MEDICAL STAFF BYLAWS
OF
LEGACY EMANUEL
HOSPITAL & HEALTH CENTER

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DEFINITIONS

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

(1) “Certified Nurse Midwife” means a nurse midwife certified by the state of Oregon as a certified nurse midwife;
(2) “Credentials Committee” means the credentials committee of Hospital;
(3) “Dentist” means a doctor of dental surgery or a doctor of dental medicine;
(4) “Ex Officio” means serving in a certain capacity by virtue of office. Individuals serving as ex officio members shall not have the right to vote and shall not be counted in determining the existence of a quorum;
(5) “Hospital” means Legacy Emanuel Hospital & Health Center;
(6) “Legacy” means Legacy Health;
(7) “Legacy Board” means the Board of Directors of Legacy, or its designee;
(8) “Legacy CEO” means the individual appointed by the Legacy Board to act as the chief executive officer on its behalf in the overall management of Legacy and shall mean the Legacy CEO or designee;
(9) “Legacy CMO” means the individual serving as Legacy’s Chief Medical Officer;
(10) “Licensed Independent Practitioners” or “LIPs” include Physicians, Dentists, Podiatrists, Certified Nurse Midwives, Nurse Practitioners and Psychologists;
(11) “Medical Executive Committee” means the medical executive committee of the Medical Staff;
(12) “Medical Quality & Credentialing Committee” is a Legacy Board committee comprised of representatives from each Legacy Medical Staff, the Legacy Board and Legacy administration;
(13) “Medical Staff” means all LIPs who are appointed to the Medical Staff;
(14) “NPDB” means the National Practitioner Data Bank;
(15) “Nurse Practitioner” means an advanced practice registered nurse who is certified by the state of Oregon as a nurse practitioner;
(16) “Oral Surgeon” means a licensed Dentist who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation of the American Dental Association;
(17) “Patient Contacts” include any admission, inpatient consultation, evaluation, procedure (inpatient or outpatient) or diagnostic test involving direct patient interaction (except in imaging and pathology) performed at Hospital. Patient Contacts do not include referrals to Hospital for diagnostic studies or for procedures performed by another practitioner.
(18) “Physician” means a doctor of medicine or doctor of osteopathy;
(19) “Podiatrist” means a doctor of podiatric medicine;
(20) “Psychologist” means a Psy.D or a Ph.D.
(21) “Randall Children’s Hospital” is a pediatric hospital that is a part of Hospital.

Words used in these bylaws shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these bylaws.
ARTICLE 1
PURPOSE

The purpose of this organization is to bring the professionals who practice at Hospital together into a cohesive body to promote high quality patient care, provide oversight in activities related to patient safety and improve patient satisfaction. To this end, among other activities, it shall screen applicants for Medical Staff membership, review privileges of Medical Staff members, evaluate and assist in improving the work done by the Medical Staff, provide education, and offer advice to the Legacy CEO or designee.

ARTICLE 2
MEDICAL STAFF MEMBERSHIP

2.A.1. Medical Staff Membership:

Qualifications and conditions for appointment to the Medical Staff are outlined in these bylaws. Medical Staff members must conform to and follow all Hospital and Medical Staff bylaws, rules, regulations and policies including, but not limited to, those regarding impairment, harassment and conduct.

2.A.2. Medical Staff Dues:

(a) The Medical Executive Committee shall have the power to determine the amount of annual dues or assessments, if any, for each category of Medical Staff membership, and to determine the manner of expenditure of such funds received.

(b) Annual dues for membership shall be due and payable at an amount set by the Medical Executive Committee. An individual who joins the Medical Staff during the last quarter of the calendar year shall not be assessed dues until the ensuing year.

(c) Failure to render payment within three months of initial billing shall be construed as a voluntary resignation from the Medical Staff.

(d) Honorary staff shall not be required to pay dues.

ARTICLE 3
CATEGORIES OF THE MEDICAL STAFF

3.A. ACTIVE STAFF

3.A.1. Qualifications:

Appointees to this category must meet all criteria and qualifications outlined in Section 11.A and must have sufficient Patient Contacts at Hospital during their most recent appointment period (at least twenty-five (25) during a two year period or thirteen (13) during a one year period).
Hospital occasionally needs LIPs in certain medical specialties who primarily maintain office practices and do not have sufficient Patient Contacts in Hospital (e.g., allergists, dermatologists, rheumatologists, pediatricians, family practitioners, and other specialties as approved by the Medical Staff) to see and treat patients in Hospital. These LIPs are eligible for active status if they provide information deemed adequate by the Medical Staff to properly evaluate their education, training, experience, competence and other qualifications to practice in Hospital.

