

**BYLAWS  
OF THE  
MEDICAL STAFF  
OF  
VIRGINIA MASON MEDICAL CENTER**

Including all Amendments Through  
December 30, 2022

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**BYLAWS OF THE MEDICAL STAFF OF  
VIRGINIA MASON MEDICAL CENTER  
Including All Amendments Through**

**December 30, 2022**

**PREAMBLE**

The Medical Staff is responsible for the quality and safety of medical care in the Hospital and must accept and assume the responsibility, with assistance and support of the administrative team of the Hospital, and subject to the ultimate authority of the Virginia Mason Franciscan Health System Board of Directors. Recognizing that quality care and the protection of the best interests of each patient are best obtained through concerted effort, the Practitioners practicing in the Hospital thereby organize themselves in conformity with these Bylaws, the Rules and Regulations of the Medical Staff ("Medical Staff Rules"), and applicable Medical Staff and Hospital Policies.

**I. DEFINITIONS**

1. "Allied Health Professional" or "AHP" means an individual (other than a Physician (M.D. or D.O.), Dentist (D.D.S. or D.M.D.), or Podiatrist (D.P.M.)) who is licensed or certified to practice a health care profession and may be credentialed pursuant to these Bylaws and the Credentials Manual but is not eligible for Medical Staff Membership or entitled to certain rights granted Medical Staff Members pursuant to these Bylaws.
2. "Board Certification," with respect to Physicians, Dentists and Podiatrists, relates to obtaining certification in their primary area of practice at the Hospital, from the appropriate specialty/subspecialty Board recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Board of Podiatric Medicine (ABPM), the American Board of Multiple Specialties in Podiatry (ABMSP), the American Board of Foot and Ankle Surgery (ABFAS), or the American Board of Oral and Maxillofacial Surgeons (ABOMS) or other Dental specialty Board as required in the applicable Privileges form in the clinical specialty for which Privileges are requested. "Board Certification," with respect to AHPs, relates to certification by a recognized certifying agency, if applicable.
3. "Board of Directors" or "Board" means the governing body of Virginia Mason Franciscan Health System.
4. "Clinical Activity" includes admitting, consulting, performing procedures, ordering medications, reading medical imaging, examining specimens and biopsies, administering and monitoring anesthesia, or otherwise being directly involved in the care of a patient.

5. “Clinical Privileges” or “Privileges” means the permission granted by the Board of Directors to a Member, AHP or Non-ACGME Fellow to render specific patient services.
6. “Credentialing Manual” means the *Credentialing and Privileging Policy and Procedure Manual*, adopted by the Medical Staff and approved by the Board, as amended from time to time, which is made a part of and incorporated into these Bylaws.
7. “ex-officio” means service by virtue of office or position held. An ex-officio appointment is with vote unless specified otherwise.
8. “Hospital” means the facilities of the Virginia Mason Medical Center that are licensed as an acute care hospital under Section 70.41 of the Revised Code of Washington (“RCW”).
9. “Hospital Administration” or “Hospital Administrator” means the administrative executive leader accountable and responsible for administrative oversight of the Hospital.
10. “Medical Staff” means the organizational component of the Hospital that includes all Physicians, Dentists and Podiatrists who have been granted recognition as Members pursuant to these Bylaws.
11. “Member of the Medical Staff” means any Physician, Dentist or Podiatrist who has been appointed to the Medical Staff.
12. “Physician” means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine or osteopathy.
13. “Practitioner” means a Physician, Dentist, Podiatrist, Allied Health Professional, or non-ACGME fellow.
14. “Professional Competence or Conduct” means an individual’s level of competence or professional conduct that affects or could adversely affect the health or welfare of a patient or patients.
15. All references to an “Article” and “Section” shall mean the referenced provision of these Bylaws.

## **II. PURPOSE AND AUTHORITY**

The purpose of this Medical Staff is to organize the activities of, and provide oversight for the quality of care, treatment and services provided by, Practitioners with Medical Staff membership and/or Clinical Privileges at the Hospital, and to carry out other functions delegated to the Medical Staff by the Board of Directors.

The Medical Staff may exercise its authority as is reasonably necessary to discharge its responsibilities, in accordance with these Bylaws, the Medical Staff Rules, and the corporate Bylaws of Virginia Mason Medical Center, and subject to the authority and approval of the Board of Directors.

### **III. DELEGATION OF FUNCTIONS**

- A. When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual or the committee through its chair, may delegate performance of the function to one or more designees.

### **IV. MEDICAL STAFF MEMBERSHIP**

#### **A. Nature of Medical Staff Membership**

Membership on the Medical Staff may be extended to and maintained by only those professionally competent Physicians, Dentists and Podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws, the Medical Staff Rules. Appointment to the Medical Staff and/or the granting of Clinical Privileges shall confer only such rights, prerogatives and Clinical Privileges as have been granted by the Board in accordance with these Bylaws. A Member is neither an employee nor an independent contractor of the Hospital unless such a relationship is separately established between the Hospital and the Member.

#### **B. Qualifications for Membership on the Medical Staff**

1. Threshold Eligibility Criteria. Except as set forth herein, membership on the Medical Staff shall be limited to Physician, Dentist or Podiatrist who:
  - a. Licensure
    - (1) Hold a current, valid license to practice medicine, osteopathy, or podiatry in the State of Washington, that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licenses; and have never had a license to practice denied, revoked, or restricted by any state licensing agency; or
    - (2) Hold a current, valid, and unrestricted limited physician and surgeon license according to RCW 18.71.095 permitting the practice of medicine at the Hospital and the program specified in the licensure application;
  - b. Possess a current Federal Drug Enforcement Agency (DEA) number applicable to the location with a Washington State address,



if practicing medicine, dentistry, or podiatry and the requested Clinical Privileges contemplate prescribing controlled substances.

- c. Demonstrate proof of graduation from an appropriately accredited professional school and completion of an Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), American Dental Association (ADA), or American Podiatric Medical Association (APMA) approved residency program.
- d. Be currently certified and maintain certification by a professional board recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Board of Multiple Specialties in Podiatry (ABMSP), American Board of Foot and Ankle Surgery (ABFAS), the American Board of Podiatric Medicine (ABPM), or the American Board of Oral and Maxillofacial Surgeons (ABOMS) or other dental specialty board as required in the applicable Privileges form in the clinical specialty for which Privileges are requested.
  - (1) If not board certified at the time of initial appointment, board certification must be achieved within two years.
  - (2) Board certification requirements do not apply to Dentists (other than oral and maxillofacial surgeons) or to Honorary Staff.
- e. Have never had medical staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by a healthcare facility, including this Hospital, or health plan for reasons related to Professional Competence or Conduct.
- f. Have never resigned medical staff appointment or relinquished clinical privileges during an investigation or in exchange for an agreement to not conduct such an investigation by any health care facility, including this Hospital.
- g. Have never been, and are not currently, excluded, suspended, debarred, or otherwise ineligible (and not the current subject of any process of exclusion, suspension, debarment, or other ineligibility) from participation in Medicare, Medicaid, or other federal or state health care program, nor have been convicted of, or required to pay civil penalties for, any federal or state governmental or private third-party payer fraud or program abuse.
- h. Have never been convicted of nor entered a plea of guilty or no contest to, any felony or misdemeanor relating to insurance or health care fraud or abuse, or violence.

- i. Demonstrate a willingness and capability, based on current attitude and evidence of performance, to work with and relate to others in a cooperative, professional and non-retaliatory manner, to refrain from disruptive conduct, and to promote a culture of safety, such that all patients treated by them will receive quality care.
  - j. Possess the qualifications and ability to perform safely and competently all functions essential for the exercise of the Clinical Privileges requested; demonstrates freedom from abuse of any type of substance or chemical that affects cognitive, motor or communication ability in any manner that interferes with, or has a reasonable probability of interfering with, the qualifications for membership, such that patient care is or is likely to be adversely affected; and possesses such other qualifications evidencing the Practitioner's fitness for duty as may be required by the Hospital.
  - k. Maintain and demonstrate adequate levels of professional liability insurance coverage at all times during their tenure as a Member and/or holding of Clinical Privileges at the Hospital, but at no time shall this coverage be less than One Million Dollars (\$1,000,000) per occurrence and Three Million Dollars (\$3,000,000) in the aggregate without specific written consent of the Board. This minimum required insurance level may be adjusted and specific coverage requirements established for each specialty by the Board of Directors upon recommendation of the Medical Executive Committee.
2. Waiver of Criteria. Any individual who does not satisfy a criterion for membership to the Medical Staff may request that such criterion be waived. The individual requesting the waiver bears the burden of demonstrating qualifications that are equivalent to or exceed the criterion in question. The Board may grant waivers in exceptional cases after considering the findings of the Medical Executive Committee or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. No applicant is entitled to a waiver, and the grant of a waiver shall not set a precedent or be deemed to apply to any other applicant. A determination to deny a waiver is not a denial of Medical Staff membership or Clinical Privileges and shall not give rise to any hearing or review procedure under these Bylaws.

**C. Effect of Other Affiliations**

All individuals must apply or reapply for appointment to the Medical Staff and are subject to approval by the Board. No individual shall be automatically entitled to appointment or reappointment to the Medical Staff, assignment to a

particular staff category, or the granting or renewal of particular Clinical Privileges merely because the practitioner:

1. is licensed to practice in this or any other state;
2. holds a certain degree;
3. is a member of any particular professional organization;
4. is certified by a particular specialty board;
5. is the member of the faculty of a medical school;
6. resides in the geographic service area of the Hospital;
7. had, or presently has, Medical Staff membership or particular Clinical Privileges at this Hospital;
8. had, or presently has, medical staff membership or Clinical Privileges at another hospital or health care facility;
9. is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

**D. Managing Matters of Medical Staff Member Health**

Members of the Medical Staff shall be assisted in the identification and management of matters relating to their own individual health, as well as that of other members. Policies and procedures governing these issues shall provide for the education of the Medical Staff in these matters and shall outline methods of addressing concerns that are separate from the disciplinary process.

**E. Basic Responsibilities of Medical Staff Membership**

As a condition of being granted appointment, reappointment, and/or Clinical Privileges, and as a condition of ongoing appointment and maintenance of Clinical Privileges, every Member specifically agrees to the following:

1. Provide patients with efficient and high-quality care meeting the professional standards of the Medical Staff.
2. Abide by the Medical Staff Bylaws, the Medical Staff Rules and Regulations, the Credentialing Manual, and the Virginia Mason Health System Code of Conduct.
3. Demonstrate respectful interactions and behaviors consistent with the Physician and Advanced Practice Provider Compact.
4. Participate in quality and peer review activities.

5. Participate in continuing education programs as determined by the Medical Staff.
6. Adhere to applicable guidelines, policies, and standard work.
7. Maintain and demonstrate compliance with the Hospital's Fitness for Duty Policy.
8. Fulfill such other obligations as required by the specific category of Medical Staff to which such individual is a member, as specified in these Bylaws or the Medical Staff Rules.
9. Continue to fulfill conditions for membership set forth in these Bylaws.
10. Refrain from harassment against any individual (e.g., against another Medical Staff member, employee, patient or visitor) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender or sexual orientation.
11. Maintain confidentiality according to the Health Insurance Portability and Accountability Act of 1996 (HIPPA), in effect and as amended.
12. Complete medical records in a legible and timely manner.
13. Promptly notify Medical Staff Services in writing of any professional sanctions including the initiation of formal proceedings to deny, revoke, terminated, suspend, restrict, reduce, limit, sanction, place on probation, monitor, exclude, or not renew for any of the following: (a) license to practice any profession in any jurisdiction; (b) other professional registration or certification in any jurisdiction; (c) specialty or subspecialty board certification; (d) membership on any hospital medical staff; (e) Clinical Privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc. (f) Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any federal or state public program; (g) professional society membership or fellowship; (h) participation/ membership in an HMO, PPO, IPA, PHO, Health Plan or other entity; (i) academic appointment; (j) authority to prescribe controlled substances (DEA or other authority); (k) voluntarily not renew any of the above (a-j) in order to avoid an adverse action or to prelude an investigation.
14. Promptly notify Medical Staff Services in writing of review or disciplinary action by an ethics committee, licensing board, medical disciplinary board, professional association or educational institution.
15. Promptly notify Medical Staff Services in writing of findings of unprofessional conduct by any state professional disciplinary board.

16. Promptly notify Medical Staff Services in writing of any report to a state, federal, national data bank, or state licensing or disciplinary entity.
17. Promptly notify Medical Staff Services in writing of any criminal violation.
18. Promptly notify Medical Staff Services in writing of the development of any mental or physical condition or other situation that could significantly compromise the member's ability to perform the functions associated with the member's Clinical Privileges in a safe and effective manner.
19. Promptly notify Medical Staff Services in writing of any other action that would affect Medical Staff standing and/or Clinical Privileges.

## **V. MEDICAL STAFF CATEGORIES**

### **A. Categories.**

There are six (6) categories of membership on the Medical Staff: Active, Courtesy, Ambulatory and Consulting, Telemedicine, Affiliate and Honorary. At each time of reappointment, the Member's category shall be determined.

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership or Clinical Privileges, by other sections of these Bylaws and by the Medical Staff Rules. Clinical Privileges, which are distinct from staff category prerogatives, are awarded individually based upon training, experience, demonstrated competence, etc., and are discussed in Section VII.

