SAINT ALPHONSUS MEDICAL CENTER
ONTARIO

BYLAWS
OF THE MEDICAL STAFF
# MEDICAL STAFF BYLAWS

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PREAMBLE

WHEREAS, Saint Alphonsus Medical Center – Ontario, Inc., is a non-profit Oregon corporation and a subsidiary of Saint Alphonsus Health System, Inc., and Idaho non-profit corporation;

WHEREAS, the purpose of the corporation is to serve as a general Hospital providing patient care, education and research consistent with the theological teachings of the Roman Catholic Church;

WHEREAS, the goal of the Board and the Medical Staff is to strive for quality medical care in the Hospital;

WHEREAS, the Board wishes to delegate to the Medical Staff overall responsibility for monitoring the quality of medical care in the Hospital and reporting thereon and accounting therefore to the Board and the authority and responsibility to make recommendations to the Board concerning an applicant's appointment or reappointment to the Medical Staff of the Hospital and the clinical privileges such applicant shall enjoy in the Hospital;

WHEREAS, it is the intent and purpose of these Bylaws that the initiation and conduct of professional review actions hereunder comply in all material respects with the provisions of Section 412 of the Health Care Quality Improvement Act of 1986, a copy of which is included in the Appendix to these Bylaws;

WHEREAS, the cooperative efforts of the Medical Staff, the Board and Hospital Administration are necessary to provide quality medical care to patients in the Hospital;

THEREFORE, to discharge these duties and responsibilities to the Hospital in an orderly fashion, the physicians, oral surgeons, dentists, and podiatrists practicing in the Hospital shall function and act in accordance with the following Bylaws and procedures which have been approved by the Board and the Medical Staff.
The name of this organization is the "Medical Staff of Saint Alphonsus Medical Center - Ontario."
PURPOSE

The purposes and responsibilities of the Medical Staff of Saint Alphonsus Medical Center - Ontario shall be:

1. To monitor the overall quality of medical care in the Hospital and to make recommendations thereon to the Board.

2. To establish a credentials program and procedures; to make recommendations to the Board concerning the appointment or reappointment of an applicant to the Medical Staff of the Hospital; to recommend to the Board the clinical privileges such applicant or appointee shall have in the Hospital, and to review and evaluate on a continuing basis such clinical privileges as have been given; to recommend to the Board any appropriate action that may be necessary in connection with any appointee to the Medical Staff and to account to the Board therefore.

3. To establish procedures whereby issues concerning the Medical Staff, the Hospital Administration, and the Board may be discussed so that the Medical Staff participates in the policy making and planning process of the Hospital.

4. To establish rules and regulations to govern actions and professional responsibilities of the Medical Staff.

5. To provide an appropriate educational setting that will lead to advancement in professional knowledge and skill, and encourage and support such clinical and basic research as may be authorized from time to time by the Board.

6. To discharge such other duties and responsibilities delegated to the Medical Staff by the Board.
DEFINITIONS

When the terms listed below appear in these Bylaws, they shall have the meaning as defined below unless otherwise defined in these Bylaws.

1. AD HOC COMMITTEE, means a committee created under these Bylaws for a limited purpose or specific task at the completion of which the committee ceases to exist.

2. ADMISSION, means a patient who comes to the Hospital for medical or surgical care whether as an inpatient or as an outpatient in any department, for observation or treatment by a member of Medical Staff.

3. ADVERSELY AFFECTING, (as used in the definition of Professional Review Action) is defined to include reducing, restricting, suspending, revoking, denying, or failure to renew clinical privileges or membership.

4. APPLICANT, means any qualified physician, dentist, oral surgeon or podiatrist who has fully completed an application for appointment or reappointment to the Medical Staff of the Hospital and whose application has been accepted by the Hospital as complete and appropriate. For the purposes of Article XII only, applicant shall refer to any individual who makes any inquiry regarding any Medical Staff or allied health personnel position.

5. ATTENDING PHYSICIAN, for any particular patient means the Medical Staff member who has responsibility for providing and supervising care for such patient. The Medical Staff member who admits the patient to the Hospital shall be the attending physician for such patient until such time as the overall responsibility for care of the patient is assigned to and accepted by another member of the Medical Staff.

6. BOARD OF DIRECTORS, means the Ontario Community Hospital Board, which is a committee of the Board of Trustees of Saint Alphonsus Medical Center – Ontario, Inc., a subsidiary of Saint Alphonsus Health System, Inc. The Ontario Community Hospital Board has been delegated responsibility by the Saint Alphonsus Medical Center – Ontario, Inc. Board, and has responsibility, authority and accountability for the oversight of the affairs of the Medical Staff, including its credentialing and peer review activities.

7. PRESIDENT/CHIEF EXECUTIVE OFFICER aka PRESIDENT, means the Administrator who is appointed by the governing body to act in its behalf in the overall management of the Hospital.

8. CLINICAL PRIVILEGE OR PRIVILEGES, means permission granted to a physician, dentist, oral surgeon or podiatrist, or a member of the allied health personnel to independently provide medical or other patient care services in the Hospital, within well-defined limits, based on the individual's professional license, experience, competence, education, training, judgment and other criteria set forth in these Bylaws.

9. DENTIST, means an individual with a degree of doctor of dental surgery or doctor of dental medicine or similar degree and who is fully licensed in Oregon to practice dentistry in all its phases.
10. EXECUTIVE COMMITTEE, means the Executive Committee of the Medical Staff unless it is specifically written "Executive Committee of the Board." The Executive Committee is a "professional review body" as such term is defined in Section 431(11) of the Health Care Quality Improvement Act of 1986. (See copy of Act attached as Appendix 1.)

11. EX OFFICIO, means service as a member of a body by virtue of an office or committee position held and, unless otherwise expressly provided, means without voting rights.

12. FOCUSED PROFESSIONAL PRACTICE EVALUATION or FPPE, means a time-limited evaluation of a Member’s or AHP’s competence in performing a specific Clinical Privilege(s) and professional behavior.

13. HOSPITAL, means Saint Alphonsus Medical Center - Ontario of Ontario, Oregon, and is a "health care entity" as such term is defined in Section 431(4) of the Health Care Quality Improvement Act of 1986 and is a "Hospital" as such term is defined in Section 431(5) of the Health Care Quality Improvement Act of 1986. (See copy of Act attached as Appendix 1.)

14. MEDICAL STAFF is a single, organized group of those physicians, oral surgeons, dentists and podiatrists who have been granted recognition as members of the Medical Staff of Saint Alphonsus Medical Center - Ontario pursuant to the terms of these Bylaws. The Medical Staff is not a separate entity apart from the Hospital. It is an integral part of the Hospital and operates as an extension of the governing Board.

15. An INVESTIGATION is a specified and directed review of a physician’s performance or conduct in response to a request for corrective action. An investigation may be initiated only by the Medical Staff’s Executive Committee and it must be documented in writing in the minutes of the Medical Executive Committee meeting. The routine functions of the Medical Staff, of its committees, and all discussions with a physician relating to these matters do not constitute an investigation.

16. MEDICAL STAFF MEMBER or MEMBER, means a physician, dentist, oral surgeon or podiatrist who has applied for and who has obtained current Medical Staff membership.

17. MEDICO-ADMINISTRATIVE OFFICER, means a practitioner, employed by or otherwise serving the Hospital on a full-time or part-time basis, whose duties include responsibilities some of which are administrative in nature, some clinical in nature and some both administrative and clinical in nature.

18. ONGOING PROFESSIONAL PRACTICE EVALUATION or OPPE, means ongoing collection, verification and evaluation of data relevant to a Member’s or AHP’s clinical competence and professional behavior.

19. ORAL SURGEON means an individual with a doctor of dental surgery degree or a doctor of dental medicine degree and who has completed an ADA accredited graduate program in oral and maxillofacial surgery or is certified by an accredited Board in oral and maxillofacial surgery.
20. PHYSICIAN, means an individual with a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) degree who is fully licensed in Oregon (or Idaho if provider has only Ambulatory status) to practice medicine in all its phases. The term does not include dentists, medical assistants, or medical students.

21. PODIATRIST, means an individual with a degree in podiatry who is fully licensed in Oregon to practice podiatry in all its phases.

22. PRACTITIONER, whenever the term practitioner appears, unless otherwise expressly provided, shall be interpreted to refer to any appropriately licensed medical professionals permitted by law and by the Hospital to provide patient care services independently and who have applied for or are exercising clinical privileges that allow them to provide patient care services independently.

23. PREROGATIVE means a participatory right granted, by virtue of staff status or otherwise, to a member, or member of the allied health personnel and exercisable subject to the conditions imposed in these Bylaws, and in other Hospital and Medical Staff policies.

24. PROFESSIONAL REVIEW ACTION, is an action or recommendation of a professional review body which is taken or made in the conduct of a professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician.

A. Includes a formal decision not to take action.
B. Includes professional review activities relating to a professional review action.
C. Action is not based on competence or professional conduct if it is based primarily upon:
   1. Professional Memberships;
   2. Fees, advertising or “other competitive acts”;
   3. Participation in health plans;
   4. Participation in group practices;
   5. Any other matter that does not relate to the competence or professional conduct of a physician.

25. PROFESSIONAL REVIEW ACTIVITY means an entity’s activities with respect to individual physicians:
A. To determine clinical privileges or membership.
B. To determine the scope of privileges or membership.
C. To change or modify privileges or membership.

26. RESIDENT, means an individual with a medical degree undergoing specialized training under the supervision of an active staff member.

27. SPECIAL NOTICE, means written notification given either by personal delivery or by certified or registered mail, return receipt requested. Refusal to accept special notice sent by registered mail shall constitute receipt of such notice.
28. STANDING COMMITTEE, means a permanent committee created under these Bylaws to perform a continuing function and consisting of Medical Staff, and in some circumstances, Non-Medical Staff members.

29. INDEPENDENT ALLIED HEALTH PROFESSIONAL (IAHP) means a licensed individual other than a licensed physician who is permitted by law and by the Hospital to provide patient care services independently with an appropriate level of supervision by or in coordination with a physician member of the Medical Staff. IAHPs include: nurse practitioners, nurse midwives, certified registered nurse anesthetists. IAHPs shall not be eligible for membership in the Medical Staff.

30. DEPENDENT ALLIED HEALTH PROFESSIONAL (DAHP) names a healthcare professional who is not permitted by law and/or by the Hospital to provide patient care services independently. A DAHP is an employee of a physician group practice or an employee of an active or provisional member of the Medical Staff who performs a portion of his or her professional responsibilities within the Hospital. DAHPs must remain under the control and general supervision of a physician member of the Medical Staff to insure adequate overall patient protection. DAHPs are not eligible for membership in the Medical Staff.
ARTICLE I.
MEDICAL STAFF MEMBERSHIP

PART A. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of Saint Alphonsus Medical Center - Ontario and/or the exercise of clinical privileges, temporary or otherwise, is a privilege which shall be extended only to professionally competent physicians, dentists and podiatrists, who continuously meet and satisfy the qualifications, standards and requirements set forth in these Bylaws. No physician, dentist or podiatrist is automatically entitled to membership on the Medical Staff or to the exercise of particular clinical privileges merely because of being licensed to practice in this or in any other state, or because of being a member of any professional organization, or because of being certified by any clinical board, or because of having, in the past or present, staff membership or privileges at another health care facility or in another practice setting. Appointment to and membership on the Medical Staff shall confer on the member only such clinical privileges and prerogatives as have been specifically granted by the Board in accordance with these Bylaws.

PART B. BASIC QUALIFICATIONS FOR MEMBERSHIP

Section 1. Basic Qualifications

Only physicians, oral surgeons, dentists and podiatrists licensed to practice in the State of Oregon (or Idaho if provider has only Ambulatory status), who:

A. Document their background, experience, education, training, current competence, physical health status with sufficient adequacy to demonstrate to the Executive Committee and the Board that any patient treated by them will receive care and supervision at a level of quality and efficiency generally accepted in the community;

B. Document that they reside and practice close enough to the Hospital to provide continuous care and supervision of their patients, or document a coverage arrangement acceptable to the Executive Committee and the Board;

C. Document compliance with all requirements set forth in these Bylaws, the Medical Staff rules and regulations, or elsewhere for appointment to the staff status to which the applicant requests appointment, including compliance with professional liability insurance coverage requirements;

D. Board certification or admissibility, or actively pursuing board certification. Medical Staff Member must be Board Certified within (7) years following the successful completion of accredited training. Board Certification is not required for General Dentistry. Failure to do so constitutes a voluntary relinquishment of membership and privileges (without rights to the hearing and appeals process of these Bylaws) and will require reapplication to Saint Alphonsus Medical Center - Ontario once board certification is obtained. Ontario Providers who met prior qualifications for membership will be exempt from board certification and recertification prior to 2007.

E. Are determined, on the basis of documented references,
1. to adhere strictly to the ethics and codes of their respective professions and those applicable to Catholic Health Facilities with respect to their clinical work and other activities within the Hospital;

2. to work cooperatively with others;

3. to be willing to participate in the discharge of staff responsibilities, including peer review and other quality assurance activities;

4. to be currently appropriately licensed; and

5. to have satisfactorily completed;
   a. As to physicians, a minimum of three (3) years post-graduate inpatient training at an accredited training institution;
   b. As to Podiatrists, a minimum of three (3) year post-graduate inpatient training at an accredited training institution;
   c. As to Dentists, their respective medical societies' equivalent training program.

F. Document their ability to provide care to patients at the Hospital in an economical and efficient manner without adversely affecting the general operation of the Hospital; provided, however, that determinations of failure to satisfy this qualification shall be based primarily (but not exclusively) on appropriate comparisons of the practitioner's practice patterns with accepted practitioner practice patterns as the same may be determined and interpreted from time to time by the Executive Committee and/or the Board;

G. Are not currently excluded from any healthcare program, funded in whole or in part by the federal government, including Medicare or Medicaid; shall be eligible for membership on the Medical Staff.

Section 2. Out of State Practitioners.

Practitioners practicing in other states or jurisdictions must have an Oregon license (or Idaho if provider has only Ambulatory status) in order to be admitted to membership in the Medical Staff.

Section 3. Nondiscrimination.

Medical Staff membership or particular clinical privileges shall not be denied on the basis of sex, age, race, creed, color, or national origin, or handicaps that can be accommodated without compromising patient care.

Section 4. Administrative and Medico-Administrative Officers.

A. Without Privileges.

1. A physician, dentist or podiatrist employed by the Hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the Hospital and to the terms of their contract or other conditions of their engagement and need not be a member of the Medical Staff.
B. With Privileges.

1. A medico-administrative officer must be a member of the Medical Staff and must achieve the status by the procedure provided in these Bylaws. The officer's clinical privileges must be delineated in accordance with Article VII herein. The Medical Staff membership and clinical privileges of any medico-administrative officer shall not be contingent upon the officer's continued occupation of that position unless otherwise provided in the officer's Agreement with the Hospital.

PART C. BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Section 1. Basic Responsibilities.

Each member of the Medical Staff shall:

A. Conduct or cause to be conducted a basic medical appraisal of all patients admitted by the member to the Hospital, provide the member's patients with continuous care and supervision, (or arrange a suitable alternative for such care or supervision), thereby providing a level of care generally accepted in the community.

B. Strictly abide by the Medical Staff Bylaws and rules and regulations and by all other standards, policies and rules of the Hospital and the Board, the Ethical and Religious Directives for Catholic Health Care Services with respect to all clinical work and other activities within the Hospital, and the Principles for Medical Ethics of the American Medical Association, which are by this reference incorporated herein.

C. Discharge such staff, service, committee and Hospital functions for which the member is responsible by appointment, election or otherwise.

D. Satisfy the requirements for attendance at all meetings of the staff and of the department and committees to which the member is appointed.

E. Pay all applicable staff dues assessed to each category.

F. Prepare and complete in timely manner the medical and other required records for all patients the member admits or in any way provides care to in the Hospital.

G. Participate in continuing education, peer review and other quality assurance, quality maintenance and patient assessment activities, including serving on ad hoc committees and acting as a proctor/supervisor, and in connection therewith, maintain the confidentiality of all peer review, quality assurance and maintenance and patient assessment activities.

H. Disclose to the appropriate Chief of Service or the Credentials Committee Chief, any information personally known by the member concerning an applicant and/or member which would call into question the ability of the applicant or member to provide quality care or which would raise questions about the morals or professional ethics of the applicant or member.

I. Provide the Hospital and Medical Staff with the member's current mailing and street address.
J. All Physicians (and other practitioners as the Board may determine) must obtain and keep in full force and effect professional liability insurance insuring the members’ professional activities in an amount not less than 1,000,000 per claim/occurrence and 3,000,000 annual aggregate through a company with current requirements as approved by the Board.

K. Disclose to the Credentials Committee Chief involvement in a professional liability action if the Medical Staff member has been named as a Defendant in said action and if the action is pending at the time of application for membership or at the time of reappointment for membership on the Medical Staff. If a final judgment or a settlement has been entered or agreed upon, the applicant or reapplicant shall disclose to the Credentials Committee Chief the fact that a final judgment has been entered or the fact that a settlement has been reached. The terms of the settlement need not be disclosed.

L. Provide, on an annual basis, the Hospital with proof of professional liability insurance coverage in the amounts reflected in paragraph (j) above. (A copy of the member's insurance policy's declarations page is adequate for this purpose.)

M. Immediately, upon notice of any proposed or actual exclusion from any federally funded healthcare program, disclose to the Hospital President/Chief Executive Officer, by telephone call and in writing, any notice to the Member or his or her representative of proposed or actual exclusion and/or any pending investigation of the Member from any healthcare program funded in whole or in part by the federal government, including Medicare or Medicaid.

N. Participate in such emergency service coverage or consultation panels as may be determined by the Medical Executive Committee and/or the Board.

O. Confirmation must be received by the Medical Staff Office that the applicant has successfully completed appropriate SAMC-O electronic health record training prior to admitting or managing patients.

**PART D. DURATION OF APPOINTMENT**

**Section 1. Duration of Appointments to the Provisional Staff.**

Provisional staff appointments shall be for twelve (12) months and may not be renewed more than once for an additional twelve (12) month period for a maximum total term of two (2) years if not able to qualify. If the provisional member fails within that period to furnish the statements required in Article V, Part F, Section 1, the provisional member's staff status or particular clinical privileges, as applicable, shall automatically terminate.

**Section 2. Duration of Temporary and Emergency Privileges.**

Appointments for Temporary and/or Emergency Privileges shall be made on a case-by-case basis as set forth in Parts E of Article VII. The aggregate duration of a physician’s Temporary and Emergency Privileges shall not exceed 120 days within a two year period.

**Section 3. Duration of Other Appointments.**

All other appointments to each category of the Medical Staff shall be for a period of not more than two (2) years, at which time a formal reappointment must occur for the Medical Staff to continue his or her membership.
PART E. LEAVE OF ABSENCE

Section 1. Leave Status.

A Medical Staff member or Allied Health Professional who will voluntarily be away from hospital practice for more than 90 days may, for good cause, be granted a leave of absence by the MEC for a definitely stated period of time not to exceed one (1) year. A leave of absence in excess of one (1) year may be granted on a case-by-case basis. A request to the Chief of the service in which the staff member seeking leave has clinical privileges, shall state the beginning and ending dates of the requested leave, and the reasons the staff member is seeking leave.

Voluntary requests for leave shall be effective only upon satisfaction of the following conditions:

A. the staff member has made arrangements for the continuous care and supervision for his patients in the Hospital;
B. the staff member has been relieved, in writing, of all staff, service, committee and Hospital functions by the applicable service committee chief;
C. the physician has completed all medical and other required records for all patients he admitted or provided care to in the Hospital; and
D. The staff member has provided evidence satisfactory to the Executive Committee and the Board that good cause exists for granting such leave.

The Executive Committee shall review each request for a leave and all applicable information and shall forward to the President/Chief Executive Officer for transmittal to the Board its report and recommendation that the leave be granted or denied. Thereafter, the procedures provided in Article VI, Part D, Sections 6-10 shall be followed.

Those Staff members, who will be away from hospital practice due to medical necessity, will be granted a leave of absence by the Board for a period of time not to exceed one (1) year. A leave of absence in excess of one (1) year may be granted on a case-by-case basis. A request to the Chief of the service in which the staff member seeking leave has clinical privileges, shall state the reason the staff member is seeking leave accompanied by a physician note. Dependent upon the nature of medical leave, the request may come from the family of member. If possible, the Medical Staff member or Allied Health Professional should: (a) make arrangements for the continuous care and supervision for his patients in the Hospital; and (b) complete all medical and other required records for all patients he admitted or provided care to in the Hospital.

