meet the needs of the community;

I. Direct staff organizational activities, including staff bylaws review and revision, staff officer and committee nominations, liaison with the Medical Executive Committee and hospital administration, and review and assist in achieving hospital accreditation;

J. Coordinate the care provided by members of the medical staff with the care provided by the nursing service and with the activities of other hospital patient care and administrative services; and

K. Engage in other functions reasonably requested by the Medical Executive Committee and Board of Commissioners;

L. Develop and maintain surveillance over quality cancer care within the hospital through participation in a standing, multi-disciplinary Cancer Committee which meets the cancer program standards set forth by the American College of Surgeons Commission on Cancer. This may be achieved through a joint committee with other local organizations;

M. Develop and maintain surveillance over quality trauma care within the hospital through participation in a join, multi-specialty Trauma Oversite Committee with the other Tri-City hospitals which meet standards set by the Washington State WAC's for trauma care.

ARTICLE VII. MEDICAL STAFF MEETINGS

SECTION 1. ANNUAL AND QUARTERLY MEDICAL STAFF MEETINGS

The annual meeting of the medical staff shall be held during the last quarter of each year to elect officers as necessary. Written notice of the meeting shall be sent to all medical staff members and

conspicuously posted. The medical staff will meet quarterly in a social environment to bolster collegiality and communication within the medical staff, i.e. President's Report.

SECTION 2. SPECIAL MEETINGS

A. The president may call a special meeting of the medical staff at any time. The president shall call a special meeting within twenty (20) calendar days after receipt of a written request thereof signed by not less than 20% of the voting members of the medical staff, or upon a resolution by the Medical Executive Committee. Such request or resolution shall state the purpose of the meeting. The president shall designate the time and place of any special meeting.

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

SECTION 3. QUORUM

Medical staff, Medical Executive, and Quality Management committee meetings: Simple majority of the voting members. Excused absences do not count in determining the quorum. All other department and committee meetings: Those present and voting, as long as there is greater than one person.

SECTION 4. ATTENDANCE REQUIREMENTS

Members of the medical staff are encouraged to attend meetings of the medical staff. Meeting attendance will not be used in evaluating members at the time of reappointment.

Members of the Medical Executive Committee and Medical Staff Quality Management Committee are expected to regularly attend the meetings held and represent their departments.

SECTION 5. SPECIAL MEETING REQUIREMENTS

When a suspected deviation from standard clinical or professional practice is identified, the medical staff president or the applicable department chair may require the practitioner to confer with him or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the conference at least five (5) days prior to the conference, including the date, time and place, and a statement of the issue involved, and that the practitioner's appearance is mandatory.

Failure of the practitioner to appear at any such conference, unless excused by the Medical Executive Committee chair upon showing good cause, may result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the Medical Executive Committee may direct. A suspension under this section will remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee and the Board of Commissioners. Such resolution shall be made in a timely manner.

SECTION 6. PARTICIPATION BY ADMINISTRATOR

The Administrator and any representative assigned by the Administrator may attend any committee or departmental meetings of the medical staff.

SECTION 7. ROBERT'S RULES OF ORDER

When needed, the latest edition of Robert's Rules of Order shall prevail at all meetings of the general staff, Medical Executive Committee, and department meetings, except that the chairperson of any meeting may vote.

SECTION 8. NOTICE OF MEETINGS

Routine meetings will be held on the day, time and place, as agreed upon, unless the meeting is canceled. Members will be notified as soon as possible.

SECTION 9. ACTION OF COMMITTEE/DEPARTMENT

The recommendation of a majority of its voting members present at a meeting at which a quorum is present shall be the action of a committee or department. Such recommendation will then be forwarded to the Medical Executive Committee for final action.

SECTION 10. RIGHTS OF EX OFFICIO MEMBERS

Except as otherwise provided in these bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members thereof, except they shall not vote or be counted in determining the existence of a quorum.

SECTION 11. MINUTES

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding officer shall sign the minutes and copies thereof shall be submitted to the Medical Executive Committee. A file of the minutes of each meeting shall be maintained.

ARTICLE VIII. CONFIDENTIALITY, IMMUNITY AND RELEASE

SECTION 1. SPECIAL DEFINITIONS

For the purposes of this Article, the following definitions will apply:

A. INFORMATION means record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 5B of this Article.

B. MALICE means the dissemination of a known falsehood or of information with a reckless disregard for whether it is true or false, or the absence of a reasonable belief that an action, statement or recommendation is warranted by the facts.