3.A.2. Prerogatives:

Appointees to this category may:

(a) exercise the privileges granted without limitation, except as otherwise provided in the Medical Staff Rules and Regulations or by specific privilege restriction;
(b) vote on all matters presented at the annual meeting and special meetings of the Medical Staff and at department, section, and committees to which they are appointed, and vote on all other matters presented to the Medical Staff in accordance with these bylaws;
(c) hold office, serve as department chair or section chair, and sit on or be chair of any committee, unless otherwise specified elsewhere in these bylaws; and
(d) attend Medical Staff and Hospital education programs.

3.A.3. Responsibilities:

Appointees to this category must meet all responsibilities and requirements outlined in Section 11.B.2. They must also:

(a) actively participate in patient care assessment and other performance improvement activities, supervise provisional appointees of the same profession, and discharge such other Medical Staff functions as may from time to time be required;
(b) for Medical Staff members with attending privileges, be within a thirty (30) minute response time of Hospital when on call; and
(c) participate in emergency service and other rotational obligations if asked to do so by the Medical Executive Committee.

3.B. COURTESY STAFF

3.B.1. Qualifications:

Appointees to this category must meet all criteria and qualifications outlined in Section 11.A. and:

(a) shall not exceed a maximum number of Patient Contacts at Hospital during their most recent appointment period (twenty-four (24) during a two year period or twelve (12) during a one year period). Appointees with more than the maximum number of Patient Contacts at Hospital during their most recent appointment period shall be considered for advancement to the Active Staff; and
(b) be appointees in good standing of the active medical staff of another hospital or health care facility that has a formal quality improvement and patient safety program with clinical privileges and sufficient Patient Contacts during their most recent appointment
period (at least twenty-five (25) during a two year period or thirteen (13) during a one year period) and provide documentation of Patient Contacts, if requested.

3.B.2. Prerogatives:

Appointees to this category may:

(a) exercise the privileges granted without limitation, except as otherwise provided in the Medical Staff Rules and Regulations or by specific privilege restriction;
(b) vote on all matters presented at the annual meeting and special meetings of the Medical Staff and at department, section, and committees to which they are appointed, and vote on all other matters presented to the Medical Staff in accordance with these bylaws;
(c) hold office, serve as department chair or section chair and sit on or be chair of any committee, unless otherwise specified elsewhere in these bylaws; and
(d) attend Medical Staff and Hospital education programs.

3.B.3. Responsibilities:

Appointees to this category must meet all responsibilities and requirements outlined in Section 11.B.2. They must also:
(a) participate in emergency service and other rotational obligations if asked to do so by the Medical Executive Committee; and
(b) be within a thirty (30) minute response time of Hospital when on call.

3.C. AFFILIATE MEDICAL STAFF

3.C.1. Qualifications:

Appointees to this category must meet all criteria and qualifications outlined in Section 11.A. and must contribute to Hospital or the Medical Staff through one or more of the following:
(a) refer patients to members of the Active Staff;
(b) order diagnostic or therapeutic services at Hospital;
(c) serve as an Officer of the Medical Staff;
(d) serve on Hospital or Medical Staff Committee(s);
(e) accept and provide office-based care to patients referred from Hospital’s Emergency Department;
(f) participate in Hospital or Medical Staff quality improvement activities, including case review;
(g) teach Medical Staff, nurses, residents and/or other Hospital staff subject to the limitations set forth in Section 3.C.4. of these bylaws; or
(h) conduct clinical research at Hospital.

3.C.2. Prerogatives:

Appointees to this category may:
(a) vote on all matters presented at the annual meeting and special meetings of the Medical Staff and at department, section, and committees to which they are appointed, and vote on all other matters presented to the Medical Staff in accordance with these bylaws;
(b) hold office, serve as department chair or section chair, and sit on or be chair of any committee, unless otherwise specified elsewhere in these bylaws;
(c) attend Medical Staff and Hospital education programs; and
(d) visit his/her patients in Hospital and access patient medical records. May submit notes (not orders; not consultation reports) to provide for continuity of care.

3.C.3. Responsibilities:
Appointees to this category must meet all responsibilities and requirements outlined in Section 11.B.2, as appropriate. Appointees with patients requiring hospitalization must also have an arrangement with a member of the Medical Staff with appropriate privileges to manage the admission and care of such patients.

3.C.4. Limitations:
Appointees to this category may not practice, admit patients, perform consults, exercise clinical privileges or write orders at Hospital.