### **B. Active Staff**

1. Qualifications. The Active Staff shall consist of Members who:
  - a. meet the qualifications for membership set forth in Section IV.B;
  - b. maintain Clinical Activity on a minimum of ten (10) patients per year in the emergency, inpatient, or hospital-based outpatient clinical areas; and
  - c. are regularly involved in Medical Staff functions, as determined by the Medical Staff.
2. Prerogatives. Except as otherwise provided, a Member of the Active Staff may:
  - a. admit patients to the Hospital, subject to the rules and policies governing Hospital admissions, and engage in Clinical Activity via the exercise of the Member's specific Clinical Privileges;

- b. attend and vote on matters presented at general and special meetings of the Medical Staff and any committee(s) to which the Member is assigned, appointed or elected, and attend, in a non-voting capacity, any open committee meetings;
  - c. hold Medical Staff office and serve as a voting member of Medical Staff committees in accordance with any qualifying criteria set forth in applicable rules, regulations, policies and procedures; and
  - d. attend educational programs of the Medical Staff.
- 3. Obligations. In addition to all basic responsibilities, a Member of the Active Staff must:
  - a. Provide care according to the Medical Staff Rules.
  - b. Accept and carry out Medical Staff Committee assignments.
  - c. Consistent with Clinical Privileges, participate in emergency department call coverage or in other hospital coverage arrangements as determined by the Department to which the Member is assigned with approval by the Medical Executive Committee.
  - d. Provide emergency care, screening, and consultation as appropriate for any patients admitted to the Hospital or who present to the Hospital during an emergency.
- 4. Transfer of Active Staff Status. If a Member of the Active Staff fails to fulfill the minimum Clinical Activity required of this category, the Member will be automatically transferred, without right to a hearing, to the appropriate category, if any, for which the Member is qualified.

**C. Courtesy Staff**

- 1. Qualifications. The Courtesy Staff shall consist of Members who:
  - a. meet the qualifications for membership set forth in Section IV.B; and
  - b. maintain Clinical Activity on a minimum of three (3) patients per year in the emergency, inpatient, or outpatient procedural areas in the Hospital.
- 2. Prerogatives. Except as otherwise provided, a Member of the Courtesy Staff may:

- a. admit patients to the Hospital, subject to the rules and policies governing Hospital admissions, and engage in Clinical Activity via the exercise of the Member's specific Clinical Privileges;
  - b. be appointed to one or more committee(s) as a voting or non-voting member, as set forth in the committee's establishing document(s), but may not hold staff or committee office; and
  - c. attend, meetings of the Medical Staff and any open committee meetings in a non-voting capacity;
  - d. attend educational programs of the Medical Staff.
3. Obligations. In addition to all basic responsibilities, a Member of the Courtesy Staff must:
- a. Provide care according to the Medical Staff Rules.
  - b. Provide emergency care, screening, and consultation as appropriate for any patients admitted to the Hospital or who present to the Hospital during an emergency.
4. Transfer of Courtesy Status. If a Member of the Courtesy Staff fails to fulfill the minimum Clinical Activity required of this category, the Member will be automatically transferred, without right to a hearing, to the appropriate category, if any, for which the Member is qualified. If a Member of the Courtesy Staff engages in Clinical Activity for ten (10) or more patients per year in the emergency, inpatient or outpatient procedural areas of the Hospital, the Member will be automatically transferred to the Active Staff.

**D. Ambulatory and Consulting Staff**

1. Qualifications. The Ambulatory and Consulting Staff shall consist of Members who:
- a. meet the qualifications for membership set forth in Section IV.B; and
  - b. either (i) maintain practices in the community, primarily treat outpatients, and may refer their patients to other Medical Staff Members for hospitalization, provided that the referral of patients is not required, or (ii) possess specialized skills needed at the Hospital on an occasional basis for consultation on patients or for teaching or research activities, as determined by the appropriate Department Chief.

2. Prerogatives.
  - a. A Member of the Ambulatory and Consulting Staff may: exercise the Member's specific Clinical Privileges; attend, in a non-voting capacity, meetings of the Medical Staff; and attend educational programs of the Medical Staff.
  - b. A Member of the Ambulatory and Consulting Staff may not admit patients to the Hospital or hold Medical Staff office.
3. Obligations. In addition to all basic responsibilities, a Member of the Ambulatory and Consulting Staff must:
  - a. Provide care according to the Medical Staff Rules.
  - b. Provide emergency care, screening, and consultation as appropriate for any patients admitted to the Hospital or who present to the Hospital during an emergency.

**E. Telemedicine Staff**

1. Qualifications. The Telemedicine Staff shall consist of Members who:
  - a. meet the qualifications for membership set forth in Section IV.B;
  - b. are based at non-Hospital locations and facilities; and
  - c. are willing and able to provide telemedicine consulting services that have been determined to be needed to assist other Medical Staff Members with caring for patients at the Hospital.
2. Prerogatives.
  - a. A Member of the Telemedicine Staff may: exercise the Member's specific Clinical Privileges via electronic communications link according to the applicable rules, regulations, policies and procedures; attend, in a non-voting capacity, meetings of the Medical Staff; and attend educational programs of the Medical Staff.
  - b. A Member of the Telemedicine Staff may not admit patients to the Hospital or hold Medical Staff office.
3. Obligations. A Member of the Telemedicine Staff must adhere to all basic responsibilities and provide Telemedicine Services according to the Medical Staff Rules.



**F. Affiliate Staff**

1. The Affiliate Staff shall consist of those Physicians, Dentists or Podiatrists who desire to be associated with, but who do not intend to manage patient care in, the Hospital. The primary purpose of the Affiliate Staff is to permit such individuals access to hospital services for their patients by referral of patients to Members of the Active or Courtesy Staff for admission and/or treatment. Qualifications. Individuals requesting appointment to the Affiliate Staff must submit an application in accordance with these Bylaws and the Credentialing Manual.
2. Prerogatives. A Member of the Affiliate Staff may:
  - a. attend, in a non-voting capacity, meetings of the Medical Staff; and attend educational programs of the Medical Staff;
  - b. refer patients to Members of the Active or Courtesy Staff for admission and/or treatment;
  - c. visit their patients when admitted to the Hospital and review their medical records, but may not write orders or make medical record entries or actively participate in the provisions or management of care to patients;
  - d. order outpatient diagnostic tests through the electronic medical record and endorse results; and
  - e. communicate with Members of the Active or Courtesy Staff through electronic health record messaging functionality.
3. A Member of the Affiliate Staff may not hold Clinical Privileges and may not admit or treat patients at the Hospital.
4. Affiliate Staff membership may be terminated by the Board (or its designee) upon recommendation of the Medical Executive Committee, without rights to the hearing or appeal procedures set forth in Appendix 1 to these Bylaws, unless such hearing or review is required by law or regulation.

**G. Honorary Staff**

The Honorary Medical Staff shall consist of Physicians, Dentists and Podiatrists who are not in active practice in the Hospital. These may be physicians who have retired from active hospital service or physicians of outstanding reputation not necessarily residents in the community. The Board shall appoint members of the Honorary Staff upon recommendation of the Medical Executive Committee, and may discontinue such appointment without right to a hearing or appeal. The duration of Honorary Staff membership may be indefinite.

The Honorary Staff shall have none of the specific qualifications, rights, or obligations provided for other staff categories but may attend educational programs of the Medical Staff.

## **VI. CLINICAL PRIVILEGES**

### **A. Obtaining, Maintaining and Exercising Clinical Privileges**

1. No Practitioner, including those in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless the individual is a Member of the Medical Staff and/or has been granted Clinical Privileges, in accordance with the procedures set forth in these Bylaws, the Resident Manual and/or the Credentialing Manual.
2. Designation of Privileges. Except as otherwise provided, each Practitioner practicing at the Hospital shall be entitled to exercise only those particular Clinical Privileges specifically granted to them by the Board.
3. Professional Practice Evaluation. All initially requested Privileges shall be subject to a period of focused professional practice evaluation (“FPPE”). The Medical Staff and privileged AHPs will also engage in ongoing professional practice evaluation (“OPPE”) to identify professional practice trends that affect quality of care and patient safety. Information from these evaluations will be factored into decisions to maintain existing Clinical Privileges, to revise existing Privileges, or to revoke an existing Privilege. In addition, each Practitioner may be subject to focused practice evaluation when issues affecting the provision of safe care are identified. The requirements and processes for conducting FPPEs and OPPEs are set forth in detail in the Credentialing Manual.

### **B. Temporary, Single-Case Temporary, Emergency and Disaster Privileges**

1. Temporary Clinical Privileges. Temporary Clinical Privileges may be granted to a qualified Practitioner in the event of an important patient care, treatment or service need. In order to obtain Temporary Privileges, the Practitioner must (a) meet the qualifications for Medical Staff membership set forth in Section III.B and (b) have submitted a complete application that raises no concerns and be awaiting review and approval by the Medical Executive Committee. Temporary Clinical Privileges may be granted by the Hospital President or by the Chief Clinical Officer, upon the recommendation of the Chief of Staff or, if designated by the Chief of Staff, by the Department Chief, Department Deputy Chief, or Chair of the Credentials Committee. Temporary Clinical Privileges may not exceed a period of ninety (90) calendar days from the date the Temporary Privileges were granted.

These Bylaws and the Medical Staff Rules shall govern the exercise of all Temporary Clinical Privileges.

2. Single-Case Temporary Clinical Privileges. Based on documentation of important patient care needs, Single-Case Temporary Clinical Privileges may be granted to a qualified Practitioner, who is not a Member or an applicant for membership, upon the written application for specific temporary Clinical Privileges. Single-Case Temporary Clinical Privileges may be granted in the same manner as Temporary Clinical Privileges. Single-Case Temporary Privileges may not exceed a period of ninety (90) calendar days and no individual shall be granted such Privileges for more than three (3) cases per calendar year, unless an exception is granted by the Medical Executive Committee for good cause.

Single-Case Temporary Clinical Privileges will be granted with evidence of current competence and upon telephonic confirmation or receipt of a copy of appropriate licensure, DEA registration, and confirmation of professional liability coverage in an amount of no less than One Million Dollars (\$1,000,000) per occurrence and Three Million Dollars (\$3,000,000) in the aggregate. Such information must reasonably support a favorable determination that the requesting Physician or AHP has the required qualifications, ability, and judgment to exercise the Privileges requested. These Bylaws and the Medical Staff Rules shall govern the exercise of all Single-Case Clinical Temporary Privileges.

The Hospital President, their designee, the Chief Clinical Officer, or the Chief of Staff may, after consultation with the appropriate Department Chief, immediately terminate any or all Single-Case Temporary Clinical Privileges.

3. Emergency Privileges. In case of an emergency in which serious or permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, and in which any delay in administering treatment could add to that danger, any Medical Staff Member is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the Practitioner's license, and regardless of Department affiliation, Medical Staff category, or scope of Privileges. A Medical Staff member acting in such an emergency may request such assistance as may be required to treat the condition causing the emergency. A Medical Staff member exercising emergency Privileges shall summon all necessary consultative assistance and arrange for appropriate follow-up care.
4. Disaster Privileges. In the case of a disaster in which the Hospital's emergency management plan has been activated and the Hospital is unable to handle immediate patient care needs with available members of the Medical Staff, the Hospital President, the Chief Clinical Officer, the Chief

of Staff, or their designee shall have authority to grant Disaster Privileges to Physicians, Dentists or Podiatrists, and/or any AHPs who may, within the scope of their license, render care without direction or supervision (collectively, “Disaster Volunteers”), as may be determined necessary for the care of hospital patients under the circumstances presented. The granting of Disaster Privileges is not required and such Privileges shall be granted on a case-by-case basis, in accordance with the requirements set out in the Medical Staff Rules, the Credentialing Manual, and any other relevant Medical Staff or Hospital policy.

Each Disaster Volunteer’s license shall be verified via primary sources as soon as the disaster is under control or within 72 hours after the Disaster Volunteer presents to the Hospital, whichever comes first. If extraordinary circumstances preclude primary source verification within 72 hours of a Disaster Volunteer’s arrival, the Hospital shall: (a) document (i) the reason(s) verification could not be performed within 72 hours, (ii) evidence of the Disaster Volunteer’s ability to continue to provide adequate care, treatment and services, and (iii) evidence of the Hospital’s attempt to perform primary source verification; and (b) complete primary source verification as soon as possible.

All Disaster Privileges shall automatically terminate when the Hospital’s emergency management plan is no longer in effect or the Disaster Volunteer(s)’s services are no longer needed. Disaster Privileges may also be terminated at any time by the Hospital President, the Chief Clinical Officer, the Chief of Staff, the appropriate Department Chief or the designees. The provisions of the Bylaws and the Credentialing Manual pertaining to hearings and review shall not apply to such terminations. All persons requesting or receiving Disaster Privileges shall be bound by these Bylaws and the Hospital Medical Staff Rules and all Hospital policies and procedures.

## **VII. GRADUATE MEDICAL EDUCATION PROGRAMS**

In keeping with its core educational mission, the Hospital is the setting for certain graduate medical education residency and fellowship programs approved by the Accreditation Council for Graduate Medical Education (“ACGME”) and sponsored by Virginia Mason Franciscan Health, Virginia Mason Medical Center or other educational institutions.

### **A. Graduate Medical Education Residency Programs and Committees**

1. Each sponsoring institution and its resident education committee will operate its own program. These committees shall also establish general program policies and requirements to govern the workings of each specific program, including issues related to the use of the Hospital facilities by each program.

2. The Graduate Medical Education Committee of Virginia Mason Franciscan Health, the Graduate Medical Education Committee (“GMEC”) of Virginia Mason Medical Center and the Designated Institutional Official provide a report to the Medical Executive Committee on a regular basis, but no less than annually through the Annual Institutional Report, which includes, at a minimum, the most recent institutional letter of notification, results of ACGME surveys of residents/fellows and core faculty members and each of its ACGME-accredited programs’ ACGME accreditation information, including accreditation and recognitions statuses and citations.
3. Upon review by the Medical Executive Committee, this Annual Institutional Report findings are also reported to the Board of Directors, including information about the quality of care, treatment, and services and educational needs.
4. The Medical Staff shall at all times be in compliance with residency review committee standards.

**B. Clinical Faculty**

All Members of the Active and Courtesy Staffs shall be members of the Clinical Faculty. Members of the Clinical Faculty shall be familiar with and contribute to the educational mission of Virginia Mason Franciscan Health, Virginia Mason Medical Center, and any other sponsoring institution, and shall be supportive of house staff from any such institution.

**C. Core Teaching Faculty**

Each ACGME-approved residency and fellowship training program shall receive specific support from the Core Teaching Faculty. Virginia Mason Franciscan Health program directors appoint and approve the Core Teaching Faculty for each Virginia Mason Franciscan Health teaching program. The rights and responsibilities of the Core Teaching Faculty at Virginia Mason Medical Center, including application processes, performance standards, and procedures for revoking or restricting Core Teaching Faculty status, shall be established by the Virginia Mason Franciscan Health GMEC and will follow GME established standard practice for faculty appointment.