Those staff members that enter a diversion program for mental health issue or substance abuse will notify the President/Chief Executive Officer or his designee and will be granted leave of absence.

Those staff members activated/deployed for military duty shall provide notice of the leave of absence to the Chief of Service for transmittal to the Executive Committee and Board. Staff members leaving for military service shall complete all medical and other required records for all patients admitted or provided care by the staff member. Deployed staff members shall make reasonable efforts to provide for continuous care and supervision of patients in the Hospital.

Section 2. Termination of Leave.

If the staff member’s term of appointment will expire during the requested leave of absence, the reappointment process may be followed prior to the start of the leave, with the consent of the Credentials
Committee and Executive Committee. Otherwise, the staff member may pursue reappointment during the leave of absence or allow expiration of privileges. If the staff member’s term of appointment expires during the leave, temporary privileges may be granted for up to 120 days.

At least thirty (30) days prior to the termination of the leave, or at any earlier time, any staff member on a leave of absence must request reinstatement of the member's privileges and prerogatives by submitting a written notice to that effect to the Medical Staff Office for transmittal to the Executive Committee. The staff member shall submit a written summary of his relevant activities during the leave, including activities bearing on maintaining current competence, as well as any other information required for the credentialing process. A practitioner returning from a leave of absence for health reasons must provide a report from his/her physician that answers any questions that the Chief of Service and/or the Officers of the MEC may have as part of considering the request for reinstatement. A practitioner returning from a leave of absence from mental health issue or substance abuse must provide a report from the diversion program that answers any questions that the Chief of Service and/or the Officers of the MEC may have as part of considering the request for reinstatement.

The Executive Committee shall consider the documentation compiled and other relevant information available and shall make a recommendation to the Board concerning the reinstatement of the member's privileges and prerogatives. Failure to request reinstatement or to provide a summary of activities as provided above shall result in termination of staff membership, privileges and prerogatives without right of hearing or appellate review. However, before such termination becomes effective, the President/Chief Executive Officer shall write to the staff member indicating that such termination will become effective within 30 days of the date of the letter unless a written notice as provided above is received within that time. If such notice is not received from the staff member within said 30 days, the termination shall become effective on the 30th day following mailing of said letter to the staff member. Such termination shall not be deemed "adverse." A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

Staff members deployed for military service shall be deemed “inactive” if the term of appointment expires while deployed. Upon return, the staff member shall provide a summary of activities during deployment related to maintenance of clinical competency. The process above shall then be followed to return the staff member’s prior medical staff category.

PART F. MANDATORY MEMBERSHIP

Except as otherwise expressly provided in these Bylaws, no physician, oral surgeon, dentist, or podiatrist shall practice at Hospital without first obtaining membership in the appropriate Medical Staff category delineated in the following Article V.
ARTICLE II.
CATEGORIES OF THE MEDICAL STAFF

PART A. CATEGORIES

The staff shall be divided into categories, which shall include the following: active, courtesy, consulting, provisional, active ambulatory, and emeritus. The staff categories, and certain of the duties and responsibilities associated with each category, are summarized below.

PART B. ACTIVE STAFF

Section 1. Qualifications.

The active staff shall consist of physicians, oral surgeons, dentists, and podiatrists, each of whom:

A. Meets the basic qualifications set forth in Article IV, Part B, Section 1.

B. Regularly admits patients to, or is otherwise regularly involved in the care and supervision of patients in the Hospital.

C. Has an office or residences which, in the opinion of the Executive Committee, are located closely enough to the Hospital to allow provision and continuity of quality care.

D. Except for good cause shown as determined by the Medical Staff, has satisfactorily completed a designated term in the provisional staff category.

Section 2. Prerogatives.

Except as otherwise provided, the prerogatives of an active Medical Staff member are:

A. To admit patients to the Hospital as follows:

1. A physician member of active staff may admit patients without limitation.

2. A qualified oral surgeon member trained and granted privileges to conduct basic medical appraisals may admit patients without concomitant medical problems and assess the medical risks of the proposed surgical procedure.

3. A dentist member may admit patients provided it is demonstrated at the time of admission that a physician member of the Medical Staff has assumed responsibility for the basic medical appraisal of the patient and for the care of any medical problem that may be present or may arise during Hospitalization. The admitting dentist shall be responsible for that part of the basic medical appraisal for the dentist's patients that relates to dentistry.

B. Exercise such clinical privileges as are granted to the member pursuant to these Bylaws.
1. Vote on all matters presented at meetings of the Medical Staff and of services and committees to which the member is appointed.

2. Hold office in the staff organization and in the service and committees to which the member is appointed.

Section 3. Responsibilities.

Each member of the active staff shall:

A. Assume and continuously meet all basic responsibilities set forth in Article IV, Part C, Section 1.

B. Attend staff and service meetings and meetings of committees to which the active Medical Staff member has been appointed.

C. Perform all on-call duties and assignments assigned to such member by the service chief and approved by the Executive Committee with the exception of any physician excused by the Chief of the Service to which he or she is assigned with approval of the Executive Committee. All on-call duties, assignments, and any exceptions shall be reviewed at each reappointment period.

D. Pay such dues as may be required of members of active staff.

PART C. COURTESY STAFF

Section 1. Qualifications.

The courtesy Medical Staff shall consist of physicians, oral surgeons, dentists, and podiatrists, each of whom:

A. Qualifications. Continuously meets the general qualifications set forth in Article IV, Part B, Section 1;

B. Limited involvement. A Member of Courtesy Medical Staff:

1. Shall perform at least one (1) procedure each year;

2. Shall not perform more than twelve (12) procedures (as defined in subsection (e) below) in a calendar year.

C. Peer Review. Is within one of the following two categories:

1. Is a physician member of the Active Staff, or its equivalent, at another Hospital and is subject to professional peer review; or

2. Is a dentist or podiatrist;

D. Provisional Staff. Has satisfactorily completed a designated term in the provisional staff category (the proctorship required by Article VII, Part C, Section 1, may be waived by the Medical Executive Committee as provided in said Article);
E. Definition of Procedures. "Procedures" as used in this Section 1, means, in the aggregate:

1. As to all physicians, dentists or podiatrists: inpatient procedures, outpatient procedures, and admissions, but does not include situations where the physician, oral surgeon, dentist, or podiatrist acts as the assistant;

2. As to pathologists, anesthesiologists, and radiologists: the reading of diagnostic films, review of test results, and the provision of any other test review services.

F. Pay such dues as may be required of members of courtesy staff.

Section 2. Prerogatives.

Except as otherwise provided, the courtesy Medical Staff members shall be entitled to:

A. Admit patients to the Hospital within the limitations provided in this Article V, Part C, Section 1(b);

B. Exercise such clinical privileges as are granted pursuant to these Bylaws; and

C. Attend meetings of the Medical Staff and the service to which the member is appointed, including open meetings and educational programs, but shall have no right to vote at such meetings, except within those committees where the right to vote is specified at the time of appointment.

Courtesy staff members shall not be eligible to vote at staff meetings or hold office in the Medical Staff organization or become members of any standing committee of this Medical Staff organization except as may be specified at time of appointment.

Section 3. Responsibilities.

Each member of the courtesy staff shall:

A. Meet the basic responsibilities set forth in Article IV, Part C, Section 1.

B. Attend meetings of those committees to which the member is appointed.

Section 4. Limitation.

Courtesy staff members who perform more than twelve (12) procedures or who regularly admit patients or who regularly care for patients at the Hospital shall be obligated, following review and recommendation by the Medical Executive Committee, to seek appointment to the active staff category.

The 12 procedure requirement or the need to seek appointment to medical staff can be waived by the Executive Committee, under extraordinary conditions, for a physician who is providing a critical need such as providing coverage for emergency department patients. This would be for 90 days, but can be extended for additional 90 day periods if the critical need persists.
PART D. CONSULTING STAFF

The Consulting Staff consists of physicians who are recognized specialists and who:

A. Are willing to serve in a consulting capacity;

B. Are members of the Active or Provisional Medical Staff of another appropriately accredited Hospital (although exceptions to this requirement may be made by the Medical Executive Committee); and

Members of the Consulting Staff shall provide their services in the care of patients whenever reasonably possible on request of any member of the Active, Courtesy, or Provisional Staff. Members of the Consulting Staff will not have independent admitting privileges. They are not eligible to hold office in the Medical Staff; pay such dues as may be required of members of Consulting staff; they are not required to attend meetings of Medical Staff nor have the right to vote at such meetings. Members of Consulting Staff must have a license allowing them to practice in the State of Oregon (or Idaho if the provider has only Ambulatory status). When permitted by law, a member of the Consulting Medical Staff may provide telemedicine or video-medical services.

Section 1. Responsibilities.

Each member of the Consulting Staff shall:

A. Assume and continuously meet all basic responsibilities set forth in Article IV Part C Section 1.

B. Attend staff and service meetings and meetings of committees as may be requested by the Credentials Committee, the Executive Committee, service chief, or the President/Chief Executive Officer.

C. Perform all on-call duties and assignments assigned to such member by the service chief and approved by the Executive Committee.

D. Pay such dues as may be required of members of consulting staff.

PART E. LOCUM TENENS STAFF

Section 1. General Statement.

In light of a general, on-going, shortage of a variety of health care professionals in the community served by the Hospital, the Hospital is committed to fostering long-term relationships with providers who serve the Hospital’s community on a temporary or locum tenens basis. Although these providers may not be interested in permanently relocating to the community served by the Hospital, they are often interested in assisting the Hospital with meeting a short-term community needs. A Locum Tenens Staff must meet nearly all of the requirements and qualifications of an Active Provisional Staff Member.

The exceptions being:

A. Provided the Locum Tenens Staff lodges near the Hospital during times of local assignments, the Locum Tenens Staff shall not be required to maintain a permanent residence or practice in or near the community served by the Hospital;
B. provided the Locum Tenens Staff receives formal reappointment every two years, the aggregate duration of appointment is not limited (but can be limited by the Board or the President/Chief Executive Officer);

C. the Locum Tenens Staff is not required to advance or seek to advancement to the Active or Courtesy Staff; and

D. the minimum number of procedures the Locum Tenens Staff must perform at the Hospital is three (3) during a one-year period;

E. the maximum number of days a Locum Tenens Staff can work at the Hospital is Two Hundred Forty (240) days every two years;

F. Proctoring requirements will be decided per the service the Locum Tenens practices or the MEC.

Section 2. Qualifications.

The Locum Tenens Staff may consist of physicians, dentists, podiatrist, each of whom must be appointment pursuant to Article IV, Part D, Section 3 and meet the following:

A. Qualifications. Except as provided in subsection (c) of this Section 1, meets the general qualifications set forth in Article IV, Part B, Section 1;

B. Admits patients to, or is otherwise involved in the care and supervision of patients in the Hospital.

C. Typically maintains a permanent residence outside of the community served by the hospital; but during the terms of local assignment (as determined by the Board or President/Chief Executive Officer), lodges or resides close enough to Hospital to allow provision and continuity of quality care.

D. Limited involvement. An individual may not be a Locum Tenens Staff if it would be more appropriate for the individual to serve on the Active, Courtesy, Consulting, or Provisional Staff.

E. Pays such dues (if any) as may be required of members of the Locum Tenens Staff applicable to the terms of appointment or terms of local assignment.

Section 3. Prerogatives.

During the terms of local assignment and except as otherwise provided in these Bylaws, the prerogatives of a Locum Tenens Staff are:

A. To admit patients to the Hospital as follows:

1. A physician member of Locum Tenens Staff may admit patients without limitation during the terms of local assignment as assigned by the Credentials Committee or President/Chief Executive Officer.
2. A qualified oral surgeon member trained and granted privileges to conduct basic medical appraisals may admit patients without concomitant medical problems and assess the medical risks of the proposed surgical procedure.

3. A dentist member may admit patients provided it is demonstrated, at the time of admission that a physician member of the Medical Staff has assumed responsibility for the basic medical appraisal of the patient and for the care of any medical problem that may be present or may arise during Hospitalization.

4. The admitting dentist shall be responsible for that part of the basic medical appraisal for the dentist's patients that relates to dentistry.

B. Exercise such clinical privileges as are granted to the member pursuant to these Bylaws.

C. Locum Tenens Staff members shall not be eligible to vote at staff meetings, be an officer of the Medical Staff, or serve as a member of a standing committee of the Medical Staff organization except as may be specified for each term of local assignment.

Section 4. Responsibilities.

Each member of the Locum Tenens Staff shall:

A. Assume and continuously meet all basic responsibilities set forth in Article IV, Part C, Section 1.

B. Attend staff and service meetings and meetings of committees as may be requested by the Credentials Committee, the Executive Committee, service chief, or the President/Chief Executive Officer.

C. Perform all on-call duties and assignments assigned to such member by the service chief and approved by the Executive Committee.

PART F. PROVISIONAL STAFF

Section 1. Qualifications.

The Provisional Staff shall consist of physicians, oral surgeons, dentists, and podiatrists, each of whom:

A. Is eligible for advancement to full Active, full Courtesy, or full Active Ambulatory staff membership and, in the ordinary course of events, will be advanced to Active, Courtesy, or full Active Ambulatory staff status after serving not more than two years on the Provisional Staff.

B. Meets the basic qualifications specified in Article IV, Part B, Section 1.

Section 2. Prerogatives of Provisional Active Staff.

The prerogatives of a Provisional Active Staff member shall be to:
A. Admit patients to the Hospital under the same conditions as specified for Active Staff members (see this Article V, Part B, Section 2(a)).

B. Exercise such clinical privileges as are granted to him or her pursuant to these Bylaws.

C. Vote on all matters presented at general and special meetings of the Medical Staff, and the service and committees to which the member is appointed.

Provisional Active Staff members shall not be eligible to hold office in this Medical Staff organization and will not be required to pay dues the remainder of the first fiscal year they are appointed.

Section 3. Prerogatives of Provisional Courtesy Staff.

The prerogatives of a Provisional Courtesy Staff member shall be to:

A. Admit patients to the Hospital under the same conditions as specified for courtesy staff members (see this Article V, Part C, Section 2(a)).

B. Exercise such clinical privileges as are granted to the member pursuant to these Bylaws.

C. Pay such dues as may be required of members of the Courtesy Staff.

Provisional Courtesy Staff members shall not be eligible to vote or to hold office in this Medical Staff organization.

Section 4. Prerogatives of Provisional Active Ambulatory Staff.

The prerogatives of a Provisional Active Ambulatory Staff member shall be to:

A. Exercise such clinical privileges as are granted to the member pursuant to these Bylaws.

Provisional Ambulatory Staff members shall not be eligible to hold office in this Medical Staff organization and will not be required to pay dues the remainder of the first fiscal year they are appointed.

Section 5. Responsibilities.

Each member of the Provisional Medical Staff shall be required to discharge the same responsibilities as those specified for members of the Active Medical Staff, Courtesy Medical Staff, or Ambulatory Active Medical Staff respectively. (See this Article IV, Part B and Part C.) Failure to discharge such responsibilities shall constitute grounds for denial of advancement to Active Staff membership or Courtesy Staff membership.

Section 6. Observation and Confirmation Requirements.

Each Provisional Staff member shall be assigned to a service where the member's performance shall be observed by the chief of the service or such chief's designee, and may be observed by a committee of service members appointed by the chief, to determine eligibility for membership in the staff category to which the member may seek appointment and for exercising the clinical privileges requested. In evaluating a Provisional Medical Staff member at the close of the provisional period,
courtesy status may be granted even if the applicant had minimal activity during the provisional period providing that the Provisional Medical Staff member is on the active staff of another JCAHO accredited institution, has adequate professional references from that institution, and his expertise will contribute to patient care at Saint Alphonsus Medical Center - Ontario. A Provisional Medical Staff member shall not be advanced to the Active Staff or Courtesy Staff until the member has furnished to the Executive Committee and to the President/Chief Executive Officer:

A. A statement signed by the chief of the service to which the member is assigned and of each service in which the member exercises privileges that the Provisional Staff member meets all of the qualifications, has discharged all of the responsibilities, and has not exceeded or abused the prerogatives of the provisional staff category.

B. A statement signed by the chief that the Provisional Staff member has demonstrated the ability to exercise the clinical privileges granted to or requested by the Provisional Staff member and has demonstrated the ability to work cooperatively with others.

C. A statement reflecting approval by the Credentials Committee, Executive Committee, and Board of the change in status from Provisional to Active or Courtesy Staff.

PART G. ACTIVE AMBULATORY STAFF

Section 1. Qualifications.

Appointees to the Active Ambulatory Medical Staff must:

A. Continuously meets the general qualifications set forth in Article IV, Part B, Section 1, Article IV, Part C, Section 1, with the exception of item (n)

B. Be a primary care provider. For purposes of the Active Ambulatory Medical Staff category, “primary care provider” shall include the following physicians: family medicine, internal medicine, occupational medicine and pediatricians.

Section 2. Prerogatives.

Appointees to the Active Ambulatory Medical Staff category may:

A. May attend staff and service meetings and meetings of committees to which the member is appointed.

B. Shall pay such dues as may be required of members of Ambulatory Medical Staff.

PART H. EMERITUS STAFF

Section 1. Qualifications.

A physician, oral surgeon, dentist, or podiatrist who has been on the active Medical Staff and who wishes to withdraw from active Medical Staff membership may, at the member's request, advance to the emeritus staff category. The emeritus staff shall be considered retired from active practice.

Section 2. Prerogatives.
Emeritus staff members are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital. The prerogatives of an emeritus staff member shall be to attend staff and department meetings and any staff or Hospital educational meetings. Emeritus staff members shall not vote, shall not hold office, and shall not be members of standing committees of the Medical Staff.

PART I. LIMITATION OF PREROGATIVES

The prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a practitioner's staff membership, by other sections of these Bylaws, and by other policies of the Hospital.

PART K. MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a member, the Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of these Bylaws.

ARTICLE III.

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

PART A. GENERAL PROCEDURE

The Medical Staff, through its services, committees and officers, shall investigate and consider each application for appointment or reappointment to any staff status and each request for modification to staff status and shall adopt and transmit recommendations thereon to the Board. The Medical Staff shall also perform these same investigation, evaluation and recommendation functions in connection with any individual who is not eligible for Medical Staff membership (i.e., allied health personnel) but who seeks to exercise clinical privileges or to hold staff status other than as a member.

PART B. APPLICATION FOR INITIAL APPOINTMENT

Section 1. Application Form.

Each application for appointment to staff status shall be submitted electronically. A $300.00 application fee will be submitted with the application for membership and/or privileges. The forms shall be obtained from the President/Chief Executive Officer or his designee.

Section 2. Content.

The application form shall include but shall not be limited to:

A. Acknowledgment and Agreement: A statement that the applicant has received, read and been oriented in the Bylaws and rules and regulations of the Medical Staff and that the applicant agrees to be bound by the terms thereof if the applicant is granted staff status and/or clinical privileges, and to be bound by the terms thereof in all matters relating to consideration of the applicant's application without regard to whether or not staff status is granted.
B. Qualifications: Detailed information concerning the applicant's qualifications, including information in satisfaction of the basic qualifications specified in Article IV, Part B, and of any additional qualifications specified in these Bylaws, the Medical Staff rules and regulations, or elsewhere for the particular staff status to which the applicant requests appointment.

C. Requests: Specific requests stating the staff status and clinical privileges for which the applicant wishes to be considered.

D. References: The names of at least three (3) peers who have worked with the applicant and observed the applicant's professional performance in the recent past and who can provide reliable information based on significant personal experience as to the applicant's current competence, ethical character and ability to work with others and other qualifications for eligibility under these Bylaws. One (1) of the 3 peers must include the department chair at their current hospital or training director if within 5 years of training. In the case of any applicant other than a physician applicant, the applicant shall, in addition to peer references, list at least one (1) physician reference.

E. Other Facilities: The name and addresses of all other health care facilities or settings where the applicant has provided clinical services in the past 10 years.

F. Work History: The name and addresses of all employment for the past 10 years.

G. Professional Sanctions: Information as to whether the applicant's staff status and/or clinical privileges have ever been revoked, suspended, reduced, or not renewed (voluntarily or involuntarily) at this or any other Hospital or health care institution or whether any proceeding is pending or has been instituted which, if decided adversely to the applicant, would result in any of the foregoing. Information as to whether any of the following have ever been (voluntarily or involuntarily) suspended, restricted, revoked or denied:

1. Membership/fellowship in local, state or national professional organizations;

2. Specialty board certification;

3. License to practice any profession in any jurisdiction; or

4. Drug Enforcement Agency (DEA) number. If any such actions were ever taken or instituted or are pending, the particulars thereof shall be included.

