

**BYLAWS OF
THE MEDICAL STAFF
OF
TUALITY COMMUNITY HOSPITAL**

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ARTICLE I

DEFINITIONS

The following definitions shall apply to terms used in these Bylaws:

- ¹²(1) "Allied Health Professional" (AHP) means a licensed or certified individual, other than a member of the Medical Staff or a limited licensed independent practitioner, who is permitted to exercise limited clinical privileges under an appropriate level of supervision by a member of the Medical Staff who has been accorded privileges to provide such care in the hospital. The following, without limitation, are deemed Allied Health Professionals: clinical psychologists, speech pathologists, licensed clinical social workers, surgical nurse assistants, and others identified by the Board who by their technical knowledge and skill contribute to patient care.
- (2) "Board" means the Governing Board of Tuality Community Hospital, Inc., who have the overall responsibility for the conduct of the hospital, including the Medical Staff;
- (3) "Chief Executive Officer" means the Executive Director of the hospital or his/her designee;
- ³(4) "Medical Executive Committee (MEC)" means the Medical Executive Committee of the Medical Staff unless specifically written "Executive Committee of the Board";
- ⁴⁵(5) "Hospital" means Tuality Community Hospital and Tuality Forest Grove Hospital.
- ⁶⁷⁸(6) Hospital-based independent departments will consist of, but not be limited to, Pathology, Diagnostic Imaging, Emergency Department, Radiation Therapy, and Urgent Care.
- ⁹¹⁰¹¹(7) "Limited License Independent Practitioner" means a licensed or certified health care practitioner whose professional license to practice is limited to less than the full scope of practice of a licensed M.D. or D.O.. Limited License Independent Practitioners may practice only within the scope of their delineated privileges. Limited License Independent Practitioners include, without limitation, certified nurse practitioners (including certified

¹ Amended 5/22/2008

² Amended 12/17/2015

³ Amended 6/27/2002

⁴ Amended 2/26/2004

⁵ Amended 11/21/2013

⁶ Amended 11/21/2013

⁷ Amended 6/27/2002

⁸ Amended 9/21/2014

⁹ Amended 11/21/2013

¹⁰ Amended 5/22/2008

¹¹ Amended 12/17/2015

registered nurse anesthetists and certified nurse midwives), Physician Assistants, and other independent practitioners identified by the Board.

- (8) "Physicians" means doctors of medicine (M.D.) and doctors of osteopathy (D.O.), podiatrists (DPM), dentists (DMD or DDS), and oral surgeons (DMD or DDS) who are currently licensed to practice as such in the State of Oregon.
- (9)¹² "Practitioner" means any individual who is qualified to practice a health care profession (for example, a physician or nurse) and is engaged in the provision of care and services. Practitioners are often required to be licensed as defined by law.
- ¹³¹⁴(10) "Tuality Community Hospital" means both the Hospital facility in Hillsboro, Oregon, and Forest Grove, Oregon. When referring to only the facility in Hillsboro, Oregon, it shall be referred to as "Tuality Community Hospital in Hillsboro". When referring to only the facility in Forest Grove, Oregon, it shall be referred to as "Tuality Forest Grove Hospital".
- (11)¹⁵ "Emergency Department Call Schedule" means the on-call schedule utilized for emergency patients and unassigned inpatients.

¹² Amended 4/27/06

¹³ Amended 5/1/97

¹⁴ Amended 6/27/2002

¹⁵ Amended 10/26/2017

ARTICLE II

CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Board, except as otherwise provided in this Article, and shall be made to one of the following categories of the staff.

ARTICLE II - PART A: ACTIVE STAFF^{16 17 18 19 20 21}

The Active Staff shall consist of those physicians who admit or refer a majority of their patients, or are involved in the care and treatment of more than twelve (12) hospital patients per year and an Emergency Department Call Schedule exists for that physician's specialty. Care and treatment of patients is measured by Tuality Community Hospital or Tuality Forest Grove Hospital admissions, consultations and procedures (inpatient or outpatient) needing hospital care, per year. Each appointee to the Active Staff shall agree to assume all the functions and responsibilities of appointment to the Active Staff, including, where appropriate, service patients, emergency service care, consultation, and teaching assignments. Active Staff shall complete all medical records of their patients. Active Staff appointees shall be entitled to vote, hold office, serve on Medical Staff committees, and serve as chairperson of such committees. They shall be required to attend Medical Staff and clinical service or hospital-based independent department meetings.

ARTICLE II - PART B: COURTESY STAFF

²²²³ The Courtesy Staff shall consist of physicians of demonstrated competence qualified for staff appointment who do not desire appointment to the Active Staff or who are not eligible for appointment to the Active Staff because: (1) they are involved in the care and treatment of no more than twelve (12) hospital patients per year and an Emergency Department Call Schedule exists for that physician's specialty. Care and treatment of patients is measured by hospital admissions, consultations, or procedures (inpatient or outpatient) or (2) by reason or residence some distance from the hospital, are not eligible to fulfill the requirements for appointment to the Active Staff. When a practitioner's clinical activity exceeds twelve (12) patients, over the preceding twelve months, he/she shall be considered for eligibility for appointment to the Active Staff by the Medical Executive Committee and his/her conversion to the Active Staff is considered mandatory if the Medical Executive Committee so decides. Courtesy Staff appointees shall complete all medical records of their patients, shall have no mandatory staff committee responsibilities, may not vote except in committee meetings, and may not hold office. They are encouraged to attend staff meetings. If they are appointed to a committee, they may vote in that committee.

¹⁶ Amended 10/3/96

¹⁷ Amended 6/27/2002

¹⁸ Amended 9/25/2005

¹⁹ Amended 4/27/2006

²⁰ Amended 6/27/2013

²¹ Amended 9/21/2014

²² Amended 9/20/2012

²³ Amended 6/27/2013

ARTICLE II – PART C: AFFILIATE STAFF²⁴

The Affiliate Staff shall consist of physicians of demonstrated competence qualified for staff appointment under the general credentialing qualifications. The Affiliate Staff shall include physician members who do not have admitting privileges due to professional licensure, or who do not have a Tuality Healthcare hospital practice, i.e., no clinical privileges, but who wish to be associated with Tuality Healthcare for purposes of continuing education, collegial association and/or to establish and maintain a referral network. The Affiliate Staff may attend medical staff meetings and may serve on committee as assigned, but may not vote or hold office.

ARTICLE II - PART D: HONORARY STAFF²⁵

²⁶The Honorary Staff shall consist of physicians who have retired from active hospital practice and who are of outstanding reputation, not necessarily residing in the community. Persons appointed to the Honorary Staff shall not be eligible to admit or attend patients, to vote, to hold office, or to serve on standing Medical Staff committees, but may be appointed to special committees as a guest. They may, but are not required to, attend any Medical Staff meetings. Honorary Staff are not considered members of the medical staff.

ARTICLE II - PART E: LIMITED LICENSE INDEPENDENT PRACTITIONER STAFF

Section 1. General

²⁷Limited license independent professionals are members of the Medical Staff but have none of the privileges of Medical Staff members, unless specifically noted in these bylaws. They may be granted privileges within the scope of their professional training and as specifically granted by the hospital subject to these Bylaws and all Medical Staff Rules and Regulations. A limited license independent practitioner may be granted privileges to admit patients and to exercise such privileges as are consistent with their training, including training in the inpatient setting.

Section 2. Qualifications of Limited License Independent Practitioners ²⁸

- (a) Each limited license independent practitioner must hold a current license, a certificate or such other credentials as may be required by applicable state law, these Medical Staff Bylaws, and the Medical Staff Rules and Regulations. Each must satisfy the basic qualifications required for Medical Staff membership including, without limitation, professional liability insurance coverage, and possess current competence in a discipline which the Board has determined by policy to allow to practice in

²⁴ Amended 10/28/2004

²⁵ Amended 9/21/2014

²⁶ Amended 4/28/2016

²⁷ Amended 12/17/2015

²⁸ Amended 9/21/2014

the hospital. The Board may, in consultation with the Medical Staff, establish additional qualifications required of limited license independent practitioners. Such a practitioner shall only provide services to patients within the scope of practice authorized by license, verified insurance coverage, certification or credentials and specifically delineated privileges.

²⁹(b) Application for staff appointment and clinical privileges as a limited license independent practitioner shall be generally processed in accordance with the procedures set forth in these Medical Staff Bylaws for appointment and delineation of privileges. An individual applying for clinical privileges as a limited license independent practitioner must have a physician member of the Medical Staff who has agreed to be a supervising/collaborating physician.

(c) Certified nurse midwives must have an arrangement with an obstetrician who is available per the Rules and Regulations requirements, for assistance in the event of complications or the need for cesarean section delivery.

Section 3. Privileges and Responsibilities of Limited License Independent Practitioners

³⁰

³¹³²³³(a) A limited license practitioner must have an arrangement with one or more supervising/collaborating physicians on the Medical Staff who have agreed to perform physician services which are outside the scope of practice of the limited license practitioner, or which are required by Medicare/Medicaid conditions of participation, Joint Commission standards, and conditions of reimbursement to the hospital for services initiated by the limited license independent practitioner. The supervising/collaborating physician will have responsibility for the patient's care and documentation of care for any activities which are outside the delineated privileges of the limited license independent practitioner. The supervising/collaborating physician shall be promptly available for consultation or evaluation of a patient of a limited license independent practitioner if there is any question about the patient's condition or care. The supervising/collaborating physician shall participate in peer review activities involving care by the limited license independent practitioner.

³⁴(b) Limited license independent practitioners with inpatient privileges shall:

³⁵(1) Exercise independent judgment in their areas of competence provided that a supervising/collaborating physician has

²⁹ Amended 8/27/2015

³⁰ Amended 9/21/2014

³¹ Amended 9/20/2012

³² Amended 9/21/2014

³³ Amended 8/27/2015

³⁴ Amended 8/27/2015

³⁵ Amended 8/27/2015

responsibility for areas of care outside the scope of privileges of the limited license independent practitioner;

- ³⁶³⁷³⁸(2) Be located within the geographic service area of the hospital, close enough to fulfill their responsibilities and to provide timely care for their patients. The supervising/collaborating physician must also meet this criteria;
- (3) Record reports and progress notes in the patient's records and issue orders for treatment provided that such activities are within the scope of their professional practice and are specifically permitted by delineated clinical privileges;
- ³⁹⁴⁰⁴¹(4) Admit or discharge patients, if privileges requested and approved. All admitting orders will require co-signature from the supervising/collaborating physician within 24 hours, with exception of Certified Nurse Midwives.
- ⁴²⁴³⁴⁴⁴⁵(5) Perform history and physical examinations, if privilege requested and approved. All history and physical examinations will be documented within the appropriate area of the patient's chart and will require co-signature of the supervising/collaborating physician within 24 hours, with exception of Certified Nurse Midwives. The supervising/collaborating physician shall be responsible for the components of the admitting history and physical and for all aspects of patient care which are outside the delineated clinical privileges of the limited license independent practitioner.

⁴⁶(c) Limited license independent practitioners with outpatient privileges shall:

- (1) Exercise independent judgment in their areas of competence provided that a supervising/collaborating physician has responsibility for areas of care outside the scope of privileges of the limited license independent practitioner;
- (2) Record reports and progress notes in the patient's records and issue orders for treatment provided that such activities are within the scope of their professional practice and are specifically permitted by delineated clinical privileges;

³⁶ Amended 11/21/2013

³⁷ Amended 4/27/2000

³⁸ Amended 8/27/2015

³⁹ Amended 11/21/2013

⁴⁰ Amended 8/27/2015

⁴¹ Amended 12/17/2015

⁴² Amended 11/21/2013

⁴³ Amended 4/27/2000

⁴⁴ Amended 8/27/2015

⁴⁵ Amended 12/17/2015

⁴⁶ Amended 8/27/2015

⁴⁷⁴⁸(d) All limited license independent practitioners who are granted privileges will be required to adhere to the Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) process set forth in Article V, Part B, Section 1, of these Bylaws.

⁴⁹⁵⁰⁵¹(e) Should any hospital employee have any questions regarding the clinical competence or authority of the limited license independent practitioner, either to act or to issue instructions in a particular instance, such hospital employee has the right to contact the Supervising/Collaborating Physician, then as appropriate the Clinical Service Chief or Medical Staff President to validate the order of the limited license independent practitioner. Any act or instruction of the limited license independent practitioner can be delayed until such time as the hospital employee can be certain that the act is clearly within the scope of the limited license independent practitioner's activities as approved by the Medical Staff.

⁵²(f) Limited license independent practitioners may serve without vote on appropriate committees of the Medical Staff as appointed by the Medical Executive Committee. They may be invited to attend Medical Staff meetings and may, as a condition of continued privileges, be required to attend meetings involving the clinical review of patient care in which they participated.

⁵³(g) Level of Supervision Required for Physician Assistants

A Physician Assistant applying for clinical privileges as a Limited License Independent Practitioner must have a physician member of the Medical Staff who has agreed to be a supervising physician.

(1) Physician Assistants with inpatient privileges

The supervising physician shall be responsible for the components of the admitting history and physical and for all aspects of patient care which are outside the delineated clinical privileges of the Physician Assistant. The supervising physician shall co-sign all admitting orders and history and physical examinations within 24 hours. The supervising physician is required to see all inpatients daily and to document their involvement in the progress notes. "General supervision" shall not require the actual physical presence of the supervising physician.

⁴⁷ Amended 8/27/2015

⁴⁸ Amended 12/17/2015

⁴⁹ Amended 9/20/2012

⁵⁰ Amended 9/21/2014

⁵¹ Amended 8/27/2015

⁵² Amended 9/21/2014

⁵³ Amended 12/17/2015

(2) Physician Assistants with outpatient privileges:

The supervising physician shall be responsible for all aspects of patient care which are outside the delineated clinical privileges of the Physician Assistant. "General supervision" shall not require the actual physical presence of the supervising physician

⁵⁴Section 4. Denial and Removal Procedures

The hospital retains the right either through its CEO or upon recommendation of the Medical Executive Committee to deny, suspend, terminate or curtail any or all of the privileges, or functions of any Physician Assistant or Physician Assistant Applicant subject to the fair review procedures of section 5 below, in place of any procedures in Article VII or any procedures under the corporate Bylaws.

⁵⁵Section 5. Fair Hearing and Appeal

- (a) Physician Assistants or Physician Assistant Applicants who are to be denied, suspended, terminated or curtailed shall be notified by special notice by the CEO or designee of the reasons for such action and, if they so request within thirty (30) days, shall be entitled to have such action reviewed by a special committee appointed by the Medical Executive Committee which shall be composed of members not in direct economic competition with the practitioner. At any review meeting the practitioner shall be allowed to be present and fully participate. The special committee can recommend to the Medical Executive Committee to accept, reject or modify the decision to deny, suspend, terminate or curtail subject to review and final decision by the Board.
- (b) When a Physician Assistant employed by a Medical Staff physician is to be denied, terminated or curtailed, the physician employer, as well as the Physician Assistant, shall be notified in writing by the CEO or designee of the reasons for such action and be awarded an opportunity to be reviewed by a special committee appointed by the Medical Executive Committee. The special committee, which shall be composed of members not in direct economic competition with the Physician Assistant or physician employer, can recommend to the Medical Executive Committee to accept, reject or modify the decision to deny, curtail or terminate subject to review and final decision by the Board.

Section 4. Voting Rights for Certified Nurse Midwives⁵⁶

Certified Nurse Midwives who are granted admitting privileges, shall be entitled to vote in the same manner as Active members of the medical staff.

⁵⁴ Amended 12/17/2015

⁵⁵ Amended 12/17/2015

⁵⁶ Amended 9/20/2015

ARTICLE II - PART F: ALLIED HEALTH PROFESSIONALS

Section I. General

⁵⁷Allied health professionals (AHP) are not members of the Medical Staff and accordingly, have none of the privileges of staff members. ⁵⁸Persons in this group must remain under the general supervision of specified members of the Medical Staff to ensure adequate overall patient protection. The degree of supervision may vary depending on the category of allied health professional and the qualifications of the individual allied health professional.

Section 2. Qualifications of Allied Health Professionals

Each allied health professional must hold a current license, certificate or such other credentials as may be required by applicable state law, these Medical Staff Bylaws, and the Medical Staff Rules and Regulations. Each must satisfy the basic qualifications required for Medical Staff membership including, without limitation, professional liability insurance coverage and possess current competence in a discipline which the Board has determined by policy to allow to practice in the hospital. The Board may, in consultation with the Medical Staff, establish additional qualifications required of members of any category of allied health professional. An allied health professional shall only provide services to patients within the scope of practice authorized by license, certification or credentials and within specifically delineated privileges.

Section 3. Privileges and Responsibilities of Allied Health Professionals

- (a) The degree of participation of allied health professionals in patient care shall be within the limits of their professional skills and abilities and determined according to protocol or privileges recommended to and approved by the Board.
- (b) Allied health professionals shall:
 - (1)⁵⁹⁶⁰⁶¹⁶² Perform care in their areas of competence and
 - (2) ⁶³Record reports and progress notes on the patient records and issue orders for treatment to the extent established in the Rules and Regulations of the Medical Staff, Medical staff and hospital policies, provided that such orders are within the scope of the AHP's license, certificate, or other credentials and delineated privileges.

⁵⁷ Amended 9/21/2014

⁵⁸ Amended 9/20/2012

⁵⁹ Amended 2/22/2001

⁶⁰ Amended 4/26/2012

⁶¹ Amended 9/20/2012

⁶² Amended 8/27/2015

⁶³ Amended 4/26/2012

⁶⁴⁶⁵(c) Supervision Monitoring and Review

⁶⁶Supervision of all Allied Health Professionals, with inpatient or outpatient privileges, will be done through the credentialing process via the Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) processes.

⁶⁷⁶⁸(d) Application for clinical privileges as an allied health professional shall be processed in accordance with the procedures set forth in these Medical Staff Bylaws for delineation of privileges.