**D. Prerogatives and Supervision of Residents and Fellows in ACGME-Approved Programs**

1. The residents and fellows participating in an ACGME-approved residency or fellowship program:
  - a. are not eligible for membership on the Medical Staff and are not granted Clinical Privileges. The selection of such residents and fellows for participation and the scope of patient care activities

they may perform shall be determined in accordance with the rules and regulations governing each such residency or fellowship program, as further described in the Resident Manual, which governs the activity of all residents and fellows in ACGME-approved programs;

- b. will be supervised in the carrying out of all patient care responsibilities by a member of the Clinical Faculty. The supervising member of the Clinical Faculty shall at all times have been granted Clinical Privileges that include the care being supervised. Such supervision shall be performed in accordance with the applicable provisions of the Medical Staff Rules, and the Resident Manual;
- c. may attend, in a non-voting capacity, meetings of the Medical Staff and open meetings of the applicable residency review committee; and may attend educational programs of the Medical Staff.

- 2. The termination or restriction of a resident's or fellow's participation in an ACGME-approved program shall be governed by the applicable provisions of the Resident Manual and shall not give rise to the hearing or appeal rights set forth in these Bylaws.

## **VIII. NON-ACGME FELLOWS**

The Hospital also is the setting for certain medical education fellowship programs that are not subject to approval by the ACGME. The fellows who participate in such non-ACGME approved programs must be licensed in accordance with Section III.B.1.a.

### **A. Fellowship Participation**

The selection of fellows for participation in a non-ACGME program shall be determined in accordance with the rules and regulations governing each such program.

### **B. Fellows with Unrestricted Licensure**

- 1. Medical Staff Membership. Non-ACGME fellows holding an unrestricted license as a Physician, Dentist or Podiatrist, as described at Section III.B.1.a(1), may, but are not required to, apply for membership on the Active or Courtesy or Ambulatory and Consulting Staffs. As a condition of appointment to the Medical Staff, such fellows must:
  - a. Have and maintain approval to participate in the non-ACGME fellowship program;
  - b. Meet the qualifications for membership set forth in Section III.B; and

- c. Meet the Clinical Activity requirements for the staff category to which they have applied.
- 2. Clinical Privileges. If a fellowship's clinical learning environment includes the provision of patient care, non-ACGME fellows are required to obtain Clinical Privileges. The procedural provisions of these Bylaws and of the Credentialing Manual shall apply when processing all such requests for Clinical Privileges.
- 3. Prerogatives. A non-ACGME fellow who is a Member shall have all of the prerogatives of the staff category to which the Member is appointed. A non-ACGME fellow who is not a Member shall have the same prerogatives as a fellow with a limited license, as set forth below.

**C. Fellows with Limited Licensure**

- 1. Medical Staff Membership. Non-ACGME fellows holding a limited physician and surgeon license according to RCW 18.71.095, as further described at III.B.1.a(2), are not eligible for Medical Staff membership.
- 2. Clinical Privileges.
  - a. Such non-ACGME fellows are required to obtain Clinical Privileges, provided that they: have and maintain approval to participate in the non-ACGME fellowship program; and meet the qualifications for membership set forth in Section III.B.
  - b. Clinical Privileges requested and granted shall be only for a period of one year, and may not exceed the scope of the training program activities.
  - c. The procedural provisions of these Bylaws and of the Credentialing Manual shall apply when processing all such requests for Clinical Privileges.
- 3. Prerogatives. A non-ACGME fellow with limited licensure may:
  - a. admit patients subject to the rules and policies governing Hospital admissions, and exercise such specific Clinical Privileges as are granted pursuant to Article V;
  - b. attend, in a non-voting capacity, meetings of the Medical Staff and attend educational programs of the Medical Staff.

**D. Obligations**

All non-ACGME fellows must provide care according to the Medical Staff Rules.

**E. Termination or Restriction**

1. The termination or restriction of a fellow's participation in a non-ACGME program shall be governed by the rules and regulations governing each such program and shall not give rise to the hearing or appeal rights set forth in these Bylaws.
2. Any termination or restriction of a fellow's Medical Staff membership or Clinical Privileges that is independent of the fellow's participation in a non-ACGME program shall be subject to the procedural provisions of these Bylaws and of the Credentialing Manual.

**IX. ALLIED HEALTH PROFESSIONALS**

**A. Relationship to Medical Staff**

Allied Health Professionals are not eligible for Medical Staff membership. AHPs may be granted Clinical Privileges within the scope of their professional license. In certain circumstances, AHPs are categorized based on the level of supervision required, as follows:

1. "Ambulatory Clinical Pharmacist" – a Washington-licensed pharmacist who works in direct patient care areas of the Hospital (inpatient or outpatient), is employed by the Hospital, and functions under a Collaborative Drug Therapy Agreement approved by the State of Washington.
2. "Independent AHP" – a Washington-licensed AHP who is permitted by such license to provide services independently in the Hospital, without the direction or supervision of a Physician, Dentist or Podiatrist. Independent AHPs include Advanced Registered Nurse Practitioners, Optometrists and Certified Registered Nurse Anesthetists.
3. "Sponsored AHP" – a Washington-licensed AHP who provides services under the direction and supervision of a Physician, Dentist or Podiatrist. Sponsored AHPs include Physician Assistants.

The Board shall designate the specific types of AHPs who are authorized to provide services in the Hospital, and identify the appropriate category for each such AHP. The Board may, from time to time, review and modify the categories or types of AHPs so authorized, upon the advice and consultation of, or at the recommendation of, the Medical Executive Committee of the Medical Staff.



**B. Allied Health Professionals**

1. Qualifications. An AHP must:

- a. hold a current, valid license in the State of Washington for the AHP's area of practice that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licenses; and have never had a license to practice denied, revoked, or restricted by any state licensing agency; and
- b. meet all other qualifications for membership set forth in Section III.B.1.b-j; and
- c. meet such other additional qualifications as may be established by the Medical Executive Committee for any particular type or category of AHP.

2. AHP Clinical Privileges.

- a. Applications for AHP Clinical Privileges shall be submitted and processed as set forth in the Credentialing Manual. An AHP shall be individually assigned to the appropriate Department and shall be subject to a six (6) month period of Focused Professional Practice Evaluation.
- b. An AHP may only obtain Clinical Privileges falling within the individual's scope of practice. In addition, such Privileges are subject:
  - (1) for an Ambulatory Clinical Pharmacist, to the Collaborative Drug Therapy Agreement in effect for that Pharmacist;
  - (2) for a Sponsored AHP, to all applicable instructions and supervision of the AHP's supervising or sponsoring Medical Staff Member with the appropriate Clinical Privileges; and
  - (3) for all AHPs, to any limitations set forth in the Hospital Bylaws, these Medical Staff Bylaws, the Medical Staff Rules, and the Credentialing Manual.

3. Prerogatives. An AHP may:

- a. exercise such Clinical Privileges as are specifically granted to such AHP;

- b. generate orders subject to the Medical Staff Rules, any applicable statements of qualifications for the type or category of AHP, the scope of the AHP's license, certificate, or other legal credentials;
  - c. be appointed to Medical Staff and Department committees, attend, and vote at the meetings of such committees;
  - d. attend Medical Staff educational programs and clinical meetings related to their discipline; and
  - e. exercise such other prerogatives as the Medical Executive Committee may afford to AHPs in general or to a specific type or category of AHP.
4. Obligations. Each AHP shall:
- a. exercise appropriate responsibility within the AHP's area of professional competence for the care of each patient in the Hospital for whom the AHP is providing services, or arrange (or, if applicable, alert the principal attending physician of the need to arrange) a suitable alternative for such care;
  - b. participate as appropriate in quality assurance program activities, supervise new appointees in the same profession during Professional Practice Evaluation, and discharge such other Medical Staff functions as may be required from time to time;
  - c. abide by the Medical Staff Bylaws, the Medical Staff Rules, policies and procedures of the Hospital, the Virginia Mason Health System Code of Conduct and the code of ethics of all applicable professional organizations.
5. Procedure. Except as otherwise provided, the procedures for credentialing and privileging set forth in these Bylaws and the Credentialing Manual shall govern the process by which AHPs obtain Clinical Privileges. AHPs shall not be entitled to the procedures set forth in Appendix 1.

## **X. PROCESS FOR APPOINTMENT, REAPPOINTMENT, CREDENTIALING AND PRIVILEGING**

### **A. General Conditions; Duration of Appointment and Reappointment**

- 1. Application Required. All applicants for appointment or reappointment to the Medical Staff, and/or Clinical Privileges ("Applicants") shall proceed in accordance with the procedures and requirements set forth in the Credentialing Manual. The requirements for the application form, which shall be developed by the Medical Executive Committee, shall be included in the Credentialing Manual.

2. Ineligibility Following Adverse Action. A Practitioner whose application for appointment or reappointment has been denied, or whose Medical Staff membership and/or Clinical Privileges have been terminated (a) for administrative reasons in accordance with Sections XI.D.4 and E, or (b) based on an Adverse Recommendation, and following the exercise or waiver of any applicable hearing and review rights set forth in Appendix I, shall be ineligible to apply for appointment or reappointment to the Medical Staff and/or for any Clinical Privileges, for a period of two (2) years after such action has become final.
3. Burden of Providing Information: Incomplete Application.
  - a. In connection with applications for appointment or reappointment, advancement or transfer of Medical Staff category, or new or expanded Clinical Privileges, an Applicant has the burden of producing information for an adequate evaluation of current competence, character, ethics and other qualifications for the Clinical Privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information.
  - b. Each Applicant has the burden of demonstrating the accuracy and completeness of all statements made and information provided by the Applicant in support of the application.
  - c. Applicants are responsible for providing a complete application, including adequate responses from references and all information requested from third parties for proper evaluation.
  - d. An application will be complete when all questions on the application are answered, all supporting documentation is submitted, and all primary-source verifications are complete. An application will be incomplete if the need arises for new, additional, or clarifying information. The Applicant will be notified about any information that remains unverified or outstanding.
  - e. An incomplete application will not be processed. If an application remains incomplete sixty (60) calendar days after additional information has been requested from an Applicant, it will be filed as incomplete and automatically withdrawn from processing.
  - f. A Member whose Application is withdrawn as incomplete shall not be eligible for appointment or reappointment to the Medical Staff or renewal of Clinical Privileges, and such membership and Privileges shall expire at the end of the current appointment term. If such Member subsequently wishes to reapply, a new application

shall be submitted and processed in accordance with the requirements set forth in the Credentialing Manual.

- g. Applicants and Members are responsible for notifying the Department Chief and the Medical Staff Office of any change in status or any change in the information provided on the application.

4. Misstatements and Omissions.

- a. Any misstatements in, or omission from, the application is grounds to discontinue processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee will review the response and determine whether the application should be processed further.
- b. If appointment has been granted prior to the discovery of a misstatement or omission, the individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The individual may also have an opportunity to meet with the Credentials Committee to explain the misstatement or omission. The Credentials Committee will review the response and determine whether the appointment and Privileges should be deemed to be automatically relinquished pursuant to these Bylaws.
- c. No action taken pursuant to this Section will entitle the Applicant or Member to a hearing or appeal.

5. Board Action. The Board shall be responsible for: (a) initial appointments and reappointments to the Medical Staff; (b) the granting of initial, renewed, or revised Clinical Privileges; and (c) the restriction, modification, or revocation of such appointments or Privileges. The Board may delegate its authority to act under this provision to a committee consisting of at least two (2) Board Members in order to expedite the necessary Board actions under this Article. The Board shall, if it deems appropriate, ratify the decisions of this committee at its next regularly scheduled meeting. The Board shall base any action under this provision in part on the recommendations of the Medical Executive Committee, the results of the recommendations of the Credentials Committee and the Medical Executive Committee, and any decision made by an appointed committee to which the Board has delegated credentialing authority.

6. Duration. Except as otherwise set forth herein, appointments and reappointments to categories of the Medical Staff shall be for a period of not more than two (2) years.

7. Nondiscrimination. Medical Staff membership or Clinical Privileges shall not be denied on the basis of age, sex, religion, race, creed, color, disability, veteran's status, national origin, sexual orientation, or any physical or mental impairment, except that membership may be denied or restricted if an Applicant or Member's impairment prevents or materially impairs the Applicant or Member's ability to provide quality patient care, fulfill the duties of Medical Staff membership or otherwise comply with the bylaws, rules and policies of the Medical Staff and Hospital, or any other basis prohibited by law.

**B. Credentialing Process**

1. Each Applicant's qualifications must be evaluated through the credentialing process set forth in the Credentialing Manual prior to being granted Medical Staff membership and/or Clinical Privileges at the Hospital. The Credentials Committee evaluates each Applicant's credentials and makes recommendations to the Medical Executive Committee regarding membership, Medical Staff category, and assignment of Clinical Privileges. The Medical Executive Committee makes recommendations to the Board, or the Executive Committee of the Board for expedited credentialing, which makes the decision to approve membership and grants Clinical Privileges.
2. Request for Privileges. Every application for Medical Staff appointment and/or Clinical Privileges must contain a request for the specific Clinical Privileges desired by the Applicant and for assignment to a Department consistent with the nature of their practice. Requests shall be evaluated using the criteria set forth in these Bylaws, the Credentialing Manual, and the Medical Staff Rules, including an evaluation of the Applicant's training, experience, demonstrated competence, and credentialing information. The Applicant shall have the burden of establishing their qualifications and competency in the requested Clinical Privileges, including the provision of any information related to the application for Privileges as requested by the Medical Staff. An Applicant who does not meet the membership or privileging criteria shall be ineligible for such membership or privileges, and their application will not be processed. An Applicant who is deemed ineligible for membership or privileges is not entitled to a fair hearing or any rights or due process provided under the Medical Staff Bylaws.
3. Renewals. The Medical Staff and Privileged Allied Health Professionals must submit a reappointment application if they wish to renew their membership and Clinical Privileges prior to expiration. Requests for reappointment shall be evaluated using criteria set forth in these Bylaws, the Credentialing Manual, and the Medical Staff Rules. The applicant shall have the burden of establishing their qualifications and competency in the

requested Clinical Privileges, including the provision of any information related to the application for Privileges as request by the Medical Staff.