H. Professional Liability Insurance: In the case of physicians, dentists and podiatrists, a statement that the applicant carries at least the minimum amount of professional liability insurance coverage as required by these Bylaws (see Article IV, Part C,1,(J)) and information on the applicant's malpractice claims history and experience for the past 10 years, including a consent to the release of information by his present and any past professional liability insurance carriers and a waiver of any privilege relating thereto. The applicant shall provide proof of insurance coverage with a certificate of insurance or other appropriate evidence, in a form acceptable to the Hospital. If the application is for staff status as a medical assistant and the applicant is an employee or independent contractor of a staff member, the application shall include a provision for indemnification of the Hospital and Medical Staff signed by such staff member indemnifying the Hospital and Medical Staff against all claims and losses arising out of the acts or omissions of the applicant.
I. Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions of Article XVII.

J. Administrative Remedies: A statement whereby the applicant agrees that, if an adverse ruling is made with respect to the applicant's staff status or clinical privileges, the applicant's will exhaust the administrative remedies afforded by these Bylaws before resorting to legal action.

K. Identification: The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following:
   1. A current picture hospital ID card
   2. A valid picture ID issued by a state or federal agency (e.g., driver's license or passport)

L. Licenses: The submitted application shall include a copy of all the applicant's current and past out of state licenses to practice, as well as any narcotics licenses.

M. Other: Such other information as the Executive Committee or the Board may require.

PART C. EFFECT OF APPLICATION


By applying for appointment or reappointment, the applicant:

A. Signifies the applicant's willingness to appear for all interviews in regard to the applicant's application.

B. Authorizes Hospital representatives to consult with others who have been associated with the applicant and/or who may have information bearing on the applicant's competence and qualifications, whether or not such other persons are listed as references by the applicant, and authorizes persons consulted with to provide such information.

C. Consents to the inspection by Hospital representatives of all records and documents that, in the sole opinion of any Hospital representative, may be pertinent to an evaluation of the applicant's licensure, specific training, experience, current competence, and physical and mental health and emotional stability.

D. Releases from any liability all Hospital representatives for their acts performed in connection with evaluating the applicant and the applicant's credentials.

E. Releases from any liability all individuals, corporations and organizations who provide information, including otherwise privileged or confidential information, to the Hospital and Hospital representatives concerning the applicant's competence, training, experience, background, professional ethics, character, physical and mental health, emotional stability and other qualifications for the requested staff status and/or clinical privileges.

F. Authorizes and consents to Hospital representatives providing
   1. other Hospitals,
2. governmental and quasi-governmental entities, and

3. professional associations and other organizations concerned with provider performance

4. and the quality and efficiency of patient care which associations and organizations have been reviewed and approved by the Executive Committee,

5. with any information the Hospital or the Hospital representatives may have concerning the applicant, and releases the Hospital and Hospital representatives from liability for so doing; provided that such furnishing of information is done without malice and provided that if the Medical Staff applicant has not requested that the information be provided, that the Medical Staff applicant is given timely notice that the information is being furnished.

G. Agrees to be bound by all the provisions hereof, the Medical Staff rules and regulations and the policies of the Hospital, including all those in force during the pendency of the applicant's application and time of the applicant's appointment.

H. Represents and warrants to the Hospital and the Medical Staff that all information provided by the applicant is true, correct and complete in all material respects and agrees to indemnify the Hospital and the Medical Staff from any liability or loss resulting from a breach of the representation and warranty; and further agrees that material misstatements, false statements, inaccurate, incomplete statement, omission or misleading statements may be grounds for suspension or termination with a hearing under Article XI.

I. Agrees that updated information will be provided as soon as practicable concerning each change to a response to any question on the application or reappointment application.

J. Agrees that any lawsuit brought by the applicant against an individual or organization providing information to a Hospital representative or against a Hospital representative shall be brought in a Court, federal or state, in the state in which the Defendant resides or is located.

K. Pledges to provide continuous quality care for his/her patients.

L. Agrees to a physical or mental status evaluation as the MEC may require by a physician mutually agreed upon by the parties or, in case of disagreement, a physician determined by the Board. Taking or passing a physical or mental examination must not be part of the application process, but the exercise of clinical privileges that are otherwise granted may be made subject to the successful completion of such examination.

For purposes of this section, the term "Hospital representative" includes the Board, its individual members and committees; the President/Chief Executive Officer; and all Medical Staff members, services and committees which have responsibility for collecting or evaluating the applicant's credentials or acting upon his application; and any authorized representative of any of the foregoing (which authorization need not be in writing), including legal counsel for such Hospital representatives.

**PART D. PROCESSING THE INITIAL APPOINTMENT APPLICATION**

Section 1. Applicant's Burden.
The applicant shall have the burden of producing adequate information for a proper evaluation of the applicant's qualifications, experience, background, training, ability, professional ethics, physical health status and, upon request of the Executive Committee or the Board, mental health status and emotional stability, and of resolving any doubts about these or any of the other basic qualifications specified in these Bylaws. Action on the application shall not be taken until said information has been made available and verified.

Section 2. Verification of Information.

The applicant shall deliver a completed application to the Credentials Verification Office, who, in a timely fashion, through the Medical Staff office, shall do the following for new applicants:

A. Verify the applicant’s current licensure (documented internet or phone verification is acceptable), specific training, experience and current competence through appropriate primary sources;

B. Verify Board Certification;

C. Query the National Practitioner Data Bank;

D. Verify professional liability insurance coverage;

E. Verify professional malpractice claim information;

F. Assure the presence of completed administrative and clinical reference questionnaires and all other required forms and consents;

G. Assure the presence of the required peer references;

H. Verify the status of privileges at other health care facilities for the past 10 years;

I. Verify employment history for the past 10 years;

J. Obtain an AMA Master file report, as appropriate. If no AMA is available, Verification of Medical School, Post Graduate Training, Fellowship, or any other Professional Training;

K. Check for sanctions and exclusions through the Office of the Inspector, System Award Management, and Medicare Opt Out;

L. Verify NPI;

M. Perform a Criminal Background check for the past 10 years.

N. Verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents:

1. A current picture hospital ID card.
2. A valid picture ID issued by a state or federal agency (e.g., driver’s license or passport).

The Credentials Verification Office shall notify the applicant of any failure of others to respond to such collection or verification efforts. After such notice, the applicant shall have the obligation to
obtain responses to requests for information. (See Section 11 of this Article regarding time limits and extension of time for good cause.) When collection and verification is accomplished by receipt of responses from all persons or entities so contacted, the Credentials Verification Office shall transmit the application and all related materials to the chief of each service in which the applicant seeks privileges and to the Credentials Committee.

Acceptance of Primary Source Verification: All documents that have been sourced verified by another Joint Commission Accredited Saint Alphonsus Health System hospital may be accepted by Saint Alphonsus Medical Center – Ontario.

Section 3. Service Action.

Upon receipt, the chief of each such service shall review the application and related documentation and may conduct a personal interview with the applicant, and transmit to the Credentials Committee a recommendation as to staff status and/or clinical privileges to be granted, and any special conditions recommended to be attached to the appointment. The chief, in his discretion, may require that the applicant be interviewed by other members of the Medical Staff.

Any person currently holding an appointment to the Medical Staff shall have the right to appear in person before the Chief of the Credentials Committee to discuss in private and in confidence any concerns the person may have about the applicant.

A service chief may also recommend that the Executive Committee defer action on the application. The reason for each recommendation and any proposed special conditions shall be concisely stated in the report.

A service chief, to the extent appropriate, may delegate to other members of his service, the duties and responsibilities set forth in this Section 3.

Section 4. Credentials Committee Action.

Within thirty (30) days following receipt of the completed application, the Credentials Committee shall review the related documentation compiled, and such other information available to it that may be relevant to consideration of the applicant's qualifications for the staff status requested. The Credentials Committee may conduct, if it so desires, a personal interview with the applicant. The Credentials Committee shall then transmit to the Executive Committee a written report including its recommendations that the applicant be provisionally appointed, that the applicant be rejected for Medical Staff membership, or that the action be deferred. If appointment is recommended, the report shall also contain recommendations as to service assignment, clinical privileges to be granted and any special conditions to be attached to the appointment. The reason for each recommendation shall be concisely stated. Any minority views shall also be reduced to writing, supported by concise statements of reasons and transmitted with the majority report.

Section 5. Executive Committee Action.

A. Executive Committee: At its next regular meeting after receipt of the Credentials Committee report and recommendations, the Executive Committee shall consider the report, the application, the related documentation compiled and other relevant information available to it. The Executive Committee may conduct, if it so desires, a personal interview with the applicant. The Executive Committee shall then forward to the President/Chief Executive Officer for transmittal to the Board, the application, related documentation and relevant information and a written report and recommendation as to staff status and, if appointment is
recommended, as to service assignment, clinical privileges to be granted and any special conditions to be attached to the appointment. The Executive Committee may also defer action on the application pursuant to Section 6 (a) of this part. The reasons for each recommendation shall be concisely stated. Any minority views shall also be reduced to writing, supported by concise statements of reasons, and transmitted with the majority report.

B. Withdrawal: An applicant may at any time withdraw his or her application from further consideration in which case the application shall not be transmitted to the Board for action. An application which is withdrawn shall not be deemed rejected or denied provided that it is withdrawn prior to the conduct of a hearing under Article XI.

Section 6. Effect of Executive Committee Action.

A. Deferral: Action by the Executive Committee to defer the application for further consideration must be followed up within thirty (30) days of deferral with a subsequent favorable or adverse recommendation.

B. Favorable Recommendation: When the recommendation of the Executive Committee is favorable to the applicant, the President/Chief Executive Officer shall promptly forward it, together with the application and all related documentation, to the Board.

C. Adverse Recommendation: When the recommendation (including those made after deferral) of the Executive Committee is adverse to the applicant, the President/Chief Executive Officer shall promptly so inform the applicant by special notice. If the applicant is a physician, dentist or podiatrist, the applicant shall be entitled to the procedural rights as provided in Article XI. For the purposes of this section, an "adverse recommendation" by the Executive Committee is as defined in Article X, Part A, Section 5(b).

Section 7. Board Action.

A. On Favorable Executive Committee Recommendation: The Board shall, in whole or in part, adopt or reject a favorable recommendation of the Executive Committee, or refer the recommendation back to the Executive Committee for further consideration stating the reasons for such referral back and setting a reasonable time limit within which a subsequent recommendation shall be made. If the Board's action is adverse to the applicant as defined in Article X, Part A, Section 5(b), the President/Chief Executive Officer shall promptly so inform the applicant by special notice. If the applicant is a physician, dentist or podiatrist, the applicant shall be entitled to the procedural rights as provided in Article XI.

B. Without Benefit of Executive Committee Recommendation: If the Board does not receive an Executive Committee recommendation within the time period specified in this Article VI, Part D, Section (11), it may after five (5) days notice to the Executive Committee take action on its own initiative. If such action is favorable, it shall become effective as of the decision of the Board. If such action is adverse, as defined in Article XI, Part A, Section 2(b), the President/Chief Executive Officer shall promptly so inform the applicant by special notice. If the applicant is a physician, dentist or podiatrist, the applicant shall be entitled to the procedural rights as provided in Article XI.

C. After Procedural Rights: In the case of an adverse Executive Committee recommendation pursuant to this Article VI, Part D, Section 6(c) or an adverse Board decision pursuant to this Article VI, Part D, Section 7(a) or 7(b), the Board shall take final action in the matter only
after the applicant has exhausted or has waived the applicant's procedural rights as provided in Article XI, if the applicant is a physician, dentist, or podiatrist. Action thus taken shall be the conclusive decision of the Board, except that the Board may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore and shall set a reasonable time limit within which a subsequent recommendation to the Board shall be made. After receipt of such subsequent recommendation, the Board shall make a final decision.

Section 8. Denial for Reasons Other than Professional Conduct or Competence.

A recommendation by the Executive Committee, or a decision by the Board, to deny staff status or particular clinical privileges either:

A. Because the Hospital does not then provide adequate facilities for supportive services for the applicant and the applicant's patients, for whatever reason, including but not limited to utilization levels then existing or services not then offered; or

B. Because of inconsistency with the Hospital's plans in respect to its development, including the mix of patient care services to be provided, as currently being implemented;

1. shall be considered adverse and shall entitle the applicant, if a physician, dentist or podiatrist, to the procedural rights as provided in Article XI; provided, however, that, in a proceeding under Article XI, a determination made without malice by the Board not to offer a service or not to expand a service, or a determination made without malice by the Board that Hospital facilities are not adequate or appropriate for the offering or expansion of a service shall not be subject to challenge with regard to the validity or appropriateness of such determination. A denial of staff status or particular clinical privilege pursuant to this Section 8 shall not trigger the reporting requirements of the National Practitioner Data Bank law.


A. Notice of the Board's decision shall be given, in writing, to the Chief of the Executive Committee, to the Chief of the Credentials Committee, to the Chief of each service concerned and to the applicant

B. A decision and notice to appoint shall be in writing and shall include: (1) the staff status to which the applicant is appointed; (2) the service to which the applicant is assigned; (3) the clinical or service privileges the applicant may exercise; and (4) any special conditions attached to the appointment.

Section 10. Reapplication after Adverse Appointment Decision.

Any applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply for a period of two (2) years from the date of the final adverse decision. These two (2) years can be modified if the applicant can show good cause for waiving the two (2) year period. Any such reapplication shall be processed as an initial application.

Section 11. Time Periods for Processing.
A. President/Chief Executive Officer. Applications for staff appointment shall be considered in a timely manner by all individuals and committees required by these Bylaws to act thereon, shall be processed within the time limits specified in any applicable law and, except for good cause, shall be processed within the time periods specified in this Section. If the application is complete and if all references have responded, and all other information has been provided by the applicant, the Credentials Verification Office shall transmit the complete application to the applicable Chief of Service and to the Credentials Committee within ninety (90) days after receiving the application unless there is a legitimate reason for an extension and good cause has been shown in which event the President/Chief Executive Officer may allow ten (10) additional days for applicant to complete the application. If, however, the application is not complete, references have not responded, or there is a legitimate reason for an extension, the Chief Executive Officer shall proceed as follows:

1. Incomplete Application. If the application is incomplete, the Credentials Verification Office shall notify the applicant, in writing, and will allow the applicant ten (10) additional days to complete the application.

2. References Responses Not Received. If the applicant’s references have not been received within the ninety (90) day period, the Credentials Verification Office will notify the applicant in writing and will provide the applicant ten (10) additional days to obtain the references.

3. Good Cause. If the applicant notifies the President/Chief Executive Officer of some other problem with the application, and further shows good cause why an additional ten (10) days should be allowed, then the President/Chief Executive Officer may allow ten (10) additional days to the applicant.

   a. Should the applicant fail to complete the application within the ten (10) additional days; or if responses from the applicant's references are not received within the ten (10) additional days; or if good cause is not shown why the ten (10) day extension should be allowed (or if allowed, at the end of the ten (10) days the deficiency has not been corrected), then the application shall be deemed rejected. Such rejection shall not be deemed to be adverse to the applicant and the applicant may reapply.

B. Chief of Service and Credentials Committee. The Chief of Service and Credentials Committee shall act upon an application within thirty (30) days following receipt of the completed application.

C. Executive Committee. The Executive Committee shall process the application at the next regular meeting following receipt of the Credential Committee's report. The Executive Committee, shall make its initial recommendation to the Board within sixty (60) days from the date that the application was transmitted by the Credentials Committee and Chief of Service to the Executive Committee.

D. Board. The Board (or its applicable sub-committee) shall take action on the application within sixty (60) days following receipt of final recommendation from the Executive Committee.

PART E. DELEGATED CREDENTIALING

Section 1. CREDENTIALING AND PRIVILEGING
Centers for Medicare and Medicaid (CMS) allow for a process for originating site hospitals (location of the patient) to rely on the credentialing and privileging decisions of the distant site hospital (location of the specialist) for practitioners providing services via telemedicine.

In order for the originating site Saint Alphonsus Medical Center - Ontario to utilize credentialing and privileging information from the distant site in credentialing and privileging decisions, the following conditions must be met:

A. The distant site must be Joint Commission (TJC) accredited and a Medicare participating hospital;
B. The practitioner must be currently privileged at the distant site for the services to be provided at the Saint Alphonsus Medical Center - Ontario and provide a current list of the practitioner’s privileges;
C. The distant site practitioner holds a current state issued license in the state of Oregon;
D. A current agreement must be in place between the Saint Alphonsus Medical Center - Ontario and the distant site which clearly describes in detail, credentialing and privileging procedures that meet or exceed the same standards as Saint Alphonsus Medical Staff – Ontario Members providing hands on medical care and;
E. Saint Alphonsus Medical Center - Ontario must have evidence of an internal review of the practitioner’s performance of their privileges and sends information that is useful to assess the practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information will include all adverse outcomes related to sentinel events, considered reviewable by the TJC that result from the telemedicine services provided and complaints from patients, other practitioners, or staff.

Additionally, remote sites may rely on Saint Alphonsus Medical Center - Ontario credentialing within the limits of TJC and CMS rule with current agreement in place.

**PART F. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)**

**Section 1. Maintaining Privileges**

Ongoing evaluation will allow the organized Medical Staff to identify professional practice trends that impact quality of care and patient safety or data that will trigger more in-depth review. Triggers will be defined by individual Services. Such identification may require intervention by the organized medical staff.

In an effort to evaluate providers that hold privileges, the Medical Staff Office in conjunction with the Quality Department, and Health Information Department will collect and display data approximately every six (6) months (not to exceed 12 months) that will allow the Quality and Safety Committee to evaluate the performance of clinical practice and/or competence of providers of the Medical Staff.

The data includes analysis of zero or low volume privilege performance by the practitioner (as determined by the Quality and Safety Committee).
A. Zero or low volume performance of a privilege evaluated to determine possible reasons, including:
   1. The practitioner is no longer performing the privilege
   2. The practitioner is performing this privilege at another institution
   3. The privilege is a low volume procedure that has yet to be done

The Quality and Safety Committee will receive OPPE reports as outlined above and one of the following recommendations will be made based on trends and triggers:

A. No adverse trends or triggers were identified during the review period and performance is within acceptable thresholds, or
B. Trends and triggers cause in-depth review and performance does not warrant a more specific evaluation; or
C. Concerns or adverse trends identified through the OPPE process will initiate a more specific evaluation (FPPE). Such recommendation will be reported to the Medical Executive Committee for their review and recommendation. Based on this analysis, several possible actions could occur, including but not limited to:
   1. Revoking the privilege because it is no longer required
   2. Suspending the privilege(s)
   3. Determining that the zero or low performance of a procedure should trigger a focused review whenever the practitioner actually performs the privilege

Section 2. Peer to Peer Support

Saint Alphonsus recognizes that peer to peer support for Medical Staff Members who have been involved in an unexpected adverse event or other significant patient care matter ("event") is an important and desirable element of an effective peer review process ("Peer to Peer Support"). Peer to Peer Support at Saint Alphonsus is confidential and protected under Idaho Code Section 39-1392 et seq. and Oregon Rev. Statutes 41.675.7. Peer to Peer support involves providing support to impacted Medical Staff Members in the form of listening, mentoring, informal, non-clinical counsel, and potential referral to other support services to help the Medical Staff Member on a personal level in follow up to an event. Medical Staff Members may be referred to the Medical Director of the Peer to Peer Support Program through the Case Identification Processes outline in this policy. The Medical Director of the Peer to Peer Support Program will then triage and refer appropriate matters to a Peer to Peer supporter, who may offer support to the identified Medical Staff Member. Peer to Peer Support is intended to provide personal support to Medical Staff members as part of the peer review process, but is separate from, and not intended to supplant, the evaluation of events and data by the Medical Staff and Saint Alphonsus to determine whether opportunities for improvement exist or whether other follow up under the Medical Staff Bylaws is necessary.

PART G. REAPPOINTMENT PROCESS
Section 1. Information Form for Reappointment.

Within one hundred fifty (150) days of expiration of the reappointment of applicant's staff membership, the Credentials Verification Office shall deliver a Request for Reappointment to a reappointment applicant.