(e) Allied health professionals may serve without vote on appropriate committees of the Medical Staff as appointed by the President of the Medical Staff. Such allied health professionals may be invited to attend Medical Staff meetings and may, as a condition of continued privileges, be required to attend meetings involving the clinical review of patient care in which they participated.

(f)⁶⁹⁷⁰ Should any hospital employee have any question regarding the clinical competence or authority of the allied health professional either to act or to issue instructions, such hospital employee has the right to require that the individual's supervising physician or Chief of Services/Medical Director of the Department validate, either at the time or later, the order of the allied health professional. Any act or instruction of the allied health professional shall be delayed until such time as the hospital employee can be certain that the act is clearly within the scope of the allied health professional's activities as approved by the Medical Staff. At all times, the supervising physician or attending physician will remain responsible for the patient and acts of the allied health professional, as only within the limits of their privileges within the hospital.

Section 4. Denial and Removal Procedures

⁷¹The hospital retains the right either through its CEO or upon recommendation of the Medical Executive Committee to deny, suspend, terminate or curtail any or all of the privileges, or functions of any applicant or allied health professional subject to the fair review procedures of section 5, in place of any procedures in Article VII or any procedures under the corporate Bylaws.

Section 5. Fair Hearing and Appeal

⁶⁴ Amended 8/27/2015

⁶⁵ Amended 12/17/2015

⁶⁶ Amended 12/17/2015

⁶⁷ Amended 9/21/2014

⁶⁸ Amended 8/27/2015

⁶⁹ Amended 4/26/2012

⁷⁰ Amended 8/27/2015

⁷¹ Amended 6/27/2002

- ⁷²(a) Applicants and allied health professionals who are to be denied, suspended, terminated or curtailed shall be notified by special notice by the CEO or designee of the reasons for such action and, if they so request within thirty (30) days, shall be entitled to have such action reviewed by a special committee appointed by the Medical Executive Committee which shall be composed of members not in direct economic competition with the practitioner. At any review meeting the practitioner shall be allowed to be present and fully participate. The special committee can recommend to the Medical Executive Committee to accept, reject or modify the decision to deny, suspend, terminate or curtail subject to review and final decision by the Board.
- ⁷³(b) When an allied health professional employed by a Medical Staff physician is to be denied, terminated or curtailed, the physician employer, as well as the allied health professional, shall be notified in writing by the CEO or designee of the reasons for such action and be awarded an opportunity to be reviewed by a special committee appointed by the Medical Executive Committee. The special committee, which shall be composed of members not in direct economic competition with the allied health professional or physician employer, can recommend to the Medical Executive Committee to accept, reject or modify the decision to deny, curtail or terminate subject to review and final decision by the Board.

ARTICLE II - PART G: TELEMEDICINE⁷⁴

⁷⁵All practitioners who are responsible for the patients care, treatment and services via telemedicine link are credentialed and privileged to do so through one of the following mechanisms:

- 1) The hospital fully privileges and credentials the practitioner according to the Medical Staff Bylaws and credentialing policies, or
- 2) The hospital privileges practitioners using credentialing information from a Joint Commission accredited organization.

Telemedicine practitioners are not considered members of the medical staff and do not have the rights or benefits of membership and do not have access to Article VI Hearings and Appeals in these Bylaws.

ARTICLE II - PART H: SPECIAL MEMBERSHIP REQUIREMENTS

Section 1. General

Dentists, oral surgeons, podiatrists or Medical Physician Residents who are providing professional services to or in the hospital are eligible to be appointed to

⁷² Amended 6/27/2002

⁷³ Amended 6/27/2002

⁷⁴ Amended 4/28/2016

⁷⁵ Amended 10/27/2011

the Medical Staff as Active, Courtesy or Honorary members and to be granted clinical privileges in the hospital.

Section 2. Dentists, Oral Surgeons and Podiatrists

(a) Each individual dentist, oral surgeon or podiatrist shall file a standard Medical Staff application. Each applicant shall be evaluated by the appropriate clinical service, which shall recommend to the Medical Executive Committee, for recommendation to the Board, the clinical privileges the applicant shall be permitted to exercise in the hospital.

⁷⁶⁷⁷⁷⁸(b) Dentists, oral surgeons and podiatrists shall be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff and may only engage in acts within the scope of practice specifically approved for them by the Board. The dentist, oral surgeon, or podiatrist may perform the history and physical on their patients whose physical status falls within ASA class 1 and ASA class 2. Patients in ASA class 3, ASA class 4, and ASA class 5 will require a history and physical by a MD/DO physician licensed in Oregon. The dentist, oral surgeon, podiatrist must have an arrangement with a cooperating physician on the Medical Staff who agreed to perform physician services which are outside the scope of practice of the dentist, oral surgeon or podiatrist for any patient who requires such services. This would include appropriate care for patients who develop postoperative complications or require unplanned admission to the hospital.

⁷⁹Definition of ASA Classes:

Class 1	A normal healthy patient.
Class 2	A patient with mild, systemic disease
Class 3	A patient with severe systemic disease that limits activity
Class 4	A patient with an incapacitating disease that is a constant threat to life (heart failure, renal failure)
Class 5	A moribund patient who is not expected to survive without surgery (ruptured aneurysm, head trauma with increasing intracranial pressure)

Section 3. Medical Residents⁸⁰

⁸¹Residents will be granted privileges to treat patient(s) in accordance with the following:

(1) A letter of confirmation that the resident is in an accredited training program.

⁷⁶ Amended 6/24/99

⁷⁷ Amended 6/5/97

⁷⁸ Amended 6/27/2002

⁷⁹ Revised 12/10/98

⁸⁰ Amended 2/26/98

⁸¹ Amended 9/20/2012

- (2) Verification of adequate liability insurance coverage.
- ⁸²(3) A statement of agreement by the patient(s) obtained prior to care and documented in the medical record.
- (4) A statement signed by the physician or surgeon, assuming responsibility for the resident.
- (5) An affiliation agreement with the training school.
- ⁸³(6) Criminal background check and National Practitioner Data Bank query will be completed.

This section shall not apply to medical residents making application for initial clinical privileges under Article V - Part D, Section 1 (a).

⁸² Amended 9/20/2012

⁸³ Amended 9/19/2013

ARTICLE III

ORGANIZATION OF THE MEDICAL STAFF

ARTICLE III - PART A: GENERAL

Section 1. Medical Staff Year

For the purpose of these Bylaws, the Medical Staff year commences on the 1st day of June and ends on the 31st day of May each year.

Section 2. Dues⁸⁴⁸⁵

The Medical Executive Committee shall identify those individuals required to pay annual dues as established by the Medical Staff. Medical Staff dues delinquent for sixty (60) days after bills are mailed will result in the posting by regular mail and certified mail, informing the Medical Staff member of a ten (10) day period from the date of receipt for payment of dues. Failure to pay dues in that ten (10) day grace period will result in the voluntary relinquishment of Medical Staff appointment. The CEO, or his/her designee, will also notify the Service Chiefs or Chief of hospital-based independent departments and the Medical Executive Committee of the voluntary relinquishment of Medical Staff appointment. Following voluntary relinquishment of Medical Staff appointment, the former appointee may apply for Medical Staff appointment. The requirements and procedures for this application will be the same as those for a practitioner applying to the Staff for the first time. Honorary Staff members are not required to pay dues.

Section 3. Credentials File Confidentiality/Access ⁸⁶

The credentials files and quality assurance files of the Tuality Medical Staff applicants, members and past members are the property of Tuality Community Hospital. Confidentiality of and limited access to the credentials files of Tuality Community Hospital are maintained pursuant to ORS 41.675, the Oregon statute regarding peer review protection. Credentialing communications, information and records will be disclosed only in the furtherance of credentialing/peer review and quality review activities.

ARTICLE III - PART B: OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be the President, President-Elect, and Past-President. Officers must be appointed to the Active Staff for at least one year immediately prior to their nomination and election and must continue so during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

⁸⁴ Amended 12/5/96

⁸⁵ Amended 10/28/04

⁸⁶ Amended 12/10/98

Section 1. The President

A nominee for President, in addition to other requirements in Article III, Part B, shall have been on the Active Staff for at least three years at the time of nomination. The President shall:

- (a) act on behalf of the Board as a Chief Medical Officer of the hospital, in coordination and cooperation with the Chief Executive Officer in matters of mutual concern involving the hospital;
- (b) call, preside at and be responsible for the agenda of all general meetings of the Medical Staff;
- (c) appoint committee chairpersons and members to all standing, special, and multidisciplinary Medical Staff committees as appropriate;
- (d) serve as ex-officio member of all Medical Staff committees other than the Medical Executive Committee, with vote;
- (e) represent the views, policies, needs and grievances of the Medical Staff and report on the medical activities of the staff to the Board and to the Chief Executive Officer;
- (f) provide day-to-day liaison on medical matters with the Chiefs of the Clinical Services and Chiefs of the Hospital-Based Independent Departments, Chief Executive Officer and the Board;
- (g) receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care;
- (h) be the spokesman for the Medical Staff in its external professional and public relations; and
- (i) serve as Chairperson of the Medical Executive Committee.
- (k) serve as chairperson for the Tuality Hospitals Board responsible for quality review and Medical Staff activity review⁸⁷

Section 2. President-Elect

The President-Elect shall:

- (a) assume all the duties and have the authority of the President in the event of the President's temporary inability to perform due to illness, being out of the community, or being unavailable for any other reason;

⁸⁷ Amended 3/23/2017

- (b) be a member of the Medical Executive Committee of the Medical Staff and of the Joint Conference Committee;
- (c) automatically succeed the President when the President fails to serve for any reason during his/her term of office;
- (d) serve as co-chairperson of the Hospital Quality Management Committee; and ⁸⁸
- (e) perform such duties as are assigned to him/her by the President.

When the office of the President is vacated prematurely, the President-Elect shall assume the office for the remainder of the Medical Staff term. Such an assumption of office shall not be counted as a term in office, unless it occurred in the first year of the two-year term. In such an event, a new President-Elect shall be elected at the first regular staff meeting after the President-Elect assumes the vacated office of President.

Section 3. Past-President

The Past-President shall:

- (a) Serve as Chairperson of the Nominating Committee; and
- ⁸⁹(b) Serve as Chairperson of the Internal Affairs Committee; and
- ⁹⁰(c) Serve as member of the Medical Executive Committee, for a two-year term.

Section 4. Election of Officers/Medical Executive Committee Members-at-Large⁹¹

- (a) President-Elect and Medical Executive Committee members-at-large of the Medical Staff ballots will be finalized at the Annual Meeting of the Medical Staff. Ballots will be distributed within 24 hours of the Annual Meeting to the Medical Staff eligible to vote. The ballots must be returned and received within three (3) weeks from the date of the Annual Meeting. Ballots which are not received within three (3) weeks of the Annual Meeting will not be counted. The vote shall be by written secret ballot. The election of the President and President-Elect shall become effective as soon as approved by the Board. Each officer shall assume office and then serve until his/her successor has been elected and his/her election approved by the Board where required.
- (b) In any election, if there are three or more candidates for President-Elect and no candidate receives a majority, the 2 candidates with the most votes will

⁸⁸ Amended 3/23/2017

⁸⁹ Amended 9/9/2007

⁹⁰ Amended 4/26/2001

⁹¹ Amended 10/26/2006

remain on the second ballot or distribution until a majority is obtained by one candidate.

- (c) The President-Elect will succeed to the office of President automatically after the election and as soon as approved by the Board. The President shall automatically become the Past-President.
 - (d) If there is a vacancy in the office of the President, the President-Elect shall serve out the remaining term. If a vacancy occurs in the office of President-Elect or a Medical Executive Committee member-at-large the Nominating Committee will be reconvened and a special election called.
 - (e) ⁹²The Past-President will become the Chairperson of the Nominating Committee, and the committee will function for a two-year period. The committee will be comprised of three members, the past-president and two members appointed by the Medical Staff at the annual meeting at which the President-Elect has been elected.
- ⁹³A minimum of one nominee for President-Elect and for each open Medical Executive Committee members-at-large position will be selected by the Nominating Committee, contacted as to their willingness to serve 30 days prior to the Annual Meeting. The slate of nominees will be presented to the Medical Staff at the Annual Meeting. Nominations from the floor will be accepted at the Annual Meeting of the Medical Staff, provided these nominees have been contacted and have agreed to serve if elected.
- (f) The term of office for officers and Medical Executive Committee members-at-large shall be two years.
 - (g) ⁹⁴Ballots will be mailed to all Active Medical Staff members in secrecy envelopes such that the exterior envelope can be signed so as to ensure single ballots are received from eligible Medical Staff members.
 - (h) ⁹⁵Ballots will be counted by a team to consist of at least two individuals who should include the President, Chief of Medicine Clinical Service and Chief of Surgery Clinical Service.

Section 5. Removal of Officers

The Medical Executive Committee may, by a two-thirds majority vote, remove any Medical Staff officer or Medical Executive Committee member-at-large for conduct detrimental to the interests of the Medical Staff or hospital, or if he/she is suffering from a physical or mental infirmity that renders him/her incapable of fulfilling the duties of his/her office, providing notice of the meeting at which such action takes place shall have been given in writing to such individual at least ten days prior to the

⁹² Amended 4/4/96

⁹³ Amended 8/7/97

⁹⁴ Amended 10/26/2006

⁹⁵ Amended 10/26/2006

date of such meeting. The individual shall be afforded the opportunity to speak in his/her own behalf before the Committee prior to the taking of any vote on his/her removal.

If the Medical Executive Committee's action is to remove the individual, said action shall result in the immediate suspension from office and the rights and duties appertaining, provided, however, that written notice of said action shall be forthwith given to the individual, which notice shall state the reason for the action taken. Within five days of the giving of the notice, the suspended individual may, if desired, file with the Medical Executive Committee written notice of appeal of said action. Hearing on the appeal shall be held by the Medical Staff membership at a special meeting called for that purpose and within ten days of the notice of appeal. The Medical Staff membership, by a majority vote, may recommend to the Board the reversal of Medical Executive Committee's action and recommend a reinstatement of the individual. If the vote by the membership sustains committee's action or if no appeal has been taken, the matter shall be referred to the Board for review and the removal or reinstatement will be effective when approved by the Board.

The action by the Board shall be final with no right of hearing or appeal there from.

Section 6. Compensation⁹⁶

The Medical Staff President, President-Elect, Chief of Medicine, and Chief of Surgery will receive compensation as mutually agreed upon by the Medical Staff and the Board.

ARTICLE III - PART C: MEETINGS OF THE MEDICAL STAFF

Section 1. Annual Staff Meeting⁹⁷⁹⁸

The annual meeting shall be held on a date after the third Monday in May and before the third Monday in June each year.

Section 2. Regular Staff Meetings

The Medical Staff shall meet as needed, when called by the President or Medical Executive Committee for the purpose of acting on any other matters placed on the agenda by the President or Medical Executive Committee.

Section 3. Special Staff Meetings

Special meetings of the Medical Staff may be called at any time by the Board, the Chief Executive Officer, the President of the Medical Staff, a majority of the Medical Executive Committee or a petition signed by any five members of the Active Staff. In the event that it is necessary for the staff to act on a question without being able to

⁹⁶ Amended 4/22/2004

⁹⁷ Amended 10/26/2006

⁹⁸ Amended 5/23/2012

meet, the voting staff may be presented with the question by mail and their votes returned to the President 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.

Section 4. Quorum

The presence of one-third of the persons eligible to vote shall constitute a quorum for any regular or special meeting of the Medical Staff. This quorum must exist for any action to be taken. A quorum once having been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

Section 5. Agenda

(a) The agenda at any regular meeting shall be:

Business:

- (1) call to order;
- (2) acceptance of the minutes of the last regular and of all special meetings;
- (3)⁹⁹ safety story
- (4) old business;
- (5) new business;
- (6) committee/clinical service division business;
- (7) adjournment

ARTICLE III - PART D: CLINICAL SERVICES AND HOSPITAL BASED INDEPENDENT DEPARTMENTS

Section 1. Organization

The medical staff shall be divided into clinical services and hospital-based independent departments. Each service or hospital-based independent department shall be organized as a separate component of the medical staff and shall have a chief of service selected and entrusted with the authority, duties and responsibilities specified in Section 11.

Section 2¹⁰⁰. Current Clinical Services and Hospital-Based Independent Departments

¹⁰¹The current clinical services are medicine and surgery. The current hospital-based independent departments are Pathology, Diagnostic Imaging, Emergency Department, Radiation Therapy, and Urgent Care.

Section 3. Future Clinical Services and Hospital-Based Independent Departments

⁹⁹ Amended 10/30/2014

¹⁰⁰ Amended 10/30/2014

¹⁰¹ Amended 4/25/2002

The Medical Executive Committee will periodically restudy this structure and recommend what action is desirable or necessary in creating new services or in departmentalizing the staff for better organization, efficiency or improved patient care.

Section 4. Assignment

Every staff member must have a primary affiliation with the service or hospital-based independent department which most closely reflects the staff member's professional training and experience in the clinical area in which the staff member's practice is concentrated. A practitioner may be granted clinical privileges in one or more services or hospital-based independent department and the practitioner's exercise of privileges within the jurisdiction of any service or hospital-based independent department is always subject to the Rules and Regulations of that service or hospital-based independent department and the authority of the chief. In addition, there will be a non-voting member from hospital administration and from nursing service (other members may be assigned as deemed necessary to carry out the duties and responsibilities of the clinical service) assigned to each clinical service or hospital-based independent department.

¹⁰²Section 5. Meetings

All clinical services and hospital-based independent departments shall meet at least quarterly and minutes shall be maintained, unless otherwise specified, at a time set by the chief of the service or hospital-based independent department. The agenda for the meeting and its general conduct shall be set by the chief. All meetings are open to all members of the Medical Staff, but can be closed on the order of the chief of the service or hospital-based independent department. The hospital-based independent departments of Pathology, Diagnostic Imaging, and Emergency Department will be expected to send a representative to the Medicine and Surgical Clinical Service meetings to provide continuity of information. Discussion at regular meetings will include a review of the Medical Executive Committee activities, necessary revisions of hospital Bylaws, quality improvement activities, announcement of Medical Staff applicants, and other medical staff business.