C. PRACTITIONER means a staff member or applicant.

D. REPRESENTATIVE means the Board of Commissioners and any member of a committee thereof, the administrator of the hospital, president of the medical staff organization and any member, officer, department, section or committee thereof, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

E. THIRD PARTIES mean both individuals and organization providing information to any representative.

SECTION 2. AUTHORIZATIONS AND CONDITIONS

By applying for, or exercising, clinical privileges within this hospital, a practitioner:

A. Authorizes representatives of the hospital and the medical staff to solicit, provide and act upon information bearing on their professional ability and qualifications.

B. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article.

C. Acknowledges that the provisions of this Article are express conditions of this application for, or acceptance of, staff membership, or their exercise of clinical privileges at this hospital.

SECTION 3. CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, shall to the fullest extent permitted by law, be confidential and shall not be disseminated or used in any way except as provided herein or otherwise provided by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general hospital records.

SECTION 4. IMMUNITY FROM LIABILITY

A. For Action Taken : No representative of the hospital or medical staff shall be liable in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of their duties as a representative, if such representative acts in good faith and without malice. Regardless of any provisions of state law to the contrary, truth shall be an absolute defense for a representative in all circumstances.

B. For Providing Information : No representative of the hospital or medical staff, and no third party shall be liable in any judicial proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this hospital or medical or any other hospital, organization of health professionals, or other health-related or educational institution or organization concerning a practitioner who is or has been an applicant to or member of the staff or who did or does exercise clinical privileges at this hospital, provided that such representative or third part acts in good faith and without malice.

SECTION 5. ACTIVITIES AND INFORMATION COVERED

A. Activities: The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other educational or health-related institution's or organization's activities concerning, but not limited to:

1. Applications for appointment and clinical privileges;

2. Periodic reappraisals for re-appointment and clinical privileges;

3. Corrective action;

4. Hearings and appellate reviews;

5. Case management resources functions;

6. Malpractice loss prevention; and

7. Other hospital, department, section, committee, and subcommittee activities related to monitoring and evaluation and maintaining quality patient care and appropriate professional conduct.

B. Information: The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, professional ethics, ability to cooperate with others, economic efficiency or any other matter that might directly or indirectly affect patient care or the efficient functioning of an institution or organization.

SECTION 6. RELEASES

Each practitioner shall, upon request of the hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of the State of Washington, and such releases or copies thereof may be submitted to third parties from whom information, as described in Section 5B of this Article is sought. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

SECTION 7. CUMULATIVE EFFECT

Provisions in these bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

ARTICLE IX. FAIR HEARING PROCESS

SECTION 1. RIGHT TO A HEARING

In the event of corrective action recommended by the Medical Executive Committee or the credentialing or privileging action recommended by the Medical Executive Committee involves a denial, reduction, suspension, or revocation of clinical privileges or suspension or termination of Medical Staff membership for more than thirty (30) days due to concerns of competence or professional conduct ("unfavorable actions"), the affected practitioner shall be entitled to a hearing as provided in this Article as further described in the Corrective Action & Fair Hearing Plan prior to the Medical Executive Committee forwarding its recommendation to the Board for final action. The affected practitioner shall also be entitled to a hearing as provided in this Article as further described in the Corrective Action & Fair Hearing Plan if the Board takes unfavorable action on its own initiative without a recommendation of the Medical Executive Committee. However, the following shall not entitle a Medical Staff Member or practioner to a hearing or review under the Bylaws or Medical Staff Policies:

a. the issuance of a letter of warning, admonition, censure or reprimand;

b. the denial, termination or reduction of temporary or disaster privileges;

c. the reduction or suspension of clinical privileges for less than 30 days;

d. the imposition of probation, monitoring or a requirement of consultation other than mandatory concurring consultation;

e. automatic relinquishment of clinical privileges under these Bylaws;

f. a requirement for additional training or continuing education;

g. grant of privileges or membership for a period of less than 2 years; or

h. any action, event, or recommendation not explicitly provided with hearing or review rights under these Bylaws.

SECTION 2. HEARING PROCESS

A. The procedural details related to the hearing and appeal processes are outlined in detail in the Corrective Action & Fair Hearing Plan.

B. Request for a Hearing for any of the circumstances identified in Article I, Section 9.C must be in writing and delivered to the President within thirty days after the affected practitioner is notified of an unfavorable action.