4. Additional Privileges. In order to obtain additional Clinical Privileges, a Member of the Medical Staff must submit an application on the prescribed form and shall state the type of Privileges desired, previous training and experience relevant to the requested Privileges, and any other information required to demonstrate qualification for the requested Privileges. The procedures for consideration of initial appointments and reappointments shall apply to applications for additional Privileges.
5. Application Timeline. All Applicants must complete their applications in a timely manner and in good faith. Each application generally will be processed within one hundred eighty (180) calendar days from receipt of a complete application. These time periods are deemed guidelines and do not create a right for the Practitioner to an application processed within these time periods.
6. Expedited Privileges. An expedited approval process may be used for initial appointment and reappointment to the Medical Staff and for granting Privileges when the application is complete and verified. The following criteria make an application ineligible for expedited Privileges:
  - a. The Medical Executive Committee makes a recommendation that is adverse or has limitations.
  - b. There is a current challenge or a previously successful challenge to the Applicant's professional licensure or registration.
  - c. The Applicant has been involuntarily terminated from medical staff membership at another hospital.
  - d. The Applicant has had clinical privileges at another hospital involuntarily limited, reduced, denied, or otherwise restricted.
  - e. There has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the Applicant.

To expedite approval, two voting members of the Executive Committee of the Board must make the final approval and may do so through electronic vote after recommendation from the Credentials Committee and the Medical Executive Committee. If an application is ineligible for expedited credentialing, it must go to the full Board for approval.

#### **C. Leave of Absence**

A member of the medical staff or privileged AHP may request a leave of absence by submitting a written request to the Medical Staff Services. Except in extraordinary circumstances, this request will be submitted at least 30 days prior to the anticipated start of the leave, unless the leave is precipitated by urgent circumstances, in order to ensure adequate coverage of clinical and/or administrative activities. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

Except for uncomplicated family medical leaves, members of the medical staff and privileged AHP must report to the Medical Staff Services any time they are away from patient care responsibilities for longer than 30 days for reasons related to their physical or mental health or related matter that would affect their ability to care for patients safely and competently. Under such circumstances, the Chief of Staff, in consultation with the Department Chief, may trigger an automatic medical leave of absence.

The Medical Staff Services will forward any request for leave of absence to the Department Chief and Chief of Staff who will determine whether a request for a leave of absence shall be granted. Granting of leave of absence shall be forwarded to the Credentials Committee and Medical Executive Committee as informational.

During the leave of absence, the individual shall not exercise any clinical privileges. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement shall then be reviewed by the Department Chief, Chair of the Credentials Committee, and the Chief of Staff. If it is a consensus of these individuals to recommend favorably on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee and the Medical Executive Committee for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee and Medical Executive Committee for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.

If the leave of absence was for health reasons (except for uncomplicated family medical leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming clinical practice and safely exercising the clinical privileges requested.

Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless extension is granted by the Chief of Staff in consultation with the Department Chief. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.

Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of Medical Staff appointment and clinical privileges.

In the event it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

**D. Matters Governed by Employment Agreement or Other Express Written Contract**

These Bylaws apply specifically to a Practitioner's membership on the Medical Staff, and do not govern the Practitioner's employment or contractual relationship with the Hospital or any other entity. A Practitioner's employment or independent contractor agreement with the Hospital may, by its terms, indicate that such agreement shall supersede these Bylaws, and that an administrative relinquishment of membership and/or Clinical Privileges will take place when the contract or agreement ends. In such a case, the termination of membership and/or Clinical Privileges shall not entitle the Practitioner to the Hearing and Review procedures set forth in Appendix 1 to these Bylaws, unless such hearing or review is required by law or regulation.

**XI. CORRECTIVE ACTION**

**A. Pre-Corrective Action Measures**

In some circumstances, appropriate measures may be taken prior to corrective action including, without limitation, collegial intervention, focused or routine monitoring and education, referral for specific education or evaluation, implementation of a behavioral agreement, and/or a letter of instruction, admonition, or warning, in accordance with these Bylaws and the Medical Staff Rules.

**B. Investigations**

1. Criteria for Initiation; Initiation. A request for an investigation may be submitted to the Medical Executive Committee by the Chief of Staff, any Department Chief, a standing committee of the Medical Staff, the Hospital



President, the Chief Executive Officer, the Executive Vice President, the Chief Clinical Officer, the Chief Medical Officer or the Board whenever a Practitioner allegedly has engaged in conduct that is, or is reasonably likely to be: (a) detrimental to the quality of healthcare, patient safety or to the professional standards of the Hospital Medical Staff; (b) disruptive to Hospital operations; (c) inconsistent with the professional standards of the Hospital Medical Staff; (d) unethical or in violation of any state or federal law, regulation, or billing guidelines; (e) in violation of any state or federal law or regulation relating to the confidentiality and privacy of healthcare information; or (f) in violation of Medical Staff Bylaws, Medical Staff Rules, or policies and procedures of the Hospital and its Medical Staff. All requests for investigation shall be in writing, submitted to the Medical Executive Committee, and supported by reference to the specific activities or conduct that constitute the grounds or reason for the request. If the Medical Executive Committee initiates the request, it shall make an appropriate recordation of the reasons.

2. Consideration by MEC. Upon receiving a request for investigation, the Medical Executive Committee shall meet as soon as practicable to consider the matter and may, in its discretion, take such action as it deems appropriate including, without limitation, any one or a combination of the following actions:
  - a. Determine that an investigation currently is not warranted, and that no further action is necessary at that time.
  - b. Determine that an investigation is warranted and should be initiated.
  - c. Summarily suspend all or part of the Practitioner's Clinical Privileges.
  - d. Determine that the allegations are sufficiently explained, no further investigation is needed, and take action as set forth at Section X.B.7.
3. If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself or may assign the task to an appropriate Medical Staff officer or standing or ad hoc investigating committee of the Medical Staff. In the event the Board believes the Medical Executive Committee has incorrectly determined that an investigation is unnecessary, it may direct the Medical Executive Committee to proceed with an investigation.
4. Ad hoc Investigating Committee. If the investigation is assigned to an ad hoc investigating committee, such committee shall consist of at least three

(3) members of the Department(s) to which the involved Practitioner(s) is/are assigned. One or more non-physician members of the committee also may be appointed, as appropriate. The Medical Staff officers shall appoint the ad hoc investigating committee, and may consult with the Chief of the relevant Department(s) in making such appointments.

5. Investigation. The Practitioner shall be notified within three (3) working days of the Medical Executive Committee's decision and that the investigation is being conducted, and shall be given an opportunity to provide information in the manner determined by the Medical Staff officer or ad hoc investigating committee conducting the investigation. The investigation may, but is not required to, include one or more conferences with the Practitioner to ascertain the pertinent facts relevant to the request and/or to discuss possible disposition of the matter. Such conferences between the Practitioner and the person or committee conducting the investigation, and the interview(s) of any other individual by such person or committee, shall not constitute a formal proceeding as described in the Hearing and Review Procedures set forth in Appendix 1 to these Bylaws, and shall not be subject to the procedural rules set forth therein. Accordingly, the Practitioner may not have counsel in attendance at such a conference without consent of the Chief of Staff.
6. Investigative Report. The person or committee conducting the investigation shall provide a signed, written report of its findings to the Medical Executive Committee within forty-five (45) working days of the Medical Executive Committee's decision to conduct an investigation. Such a report shall include a description of the process that was followed, the pertinent facts ascertained, any conclusions drawn, and a recommended disposition of the matter. If the person or committee has reached any consensus with the affected Practitioner as to a satisfactory result, such potential resolution should be described.
7. Medical Executive Committee Action. As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action, which may include, without limitation:
  - a. Determining no corrective action will be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the Practitioner's file.
  - b. Deferring action for a reasonable time where circumstances warrant.
  - c. Issuing letters of admonition, censure, reprimand or warning, or directing the Practitioner's Department Chief to do so, provided that nothing herein shall be deemed to preclude the appropriate

physician leadership from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event a formal letter is issued, the affected Practitioner may make a written response which shall be placed in the Practitioner's file.

- d. Summarily suspending all or part of the Practitioner's Clinical Privileges as set forth below.
  - e. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring.
  - f. Recommending reduction, modification, suspension or revocation of clinical privileges.
  - g. Recommending reductions of membership status or limitation of any prerogatives directly related to the Practitioner's delivery of patient care.
  - h. Recommending suspension, revocation or probation of Medical Staff membership.
  - i. Taking other actions deemed appropriate under the circumstances.
8. Subsequent Action. If corrective action constituting an Adverse Recommendation, as defined in the Hearing and Review Procedures set forth in Appendix 1 to these Bylaws, is taken or recommended against a Physician or Dentist, such individual may request a hearing review as provided therein. The affected Practitioners may not request a review of the recommended disposition by the person or committee conducting the investigation, but only the Adverse Recommendation made by the Medical Executive Committee.
9. No Investigation Required. Nothing in this Article shall be deemed to require that an investigation be conducted before the Medical Executive Committee may take or recommend a corrective action constituting an Adverse Recommendation, or to otherwise limit the authority of the Medical Executive Committee, Chief of Staff or Medical Staff Officers or Department Chiefs to perform their duties as set forth herein and in the Medical Staff Rules.

**C. Summary Suspension, Reduction, or Restriction of Clinical Privileges; Further Action**

1. Imposition: Notice. Whenever a Practitioner's conduct appears to require that immediate action be taken to protect the life or well-being of any individual, or to reduce a substantial and imminent likelihood of

significant impairment of the life, health or safety of any individual, then the Chief of Staff, the Medical Executive Committee, any Department Chief, the Chief Clinical Officer, the Hospital President, or the Board may summarily suspend, reduce, or restrict the Practitioner's Clinical Privileges (collectively, a "summary suspension"). Unless otherwise stated, such an action shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the Medical Executive Committee, the Chief of Staff, and the Hospital President. The Hospital President or their designee shall inform the Admitting Office, the Medical Staff Office, and other pertinent service areas of any such summary suspension as soon as reasonably possible. In addition, within one (1) working day of imposition of the summary suspension, the affected Practitioner shall be provided with a written notice of the action that: (a) includes sufficient information to demonstrate the necessity of the summary suspension; (b) informs the Practitioner of the right to an informal interview upon a written request for such an interview; and (c) if applicable, indicates that the suspension could become reportable to the national Practitioner Data Bank.

2. At any time, the summary suspension may be revoked by the same individual or body that initially imposed it upon a determination that the suspension is no longer needed to protect the best interests or safety of any individual.
3. If not first revoked, the summary suspension shall be reviewed by the Medical Executive Committee within fifteen (15) working days. If the Practitioner requests an interview, he or she shall be afforded an opportunity to appear and be heard. Any such interview shall be informal and not in the nature of a hearing, and the Practitioner may not have counsel present without the consent of the Chief of Staff. After duly considering the matter, the Medical Executive Committee may, without limitation: (a) recommend that the summary suspension be modified, continued, or terminated; (b) initiate an investigation under Section X.B; and/or (c) take action in accordance with Section X.B.7.
4. If the Medical Executive Committee does not revoke the summary suspension following this review, the affected Practitioner may request a hearing in accordance with the Hearing and Review Procedures set forth in Appendix 1 to these Bylaws. However, the terms of the summary suspension shall not be affected by such request.
5. Patient Care. Immediately upon imposition of a summary suspension, the Chief of Staff or responsible Department Chief shall arrange alternative coverage for the patients of the suspended Practitioner who remain admitted to the Hospital. The wishes of the patient shall be considered in the selection of such alternative Practitioner, where feasible.

**D. Administrative Suspensions**

1. In the following instances, a Practitioner's Medical Staff membership, Clinical Privileges, and/or other related prerogatives may be suspended or limited (an "Administrative Suspension") as further described. As used here, "other related prerogatives" means voluntary on-call service for the emergency department, admitting patients, scheduling and performing surgery or procedures, assisting in surgery, consulting on Hospital cases and writing notes or orders.
  - a. Automatic Administrative Suspension. An Administrative Suspension shall be imposed automatically in the following circumstances:
    - (1) Licensure. Whenever a Practitioner's license or other legal credential authorizing him or her to practice in the state of Washington has been relinquished or expired;
    - (2) DEA Certificate: Whenever a Practitioner's DEA certificate is revoked or suspended, or has expired; or
    - (3) Medicare Exclusion: Whenever a Practitioner's eligibility as a provider in the Medicare, Medicaid, or other public programs expires or is suspended or terminated for reasons other than inappropriate conduct.
  - b. Professional Liability Insurance. An Administrative Suspension shall be imposed by the Chief of Staff, Chief Clinical Officer or Hospital President for failure to provide satisfactory evidence of required current professional liability insurance or upon receipt by Virginia Mason of notice of cancellation of such insurance.
  - c. Medical Records. An Administrative Suspension shall be imposed automatically, after notice of delinquency and subsequent failure to complete medical records as required by the Medical Staff Rules. Bona fide vacation or serious illness or death in the immediate family may constitute an excuse, subject to approval by the applicable Department Chief in consultation with the Chief of Staff or designee thereof.
  - d. Health Screenings. An Administrative Suspension shall be imposed by the Chief of Staff, Chief Clinical Officer or Hospital President or designee thereof, for failure to comply with the Virginia Mason Medical Center policy for Employee Health Immunization and Screening Requirements and the policy for COVID-19 Vaccination.

2. Notice. The affected Practitioner shall be informed of an Administrative Suspension in writing by certified mail, return receipt requested, delivery via overnight carrier, or some other mechanism that can be tracked. The Practitioner also may receive a courtesy notice by other means, including hand delivery or email.
3. Lifting the Suspension. The Administrative Suspension shall be lifted upon receipt of satisfactory evidence that the Provider has satisfied the requirements underlying the Suspension. An Administrative Suspension for delinquent medical records may be lifted by the Chief of Staff, other Medical Staff Officer or Department Chief, upon a determination that there was a valid excuse for the delinquency and there is approval of a written plan for completion of the records by a specific deadline, not to exceed two weeks from the date the suspension is lifted.
4. Voluntary Resignation. If the Practitioner does not submit such satisfactory evidence or otherwise obtain lifting of an Administrative Suspension within sixty (60) calendar days after having received notice thereof, the Practitioner will be deemed to have voluntarily resigned their Medical Staff membership and/or Clinical Privileges. Any subsequent request for reinstatement shall be processed as an initial application.
5. Patient Care. Immediately upon imposition of an Administrative Suspension, the Chief of Staff or responsible Department Chief shall arrange alternative coverage as set forth above. Practitioners whose Clinical Privileges have been suspended for delinquent records may admit patients only in emergency situations.
6. A Practitioner subject to any Administrative Suspension shall not be entitled to a hearing described in the Hearing and Review Procedures set forth in Appendix 1 to these Bylaws.