The reappointment applicant shall return that document to the Credentials Verification Office not later than seventy-five (75) days from the date it was delivered to the reappointment applicant. Failure to return the form shall be deemed a voluntary resignation from staff status and shall result in automatic termination of staff status together with all clinical privileges at the expiration of such persons' current term; provided that no automatic termination shall be effective unless the staff member has been provided written notice of this failure to provide the necessary information. Such action shall not be deemed to be adverse to the applicant.

Section 2. Content of Request for Reappointment Form.

The Request for Reappointment form shall be on a form prescribed and approved by the Board and the Medical Staff and shall require and, when completed shall contain, information necessary to maintain as current the information contained in the initial application form, plus any request for modification of staff status or privileges which the reappointment applicant may desire to make. The form shall also contain a reference to the portion of the Bylaws which reflects the mechanisms for reappointment.

Section 3. Verification of Information.

A. The applicant shall deliver a completed Request for Reappointment form to the Credentials Verification Office, who shall, in a timely fashion, seek to collect or verify to the extent appropriate:

1. Verify current licensure (documented internet or phone verification is acceptable);

2. Verify professional liability insurance coverage;

3. Query the National Practitioner Data Bank;

4. Assure the presence of the required peer references;

5. Assure the presence of completed administrative and clinical reference questionnaires and all other required forms and consents;

6. Check for sanctions and exclusions through the Office of the Inspector General;

7. Assemble performance data including performance improvement profiles, information concerning the applicant’s participation in relevant continuing medical education; comparative physician profiles; and peer review actions;

8. Any other materials or information deemed pertinent, including information regarding the applicant’s professional activities, performance and conduct in this or any other health care setting.
When collection and verification is accomplished by receipt of responses from all persons or entities so contacted, the Credentials Verification Office shall transmit the Request for Reappointment form and related information to the applicant's service chief, the chief of any other service in which privileges are requested, and the Credentials Committee. The provisions of this Article VI, Part D, Sections 1 and 2 shall apply to applications for reappointment, except that Article VI, Part E, Section 8 shall control processing time periods.

B. An applicant for reappointment to the Courtesy Medical Staff who is a physician but not a member of the Active Staff, or its equivalent, at another hospital (the category of Courtesy Medical Staff membership defined by Article V, Part C of these Bylaws) shall include, as part of the information responsive to the requirements of paragraph (a), immediately above, a list of the number of procedures of each type for which the applicant is requesting privileges that the applicant has performed during the expiring period of appointment or reappointment. The list shall also identify the hospitals or other institutions at which the applicant has performed each type of procedure.

Section 4. Service Action.

The appropriate service chief shall review the Request for Reappointment form and the applicant's file and shall transmit to the Credentials Committee the service chief's report and recommendation that appointment be either renewed, renewed with modified staff status and/or clinical privileges, renewed with special conditions, or terminated. A chairman may also recommend deferral of action. Each such report shall satisfy the requirements of Article VI, Part D, Section 3.

Section 5. Credentials Committee Action.

The Credentials Committee shall review each Request for Reappointment form and all related and relevant information available on each applicant being considered for reappointment, including the recommendation of each service in which the applicant has requested privileges and shall transmit to the Executive Committee its report and recommendation that appointment be either renewed, renewed with modified staff status and/or clinical privileges, renewed with special conditions, or terminated. The Credentials Committee may also recommend that the Executive Committee defer action. Each such report shall satisfy the requirements of Article VI, Part D, Section 4. Any minority views shall also be reduced to writing and transmitted with the majority report.

Section 6. Executive Committee Action.

The Executive Committee shall review each Request for Reappointment form and all other related and relevant information available to it and shall forward to the Credentials Verification Office for transmittal to the Board its report and recommendation that appointment be either renewed, renewed with modified staff status and/or clinical privileges, renewed with special conditions, or terminated. The committee may also defer action. Each such report shall satisfy the requirements of this Article VI, Part D, Section 5. Any minority views shall also be reduced to writing and transmitted with the majority report.

Section 7. Final Processing and Board Action.

Thereafter, the procedure provided in Article VI, Part D, Sections 5 Sections 6 through 10 shall be followed. For purposes of reappointment, the terms "applicant" and "appointment" as used in those sections shall be read, respectively, as "reappointment applicant" and "reappointment."
Section 8. Time Periods for Processing.

After the Medical Staff’s return of the Request for Reappointment as provided in Section 1 of this Part D, and, except for good cause shown by the reappointment applicant, each person, service and committee required by these Bylaws to act thereon shall complete such action in a timely fashion so that all reports and recommendations concerning reappointment are transmitted to the Executive Committee for its consideration and action pursuant to Article VI, Part E, Section 6, prior to the expiration date of the previous appointment of the applicant. The Credentials Verification Office shall not transmit an Application for Reappointment until the information required to complete the application has been collected and verified. If responses from references have not been received within seventy-five (75) days from the date of the delivery of the Request for Reappointment form to the reappointment applicant, the Credentials Verification Office shall notify the reappointment applicant of the deficiencies in the information required. If the reappointment applicant fails to correct those deficiencies within ten (10) days, and in absence of good cause shown by the reappointment applicant, the application shall be deemed rejected. Such action shall not be deemed to be adverse to the applicant. The applicant may reapply for reappointment. Such request for reappointment shall not, however, toll the expiration of the applicant's staff status and the reappointment applicant shall not be a member of Medical Staff following such expiration of appointment unless the reappointment applicant has obtained a continuance of appointment pursuant to Section 9 below.

PART H. REQUESTS FOR MODIFICATION OF APPOINTMENT

A staff member may, either in connection with reappointment or at any other time, request modification of the member's staff status, service assignment or privileges by submitting a written application to the Medical Staff Office on the prescribed form. Such application shall be processed in substantially the same manner as provided in this Article VI, Part E, for reappointment.

PART I. MONITORING CONTINUING ELIGIBILITY

The President/Chief Executive Officer, through the Medical Staff Office, will continuously monitor, periodically verify and maintain current information on each Medical Staff Member, including licensure, non-excluded provider status, narcotics permits, and professional liability insurance.

ARTICLE IV.
CLINICAL PRIVILEGES

PART A. EXERCISE OF CLINICAL PRIVILEGES RESTRICTED

Except as otherwise provided in these Bylaws, any member of Medical Staff providing clinical services at this Hospital shall be entitled to exercise only those clinical privileges specifically granted.
Said privileges and services shall be Hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon and shall be subject to the rules and regulations of the clinical service and the authority of the service chief and the Medical Staff. Medical Staff privileges may be granted, continued, modified or terminated by the Governing body of this Hospital only upon recommendation of the Medical Staff, only for reasons directly related to the quality of patient care and other provisions of the Medical Staff Bylaws, and only following the procedures outlined in these Bylaws.

**PART B. DETERMINATION AND DELINEATION OF PRIVILEGES**

**Section 1. Request for Privileges.**

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a member for a modification of clinical privileges may be made at any time, but such request must be supported by documentation of training and/or experience supportive of the request.

**Section 2. Basis for Privileges Determinations.**

Each recommendation concerning the appointment or reappointment of an applicant and the clinical privileges to be granted to the applicant, and the determinations made with respect thereto, shall be based upon the following:

A. The applicant's demonstrated current competence, current licensure, and clinical judgment in the treatment of patients.

B. The applicant's professional ethics.

C. The applicant's education, training and experience.

D. The applicant's participation in continuing medical education.

E. The applicant's meeting of the qualifications for staff status and the applicant's anticipated ability in or history with respect to fulfilling other responsibilities of staff status.

F. The applicant's anticipated and/or historical use of the Hospital facilities.

G. The applicant's discharge of obligations with the Hospital.

H. The applicant's compliance with the Medical Staff Bylaws, rules and regulations and Hospital and Board policies in this Hospital and others where the applicant has provided clinical services.

I. The applicant's cooperation with other members, patients and Hospital employees.

J. The applicant's disruption, if any, of Hospital operations.

K. The applicant's physical health, mental health and emotional stability.

L. Any other matters bearing on the applicant's ability and willingness to contribute to patient care practices in the Hospital.
M. Observed clinical performance and the documented result of quality assurance activities conducted at the Hospital or other health care facilities.

N. Information concerning clinical performance obtained from staff members, peers and other sources, especially other institutions and health care settings, where the applicant exercises or has exercised clinical privileges.

O. The previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration and non-excluded provider status.

P. Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another Hospital.

Q. The individual's documented experience in categories of treatment areas or procedures.

R. The results of treatment provided by the applicant.

S. Conclusions drawn from quality assurance activities.

T. The location of the residence of the applicant.

U. The applicant shall practice a branch of health care or a specialty which is consistent with the purposes, treatment, philosophy, methods and resources of the Hospital and for which the Hospital has a current need.

When the privileged delineation is primarily based upon experience, the individual's credential's record must reflect the specific experience and results that form the basis of the grant of privileges.

**Section 3. Form of Delineation of Privileges.**

The delineation of an individual's clinical privileges shall include the limitations, if any, on an individual's privileges to admit and treat patients or direct the course of treatment for the conditions for which the patients were admitted.

**Section 4. Conditions for Privileges for Dentists, Oral Surgeons and Podiatrists.**

A. **Admissions.** Dentists who are members of the Medical Staff may only admit patients if a physician member of the Medical Staff conducts or directly supervises the admitting history and comprehensive physical examination (except the portion related to dentistry), and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during Hospitalization which are outside of the dentist's lawful scope of practice. Oral Surgeons and Podiatrists may be credentialed to perform the History and Physical on their own patient within the scope of their education and experience and if needed to obtain consultation from a physician member with regard to medical or surgical factors outside of their scope of licensure, education or experience.

B. **Surgery.** Surgical procedures performed by dentists shall be under the overall supervision of the Chief of the Service of Surgery or the Chief's designee.
C. Medical Appraisal. All patients admitted for care in the Hospital by a dentist, shall immediately receive the same basic medical appraisal as patients admitted to other services and a physician member shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient where a dispute exists regarding proposed treatment between a physician member and a dentist based upon medical or surgical factors outside of the scope of licensure of the dentist. The treatment will be suspended insofar as possible while the dispute is resolved by the appropriate service. Oral surgeons and Podiatrists are permitted to provide a medical appraisal of their own patients within the scope of their education and experience and to obtain consultation from a physician member with regard to medical or surgical factors outside of their scope of licensure, education or experience.

Section 5. Condition for the Exercise of Clinical Privileges by All Practitioners.

As a condition to the exercise of clinical privileges at the Hospital, each practitioner agrees, upon request of the Hospital or its Medical Staff, to provide appropriate and necessary emergency or non-emergency medical treatment within the scope of such practitioner's privileges to any patient seeking such treatment regardless of such a patient's ability to pay.

PART C. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

Section 1. General Provisions.

There are two types of Focused Professional Practice Evaluation (FPPE).

A. Except as otherwise determined by the Medical Executive Committee, all provisional members of the Medical Staff and all members granted new clinical privileges shall be subject to a period of FPPE. Each provisional staff member or recipient of new clinical privileges shall be assigned to a service where performance on an appropriate number of cases as established by the Medical Executive Committee, or the service as designee of the Medical Executive Committee, shall be observed by the Chief of the service, or the chief's designee, during the period of FPPE specified in the service's guidelines, to determine suitability to continue to exercise the clinical privileges granted in that service. The exercise of clinical privileges in any other service shall also be subject to direct observation by that service's chief or his designee. The member shall remain subject to such FPPE until the medical credentials committee has been furnished with:

1. A summary, report, or evaluation delivered by the Chief of Service or the Chief's designee, describing the type and number of cases observed and including an evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for a practice in that service, or, if applicable, has discharged all of the responsibilities of membership in the Hospital's allied health professional category, and that the applicant has not exceeded or abused the privileges extended.

2. Following receipt, review, and acceptance of the materials described in Part C, Section 1(a) above, the Credentials Committee shall make its recommendation regarding extension of clinical privileges to the Executive Committee.

3. The Chief of the Service, or the Chief's designee, shall have the authority, to intervene in any procedure or operation being conducted by the provisional member or the
member granted new clinical privileges if the evaluator reasonably believes that such intervention is necessary for the protection of the patient.

B. When analysis of selected quality monitors or triggers demonstrates an opportunity for improvement, an improvement action plan may be established with the goal of reducing the occurrence of undesirable rates, trends, or sentinel events in the future. Improvement Action Plans may be initiated by the Chief of the Medical Staff, or the Medical Executive Committee.

Such improvement action plans will be considered quality improvement initiatives unless initiated by the MEC as an investigation or a corrective action pursuant to Article X. The Medical Executive Committee will appoint an individual or group responsible for the design, implementation and completion of the improvement action plan. The individual or group will report the results of the plan to the Medical Executive Committee on a timely basis.

1. The provider shall remain subject to such improvement action plan until the Medical Executive Committee has been furnished with a summary report or evaluation delivered by the Chief of Service or his/her designee indicating that the need for continued monitoring or improvement in the areas identified as ended. Following receipt, review and acceptance of the report, the provider will be notified that the conditions for the improvement action plan have been satisfied.

2. If the Medical Executive Committee, based on a report of the Chief of Service or his/her designee, determines that the provider has not satisfied the conditions of the improvement action plan or that the quality concerns that are the basis for the improvement action plan have not been resolved, the Medical Executive Committee has the following options:

   a. Continue with an improvement action plan for additional time;

   b. Initiate a request for corrective action pursuant to Article X, Part A.

   c. If the improvement action plan was initiated as part of an investigation for corrective action pursuant to Article X, Part A, the Medical Executive Committee may make one of the recommendations in Article X, Part A. Section 5.

3. Any improvement action plan or Medical Executive Committee recommendation that constitutes an adverse action per Article III or Article X, Part A, Section 5(b), the provider shall be entitled to the process in Article XI.

4. The Chief of the Service or his/her designee shall have the authority to intervene in any procedure or operation being conducted by the provider if the Chief of Service or his/her designee reasonably believes that such intervention if necessary for the protection of the patient.

Section 2. Failure to Obtain Certification.

If a provisional member of the Medical Staff fails within the time of provisional membership to furnish the certification required, or if a member exercising new clinical privileges fails to furnish such certification within the time allowed by the service, those specific clinical privileges shall automatically terminate, and the member shall not be entitled to a hearing.
Section 3. Medical Staff Advancement.

The failure to obtain certification for any specific clinical privileges shall not, of itself, preclude advancement in Medical Staff category of any member. If such advancement is granted in the absence of such certification, continued proctorship on the uncertified procedure shall continue for the specified time period.

Section 4. Failure to Have Sufficient Cases.

The failure of a provisional member of Medical Staff to perform a sufficient number of cases because of a lack of cases shall be reason for extending the period of proctorship.

PART D. MODIFICATION OF CLINICAL PRIVILEGES

Section 1. Duration of Clinical Privileges.

A grant of clinical privileges (clinical privileges as used herein mean those privileges other than emergency privileges or temporary privileges) shall be effective for a period of two years from date of grant unless modified, relinquished or terminated earlier by reason of action taken under, these Bylaws and except as set forth in this Part D.

Section 2. Review of Clinical Privileges.

A member's privileges shall be reviewed concurrently with review of that member's request for reappointment. The basis for grant of privileges shall be as set forth in this article.

On its own, upon recommendation of the Credentials Committee or pursuant to a request under Article X, Section 1, the Executive Committee may recommend a change in the clinical privileges or service assignments of a member. The Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to proctoring in accordance with procedures similar to those outlined in Section C above.

PART E. TEMPORARY CLINICAL PRIVILEGES

Section 1. Circumstances.

Upon the written concurrence of the Chief of the service where the privileges will be exercised, and the Chief of Staff, the President/Chief Executive Officer (or the President/Chief Executive Officer's designated representative should the President/Chief Executive Officer be unavailable) may grant temporary privileges, not to exceed an aggregate duration of one hundred twenty (120) days by any individual, in the following circumstances:

A. Peer Review Activities. When necessary for conducting peer review activities, the Board may admit a person to the Medical Staff for a limited period of time. Such membership shall be solely for the purpose of conducting peer review in a particular case or situation, and the temporary membership shall terminate upon the temporary member's completion of duties in connection with the peer review matter. Such an appointment need not involve the procedures specified in Article VI and the member shall exercise no privileges other than those necessary for conducting peer review in the particular case or situation.
B. **Pendency of Initial Application**: An initial applicant awaiting Executive Committee and Board Action who meets the further qualifications of Article VII, Part E, Section 2 may be awarded temporary privileges not to exceed 60 days. In exercising such privileges, the applicant shall act under the supervision of the Chief of the service to which the applicant is assigned and in accordance with the provisions of this Article VII, Part E, Section 2.

C. **Important Patient Care Need.** Upon receipt of a written request, a practitioner who is not an applicant for membership may be granted temporary privileges for the care of one or more specific patients provided that an active, or courtesy, or provisional staff member shall be the attending physician for such patients. Such privileges shall be restricted to the treatment of not more than three (3) patients in any one-year by any practitioner.

### Section 2. Limitations

An applicant for temporary privileges must establish or provide to the Department Chief, Chief of the Executive Committee, Chief of the Credentials Committee, or President/Chief Executive Officer of the Hospital:

A. A completed application and request for temporary privileges;

B. Not less than three (3) medical letters of reference all of which must have been written not more than twelve (12) months prior to the date of the application;

C. Proof of appropriate professional liability insurance coverage (in an amount not less than that required of members of the Saint Alphonsus Medical Staff - Ontario);

D. Proof of current DEA authority and state licensure;

E. Proof of non-exclusion from federal or state reimbursement programs; and

F. Any other documentation required by the application.

The documentation and application shall be reviewed, and the information contained therein shall be verified (verbally or in writing) by the Credentials Verification Office designee. In addition, the Credentials Verification Office designee shall make a National Practitioner Data Bank inquiry concerning the applicant. Privileges granted may be renewed for one (1) successive period of thirty (30) days but such renewal shall not exceed the term of appointment sought by the applicant; shall be limited to the treatment of patients of a practitioner for whom the applicant is replacing or otherwise consistent with the request of the applicant (care of a specific patient); and shall not entitle such practitioner to admit or attend his/her own patients. The thirty (30) day period may be waived or shortened in situations determined to be an emergency by the President/Chief Executive Officer.

### Section 3. Conditions.

Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting applicant's qualifications, ability and judgment to exercise the privileges requested. Special requirements of consultation and reporting maybe imposed by, and in the discretion of, the Chief of the Service responsible for supervision of an applicant granted temporary privileges. Before temporary privileges are granted, the applicant must acknowledge in writing that he or she has received and read the Medical Staff Bylaws, rules and regulations and that he or she agrees to be bound by the terms thereof in all matters relating to his or her temporary privileges.
Additionally, the applicant must provide proof that he or she is full licensed in the state of Oregon (or Idaho if provider has only Ambulatory status) or otherwise authorized under Oregon or Idaho law to exercise his or her temporary privileges and proof of professional liability insurance as required by these Bylaws.

A. The criteria provide that an applicant for privileges is ineligible for the expedited process if any of the following is occurred:

1. The applicant submits an incomplete application.
2. The Medical Staff Executive Committee makes a final recommendation that is adverse or has limitations.

B. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process:

1. There is a current challenge or a previously successful challenge to licensure or registration.
2. The applicant has received an involuntary termination of medical staff membership at another hospital.
3. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.
4. The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Section 4. Termination.

The President/Chief Executive Officer, or in his absence, his designee, may at any time upon reasonable notice under the circumstances and for any reason, after consultation with the Service Chief responsible for supervision or the Chief of the Medical Staff, terminate, deny or modify any or all temporary privileges granted. Such actions, unless otherwise described, are deemed not to relate to the applicant’s professional competence or conduct and do not entitle him or her to a hearing under the Fair Hearing Plan. In the event of any such termination, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the Service Chief responsible for supervision or, in his or her absence, by the Chief of the Executive Committee. The wishes of the patient shall be considered where feasible, in choosing a substitute. For those applicants granted temporary privileges pending Executive Committee and Board approval, temporary privileges shall automatically terminate if there is an unfavorable recommendation from either the Executive Committee or Board.

PART F. EMERGENCY PRIVILEGES

In the case of an emergency (meaning that immediate treatment is necessary to prevent serious or permanent harm, to preserve life or to prevent serious deterioration or aggravation of a condition), any practitioner, to the degree permitted by the practitioner's license and regardless of service, staff status, or clinical privileges, shall be permitted to do, and be assisted by Hospital personnel in doing everything possible to save the life of a patient or to save the patient from serious harm, or to take such other action
as may be necessary. The practitioner must request assistance as soon as possible to arrange for follow-up care by an appropriately privileged practitioner or request the privileges necessary to continue to treat the patient.