C. A Hearing shall be held not less than thirty days and not more than 60 days after the Affected Practitioner has submitted a request for Hearing to the President.

D. The Hearing Panel shall be composed of not less than three members of the Medical Staff appointed by the Medical Executive Committee. One member shall have the same healing arts licensure as the Affected Practitioner and where feasible one member should be an individual practicing in the same specialty as the Affected Practitioner. All other members shall have MD or DO degrees, unless otherwise agreed upon by the parties. The members of the Hearing Panel must not be in direct economic competition with or be a partner of the Affected Practitioner. Knowledge of the matter involved shall not preclude a member of the Medical staff from serving as a member of the Hearing Panel. The Hearing Panel members shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, initial decision makers, or otherwise shall not have actively participated in the consideration of the matter leading up to the recommendation or action.

E. In the event that it is not feasible to appoint a Hearing Panel from the Active Staff, the Medical Executive Committee may appoint members from other staff categories or even practitioners who are not members of the Medical Staff.

F. The Hearing Panel shall elect its Chair.

G. The Hearing will be presided over by a Hearing Officer.

H. The Hearing Process shall include

1. Prehearing exchange of information and discovery;

2. Right of the parties to call witnesses;

3. Right of the parties to be represented by counsel;

4. Right of the parties to present evidence;

5. Right of the parties to present a written statement at the close of all presentations and evidentiary rebuttals;

6. Review of the decision of the Hearing Panel by the Medical Executive Committee and subsequently by the Board;

7. Right of the Affected Practitioner to appeal an adverse decision of the Hearing Panel.

I. The Member shall have the burden of proving by clear and convincing evidence that the unfavorable recommendations or actions that led to the hearing are arbitrary, unreasonable or capricious.

J. Appeal of the Hearing Panel decision to the Board must be requested by the Affected Practitioner in writing to the President within 15 days of receiving notice of an adverse decision of the Hearing Panel, approved by the Medical Executive Committee.

K. The Board may sit as a body of the whole as the Appeal Board, or it may appoint an Appeal Board which shall be composed of not less than three members of the Board. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not participate in bringing the charges or take part in the hearing on the same matter. The members of the Appeal Board must not be in direct economic competition with or be a partner of the Affected Practitioner. The Affected Practitioner shall be entitled to orally question and challenge the impartiality of the members of the Appeal Board.

L. The Appeal Board may, at its own discretion, select an attorney to assist in the proceeding. If an attorney is selected, he/she may act as an appellate Hearing Officer and shall have all of the authority of and carry out all of the duties assigned to a Hearing Officer.

M. The Appeal Board shall limit its review to the record of the hearing before the Hearing Panel, the Hearing Panel's report and recommendations, and any written briefs submitted by the parties. However, the Appeals Board may, in its sole discretion, accept additional issues or oral or written evidence subject to the same rights of cross-examination and rebuttal provided at the Hearing Panel hearing, but only upon a showing of good cause that such issues could not, with reasonable diligence, be presented to the Hearing Panel in the course of the hearing.

N. At the conclusion of the appellate review, including oral argument, the Appeal Board shall, at a time convenient to itself, conduct deliberations outside the presence of the parties and their representatives, to determine whether to affirm or reverse the decision of the Hearing Panel.

O. The Appeal Board may affirm the decision, reverse the decision, or remand the matter for further review by the Hearing Panel.

P. If the full Board is sitting as the Appeal Board, then the final action of the Appeal Board shall constitute the final action of the Board.

Q. If the Appeal Board is comprised of fewer members than the full Board, then the decision of the Appeal Board shall be considered by the Board for final action within thirty days of receipt of the Appeal Board's decision.

SECTION 3. EXCEPTIONS TO HEARING RIGHTS.

In addition to the exceptions set forth in Section 1 of this Article, the hearing rights of the Bylaws and the Corrective Action & Fair Hearing Plan do not apply to:

A. An applicant or Medical Staff member whose application for Medical Staff membership and privileges was denied or whose Medical Staff membership and privileges are terminated on the basis that the privileges sought or held are granted only pursuant to a closed staff or exclusive use policy or agreement.

B. Medical Staff Members who are serving Trios in a medico-administrative capacity or who are otherwise employed by Trios. Removal from office or termination of employment of such individuals shall be governed by the terms of their individual contracts and agreements with Trios. However, the hearing rights of these Bylaws shall apply to the extent that Medical Staff membership status or clinical privileges, which are independent of the practitioner's contract or terms of employment, are also removed or suspended, unless the contract or terms of employment provide otherwise.