Section 6. Functions

Each service or hospital-based independent department shall include these following general functions:

- (a) coordinate the professional services of those exercising privileges under its jurisdiction with those of other services and clinical units and with the hospital and medical staff support services;

¹⁰² Amended 12/20/2012

- (b) establish minimum requirements for the clinical privileges that may be exercised within this service and monitor the exercise of privileges actually delineated;
- (c) monitor, on a continuing basis, the performance of those with clinical privileges in the service for adherence to staff, hospital and service policies and procedures, including requirements for alternate coverage and for obtaining consultation for adherence to sound principles of clinical practice generally, for unexpected patient care management events and for patient safety;
- (d) be responsible to the Medical Executive Committee for the quality of care provided at the hospital in the areas of professional practice and specialization subject to the clinical service or hospital-based independent department's authority, participating in the quality care plan as defined by the Board; and performing other activities as their professional judgment warrants;
- (e) establish guidelines for the granting of clinical privileges and the performance of specified services within the clinical services and hospital-based independent departments;
- (f) conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in the state-of-the-art and to findings of review, evaluation and monitoring activities;
- (g) meet at least quarterly for the purpose of receiving, reviewing and considering quality management findings and the results of other review, evaluation and monitoring activities and of performing or receiving reports on other clinical service, department and staff functions; and
- (h) establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

Section 7. Qualifications of Service Chiefs and Hospital-Based Independent Department Chiefs

¹⁰³Each service and hospital-based independent department shall have a chief who is a member of the active medical staff in at least one of the clinical areas covered by the service or department. Qualifications include certification by an appropriate specialty board or affirmatively established comparable competence through the credentialing process.

Section 8. Selection

¹⁰³ Amended 7/26/2007

Service chiefs shall be elected every two years by those members of this service who are eligible to vote for the general officers of the medical staff.

For purpose of this election, each chief of service shall appoint a nominating committee of three members at least 60 days prior to the meeting at which the election is to take place.

The recommendations of the nominating committee shall be circulated to the voting members of each service at least 20 days prior to the election. Nominations also may be made from the floor when the election meeting is held as long as the nominee is present and consents to the nomination. Vacancies due to any reason shall be filled for the unexpired term by special election by the respective service with such mechanisms as that clinical service may adopt.

Chiefs of hospital-based independent departments shall be contractually designated by hospital administration after consultation with the Medical Executive Committee.

Section 9. Term of Office¹⁰⁴

Each service chief shall serve a two-year term which coincides with the medical staff year or until a successor is chosen, unless the chief shall sooner resign or be removed from office or lose medical staff privileges or clinical privilege in that service. Each service chief shall assume office at the annual staff meeting and then serve until his/her successor has been elected and his/her election approved by the Board, where required. Service chiefs shall be eligible to succeed themselves.

Section 10. Removal

After election and ratification, removal of service chiefs from office may occur for cause by the Medical Executive Committee in accordance with Article III, Part B, Section 5, or by a two-thirds vote of the service members eligible to vote on service matters who cast votes.

Section 11. Roles Responsibility and Authority of Service Chiefs and Hospital-Based Independent Department Chiefs¹⁰⁵

- (a) General:
A chief has the responsibility and authority to do everything necessary to carry out the functions delegated to the service chief, by the Governing Board, and by the Medical Executive Committee and as specified in these Bylaws.
- (b) Specifics:
¹⁰⁶A chief shall designate a qualified assistant chief to assume all the responsibility and authority of the chief in the chief's temporary absence. A chief has these specific roles, responsibilities and authority:

¹⁰⁴ Amended 9/12/2004

¹⁰⁵ Amended 7/27/2017

¹⁰⁶ Amended 7/27/2017

- (1) participate on a continuous basis in managing the service/department through cooperation and coordination with the nursing and other patient care services, hospital management and the president of the medical staff on all matters affecting patient care;
- (2) implement within the service/department actions taken by the medical staff, Medical Executive Committee and the Governing Board;
- ¹⁰⁷(3) clinically related activities of the department
- ¹⁰⁸(4) administratively related activities of the department, unless otherwise provided by the hospital
- ¹⁰⁹(5) recommend to the medical staff the criteria for clinical privileges in the service/department;
- ¹¹⁰(6) recommend clinical privileges for each member of the department
- (7) review and make recommendations on all proposed new or revised forms which become part of permanent medical records. New or revised forms recommended by the Service Chiefs shall be submitted to the Medical Executive Committee for approval and adoption;
- ¹¹¹¹¹²(8) provide input into and approve the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;
- ¹¹³(9) present written reports as appropriate, requested or required to the Medical Staff, to the Medical Executive Committee and to other staff or hospital committees or officials when appropriate or required;
- (10) review data/information forwarded from the Medical Staff committee charged with quality review, risk management or utilization management activities;
- (11) respond to requests from and recommendations by said committee and make recommendations or take action as appropriate; and
- (12) ¹¹⁴prepare and transmit to the appropriate authorities, as required by the Medical Staff Bylaws or other relevant protocols recommendations concerning appointment, reappointment, delineation of clinical

¹⁰⁷ Amended 7/27/2017

¹⁰⁸ Amended 7/27/2017

¹⁰⁹ Amended 4/24/2008

¹¹⁰ Amended 7/27/2017

¹¹¹ Amended 7/26/2007

¹¹² Amended 4/24/2008

¹¹³ Amended 4/24/2008

¹¹⁴ Amended 7/26/2007

privileges or specified services and corrective action with respect to practitioners or in the service/department;

- (13) ¹¹⁵¹¹⁶ assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization;
- (14) ¹¹⁷¹¹⁸ make recommendations for sufficient number of qualified and competent persons to provide care, treatment, and services;
- (15) ¹¹⁹¹²⁰ make determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services;
- (16) ¹²¹¹²² assist in the maintenance of quality control programs, as appropriate;
- (17) ¹²³¹²⁴ recommend space and other resources needed by the department or service.
- (18) ¹²⁵ Integrate the department or service into the primary functions of the organization;
- (19) ¹²⁶ coordinate and integrate interdepartmental and intradepartmental services;
- (20) Orientation and continuing education of all persons in the department or service.
- (21) ¹²⁷¹²⁸ continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;
 - a. integrating the six (6) areas of “General Competencies” developed by the Accreditation Council Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative into the Credentialing and privileging process.

¹¹⁵ Amended 4/24/2008

¹¹⁶ Amended 7/26/2007

¹¹⁷ Amended 4/24/2008

¹¹⁸ Amended 7/26/2007

¹¹⁹ Amended 4/24/2008

¹²⁰ Amended 7/26/2007

¹²¹ Amended 4/24/2008

¹²² Amended 7/26/2007

¹²³ Amended 4/24/2008

¹²⁴ Amended 7/26/2007

¹²⁵ Amended 4/24/2008

¹²⁶ Amended 4/24/2008

¹²⁷ Amended 4/24/2008

¹²⁸ Amended 7/27/2017

- i. Patient Care
- ii. Medical/Clinical Knowledge
- iii. Practice-based learning and improvement (CME)
- iv. Interpersonal and communication skills
- v. Professionalism
- vi. Systems-based practice
- b. Focus Professional Practice Evaluation (FPPE) – evaluation on specific aspects of practitioners performance
- c. Ongoing Professional Practice Evaluation (OPPE) – continuously evaluate a practitioner’s performance.

Section 12. Quorum

The presence of one-half of the total membership of the clinical service or hospital-based independent department eligible to vote at any regular or special meeting shall constitute a quorum for all actions. A quorum once having been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

ARTICLE III - PART E: COMMITTEE MEETINGS

Section 1. Committee Meetings

Clinical Service Chiefs may designate clinical specialties to meet as committees. All committees shall meet at least quarterly, unless otherwise specified, at a time set by the chairperson of the committee. The chairperson will be appointed by the Clinical Service Chief. The agenda for the meeting and its general conduct shall be set by the chairperson. All meetings are open to all members of the Medical Staff, but can be closed on the order of the committee chairperson.

Section 2. Special Committee Meetings

- (a) A special meeting of any committee may be called by or at the request of a petition signed by not less than one-fourth of the members of the committee. Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting shall be given to each member of the committee not less than three (3) business days before the time of such meeting or posted in the hospital as required by these Bylaws. If mailed, 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. The attendance of any member at a meeting shall constitute a waiver of the individual's notice of such meeting.
- (b)¹²⁹ In the event that it is necessary for a committee to act on a question without being able to meet, the voting members may be presented with the question, in person, by fax, by email or by mail, and their vote returned to the

¹²⁹ Amended 10/30/2014

chairperson of the committee. Such a vote shall be binding so long as the question is voted on by the majority of the committee eligible to vote.

Section 3. Quorum

The presence of one-half of the total membership of the committee eligible to vote at any regular or special meeting shall constitute a quorum for all actions. A quorum once having been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

Section 4. Minutes

Minutes of each meeting of each committee shall be prepared and shall include a record of the attendance of members, of the recommendations made, and of the votes taken of each matter. The minutes shall be signed by the presiding chairperson and copies thereof shall be promptly forwarded to the Chief of Service and at the same time to the Chief Executive Officer unless otherwise specified for certain committees in Article IV. Each committee shall maintain a permanent file of the minutes of each of its meetings. The Chairperson at each meeting shall ensure an individual is appointed for maintaining minutes.

¹³⁰Section 5. Committee Charter

Clinical specialty committees and other committees shall create and maintain a Committee Charter. All committee charters and charter revisions must be approved by the Medical Executive Committee. Committee Charters shall state the following: The Purpose of the Committee, Appointment Process and Length of Term of Chairperson(s) and Membership, Membership Participant Categories, Quorum Requirement, Roles and Responsibilities of the Membership, and Meeting Frequency. Should a charter not exist or not address these items, the Bylaws will prevail.

ARTICLE III - PART F: PROVISIONS COMMON TO ALL MEETINGS

Section 1. Posting Notice of Meetings

The Medical Staff office will notify members of the Medical Staff monthly of all regular staff meetings and committee meetings, such notice to be given at least forty-eight (48) hours in advance of said meeting.

Section 2. Attendance Requirements

- (a) Each appointee to the Active Staff shall be required to attend at least 50% of all regular clinical service or hospital-based independent department meetings and 50% of the applicable committee meetings in each year but is expected to

¹³⁰ Amended 7/24/2014

attend all meetings. Any person who is compelled to be absent from any meeting shall promptly submit his/her desire to receive credit for attendance at that meeting. Credit shall then be at the discretion of the Medical Executive Committee. Failure to maintain the required attendance for a year will cause the appointee to the Active Staff to be placed on probation for one year during which his/her voting privileges will be suspended. If his/her attendance during the year of probation is 50% or over, his/her full staff voting privileges will be restored. The failure of any person required to do so, to meet the foregoing annual staff meeting and other attendance requirements during the probation year shall constitute grounds for action leading to revocation of Medical Staff appointment unless he/she elects to change status to Courtesy Staff, providing such change is permitted by his/her utilization of the hospital. Reinstatement of an appointment which has been revoked because of absence from the required number of staff meetings during the probation year shall be made only upon application, and all such applications shall be processed in the same manner as applications for initial appointment.

- (1) Duly appointed or elected committees of the Medical Staff may review records of all work done within their jurisdiction for purposes of evaluation of care without notification to staff members involved.
 - (2) Any person appointed to the Medical Staff whose clinical work is scheduled for discussion at a regular clinical service, hospital-based independent department or committee meeting shall be so notified and shall be expected to attend such a meeting if it is apparent that a severe criticism or a sanction may be recommended. After said notification, the member will be given full opportunity to be heard at said meeting and appropriate action will follow and the member will be notified in writing of the result.
 - (3) If the involved staff member fails to attend said meeting or fails to make a response or showing satisfactory to the service/department, or committee and in the view of that body the said deviation from acceptable clinical practice is severe enough, a notice to the individual shall so state and it shall be sent, return receipt requested.
 - (4) Recommendations made pursuant to (2) or (3) above will be sent to the appropriate committee for review and/or action.
- (b) The President of the Medical Staff shall notify the Medical Executive Committee of the failure of an individual to attend any meeting with respect to which he/she was given notice that attendance was mandatory, and unless excused by the Medical Executive Committee upon showing of good cause, such failure shall result in an automatic suspension of all or such portion of the individual's admitting privileges as the Medical Executive Committee may direct and such suspension shall remain in effect until the matter is resolved. In all other cases, if the individual shall make a timely request for postponement supported by an adequate showing that his/her absence will be unavoidable, the presentation may be postponed until not later than the regularly scheduled meeting. Otherwise, the

pertinent clinical information shall be presented and discussed as scheduled.

- (c) Persons appointed to the Courtesy category of the Medical Staff shall be expected to attend and participate in clinical service or hospital-based independent department meetings unless unavoidably prevented from doing so but shall not be required to do so as a condition of continued staff appointment.

Section 3. Rules of Order

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

Section 4. Voting

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.

ARTICLE IV

COMMITTEES OF THE MEDICAL STAFF

ARTICLE IV - PART A: APPOINTMENT

¹³¹Section 1. Designation

Medical staff committees shall include, but not be limited to, the medical staff meeting as a committee of the whole, meetings of clinical services/hospital-based departments, committees, standing committees, and meetings of special or ad hoc committees created by the Medical Executive Committee, president of the medical staff or clinical services chiefs. The specific committees described in this Article shall be the standing committees of the medical staff. Special or ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the president of the Medical Staff, subject to consultation with and approval by the Medical Executive Committee. Medical staff committees shall be responsible to the Medical Executive Committee.

Section 2. General Provisions

(a) Terms of Committee Members

Unless otherwise specified, committee members shall be appointed for a term of 2 years, and shall serve until the end of this period or until the member's successor is appointed, unless the members shall sooner resign or be removed from the committee.

(b) Removal

If a member of a committee ceases to be a member in good standing of the medical staff, or loses employment or a contract relationship with the hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the Medical Staff President, subject to consultation with the Medical Executive Committee.

(c) Vacancies

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided, however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.

¹³¹ Amended 12/20/2012

(d) Continuation of Committee Terms

In the event any committee has an uncompleted project or there is a continuing corrective action procedure pursuant to Article VI or a continuing hearing procedure pursuant to Article VII, the president of the medical staff has the discretion to request the members of the committee to continue to act in their former capacity until the project or procedure is completed.

(e) Committee Meetings

Clinical Service Chiefs may designate clinical specialties to meet as committees. All committees shall meet at least quarterly, unless otherwise specified, at a time set by the chairperson of the committee. The chairperson will be appointed by the Clinical Service Chief. The agenda for the meeting and its general conduct shall be set by the chairperson. All meetings are open to all members of the Medical Staff, but can be closed on the order of the committee chairperson.

(f) Ex-Officio Members

The Chief Executive Officer and the President of the Medical Staff or their respective designees shall be ex-officio members on all committees; the Chief Executive Officer, without vote, the President, with vote. Committee members who are not part of the Medical Staff will be considered ex-officio without vote.

ARTICLE IV - PART B: MEDICAL EXECUTIVE COMMITTEE

Section 1. Composition¹³²

The Medical Executive Committee shall consist of the following persons:

¹³³(a) the President, President-Elect and Past-President of the medical staff,

(b) the Clinical Service Chiefs of Medicine and Surgery; and

¹³⁴(c) four at-large physician members of the active medical staff who shall be nominated and elected for a two-year term in the same manner as provided in Article III, Part B, Section 4 for the nomination and election of the Medical Staff President, with the same provisions for removal as provided in Article III, Part B, Section 5 , and

¹³⁵¹³⁶(d) at least 2 members of the Medical Executive Committee will be primary care specialties and at least 2 members of the Medical Executive Committee will be non-primary care specialties.

¹³² Amended 5/1/97

¹³³ Amended 4/26/2001

¹³⁴ Amended 4/26/2001

¹³⁵ Amended 4/26/2001

¹³⁶ Amended 5/25/2016

Section 2. Duties^{137 138}

The duties of the Medical Executive Committee shall include, but not be limited to:

- (a) representing and acting on behalf of the medical staff in the intervals between medical staff meetings, subject to such limitations as may be imposed by these Bylaws;
- (b) reporting to the medical staff at each regular staff meeting;
- (c) coordinating and implementing the professional and organizational activities and policies of the medical staff;
- (d)¹³⁹ receiving and acting upon reports and recommendations from medical staff clinical services, hospital-based independent departments, the Hospital Quality Management Committee and other committees;¹⁴⁰
- (e) recommending actions to the Governing Board and Chief Executive Officer on matters of a medical-administrative nature;
- (f)¹⁴¹ submitting periodic reports to the Governing Board on its activities and the status of pending applications;
- (g) establishing the structure of the medical staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assurance activities and mechanisms of the medical staff, termination of medical staff members and fair hearing procedures, as well as other matters relevant to the operation of an organized medical staff;
- (h) evaluating the medical care rendered to patients in the hospital;
- (i) developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster;
- (j) participating in the development of all medical staff and appropriate hospital policy, practice and planning;
- (k) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in medical staff corrective or review measures when warranted;

¹³⁷ Amended 5/1/97

¹³⁸ Amended 12/18/2014

¹³⁹ Amended 6/27/2002

¹⁴⁰ Amended 3/23/2017

¹⁴¹ Amended 6/22/2000

- (l) identifying an individual who will be responsible for collecting and being custodian of staff dues and funds, and making disbursements authorized by the Medical Executive Committee or its designees;
- (m) designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the medical staff, and approving or rejecting appointments to those committees by the president of the medical staff;
- (n) assisting in the obtaining and maintenance of accreditation;
- (o) appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the medical staff;
- (p) reviewing the qualifications, credentials, performance and professional competence and character of applicants and staff members, and making recommendations to the Governing Board regarding staff appointments and reappointments, assignments to departments, clinical services, or hospital-based independent departments, clinical privileges, and corrective action;
- (q) reviewing the quality and appropriateness of services provided by contract physicians;
- (r) ¹⁴²¹⁴³ reviewing and evaluating the qualifications of each practitioner applying for initial appointment, reappointment, or modification of clinical privileges and, in connection therewith, obtaining and considering the recommendations of the appropriate clinical services. Gender, race, creed, national origin, sexual orientation and transgender status are not used in making decisions regarding the granting or denying of clinical privileges and medical staff membership;
- (s) submitting required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, clinical service or hospital-based independent departments, clinical privileges, and special conditions;
- (t) investigating, reviewing and reporting on matters referred by the president or the clinical services or hospital-based independent departments regarding the qualifications, conduct, professional character or competence of any applicant or medical staff members;
- (u) serving as Bylaws Committee, conducting annual review of the medical staff Bylaws, and the Rules and Regulations, making recommendations, consulting an attorney if necessary, and then presenting recommendations to the

¹⁴² Amended 12/20/2012

¹⁴³ Amended 5/27/2010

Medical Staff for vote. The Medical Executive Committee may also choose to appoint an Ad Hoc Bylaws Committee as needed;

- (v) reviewing and making recommendation on forms promulgated by the medical staff and its services and hospital-based independent departments;
- (w) cooperating with the Medical Records Department to assure that all medical records are completed promptly and within a reasonable time after discharge, are clinically pertinent, and are adequate for use in patient care evaluation studies, and when necessary, as medicolegal documents; and
- (x)¹⁴⁴ formulating administrative medical records procedures in conjunction with the Manager of Medical Records, as may be necessary to assure that the department provides the best possible services to the Medical Staff and the Hospital.