3.D. HONORARY STAFF

3.D.1. Qualifications:
To be designated as Honorary staff, an individual must:
(a) be recommended for Honorary status by the Medical Executive Committee;
(b) possess an outstanding reputation;
(c) have made noteworthy contributions to the health and medical sciences or have previous longstanding service as an Active member in good standing of the Medical Staff for a minimum of five continuous years; and
(d) continue to adhere to high professional and ethical standards.

Honorary staff are not required to meet criteria and qualifications outlined in Section 11.A.

3.D.2. Prerogatives and Responsibilities:
Honorary staff:
(a) may attend Medical Staff and department meetings;
(b) may attend Medical Staff and Hospital education programs;
(c) are not required to pay dues; and
(d) are not required to meet the responsibilities and requirements outlined in Section 11.B.2.

3.D.3. Limitations:
Honorary staff:
(a) are not members of the Medical Staff;
(b) may not practice, admit patients, exercise clinical privileges or write orders at Hospital;
(c) may not vote on matters presented to the Medical Staff; and
(d) may not hold office.

3.E. INTERNS AND RESIDENTS:

Except for the Chief Resident, interns and residents in training at Hospital shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to perform only those functions set out in approved training protocols. Program Directors are responsible for verifying the qualifications and credentials of each resident permitted to function in Hospital. Residents, who provide services under a contract as described by Hospital policy, shall meet the qualifications and credentials outlined in said Hospital policy and shall be permitted to perform only those functions outlined in their job description.

ARTICLE 4
OFFICERS

4.A.1. Officers of the Medical Staff:

The officers of the Medical Staff shall be:

(a) President;
(b) President-elect;
(c) Immediate Past President;
(d) Randall Children’s Hospital Chairman; and
(e) Randall Children’s Hospital Chairman-Elect.

4.A.2. Qualifications of Officers and Chairs:

Except as otherwise provided, only those members of the Medical Staff who satisfy the following criteria shall be eligible to serve as Medical Staff officers, department chairs, section chairs, or committee chairs:

(a) are in good standing, have served on the Medical Staff for at least three years, and continue to be in good standing during their term of office;
(b) have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
(c) are not presently serving as a Medical Staff officer, corporate officer, department chair, physician leader or employee at any other non-Legacy hospital or medical staff and shall not so serve during their term of office;
(d) are willing to faithfully discharge the duties and responsibilities of the position to which they are elected or appointed;
(e) have had prior Medical Staff leadership or committee experience;
(f) possess and have demonstrated an ability for harmonious interpersonal relationships;
(g) have constructively participated in Medical Staff affairs, including peer review activities;
(h) are knowledgeable concerning the duties of the office;
(i) possess written and oral communication skills;
(j) agree to participate in Medical Staff education;
(k) agree to comply with other duties as listed in job description; and
(l) for purposes of the Randall Children’s Hospital Chairman, a full-time pediatric specialist means a member of Pediatric Medicine or Pediatric Surgery department who primarily practice Pediatrics greater than 40% of the time.

4.A.3. Election of Officers:

(a) Officers shall be elected by the members of the Medical Staff and shall be confirmed by the Legacy Board. Provided, however, the Randall Children’s Hospital Chairman shall be elected by members of the Medical Staff in the Pediatric Medicine and Pediatric Surgery departments.

(b) The nominating committee shall be appointed by the Medical Executive Committee and may include members of the Medical Executive Committee. This committee shall offer one or more nominees for each office. Nominations shall be announced and the names of the nominees distributed to all members of the Medical Staff at least thirty (30) days before the annual meeting.

(c) Nominations may also be made by a petition signed by at least five percent (5%) of the members of the Medical Staff. All such nominees shall meet all the criteria outlined in this section and shall have agreed to be nominated. Such petition shall be submitted to the Medical Staff Office at least twenty (20) days prior to the annual Medical Staff meeting.

(d) The candidate who receives a majority vote of the Medical Staff shall be elected. If no candidate receives a majority vote, then the Medical Staff shall hold a runoff election, to be held as soon as practicable, between the two candidates with the most votes.

4.A.4. Term of Office:

All officers shall take office on the first day of the calendar year and shall serve a term of two years. The Randall Children’s Hospital Chairman shall serve a two year term.

4.A.5. Vacancies in Office:

Vacancies in office, except the office of President of the Medical Staff, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of the President of the Medical Staff, the President-elect shall serve the remainder of the term.