**E. Automatic Relinquishment of Membership and/or Privileges**

A Practitioner's Medical Staff membership and/or Clinical Privileges shall be automatically relinquished upon any of the following: action by the State Medical Quality Assurance Commission, or other agency of the State of Washington, revoking or suspending the Practitioner's license or certification to practice; action by federal or state government officials to suspend or terminate the Practitioner's eligibility as a provider in the Medicare, Medicaid, or other public programs based on a finding of inappropriate conduct; or the conviction of the Practitioner of any crime related to fraudulent or other improper conduct in the practice of medicine. The Medical Staff Office or its designee shall inform the Practitioner of this automatic relinquishment of Privileges by certified mail, return receipt requested, delivery via overnight carrier, or some other mechanism that can be tracked. Such automatic relinquishment shall not give rise to a hearing

described in the Hearing and Review Procedures set forth in Appendix 1 to these Bylaws.

## **XII. CONFIDENTIALITY, IMMUNITY, AND RELEASE**

### **A. Confidential Information**

Information with respect to any Practitioner that is submitted, collected or prepared by any individual or any Board or committee member or representative of this or any other care facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and privileged and shall not be disseminated to anyone other than an authorized representative of that Practitioner or a duly authorized investigator, contractor, representative or committee outlined in Virginia Mason Medical Center's Coordinated Quality Improvement Plan (CQIP), nor used in any way except as provided herein or except as otherwise permitted or required by law. This information shall not become part of any particular patient's file or of general Hospital records.

### **B. Breach of Confidentiality**

Except as may be required by law, any breach of confidentiality of the discussions or deliberations of the Medical Executive Committee, any standing or ad hoc committee of the Medical Executive Committee, individual Departments, or the Medical Staff is outside appropriate standards of conduct for this Medical Staff, and shall be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

### **C. Release of Liability**

To the fullest extent permitted by law pursuant to the Health Care Quality Improvement Act of 1986, RCW 4.24.250, and RCW 70.41.200 or the corresponding provisions of any subsequent state or federal statute providing immunity or confidentiality for quality improvement, Peer Review, or related activities, as a condition of applying for or maintaining Medical Staff Membership, Privileges, or AHP Scope of Practice, each Practitioner and AHP acknowledges and grants immunity to each Member or representative of the Health System's Medical Staff, the Health System, the Hospital, and all third parties from civil liability for damages or other relief arising out of:

1. Providing information to a representative of the Medical Staff, Health System, Hospital, or any other health care facility concerning an applicant, Member of the Medical Staff, or AHP who did, or does, exercise Privileges or Scope of Practice, as applicable, or provide services to the Health System; or

2. Providing services to the Medical Staff, Health System, or Hospital, or by reason of otherwise participating in a Medical Staff or Health System Credentialing, Privileging, quality improvement, or Peer Review activity.

**D. Confidential Information Designated**

The confidentiality and immunities provided by this Article shall be applied to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facilities or organization's professional review or quality related activities concerning, but not limited to:

1. Applications for appointment, Clinical Privileges or specified services;
2. Periodic reappraisals for reappointment, Clinical Privileges or specified services;
3. Corrective action;
4. Hearing and appellate reviews;
5. Patient care audits;
6. Utilization reviews;
7. Investigative and reporting activities;
8. Reviews associated with Professional Practice Evaluations and peer review; and,
9. Morbidity and mortality reviews.

The acts, communications, reports, recommendations, disclosures and other information referred to in this Section may relate to a Practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or any other matter that might affect or relate to the quality of patient care.

**E. Release of Practitioner**

Each Practitioner shall, upon request of the Hospital, execute general and specific releases that allow for the release of confidential information to Hospital employees and agents with a need to obtain such information to perform credentialing or other duties necessary under these Bylaws. Practitioners shall also execute such documents as may be necessary to release such personnel from liability for actions taken in furtherance of their duties at the Hospital. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.



**F. Other Applicable Laws**

Provisions in these Bylaws and in application forms relating to the authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof; and in the event of conflict, the applicable laws or Bylaw provision providing the greatest level of immunity from liability or greatest level protection to the Hospital shall be controlling.

**XIII. MEDICAL STAFF OFFICERS AND AT LARGE REPRESENTATIVES OF THE MEDICAL EXECUTIVE COMMITTEE**

**A. Officers of the Medical Staff**

The Officers of the Medical Staff shall be the Chief of Staff, the Deputy Chief of Staff, the Chief Clinical Officer, and the Secretary. The Deputy Chief of Staff shall be the Chair of the Credentials Committee. The Hospital President shall serve as Secretary.

**B. Qualifications of Officers**

1. Candidates for positions of Chief of Staff, Deputy Chief of Staff and other elected positions on the Medical Executive Committee must be Active Staff Members at the time of their nomination, election and/or appointment, and must remain Active Medical Staff Members in good standing during their term of office. Failure to maintain such status shall result in immediate removal from office and create a vacancy in the office involved.
2. Candidates for nomination for Chief of Staff must have been Members of the Active Staff for not less than three (3) years (unless exempted from this requirement by the Medical Executive Committee), and must be actively involved in the clinical practice of medicine.

**C. At Large Representatives of the Medical Executive Committee**

There shall be four (4), elected, At Large Representatives to the Medical Executive Committee, at least two (2) of whom shall be Physicians employed by the Hospital. The term of office of the At Large Representatives shall be two (2) years, with no more than one-half (1/2) of the At Large Representatives being elected in any one (1) year.

**D. Election of the Chief of Staff and At Large Representatives of the Medical Executive Committee**

1. A Nominating Committee shall make nominations for the Chief of Staff and At Large Representatives to the Medical Executive Committee.

- a. The Nominating Committee shall consist of at least eight (8) or more individuals, including at least six (6) Members of the Active Staff appointed by Chief of Staff, the Chief Clinical Officer, the Chief Nursing Officer and the Hospital President. At least four (4) of the appointed Active Staff Members must not currently sit on the Medical Executive Committee. The Nominating Committee shall offer one or more nominees for each position in a formal report. No person shall be nominated by the Committee without consent.
  - b. Nominations may also be made by a petition signed by at least twenty (20) Members of the Active Staff and filed with the Secretary of the Medical Staff at least five (5) working days prior to the time of election.
2. The report of the Nominating Committee shall be sent to each Member of the Active Staff, and the election shall be conducted by electronic ballot capable of appropriate authentication prior to the annual Medical Staff meeting. The ballot shall set forth a deadline by which all votes must be received.
3. The candidate for Chief of Staff receiving the majority of votes cast shall be elected. If a majority is not obtained on the first ballot, a second election shall be held between the two (2) candidates receiving the highest number of votes. The candidate(s) for At Large Representative receiving the highest number of votes shall be elected to fill the available seat(s).
4. Only Members of the Active Staff shall be eligible to vote.
5. The election of the Chief of Staff and the appointment of the Deputy Chief of Staff shall be ratified by the Board at the next regular meeting of the Board following the Medical Staff election.

**E. Term of Office of Medical Staff Officers**

The Chief of Staff shall serve a three (3) year term and may be reelected for up to two (2) successive terms. The Deputy Chief of Staff shall be appointed for a term of one (1) year, and may be reappointed to successive terms without limitations. The Hospital President shall serve as Secretary for the duration of their tenure as Hospital President.

**F. Removal of the Chief of Staff or At Large Representatives of the Medical Executive Committee and Vacancies of Office**

1. The Chief of Staff and the At Large Representatives of the Medical Executive Committee may be removed from office for: (a) failure to satisfy the qualifications for Medical Staff membership; (b) being subject to an Adverse Recommendation by the Medical Executive Committee; (c)

being subject to an automatic relinquishment of membership and/or Clinical Privileges or an Administrative Suspension; or (d) such other valid cause including, without limitation, gross neglect or misfeasance in office or serious acts of moral turpitude.

2. A proposal to remove the Chief of Staff or an At Large Representative may be submitted to the Medical Staff (a) by the Medical Executive Committee, or (b) upon the petition of at least thirty percent (30%) of the Members of the Active Staff. The vote on removal shall be submitted to the Members of the Active Staff by electronic ballot capable of appropriate authentication, and shall set forth a deadline by which votes must be received, which shall be at least ten (10) working days after distribution of the ballot. Removal shall be effectuated on the affirmative vote of a majority of the Active Staff.
3. In addition, such removal may be performed by the Board acting on its own recommendation.
4. If there is a vacancy in the Office of the Chief of Staff, a Nominating Committee shall be promptly appointed by the Secretary under the procedures outlined in this Article. The Nominating Committee shall offer one or more nominees to fill the vacancy in a report submitted to the Members of the Active Staff. An election pursuant to this Article shall be held to elect an officer to serve out the remainder of the Chief of Staff's term. The Deputy Chief of Staff shall serve as the interim Chief of Staff until the vacancy is filled.
5. If there is a vacancy in the office of one or more of the At Large Representatives to the Medical Executive Committee, the Medical Executive Committee shall appoint a Member of the Active Staff to serve out the remainder of the representative's term of office.

**G. Duties of Officers**

1. Chief of Staff. The Chief of Staff shall serve as the Chief Administrative Officer of the Medical Staff to:
  - a. Act in coordination and cooperation with the Board and Hospital Administration in all matters of mutual concern within the Hospital;
  - b. Serve as an ex-officio member of the Medical Executive Committee and call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff and Medical Executive Committee;
  - c. Serve as ex-officio member of all other Medical Staff committees, without vote;

- d. Be responsible for the enforcement of these Bylaws and the Medical Staff Rules, for implementation of sanctions and corrective action where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested affecting a Practitioner;
  - e. Appoint committee members to all standing and special Medical Staff committees except the Medical Executive Committee;
  - f. Represent the views, policies, needs, and grievances of the Medical Staff to the Board and to Hospital Administration;
  - g. Receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide quality medical care;
  - h. Assist in resolving issues and concerns raised by the Chiefs of any Department;
  - i. Ensure the implementation processes to identify and manage matters of individual physician health that is separate from the corrective action process;
  - j. Coordinate with and assist the efforts of the Virginia Mason Franciscan Health Corporate Responsibility Program. Such efforts will include assuring that all members of the Medical Staff are aware of and comply with internal policies and relevant legal requirements, particularly those pertaining to the appropriate participation of Medical Staff in proper documentation, coding, and billing of hospital services, as well as the maintaining of the privacy of patient health care information and the appropriate screening and care of patients with emergency medical conditions; and
  - k. Grant Disaster Privileges to Disaster Volunteers in the case of a mass casualty disaster.
2. Deputy Chief of Staff. The Deputy Chief of Staff shall be an ex-officio member of the Medical Executive Committee. The Deputy shall assist the Chief in all matters as requested, shall serve as Chief of Staff in the absence of the duly elected Chief, and shall perform other duties as ordinarily pertains to this office.
  3. Secretary. The Secretary, the Hospital President, shall be an ex-officio member of the Medical Executive Committee. The Secretary shall be responsible for ensuring that accurate and complete minutes of all Medical Staff meetings are kept, shall call Medical Staff meetings on the order of

the Chief of Staff, shall attend to all correspondence and shall perform other duties as ordinarily pertains to this office.

4. Chief Clinical Officer. The Chief Clinical Officer shall assist the Chief in all matters as requested and shall perform other duties as ordinarily pertains to this office. The Chief Clinical Officer shall attend to all correspondence and shall perform other duties as ordinarily pertains to this office.
5. At Large Representatives. The At Large Representatives of the Medical Executive Committee shall serve as regular members of that Committee, with the same responsibilities and privileges as other members. The At Large Representatives shall attend and actively participate in meetings of the Medical Executive Committee.
6. Non-Voting Guests. The Medical Executive Committee Officers may invite non-members of the Medical Staff to provide expertise and guidance on Medical Executive Committee business.

#### **XIV. CLINICAL DEPARTMENTS**

##### **A. Organization of Clinical Departments**

The Medical Staff shall be organized into Departments as follows:

1. Anesthesiology.Hospital Care. Hospital Care shall include: Critical Care, Neonatal Intensive Care, Emergency Medicine, Hospital Medicine, and Neurohospitalists.
2. Medicine. Medicine shall include: Asthma, Allergy and Immunology, Cardiology, Dermatology, Endocrinology and Metabolism, Gastroenterology, Hematology/Oncology and Radiation Oncology, Hyperbaric Medicine, Infectious Disease, Integrative Medicine, Nephrology, Neurology, Palliative Medicine, Physical Medicine and Rehabilitation, Rheumatology, Psychiatry and Psychology, Pulmonary Medicine, and Sleep Medicine.
3. Pathology. Pathology shall include: Anatomic Pathology and Clinical Pathology.
4. Primary Care. Primary Care shall include: Family Practice, General Internal Medicine and Pediatrics.
5. Radiology.

6. Surgery. Surgery shall include: Cardiac Surgery, Dentistry and Oral Surgery, Fertility and Reproductive Endocrinology, General Surgery, Gynecology, Gynecologic Oncology, Obstetrics, Hand Surgery, Neurosurgery, Ophthalmology and Optometry, Orthopedic Surgery, Otolaryngology, Plastic Surgery, Podiatry, Sports Medicine, Thoracic Surgery, Transplantation, Urology, and Vascular Surgery.

**B. Assignment to Departments**

Each Member of the Medical Staff and AHP with Clinical Privileges shall be assigned to an appropriate Department. The Credentials Committee shall recommend to the Medical Executive Committee the Department assignments for all Practitioners. The exercise of Clinical Privileges within a Department is subject to the clinical practice, standards, and protocols of that Department and to the authority of the Department Chiefs.