¹⁴⁵The Chairperson of the Medical Executive Committee, his/her representative and such members of his/her committee as may be necessary shall be available to meet with the Board or its applicable committee on all recommendations that the Medical Executive Committee may make. Between meetings of the Medical Executive Committee, the Chairperson of the Medical Executive Committee shall be empowered to act in situations of urgent or confidential concern where not prohibited by these Bylaws.

Section 3. Meetings, Reports, and Recommendations

The Medical Executive Committee shall meet at least once each month or more often if necessary to transact business. The designated individual will maintain reports of all meetings, which reports shall include the minutes of the various committees of the staff. Copies of all minutes and reports of the Medical Executive Committee shall be transmitted to the Chief Executive Officer routinely as prepared and important actions of the Medical Executive Committee shall be reported to the staff on a regular basis, at meetings of the Medical Staff, Clinical Service meetings, or by mail. Recommendations of the Medical Executive Committee shall be transmitted to the Chief Executive Officer and through him/her to the Board as the committee deems appropriate.

ARTICLE IV - PART D: HOSPITAL QUALITY MANAGEMENT COMMITTEE ¹⁴⁶

The Medical Staff will engage in quality activity by participating in the Hospital Quality Management Committee (refer to committee charter), as well as, participating in the Hospitals Board of Directors committee (refer to committee charter).

¹⁴⁴ Amended 6/27/2002

¹⁴⁵ Revised 6/24/99

¹⁴⁶ Amended 3/23/2017

ARTICLE IV - PART E: LIBRARY/CME COMMITTEE

Section 1. Composition^{147 148}

The Library/CME Committee shall consist of at least five Medical Staff members appointed by the Medical Staff President, including a physician who is involved in the Quality Management program. In addition, the Committee shall also include the Medical Librarian, a representative from Hospital Administration, a representative from either the Risk Management or Quality Assurance Department, and other members as needed.

Section 2. Duties

The duties of the Library/CME Committee include, but are not limited to, the following:

- (1) Be responsible for the supervision and/or coordination of all educational activities of the Medical Staff;
- (2) Be a forum for the discussions of overall institutional policies relative to medical staff education programs which may transcend the interest of any individual department;
- (3) Use the issues and findings of the quality review process of the hospital and medical staff in program planning for continuing education;
- (4) Recommend an annual budget for Medical Staff purchasing of library materials;
- (5) Approve all Medical Staff purchases for the Library;
- (6) Review library reports;
- (7) Act as an advocate for the Library; and
- (8) Advise the Librarian on miscellaneous issues as requested.

Section 3. Meetings¹⁴⁹

The Library/CME Committee shall meet quarterly, or on an as needed basis and shall report regularly to the Medical Executive Committee.

ARTICLE IV - PART F: CREATION OF STANDING COMMITTEES

147 Amended 2/2/95
148 Amended 7/25/2019
149 Amended 7/25/2019

The Medical Executive Committee of the Medical Staff may, by resolution, and upon approval of the Board without amendment of these Bylaws, establish a staff committee to perform one or more staff functions. In the same manner, the Medical Executive Committee may by resolution and upon approval by the Board dissolve or rearrange committee structure, duties or composition as needed, to better perform the Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to a standing or special committee shall be performed by the Medical Executive Committee of the Medical Staff.

Section 1. Composition

Each standing committee will have the chairperson and committee members appointed annually by the Medical Staff President.

Section 2. Duties

Each standing committee will be responsible for review and analysis of patient care within their jurisdiction as assigned to them by the Medical Executive Committee. Each committee shall meet as often as necessary to transact its business and shall maintain a permanent record of its findings, proceedings and action; and shall report to the Medical Executive Committee.

ARTICLE IV - PART G: INTERNAL AFFAIRS COMMITTEE

Section 1. Composition

¹⁵⁰¹⁵¹The Internal Affairs Committee shall consist of persons appointed from the Active Staff and shall be selected by its chairperson. The term of the chairperson's office will be for two years. The chairperson will be the Past-President and the committee will function for a two-year period. The composition of the committee will be expected to change from time to time at the wish of the chairperson, varying with the task of the committee.

Section 2. Duties

- (a) Assist Medical Staff in assuring timely completion of clinically relevant sections of the medical record.

The Medical Records Department shall notify the chairperson of this committee of all charts delinquent in the major clinical classifications. The chairperson will encourage prompt completion of delinquent charts. The chairperson, at his/her discretion, may seek committee assistance in this function. Repeated non-compliance with requirements for chart completion, as defined in the Rules and Regulations, may lead the chairperson to refer the delinquent practitioner to the Medical Executive Committee for further action.

¹⁵⁰ Amended 9/9/2007

¹⁵¹ Amended 8/7/97

- (b) Assist practitioners who have developed problems which would compromise their ability to practice medicine.

It is recognized that from time to time practitioners develop problems which compromise their ability to practice medicine. Alcoholism, drug dependency, emotional disorders, and physical handicaps are examples of such problems. In cases where concern over such matters arises, the chairperson shall constitute a committee to offer its assistance to the practitioner. If the Internal Affairs Committee considers the issue to be substantial, the Committee will report its findings to the Medical Executive Committee.

- ¹⁵²(c) Be available to assist in resolving professional conflicts among medical staff members.

It is recognized that from time to time conflicts may develop among practitioners or between groups of practitioners which would work to the detriment of maintaining a smooth functioning, harmonious staff. In such instances, the chairperson, with or without a specially constituted committee, will endeavor to lend assistance in resolving the conflicts. These issues will be referred to the Internal Affairs Committee by the President of the Medical Staff, the Medical Executive Committee, or the Chief Executive Officer. The Internal Affairs Committee has no enforcement responsibilities and only reports to the Medical Executive Committee.

- ¹⁵³(d) Investigate behavioral concerns brought to it by the President of the Medical Staff, Medical Executive Committee, or Chief Executive Officer.

Behavioral concerns include

- (1) A physician's failure to comply with any of the following pertaining to his/her behavior or conduct in the hospital;
 - a. The ethics of his/her profession
 - b. The Bylaws and policies of the hospital
 - c. The Bylaws, Rules and Regulations, and policies of the Medical Staff
- (2) Behavior or conduct that is considered to be lower than the standards of the hospital.
- (3) An inability to work harmoniously with others to the extent that it affects the orderly operation of the hospital or Medical Staff organization.

If the Internal Affairs Committee considers the issue to be substantial, the Committee will report its findings to the Medical Executive Committee.

ARTICLE IV - PART H: SPECIAL COMMITTEES

¹⁵² Amended 2/26/2015

¹⁵³ Amended 2/26/2015

- (a) Special committees shall be appointed by the President of the Medical Staff as they are required. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Medical Executive Committee. Such committees will be disbanded at the completion of the assigned activities.

ARTICLE IV - PART I: JOINT CONFERENCE COMMITTEE

The Joint Conference Committee will be comprised of three Tuality Community Hospital Medical Staff members appointed by the Medical Staff President, one of whom will be the President-Elect, three Board members appointed by the Board Chairperson, and one other member selected jointly by the Medical Staff President and the Board Chairperson. When the Governing Board does not concur with a Medical Staff recommendation relative to Medical Staff appointment, reappointment, or termination of appointment, and the granting or curtailment of clinical privileges, this committee will review the recommendation before the Governing Board renders a final decision. This committee will then give a recommendation to the Governing Board.

ARTICLE V

APPOINTMENT TO THE MEDICAL STAFF

ARTICLE V - PART A: QUALIFICATIONS FOR APPOINTMENT AND/OR PRIVILEGES

1. Appointment to the Medical Staff of Tuality Community Hospital is a privilege which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. All individuals practicing medicine, dentistry, oral surgery, and podiatry in this hospital, unless excepted by specific provisions of these Bylaws, must first have been appointed to the Medical Staff.
2. Only physicians, dentists, oral surgeons and podiatrists who (a) are currently licensed to practice in Oregon; (b) are located within the geographic service area of the hospital, close enough to provide timely care for their patients; and (c) can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation and character, and their ability to work harmoniously with others sufficiently to convince the hospital that all patients treated by them in the hospital will receive quality care and that the hospital and its Medical Staff will be able to operate in an orderly manner shall be qualified for appointment to the Medical Staff. The word "character" is intended to include the applicant's mental and emotional stability.
3. No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that (a) he/she is licensed to practice any profession in this or any other state, (b) he/she is a member of any particular professional organization, or (c) he/she had in the past, or currently has, Medical Staff appointment or privileges in another hospital.
4. ¹⁵⁴¹⁵⁵No individual shall be denied clinical privileges or medical staff membership on the basis of gender, race, creed, national origin, sexual orientation and transgender status.
5. Persons holding appointments to the Medical Staff who have contractual or employment relationships with the hospital will be governed by the provisions of their contracts or terms of employment as well as by these and the hospital's Bylaws. However, since the parties have entered into a negotiated relationship, in the event of a conflict between the Medical Staff Bylaws and the contractual or employment terms, the contractual or employment terms shall be controlling.

¹⁵⁴ Amended 5/27/2010

¹⁵⁵ Amended 12/22/2012

6. ¹⁵⁶Only professionals licensed, certified or otherwise legally qualified to practice in the State of Oregon who can satisfactorily document the following are eligible to apply for either appointment or award of clinical privileges:
 - (a) Medicare/Medicaid participation
 - (b) Ability to meet terms of Medicare/Medicaid Conditions of Participation applicable to the Hospital

ARTICLE V - PART B: CONDITIONS OF APPOINTMENT

¹⁵⁷Section 1. FPPE/OPPE Process

All practitioners granted privileges at Tuality Healthcare, regardless of their membership category, will be required to go through an initial Focused Professional Practice Evaluation. Once a practitioner has successfully completed the FPPE process, and upon recommendation by the Chief/Medical Director of their services and approval by the MEC, the practitioner will be placed in the Ongoing Professional Practice Evaluation (OPPE) process.

Any existing practitioner granted additional clinical privileges after initial appointment, will go through an FPPE for the additional privilege(s) granted. As well as, any existing practitioner that has specific concerns identified during the course of their appointment will be placed in a FPPE.

Section 2. Rights and Duties of Appointees

Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board and shall require that each appointee assume such reasonable duties and responsibilities as the Board or the Medical Staff shall require.

- a. ¹⁵⁸The medical history and physical examination are completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy (refer to Rules and Regulations Section IX – Medical Records).
 - i. ¹⁵⁹History and Physical is completed within 30 days prior to admission or procedure (refer to Rules and Regulations Section IX – Medical Records).
 - ii. ¹⁶⁰History and Physical is in the patient's chart prior to a procedure or within 24 hours of admission (refer to Rules and Regulations Section IX – Medical Records).

Section 3. Time Requirements for Promotion

¹⁵⁶ Amended 2/24/2000

¹⁵⁷ Amended 6/25/2015

¹⁵⁸ Amended 10/27/2011

¹⁵⁹ Amended 5/28/2015

¹⁶⁰ Amended 5/28/2015

The period of time and qualification requirements stated in these Bylaws for promotion to the Active Staff may be altered as to specific applicants by the Board on its own motion or as recommended to the Board by the Medical Executive Committee if the Board concurs with the recommendation.

¹⁶¹¹⁶²Section 4. Duty of Interim Report

Acceptance of any appointment to the Medical Staff or exercise of any clinical privilege shall constitute the appointee/professional's agreement that he/she will:

- (a) ¹⁶³Notify the administrator promptly of any action by the Board of Medical Examiners, loss of DEA certification, proposed or actual change in his/her licensure, Medicare-Medicaid right of participation, clinical privileges at any other institution, or liability insurance modification or cancellation, or any other item which could affect hospital privileges.
- (b) ¹⁶⁴Notify the Administrator promptly of the following:
 - (1) Any professional liability settlement or judgment,
 - (2) any state or federal criminal violation (felony or misdemeanor),
 - (3) any conviction of drug or alcohol offense,
 - (4) any entry or participation in a rehabilitation program,
 - (5) any change in health status that relates to the ability to perform the clinical privileges requested,
 - (6) any adverse determination by a medical professional review organization, or
 - (7) the commencement of a formal investigation or the filing of charges by any federal or state agency against the practitioner, unless such information is exempt from disclosure by law.

In the event a practitioner is in a rehabilitation or diversion program, applicant agrees to report to the Administrator upon entering the program, on a quarterly basis thereafter and on discontinuation of the program, either successfully or unsuccessfully. The practitioner shall authorize the Program to submit a written statement to the Administrator regarding the practitioner's treatment. Notify Tuality Healthcare's Administrator and appropriate Chief of the Clinical Service or hospital-based department promptly of any conviction regarding violation of any state or federal law. The Administrator and Chief of the Clinical Service or hospital-based department upon receiving notice will evaluate and discuss if any further action might be warranted.
- (c) Continuously maintain compliance with all criteria relevant to his/her appointment or clinical privileges.

ARTICLE V - PART C: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

Section 1. Information

¹⁶¹ Amended 2/24/2000

¹⁶² Amended 10/22/2009

¹⁶³ Amended 10/22/2009

¹⁶⁴ Amended 10/22/2009

Applications for appointment to the Medical Staff shall be in writing, and shall be submitted on forms prescribed by the Board after consultation with the Medical Executive Committee. These forms shall be obtained from the Chief Executive Officer or his/her designee. The application shall require detailed information concerning the applicant's professional qualifications including:

- (a) the names of at least two physicians, or other practitioners, as appropriate who have had recent extensive experience in observing and working with the applicant and who can provide adequate information pertaining to the applicant's present professional competence and character;
- ¹⁶⁵(b) information as to whether the applicant's Medical Staff appointment or clinical privileges at any other hospital or health care facility have ever been or are in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily or involuntarily relinquished;
- (c) information as to whether his/her membership in local, state or national professional societies or his/her license to practice any profession in any state, or his/her narcotic license has ever been suspended, modified, voluntarily relinquished, or terminated. The submitted application shall include a copy of all the applicant's current licenses to practice, as well as a copy of his/her narcotics license, professional school diploma, and certificates from all post graduate training programs completed;
- ¹⁶⁶(d) information as to whether the applicant has currently in force professional liability insurance coverage that covers all privileges granted and performed in the hospital, in a minimum amount established by Board policy. The name of the insurance company and the amount and classification of such coverage should be disclosed;
- (e) a consent to the release of information from his/her present and past malpractice insurance carriers;
- (f) information on the applicant's current physical and mental health conditions that may affect the ability to perform professional or medical staff duties or that may require a reasonable accommodation;
- (g) information as to whether the applicant has ever been convicted in a criminal action and details about any such instance;
- (h) information as to whether the applicant has any currently pending liability actions and any final judgments and settlements of liability actions, and details about any such instances; and

¹⁶⁵ Amended 2/26/2015

¹⁶⁶ Amended 2/26/2015

- (i) ¹⁶⁷information regarding Medicare/Medicaid participation status and any prior or existing sanction; and
- (j) such other information as the Board may require.

Section 2. Undertakings

Every application for staff appointment shall be signed by the applicant and shall contain:

- (a) the applicant's specific acknowledgment of his/her obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the hospital for whom he/she has responsibility;
- (b) his/her agreement to abide by all Bylaws and policies of the hospital, including all Bylaws, Rules and Regulations of the Medical Staff as shall be in force from time to time during the time he/she is appointed to the Medical Staff. The applicant has the burden of proving the facts in his/her application and to subsequently attest that he/she has, in fact, abided by the Bylaws and policies of the hospital;
- (c) his/her agreement to accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to him/her by the Board and the Medical Staff;
- ¹⁶⁸(d) a statement that the applicant has received and read a copy of the Bylaws, Rules and Regulations of the Medical Staff as are in force at the time of his/her application and that he/she has agreed to be bound by the terms thereof in all matters relating to consideration of his/her application without regard to whether or not he/she is granted appointment to the Medical Staff or clinical privileges;
- (e) a statement of his/her willingness to appear for personal interviews in regard to his/her application;
- (f) a statement that any misrepresentation or misstatement in, or omission from the application whether intentional or not, shall constitute cause for automatic and immediate rejection of the application resulting in denial of appointment and clinical privileges. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in summary dismissal from the Medical Staff; and
- (g) a statement that the applicant will:
 - (1) refrain from fee splitting or other inducements relating to patient referral;

¹⁶⁷ Amended 2/24/2000

¹⁶⁸ Amended 6/27/2002

- (2) refrain from delegating responsibility for diagnosis or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;
- (3) refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;
- (4) seek consultation whenever necessary; and
- (5) abide by generally recognized ethical principles applicable to his/her profession.