In addition, emergency privileges may be granted by the President/Chief Executive Officer, Chief of Service or Chief of Medical Staff, or their designees, when the emergency management plan has been activated and the organization is unable to handle the immediate patient need. Emergency privileges may be granted in such a situation upon presentation of a valid picture ID issued by a state, federal or regulatory agency.

Any practitioner receiving emergency privileges pursuant to the above paragraph shall be provided with a badge that identifies the provider as a volunteer provider.

At such time as the immediate situation requiring emergency privileges is under control (even if the emergency management plan is still in effect), the President/Chief Executive Officer, through the Medical Staff Office personnel, will source verify credentials and privileges of those practitioners given emergency privileges pursuant to the process for verification of temporary privileges in Article VII, Sections 2 and 3. This shall be completed within 72 hours from the time the practitioner presents to the facility to the extent feasible in the judgment of the President/Chief Executive Officer. If the verification of credentials and privileges cannot occur within 72 hours, it shall be completed as soon as practicable in the judgment of the President/Chief Executive Officer based upon the situation requiring the need for emergency privileges. If the verification process determined the practitioner does not meet the standards for temporary privileges, the emergency privileges shall be immediately terminated by the President/Chief Executive Officer, the Chief of Service, the Chief of Staff, or their designees.

For quality review purposes, a list of all patient encounters will be kept for retrospective medical record review at a later date. All notations in the medical record will reflect the physician is working under disaster privileges.

ARTICLE V.

IMPAIRED PRACTITIONER

PART A. PURPOSE

It is the policy of Saint Alphonsus Medical Staff to properly investigate and act upon concerns that a Practitioner is suffering from impairment. This chapter provides a process for reporting concerns that a Practitioner is impaired and for investigating and acting on concerns that a Practitioner is impaired. Under the chapter, the Medical Staff takes into consideration the potential rehabilitation of the impaired Practitioner. The Medical Staff will conduct its investigation and act in accordance with state and federal law including, but not limited to, the Americans with Disabilities Act (ADA), when applicable.

PART B. DEFINITION

For the purpose of this chapter, “impairment” is defined as a condition that adversely affects the ability of a Practitioner to provide medical care with reasonable skill and safety because of excessive use or
abuse of drugs or medications, or mental or physical illness (including, but not limited to deterioration through the aging process, or loss of motor skills). The Medical Staff recognizes that this definition is broader than the ADA’s definition of “impairment.”

**PART C. PROCEDURE FOR REPORT AND INVESTIGATION**

Section 1. Report
If any individual has reasonable suspicion that a Practitioner is impaired, such person will provide a written report to the President or President Elect of the Medical Staff, the chairperson of the Practitioner’s department, or the Medical Director, Physician Relations. The report does not have to include conclusive proof of impairment, but will include a factual description of the incident(s) that led to the person’s concern.

Section 2. Initial Review
After receipt of a report concerning a Practitioner’s potential impairment, the recipient will evaluate whether it appears there is sufficient evidence to warrant further investigation. If so, the President of the Medical Staff, or his/her designee, may:

A. meet personally with the Practitioner; and/or

B. Refer the report for investigation to an appointed investigator.

Section 3. Investigator
For the purposes of this policy, the Investigator will be assigned by the Medical Staff President and may include a Medical Staff Leader, Department Chair, Ad Hoc Committee or the Physician Professional Practice Committee.

Section 4. Investigation
The investigation of a Practitioner’s potential impairment may include, but is not limited to, any of the following:

A. an interview with the Practitioner;

B. the review of any and all documents or other materials relevant to the investigation and the Practitioner’s potential impairment;

C. interviews with any and all individuals involved in the incidents or who may have information relevant to the investigation, provided that any specific inquiries made are related to the performance of the Practitioner’s clinical privileges or scope of practice consistent with proper patient care at the Hospital, and that confidentiality is maintained;

D. the requirement that the Practitioner undergo a complete medical examination (including a psychiatric evaluation, if appropriate) as directed by the appointed Investigator, provided the exam is related to the performance of the Practitioner’s duties and privileges; and/or
E. A requirement that the Practitioner submit to a drug test/screening, in compliance with the Oregon Code, if appropriate to the potential impairment.

**PART D. CLASSIFICATION OF IMPAIRMENT**

If the Investigator finds sufficient evidence that the Practitioner is impaired, the Investigator, in consultation with legal counsel, will determine the nature of the impairment and whether it is classified as a disability under the ADA. If the impairment is classified as a disability under the ADA, it will be subject to the provisions of Section 9; otherwise, it will be subject to the provisions of Section 10. (Rev. 6/06)

**PART E. RECOMMENDATION**

The Investigator will evaluate the information gathered during its investigation and recommend action to the Medical Executive Committee for subsequent review and approval of the Board, through the President/Chief Executive Officer. The recommendation may include the Practitioner’s participation in an appropriate rehabilitation program as discussed in Section 9 of this policy.

**PART F. COMMUNICATION OF INVESTIGATION**

Once the investigation is done and acted on, the Medical Staff will inform the person who filed the report. The Practitioner will be informed of the results of the investigation.

**PART G. CONFIDENTIALITY/DOCUMENTATION OF INVESTIGATION**

The investigation and evaluation of a Practitioner’s potential impairment will be confidential and will be conducted pursuant to the Oregon Peer Review Statute, Oregon Code ORS 41.675. 7:33. All participants in the investigation will refrain from discussing the investigation with anyone outside of the process described in this policy. The investigative report and recommendation will be included in the Practitioner’s Professional Practice file.

**PART H. NO ABUSE OF POLICY**

Any Hospital employee or Practitioner who fabricates allegations of a Practitioner’s potential impairment may be subject to appropriate disciplinary action, up to and including termination of employment (for Hospital employees) or corrective action (for Practitioners).

**PART I. IMPAIRMENT CLASSIFIED AS A DISABILITY UNDER THE ADA**

Section 1. Reasonable Accommodation
If the Practitioner’s impairment is a disability under the ADA, a determination by the Investigator, in consultation with legal counsel, will be made as to the following:
A. Whether a reasonable accommodation may be made such that the Practitioner would be able to competently and safely perform his or her clinical privileges and the duties and responsibilities of his or her medical staff appointment;

B. Whether such reasonable accommodation would create an “undue hardship” upon the Hospital in that the reasonable accommodation would be excessively expensive, substantial or disruptive, or would fundamentally alter the nature of the Hospital’s operations or the provision of patient care; and

C. Whether the impairment constitutes a “direct threat” to the health or safety of the Practitioner, patients, staff or others within the Hospital. A direct threat must involve a significant risk of substantial harm based upon medical analyses and/or other objective evidence. If the Practitioner appears to pose a direct threat because of a disability, the Investigator must also determine whether it is possible to eliminate or reduce the risk to an acceptable level with a reasonable accommodation.

Section 2. Voluntary Agreement
If it is determined that a reasonable accommodation may be made as described above, attempts will be made to work out a voluntary agreement with the Practitioner, so long as the arrangement would neither constitute an undue hardship upon the Hospital or create a direct threat, also as described above. The President/Chief Executive Officer will approve any agreement before it becomes final and effective.

Section 3. Other Recommendation
If the Hospital is unable to make a reasonable accommodation or if a voluntary agreement cannot be reached with the Practitioner, the Investigator, via the Medical Executive Committee, will make a recommendation and report to the Board of Trustees, through the President/Chief Executive Officer, as to appropriate action to be taken. If the Investigator’s recommendation would provide the Practitioner with a right to a hearing as described in the Medical Staff Bylaws, the President/Chief Executive Officer will promptly notify the Practitioner of the recommendation in writing, by certified mail, return receipt requested. The recommendation will not be forwarded to the Board until the individual has exercised or has been deemed to have waived the right to a hearing as provided in the Medical Staff Fair Hearing Plan. (Rev. 6/06)

PART J. IMPAIRMENTS THAT ARE NOT DISABILITIES UNDER THE ADA

Section 1. Recommendation
A. If the impairment is not a disability under the ADA, depending on the nature and severity of the impairment, the Investigator’s recommendation may include, but is not limited to, any of the following:

B. If the Practitioner acknowledges the existence of impairment and agrees to fully cooperate and comply with an appropriate rehabilitation plan, the Practitioner may be placed on a medical leave subject to approval by the President/CEO and the President of the Medical Staff. Any such medical leave will be subject to the provisions of Section 11 below;
C. If the Practitioner either denies the existence of impairment or fails to fully cooperate with the required course of rehabilitation, a review will be requested under the Medical Staff Bylaws; or

D. If the criteria under Section 8 of the Corrective Action Plan exist, precautionary suspension will be imposed.

**PART K. REHABILITATION AND REINSTATEMENT**

**Section 1. Practitioner Recovery Network**

If appropriate, the impaired Practitioner will be referred to the Oregon Medical Association Practitioner Recovery Network (HPSP), or Physicians Referral Network (PRN), if licensed in Idaho which will assist the Practitioner in locating a suitable rehabilitation program. The Practitioner may be placed on a medical leave for purposes of participation in the program. A Practitioner will not be reinstated until it is established, to the Hospital’s satisfaction, that the Practitioner has successfully completed a HPSP-sanctioned program or PRN sanctioned program, if licensed in Idaho.

**Section 2. Eligibility for Reinstatement**

Upon sufficient proof that a Practitioner who has been found to be suffering from impairment has successfully completed a HPSP-sanctioned rehabilitation program, or PRN sanctioned rehabilitation program, if licensed in Idaho, the Hospital at its discretion, may consider that Practitioner eligible for reinstatement to the Medical Staff. Sufficient proof includes but is not limited to a letter from the director of the rehabilitation program where the Practitioner was treated confirming that:

A. The Practitioner participated in the program;

B. The Practitioner is in compliance with all of the terms of the program;

C. Whether, in the director's opinion, the Practitioner is capable of resuming medical practice and providing continuous, competent care to patients; and

D. Whether, in the opinion of the director, the Practitioner should participate in an aftercare program.

**Section 3. Reinstatement**

In considering an impaired Practitioner's eligibility for reinstatement, the Hospital must make a decision in the best interest of patient care. Assuming all of the information received indicates that the Practitioner is rehabilitated and capable of resuming care of patients, the following additional precautions should be taken when restoring clinical privileges, the Practitioner:

A. Must identify another Practitioner who is willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability;
B. Will be required to obtain periodic reports from his or her primary treating physician or psychologist or monitoring physician for a period of time specified by the President/Chief Executive Officer, Chief of Staff and the Vice Chief of Staff, verifying that the Practitioner is continuing treatment or therapy, and that his or her ability to treat and care for patients in the Hospital is not impaired;

C. Exercise of clinical privileges in the Hospital will be monitored by the department chairperson or designee; and

D. Must agree to submit to an alcohol or drug-screening test (if appropriate to the impairment) at the request of the President/Chief Executive Officer or designee, the Medical Staff President or the chairperson of the Practitioner’s department.

PART L.  AFTER CARE PROGRAM

Any after-care programs and/or monitoring will be coordinated by the HPSP or PRN, if licensed in Idaho, based on the after-care program prescribed by the director of the rehabilitation program. In order to assure appropriate aftercare treatment, the impaired Practitioner will be required to sign and comply with an aftercare contract with the HPSP or PRN, if licensed in Idaho.

ARTICLE VI.

EXCLUSIVE SERVICES

PART A.  EXCLUSIVITY POLICY

In recognition of the Hospital's policy that certain Hospital Facilities will be used on an exclusive basis and certain medical services will be provided on an exclusive basis in accordance with contracts between the Hospital and practitioners selected by the hospital and the Board. Applications for appointment and clinical privileges relating to those Hospital facilities and services specified in Article VI, Part B, will not be accepted for processing, except for applications by professionals who have been granted exclusive rights under a contract with the Hospital, and practitioners employed or engaged by the professionals holding such exclusive rights to perform services under a contract with the Hospital.

For each of these areas subject to the Hospital's exclusivity policy, the physicians or group of physicians who are under contract to the Hospital assume exclusive responsibility for adequate medical staffing, continuous coverage, maintenance of standards, organization and operation of their respective areas by virtue of their contract. All practitioners rendering service are doing so under authority of the contract.
Physicians practicing in those areas subject to the exclusivity policy will be either themselves the contracting physicians, members of a contracting group, or physicians who are in association with, or under contract to, the contracting physicians or group. All such physicians must apply for, receive, and maintain Medical Staff Membership and privileges commensurate with their practice and responsibilities.

PART B. FACILITIES AND SERVICES TO THE EXCLUSIVITY POLICY

Hospital facilities and services subject to the foregoing exclusivity policy include medical pathology, radiology, anesthesiology, hospitalist, and emergency room services at the Hospital. The Medical Staff and the Board reserve the right, from time to time, in its sole discretion, to make other Hospital facilities and services subject to the exclusivity policy and to enter into exclusive contractual arrangements with practitioners.

PART C. MEDICAL STAFF ASSISTANCE WITH AND RECOMMENDATIONS REGARDING CONTRACTING

If requested by Hospital Administration, or an existing contracting physician or group, the Medical Staff Officers who do not have conflict due to direct involvement in an exclusive contract will make recommendations to facilitate and assist Hospital Administration and contracting Physicians/Groups with contract negotiations and the resolution of contract issues. The ultimate authority for all contracts relating to exclusive facilities and services rest with the Board of Trustees.

PART D. EFFECT OF CONTRACT EXPIRATION OR TERMINATION

The effect of expiration or termination of a contract between a practitioner and the Hospital on a practitioner's staff status and clinical privileges will be governed by the terms of the practitioner's contract with the Hospital. No action, recommendation or decision by the Hospital or the Board with regard to the expiration, termination or failure to renew any such contract with a practitioner will be subject to or conditioned upon any proceedings or exercise of rights under these Bylaws. Practitioner's exercising privileges subject to the exclusivity policy will, upon termination of the contract or relationship described above, automatically relinquish their privileges, notwithstanding any other provision of these Medical Staff Bylaws to the contrary.

ARTICLE VII.

CORRECTIVE ACTION
PART A. ROUTINE PROCEDURE FOR CORRECTIVE ACTION

Section 1. Criteria for Initiation and Determination

Whenever the Chief of Staff, the Chief of a Service, the Chairman of the Credentials Committee, a majority of the Credentials or Executive Committee, the Chairman of any other committee, or a majority of that committee, the Chairman of the Board, or the President/Chief Executive Officer has reasonable cause to question, with respect to a Medical Staff member:

A. clinical competence;

B. care or treatment of a patient or patients or the member's management of a case;

C. known or suspected violation of the Bylaws or policies of the Hospital, or the Bylaws, rules or regulations of the Medical Staff relating to professional activity, or the member's known or suspected failure to comply with the ethics of the member's profession;

D. whether or not the member's behavior or conduct is lower than the standards or aims of the Medical Staff or the Hospital; or

E. the member's ability to work harmoniously with others and avoid disruption to the operations of the Hospital or Medical Staff organization, a written request for an investigation of the matter shall be addressed and delivered to the Executive Committee and shall specifically state the activity or conduct giving rise to the request.

Section 2. Notification of President/Chief Executive Officer.

The Chairman of the Executive Committee shall promptly notify the President/Chief Executive Officer in writing of all requests for corrective action regarding a Medical Staff member received by the Executive Committee and shall keep the President/Chief Executive Officer fully informed of all action taken in connection therewith.

Section 3. Investigative Procedure.

The Executive Committee shall meet as soon after receiving the request as is practical. At that meeting, if there is reliable information that indicates that a Medical Staff Member may have exhibited acts, demeanor, or conduct reasonably like to be:

A. Detrimental to patient safety or the delivery of quality patient care within the Hospital;

B. Contrary to Hospital rules and regulations or policies and/or distributive to Hospital operations;

C. Unethical;

D. Contrary to the Medical Staff Bylaws and Rules and Regulations; or
E. Below applicable professional or clinical standards, the Executive Committee shall adopt one of the two (2) following courses of action:

F. If the request for corrective action contains information sufficient to warrant immediate action or an immediate recommendation, the Executive Committee, at its discretion, shall take such appropriate action or make such appropriate recommendation as provided in this Article X, Part A, Section 5, with or without (at its discretion) a personal interview with the member named in the request for corrective action.

G. If the request for corrective action does not contain information sufficient to warrant action or to warrant an immediate recommendation, the Executive Committee shall:

   1. forward the request to the Chief of Service wherein the affected member has privileges with a written request for an investigation; the Chief of Service shall immediately appoint an ad hoc committee to investigate the matter, or
   2. Appoint an Ad Hoc Committee to investigate the matter. These actions shall be recorded in the Minutes of the Executive Committee meeting.

H. Notwithstanding the provisions of Article X, Part A, Section 3(b) above, the Ad Hoc Committee appointed by the Executive Committee or the Chief of Service may consist of practitioners from Medical Staffs of other institutions, or those as requested from the Board of Medical Examiners pursuant to ORS 441.055(6)(2)(11) and OAR 847-10-095.

I. No member of the MEC or Ad Hoc Committee should discuss with the practitioner being investigated any issues related to the investigation outside of the formal investigation process. If such member should choose to hold such discussion they should recuse themselves from any deliberation related to the allegations.

The Ad Hoc committee appointed by either the Executive Committee or the Chief of Service shall consist of at least three persons who shall be Medical Staff members. The investigating committee shall not include partners or associates of the affected individual or any of the members of the Executive Committee. The Executive Committee, its ad hoc committee or the ad hoc committee appointed by the Chief of Service, shall have available to them the full resources of the Medical Staff and the Hospital to aid in their investigation, as well as the authority to use outside investigation services. The member against whom corrective action has been requested shall have an opportunity to meet with this Committee before it makes its report to the Executive Committee. At this meeting, the affected practitioner shall be informed of the nature of the evidence supporting the investigation requested and shall be invited to discuss, explain, or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in these Bylaws with respect to hearings shall apply to this meeting. A record of such interview shall be made by the ad hoc committee and shall be included in its report to the Executive Committee. This investigation process shall be carried out as rapidly as possible.

Section 4. Interim Suspension.

At any time during the investigation, the Executive Committee, with the approval of the President/Chief Executive Officer, if the incidents, facts, or events reflected in the request for corrective action raise serious concerns about patient's safety or if the affected practitioner is engaging in extreme
disruptive behavior, may suspend all or any part of the clinical privileges of the member being investigated. The suspension shall be administrative in nature and shall be for the protection of the Hospital patients and shall not be an indication of the validity of the charges against the affected practitioner. The suspension shall remain in effect during the investigation only and there shall be no right of appeal from that suspension. If the report of the Committee is adverse to the practitioner, the suspension shall remain in effect until final Board action unless lifted by the Board prior to such action. If such a suspension is placed in effect, the investigation shall be completed within 60 days unless extended for good cause. The 60 days shall be measured from the date of imposition of the suspension. Reasons for delay shall be transmitted to the Board so that it may consider whether the suspension should be lifted. If the suspension is for administrative reasons, it will not be reported to the National Practitioner Data Bank. If it is to protect patients, then the suspension must be reported if it extends beyond fourteen (14) days.

Section 5. Procedure Thereafter

A. Following the investigation (if necessary), the Executive Committee shall determine if corrective action is appropriate. If the Executive Committee determines that corrective action is not appropriate, it shall issue a written report to that effect. If the Executive Committee determines that corrective action is appropriate, it may:

1. Issue a written warning;

2. Issue a letter of reprimand;

3. Impose terms of probation, including requirements for additional education and training;

4. Impose a requirement for review and/or consultation;

5. Recommend reduction or modification of clinical privileges;

6. Recommend suspension of clinical privileges for a term;

7. Recommend revocation of staff appointment; or

8. Take such other actions or make such other recommendations as the Executive Committee which may accept, modify or reject the recommendation.

If a subcommittee of the Executive Committee, or an ad hoc committee appointed by the Chief of Service was used, a written report must be submitted to the Executive Committee which may accept, modify or reject the recommendation.

B. Any recommendation by the Executive Committee for reduction, restriction, suspension, revocation, denial, or failure to renew clinical privileges or membership, shall be an adverse recommendation and shall be deemed to have adversely affected the Physician. Any such adverse recommendation shall include the nature of the professional review action; the reasons for the proposed action; the right to request a hearing; applicable time limits within which the hearing must be requested (in any event not less than thirty (30) days from date of
delivery of the adverse recommendation) and a summary of the individual's hearing rights. Such a recommendation shall be forwarded to the President/Chief Executive Officer who shall promptly notify the affected individual by special notice and as defined in Article III. The President/Chief Executive Officer shall then hold the recommendation until the individual has exercised or has been deemed to waive his rights as provided in Article XI. At the time the individual has been deemed to have waived his rights as provided in Article XI, the President/Chief Executive Officer shall forward the recommendation of the Executive Committee, together with all supporting documentation, to the Board. The Chairman of the Executive Committee or his designee shall be available to answer any questions that may be raised with respect to the recommendation by the Board.