**C. Qualifications and Selection of Department Chiefs**

1. Each Department shall be under the authority of a Department Chief.
2. Each Department Chief shall be a member of the Active or Courtesy Staff (with the exception of the Department Chief of Primary Care, who will maintain Consulting/Ambulatory category) and maintain certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.
3. The Chief Clinical Officer and Hospital President shall appoint and have the authority to remove each Department Chief.

**D. Rules and Responsibilities of Department Chiefs**

Each Department Chief shall:

1. Be accountable for overseeing all clinically related activities of the Department;
2. Be accountable for overseeing all administratively related activities of the Department, unless otherwise provided by the hospital;
3. Maintain a continuing surveillance of the professional performance of all Practitioners in their Department who have delineated clinical privileges
4. Recommend to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the Department;
5. Recommend Clinical Privileges for each member of the Department and transmit to the Credentials Committee and Medical Executive Committee the Department recommendations concerning staff classification, the

appointment and reappointment, and the delineation of Clinical Privileges for all Practitioners in their Department;

6. Assess and recommend to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Department or the organization;
7. Integrate the Department or service into the primary functions of the organization;
8. Coordinate and integrate interdepartmental and intradepartmental services;
9. Develop and implement policies and procedures that guide and support the provision of care, treatment and services;
10. Partner with administrative leadership to ensure sufficient number of qualified and competent persons to provide care, treatment, and services;
11. Partner with administrative leadership to ensure the qualifications and competence of the Department's non-Practitioner personnel who provide patient care, treatment, and services;
12. Continuously assess and improve the quality of care, treatment, and services;
13. Maintain quality control programs, as appropriate in conjunction with other standing committees of the Medical Staff;
14. Make appropriate recommendations to the Medical Executive Committee regarding the content of these Bylaws and the Medical Staff Rules as they affect the Department and be responsible for enforcing the provisions of these documents and all policies and procedures within the Department;
15. Be responsible for implementation within their Department of actions taken by the Medical Executive Committee;
16. Support orientation and continuing education of all persons in the Department of service;
17. Partner with administrative leadership to ensure space or other resources needed by the Department or service are available;
18. Support the efforts of the Virginia Mason Integrity Committee to implement the Integrity Program.

## **XV. COMMITTEES**

### **A. Medical Executive Committee (“MEC”)**

1. Composition. The Medical Executive Committee shall be the Executive Committee of the Medical Staff. The Medical Executive Committee shall be a standing committee and shall consist of: from the Medical Staff, the Chief of Staff, the Deputy Chief of Staff, the Chiefs of each Department, and the At Large Representatives; and, from the Hospital, the Hospital President, the Chief Clinical Officer, the Medical Director of Perioperative and Procedural Services, the Chief Nursing Officer or designee, and the executive accountable for Quality and Patient Safety. The Chief of Staff shall preside. Each member of the Medical Executive Committee shall have one (1) vote on Committee matters. Any individual who occupies two membership roles shall have only one vote.
2. Duties. The duties of the Medical Executive Committee shall be:
  - a. To represent and to act on behalf of the organized Medical Staff subject to such limitations as may be imposed by these Bylaws;
  - b. To implement policies of the Medical Staff not otherwise the responsibility of a particular Department;
  - c. To provide liaison between the Medical Staff and Hospital Administration and the Board;
  - d. To account to the Board for the medical care rendered to patients in the Hospital;
  - e. To oversee and account to the Board for the safety and quality of patient care provided by, and the related educational and supervisory needs of, the participants in graduate medical education programs of the Hospital and other sponsoring institutions
  - f. To ensure that the Medical Staff is kept abreast of the accreditation status of the Hospital;
  - g. To ensure the implementation of processes to identify and manage matters of individual physician health that is separate from the corrective or review measures when warranted;
  - h. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participating in Medical Staff corrective or review measures when warranted;



- i. To coordinate with and assist the efforts of the Virginia Mason Integrity Committee to implement the Integrity Program. Such efforts will include assuring that all members of the Medical Staff are aware of and comply with internal policies and relevant legal requirements, particularly those pertaining to the appropriate participation of Medical Staff in proper documentation, coding, and billing of hospital services, as well as the maintaining of the privacy of patient health care information and the appropriate screening and care for patients with emergency medical conditions; and
  - j. To make appropriate recommendations from time to time to the Board through the Chief of Staff concerning the discharge of Medical Staff responsibilities, including:
    - (1) the structure of the Medical Staff;
    - (2) the process used to review credentials and to delineate Clinical Privileges;
    - (3) Medical Staff membership;
    - (4) the delineation of Clinical Privileges for each Practitioner privileged through the Medical Staff process;
    - (5) the Medical Executive Committee's review and actions on reports of the Medical Staff committees, Departments and other assigned activity groups;
    - (6) the participation of Medical Staff in organizational performance improvement activities, as well as the mechanism used to conduct, evaluate and revise such activities;
    - (7) procedures for Medical Staff membership termination; and
    - (8) provisions for fair hearing procedures, as outlined in the Hearing and Review Procedures set forth in Appendix 1 to these Bylaws.
3. Meetings. The Medical Executive Committee shall meet regularly at least three (3) times per year and specially when called by the Chief of Staff. The Committee will maintain a permanent record of its proceedings and actions. A majority of the total number of voting members of the Medical Executive Committee shall constitute a quorum. The vote of a majority of the voting members present at a meeting at which a quorum is present shall constitute action by the Medical Executive Committee. Action may be taken without a meeting of the Medical Executive Committee by

sending the contemplated action to each committee member electronically for a vote. A majority of the total number of voting members of the Medical Executive Committee must cast an electronic vote before the votes may be counted. A majority of the members casting an electronic vote shall constitute an action by the Medical Executive Committee.

**B. Standing Committees**

The following Committees shall be standing committees of the Medical Staff and are accountable to the Medical Executive Committee. Details regarding committee membership, terms, key activities, meeting frequency, quorum and voting shall be outlined in the Medical Staff Rules or Committee Charters. Each committee shall have an appointed Chair. The Chief of Staff shall act as coordinator between the committee chairs and the Medical Executive Committee.

1. Credentials Committee. The purpose of the Credentials Committee is to review applications, approve applicant credentials, make recommendations for appointment and reappointment to all categories of the medical, dental and Allied Health Professional staff, and to make recommendations regarding the granting of Clinical Privileges. This Committee also develops and recommends policies and procedures for all credentialing and privileging activities.
2. Peri-Operative and Procedural Services Steering Committee. The purpose of the Peri-Operative and Procedural Services Steering Committee is to provide policy direction and support for efforts to continuously improve the quality of perioperative services at the Hospital.
3. Pharmacy and Therapeutics Committee. The purpose of the Pharmacy and Therapeutics Committee is to serve in an oversight role for all matters that pertain to the use of medications including establishing policy on the safe and therapeutic use of medications, standards that define best practices (e.g., clinical guidelines, protocols, pathways), and performance improvement efforts related to the procurement, prescribing, dispensing, administering and monitoring of medications. The Pharmacy and Therapeutics Committee is responsible for approving medication management policies and drug formulary decisions.
4. Graduate Medical Education Committee. The purpose of the Virginia Mason Franciscan Health Graduate Medical Education Committee is to set policy relating to the Virginia Mason Franciscan Health graduate medical education programs, advise on medical student programs, appoint teaching faculty, and act in an advisory capacity to the Designated Institutional Official.
5. Utilization Review Committee. The purpose of the Utilization Review Committee is to provide review of services furnished to all patients,

regardless of payer and promote appropriate and efficient utilization of services provided by Virginia Mason Hospital and the Medical Staff.

**C. Leadership Council**

The Leadership Council shall be composed of the Chief Medical Officer, Chief Clinical Officer Chief of Staff, Hospital President, and Division Vice President of Quality and Safety. The purpose of the Leadership Council is to advise on complex quality of care concerns as needed and determine the appropriate avenue for further review and follow up. The Leadership Council shall have no power to take action, and shall provide advice to the Medical Staff. The members may request the presence of other individuals to advise the Council, as appropriate.

**D. Special Committees**

Special and ad hoc committees may be created by the Medical Executive Committee from time to time, as required to carry out the duties of the Medical Staff. Members of such special committees shall be appointed by the Chief of Staff. Such committees shall not have power of action unless specifically granted by the motion that created the committee.

**XVI. HISTORY AND PHYSICAL**

A history and physical (H&P) assessment must be completed and documented on all patients undergoing surgical procedures which require anesthesia service, undergoing sedation for diagnostic or therapeutic procedures, or being admitted as a medical patient.

1. Contents. The H&P must contain the following:
  - a. Chief complaint;
  - b. Review of active medical problems;
  - c. Review of systems;
  - d. Medications;
  - e. Allergies;
  - f. Relevant social and family history;
  - g. Directed physical exam (the extent of the exam is directed by the review of systems and the patient's history); and
  - h. Diagnosis.
2. Timeframes. The H&P must be performed and documented in the medical record within the following timeframes.

- a. An H&P assessment must be performed and documented for each patient no more than thirty (30) calendar days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.
  - b. An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within thirty (30) calendar days before admission or registration. Daily progress notes may serve as the update.
  - c. H&Ps older than thirty (30) calendar days must be repeated.
  - d. In an emergency, if there is not time to document a complete H&P prior to the surgery or procedure, a note documenting the preoperative diagnosis is recorded by the surgeon prior to surgery/procedure.
3. Authorization of History and Physical. A H&P examination and update as described in Sections (1.a)(1.b)(1.c) above may be performed and documented by the following:
  - a. A qualified Physician or podiatrist who is a Member and has Clinical Privileges to perform specific diagnostic and therapeutic procedures.
  - b. Nurse Practitioners (ARNP) and Physicians Assistants (PA) may perform part or the entire H&P exam if granted Clinical Privileges to do so.
  - c. Resident Physicians or podiatrists who hold a full or limited license in the State of Washington.
4. Outside History and Physicals. An H&P performed within thirty (30) calendar days before admission or registration may be performed by qualified individuals who hold licensure within the State of Washington, including qualified Physicians or podiatrists, Nurse Practitioners, and Physician Assistants.
 

In accepting an outside H&P, a Practitioner with appropriate Privileges must validate and countersign the outside H&P as being accurate and up-to-date. H&P's performed by providers who do not practice within the State of Washington are not acceptable and must be repeated.
5. Documentation.

- a. The H&P may be dictated, directly entered into the Clinical Information System (CIS), or handwritten.
- b. A handwritten, transcribed, or direct entry H&P must be in the patient's medical record within 24 hours of admission.

## **XVII. CONFLICT RESOLUTION**

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by written petition signed by at least thirty percent (30%) of the Members of the Active Staff regarding a proposed or adopted Bylaws revision, Rule or policy, or other issue of significance to the Medical Staff, the Chief of Staff shall convene a meeting with the petitioners' representative(s). The foregoing petition shall include a designation of up to five Members of the Active Staff who shall serve as the petitioners' representative(s). The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The Medical Executive Committee's and the petitioners' representative(s) shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the Hospital. Resolution at this level requires a majority vote of the Medical Executive Committee's representatives at the meeting and a majority vote of the petitioner's representatives. If resolution is not achieved at such meeting, the conflicts may be addressed at a Special meeting of the Medical Staff as described in Section XVII.B. Unresolved differences shall be submitted to the Board for its consideration in making its final decision with respect to the proposed Bylaw, Rule, policy, or issue.

## **XVIII. MEETINGS OF THE MEDICAL STAFF**

### **A. Annual Meeting**

The Annual Meeting of the Medical Staff shall be held during the fourth quarter of each year. Notice of the Annual Meeting shall be mailed, transmitted via electronic mail or otherwise provided to each Active Staff Member at least ten (10) working days before the time set for the meeting, and shall include the agenda for the meeting, which may include recognition of the retiring Officers and Medical Staff, reports on the year's activities and accomplishments and discussion of topics of current interest. Officers for the ensuing year shall take office on January 1 of the calendar year immediately following the Annual meeting.

### **B. Special Meetings**

1. Special meetings of the Medical Staff may be called at any time by the Chief of Staff and shall be called at the request of the Board, the Medical Executive Committee, or on the petition of any twenty (20) Members of the Active Medical Staff. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Sufficient

notice of any special meeting shall be mailed, transmitted via electronic mail or otherwise delivered for each Active Staff Member at least forty-eight (48) hours before the time set for the meeting, which notice shall include the stated purpose of the meeting.

2. The agenda at special meetings shall be:
  - a. Reading of the notice calling the meeting.
  - b. Conducting the business for which the meeting was called.
  - c. Adjournment.

**C. Attendance of Meetings**

1. Each Member of the Active Staff shall make their best efforts to attend the regularly scheduled meetings of their Department, or request to be excused by the Department Chief.
2. Members of the Courtesy, Ambulatory and Consulting, Telemedicine, Affiliate, and Honorary categories of the Medical Staff shall be encouraged to attend meetings, as applicable.

**D. Quorum; Action by Medical Staff**

Thirty percent (30%) of the total membership of the Active Staff shall constitute a quorum at any meeting of the Medical Staff. Except as otherwise required, the action of a majority of those Members of the Active Staff who are present and voting at a meeting of the Medical Staff at which a quorum is present shall be the action of the group.

**XIX. RULES AND REGULATIONS AND POLICIES**

The Medical Staff shall adopt such Rules and Regulations and Policies as may be necessary to implement more specifically the general principles found within its Bylaws, subject to the approval of the Board. These shall relate to the proper conduct of Medical Staff organizational activities, as well as, define the scope of Clinical Privileges that are granted each Practitioner in the Hospital.

**A. Medical Executive Committee Approval**

1. The Medical Executive Committee may adopt new Rules and Regulations and Policies, and amendments thereto, as needed, to reflect clinical, quality, regulatory, legal, and other considerations, without the approval of the Medical Staff.
2. In cases of a documented need for an urgent amendment to the Rules and Regulations necessary to comply with law or regulation, the Medical

Executive Committee may, provisionally adopt and the Board may provisionally approve an urgent amendment. Immediately thereafter, the amendment will be distributed to the Medical Staff for retrospective review and comment. If there is no conflict between the Medical Executive Committee and the Medical Staff, the provisional amendment stands. If there is a conflict over the provisional amendment, the process for resolving conflicts between the Medical Staff and the Medical Executive Committee shall be implemented. If necessary, a revised amendment shall then be submitted to the Board for action.