¹⁶⁹Section 3. Burden of Providing Information

The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications. He/she shall have the burden of providing evidence that all the statements made and information given on the application are factual and true. The Oregon Practitioner Credentialing Application (OPCA) cannot be accepted for processing until all information is received and the application is deemed complete.

Section 4. Authorization to Obtain Information

The following statements and which form a part of these Bylaws, are express conditions applicable to any medical staff applicant, any appointee to the Medical Staff and to all others having or seeking clinical privileges in the hospital, whether or not included on the application form. By applying for appointment, reappointment or clinical privileges, the applicant expressly accepts these conditions during the processing and consideration of his/her application, whether or not he/she is granted appointment or clinical privileges. This acceptance also applies during and following the time of any appointment or reappointment.

(a) Immunity:

To the fullest extent permitted by law, the applicant or appointee releases from any and all liability, and extends absolute immunity to the hospital, its authorized representatives and any third parties as defined in subsection (c) below, with respect to any acts, communications or documents, recommendations or disclosures involving the applicant or appointee, concerning the following:

- (1) applications for appointment or clinical privileges, including temporary privileges;
- (2) evaluations concerning reappointment or changes in clinical privileges;

¹⁶⁹ Amended 2/26/2015

- (3) proceedings for suspension or reduction of clinical privileges or for revocation of Medical Staff appointment, or any other disciplinary sanction;
- (4) summary suspension;
- (5) hearings and appellate reviews;
- (6) medical care evaluations;
- (7) utilization review;
- (8) other activities relating to the quality of patient care or professional conduct;
- (9) matters or inquiries concerning the applicant's or appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; or
- (10) any other matter that might directly or indirectly have an effect on the individual's competence, on patient care or on the orderly operation of this or any other hospital or health care facility.

The foregoing acts, communications or documents, shall be privileged to the fullest extent permitted by law. Such privileges shall extend to the hospital and its authorized representatives, and to any third parties.

(b) Authorization to Obtain Information:

The applicant or appointee specifically authorizes the hospital and its authorized representatives to consult with any third party who may have information bearing on the applicant's or appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter reasonably having a bearing on the applicant's or appointee's satisfaction of the criteria for initial and continued appointment to the Medical Staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be material to such questions. The applicant or appointee also specifically authorizes said third parties to release said information to the hospital and its authorized representatives upon request.

(c) Definitions:

- (1) As used in this section, the term "hospital and its authorized representatives" means the hospital corporation and any of the following individuals who have any responsibility for obtaining or evaluating the applicant's credentials, or acting upon the applicant's or

appointee's application or conduct in the hospital; the members of its Board and their appointed representatives; the Chief Executive Officer or his/her designees; other hospital employees; consultants to the hospital; the hospital's attorney and his/her partners; associates or designees; and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating the applicant's or appointee's credentials, or acting upon his/her application or conduct in this hospital.

- (2) As used in this section, the term "third parties" means all individuals, including appointees to the hospital's Medical Staff, and appointees to the Medical Staffs of other hospitals or other physicians or health practitioners, nurses or other organizations, associations, partnerships and corporations or government agencies, whether hospitals, health care facilities or not, from whom information has been requested by the hospital or its authorized representatives.

ARTICLE V - PART D: OBTAINING AND MAINTAINING CLINICAL PRIVILEGES¹⁷⁰

Section 1. Application for Initial Clinical Privileges¹⁷¹¹⁷²¹⁷³

Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice in the hospital. Each individual who has been given an appointment to the Medical Staff of the hospital shall be entitled to exercise only those clinical privileges specifically granted by the Board, except as stated in policies adopted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, demonstrated competence and judgment, references and other relevant information. Gender, race, creed, national origin, sexual orientation and transgender status are not used in making decisions regarding the granting or denying of clinical privileges and medical staff membership. The applicant shall have the burden of establishing his/her qualifications for and competence to exercise the clinical privileges he/she requests. Below are the exclusive categories of application for initial clinical privileges.¹⁷⁴

- (a) ¹⁷⁵¹⁷⁶¹⁷⁷¹⁷⁸¹⁷⁹¹⁸⁰¹⁸¹Board Certified Physician Applicant: The initial physician applicant for active, courtesy or affiliate categories applying after 7/1/98, with the exception of Urgent Care which shall be after 1/1/2009, must have received certification by his/her specialty Board, such Board to be a member of the American Board of Medical Specialties, American Osteopathic Association,

¹⁷⁰ Amended 4/30/2015

¹⁷¹ Amended 02/26/98

¹⁷² Amended 5/27/2010

¹⁷³ Amended 12/20/2012

¹⁷⁴ Amended 4/30/2015

¹⁷⁵ Amended 8/22/99

¹⁷⁶ Amended 2/26/08

¹⁷⁷ Amended 12/30/08

¹⁷⁸ Amended 9/12/09

¹⁷⁹ Amended 3/24/2011

¹⁸⁰ Amended 9/18/2011

¹⁸¹ Amended 4/30/2015

American Board of Podiatric Surgery, and the American Dentistry Association. Note: The American Dentistry Association does not recognize certification for General Dentistry (DMD/DDS) by the Academy of General Dentistry and/or the American Board of Dentistry. For physicians requesting privileges, the physician must be board certified within the specialty/subspecialty they are requesting privileges.¹⁸²

- (b) ^{183 184 185}Non-Board Certified Physician Applicant: The initial physician applicant who is not Board Certified may make application for Medical Staff membership if any of the following criteria are met:
- 1) Resident/Fellowship Applicant: The initial physician applicant is in the final year of a residency or fellowship program.

As a condition of continued membership, the Resident/Fellowship Applicant must

- (A) ¹⁸⁶complete the final year of the residency or fellowship program within one year of application to the Medical Staff and
- (B) ^{187 188}obtain certification by a specialty Board, (such Board to be a member of the American Board of Medical Specialties or approved by the American Osteopathic Association), within the time allotted for this by the specific board but not more than five (5) years from the date the applicant completed the residency/fellowship program. For physicians requesting privileges, the physician must be board certified within the specialty/subspecialty they are requesting privileges.
- (C) ¹⁸⁹Failure to meet these two conditions of continued membership shall result in voluntary resignation, unless an extension has been approved. If an initial Resident/Fellowship applicant has not obtain board certification within five (5) years of the date of completion of the residency/fellowship program and has maintained eligibility for Board Certification then an application by the physician may be considered to be given an extension of time by the Medical Executive Committee to obtain board certification. Such consideration would be based on TCH needs at the time, appropriate justification by the applicant for an extension, and documentation showing this physician has been practicing this specialty within the last year.
- (D) ^{190 191}Insofar as medical residents are concerned, there shall be an exception to the special qualifications requirements delineated for medical residents in ARTICLE II - PART H: SECTION 3.

- 2) ¹⁹²Board-Eligible Applicant:

¹⁸² Amended 9/17/2017

¹⁸³ Amended 4/30/2015

¹⁸⁴ Amended 9/20/2015

¹⁸⁵ Amended 12/15/2016

¹⁸⁶ Amended 4/30/2015

¹⁸⁷ Amended 4/30/2015

¹⁸⁸ Amended 9/17/2017

¹⁸⁹ Amended 9/17/2017

¹⁹⁰ Amended 4/30/2015

¹⁹¹ Amended 9/17/2017

¹⁹² Amended 4/30/2015

(A) ¹⁹³ ¹⁹⁴The initial physician applicant is within five (5) years of the date of completion of the residency/fellowship program and has maintained eligibility for Board Certification.

¹⁹⁵ ¹⁹⁶As a condition of continued membership, the Board-Eligible Applicant must obtain certification by a specialty Board, (such Board to be a member of the American Board of Medical Specialties or approved by the American Osteopathic Association), within the time allotted for this by the specific board but not more than five (5) years from the date of completion of the residency/fellowship program. For physicians requesting privileges, the physician must be board certified within the specialty/subspecialty they are requesting privileges. Failure to meet this condition of continued membership shall result in voluntary resignation from the Medical Staff.

(B) ¹⁹⁷ ¹⁹⁸If an initial physician applicant has not obtain board certification within five (5) years of the date of completion of the residency/fellowship program and has maintained eligibility for Board Certification then an application by the physician may be considered to be given an extension of time by the Medical Executive Committee to obtain board certification. Such consideration would be based on TCH needs at the time, appropriate justification by the applicant for an extension, and documentation showing this physician has been practicing this specialty within the last year.

3) ¹⁹⁹Eligible individuals who have been granted an exception as noted above, shall be granted no more than a (2) two year extension. Failure to obtain Board Certification or regain Board Certification within the approved extension time and are ineligible to request additional extension time as they have reached the maximum total allowable of two years shall result in voluntary resignation from the Medical Staff.

4) ²⁰⁰Non-United States Board Certification: There may be special circumstances wherein a specialist with board certification in his/her specialty has obtained this certification from a board outside of the United States. If this board is deemed by the MEC to be at least equivalent to ABMS or those approved by AOA, then application by this physician may be considered. Such consideration would be based on TCH needs at the time, the practicalities for this physician repeating the equivalent board in the US, and documentation showing this physician has been practicing this specialty within the last year and for a reasonable period of time previously.

¹⁹³ Amended 11/15/2015

¹⁹⁴ Amended 9/17/2017

¹⁹⁵ Amended 4/30/2015

¹⁹⁶ Amended 9/17/2017

¹⁹⁷ Amended 11/15/2015

¹⁹⁸ Amended 9/17/2017

¹⁹⁹ Amended 9/17/2017

²⁰⁰ Amended 9/20/2015

5) ²⁰¹Board Certification Exemption by a Tuality Healthcare Clinical Affiliation Partner (Healthcare Organization specifically contracted with Tuality Healthcare for clinical services): On a case-by-case basis the MEC can review a request for application by a provider who is currently granted privileges with a Tuality Healthcare Clinical Affiliation partner and who has received a board certification exemption from that organization. The MEC on a case-by-case basis can approve an exemption of the board certification requirement to the applicant and the provider may apply for membership and/or privileges at Tuality Healthcare. Such consideration would be based on Tuality Community Hospital needs at the time and the services the individual applicant can provide to Tuality Healthcare.

(c)²⁰²²⁰³²⁰⁴ Occupational Medicine Physician Applicant:

Physicians applying for Occupational Medicine privileges with no hospital admitting privileges will not be required to meet the Board Certification or eligibility requirement of Article V - Part D, Section 1, subsections (a) and (b). Occupational Medicine applicants are required to have completed a residency in other complementary medical specialties, including Family Practice or Internal Medicine as approved by the Medical Executive Committee and the Tuality Healthcare Board.

(d)²⁰⁵²⁰⁶ Tuality Forest Grove Emergency Medicine Physician Applicant:

Physicians applying for Emergency Medicine privileges at Tuality Forest Grove Emergency Department only must be board certified in one of the following specialties; Emergency Medicine, Internal Medicine, Family Medicine, or General Surgery.

(e)²⁰⁷²⁰⁸ Allied Health Professional/Limited License Independent Practitioner:

1. Practitioners applying under this staff category are not required to meet the Board Certification or eligibility requirement of Article V – Part D, Section 1, subsections (a) and (b).
2. ²⁰⁹Application for privileges shall be generally processed in accordance with the procedures in these medical staff Bylaws for delineation of privileges

Section 2. Maintaining Clinical Privileges²¹⁰

(a)²¹¹²¹²²¹³Maintenance of Board Certification:

²⁰¹ Amended 12/15/2016

²⁰² Amended 12/30/08

²⁰³ Amended 3/24/2011

²⁰⁴ Amended 4/30/2015

²⁰⁵ Amended 12/18/2014

²⁰⁶ Amended 4/30/2015

²⁰⁷ Amended 2/26/08

²⁰⁸ Amended 4/30/2015

²⁰⁹ Amended 4/30/2015

²¹⁰ Amended 4/30/2015

²¹¹ Amended 9/12/09

²¹² Amended 3/24/2011

Upon obtaining board certification status, physicians must maintain their board certification status in order to maintain their medical staff membership and privileges at Tuality Healthcare. Should recertification not be attained, the physician who is in good standing can petition the Medical Executive Committee to allow them to retake their board recertification examination on an annual basis and obtain recertification within two years from loss of certification to re-attain board certification in order to maintain membership and privileges. If board certification is not re-attained within this period it is considered a voluntary resignation from the Medical Staff and not eligible for a hearing or appeal.

(b)²¹⁴Waiver of Board Certification for active or courtesy physicians who joined the Medical Staff prior to 7/1/1998:

1. An active or courtesy physician who was a member of the medical staff prior to 7/1/1998 may request that an exception be made and their maintenance of board certification be waived. When such a request is made, the physician requesting the waiver shall bear the burden of demonstrating their education, training, experience and competence are equivalent to or exceed Tuality Healthcare's board certification requirement.
2. The Tuality Healthcare Board may grant a waiver after considering the findings of the Medical Executive Committee regarding the specific qualifications of the physician in question. The findings shall include a statement concerning what is in the best interest of the patients, Tuality Healthcare and the community.
3. In the event the Tuality Healthcare Board determines **not** to grant a waiver, the physician requesting the exception shall not be entitled to a fair treatment hearing as set forth in the Medical Staff Bylaws in regards to this request for waiver the Board Certification requirement and shall be deemed to be ineligible to request appointment or clinical privileges.
4. If the Tuality Healthcare Board grants a waiver to a physician, that waiver shall not be deemed to set a precedent for any other applicant or appointee.

Section 3. Physicians Under Contract with the Hospital

²¹⁵From time to time, the hospital may enter into contract or employment relationships with physicians or groups of physicians including those in medico-administrative positions. Termination or expiration of such relationships, including the Medical Staff appointment and clinical privileges of such physicians shall be governed by the written terms of the contract or employment. If the contract or employment terms are silent on the matter, expiration or termination of such a relationship alone will not affect the individual's staff appointment or clinical privileges; except that the individual may not thereafter exercise any clinical privileges for which exclusive arrangements have been made by the hospital with any other individual or individuals. In the event of a conflict between these Bylaws and the contract or employment terms, the contract or employment terms shall apply.

²¹³ Amended 3/27/2014

²¹⁴ Amended 10/27/2011

²¹⁵ Amended 6/27/2002

ARTICLE V - PART E: PROCEDURE FOR INITIAL APPOINTMENT

Section 1. Submission of Application

The application for Medical Staff appointment shall be submitted by the applicant to the Chief Executive Officer or his/her designee. After collecting references and other information or materials deemed pertinent, the Chief Executive Officer or his/her designee shall determine the application to be complete and transmit the application and all supporting materials to the Clinical Service or Hospital-Based Independent Department for evaluation. It is the responsibility of the applicant to provide that his/her application is complete, including adequate responses from references. An incomplete application will not be processed.

Section 2. Definition

As used in Part E of Article V "adverse recommendation," whether by the Clinical Service or Hospital-Based Independent Department, Medical Executive Committee, hearing panel, hearing officer or other body processing this matter, means a recommendation to the Board to deny initial appointment or requested privileges.

Section 3. Credentialing Procedure

- (a) ²¹⁶Upon receipt of the completed application for appointment the applicant's name shall be posted so that each person appointed to the Medical Staff may have an opportunity to submit to the Committee, in writing, information bearing on the applicant's qualifications for staff appointment. In addition, any person appointed to the Medical Staff shall have the right to meet with the Chief of the Clinical Service or the Chief of the Hospital-Based Independent Department or meet with the Medical Executive Committee to discuss in private and in confidence any concerns he/she may have about the applicant. The appropriate Chief of Service or Chief of the hospital-based independent department shall make a recommendation on the applicant to the Medical Executive Committee.
- (b) Absent a delegation or referral of the matter by the Chief of the Clinical Service or the Chief of the Hospital-Based Independent Department for investigation or to a hearing panel, hearing officer or other body as hereinafter provided, the Medical Executive Committee shall conduct such review of the application, records and information, or conduct such an investigation as it believes indicated. The Medical Executive Committee shall examine the evidence of the character, professional competence, qualifications, prior behavior and ethical standing of the applicant and shall determine through information obtained from references given by the applicant the service/department recommendations, and other sources available to the Committee, whether the applicant has established and meets all the necessary qualifications for the category of staff appointment and clinical

²¹⁶ Amended 4/2/2015

privileges requested by him/her. As part of this process, the Medical Executive Committee may require a physical or mental examination of the applicant by a physician or physicians satisfactory to the Committee, and shall require that the results be made available for the Committee's consideration prior to a final appointment. Should the matter be delegated or referred for investigation to a body other than the Medical Executive Committee, then the Medical Executive Committee may authorize the obtaining of said examination and the furnishing of the same to said other body as herein described.

As part of the process of making a recommendation, the Medical Executive Committee, or if applicable the other investigative body, may meet with the applicant to discuss any aspects of his/her application, his/her qualifications and his/her requested clinical privileges.

- (c) If the matter is processed by the Medical Executive Committee, then said Committee shall make a recommendation to the Board within ninety (90) days after receipt of the completed application for appointment. If processing the matter has been referred to an investigative body by the Medical Executive Committee, then the time for furnishing the report to the Board or to the applicant shall be extended for such time as is reasonably required for an expeditious conclusion of the investigation, but in any event said time shall not exceed 180 days from the date the application file for admission was complete. In the event of a delay beyond the 90-day period, the Medical Executive Committee shall send a letter to the applicant explaining the delay.