C. Medical Staff members whose clinical privileges are terminated or reduced due to a change in Medical Staff category.

D. The Honorary Staff and Resident Staff.

E. In instances of Automatic Suspension or Administrative Suspension.

SECTION 4. AUTOMATIC SUSPENSION.

A. The full details of the indications for and process by which a Medical Staff member may be subject to an automatic suspension of his/her clinical privileges are found in the Corrective Action & Fair Hearing Plan.

B. The indications for an automatic suspension of a Medical Staff member's clinical privileges include, but are not limited to:

1. Revocation, suspension, or voluntary termination of

    a. Professional license

    b. Drug Enforcement Administration prescribing authority

    c. Professional liability insurance.

2. Failure to submit reappointment materials to continue Medical Staff membership including payment of required fee.

3. Failure to provide required information pursuant to a formal request from the Medical Executive Committee, the Credentials Committee or the Board.

4. Conviction of a felony.

5. Conviction of a misdemeanor involving violation of law pertaining to controlled substances, illegal drugs, Medicare, Medicaid or other federally funded health care program, insurance fraud or abuse, or pleading nolo contendere to the same.

6. Failure to complete patient records in accordance with timeliness standards as outlined in Medical Staff Rules and Regulations.

C. Procedures related to automatic suspension of a member's clinical privileges for any of the reasons listed above include notification of the Affected Practitioner by the President or his/her designee in writing by personal delivery, mail, and/or e-mail of any suspension under this section.

D. Suspension shall continue until the cause of the suspension is remediated.

E. Should the Medical Staff member fail to correct the cause for the suspension within a reasonable time, as set forth in the notification of the suspension, the Medical Staff member is subject to termination of his/her Medical Staff membership and clinical privileges, without the right to a hearing.

SECTION 5. SUMMARY AND PRECAUTIONARY SUSPENSION

A. The full details for the indications for and the process by which a Medical Staff member may be subject to a summary or precautionary suspension of his/her clinical privileges are found in the Corrective Action & Fair Hearing Plan.

B. The indications for a summary or precautionary suspension include, but are not limited, circumstances in which a Medical Staff member's actions might reasonably be believed to result in an imminent danger to the health and/or safety of any individual or disruptive to the operations of Trios as defined in Medical Staff Bylaws, Manuals or Rules and Regulations.

C. Summary or precautionary suspension of the clinical privileges of a member may be invoked by the President or the Vice President or the CEO, or Board Chair, after consultation with the President. Once invoked, the suspension can only be lifted by the Medical Executive Committee or the Board.

ARTICLE X. HISTORY AND PHYSICAL

A complete admission history and physical examination shall be recorded within 24 hours of admission as an inpatient or prior to any procedure requiring anesthesia or any potentially hazardous diagnostic procedure as an outpatient. The medical history and physical examination may be performed by any physician or other licensed health care provider with appropriate privileges or a non-licensed independent practitioner under the supervision of or through the appropriate delegation by a Medical Staff member who is a doctor of medicine or osteopathy (Attending Physician). If delegated, this report must then be countersigned by the Attending Physician, with either a written signature at the close of the history and physical or by signing an

interim update or by making a progress note entry within 24 hours of the history and physical. If a complete history has been recorded and a physical examination performed within 30 days prior to the patient's admission to the Hospital, a reasonably durable, legible copy of these reports may be used in the patient's Hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member of the Medical Staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded. An admission note containing pertinent and relevant information should be in the chart prior to the dictated history and physical report in the chart.

When the history and physical examination are not recorded before an operation, a procedure requiring anesthesia services, or any potentially hazardous diagnostic procedure, the procedure shall be cancelled unless the attending physician provides adequate information about the patient so that the procedure may be performed.

Complete details regarding the requirements for each history and physical can be found in the Medical Staff Manuals and Policies.

ARTICLE XI. CONFLICT RESOLUTION

SECTION 1. CONFLICT RESOLUTION BETWEEN THE MEDICAL EXECUTIVE COMMITTEE AND THE GENERAL MEDICAL STAFF.