3. In all other cases in which the Medical Executive Committee proposes to adopt or amend a Rule and Regulation, it shall communicate its proposal to the Medical Staff for review and comment prior to voting thereon. If necessary, the conflict-resolution process may be implemented. Such proposals shall become effective when approved by the Board.
4. The Medical Executive Committee may adopt or amend a Policy, which shall become effective when approved by the Board. Such adoption or amendment subsequently shall be communicated to the Medical Staff.

**B. Medical Staff Approval**

The Medical Staff may submit proposals to adopt or amend the Rules and Regulations and Policies directly to the Board for consideration. Any such proposal must be approved by thirty percent (30%) of the Members of the Medical Staff eligible for voting. Voting on the proposed amendment may be accomplished through a written petition or mail vote, or electronic ballot capable of appropriate authentication. The proposal shall be provided to the Medical Executive Committee prior to submission to the Board. Requests for the names of those Members of the Medical Staff eligible for voting shall be submitted to the Chief of Staff.

**XX. BYLAWS, AMENDMENTS AND ONGOING REVIEW**

The Medical Executive Committee shall engage in a review of these Bylaws on a regular basis and as needed to reflect clinical, quality, regulatory, legal and other considerations. This review shall occur at least once every three (3) years, though there shall be no requirement to amend the Bylaws following such a review. Any amendments shall be subject to approval by the Board.

**A. Medical Staff Approval of Amendments Proposed by the MEC**

1. The Medical Executive Committee may propose amendments to the Bylaws, as needed, to reflect clinical, quality, regulatory, legal and other considerations. Such proposals shall be submitted to the Members of the Active Staff for approval either at a meeting or by mail or electronic ballot capable of appropriate authentication. The meeting notice or ballot must be sent to all Members of the Active Staff at least ten (10) working days

prior to the date of the meeting or the deadline for casting a ballot. If the vote is to be taken at a meeting, the requirements set forth by Section XVII.D shall apply. If the vote is to be taken by mail or electronically, the vote may be counted upon the receipt of ballots from thirty percent (30%) of the Active Staff, and approval shall require an affirmative vote of a majority of the ballots received.

2. Notwithstanding the foregoing, in cases of a documented need for an urgent amendment to the Bylaws necessary to comply with law or regulation, the Medical Executive Committee may provisionally adopt and the Board may provisionally approve an urgent amendment. Immediately thereafter, the amendment will be distributed to the Medical Staff for voting in accordance with the procedure set forth above. If there is a conflict over the provisional amendment, the process for resolving conflicts between the Medical Staff and the Medical Executive Committee shall be implemented. If necessary, a revised amendment shall then be submitted to the Board for action.

**B. Medical Staff Proposed Amendments to Board**

The Medical Staff may submit proposed amendments to the Bylaws directly to the Board for consideration. In order to submit an amendment directly to the Board, the proposed amendment must be approved by thirty percent (30%) of the Medical Staff eligible for voting. Voting on the proposed amendment may be accomplished through a written petition or mail vote, or electronic ballot capable of appropriate authentication. The proposed amendment shall be provided to the Medical Executive Committee prior to submission to the Board. Requests for the names of those Members of the Medical Staff eligible for voting shall be submitted to the Chief of Staff.

**C. Amendments Proposed by the Board**

The Board of Directors may propose Bylaws amendments to the Medical Executive Committee. If the Medical Staff declines to adopt such proposed amendments that the Board of Directors considers necessary to comply with law or accreditation requirements, or if any conflict exists between any provision of these Bylaws and any Hospital bylaw, rule or policy, the matter shall be referred for conflict resolution. Neither the Medical Staff nor the Board of Directors may amend these Bylaws unilaterally.

**XXI. EFFECTIVE DATE**

These Bylaws as amended shall replace any previous Bylaws and shall be effective when approved by the Board.



## **APPENDIX 1**

### **HEARING AND REVIEW PROCEDURE**

This Appendix 1 shall apply to Adverse Recommendations taken or recommended against the Medical Staff membership and/or Clinical Privileges of a Physician, Dentist or Podiatrist.

#### **A. Hearing and Review Upon Adverse Recommendation**

1. Except as otherwise stated in the Medical Staff Bylaws, when a Physician, Dentist or Podiatrist receives notice of an Adverse Recommendation, the Physician, Dentist or Podiatrist may request a hearing before a Hearing Committee of the Medical Staff, which shall be appointed as provided in this Hearing and Review Procedure. If the recommendation of the Medical Executive Committee following reconsideration after such a hearing remains adverse to the Physician, Dentist or Podiatrist, the Physician, Dentist or Podiatrist may request review by the Board of Directors as provide in this Hearing and Review Procedure. Notwithstanding any other provision of these Bylaws, no Physician, Dentist or Podiatrist shall be entitled to more than one hearing or more than one review on any matter or group of matters that are the subject of an Adverse Recommendation.
2. Adverse Recommendations shall become final only after the hearing and review rights set forth herein have been either exhausted or waived. Notwithstanding the foregoing, summary suspensions may be imposed prior to the exhaustion or waiver of these hearing and review rights, as set forth at Section X.C of the Bylaws.

#### **B. Grounds for Hearing (Adverse Recommendations)**

1. Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions, when based on a Physician, Dentist or Podiatrist's Professional Competence or Conduct, shall be deemed an "Adverse Recommendation" and constitute grounds for a hearing:
  - a. Denial of appointment or reappointment to the Medical Staff;
  - b. Denial of requested Clinical Privileges;
  - c. Denial of requested appointment to, or change, in Medical Staff category.
  - d. Summary suspension of Medical Staff membership or Clinical Privileges, which action remains in effect for fifteen (15) working days or more, or is taken intermittently for a cumulative total of more than thirty (30) calendar days in a twelve (12) month period;

- e. Involuntary restriction or reduction of Medical Staff membership or Clinical Privileges for a cumulative total of more than thirty (30) calendar days in a twelve (12) month period, which may include imposition of significant proctoring, co-admission or second opinion obligations (excluding monitoring or proctoring associated with newly granted privileges);
  - f. Reduction in staff category.
  - g. Termination of Medical Staff membership or Clinical Privileges.
  - h. Any other action or recommendation that must be reported to the National Practitioner Data Bank or the Washington State Medical Quality Assurance Commission.
2. The following actions do not constitute an Adverse Recommendation and do not give rise to any hearing or review: the issuance of a warning or a formal letter of reprimand; the imposition of a probationary period with retrospective review of practice without special requirements of consultation or supervision; the denial, termination, or reduction of temporary Privileges; or any other actions that does not serve to limit a Physician, Dentist or Podiatrist's ability to participate on the Medical Staff and/or exercise their Clinical Privileges.

**C. Notice of Adverse Recommendation; Request for Hearing**

1. When an Adverse Recommendation is taken or made, the affected Physician, Dentist or Podiatrist shall be given prompt written notice, by certified mail, return receipt requested, or similar trackable mechanism:
- a. of the action or recommendation, and a concise statement of the reasons for such action or recommendation;
  - b. of the right to request a hearing, and that such hearing must be requested in writing within thirty (30) calendar days;
  - c. with a summary of the rights granted in the hearing and/or copy of the Medical Staff Bylaws describing such rights; and
  - d. that the action or recommendation may give rise to mandatory reporting to the National Practitioner Data Bank and/or the Washington State Medical Quality Assurance Commission.

This notice shall be deemed received on the earlier of the date of delivery or, if delivery is refused, the date of attempted delivery to the Physician's, Dentist's or Podiatrist's principal office or residence.

2. The Physician, Dentist or Podiatrist shall have thirty (30) days following receipt of such notice in which to request a hearing. The request shall be in writing, addressed to the Hospital Administrator, who must receive it within the allotted period. In the event the Physician, Dentist or Podiatrist does not request a hearing within the time and in the manner described, the Physician, Dentist or Podiatrist shall be deemed to have waived any right to challenge the Adverse Recommendation and it shall become final and effective immediately.

**D. Time and Place for Hearing; Notice of Hearing and Notice of Reasons**

1. On receipt of a request for a hearing, the Hospital President shall inform the Chief of Staff, who shall then appoint the Hearing Committee and fix the date, time, and place of the hearing.
2. Within ten (10) working days of receipt of the request for hearing, the Physician, Dentist or Podiatrist shall be sent a Notice of Hearing by certified mail, return receipt requested, or similar trackable mechanism stating:
  - a. The place, time and date of the hearing, which shall be not less than thirty (30) calendar days, but not more than sixty (60) calendar days from the date of the Notice of Hearing;
  - b. A list of the witnesses (if any) who are then expected to testify at the hearing on behalf of the Medical Executive Committee; and
  - c. If known at the time of the Notice of Hearing is sent, the composition of the Hearing Committee and the name of the Hearing Officer.
3. A Notice of Reasons or Charges may be sent along with, or separate from, the Notice of Hearing, further specifying, as appropriate, the acts of or omissions with which the Physician, Dentist or Podiatrist is charged. This supplemental notice shall provide a list of the charts, if any, which are to be discussed at the hearing, if that information has not been provided previously.

**E. The Hearing Committee**

1. The Chief of Staff shall appoint the Hearing Committee, provided he or she is not in direct economic competition with the Physician, Dentist or Podiatrist. If the Chief of Staff is in direct economic competition with the Physician, Dentist or Podiatrist, the Hearing Committee shall be appointed by another member of the Medical Executive Committee not so disqualified.

2. The Hearing Committee shall consist of three (3) members of the Active Staff, at least one of whom shall have the same professional licensure of the Physician, Dentist or Podiatrist and, where feasible, practice in the same specialty. The Chief of Staff also may appoint alternate candidates for membership on the Hearing Committee to replace members who become unavailable or are disqualified. The person authorized to appoint the Hearing Committee shall designate one of the members so appointed as Chair.
3. The Hearing Committee members shall not be in direct economic competition with the Physician, Dentist or Podiatrist, shall gain no direct financial benefit from the outcome, and shall not have acted as an accuser, investigator, fact finder, initial decision maker, nor have actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved, however, does not by itself preclude appointment.
4. If it is not feasible to appoint a Hearing Committee from the Active Staff, the Chief of Staff may appoint members from other staff categories or practitioners who are not members of the Medical Staff.

**F. The Hearing Officer**

1. The person who is authorized to appoint the Hearing Committee shall also appoint a Hearing Officer to preside at the hearing. The Hearing Officer may be an attorney qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the Hospital or Medical Staff for legal advice regarding their affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer shall not be in direct economic competition with the Physician, Dentist or Podiatrist and shall gain no direct financial benefit from the outcome, other than reasonable reimbursement for serving as the Hearing Officer.
2. The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions of law, procedure or the admissibility of evidence. If the Hearing Officer determines that either party is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such action as the Hearing Officer considers to be warranted including, when appropriate and permitted under applicable law, ruling that a practitioner has waived the right to a hearing.

3. If requested by the Hearing Committee, the Hearing Officer may participate in the deliberations of the Committee, serve as legal advisor to the Committee, and/or assist the Committee in the preparation of its decision and report, but the Hearing Officer shall not be entitled to vote.

**G. Pre-Hearing Procedure**

1. The Physician, Dentist or Podiatrist shall be entitled to a reasonable opportunity to question and challenge the impartiality or qualifications of the Hearing Committee members and the Hearing Officer. The Hearing Officer shall establish the procedure by which this right may be exercised, which may include a requirement that questions or challenges be presented in writing in advance of the hearing. The Hearing Officer shall rule on any challenges in accordance with the standards and qualifications set forth herein.
2. At least ten (10) working days prior to the commencement of the hearing, the Physician, Dentist or Podiatrist shall provide the Chief of Staff with a list of witnesses who are reasonably anticipated to testify on the Physician's, Dentist's or Podiatrist's behalf; and the Chief of Staff shall update the Medical Executive Committee's witness list as previously provided in the Notice of Hearing.
3. Prior to receiving any confidential documents, the individual requesting the hearing must agree in writing that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that their counsel and any expert(s) have executed Business Associate Agreements in connection with any patient Protected Health Information contained in any documents provided.
4. Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:
  - a. copies of, or reasonable access to, all applicable patient medical records, at the individual's expense;
  - b. reports of experts relied upon by the Medical Executive Committee;
  - c. copies of relevant minutes (with portions regarding other Practitioners and unrelated matters deleted); and
  - d. copies of any other documents relied upon by the Medical Executive Committee.

Notwithstanding the foregoing, the provision of such documents and information shall not, and shall not be deemed to waive any applicable

privilege, including, without limitation any peer review privilege or attorney-client privilege.

5. The individual will have no right to discovery beyond the above information. No information will be provided regarding other Practitioners. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.
6. It shall be the responsibility of each party to exercise reasonable diligence in notifying the Chair of the Hearing Committee or the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the commencement of the hearing as possible, so that decisions concerning such matters may be made with the least possible disruption of the hearing process. Objections to any pre-hearing decisions shall be noted in the hearing record.
7. Postponements and Extensions. Once a request for a hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the Hearing Officer on a showing of good cause, or upon agreement of the parties.

#### **H. Conduct of Hearing**

1. A complete stenographic record of the proceedings shall be made, or the hearing will be audio taped and transcribed. The stenographic records, the exhibits submitted by the parties, and the Committee's findings of fact, conclusions and decision shall constitute the hearing record. The Physician, Dentist or Podiatrist shall be entitled to a copy of the transcript upon paying the reasonable cost of preparing it.
2. Failure of the Physician, Dentist or Podiatrist to appear and proceed at a hearing without good cause shall be deemed to constitute a voluntary acceptance of the action or recommendation and a waiver of all hearing rights. The issue of good cause shall be determined by the Hearing Committee.
3. The Hearing Committee may consider any relevant matter of the sort on which reasonable persons customarily rely in the conduct of serious affairs, without regard for technical rules of evidence. The Physician, Dentist or Podiatrist or the Medical Executive Committee may submit, and the Hearing Committee may request memoranda concerning any issue or issues raised in the hearing. The Hearing Committee may also take official notice of technical, scientific, or other matters of record. Those participating in the hearing shall be informed of matters of which the Hearing Committee intends to take official notice; and all such matters shall be noted or referred to in the record of the hearing. The Physician, Dentist or Podiatrist and the Medical Executive Committee shall have the opportunity to request that official notice be taken of matters, to comment

and offer arguments based on or directed to matters of which official notice is taken, and to refute matters of which official notice is taken by testimonial or documentary evidence. If requested, reasonable time shall be granted to the participants to present written or oral rebuttal of any matter of which official notice has been taken.