Section 4. Subsequent Action on the Application

- (a) Any recommendation for "adverse action" is within the jurisdiction of the Medical Executive Committee; report of review or investigation by a body other than the Medical Executive Committee shall be promptly furnished to the Medical Executive Committee which shall decide as part of its recommendation whether to accept, confirm, modify or reject said report.
- (b) When the recommendation of the Medical Executive Committee is favorable to the applicant, the Chief Executive Officer shall forward it, together with all supporting documentation, to the Board. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such clinical privileges.
- (c) When the recommendation of the Medical Executive Committee is to defer the application for further consideration, but not to refer it to an investigative body, it must be followed up within thirty (30) days by subsequent recommendation to the Board through the Chief Executive Officer for appointment to the Medical Staff with specified clinical privileges, or for rejection of the application for staff appointment.
- (d) When the recommendation of the Medical Executive Committee is an "adverse recommendation," it shall be forwarded to the Chief Executive

Officer who shall promptly notify the applicant in writing, obtaining a receipt. Part of said notification is to include a summary of applicant's right to a hearing as more particularly set forth in Article VII. The Chief Executive Officer shall then hold the application until after the applicant has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VII. If the applicant requests a hearing, it shall be provided as more particularly set forth in said Article. Subsequent to said hearing or at the time the applicant has been deemed to have waived his/her right to a hearing; the Chief Executive Officer shall forward the Medical Executive Committee's recommendation, together with all supporting documentation, to the Board.

²¹⁷(e) Appointments shall be made for a period of no more than two years.

ARTICLE V - PART F: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES²¹⁸

Section 1. Temporary Clinical Privileges for New Applicants Awaiting Board Approval²¹⁹

²²⁰²²¹²²²²²³²²⁴The medical staff Medical Executive Committee and governing board may grant temporary privileges to a new applicant for medical staff membership or privileges when he/she is waiting for a review and recommendation to the Medical Executive Committee and the governing body. Temporary privileges may be granted for a limited period of time, not to exceed 120 days, by the CEO, or his/her designee, upon recommendation by either the chief of the applicable clinical service or hospital-based department or the president of the medical staff provided a criminal background check is completed and the delegated criteria are met, as specified in the Medical Staff policy. Privileges requested must be consistent with the specialty.

²²⁵The Chief of Clinical Service may grant an exception in an emergent/urgent request for temporary privileges to not wait for the outcome of the criminal background check. The criminal background check will still be processed as part of the request for temporary privileges.

Section 2. Temporary Clinical Privileges for an Important Patient Care Need²²⁶

²²⁷ ²²⁸ ²²⁹ ²³⁰ ²³¹Temporary clinical privileges may be granted to a physician on a case-by-case basis, for a limited period of time (refer to Medical Staff Policy #MS-3

²¹⁷ Amended 7/27/2017

²¹⁸ Amended 4/28/2016

²¹⁹ Amended 4/28/2016

²²⁰ Amended 2/24/2000

²²¹ Amended 12/18/2001

²²² Amended 5/27/2010

²²³ Amended 2/23/2012

²²⁴ Amended 9/20/2012

²²⁵ Amended 9/20/2012

²²⁶ Amended 4/28/2016

²²⁷ Amended 2/24/2000

²²⁸ Amended 12/18/2001

²²⁹ Amended 12/19/2002

²³⁰ Amended 9/20/2012

²³¹ Amended 4/28/2016

Temporary Privileges), when there is an important patient care need that mandates an immediate authorization to practice. In these circumstances, temporary privileges may be granted by the CEO, or his/her designee, upon recommendation by either the chief of the applicable clinical service or hospital-based department or the president of the medical staff provided there is verification of current licensure, current competence, adequate malpractice insurance coverage, DEA, criminal background check, and results of the National Practitioner Data Bank. Such privileges shall be restricted to the specific patient(s) or important patient care need for which they were granted.

²³²The Chief of Clinical Service may grant an exception in an emergent/urgent request for temporary privileges to not wait for the outcome of the criminal background check. The criminal background check will still be processed as part of the request for temporary privileges.

Section 3. Special Requirements

Special requirements of supervision and reporting may be imposed by the Medical Executive Committee on any individual granted temporary clinical privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer or his/her designee upon notice of any failure by the individual to comply with such special conditions.

Section 4. Termination of Temporary Clinical Privileges

- (a) The Chief Executive Officer or, in his/her absence, his/her designee, may at any time, after asking for a recommendation of the President of the Medical Staff or the Medical Executive Committee, terminate an individual's temporary admitting privileges. Clinical privileges shall then be terminated when the physician's inpatients are discharged from the hospital.
- (b) The granting of any temporary admitting and clinical privileges is a courtesy on the part of the hospital. Neither the granting, denial nor termination of such privileges shall entitle the individual concerned to any of the procedural rights provided in these Bylaws with respect to hearings or appeals.
- (c) Temporary privileges shall be automatically terminated at such time as the Medical Executive Committee recommends unfavorably with respect to the applicant's appointment to the staff or at the Medical Executive Committee's discretion shall be modified to conform to the recommendation of the Medical Executive Committee that the applicant be granted different permanent privileges from the temporary privileges.

ARTICLE V - PART G: EMERGENCY CLINICAL PRIVILEGES

- (1) In an emergency involving a particular patient, a physician who is not currently appointed to the Medical Staff may be permitted by the hospital to exercise

clinical privileges to act in such emergency using all necessary facilities of the hospital, including calling for consultation necessary or desirable.

- (2) Similarly, in an emergency involving a particular patient, a physician currently appointed to the Medical Staff may be permitted by the hospital to act in such emergency by exercising clinical privileges not specifically assigned to him/her.
- (3) When the emergency situation no longer exists, such physician must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or he/she does not request such privileges, the patient shall be assigned by the President of the Medical Staff or his/her designee to an appropriate person currently appointed to the Medical Staff.
- (4) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that harm or danger.
- (5) ²³³²³⁴In circumstances of disaster(s) in which the Tuality Healthcare Disaster Plan has been activated and the hospital has deemed it cannot meet patient care needs with the present medical staff, the Chief Executive Officer (CEO) or Medical Staff President or their designee(s) may grant emergency privileges to allow practitioners who do not possess medical staff privileges at Tuality Community Hospital to practice at the hospital. Credentialing physicians in the event of disaster will be performed as specified in the Medical Staff policy.

²³³ Amended 10/24/02

²³⁴ Amended 10/27/2011

ARTICLE VI

ACTIONS AFFECTING MEDICAL STAFF MEMBERS

ARTICLE VI - PART A: PROCEDURE FOR REAPPOINTMENT

Section 1. When Application is Required

- (a) Any physician, limited license independent practitioner, or allied health professional who at the time of processing biennial reappointments to the Medical Staff, wishes to be considered for a change in his/her Medical Staff category or a change in his/her clinical privileges, or who does not desire reappointment, shall so indicate on the appropriate form submitted to the Chief Executive Officer before the month of their reappointment. All individuals who do not indicate otherwise shall be considered for reappointment to the same category of the staff with the same clinical privileges they then hold. Reappointments shall be made for a period of no more than two years.
- (b)²³⁵ ²³⁶Each physician, limited license independent practitioner, or allied health professional of the Medical Staff who wishes to be reappointed shall be responsible for submitting a complete reappointment application and notifying the Clinical Service or Hospital-Based Independent Department of any material changes in the information given there, particularly with regard to any professional competence, questions of professional ethics, infractions of hospital or Medical Staff Bylaws or rules, or alleged unacceptable conduct, or disciplinary action taken or pending against him/her in another hospital or health care facility, or any pending challenges to any licensure or registration (State or District, Drug Enforcement Administration), or the voluntary relinquishment of such licensure or registration, any voluntary or involuntary relinquishment of privileges at another hospital or health care facility, or any change in the status or amount of coverage of his/her professional liability insurance, and as stated in Article VI, information as to whether the applicant has any currently pending liability actions, final judgments or settlements of liability actions, and details about any such instances, any change in his license, and shall upon request, submit proof of such current license or insurance coverage.
- ²³⁷(c) ²³⁸A full and complete application is required for reappointment. If a complete reappointment application is not returned in time to allow for processing of the application prior to the practitioner's expiration date, the practitioner will have voluntarily resigned effective the end date of the practitioner's current appointment. Medical Staff Policy #MS-2 Reappointment provides the specific details regarding the reappointment process.

²³⁶ Amended 4/2/2015

²³⁷ Amended 9/20/2012

²³⁸ Amended 5/28/2015

Section 2. Factors to be Considered

Each recommendation concerning reappointment of a person currently appointed to the Medical Staff or a change in staff category, where applicable, shall be based upon such appointee's:

- (a) professional ethics, clinical competence and clinical judgment in the treatment of patients;
- (b) attendance at Medical Staff meetings and participation in staff duties;
- (c) compliance with the hospital Bylaws and policies and with the Medical Staff Bylaws, Rules and Regulations;
- (d) behavior in the hospital and his/her cooperation with medical and hospital personnel;
- (e) use of the hospital's facilities for his/her patients and his/her general attitude toward patients, the hospital and its personnel;
- (f) current physical or mental health and capacity to satisfactorily treat patients and perform Medical Staff duties or which may require an accommodation; and
- (g) satisfactory completion of such continuing education requirements as may be imposed by law, this hospital, or applicable accreditation agencies.
- (h) ²³⁹as well as integrating the six(6) areas of "General Competencies" developed by the Accreditation Council Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative into the Credentialing and privileging process.
 - i. Patient Care
 - ii. Medical/Clinical Knowledge
 - iii. Practice-based learning and improvement (CME)
 - iv. Interpersonal and communication skills
 - v. Professionalism
 - vi. Systems-based practice
 - vii. Ongoing Professional Practice Evaluation (OPPE) – continuously evaluate a practitioner's performance.

Section 3. Credentialing Procedure

- (a) ²⁴⁰²⁴¹Gender, race, creed, national origin, sexual orientation and transgender status are not used in making decisions regarding the granting or denying of clinical privileges.

²³⁹ Amended 10/27/2011

²⁴⁰ Amended 5/27/2010

²⁴¹ Amended 12/20/2012

- (b) The Chief of the appropriate Clinical Service or Chief of the appropriate Hospital-Based Independent Department shall review all pertinent information available including all information provided from other committees of the Medical Staff and from hospital management for the purpose of determining recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing two years. The Chief shall transmit the recommendations to the Medical Executive Committee.
- (c)²⁴²²⁴³To aid in determining whether clinical privileges should be granted or continued, the Chief of the appropriate Clinical Service or Hospital-Based Independent Department may require that a practitioner procure a physical and/or mental examination by a physician or physicians satisfactory to the Chief and make results available for the Medical Executive Committee's consideration. This request may occur any time while the practitioner is on the medical staff. This request will be based on performance/behavior concerns that affect the quality of patient care and/or patient safety. Failure of the practitioner to procure such an examination within a reasonable time after being requested to do so in writing shall constitute a voluntary relinquishment of all Medical Staff and clinical privileges until such time as the requesting chief has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.
- (d) The Medical Executive Committee shall prepare a list of persons currently holding appointment recommended for reappointment without change in staff category and clinical privileges. This list shall be considered an application to the hospital by each person on the list for reappointment to the Medical Staff and for clinical privileges for the ensuing Medical Staff years. Recommendations for non-reappointment and for changes in category or privileges, with supporting data and reasons attached, shall be handled individually.
- (e) The Medical Executive Committee shall transmit its report and recommendations to the Board through Chief Executive Officer. Where non-reappointment, non-promotion of an eligible current appointee, or a further limitation in clinical privileges is recommended, the reason for such recommendation shall be stated, documented, and included in the report. This report shall not be transmitted to the Board until the affected staff appointee has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VII. The Chief of the appropriate Clinical Service or Chief of the appropriate Hospital-Based Independent Department or the Medical Staff President shall be available to the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation.

²⁴² Amended 9/9/2001

²⁴³ Amended 10/27/2011

Section 4. Meeting with Affected Individual

²⁴⁴If, during the processing of a particular individual's reappointment or proceedings under Article VI - Part C, Section 1, it becomes apparent to the Medical Executive Committee or its Chairperson or the Chief of the appropriate Clinical Service or the Chief of the Hospital-Based Independent Department that the Committee or individual is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the Chairperson of the Medical Executive Committee or Chief of the appropriate Clinical Service or Hospital-Based Independent Department shall notify the individual of the general tenor of the possible recommendation and ask him/her if he/she desires to meet with the Medical Executive Committee prior to any final recommendation by the Medical Executive Committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated, and shall be invited to discuss, explain or refute it. This interview shall be considered reviewed as set forth in Article VI, Part C, Section 1, and not constitute a hearing and none of the procedural rules provided in these Bylaws with respect to hearings or appeals shall apply nor shall minutes of the discussion in the meeting be kept. However, the Committee shall indicate as part of its report to the Board whether such a meeting occurred.

Section 5. Action by Medical Executive Committee to Refer Matter for Investigation

The Medical Executive Committee may elect as part of its proceedings to refer the matter for investigation to be conducted by a hearings officer appointed by the Hospital and who is not in direct economic competition with the practitioner, or before a hearing panel as promulgated and implemented by the Oregon Board of Medical Examiners pursuant to ORS 441.055(6) to (11) and OAR 847-10-095.

Section 6. Procedure Thereafter

The Medical Executive Committee shall consider the record and report of any proceedings held under the next preceding section, or the proceeding conducted by the Medical Executive Committee itself. Any "adverse recommendation" as herein described by the Medical Executive Committee denying reappointment, denying a requested change in staff category or clinical privileges, or recommending reduction of existing clinical privileges shall entitle the affected individual to the procedural rights provided in Article VII. If said adverse recommendation is proposed, the Chief Executive Officer shall then promptly notify the individual of the possible adverse recommendation by mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VII, after which the Board shall be given the Committee's final recommendation.

²⁴⁴ Amended 4/2/2015

ARTICLE VI - PART B: PROCEDURES FOR REQUESTING INCREASE IN CLINICAL PRIVILEGES

Section 1. Application for Increased Clinical Privileges

²⁴⁵Whenever, during the term of his/her appointment to the Medical Staff, an individual desires to increase his/her clinical privileges, he/she shall apply in writing to the Chief Executive Officer or designee. The application shall state in detail the specific additional clinical privileges desired and the applicant's relevant recent training and experience which justify increased privileges. This application will be transmitted by the Chief Executive Officer or designee to the Chief of the appropriate Clinical Service or Chief of the appropriate Hospital-Based Independent Department Committee. Thereafter, it will be processed in the same manner as an application for initial clinical privileges if the request is made during the term of appointment, or as a part of the reappointment application if the request is made at that time.

Section 2. Factors to be Considered

²⁴⁶²⁴⁷Recommendations for an increase in clinical privileges made to the Board shall be based upon relevant recent training, observation of patient care provided, review of records of patients treated in this hospital, and review of other records and information which evaluate the individual's participation in the delivery of medical care that justify increased privileges. Gender, race, creed, national origin, sexual orientation and transgender status are not used in making decisions regarding the granting or denying of clinical privileges. The recommendation for such increased privileges may carry with it such requirements for supervision or consultation for such period of time as are thought necessary.

Section 3. Procedure Thereafter

In the event of a proposed adverse recommendation, the practitioner shall be afforded all due process rights provided in these Bylaws.

ARTICLE VI - PART C: PROCEDURE FOR ACTIONS INVOLVING CLINICAL COMPETENCE, PATIENT CARE, PROFESSIONAL ETHICS, INFRACTION OF HOSPITAL OR MEDICAL STAFF BYLAWS, OR RULES OR UNACCEPTABLE CONDUCT

Section 1. Review and Investigative Procedures

- (a) The Medical Executive Committee, as part of its Quality Management activity, shall examine the information provided to it by the clinical service or Hospital-Based Independent Department. ²⁴⁸It may elect as part of its proceedings to refer the matter for investigation as provided in Part A, Section 5 of this Article. Thereafter the Committee shall take one of the actions described in paragraph (c) of this section.

²⁴⁵ Amended 4/2/2015

²⁴⁶ Amended 5/27/2010

²⁴⁷ Amended 12/20/2012

²⁴⁸ Amended 4/2/2015

- (b) ²⁴⁹The Medical Executive Committee shall evaluate concerns referred by the Chiefs of Clinical Services and hospital-based departments, CEO, or Internal Affairs Committee.
- Violation of the Bylaws, Rules and Regulations of the Medical Staff, and Medical Staff policies
 - Code of Behavior
 - Medical Records Completion
 - Clinical Service Meeting attendance
 - Emergency Department Call Coverage
 - Continuing Education requirements
 - Failure to complete reappointment paperwork
 - Drug, Alcohol and Chemical dependence
 - Failure to pay medical staff dues
 - Repeated violations
 - Failure to maintain board certification status
 - Actions by state licensing agency
 - Conflict of interest detrimental to the operation of the hospital
 - Suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid or any public program
 - ²⁵⁰Clinical competence
- (c) After a review of the available information, the Medical Executive Committee shall take one of the following actions:
1. Find the information or report does not provide grounds for an adverse recommendation, and is not placed in the individual's quality management file;
 2. Decide that the conduct does not warrant an adverse recommendation but does require placement of the material in the individual's file;
 3. Decide that probable cause exists to report an "adverse recommendation" to the Board and if so, advise the practitioner of his/her rights to a hearing as provided in Article VII - Part A and Part B.

Section 2. Procedure Thereafter

- (a) If the practitioner elects to have a hearing, the hearing record and report shall be furnished to the Medical Executive Committee for further consideration as soon as it is available. After considering said record and report, or if the practitioner has not elected to have a hearing, the Medical Executive Committee shall make its final written recommendation to the Board and may:
1. Recommend a requirement for consultation,

²⁴⁹ Amended 1/27/2011

²⁵⁰ Amended 12/20/2012

2. Recommend reduction of clinical privileges,
3. Recommend suspension of clinical privileges for a term,
4. Recommend revocation of staff appointment,
5. Recommend that specified remedial action (see Article VII, Part B, Section 3, for examples of remedial action) be taken, or
6. Recommend that no action be taken.

If the matter be disposed of on the basis of a "no action" or "remedial action" recommendation, the person subject to investigation shall be promptly advised in writing.