C. If the action of the Executive Committee does not adversely affect the affected member's clinical privileges, the action shall take effect immediately without action of the Board and without the right of appeal to the Board. A report of the action taken and reasons therefore shall be made to the Board through the President/Chief Executive Officer and the action shall stand unless modified by the Board. In the event the Board does not accept the recommendation of the Executive Committee and reduces clinical privileges, suspends clinic privileges, revokes staff appointment, or takes any other action which adversely affects the member's clinical privileges, the President/Chief Executive Officer shall so notify the applicant by special notice as defined in Article III. In the event the individual exercises his rights to a hearing as a result of such Board action, the decision of the Board shall not be final unless the Board does not modify its decision after it has received the hearing panel reports and other relevant information.

D. Corrective actions shall only be taken:

1. In the reasonable belief that the action is in the furtherance of quality healthcare;
2. After reasonable efforts to obtain the facts;
3. After adequate notice and hearing or other procedures that are fair to the physician under the circumstances; and
4. In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3) above.

5. Any professional review action taken which adversely affects the clinical privileges of physician for a period longer than thirty (30) days shall be reported to the appropriate state licensing boards according to the requirements of the HCQIA and National Practitioner Data Bank. Additionally, if the surrender of clinical privileges by a physician is accepted while the physician is under an investigation for a reason concerning professional conduct or in return for not conducting such an investigation, the matter shall be reported to the appropriate state licensing board according to the requirements of the HCQIA and National Practitioner Data Bank.
6. A mental or physical evaluation by a physician or practitioner mutually acceptable to the parties may be requested by any investigating committee, including the Ad Hoc committee, the Medical Executive Committee, or the Board. In the event of a disagreement as to the evaluating physician, the Board shall make the final decision.

**PART B. SUMMARY SUSPENSION OF CLINICAL PRIVILEGES**

**Section 1. Grounds for Summary Suspension**

The Chairman of the Executive Committee, a Chief of Service, the Chairman of the Credentials Committee, the President/Chief Executive Officer, or the Chairman of the Board shall each have authority to suspend summarily all or any portion of the clinical privileges of a Medical Staff member or applicant whenever such action is, in the opinion of the individual exercising the right, in the best interest of patient care or safety in the Hospital, or the continued effective operation of the Hospital. Such suspension shall be for the purpose of investigation only and shall not imply any final finding of responsibility for the situation that caused the suspension. Such suspension is taken as an administrative precaution while the circumstances of questionable acts are looked into. Such summary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the President/Chief Executive Officer, and shall remain in effect unless or until modified by the President/Chief Executive Officer or the Board, or until it expires pursuant to Section 5 of this Part B, below.

**Section 2. Executive Committee Procedure**

The individual who exercises his authority under Section 1 of this Part to suspend summarily a person appointed to the Medical Staff shall immediately report his action to the chairman of the Executive Committee. At that point the Executive Committee shall take such further action which could be:

A. Sustain suspension and investigate as specified under Part A of this Article;

B. Lift suspension and investigate as specified under Part A of this Article; or

C. Lift suspension with no further action.

**Section 3. Care of Suspended Individual's Patients**

Immediately upon the imposition of a summary suspension, the appropriate department chairman or, in his absence, the President of the Medical Staff shall assign to another person appointed to the Medical Staff responsibility for care of the suspended individual's patients still in the Hospital at the time of such suspension until such time as they are discharged. The wishes of the patient shall be considered, where feasible, in choosing a substitute. It shall be the duty of the President of the Medical Staff and the department chairman to cooperate with the President/Chief Executive Officer in enforcing all suspensions.

**Section 4. No Right to Hearing.**

An individual whose privileges are summarily suspended is not entitled to a hearing as a result of a summary suspension. After the investigation triggered by summary suspension has concluded, and if the investigation results in a recommendation that is adverse to the practitioner, the practitioner shall be entitled to the hearing rights specified in Article XI.
Section 5. Duration of Summary Suspension.

A summary suspension pursuant to this Part B of this Article shall not itself remain in effect for a period longer than fourteen (14) days, but may be continued for a longer period of time as an interim suspension pursuant to Section 4, Part A, of this Article, if the requirements of an interim suspension under that Section are satisfied. A summary suspension pursuant to this Part B is an interim administrative step, but is not itself a final professional review action or recommendation, and is therefore not reportable under the requirements of the National Practitioner Data Bank law.

PART C. AUTOMATIC SUSPENSION OF CLINICAL PRIVILEGE

Section 1. Revocation of License

A practitioner, whose license, certificate or other legal credential authorizing him to practice his profession in this State is revoked, modified or suspended, shall immediately and automatically be suspended from practicing in the Hospital, from his staff status and from exercise of privileges. If such license is partially limited or restricted, clinical privileges within the scope of such limitation or restriction shall be automatically suspended. The automatic suspension provided for in this section shall continue until the license, certificate or other legal credential authorizing the practitioner to practice his profession in the state is restored.

Section 2. Failure to Maintain Professional Liability Insurance.

A person who fails to satisfy the professional liability insurance requirements of these Bylaws shall immediately and automatically be suspended from practicing in the Hospital, from his staff status and from the exercise of privileges. Such suspension shall continue until such time as the person provides to the satisfaction of the Executive Committee proof of professional liability insurance in accordance with these Bylaws.

Section 3. Drug Enforcement Administration (DEA).

A practitioner whose DEA number or other right to prescribe controlled substances is revoked or suspended shall immediately and automatically be suspended from practicing in the Hospital, from his staff status and from exercise of privileges. If such number or other right to prescribe controlled substances is partially limited or restricted, only clinical privileges within the scope of such limitation or restriction shall be automatically suspended. The suspensions provided for in this section shall continue until such time as the practitioner's DEA number or other right to prescribe controlled substances is restored.

Section 4. Failure to Maintain Records

A. Post op Reports

If it becomes known the op report has not been dictated the provider has one business day to comply from the time they are notified.

Failure to do so shall cause the providers elective admitting privileges to be automatically suspended by the Hospital until such time as the operative report is completed. The provider shall continue to provide emergency coverage while under this suspension.

B. Incomplete Medical Records
A provider who fails to complete his medical records within the time limits prescribed by these Bylaws and Rules and Regulations, shall have his admitting privileges automatically suspended by the Hospital until such time as the incomplete medical records are placed in acceptable form. This automatic suspension shall not be imposed until fifteen (15) days following notice of the problem. Such suspension shall continue until such time as the personal places said medical records in acceptable form, at which time said privileges shall be returned. The provider shall continue to provide emergency coverage while under this suspension.

Section 5. Failure to Pay Dues.

A person who:

A. fails to pay required medical staff dues before or within ninety (90) days following the due date or

B. fails to pay required medical staff dues after the third invoice, notice, and/or warning regarding the same,

Shall have his or her admitting privileges automatically suspended by the Hospital. Such suspension shall continue until such time as when the dues are current. Dues shall continue to accrue during any period of suspension of privileges.

Section 6. Care of Suspended Individual's Patients.

Immediately upon the automatic suspension of a person's privileges pursuant to this Part C of Article VIII, the appropriate department chairman or, in his absence, the President of the Medical Staff, shall assign to another person appointed to the Medical Staff responsibility for the care of the suspended individual's patients still in the Hospital at the time of such suspension until such time as they are discharged. The wishes of the patient shall be considered, if feasible, in choosing a substitute. It shall be the duty of the President of the Medical Staff and the Chief of Service to cooperate with the President/Chief Executive Officer in enforcing all such suspensions.

Section 7. Procedural Rights

Any individual whose privileges are automatically terminated or voluntarily relinquished under this Part C shall not be entitled to the review rights outlined in Article XI.

ARTICLE VIII.

HEARING AND APPEAL PROCEDURES

PART A. INITIATION OF AND RIGHT TO HEARING

Section 1. Right to and Purpose of Hearing.
An applicant or a Medical Staff member shall be entitled to a formal hearing whenever a recommendation adverse to him or her has been made by either the Executive Committee or the Board regarding those matters enumerated in Section 2 of this Part A. The affected individual also shall be entitled to a formal hearing, before the Board enters a final decision, when the affected individual did not have a formal hearing prior to a favorable recommendation by the Executive Committee, should the Board determine to reject a favorable recommendation by the Executive Committee regarding any of the matters enumerated in Section 2 of this Part A. The purpose of the hearing shall be to recommend a course of action to those acting for the Hospital, whether Medical Staff or Board, and the duties of the hearing panel shall be so defined and so carried out.

Section 2. Grounds for Hearing.

Grounds for a hearing include but are not limited to:

A. Denial of initial Medical Staff appointment.
B. Denial of requested advancement in Medical Staff category.
C. Denial of Medical Staff reappointment.
D. Denial of application for initial clinical privileges, if applicant is a physician, independent practitioner or dentist.
E. Denial of requested increased clinical privileges, if applicant is a physician, independent practitioner or dentist.
F. Revocation of Medical Staff appointment.
G. A decrease in or restriction of clinical privileges, if affected individual is a physician, podiatrist, or dentist.
H. Suspension of total clinical privileges, if the affected individual is a physician, podiatrist, or dentist.

Such action shall be deemed an “adverse recommendation” or “adverse actions” as such terms are used here in.

Section 3. Unappeasable Actions

Voluntary relinquishment, automatic relinquishment, or summary suspension of clinical privileges (as provided elsewhere in these Bylaws), or the imposition of a requirement for retraining, additional training or continuing education, whether imposed by the Executive Committee or the Board, shall not constitute ground for hearing, but shall take effect without hearing or appeal.

Section 4. Notice of Recommendation and Request for Hearing.

A. Notice of Recommendation

When a recommendation is made which, according to these Bylaws, entitles an individual to a formal hearing prior to a final decision of the Board on that recommendation, the applicant or Medical Staff member shall be given special notice by the President/Chief Executive Officer within 10 days of
the making of the recommendation. This notice shall contain a statement of the recommendations made and a statement of the reasons for the recommendation. Patient records or information supporting the recommendation may be identified. This statement may be amended or added to at any time, even during the hearing so long as materials relevant to the continued appointment or clinical privileges of the person requesting the hearing who shall have reasonable time to study this additional information and rebut it.

B. Request for Hearing.

The affected individual shall have 30 days following his or her receipt of notice to file a written request for hearing. Said request shall be made by delivering the notice to the President/Chief Executive Officer. In the event the affected individual does not request a hearing within the time and in the manner hereinabove set forth, he or she shall be deemed to have waived his or her right to such hearing, and to have accepted the action involved, and such action shall thereupon become effective immediately upon final Board Action.

Section 5. Appointment of the Hearing Panel.

When a hearing is timely requested, the Chief of the Medical Staff, after consulting with the Executive Committee, shall appoint a hearing panel which shall be composed of not less than three (3), but no more than five (5) members. The panel shall be composed of either members of the active or courtesy staff or others, where appropriate. The physicians appointed shall not have actively participated in the consideration of the matter leading to the recommendation or action being considered. Knowledge of the matter involved shall not preclude a person from serving as a member of this Committee. Persons that may be appointed may be members of the Medical Staff, practitioners from Medical Staffs of other institutions, or those as requested from the Board of Medical Examiners pursuant to ORS 441.055(6) to (11) and OAR 847-10-095. (If this process is used, the cost will be paid by Saint Alphonsus Medical Center - Ontario.) If a panel from the Board of Medical Examiners is not used, the appointment shall include a designation of the Chief. Members of the hearing panel shall not be in direct economic competition with the physician being reviewed.

Section 6. Time, Place, and Notice of Hearing

The President/Chief Executive Officer shall schedule the hearing and shall give special notice to the person who requested the hearing of its time, place, and date, which date (unless modified by mutual agreement) shall not be less than 30 days nor more than 60 days from the date of the hearing notice. Notwithstanding the foregoing, the hearing for a practitioner who is under summary suspension or other summary action which is then in effect may be held sooner than 30 days from the date of the hearing notice. The special notice shall contain a list of the witnesses then expected to testify. This list may be added to or otherwise supplemented at anytime prior to hearing.

Section 7. Procedure related to exclusion from federally funded healthcare programs.

New Applicants. New applicants to the Medical or Allied Health Professional Staffs who are currently excluded from any healthcare program funded, in whole or in part, by the federal government shall be notified that their applications will not be processed because they do not meet the basic qualifications for membership. They shall further be notified that they have no right to a hearing pursuant to this Article XI regarding the matter.
A. **Current Members.** Current Members of the Medical or Allied Health Professional Staffs who are excluded from a federally funded healthcare program shall also not have the right to a hearing under this Article regarding the resulting termination of their Staff Membership and Privileges. However, if the Member immediately notifies the President/Chief Executive Officer of the exclusion or any proposed or actual exclusion from any federally funded healthcare program as required by these Bylaws, a simultaneous request in writing by the Member for a meeting with the President/Chief Executive Officer and the Chief of Staff or their designees, to contest the fact of the exclusion and present relevant information shall be granted. If requested, such a meeting shall be held as soon as possible but in no event later than five (5) business days from the date of the written request. The President/Chief Executive Officer and the Chief of Staff or their designee shall determine within ten (10) business days following the meeting, and after such follow-up investigation as they deem appropriate, whether the exclusion had in fact occurred, and whether the Members Staff Membership and Privileges shall be immediately terminated. The determination of the President/Chief Executive Officer and the Chief of Staff or the designee regarding the matter shall be final, and the Member shall have no further procedural rights within the Hospital or its Medical Staff. The Member shall be given notice of the termination in the most expeditious manner possible and shall also promptly receive written notice of the termination.

A current Member who does not immediately notify the President/Chief Executive Officer of the exclusion or any proposed or actual exclusion from any federally funded healthcare program as required by these Bylaws shall have his or her staff membership and privileges terminated, effective immediately, as such time as the President/Chief Executive Officer or his or her designee receives reliable information of the Members exclusion. The Member shall be given notice of the termination in the most expeditious manner possible and shall also promptly receive written notice of the termination.

Whenever a Members membership and privileges are terminated pursuant to this Section, the Chief of Staff and the Members Service Chairman shall take all necessary steps to ensure that any patients currently under the Members care in the Hospital shall immediately be brought under the care of another appropriate practitioner.

No report of any action taken based on a practitioners exclusion from a healthcare program funded, in whole or in part, by the federal government shall be reported to the State Medical Board or the National Practitioner Data Bank, whether that action involves a decision to not process an application or to terminate a practitioners membership and privileges, because the action taken is based on the practitioners failure to meet a basic qualification of membership.

**PART B. PREHEARING PROCEDURE**

Section 1. **Exchange of Witness and Exhibit Lists.**

In addition to the requirement set forth in Part A, Section 6 above, requiring the special notice to include a list of witnesses, either party may make a written request for a witness list. If either party makes such a written request for a list of witnesses the other party intends to call and/or a list of the exhibits the other party intends to introduce at the hearing, each party, within ten (10) days of such request, shall furnish to the other a written list of the names and addresses of the individuals so far as is
then reasonably known, who will give testimony or evidence in support of that party at the hearing. The witness and/or exhibit list must be supplemented within a reasonable time as the names and addresses of additional witnesses and additional exhibits become known. The witness and/or exhibit list of either party, at the discretion of the hearing officer, may be supplemented at any time during the course of the hearing.

Section 2. Postponements and Extensions

Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by anyone but shall be permitted only by the Hearing Panel or its Chief acting upon its behalf on a showing of good cause.

PART C. HEARING PROCEDURE

Section 1. The Hearing Officer

The President/Chief Executive Officer may appoint a hearing officer who may be an attorney at law to preside at the hearing. He or she must not act as a prosecuting officer or as an advocate for the Board or the Executive Committee but may act as provided in Section 4 of this part. He or she may participate in the private deliberations of the hearing panel and be a legal advisor to it, but he or she shall not be entitled to vote on its recommendations.

Section 2. The Presiding Officer

The Presiding Officer at the hearing shall be the Hearing Officer or, if none has been appointed, the chief of the Hearing Panel. The Presiding Officer shall act to insure that all of the participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, that decorum is maintained throughout the hearing and that no intimidation is permitted. He or she shall determine the order of procedure throughout the hearing, and shall have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence, upon which he or she may be advised by legal counsel to the Hospital. In all instances, he or she shall act in such a way that all information relevant to the continued appointment or clinical privileges of the person requesting the hearing is considered by the Hearing Panel in formulating its recommendations. It is understood that the Hearing Officer is acting at all times for the Hospital in seeing that all relevant information is made available to the Hearing Panel for its deliberations.

Section 3. Record of Hearing

The Hearing Panel shall maintain a record of the hearing by one of the following methods: a court reporter present to make a record of the hearing or a tape recording capable of written transcription of the proceedings. The cost of such court reporter, if used, shall be borne by the Hospital. The hearing Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this state. The person requesting the hearing may request and obtain a copy of the record upon payment of reasonable charges for the copying of such record.

Section 4. Rights of Both Sides.
At the hearing, both sides shall have the following rights: to call and examine witnesses, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues and to rebut any evidence whether presented by the opposing party or requested by the Hearing Panel. If the person requesting the hearing does not testify on his or her own behalf, he or she may be called and examined as if under cross-examination.

Section 5. Admissibility of Evidence.

The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the Presiding Officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Such evidence may include, but is not limited to, any material contained in the Hospital's files regarding the person who requested the hearing and any and all applications, references and accompanying documents, so long as the person who requested the hearing is given the opportunity to comment on and, by other evidence, attempt to refute it. The Hearing Panel may interrogate the witnesses, call additional witnesses or request documentary evidence if it deems it appropriate. In such cases, the Hearing Panel shall give each party an opportunity to comment on any such additional evidence, and by other evidence, refute it.

Section 6. Official Notice.

The Presiding Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration, which could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

Section 7. Memorandum of Points and Authorities.

Each party shall have the right to submit a memorandum of points and authorities, and include therein any argument it may wish to assert immediately following the close of the Hearing. The Hearing Panel may request that such a memorandum be filed. The Hearing Panel shall have the power to specify the time limits within which any such memorandum of points and authority, and argument is to be filed with the Hearing Panel.

Section 8. Adjournment and Conclusion.

The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence (including the Memorandum of Points and Authorities), the hearing shall be closed. The Hearing Panel shall thereupon, conduct its deliberations and render a decision and accompanying report. The Hearing Panel may request the assistance of the legal counsel to the Hospital in formulating and preparing its report.

Section 9. Burden of Proof

A. In all cases in which a hearing is conducted under this Article, the Executive Committee or the Board shall initially come forward with the evidence in support of its recommendation. Thereafter, the burden shall shift to the person who requested the hearing to show by a preponderance of the evidence that the action was arbitrary, capricious or unreasonable.
B. In all cases in which a hearing is conducted under this Article, the Hearing Panel shall recommend against the person who requested the hearing unless it finds that said person has proved that the recommendation which prompted the hearing was arbitrary, capricious or unreasonable.

Section 10. Basis of Decision

The decision of the Hearing Panel shall be based upon permissible evidence produced at the hearing as described in Sections 7 and 8 of this Part C of Article VIII.

PART D. POST-HEARING PROCEDURE

Section 1. Recommendation of the Hearing Panel

Within twenty-one (21) days after the closing of the hearing, the Hearing Committee shall make a written report of its findings and recommendations in the matter and shall forward the same together with the hearing record and all other documents considered by it to the body whose adverse professional review recommendation or action occasioned the hearing. The Hearing Committee Report shall concisely state the reasons for the findings and recommendations made in the report. The hearing committee report shall specifically affirm, reverse or modify the adverse professional review recommendation or adverse professional review action which was reviewed. The affected individual shall be provided with a copy of the hearing panel's recommendation and the reasons for the findings reflected therein. If the adverse professional review recommendation or action is affirmed, the hearing committee report shall include a statement that it is the reasonable belief of the hearing committee that the action taken or recommended is warranted by the facts as presented at the hearing. The hearing committee shall request the parties to submit proposed findings and recommendations and the reasons therefore. No party shall be required to submit proposed findings and recommendations. Proposed findings or recommendations must be submitted to the committee within 14 days after the closing of the hearing. Any written statements submitted by the party after that date shall not be considered by the committee.