4. The affected Physician, Dentist or Podiatrist and the Medical Executive Committee may call and examine witnesses, cross-examine witnesses, and offer documentary evidence. The Medical Executive Committee may call the Physician, Dentist or Podiatrist to testify as a witness whether or not the Physician, Dentist or Podiatrist has already testified on their own behalf. The Hearing Committee also may examine the witnesses or call additional witnesses if it deems such action appropriate.
5. A hearing conducted pursuant to this Article is intended to resolve, on an intra-professional basis matters being on professional competency and conduct. However, in the hearing, the Physician, Dentist or Podiatrist involved has the right to representation of an attorney or other person of the Physician's, Dentist's or Podiatrist's choice. Should the Physician, Dentist or Podiatrist involved elect not to be represented by an attorney at the hearing, the Medical Executive Committee shall also not be represented by an attorney at the hearing. Nothing in the foregoing shall be deemed to deprive either party of the right to advice of legal counsel in connection with preparation for the hearing.
6. In consultation with the Chair of the Hearing Committee, the Hearing Officer may recess and reconvene the hearing at such time and intervals as may be reasonable and warranted, with due consideration for the importance of reaching an expeditious conclusion. No such recess or combination of recesses may exceed thirty (30) calendar days in length without good cause or the consent of the Physician, Dentist or Podiatrist and Medical Executive Committee. The Hearing Committee may also, in its discretion, postpone and reschedule the hearing where good cause is shown.
7. The Medical Executive Committee shall have the burden of initially presenting evidence to support the charges and its actions or recommendation. The Physician, Dentist or Podiatrist shall then have the burden of presenting evidence which demonstrates that the Medical Executive Committee's action or recommendation is arbitrary, unreasonable or not supported by substantial evidence. If the Physician, Dentist or Podiatrist is unable to rebut the Medical Executive Committee's case in this manner, the Hearing Committee shall find in favor of the Medical Executive Committee.
8. After the evidentiary presentations have been completed and any closing written statements have been submitted, the hearing shall be concluded.

9. The decision of the Hearing Committee shall be based on the evidence produced at the hearing and any written statements submitted. Within fifteen (15) working days following the conclusion of the hearing, the Hearing Committee shall issue a written decision, with a report articulating the connection between the evidence presented at the hearing and the result. The decision and report shall be delivered to the Physician, Dentist or Podiatrist, the Medical Executive Committee, the Chief of Staff and the Chair of the Board.

## **I. Appeal Procedure**

1. **Time for Appeal.** Within fifteen (15) working days after receipt of the Hearing Committee's decision, either party may request an appeal. The request for appeal must be in writing, delivered to the Chief of Staff in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within fifteen (15) working days, the opportunity for appeal shall be deemed to be waived and the Hearing Committee's report and recommendation will be forwarded to the Board of Directors for final action.
2. **Grounds for Appeal.** The grounds for appeal are limited to the following:
  - a. there was substantial failure by the Hearing Committee or the Hearing Officer to comply with this Appendix 1, so as to deny a fair hearing; or
  - b. the recommendations of the Hearing Committee were made arbitrarily or capriciously or were not supported by credible evidence.
3. **Time, Place and Notice.** Within twenty (20) working days after the receipt of the request for appeal, the Chair of the Board of Directors will give both parties notice of the time, place and date of the appellate review. The date of appellate review will be as soon as reasonably practical but no more than sixty (60) calendar days from the date of request for appeal. If, however, the request for appellate review is from a Physician or dentist who is under summary suspension then in effect, the appellate review will be held as soon as arrangements may be made, not to exceed forty-five (45) calendar days from the date of receipt of the request for appeal. The time for appellate review may be extended for good cause by the Board of Directors, or appeal board (if any).
4. **Appeal Board.** Whenever an appellate review is requested, the Board of Directors may sit as the Appeal Board or the Chair of the Board may appoint an Appeal Board which will be composed of at least three (3) members of the Board of Directors. Knowledge of the matter involved



will not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter.

5. Appeal Procedure. The proceedings on appeal will be based upon the Hearing Committee record. When requested by either party, the Appeal Board may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Additional evidence will be accepted only if the Appeal Board determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied. Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have ten (10) working days to respond. In its sole discretion, the Appeal Board may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes.
6. At the conclusion of oral argument, if allowed, the Appeal Board will conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. If a three-member Appeal Board is appointed, the Appeal Board will present to the Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the Hearing Committee decision, or remand the matter to the Hearing Committee or any other body or person for further review and decision.

**J. Board Action**

1. The Board will take final action within forty-five (45) calendar days after it (i) considers the appeal as the Appeal Board; (ii) receives a recommendation from a separate Appeal Board; or (iii) receives the Hearing Committee's report when no appeal has been requested.
2. The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Committee, and Appeal Board (if applicable).
3. Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may adopt, modify, or reverse any recommendation that it receives or refer the matter for further review.
4. The Board will render its final decision in writing, including the basis for its decision, and will send Notice of Final Decision to the Physician or

dentist and Medical Executive Committee. A copy will also be provided to the Chief of Staff.

5. Except where the matter is referred by the Board for further review, the final decision of the Board will be effective immediately and will not be subject to further review.

**K. Reporting Requirements**

The Hospital President or their designee will report actions taken against a Medical Staff Member or AHP with Clinical Privileges to professional bodies and State and Federal governmental agencies to the extent required by law. Specific reporting requirements include:

1. If a Physician, Dentist or Podiatrist does not request a hearing as provided in the Medical Staff Hearing and Review Procedure, the Hospital President or their designee will file, no later than fifteen (15) days following Physician or dentist's deadline to request a hearing, a report summarizing the Adverse Action to the National Practitioner Data Bank and the Washington State Medical Quality Assurance Commission.
2. If any Adverse Action is taken after completion of the hearing process as provided in the Medical Staff Hearing and Review Procedure, the Hospital President or their designee will file, no later than fifteen (15) days following final action by the Board as described in Medical Staff Hearing and Review Procedure, a report summarizing the Adverse Action to the National Practitioner Data Bank and the Washington State Medical Quality Assurance Commission.

**L. Exhaustion of Remedies**

If any Adverse Recommendation is taken or recommended, the Physician, Dentist or Podiatrist must exhaust the remedies afforded by these Bylaws before resorting to legal action.

**END**

## **ADOPTION HISTORY**

**Adopted** by the Active Medical Staff of the Virginia Mason Hospital – September 14, 1970.

Donald M. McElroy, M.D.

Robert M. Hegstrom, M.D.

President of Medical Staff

Secretary of Medical Staff

Approved by the Board of Virginia Mason Hospital – October 20, 1970.

John M. Davis

Edward E. Carlson

President, Board of Directors

Secretary, Board of Directors

**Amended** by the Active Medical Staff of the Virginia Mason Hospital – October 26, 1972.

Patrick A. Ragen, M.D.

John W. Huff, M.D.

President of Medical Staff

Secretary of Medical Staff

Amendments approved by Board of the Virginia Mason Hospital – November 21, 1972.

C. Henry Bacon, Jr.

Anthony Eyring

President, Board of Directors

Secretary, Board of Directors

**Amended** by the Active Medical Staff of the Virginia Mason Hospital – April 6, 1973.

Richard I. Birchfield, M.D.

William L. Topp, M.D.

President of Medical Staff

Secretary of Medical Staff

Amendments approved by Board of the Virginia Mason Hospital – May, 1973.

C. Henry Bacon, Jr.

J. Tate Mason, M.D.

President, Board of Directors

Secretary, Board of Directors

**Amended** by the Active Medical Staff of Virginia Mason Hospital – September 1975.

John W. Huff, M.D.

Donald Bauermeister, M.D.

President of Medical Staff

Secretary of Medical Staff

Amendments approved by Board of the Virginia Mason Hospital – October, 1975.

W. J. Pennington

Richard F. Jones, M.D.

President, Board of Directors

Secretary, Board of Directors

**Amended** by the Active Medical Staff of the Virginia Mason Hospital – November 3, 1977.

William L. Topp, M.D.

Roy J. Correa, Jr., M.D.

President of Medical Staff

Secretary of Medical Staff

Amendments approved by Board of the Virginia Mason Hospital – November 15, 1977.

J. Tate Mason, M.D.

Donald M. McElroy, M.D.

President, Board of Directors

Secretary, Board of Directors

**Amended** by the Active Medical Staff of the Virginia Mason Hospital – January 14, 1981.

Roy J. Correa, Jr., M.D.

David Hurlbut, M.D.

President of Medical Staff

Secretary of Medical Staff

Amendments approved by Board of the Virginia Mason Hospital – January 19, 1982.

Edward M. Andrews, Jr.

Langdon Simmons, Jr., M.D.

President, Board of Directors

Secretary, Board of Directors

**Amended** by the Active Medical Staff of the Virginia Mason Hospital – April 10, 1984.

L. Fredrick Fenster, M.D.

Thomas M. Green, M.D.

President of Medical Staff

Secretary of Medical Staff

Amendments approved by Board of the Virginia Mason Hospital – April 17, 1984.

Harry Mullikin

Jacklyn Meurk

President, Board of Directors

Secretary, Board of Directors

Amendments approved by Board of the Virginia Mason Hospital – June 17, 1986, March 17, 1987, and May 19, 1987.

Richard F. Jones, M.D.

Jacklyn Meurk

President, Board of Directors

Secretary, Board of Directors

**Amended** by the Active Medical Staff of the Virginia Mason Hospital – December 5, 1988.

Thomas M. Green, M.D.

David A. Gortner, M.D.

President of Medical Staff

Secretary of Medical Staff

Amendments approved by Board of the Virginia Mason Hospital – January 17, 1989.

Mark Hutcheson

Jacklyn Meurk

President, Board of Directors

Secretary, Board of Directors

**Amendments** approved by Board of Virginia Mason Hospital – June 18, 1992.

Richard Albrecht

Virginia Anderson

President, Board of Directors

Secretary, Board of Directors

**Amended** by Active Medical Staff of Virginia Mason Medical Center – March 20, 1995

Robert P. Gibbons, M.D.

Lynne P. Taylor, M.D.

Chief of Staff

Secretary of Medical Staff

Amendments approved by the Board of Virginia Mason Medical Center – March 21, 1995.

Harry Mullikin

Mark A. Hutcheson

Chair, Board of Directors

Secretary, Board of Directors

**Amended** by the Active Medical Staff of Virginia Mason Medical Center – September 9, 1996.

Robert P. Gibbons, M.D.

Debra G. Wechter, M.D.

Chief of Staff

Secretary of Medical Staff

Amendments approved by the Board of Virginia Mason Medical Center – September 17, 1996.

Richard Albrecht

Mark A. Hutcheson

Chair, Board of Directors

Secretary, Board of Directors

**Amended** by the Active Medical Staff of Virginia Mason Medical Center – April 27, 1999.

Robert P. Gibbons, M.D.

Donald Low, M.D.

Chief of Staff

Secretary of Medical Staff

Amendments approved by the Board of Virginia Mason Medical Center – June 15, 1999.

Richard Albrecht

Mark A. Hutcheson

Chair, Board of Directors

Secretary, Board of Directors

**Amendments** approved by the Board of Virginia Mason Medical Center – January 15, 2002.

Mark A. Hutcheson

Pam Green

Chair, Board of Directors

Secretary, Board of Directors

**Amendments** approved by the Board of Virginia Mason Medical Center – December 17, 2002.

Mark A. Hutcheson

Pam Green

Chair, Board of Directors

Secretary, Board of Directors

**Amendments** approved by the Board of Virginia Mason Medical Center – January 19, 2004.

David Williams

Pat Scott

Chair, Board of Directors

Secretary, Board of Directors

**Amendments** approved by the Board of Virginia Mason Medical Center – October 13, 2006.

Tom Van Dawark

Carolyn Corvi

Chair, Board of Directors

Secretary, Board of Directors

**Amendments** approved by the Board of Virginia Mason Medical Center – March 18, 2008.

Tom Van Dawark

Carolyn Corvi

Chair, Board of Directors

Secretary, Board of Directors

**Amendments** approved by the Board of Virginia Mason Medical Center – December 16, 2008.

Tom Van Dawark

Carolyn Corvi

Chair, Board of Directors

Secretary, Board of Directors

**Amendments** to Appendix 1, *Hearing and Review Procedures* approved by the Board of Virginia Mason Medical Center – March 17, 2009.

**Amendments** approved by the Board of Virginia Mason Medical Center – December 21, 2010.

Carolyn Corvi

James Young

Chair, Board of Directors

Secretary, Board of Directors

**Amendments** approved by the Board of Virginia Mason Medical Center – December 18, 2012

Carolyn Corvi

James Young

Chair, Board of Directors

Secretary, Board of Directors

**Amendments** approved by the Board of Virginia Mason Medical Center – June 20, 2013

James Young

Dorothy Mann

Chair, Board of Directors

Secretary, Board of Directors

**Amendments** approved by the Board of Virginia Mason Medical Center – December 17, 2013

James Young

Dorothy Mann

Chair, Board of Directors

Secretary, Board of Directors

**Amendments** approved by the Board of Virginia Mason Medical Center – July 5, 2016.

James Young

Dorothy Mann

Chair, Board of Directors

Secretary, Board of Directors

**Amendments** approved by the Board of Virginia Mason Medical Center – March 5, 2019.

Tod Hamachek

Mary McWilliams

Chair, Board of Directors

Secretary, Board of Directors

**Amendments** approved by the Board of Virginia Mason Franciscan Health – January 17, 2023.

Uli Chi

Miriam Chambliss

Chair, Board of Directors

Secretary, Board of Directors