Unless otherwise set forth in the Medical Staff Bylaws or Hospital Articles of Incorporation or Bylaws, the Medical Executive Committee, in partnership with the general Medical Staff, establishes the following process for addressing conflicting recommendations made by the Medical Executive Committee and the General Medical Staff to help ensure consistent recommendations to the Board regarding medical staff issues. A conflict raised on behalf of the general Medical Staff must be supported by a petition clearly identifying the conflict and signed by at least twenty percent (20%) of the Active Staff. The Medical Executive Committee, in partnership with the general Medical Staff will make best efforts to address and resolve all conflicting recommendations in the best of the Medical Staff. After receipt of such a petition, the Medical Executive Committee shall meet with the General Medical Staff or a representative group thereof and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Medical Staff President shall initiate a formal conflict resolution process. The formal conflict resolution process will begin with a "representatives" meeting of an equal number of representatives from the Medical Executive Committee and the general Medical Staff within thirty (30) days of the initiation of the conflict resolution process. If the Medical Executive Committee and general Medical Staff representatives meeting cannot produce a resolution to the conflict acceptable to the Medical Executive Committee and the general Medical Staff within ninety (90) days of this representatives meeting, the general Medical Staff shall have the authority to act on the issue that gave rise to the conflict. An affirmative 2/3 majority vote of the Active Staff is required to confirm the position of the general Medical Staff.

SECTION 2. CONFLICT RESOLUTION BETWEEN THE BOARD AND THE MEDICAL STAFF.

Unless otherwise set forth in the Medical Staff Bylaws or Hospital Articles of Incorporation or Bylaws, the Medical Staff, in partnership with the Board, establishes the following process for addressing conflicting recommendations made by the Board and the Medical Staff. The Medical Staff, in partnership with the Board will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the hospital, the communities we serve, and the members of the Medical Staff. When the Board plans to act or is considering acting in a manner contrary to a recommendation by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee shall meet with the Board, or a designated committee of the Board and management and seek to resolve the conflict through informal discussions. The Medical Executive Committee and Board shall make best efforts to collaborate together to resolve the conflict. Any resolution arrived at during such meeting shall be subject to the approvals of the Medical Executive Committee and the Board. If, after ninety (90) days from the date of the initial meeting, the Medical Executive Committee and Board cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act on the issue that gave rise to the conflict.

SECTION 3. EXPEDITED DETERMINATION.

If the Board determines, in the its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through the conflict resolution processes described in this Article in order to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance or other critical obligations of the Hospital, the Board may take action which will remain in effect only until the conflict resolution process is completed. Actions taken which are not susceptible to change will not be changed.

SECTION 4. EXCEPTIONS TO CONFLICT MANAGEMENT PROCESS.

The conflict management process described in this Article does not apply to issues involving disciplinary action, denial of requests for appointment, reappointment, denial of or changes in clinical privileges or any other matters relating to individual credentialing and privileging actions or actions that impact an individual practitioner.

ARTICLE XII. REVIEW, REVISION, ADOPTION, AND AMENDMENT

SECTION 1. MEDICAL STAFF RESPONSIBILITY

The medical staff shall have the responsibility to formulate, review annually, and recommend to the Board of Commissioners medical staff bylaws, policies, and amendments thereto, which shall be effective when approved by the Board of Commissioners.

SECTION 2. METHODS OF ADOPTION AND AMENDMENT

Proposed amendments to these Bylaws may be originated by the Medical Executive Committee or by a petition signed by twenty percent (20%) of the members of the Active Staff. All proposed amendments to the bylaws, must be reviewed and discussed by the Medical Executive Committee to develop verbiage prior to a medical staff vote. Such amendment may be recommended to the Board of Commissioners.

A. By the medical staff after a majority vote, provided that the proposed amendment(s) was first distributed to all members of the active category at least twenty-one (21) days prior to a medical staff vote. Each member of the active category of the medical staff will be eligible to vote on the proposed amendment via printed ballot. An affirmative vote may be cast by marking the ballot "yes" and returning it to the medical staff office. A negative vote may be cast by marking the ballot "no" and returning it to the medical staff office. A change will be approved by the medical staff providing that a simple majority of active medical staff members have returned their ballots to the medical staff office within fourteen (14) calendar days of the medical staff meeting, and providing that 75% of those ballots received have been marked "yes".

B. If the bylaws and accompanying documents are not in compliance with the requirements imposed by law, regulation, order of court of law, for accreditation, for tax purposes, or otherwise necessary in the Board's judgment and discretion, the Board of Commissioners may request appropriate amendment. Such amendment as is proposed by the Board of Commissioners shall be deemed adopted by the medical staff unless the medical staff within the time frame designated by the Board of Commissioners takes action that amends these bylaws to conform to such requirements within a reasonable period of time. Such amendments need not be approved by the medical staff.