If the hearing has been conducted by reason of an adverse recommendation by the Executive Committee, the report of the Hearing Panel shall be delivered to the Executive Committee for whatever modification, if any, it wishes to make to its original recommendation. If the hearing has been conducted by reason of an action of the Board, the report of the Hearing Panel shall be delivered to the Board.

PART E. APPEAL

Section 1. Time for Appeal

Within fifteen (15) days after the affected individual is notified of either (1) a final recommendation adverse to him made by the Executive Committee after a hearing, if he or she has requested one, or (2) an adverse recommendation from a Hearing Panel directly to the Board, he or she may request an appellate review. The request shall be in writing and shall be delivered to the President/Chief Executive Officer either in person or by certified mail, and shall include a brief
statement of the reasons for appeal. If such appellate review is not requested within fifteen (15) days as
provided herein, the affected individual shall be deemed to have accepted the recommendation involved
and it shall thereupon become final and immediately effective.

Section 2. Grounds for Appeal.

The grounds for appeal from an adverse recommendation shall be that:

A. There was substantial failure on the part of the Executive Committee or Hearing Panel to
comply with the Hospital or Medical Staff Bylaws in the conduct of hearings and
recommendations based on hearings so as to deny due process or a fair hearing.

B. The recommendation was made arbitrarily, capriciously or with prejudice.

C. The recommendation of the Executive Committee or Hearing Panel was not supported by
the evidence.

Section 3. Time, Place and Notice.

Whenever an appeal is requested as set forth in the preceding sections, the Chairman of the
Board shall, within 10 days after receipt of such request, schedule and arrange for an appellate review.
The Board shall cause the affected individual to be given special notice of the time, place and date of the
appellate review. The date of appellate review shall not be less than twenty (20) days, nor more than
forty (40) days, from the date of receipt of the request for appellate review; provided, however, that
when a request for appellate review is from a member who is under a suspension then in effect the
appellate review shall be held as soon as the arrangements may reasonably be made and not more than
fourteen (14) days from the date of receipt of the request for appellate review. The time for appellate
review may be extended by the Chairman of the Board for good cause.

Section 4. Nature of Appellate Review

The Chairman of the Board shall appoint a Review Panel composed of not less than three (3)
persons, either its own members, reputable persons outside the Hospital, or a combination of the two, to
consider the record upon which the recommendation before it was made. No member of the Review
Panel may be in direct economic competition with the affected practitioner, play any part in the
presentation of the appeal, or have participated in any earlier investigation or decision of the matter. The
Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights
cross-examination or confrontation provided at the hearing panel proceedings. Each party shall have
the right to present a written statement in support of his position or appeal, and in its sole discretion, the
Review Panel may allow each party or its representative to appear personally and make oral argument.
The Review Panel may request the assistance of the legal counsel to the Hospital in formulating and
preparing its report. The Review Panel shall recommend final action to the Board. The Board may
affirm, modify or reverse the recommendation of the Review Panel or, in its discretion, refer the matter
for further review and recommendation.

Section 5. Final Decision of the Board

Within fourteen (14) days after the conclusion of the proceedings before the Review Panel, the
Board shall render a final decision in writing and shall promptly deliver copies thereof to the affected
individual and to the Executive Committee in person or by certified mail, return receipt requested. This
final decision shall include a statement of the basis of the decision. The President/Chief Executive
Officer shall report to the State Board of Medical Examiners or other authorities as required by State and/or Federal law any final adverse professional review action.

Section 6. Further Review

Except where the matter is referred for further action and recommendation in accordance with Section 4 of this Part, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. Provided, however, if the matter is referred for further action and recommendation, such recommendations shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall in no event exceed thirty (30) days in duration except as the parties may otherwise stipulate.

Section 7. Right to One Appeal Only.

No applicant or Medical Staff appointee shall be entitled as a matter of right to more than one appellate review on any single matter which may be the subject of an appeal, without regard to whether such subject is the result of action by the Executive Committee or Hearing Panel, or a combination of acts of such bodies. However, nothing in these Bylaws shall restrict the right of the applicant to reapply for appointment to the Medical Staff or restrict the right of any member to apply for reappointment or an increase in clinical privileges after the expiration of two (2) years from the date of such Board decision unless the Board provides otherwise in its written decision.

ARTICLE IX.

ORGANIZATION OF MEDICAL STAFF

PART A. GENERAL

Section 1. Medical Staff Year.

For purposes of these Bylaws, the Medical Staff year commences on the 1st day of July and ends on the 30th day of June of each year.

PART B. OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be the Chief of Staff, Vice-Chief of Staff, and Secretary-Treasurer. Officers must be members of the active Medical Staff at the time of nomination and election and must continue as such during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Section 1. The Chief of Staff

The Chief of Staff shall:

A. Act as the chief medical officer of the Hospital, in coordination and cooperation with the President/Chief Executive Officer in matters of mutual concern involving the Hospital.

B. Call, preside at, be responsible for the agenda of, and keep a report and minutes of all meetings of the Medical Staff the Executive Committee.
C. After consultation with the President/Chief Executive Officer and subject to Board approval, appoint members to all standing, special, and multi-disciplinary Medical Staff committees except the executive committee.

D. Serve as ex-officio member of all other Medical Staff committees, without vote.

E. Represent the views, policies, needs, and grievances of the Medical Staff to the Board and to the President/Chief Executive Officer and communicate all actions and recommendations of the Executive Committee and the Medical Staff to the Board.

F. Receive, 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 medical care.

G. Be a spokesman for the Medical Staff in its external, professional and public relations.

H. In his discretion, report to the Executive Committee for its consideration, any situation which has come to his attention involving questions of clinic competency, patient care and treatment, care management, professional ethics or morals, infraction of Hospital or Medical Staff Bylaws or rules or unacceptable conduct on the part of any individual appointed to the Medical Staff.

I. Be responsible for the enforcement of Medical Staff Bylaws, rules and regulations, implementation of sanctions where those are required, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner.

Section 2. Vice-Chief of Staff

The Vice-Chief of Staff shall:

A. Assume all duties and have the authority of the Chief of Staff in the event of the Chief of Staff's temporary inability to perform due to the illness, or unavailability of the Chief of Staff.

B. Be a member of the Executive Committee and automatically succeed the Chief of Staff when the latter fails to serve for any reason.

C. Perform such duties as are assigned to him by the Chief of Staff.

Section 3. Secretary-Treasurer

The Secretary-Treasurer shall:

A. Assist the Chief of Staff in keeping accurate and complete minutes of all staff and executive committee meetings.

B. Collect and be custodian of staff dues and funds, and make disbursements authorized by the Executive Committee or its designee.
C. Call meetings on order of the Chief of Staff, attend to all correspondence and perform such other duties as pertained to his office. Where there are funds to be accounted for, he shall make an appropriate accounting as required or requested by the staff.

D. Collect all minutes and other documentation of standing committees that report to the Executive Committee (other than for those committees whose chiefs are members of the Executive Committee) and communicate all actions and recommendations of such standing committees to the Executive Committee. In case of a vacancy in the office of secretary-treasurer, the Executive Committee shall select a replacement for the remainder of the calendar year.

Section 4. Election of Officers.

A. Time of Election. Officers shall be elected at the May meeting of the Medical Staff.

B. Members eligible to vote. Only members of the active and provisional active Medical Staff shall be eligible to vote.

C. Method of Voting. Vote shall be by voice ballot unless a secret ballot is requested by any party.

D. Nominating Committee. A nominating committee shall be appointed by the Chief of Medical Staff on or before July 1 of each year. This Committee shall consist of the three immediate past chiefs of staff and the current chief of staff of the Medical Staff. This committee, during April, shall develop a slate of nominees for each office. The slate shall offer one or more nominees for each office. In making these recommendations, the nominating committee shall take into consideration recommendations received from the President/Chief Executive Officer.

E. Nominations from Floor. In addition to nominations made by the nominating committee, nominations may also be made from the floor at the time of the annual meeting.

F. Vote Necessary. Election shall be by a majority vote. If there are three or more candidates for an office and no candidate receives a majority, there shall be successive balloting. The name of the candidate receiving the fewest votes is omitted from each successive slate until a majority of the members voting is obtained by one candidate.

Section 5. Term of Office.

All officers shall serve a one year term from their election date or until a successor is elected. Officers shall take office on the first day of the Medical Staff year. Officers may be reelected for one additional term of office. After the expiration of one year following service for two years in one position, an individual may serve for two more successive terms.

Section 6. Removal from Office

The Medical Staff, by a two-thirds (2/3rds) vote, may remove any Medical Staff Officer for conduct detrimental to the interests of the Hospital, or for failure to fulfill the duties of his office in a timely, appropriate or satisfactory manner, provided that notice of the meeting at which such action takes place shall have been given in writing to such officer at least ten (10) days prior to the date of such meeting. The Officer shall be afforded the opportunity to speak in his own behalf before the Committee prior to the taking of any vote on his removal.
Section 7. Vacancies in Office

Vacancies in office during the Medical Staff year, except for the presidency, shall be filled by the Executive Committee from members of the active staff. If there is a vacancy in the office of the Chief of Staff, the Vice-Chief of Staff shall serve out the remaining term.

PART C. MEETINGS OF THE MEDICAL STAFF

Section 1. Regular Meetings

A. Annual Meetings:

The Medical Staff shall meet annually in May for the purpose of electing officers for the forthcoming year.

B. Regular Meetings:

Regular meetings of the Medical Staff shall be held on the third Thursday of the month, quarterly at 7:00 p.m., to review the care and treatment of patients served in the Hospital and to complete Medical Staff administrative duties. The Secretary-Treasurer shall transmit to the President/Chief Executive Officer such reports and recommendations as the Medical Staff may wish to make to him or to the Board of Directors. If no business needs to take place the Medical Staff Executive Committee may cancel the meeting.

C. Notice and Place of Regular Meetings:

The Executive Committee shall, by standing resolution, designate the time and place for all regular staff meetings. Notice of the original resolution and any changes thereto shall be given to each member of Staff in the same manner as provided in Section 2 of this Article XII for Notice of a Special Meeting.

Section 2. Special Meetings

A. Calling Special Meeting:

Special Meetings of the Medical Staff may be called at any time by the Board, the President/Chief Executive Officer, and the Chief of Staff of the Medical Staff or not less than one-fourth of the members of the active staff. The Chief of Staff shall call a special meeting within 15 days after receipt by him of a written request for said special meeting stating the purpose for such meeting. In the event that it is necessary for the staff to act on a question without being able to meet, the voting staff may be presented with the question by mail and their votes returned to the Chief of Staff of the Medical Staff by mail. Such a vote shall be binding so long as the question is voted on by a majority of the staff eligible to vote.

B. Notice of Special Meeting.

C. A written notice stating the place, day, hour and purpose of any special or emergency meeting of the Medical Staff shall be mailed to each member eligible to vote not less than one day before the date of such meeting and shall be posted in the Hospital as required in
these Bylaws. The notice of the meeting shall be deemed delivered when deposited in the United States Mail addressed to each member at his address as it appears on the records of the Hospital so long as the posting occurs not less than two (2) days prior to the date of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 3. Quorum

The presence of 50% of the total membership of the active Medical Staff at any regular or special meeting shall constitute a quorum for any regular or special meeting of the Medical Staff. This quorum must exist for any action to be taken. This quorum requirement shall also be applicable for purposes of amendment of these Bylaws, Rules and Regulations.

PART D. SERVICE AND COMMITTEE MEETINGS

Section 1. Service Meetings

Members of each service shall meet as frequently needed, as a service or subsection of a service at a time set by the Chief of the service or subsection to review and evaluate the clinical work of the service and to discuss any other matters concerning the service or subsection. The agenda for the meeting and its general conduct shall be set by the Chief.

Section 2. Committee Meetings

All standing committees shall meet as frequently needed, at a time set by the Chairperson of the committee. Committees may, by resolution, provide for holding regular meetings without notice other than such resolution. The agenda for the meeting and its general conduct shall be set by the chief.

Section 3. Discussion of Medical Staff Member's Clinical Work

A. Any person appointed to the Medical Staff whose clinical work is scheduled for discussion at a regular service meeting or clinic pathological conference shall be so notified at least seven (7) days in advance of the meeting and shall be expected to attend such meeting. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the individual shall so state, shall be given by special notice, and his attendance at the meeting at which the alleged deviation is to be discussed shall be mandatory and failure to attend shall be considered a voluntary relinquishment of Medical Staff appointment in accordance with Article VII, Part C, Section 3.

B. If the individual shall make a timely request for postponement supported by an adequate showing that his absence will be unavoidable, the presentation may be postponed by the chief of his service or by the Executive Committee if the service chief is the individual involved, until not later than the next regularly scheduled meeting. Otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

C. The preliminary review of clinical work to determine whether such work should be scheduled for discussion at a service meeting or clinic or pathological conference or to determine whether an apparent or suspected deviation from standard clinical practice is involved shall not require any notice to the affected member of the Medical Staff.
D. During the discussion of a member's clinical work at a service or clinic or pathological conference, the chief may require that the member excuse himself from the meeting to facilitate frank and open discussion.

Section 4. Special Meetings of Service and Committee

A. A special meeting of any service or committee may be called by or at the request of the committee chief, by the Chief of the Executive Committee or by a petition signed by not less than one-third (1/3) of the members of the service or committee. Written notice stating the place, day, hour and purpose of any special meeting shall be mailed to each member of the committee or service eligible to vote not less than three (3) days before the time of such meeting and shall be posted in the Hospital as required by these Bylaws. The notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member's address as it appears on the records of the Hospital so long as the posting occurs not less than three (3) days prior to the date of the meeting. The attendance of any member at a meeting shall constitute a waiver of the individual's notice of such meeting.

B. In the event that it is necessary for a Committee or service to act on a question without being able to meet, the voting members may be presented with the question, in person, e-mail or by mail, and their vote returned to the chief of the committee or service. Such a vote shall be binding so long as the question is voted on by a majority of the committee or service eligible to vote.

Section 5. Quorum

The presence of the greater of three (3) individuals or one-half (1/2) of the total membership of the Committee or service eligible to vote, or represented by written proxy, at any regular or special meeting shall constitute a quorum for all actions. (If the Committee consists of three people or less, two-thirds (2/3) of the membership shall constitute a quorum.) Persons serving under these Bylaws as ex officio members of a committee shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum and unless otherwise specified, shall not be entitled to vote.

PART E. PROVISIONS COMMON TO ALL MEETINGS

Section 1. Attendance Requirements

A. Each active staff member or active provisional staff member shall be required to attend at least 50% of each Committee assignment, including regular Medical Staff meetings and service meetings, or, if appropriate, service subsection, meetings in each year, but is expected to attend all meetings.

B. For large contracted groups who provide patient care services the number of votes per group will be tied to the number of providers required to be involved in committee work. These numbers will be determined by MEC and documented in the minutes.

C. Excused absence may be requested if the member provides his or her proxy to an active member in good standing with the Medical Staff. For committee meetings, the proxy must be given to another active member in good standing on such committee.
D. If a physician during a fiscal year fails to meet the meeting attendance requirement then he/she may at the discretion of the Medical Executive Committee be placed in the non-voting member category and assessed the fee set forth by the Medical Executive Committee for a period of 1 year. At the end of the year the non-voting member may ask to remain in that category or ask to be returned to full voting status.

E. The failure of any person, required to do so, to meet the foregoing annual staff meeting and other attendance requirements shall be considered at time of reappointment. Active Medical Staff Members may request a waiver of the attendance requirements for Regular Medical Staff meetings, Service Committee meetings, Standing Committee meetings, and Ad-Hoc Committee meetings. Request for a waiver must be submitted in writing in April, prior to the next fiscal year. Requests must be accompanied with a fee that is set yearly by the Medical Executive Committee, in order for the request to be considered by the MEC. This fee is in addition to the Medical Staff Dues. All monies collected through this process will be credited to the Medical Staff Account. Members who fail to meet the minimum meeting attendance the previous year will be assessed the same fee.

If a request for a waiver is approved, member will be notified. Quorum at any meeting is set by the participating voting members of the Active Medical Staff.

F. Persons appointed to the Courtesy category of the Medical Staff shall be expected to attend and participate in service meetings unless unavoidably prevented from doing so but shall not be required to do so as a condition of continued staff appointment.

Section 2. Rules of Order

Whenever they do not conflict with these Bylaws, the currently revised Robert's Rule of Order shall govern all meetings.

Section 3. Voting

Any individual who, by virtue of position, attends a meeting in more than one (1) capacity shall be entitled to only one (1) vote. The voting privileges of a staff member can only be curtailed by appropriate corrective action conducted in accordance with these Bylaws.

Section 4. Minutes and Records

Minutes of each regular and special meeting of the Medical Staff, a committee or service shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes or copies thereof shall be available to the attendees for approval at the next meeting. All minutes shall be forwarded to the Executive Committee and to the President/Chief Executive Officer. Each committee and service shall maintain a permanent file of the minutes of each meeting and all other pertinent information. Whenever joint meetings are held with the staff of another Hospital, a clear report of proceedings regarding Saint Alphonsus Medical Center - Ontario must be written and identified.

PART F. COMMUNICATION WITH THE BOARD

The Chief of Staff and Vice-Chief of Staff shall represent the Medical Staff to the Board.
PART G. MEDICAL STAFF DUES

A. The Medical Staff may assess such dues as the Medical Staff believes are appropriate and which serve to improve healthcare. Dues shall be payable annually.

B. For large contracted groups who provide patient care services annual dues per provider will be based upon # of FTEs to cover the service at Saint Alphonsus Medical Center-Ontario. The # of FTEs will be determined by MEC and documented in the minutes

C. The amount of annual dues shall be established at the annual meeting of the Medical Staff. Dues may be established in different amounts for different categories of Medical Staff. A person who:

1. fails to pay required medical staff dues before or within ninety (90) days following the due date or

2. fails to pay required medical staff dues after the third invoice, notice, and/or warning regarding the same,

Shall have his or her admitting privileges automatically suspended by the Hospital. Such suspension shall continue until such time as when the dues are current. Dues shall continue to accrue during any period of suspension of privileges. Special assessments for use outside the Hospital require an affirmative vote of not less than seventy-five percent (75%) of the active and provisional active Medical Staff. Determination and establishment of the amount of annual dues is by majority vote of a quorum.

ARTICLE X.

FUNCTION AND COMMITTEES OF THE MEDICAL STAFF

PART A. STAFF FUNCTIONS

Section 1 General Function

The Medical Staff, subject to Board approval, shall provide effective mechanisms to monitor and evaluate the quality and appropriateness of all patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms shall provide a means by which important problems and patient care can be identified and resolved and opportunities to improve care can be addressed.

Section 2 Specific Functions

By assignment to the services or to the Medical Staff committees, the following functions shall be performed by the Medical Staff:

A. To monitor and evaluate the quality and appropriateness of all patient care, and to participate fully in the Hospital's quality assurance program.
B. To conduct and review monitoring activities, including surgical case review and autopsy reports.

C. To develop and maintain surveillance over blood usage and blood transfusions and conduct reviews with respect there to.

D. To require that patient records are complete, timely and clinically pertinent.

E. To develop and maintain surveillance over drug usage and pharmacy and therapeutic policies and practices and conduct ongoing reviews with respect there to.

F. To prevent, investigate and monitor control of Hospital acquired infections and conduct reviews with respect thereto.

G. To plan for response to fire and other disasters and Hospital safety, for Hospital growth and development, and for provision of Medical services required to meet community needs.

H. To conduct and review the conduct of utilization review activities.

I. To conduct and review all credentialing activities, corrective action activities, and fair hearing proceedings.

J. To provide continuing professional education responsive to evaluation findings and new developments.

K. To direct the staff organizational activities including Staff Bylaws, rules and regulations, review and revision, staff officer committee nominations, liaison with the board and Hospital administration and review and maintenance of Hospital accreditation.

L. To coordinate the care provided by practitioners and other professionals with the care provided by the nursing service and other Hospital patient care administrative services.

M. To develop and implement staff programs, activities and functions necessary to maintain Hospital accreditation.

N. To review Medical records in cooperation with the nursing department management and administrative services, and other appropriate Hospital Staff.

O. To conduct and perform such other duties and responsibilities as are assigned by the Board.

All such functions shall be reviewed and evaluated on an annual basis and shall be conducted and performed in such a manner as to meet all licensure and accreditation requirements including, without limitation, the accreditation requirements of the joint commission on accreditation of Hospitals.