- (b) Any adverse recommendation by the Medical Executive Committee for imposition of discipline as described in items 1 through 4 in Article VI, Part C, Section 2-a, above, shall entitle the affected individual to the procedural rights provided in Article VII. Such a recommendation shall be forwarded to the Chief Executive Officer who shall promptly notify the affected individual by mail, return receipt requested. The Chief Executive Officer shall then hold the recommendation until after the individual has exercised or has been deemed to have waived his/her rights to a hearing, as provided in Article VII. At the time the individual has been deemed to have waived his/her right to a hearing, or has been afforded a hearing as herein set forth, the Chief Executive Officer shall forward the recommendation of the Medical Executive Committee, together with the record and all supporting documents to the Board. The Chairperson of the Medical Executive Committee or his/her designee shall be available to the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation.
- (c) The Board shall review said recommendation and report, but shall take no final action thereon until the individual has exercised, or has been afforded, or has been deemed to have waived the procedural rights provided in Article VII. The practitioner shall have the right to a hearing before the Board takes action. Practitioner shall not be entitled to more than one (1) hearing in any proceeding under these Bylaws.

ARTICLE VI - PART D: SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

Section 1. Grounds for Summary Suspension

- (a) The President of the Medical Staff, the Chief Executive Officer, or in his/her absence, his/her designee, or the Chairperson of the Board shall each have authority to summarily suspend all or any portion of the clinical privileges of a Medical Staff appointee or other individual whenever such action is in the best interest of the patient care or safety or the continued effective operation of the hospital or whenever such individual has violated the Bylaws, rules,

regulations, and policies of the hospital or Medical Staff. Such suspension shall not imply any final finding of responsibility for the situation that caused the suspension.

- (b) Such summary suspension shall become effective immediately upon imposition and shall not exceed fourteen (14) days in duration, shall be immediately reported in writing to the Chief Executive Officer, or in his/her absence, his/her designee, or the President of the Medical Staff, and shall remain in effect unless or until modified by the Chief Executive Officer or the Board. If, following said administrative suspension, the Medical Executive Committee decides that an adverse recommendation to the Board be made, then said suspension shall be continued but affording hearing and appeals rights as provided in Article VII.

Section 2. Executive Committee Procedure

The individual who exercises his/her authority under Section 1 of this Part to suspend summarily a person appointed to the Medical Staff shall immediately report his/her action to the Chairperson of the Medical Executive Committee. At that point, the Medical Executive Committee to which the matter has been referred shall take such further action as is required in the manner specified under Part C of this Article. The summary suspension shall remain in force after the committee takes responsibility until modified by the committee or the Chief Executive Officer, or until the matter that required the suspension is finally resolved.

Section 3. Care of Suspended Individual's Patients

Immediately upon the imposition of a summary suspension, the President of the Medical Staff shall assign to another person appointed to the Medical Staff responsibility for care of the suspended individual's patient 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 by the President of the Medical Staff in selection of a substitute. It shall be the duty of the President of the Medical Staff to cooperate with the Chief Executive Officer in enforcing all suspensions.

ARTICLE VI - PART E: AUTOMATIC SUSPENSION AND/OR VOLUNTARY RESIGNATION ^{251 252}

Section 1. Grounds for Automatic Suspension ²⁵³

1. Failure to maintain Board Certification status
2. Suspension of license or limitation of license by the provider's State Licensing Agency

²⁵¹ Amended 1/27/2011

²⁵² Amended 3/23/2017

²⁵³ Amended 3/23/2017

3. Failure to maintain medical malpractice insurance in accordance with the Tuality Healthcare Board Policy #17 Medical Staff Malpractice Insurance
4. Non-compliance with any license, certification, course completion required within the Bylaws, Rules and Regulations, and/or granted privilege requirement (e.g. DEA Certificate, Fetal Heart Monitoring Course, ACLS certification, Moderate Sedation Course, etc)

Section 2. Process for Automatic Suspension ²⁵⁴

1. In the event of automatic suspension from the Medical Staff, the CEO or his/her designee, will notify the practitioner by fax, E-Mail or phone, and by mail, return receipt requested, on the date the automatic suspension becomes effective. The CEO, or his/her designee, will also notify the Clinical Service Chief or Chief of the hospital-based independent department and the Chair of the Medical Executive Committee of the automatic suspension.
2. The practitioner shall have thirty (30) days from the start date of the automatic suspension to provide documentation to the Medical Staff Office demonstrating compliance or provide written explanation as to the lapse in compliance and the action plan to come into compliance (except for Board Certification per Bylaws Article V, Part D).
 - a. If neither documentation of compliance or written explanation is received within thirty (30) days from the start date of the automatic suspension, the practitioner will have voluntarily resigned from the medical staff.
 - b. A practitioner's written explanation shall be reviewed by the MEC and determine whether an extension to come into compliance is warranted. Should the MEC not grant an extension at that time, the practitioner will have voluntarily resigned from the medical staff. If an extension is granted, the provider's membership and/or privileges will continue to be suspended until documentation of compliance is received.
3. All automatic suspensions shall be documented and specifically considered by the Medical Executive Committee when making its recommendations for reappointment and by the Board when making its final decisions.

Section 3. Partial Automatic Privilege Suspension ²⁵⁵

When grounds for suspension are identified as noted in Section 1 above, if appropriate specific privileges may be accurately suspended rather than all privileges being suspended.

Section 4. Process for Automatic Partial Privilege Suspension

1. In the event of automatic partial privilege suspension, the CEO or his/her designee, will notify the practitioner by fax, E-Mail or phone, and by mail, return

²⁵⁴ Amended 3/23/2017

²⁵⁵ Amended 3/23/2017

receipt requested, on the date the automatic suspension becomes effective. The CEO, or his/her designee, will also notify the Clinical Service Chief or Chief of the hospital-based independent department and the Chair of the Medical Executive Committee of the automatic suspension.

2. The practitioner shall have thirty (30) days from the start date of the automatic partial privilege suspension to provide documentation to the Medical Staff Office demonstrating compliance or provide written explanation as to the lapse in compliance and the action plan to come into compliance (except for Board Certification per Bylaws Article V, Part D).
 - a. If neither documentation of compliance or written explanation is received within thirty (30) days from the start date of the automatic partial privilege suspension, the practitioner will have voluntarily relinquished affected privilege(s).
 - b. A practitioner's written explanation shall be reviewed by the MEC and determine whether an extension to come into compliance is warranted. Should the MEC not grant an extension at that time, the practitioner will have voluntarily relinquished affected privilege(s). If an extension is granted, the provider's affected privilege(s) will continue to be suspended until documentation of compliance is received.

Section 5. Additional Grounds for Suspension of Privileges ²⁵⁶

1. Drug, and/or Alcohol, and Chemical Dependence
 - a. Physicians, Nurse Practitioners, and other health care professionals will perform patient care free of the use of drugs, alcohol and/or chemical dependence, except for those drugs prescribed by a practitioner as part of appropriate medical treatment, which do not cause impairment or constitute a threat to safe patient care. Suspected violations of this policy will be reported to the President of the Medical Staff and/or Chiefs of Clinical Services and appropriate investigation will be taken as part of the duty of these staff officers. Cases of violation of this policy will be referred to the Internal Affairs Committee and then, if appropriate, to the State of Oregon's Health Professionals' Services Program (HPSP) for further evaluation and management as indicated.
 - b. The President of the Medical Staff and his designee(s) to include the Internal Affairs Committee as described and Article IV, Part G, will assist practitioners and qualified agencies in the treatment and monitoring of any Medical Staff member involved in a drug, alcohol and/or chemical dependency diversion or treatment program in an appropriate manner.
2. Standards of Conduct

Physicians, Nurse Practitioners and other health care professionals will conduct themselves while performing patient care responsibilities in a collegial and

²⁵⁶ Amended 3/23/2017

professional manner consistent with Tuality Healthcare Board Policy No. 15 Code of Behavior – Medical Staff and Allied Health Professionals. Deviation from this policy will be addressed by the President of the Medical Staff, Chiefs of Clinical Services, and/or Chief of Hospital-Based Independent Departments. Any instances of documented violation of this policy may be referred to the Internal Affairs Committee.

Section 6. Grounds for Voluntary Resignation ²⁵⁷

1. Revocation of license by the provider's State Licensing Agency
2. Any sanction resulting in removal from Medicare and Medicaid programs
3. Failure to Complete Medical Records per Medical Staff Policy #MS-9 Penalties and Voluntary Relinquishment of Medical Staff Membership and Reapplication to the Medical Staff
4. Failure to maintain Board Certification status and have not received a recertification extension approval by the MEC, per Bylaws Article V, Part D
5. Failure to pay Medical Staff Dues as required in these Bylaws
6. Upon the expiration of the individual's current clinical privileges and the individual's failure to timely submit a re-credentialing application, per Medical Staff Policy #MS-2 Reappointment
7. Satisfying Continuing Education Requirements
8. Failure to maintain continuous call coverage

Effective May 1, 2016 all practitioners granted admitting privileges at Tuality Community Hospital are required to have continuous call coverage for inpatients. The covering practitioner must be practitioner who has been granted similar privileges at Tuality Community Hospital. If a practitioner loses all previously arranged call coverage, the practitioner's new call coverage arrangement must be in place within thirty (30) days from the discontinuance. If a new call coverage arrangement is not documented within thirty (30) days from the discontinuance, the practitioner will have voluntarily resigned from the medical staff.

9. Failure to Attend Meetings Requirements

Special Meeting Attendance Requirements: Whenever suspected deviation from standard clinical or professional practice is identified, the President of the Medical Staff or applicable Clinical Service or Hospital-Based Independent Department Chief may require the practitioner to confer with him/her regarding the matter. The practitioner will be given special notice of the conference at least five (5) days prior to the conference, including the date, time, place, a statement of the issue involved, and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such conference after two notices, unless excused by the Medical Executive Committee upon showing good cause, will result in voluntarily resignation from the Medical Staff. Such termination will not give rise to a fair hearing, but will automatically be rescinded upon the practitioner's participation in the previously referenced conference.

²⁵⁷ Amended 3/23/2017

Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of clinical privileges stated in Article VI – Part E. Sections 6 and 7.

Section 7. Process for Voluntary Resignation ²⁵⁸

1. In the event of voluntary resignation from the Medical Staff, the CEO or his/her designee, will notify the practitioner by fax, E-Mail, or phone and by mail, return receipt requested, on the date the voluntary resignation becomes effective. The CEO, or his/her designee, will also notify the Clinical Service Chief or Chief of the hospital-based independent department and the Chair of the Medical Executive Committee of the voluntary resignation.
2. Following voluntary resignation, the practitioner may apply for Medical Staff appointment once all outstanding requirements have been met. The requirements and procedures for this application will be the same as those of a practitioner applying to the staff for the first time.

ARTICLE VI - PART F: OTHER SUSPENSIONS²⁵⁹

Section 1. Administrative Suspension for Repeated Violations ²⁶⁰

- (a) The President of the Medical Staff, the Chief Executive Officer, or in his/her absence, his/her designee, or the Chairperson of the Board may impose administrative suspension for repeated violations of the Bylaws, Rules and Regulations, or Standards of Conduct including but not limited to failure to produce and maintain timely medical records, unprofessional conduct, or completion of coverage requirements. ²⁶¹
- (b) Such Administrative suspension shall become effective immediately upon imposition and shall last at least five (5) days but not to exceed twenty nine (29) days, shall be immediately reported in writing to the Chief Executive Officer, or in his/her absence, his/her designee, or the President of the Medical Staff and shall remain in effect unless or until modified by the Chief Executive Officer or the Board. If, following said administrative suspension, the Medical Executive Committee decides that an adverse recommendation to the Board be made, then said suspension may be continued provided the hearing and appeals process as set forth in Article VII is followed.

Section 2. Precautionary Suspension ²⁶²

- (a) In order to carefully consider an event, suspension or issue, the President of the Medical Staff, the Chief Executive Officer, or in his/her absence, his/her designee, or the Chairperson of the Board is authorized to enforce a brief suspension not to exceed seven (7) days in order to investigate and carefully consider the event, suspension or issue. The suspension shall be immediately reported in writing to the Chief Executive Officer, or in his/her absence, his/her

²⁵⁸ Amended 3/23/2017

²⁵⁹ Amended 1/27/2011

²⁶⁰ Amended 9/12/2004

²⁶¹ Amended 3/23/2017

²⁶² Amended 9/12/2004

designee, or the President of the Medical Staff and shall remain in effect unless or until modified by the Chief Executive Officer or the Board. If, following said precautionary suspension, the Medical Executive Committee decides that an adverse recommendation to the Board be made, then said suspension may be continued provided the hearing and appeals process as set forth in Article VII is followed. ²⁶³

- (b) A precautionary suspension is not considered discipline and is not reportable to the National Practitioner Data Bank.
- (c) A Precautionary suspension may be taken as a preventive measure even in instances when there is no known or suspected imminent danger to patient or staff.

ARTICLE VI - PART G: PROCEDURE FOR LEAVE OF ABSENCE

²⁶⁴²⁶⁵Persons appointed to the Medical Staff may, for good cause, be granted leaves of absence by the Board for a definitely stated period of time. Requests of leaves of absence shall be made to the Chief of the appropriate Clinical Service or Chief of the appropriate Hospital-Based Independent Department, and shall state the beginning and ending dates of the requested leave. The Chief of the appropriate Clinical Service or Chief of the appropriate Hospital-Based Independent Department shall transmit the request together with his/her recommendation to the Medical Executive Committee, which shall make a report and a recommendation and transmit it to the Chief Executive Officer for action by the Board. If during the leave of absence the practitioner's reappointment is due for recredentialing and their reappointment reaches expiration date with no response, that practitioner will have voluntarily resigned medical staff membership and privileges. If an out-of-sequence processing fee is incurred at that time, payment of this fee will be the responsibility of the practitioner. Payment of Medical Staff dues will be required during the leave of absence.

²⁶³ Amended 3/23/2017

²⁶⁴ Amended 12/10/98

²⁶⁵ Amended 10/27/2011

ARTICLE VII

HEARINGS AND APPEALS

ARTICLE VII - PART A: INITIATION OF HEARING

Section 1. Initiation of Hearing

²⁶⁶An applicant or person holding a Medical Staff membership or appointment as a limited license independent practitioner nurse practitioner (including nurse midwives and nurse anesthetists) shall be entitled to a hearing whenever an adverse professional action has been proposed by the Medical Executive Committee or the Hospital Board regarding those matters enumerated in Part B, Section 2. Physician Assistants Hearing and Appeal rights are different and covered under Article II Section 3 Part E section 4 and 5.

Adverse professional action shall be taken; (1) In the reasonable belief that the action is in the furtherance of quality medical care; (2) after a reasonable effort to obtain the facts of the matter as outlined in these Bylaws; (3) after notice and hearing procedures as set forth in these Bylaws or after such other procedures as are fair to the practitioner under the circumstances; (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts; and (5) after adequate notice and hearing procedures as set forth in these Bylaws.

The applicant or appointee has the right to only one hearing. He/she may elect to have his/her hearing at the Medical Executive Committee level pursuant to Articles V and VI, or at the Board level as defined in Article VII.

ARTICLE VII - PART B: THE HEARING

Section 1. Notice of Right to Request Hearing and Hearing Rights

A. Notice of Right to Request Hearing

- (1) When a recommendation is made by the Medical Executive Committee, or the Hospital Board, which, according to these Bylaws, entitles an individual to a hearing prior to a final recommendation of the Medical Executive Committee or a final decision of the Board, the applicant or Medical Staff appointee shall promptly be given notice by the Chief Executive Officer, in writing, return receipt requested. This notice shall contain statements substantially as follows:
 - (a) The specific professional review action which has been proposed to be taken against the practitioner,
 - (b) Reasons for the proposed action,

²⁶⁶ Amended 12/17/2015

- (c) The practitioner has the right to request a hearing on the proposed action,
- (d) The practitioner has thirty (30) days after receiving the notice within which to submit a written request for a hearing to the Chief Executive Officer, copy to the Chairperson of the Hospital Board.
- (e) The practitioner has the rights in a hearing to an attorney, to a record of the proceeding, to present evidence and written statements and to cross examine, as more fully described below in Section 1.B.
- (f) Failure to request a hearing within the specified time period and in the proper manner may result in a loss of all rights to a hearing on the matter that is the subject of the notice, and that the practitioner will be deemed to have accepted the action taken.
- (g) The Hospital Board as required or permitted under these Bylaws to act in the matter will not be bound by the recommendation of the hearing body or its action pursuant thereto, but may take any action whether more or less severe which it deems warranted by the circumstances,
- (h) Upon receipt of the practitioner's written request for a hearing, the Chief Executive Officer will notify the practitioner in writing, return receipt requested, of the date, time and place of the hearing, which date shall be not less than 30 days after the date of the notice.

B. Notice of Hearing Rights

- (a) ²⁶⁷The notice of hearing shall include the names of the arbitrator, hearing officer or panel members, and the notice shall also include a restatement and summary of the hearing rights and requirements of this Article of the Bylaws including the following:
 - (1) The criteria, Bylaws or other requirements relied on in the adverse professional review action recommendation, decision or act,
 - (2) The hearing shall be held, as determined by the hospital as follows:
 - (a) before an arbitrator mutually acceptable to the practitioner and the hospital,

- (b) before a hearing officer, who is appointed by the hospital, by and through the Chief Executive Officer, and who is not in direct economic competition with the practitioner involved,
 - (c) before a panel of individuals who are appointed by the entity, by and through the hospital, and who are not in direct economic competition with the practitioner involved, or
 - (d) Before a hearing panel as promulgated and implemented by the Oregon Board of Medical Examiners pursuant to ORS 441.055 (6) to (11) and OAR 847-10-095,
- (3) The right to a hearing may be forfeited if the practitioner fails without good cause to appear,
 - (4) Practitioner has the right to representation by an attorney or other person of practitioner's choice at the practitioner's expense,
 - (5) ²⁶⁸Not less than ten (10) days prior to the date of the hearing, the Hospital shall furnish to practitioner a list of names so far as is then reasonably known, who will give testimony or evidence in support of the Hospital at the hearing, and to further furnish the names and addresses of additional witnesses as soon as they are identified as possible participants. The witness list may be supplemented at any time during the course of the hearing. (The Hospital has the right, by written notice, to request and be furnished a list of witnesses whom practitioner will offer at the hearing, with said notice to be given no later than ten (10) days prior to the hearing, and the names to be furnished within a reasonable time thereafter, but with the right to supplement said witness list on the same basis as that afforded the Hospital.)
 - (6) Notice that if practitioner does not testify on practitioner's own behalf, the Practitioner may be called and examined as if under cross-examination,
 - (7) Practitioner has the right to call, examine and cross-examine witnesses,
 - (8) Practitioner has the right to present evidence determined to be relevant by the hearings officer, arbitrator, panel or hearing body regardless of its admissibility in a court of law,

- (9) Practitioner has the right to obtain a copy of the hearing record upon payment of reasonable charges associated with its preparation,
- (10) Practitioner has the right to submit a written statement at the close of the hearing.
- (11) Practitioner has the right to receive the recommendation of the hearing person or body, including a statement of the basis for the recommendation.
- (12) Practitioner has the right to receive a written decision of the Hospital, including a statement of the basis for the decision.