C. Any amendment recommended by the Medical Executive Committee after formal active staff vote shall become effective only after approval by the Board of Commissioners or its authorized agent.

SECTION 3. RELATED PROTOCOLS AND MANUALS

The Medical Executive Committee will recommend to the Board of Commissioners credentials and organization and function manuals and other such manuals, rules or regulations as are necessary to further define the general policies contained in these bylaws. Upon adoption by the Board of Commissioners, these manuals and rules/regulations will be incorporated by reference and become part of these bylaws. A vote of the medical staff as provided in Article VIII, Section 2A of these bylaws is not required to adopt, amend or revise the related documents, unless otherwise stated in a specific related document.

SECTION 4. EXTERNAL EFFECTS ON BYLAWS

In the ever-changing healthcare marketplace, transactions may be made which could arguably affect the medical staff bylaws without involvement of the medical staff. To preserve the integrity of the Trios Health medical staff bylaws in certain transactions, successor in interest and affiliation effect provisions are advisable.

A. Successor in Interest

1. These bylaws, and clinical privileges accorded under these bylaws, will be binding upon the hospital and medical staff of any successor in interest in Trios Health.

B. Effect of Hospital's Affiliation

1. Affiliation with other hospitals, healthcare systems or similar entities shall not in and of itself affect these medical staff bylaws.

DEFINITIONS

ADMINISTRATOR	Administrator of Trios Health, and his authorized designee.
APPLICANT	Any practitioner who has applied for appointment, reappointment, privileges, or change in status to the medical staff or AHP.
APPLICATION	The act of applying for appointment, reappointment, privileges, or change in status to the medical staff or AHP.
BOARD OF COMMISSIONERS	Board of Commissioners of Kennewick Public Hospital District, or its designee.
BYLAWS	These bylaws, rules & regulations, Provisional manuals and policies and procedures of the Trios Health medical staff and AHP.
CREDENTIALING	The process whereby a practitioner is accepted to the medical staff or AHP and is granted practice privileges.
DISTRICT	Kennewick Public Hospital District (KPHD).
EX OFFICIO	Serves as a member of a body by virtue of office or position held. When an individual is appointed ex officio to a committee or other group, the provision or resolution designating the membership must indicate whether it is with or without vote.
HE, HIS, HIM	Shall be read as he/she, his/her, him/her respectively in all instances.
HOSPITAL	Trios Health, Kennewick, Washington.
JOINT CONFERENCE	A meeting between representatives of the Board of Commissioners, hospital administration, and the physician members of the Medical Executive Committee.
MEDICAL STAFF	The formal organization of all licensed physicians, osteopaths, dentists, and podiatric physicians who are privileged under these

	bylaws to attend patients or to provide other diagnostic, therapeutic, teaching, or research services in the hospital.
MEDICO-ADMINISTRATIVE	A practitioner, employed by or otherwise serving the hospital on a full or part-time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. Clinical responsibilities, as used herein, are those responsibilities which require a practitioner to exercise clinical judgment with respect to patient care, and it includes the supervision of professional activities of practitioners under his direction.
NOTICE	Except where specific notice provisions are otherwise provided in these bylaws, all such notices, demands, or requests required or permitted to be mailed shall be in writing, properly sealed, and shall be sent through the United States Postal Service, first class postage prepaid. An alternative delivery system may be used if it is reliable, expeditious, and if evidence of its use is obtained. Mailed notices to a member, applicant, or other person shall be to the address that last appears on the official records of the medical staff or the hospital.
PHYSICIAN	Allopathic or osteopathic physicians or dentists.
PODIATRIST	Podiatric physicians and surgeons, as defined by WAC 246-922-010 and RCW 18.22.
PRACTITIONER	Allopathic, osteopathic, or podiatric physician; dentist or allied health professional.
PRIVILEGING	The granting of practice privileges.
PRIVILEGES	The permission granted by the Board of Commissioners to a practitioner to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services (applies to scope of practice when used in lieu of privileges or clinical privileges).
RELATED MANUALS	Documents related to these bylaws, including but not limited to the Rules & Regulations, Provisional Manuals Organization and Functions Manual, the Credentialing Policies and Procedures Manual, Medical Staff Corrective Action & Fair Hearing Plan, Practitioner Health Policy, Disruptive Physicians Policy, Medical Staff Policies and Procedures, and Hospital Policies and Procedures which are pertinent to medial staff practices within the hospital.