**PART B. PROVISIONS COMMON TO ALL COMMITTEES**

Section 1 Removal
The Executive Committee, by a two-thirds (2/3) vote may remove any Chairman or Member of any Committee (other than an ex-officio member) for conduct detrimental to the interests of the Hospital, or for failure to fulfill the duties of that individual’s office in a timely, appropriate or satisfactory manner, provided that notice of the meeting at which such action takes place shall be given in writing to such Chairman or Member at least ten (10) days prior to the date of such meeting. The Chairman or Member shall be afforded the opportunity to speak in his own behalf before the Executive Committee prior to the taking of any vote on his removal. A Member of the Hospital’s Administrative Staff who is serving on a Committee may be directed not to attend at any time by the President/Chief Executive Officer.

Section 2 Composition and Appointment.

A. Chairman:

Unless otherwise provided for in these Bylaws, appointment of all committee chairmen shall be made by the Chief of the Medical Staff. All chairmen shall be selected from persons appointed to the active staff.

Such appointments shall be made by the Chief of Staff at the end of the Medical Staff year for succeeding Medical Staff year. Each appointment shall be made for an initial term of one year. After serving an initial term, a chairman may serve additional terms if reappointed by the Chief of Staff.

Unless otherwise provided, the Chairman of each Committee shall vote only when there is a tie or deadlock.

B. Members:

A Medical Staff committee established to perform one or more of the staff functions required by these Bylaws shall be composed of members of the Medical Staff and unless otherwise provided, may include non-voting representation from Active Ambulatory Staff, Hospital administration, nursing service, Medical records service, pharmaceutical services, social service and such other Hospital services as are appropriate to the function to be discharged. Non-physician staff members may be invited to attend Committee meetings by the Committee Chairperson. Non-Medical Staff members who are invited to attend on a regular basis shall be designated by the President/Chief Executive Officer, but shall attend at the pleasure of the Committee. Persons not attending on a regular basis may be designated or invited by the Committee, Medical Staff members of each committee, except as otherwise provided in these Bylaws, shall be appointed for one year terms. These appointments shall be made at the regular staff meeting in the month of May by the Chief of Staff. There is no limitation in the number of terms that a member may serve on any Committee. The involvement of a non-Medical Hospital administration staff member in any committee shall automatically terminate upon termination of such individual's employment with the Hospital.

The President/Chief Executive Officer and Chief of Staff, or their respective designees, if not made members of the Committee by these Bylaws, shall serve as ex officio members on all committees. As ex officio members, they shall serve, but shall not vote.

C. Removal:
The chairman or any member of any committee, other than an ex officio member, may be removed, at any time, by a majority vote of the Executive Committee. A member of the Hospital administrative staff who is serving on a Committee may be directed not to attend at any time by the President/Chief Executive Officer.

D. Vacancies:

Unless otherwise specifically provided, vacancies on any staff committee shall be filled in the same manner in which original appointment to such committee is made.

E. Meetings:

A staff committee established to perform one or more of the staff functions required by these Bylaws shall meet as often as is necessary to discharge its assigned duties as specified in these Bylaws or in its statement of purpose.

Section 3 Creation of Standing Committees

In addition to the specific standing committees described in this Article, the Executive Committee, by resolution, may suggest that a standing committee, as may be necessary or appropriate to perform one or more of the Medical Staff functions, be established. In order to establish a standing committee, these Bylaws must be amended. The resolution of the Executive Committee shall be delivered to the appropriate committees to initiate the process of Bylaw amendment.

The Executive Committee may, by resolution and without amendment to these Bylaws, add to the duties or charges of a currently existing committee without amending these Bylaws. However, the Executive Committee may not dissolve or rearrange committee structures without going through the Bylaw amendment process.

Any function required to be performed by these Bylaws which are not assigned to a standing or special committee shall be performed by the Executive Committee of the Medical Staff.

If a new standing committee is to be established, the Executive Committee, at the time the Committee is suggested to the Executive Committee, shall outline in a written report and with particularity, the following:

A. The composition, duties, purpose and authority of the committee;

B. The frequency of meetings and record keeping requirements; and

C. The individual or other committee or authority to which the committee is to report.

This written report shall be submitted to the Medical Staff and shall be maintained as a permanent record. If accepted by the Medical Staff, it shall be enacted as an amendment to these Bylaws following the normal amendment process.

Provision shall be made in these Bylaws or by resolution of the Executive Committee, either through assignments to the services, to staff committees, to staff officers, or officials, or to interdisciplinary Hospital committees, for the effective performance of the staff functions as specified in these Bylaws and of such other staff functions as the Executive Committee shall reasonably require.
The Executive Committee shall review, on an annual basis, all committees and their effectiveness and especially their effectiveness in monitoring and evaluating quality and appropriateness of patient care. Following such review, the Executive Committee shall suggest changes regarding the committees as the Executive Committee may deem appropriate. Such recommendations can include a suggestion that the Committee be terminated. Such recommendations shall be made to Medical Staff and, before becoming effective, must be approved by the Board.

Section 4 Creation of Ad Hoc Committees.

Unless otherwise specified in these Bylaws, ad hoc committees shall be appointed by the Executive Committee or by the Chief of Staff of the Medical Staff as required. Such committees shall confine their activities to the purpose for which they were appointed and shall report to the Executive Committee or to the committee to which they are directed to report by the Executive Committee. At the time such committees are established, the Executive Committee or Chief of Staff, as appropriate, shall outline, in the minutes of the meeting where the ad hoc committee was established, generally the following:

A. The composition, duties, purpose and authority (including the authority to compel personal appearance) of the committee;
B. Frequency of meetings and record keeping requirements; and
C. The individual or other committee to whom the committee is to report.

Section 5 Creation of Sub-committees.

Sub-committees may be appointed by the standing committees as required. Such sub-committees shall confine their activities to the purpose for which they were established and shall report to the Committee of which they are a part. At the time such sub-committees are established, the Committee establishing the sub-committee shall outline the purpose, nature, and authority of the sub-committee.

Section 6 Conflicts of Interest

In any instance where a member of a committee has a conflict of interest in any matter involving another member of the Medical Staff which comes before the committee, or in any instance where a member of the committee brought the complaint against that member, that member shall not participate in the discussion or voting on the matter and shall declare his conflict and absent himself from the meeting during the time of discussion and voting. He may be asked and may answer any questions concerning the matter before leaving.

PART C. DESIGNATION OF CERTAIN COMMITTEES

Section 1 Generally

There shall be a Medical Executive Committee and the other standing committees outlined in this Part C, Article XIV, and such other standing or committees of the Medical Staff responsible to the Executive Committee as may from time to time be necessary and desirable to perform the Medical Staff functions.
Section 2 Executive Committee.

A. Composition:

B. The Executive Committee shall consist of the officers of the Medical Staff including the Chief of Staff, Vice Chief of Staff, Secretary-Treasurer, the immediate past Chief of Staff, and the Chiefs of Services of Medicine (representing cardiology, and dermatology), Surgery (representing urology, orthopedics, podiatry, ENT, ophthalmology, oral surgery, dentistry, gynecology), OB/GYN, Pediatrics, Emergency, Family Practice, Radiology and either Anesthesia or Pathology. The President/Chief Executive Officer of the Hospital shall be an ex officio member of the Executive Committee without vote.

1. Officers of the Medical Staff shall be nominated by the Nominating Committee, and be approved by the Executive Committee and the Medical Staff.

2. At no time may an Officer of the Medical Staff, at the same time, be Chief of any Service.

3. The terms of committee members shall be for one year.

4. The Chief of Staff shall be the chairman of the Executive Committee.

5. All members of the Executive Committee shall consist of fully licensed physician members of the Medical Staff actually practicing in the Hospital.

C. Duties.

The duties of the Executive Committee shall be:

1. To make recommendations directly to the Board regarding the structure of the Medical Staff, including the creation of committees;

2. To make recommendations directly to the Board regarding the mechanism used to review credentials and to delineate individual clinical privileges;

3. To make recommendations directly to the Board regarding appointments, reappointments and grants, renewals of, terminations, or other changes in clinical privileges, staff status, staff membership, and service assignments for individual practitioners;

4. To evaluate and monitor the overall quality, efficiency and appropriateness of the Medical care rendered to patients and the clinical performance of all practitioners holding clinical privileges, including the organization of the quality assurance activities of the Medical Staff and the mechanism used to conduct, evaluate and revise such activities;

5. To make recommendations directly to the Board regarding all corrective action initiated and pursued under these Bylaws, including procedures for fair hearings, and the mechanisms pertaining to such corrective action, and hearing procedures;
6. to represent and to act, without requirement of subsequent approval, on behalf of the Medical Staff, in all matters between meetings of the Medical Staff, subject only to any limitations imposed by these Bylaws;

7. coordinate the activities and general policies of the various services and committees, and in particular, to recommend to the Board mechanism to assure the same level of quality patient care throughout the Hospital;

8. to receive and act upon service and committee reports and recommendations and to make recommendations, as appropriate, concerning them to the President/Chief Executive Officer and the Board;

9. to implement policies of the Medical Staff which are not the responsibility of the services;

10. to provide liaison among the Medical Staff, the President/Chief Executive Officer, and the Board;

11. to recommend action to the President/Chief Executive Officer on matters of a medico-administrative and Hospital management nature;

12. to identify community health needs and setting of Hospital goals and implementing programs to meet those needs.

D. Board Communication:

The chairman of the Executive Committee, his representative and such members of his committee as he deems necessary shall be available to meet with the Board or its applicable committee on all recommendations that the Executive Committee may make, it being the purpose of these Bylaws to increase direct communication between the Board and the Executive Committee on all matters within the scope of the Executive Committee's duties.

E. Interim Action:

Between meetings of the Executive Committee, an ad hoc committee composed of such members of the Executive Committee as are then available shall be empowered to act in situations of urgent and/or confidential concern where not prohibited by these Bylaws. All such actions shall, to the extent practical, be reviewed, modified, or ratified with the full Executive Committee at its next regular meeting.

F. Meetings, Reports and Recommendations:

The Executive Committee shall meet monthly or more often if necessary to transact pending business. The chairman of the Executive Committee will maintain reports of all meetings, which reports shall include by reference the minutes of the various committees and services of the staff. Copies of all minutes and reports of the Executive Committee shall be made available when requested to the Medical Staff and the President/Chief Executive Officer routinely as prepared, and important actions of the Executive Committee shall be reported to the Medical Staff as determined from time to time by the Executive Committee. Recommendations of the Executive Committee shall be transmitted to the President/Chief Executive Officer and through him to the Board as the Committee deems appropriate.
Section 3 Standing Committees

A. The Medical Staff shall have the following standing committees:

1. Quality and Safety Committee;
2. Credentials Committee;
3. Bylaws Committee;
4. Nominating Committee;

B. Composition, Purpose, Duties and Meeting.

The composition, purpose, duties, and meetings of these Committees shall be reflected in the Organizational Plan. The Bylaws Committee shall develop and provide such Organizational Plan to the Medical Staff and shall be responsible to the Executive Committee for oversight of the Organizational Plan. (The Organizational Plan shall be attached to these Bylaws for reference purposes only. The Organizational Plan is not a part of the Bylaws.)

ARTICLE XI.

STATEMENT OF RELEASE AND IMMUNITY FROM LIABILITY

The following are express conditions applicable to any applicant and to any Medical Staff member and to anyone having, seeking, requesting or exercising privileges to practice in the Hospital. In addition, these statements shall be included on the application form, and by applying for appointment, reappointment and/or clinical privileges, the applicant expressly accepts these conditions, regardless of whether or not he is granted appointment or clinical privileges. They shall apply from and after any application inquiry and during and after any appointment and reappointment. The conditions are as follows:

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

1. Applications for appointment or clinical privileges, including temporary privileges.
2. Periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges.
3. Proceedings for reduction or suspension of clinical privileges or revocation of Medical Staff appointment, or any other disciplinary sanction.
4. Summary suspension.

5. Hearings and appellate reviews.

6. Medical care evaluations.

7. Utilization reviews.

8. Proceedings for modification or suspension of professional licenses.

9. Proceedings and actions regarding professional liability insurance coverage and malpractice proceedings.

10. Other Hospital and Medical Staff, service or committee activities relating to the quality of patient care or the professional conduct of the members of the Medical Staff or of any individual granted privileges to practice in the Hospital, and concerning matters or inquiries relating to an applicant's or member's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter that might directly or indirectly have an effect on the individual's competence, or on patient care, or on the orderly operation of this Hospital or any other Hospital or health care facility including otherwise privileged or confidential information.

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

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

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

E. As used in this section the term "Hospital and its representatives" means this Hospital, the members of its Board and their appointed representatives, the President/Chief Executive Officer and his subordinates or designees, consultants to the Hospital, the Hospital's attorney and his partners, assistants or designees, and all members of the Medical Staff who have any responsibility for obtaining or evaluating the applicant's or member's credentials and/or acting upon his application or conduct in the Hospital.

ARTICLE XII.

HISTORY AND PHYSICAL

A complete admission history and physical examination shall be written or dictated by a qualified licensed provider and recorded within 24 hours of admission. A "history and physical" can include an (1) emergency department exam/evaluation; or (2) office history and physical with update performed no more than thirty (30) days before admission in which event, such information shall be placed in the medical record within 24 hours of admission. This report shall include all pertinent findings resulting from an assessment of all systems of the body. If the admission history and physical examination is performed within 24 hours – 30 days of admission, the written report shall include the date and time of the examination. The update note by a qualified licensed provider will document reexamination and that the patient was interviewed and examined. Documentation will also include any changes in the patient's condition since the time that the patient's history and physical was performed or indicate no change since the time that the patient's history and physical was performed. In the situation where the patient is going to surgery within the first 24 hours of admission, the pre-anesthesia assessment may serve as the update to the patient’s condition. In the situation where the patient is going to surgery after 24 hours of admission, the daily progress note may serve as the update to the patient’s condition.

If a complete and current history and physical examination has been performed prior to the patient's admission to the Hospital, a reasonably durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and physical examination provided these reports were prepared by a member of the Medical Staff and reflect the patient's current status. In such instances, an interval admission note that includes that the patient has been interviewed and evaluated and all additions to the history and any subsequent changes in the physical findings must be recorded.

When the history and physical examination are not recorded before an operation or other potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending practitioner shall state in writing that such delay would be detrimental to the patient. If, at the time of the operation or procedure, a history and physical examination has been dictated, but not transcribed, signed, dated and timed by the attending physician, and attached to the chart, the attending physician shall attach a handwritten, signed note to the chart reflecting significant history and physical findings. Patients admitted only for oromaxillofacial surgery by an oromaxillofacial surgeon or podiatric surgery
by a podiatrist who has been granted such privileges by the Medical Staff may complete the history and physical examination before such oromaxillofacial or podiatric surgery.

Ambulatory patients, including short stay patients, receiving general, spinal or major regional anesthesia, conscious sedation or deep sedation, require an appropriate history and physical examination to be recorded in the patient’s medical record prior to being transported to the operating room and before the administration of anesthesia/sedation. An appropriate history and physical includes, at a minimum, details of the present illness, allergies, current medications, past history, physical examination relevant to the present illness, cardiopulmonary examination, a preoperative diagnosis, and a plan of care.

Ambulatory patients, who will undergo a therapeutic or diagnostic procedure without anesthesia or sedation that is likely to result in a significant physiological effect (such as emergency surgery or hospitalization) or short stay patients who do not undergo a procedure, anesthesia, or sedation but remain in the hospital for observation, require a relevant history and physical to be recorded in the medical record. A relevant history and physical includes, at a minimum, indications for the procedure or observation, diagnosis/impression, and a plan of care.

As permitted by state law and policy, the organized medical staff may choose to allow individuals who are licensed independent allied health providers to perform part or all of a patient’s medical history and physical examination.

As permitted by state law and policy, the organized medical staff may choose to allow individuals who are not licensed independent practitioners to perform part or all of a patient’s medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified doctor of medicine or osteopathy who is accountable for the patient’s medical history and physical examination.

A summary of the requirements for completion of histories and physical examinations follows:

<table>
<thead>
<tr>
<th>PATIENT CATEGORY</th>
<th>SCOPE OF HISTORY AND PHYSICAL</th>
</tr>
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<tbody>
<tr>
<td>Inpatient</td>
<td>Complete</td>
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<tr>
<td>Ambulatory patients, including short stay patients, receiving general, spinal or</td>
<td>Appropriate</td>
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<td>major regional anesthesia, conscious sedation or deep sedation</td>
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<tr>
<td>Ambulatory patients, who will undergo a therapeutic or diagnostic procedure</td>
<td>Relevant</td>
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<tr>
<td>without anesthesia or sedation that is likely to result in a significant</td>
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<tr>
<td>physiological effect (such as emergency surgery or hospitalization)</td>
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<tr>
<td>Short stay patients who do not undergo a procedure, anesthesia, or sedation but</td>
<td>Relevant</td>
</tr>
<tr>
<td>remain in the hospital for observation</td>
<td></td>
</tr>
</tbody>
</table>
Definitions:

Complete history and physical: chief complaint, details of the present illness; allergies; current medications; relevant past, social, and family histories; an inventory by body system; the results of diagnostic tests; a physical examination; diagnosis/impression; and a plan of care.

Appropriate history and physical: details of the present illness, allergies, current medications, past history, physical examination relevant to the present illness, cardiopulmonary examination, a preoperative diagnosis, and a plan of care.

Relevant history and physical: indications for the procedure or observation, diagnosis/impression, and a plan of care.

ARTICLE XIII.

FORMULATING RULES AND REGULATIONS OF THE MEDICAL STAFF

PART A. RULES AND REGULATIONS

The Medical Staff, subject to approval of the governing body, shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles of conduct found within these Bylaws. Rules and Regulations shall establish standards of practice that are required of each physician, dentist, podiatrist, and practitioner in the Hospital, and shall act as an aid in evaluating performance under, and compliance with, these standards. Rules and Regulations shall have the same force and effect as the Bylaws and shall be a part of the Bylaws.

PART B. RESOLVING CONFLICT

Each Medical Staff Member has the right to an audience with the Medical Executive Committee, if a Medical Staff Member is unable to resolve a difficulty by first working in good faith for a reasonable time under the circumstances with his/her respective department chair. In such event a Medical Staff Member may, request to meet with the Medical Executive Committee to discuss the issue at its next scheduled meeting.

ARTICLE XIV.

AMENDMENTS

PART A. PROCESS FOR URGENT AMENDMENTS
In cases of documented need for an urgent amendment to the Medical Staff Bylaws and/or the Rules and Regulations necessary to comply with law or regulation, the Medical Staff Executive Committee, may provisionally approve an urgent amendment without prior notification of the medical staff.

In such cases, the medical staff will be immediately notified by the Medical Staff Executive Committee.

A. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment.

B. If there is no conflict between the organized medical staff and the Medical Staff Executive Committee, the provisional amendment stands.

C. If there is a conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the Medical Staff Executive Committee is implemented.

D. If necessary, a revised amendment is then submitted to the governing body for action.

PART B. AMENDMENTS OF MEDICAL STAFF BYLAWS AND/OR RULES AND REGULATIONS.

Medical Staff Bylaws and/or the Rules and Regulations may be amended or repealed at any regular meeting of the Medical Staff at which a quorum is present and without previous notice or at any special meeting on notice, by a majority vote of those active Medical Staff members present. Such changes shall become effective only when approved by the Board.

A. In such cases, the medical staff will be immediately notified by the medical executive committee.

B. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment.

C. If there is no conflict between the organized medical staff and the medical executive committee, the provisional amendment stands.

D. If there is a conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the medical executive committee is implemented.

E. If necessary, a revised amendment is then submitted to the governing body for action.

PART C. PROPOSED AMENDMENTS

A proposed amendment shall be referred to the Bylaws Committee which shall report on the amendment at the next regular meeting of the Medical Staff or at a special meeting called for such
purpose. To be adopted, an amendment shall require a majority vote of the active Medical Staff Members present. Amendments so made shall be effective only upon approval by the Board.
ARTICLE XV.

ADOPTION

These Bylaws are adopted and made effective the 20th day of August 2020, superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and each and every member of the Medical Staff shall be taken under and pursuant to the requirements of these Bylaws.

The Rules and Regulations of the Medical Staff, as reflected in the revised Bylaws, are hereby adopted and placed into effect until such time as they may be amended in accordance with the terms of these Bylaws.

APPROVED by the Medical Staff this 20th day August, 2020

ADOPTED by the Board on the 8th day of September, 2020