Section 2. Grounds for Hearing

No matter or action other than those hereinafter enumerated shall constitute grounds for a hearing:

- (a) denial of initial Medical Staff appointment;
- (b) denial of requested advancement in Medical Staff category;
- (c) denial of Medical Staff reappointment;
- (d) revocation of Medical Staff appointment;
- (e) denial of requested initial clinical privileges;
- (f) denial of requested increased clinical privileges;
- (g) decrease of clinical privileges;
- (h) suspension of clinical privileges.

Section 3. Unappealable Actions

Neither voluntary nor automatic relinquishment of clinical privileges, as provided for elsewhere in these Bylaws, nor the imposition of a requirement for retraining, additional training or continuing education, no matter whether imposed by the Medical Executive Committee, other empowered committee or the Board, shall constitute grounds for a hearing, but shall take effect without hearing or appeal.

Section 4. 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 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. Each party shall have the right to submit a memorandum of points and authorities, and the hearing body may request such memorandum to be filed following the close of the hearing. The hearing body may interrogate the witnesses, call additional witnesses, or request documentary evidence if it deems it appropriate.

Section 5. Official Notice

The hearing body 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 the State of Oregon. 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 rebuttal of any evidence submitted on official notice.

Section 6. Burden of Proof

- (a) At any hearing involving any of the following grounds for hearing: Denial of an initial Medical Staff appointment, denial of requested advancement in Medical Staff category, or denial of a request for initial or additional clinical privileges, it shall be incumbent on the person who requested the hearing initially to come forward with evidence in support of his/her position.
- (b) In cases involving a decrease of clinical privileges, denial of Medical Staff reappointment, revocation of Medical Staff appointment, or suspension of total privileges for a term, it shall be incumbent on the Board or the Medical Executive Committee, whichever body's recommendation prompted the hearing initially, to come forward with evidence in support of its recommendation. Thereafter, the person who requested the hearing shall come forward with evidence in his/her support.
- (c) In all cases in which a hearing is conducted under these Bylaws, after all evidence has been submitted by both sides, the hearing body 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 unreasonable, not sustained by the evidence, or is otherwise unfounded.

ARTICLE VII - PART C: HEARING PANEL

Section 1. Hearing Panel

Any hearing body, whether it be a hearings officer, hearing panel or other hearing body, shall be known and identified in these Bylaws as "hearing panel." When a hearing is requested, the Chief Executive Officer, acting for the Hospital Board, and after considering the recommendations of the President of the Medical Staff and the Chairperson of the Board, shall appoint a hearing panel which shall be composed of not less than three (3) members, at least one of whom shall be a

physician. Panel members shall not be in direct economic competition with the practitioner involved. The panel shall be composed of either staff appointees who shall not have actively participated in the consideration of the matter involved at any previous level, or of physicians or laymen not connected with the Hospital, or a combination of such persons. Such appointment shall include designation of the person who is to act as said Chairperson. Knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel.

As alternates to the foregoing, the entity may choose to have the hearing held before an arbitrator mutually acceptable to the practitioner and the Hospital, or before a hearings officer who is appointed by the Hospital, by and through the Chief Executive Officer, and who is not in direct economic competition with the practitioner, or before a hearing panel as promulgated and implemented by the Oregon Board of Medical Examiners pursuant to ORS 441.055 (6) to (11) and OAR 847-10-095.

Section 2. Presiding Officer

- (a) The Chief Executive Officer may appoint a presiding officer. Alternatively, the Chairperson of the hearing panel shall be the presiding officer.
- (b) The presiding officer shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, that decorum be maintained throughout the hearing, and that no intimidation is permitted. He/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/she may be advised by legal counsel to the Hospital. In all instances he/she shall act in such a way that all information relevant to the appointment, reappointment or clinical privileges of the person requesting the hearing is considered by the hearing panel in formulating its recommendations. It is understood that the presiding officer is acting at all times to see that all relevant information is made available to the hearing panel for its deliberations and recommendations to the Board.

Section 3. Time of Hearing, Postponement and Extensions

The Chief Executive Officer shall schedule a hearing and notify the affected practitioner in writing of the time, date and place. The hearing shall be held not less than 30 days from the date of the notice. Postponements and extensions of time beyond any time limit set forth in these Bylaws may be requested by anyone, but shall be permitted only by the hearing panel or its Chairperson on a showing of good cause.

Section 4. Record of Hearing

The hearing panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter 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.

Section 5. Attendance by Panel Members

Recognizing that it may not be possible for all members of the hearing panel to be present continually at all sessions of the panel, since it is necessary to conduct a hearing as soon as reasonable after the event or events that give rise to its necessity, the hearing shall continue even though certain members of the hearing panel are not present at all times. The fact that certain panel members were not physically present at all times during the hearing will not disqualify them or invalidate the hearing. Consequently, no quorum of the hearing panel shall be required in order to continue the hearing. The vote shall be by majority of those appointed to the hearing panel.

Section 6. Adjournment and Conclusion

The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participant without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

Section 7. Basis of Decision

The decision of the hearing panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

- (a) Oral testimony of witnesses;
- (b) Memorandum of points and authorities presented in connection with the hearing;
- (c) Any material contained in the Hospital's files regarding the person who requested the hearing so long as this material has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;
- (d) Any and all applications, references and accompanying documents;
- (e) All officially noticed matters;
- (f) Any other evidence that has been admitted.

Section 8. Deliberations and Recommendation of the Hearing Panel

Within twenty (20) days after final adjournment of the hearing, the hearing panel, officer, arbitrator or committee shall conduct its deliberations outside the presence of any other person except the presiding officer and shall render a recommendation, accompanied by a report which shall contain a concise statement of the reasons

justifying the recommendation made, and shall deliver such report to the Chief Executive Officer.

Section 9. Disposition of Hearing Panel Report

Upon its receipt, the Chief Executive Officer shall send a copy of the report and recommendations to the Medical Executive Committee, or the Hospital Board, as appropriate, for action as provided in the Bylaws; and to the practitioner involved, including a statement of the basis for the recommendation. Said recommendation and report shall be sent regular and certified mail to practitioner, return receipt requested.

ARTICLE VII - PART D: APPEAL

Section 1. Time for Appeal

Within ten (10) days after the affected individual is notified of a proposed adverse recommendation at the Hospital Board level, he/she may request appellate review. The request shall be in writing and shall be delivered to the Chief Executive Officer either in person or sent return receipt requested, and shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within ten (10) days as provided herein, the affected individual shall be deemed to have accepted the recommendation involved and it shall thereupon be final and immediately effective.

Section 2. Grounds for Appeal

The grounds for appeal from a recommendation shall be that:

- (a) There was substantial failure on the part of the Executive Committee, or the hearing panel to comply with the Hospital or Medical Staff Bylaws in the conduct of hearings and recommendations based upon hearings so as to deny due process or a fair hearing; or
- (b) Preliminary action by the Board to reject or modify a favorable recommendation of the Medical Executive Committee was not supported by the evidence; or
- (c) The recommendation was made arbitrarily, capriciously, or with prejudice; or
- (d) The recommendation of the Medical Executive Committee or the hearing panel was not supported by the evidence.

Section 3. Right to One Appeal and One Hearing Only

No applicant or Medical Staff appointee shall be entitled as a matter of right to more than one hearing and one appellate review of any proposed action.

Section 4. Time, Place and Notice²⁶⁹

In the event a practitioner has had a hearing, and an appeal therefrom is requested as set forth in the preceding sections, the Chairperson of the Board shall, within ten (10) days after the receipt of such request, schedule and arrange for an appellate review.

In the event the practitioner requests a hearing and has not afforded himself/herself of that right, a hearing shall be held as provided in the Bylaws. Practitioner, upon receipt of the hearing panel's recommendations to the Board, may within ten (10) days after receipt of such report, request an appeal therefrom. The Chairperson of the Board shall, within ten (10) days after receipt of a practitioner's request for appeal, schedule and arrange for said appellate review.

The Board shall cause the affected individual to be given notice of the time, place and date of the appellate review. The date of the appellate review shall not be less than twenty (20) days, nor more than forty (40) days from the date of the receipt of the request for appellate review. However, that when a request for appellate review is from an appointee who is under 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 the receipt of the request for appellate review. The time for appellate review may be extended by the Chairperson of the Board for good cause.

Section 5. Nature and Scope of Appellate Review

The Chairperson of the Board shall appoint a review panel composed of not less than three (3) persons, either its own members or reputable persons outside the Hospital, or a combination of the two to consider the record upon which the recommendation before it was made. The matter shall be reviewed on the record only and not de novo subject to the right to expand the record as determined by the review panel in its discretion.

Each party shall have the right to present a written statement in support of his/her position on appeal, and in its sole discretion, the review panel may allow each party or his/her representative to appear personally and make oral argument. The review panel shall transmit to the Board a full copy of the record and shall recommend final action to the Board. The Board may affirm, modify or reverse the recommendations of the review panel, or, in its discretion refer the matter for further review and recommendation.

Section 6. Final Decision of the Board

Within thirty (30) days after receipt of the report of the proceedings before the appellate review panel, the Board shall render a final decision in writing and shall

²⁶⁹ Amended 6/25/2015

deliver copies thereof to the affected individual and to the Medical Executive Committee, in person or by certified mail.

Section 7. Further Review

Except where the matter is referred for further action and recommendation in accordance with Section 6 of this part, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. ²⁷⁰If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and report back to the Board shall in no event exceed thirty (30) days in duration except as by the parties may otherwise stipulate.

Section 8. Hearing Rights, Appellate Review and Decision Where Matter is Before the Board with a Favorable Recommendation by the Medical Executive Committee, but Adverse Action is Under Consideration by Board

In a matter before the Board in which the practitioner's application is reported favorably to the Board but the Board is considering acting unfavorably, the Board shall proceed as follows:

1. Notify practitioner that an adverse professional action is being considered by the Board. Notice of said possible action shall be given pursuant to Article VII, Part A and B, Section 1.
2. Determine whether the practitioner has been afforded or waived right to hearing. If no hearing has been held or hearing has not been waived, the applicant shall have all the hearings rights as set forth in Article VII, Parts A through C.
3. If applicable, hold hearing.
4. Within ten (10) days after the practitioner is notified of the hearing decision, or if practitioner has waived a hearing, the practitioner may request appellate review. The request shall be in writing and shall be delivered to the Chief Executive Officer either in person or sent by mail, return receipt requested, and shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within ten (10) days as provided herein, the practitioner shall be deemed to have accepted the recommendation involved and it shall thereupon be final and immediately effective. Practitioner is entitled to all appellate rights as set forth in Article VII, Part D.
5. The Board shall render its final decision as set forth in Article VII, Part D, Section 7.

²⁷⁰ Amended 6/25/2015

ARTICLE VII - PART E: RIGHT TO REAPPLY

Section 1. Practitioner's Right to Reapply or Ask for Reappointment

Nothing in these Bylaws shall restrict the right of the applicant to reapply for appointment to the Medical Staff or restrict the right of an appointee to apply for reappointment or increase in clinical privileges after the expiration of two years from the date of such Board action unless the Board provides otherwise in its written decision.

ARTICLE VIII

²⁷¹POLICIES OF THE MEDICAL STAFF

²⁷²The Medical Staff, with the approval of the Board, shall adopt Policies to implement more specifically the general principles of conduct found in these Bylaws. Medical Staff Policies shall set standards of practice that are to be required of all providers, and shall act as an aid to evaluating performance, and compliance with these standards. Medical Staff Policies guide actions to achieve a desired outcome and shall have the same force and effect as the Bylaws.

Medical Staff Policies may be changed, repealed, or added by vote of the Medical Executive Committee at any regular or special meeting provided that copies of the proposed amendments, additions, or repeals are made available to all members of the Medical Executive Committee before being voted on. Changes in the Medical Staff Policies shall become effective only when approved by the Board.

Any voting member of the organized medical staff may propose to adopt or change Medical Staff Policies. The recommendation may be submitted from the floor at a regular meeting or special meeting called for that purpose. This requires the vote of the majority in attendance at the meeting and then be presented to the appropriate Clinical Service Department meeting for discussion and vote of majority. The recommendation from the appropriate Clinical Service Department meeting can then be forwarded directly to the Medical Executive Committee for action or directly to the Board for information or action. The Board can request feedback from the Medical Executive Committee before the Board takes action. All such changes shall become effective only when approved by the Board.

In cases of a documented need for an urgent change to Medical Staff Policies, which is necessary to comply with law or regulation, the Medical Executive Committee, as delegated by the voting members of the organized medical staff, may provisionally adopt prior to the Board's approval of the policy implementation or change. However the Board shall still have the requirement to approve the Policy and the authority to change the proposed urgent policy initiation or modification.

Upon approval by the Board, any updates or addition of new Medical Staff policies will be published in the Medical Staff newsletter and announced at Clinical Service Department meetings.

²⁷¹ Amended 1/27/2011

²⁷² Amended 6/25/2015

ARTICLE IX
RULES AND REGULATIONS OF THE MEDICAL STAFF

²⁷³The Medical Staff, with the approval of the Board, shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles of conduct found in these Bylaws. Rules and Regulations shall set standards of practice that are to be required of all persons with clinical privileges in the hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and Regulations shall have the same force and effect as the Bylaws.

²⁷⁴Particular Rules and Regulations may be amended, repealed, or added by vote of the Medical Executive Committee at any regular or special meeting provided that copies of the proposed amendments, additions, or repeals are posted and made available to all members of the Medical Executive Committee fourteen (14) days before being voted on and further provided that all written comments on the proposed changes by persons holding current appointments to the Medical Staff be brought to the attention of the Medical Executive Committee before the change is voted upon. Changes in the Rules and Regulations shall become effective only when approved by the Board.

²⁷⁵Any voting member of the organized medical staff may propose to adopt or amend Rules and Regulations. The recommendation may be submitted from the floor at a regular meeting or special meeting called for that purpose.²⁷⁶ This requires the vote of the majority in attendance at the meeting and then be presented to the appropriate Clinical Service Department meeting for discussion and vote of majority. The recommendation from the appropriate Clinical Service Department meeting can then be forwarded directly to the Board for information or Medical Executive Committee for action provided that the procedure used in amending the Medical Staff Bylaws is followed. The Board can request feedback from the Medical Executive Committee. All such changes shall become effective only when approved by the Board.

In cases of a documented need for an urgent amendment to the Rules and Regulations, which is necessary to comply with law or regulation, the Medical Executive Committee, as delegated by the voting members of the organized medical staff, may provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the Medical Executive Committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the Medical Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment the Conflict Management policy MS#43 is implemented. If necessary, a revised amendment is then submitted to the Board for action.

The Medical Staff Rules and Regulations will be reviewed by the Medical Executive Committee and amended if appropriate annually.

²⁷³ Amended 1/27/2011

²⁷⁴ Amended 8/27/2015

²⁷⁵ Amended 8/27/2015

²⁷⁶ Amended 8/3/95

ARTICLE X

BYLAWS AMENDMENTS AND REVIEW²⁷⁷²⁷⁸

All proposed amendments of these Bylaws initiated by the Medical Staff shall, as a matter of procedure, be referred to the Medical Executive Committee. The Medical Executive Committee shall report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such. They shall be voted upon at that meeting provided that they shall have been posted at least fourteen (14) days prior to the meeting.²⁷⁹ A ballot by mail shall be acceptable if sent to all eligible voting members of the Medical Staff with a minimum of 10 days to return.²⁸⁰ To be adopted, an amendment must receive a majority of the votes cast by the voting staff who are present at the time of such vote and who do vote. Amendments so adopted shall be effective when approved by the Board.

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws as are, in the committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within sixty (60) days of adoption by the Medical Executive Committee. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Medical Executive Committee. After adoption, such amendments shall, as soon as practicable, be posted on the Medical Staff bulletin board for fourteen (14) days, and sent to the Chief Executive Officer.

²⁸¹²⁸²The Medical Staff Bylaws will be reviewed by the Medical Executive Committee, and amended if appropriate, annually.

²⁷⁷ Amended 6/1/1995

²⁷⁸ Amended 1/27/2011

²⁷⁹ Amended 8/27/2015

²⁸¹ Amended 6/22/2000

²⁸² Amended 1/27/2011

ARTICLE XI

ADOPTION

These Bylaws are revised and made effective the first day of the month following hospital Board approval, superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each and every appointee to the Medical Staff shall be taken under and pursuant to the requirements of these Bylaws.

The present Rules and Regulations of the Medical Staff are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws.

APPROVED by the Medical Staff on 12/8/1994.

REVISED by the Medical Staff on 10/3/2017

President of the Medical Staff

ADOPTED by the Board on 12/8/1994.

REVISION(S) ADOPTED by the Board on 10/26/2017

THC Board Secretary/Treasure