4.A.6. Duties of Officers:

(a) President of the Medical Staff: The President of the Medical Staff shall:

   (1) act in coordination and cooperation with the Legacy CMO and the Legacy CEO in matters of mutual concern involving Hospital;
   (2) call, preside at and be responsible for the agenda of the annual and special meetings of the Medical Staff;
   (3) make recommendations to the Medical Executive Committee for appointment of committee chairs and members to all standing and special Medical Staff
committees, except the Medical Executive Committee, in accordance with the provisions of these bylaws;
(4) serve as Chair of the Medical Executive Committee;
(5) serve as ex officio member, on all Medical Staff committees other than the Medical Executive Committee;
(6) represent the views, policies, needs and grievances of the Medical Staff and report on the medical activities of the Medical Staff to the Legacy Board and to the Legacy CEO;
(7) provide day-to-day liaison on medical matters with the Legacy CEO, the Legacy CMO and the Legacy Board; and
(8) receive and interpret the policies of the Legacy Board to the Medical Staff and report to the Legacy Board on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care.

(b) President-elect: In the absence of the President of the Medical Staff, the President-elect shall assume all the duties and have the authority of the President of the Medical Staff. He/she shall perform such further duties to assist the President of the Medical Staff as the President of the Medical Staff may from time to time request. He/She shall also be a member of the Credentials Committee. The President-elect shall see to the safeguarding of Medical Staff funds, the administration of Medical Staff expenditures and the collection of dues and make periodic reports of the status of same to the Medical Staff.

(c) Randall Children’s Hospital Chairman: The Randall Children’s Hospital Chairman shall:
(1) Represent the views, policies, needs and grievances of the Pediatric Medical Staff members;
(2) Attend both Pediatric Medicine and Pediatric Surgery Department Executive Committee meetings, Randall Children’s Hospital Quality Council meeting, Officers meeting, Medical Executive Committee meeting, represent Randall Children’s Hospital at the Medical Quality & Credentialing Committee meeting, other committee meetings as necessary, and chair the combined Pediatric Medicine and Pediatric Surgery Department meeting;
(3) Advise on credentialing issues specific to Pediatric Medical Staff members;
(4) Serve as day-to-day liaison on medical matters with Chief Administrative Officer of Randall Children’s Hospital;
(5) Serve as a member of the Medical Executive Committee;
(6) Assist the Officers in ensuring Pediatric representation on all appropriate standing committees. In the event that any standing committee of the Medical Staff is composed of a majority of two thirds or greater of Adult department members, the Randall Children’s Hospital Chairman shall become a member of such committee. Other committee membership and participation shall be at the direction of the President of the Medical Staff; and
(7) Perform such further duties to assist the President of the Medical Staff as the President may assign from time to time.

4.A.7. Removal from Office:

The Legacy Board may remove any officer, but only after a joint conference with representatives of the Medical Executive Committee. The affected individual shall be invited to attend the joint
conference, but shall be excused prior to the deliberations and decision. The Medical Staff may remove any officer by petition of one-eighth \((1/8)\) of the members of the Medical Staff and a subsequent vote by at least two-thirds \(\left( \frac{2}{3} \right) \) of the members of the Medical Staff present and voting at a special meeting called for such a purpose by the Medical Executive Committee. Removal shall be for failure to fulfill those responsibilities assigned within these bylaws or other policies and procedures of the Medical Staff.

**ARTICLE 5**
**DEPARTMENTS**

5.A.1. Departments:

A department shall be organized as a clinical unit and shall have a chair who is selected and has the authority, duties, and responsibilities as set forth in these bylaws. The following departments are established:

(a) Adult Medicine
(b) Adult Surgery
(c) Mental Health
(d) Pediatric Medicine
(e) Pediatric Surgery
(f) OB/GYN

Additional departments or sections of departments, as required from time to time, may be established or dissolved by the Legacy Board after considering recommendations from the Medical Executive Committee. Each department shall have an executive committee.

5.A.2. Optional Sections:

(a) Any group of LIPs who practice in the same or similar areas and who wish to have a forum for discussion of those clinical areas may organize into a section. Any section, if organized, shall not be required to hold any number of regularly scheduled meetings.
(b) Sections may perform any of the following activities:
   (1) Continuing education;
   (2) Discussion of policy;
   (3) Discussion of equipment needs;
   (4) Development of recommendations for the department chair or Medical Executive Committee;
   (5) Participation in the development of criteria for clinical privileges (when requested by the department chair); and
   (6) Discussion of a specific issue at the special request of a department chair or the Medical Executive Committee.
(c) Except in extraordinary circumstances, no minutes or reports shall be required reflecting the activities of sections. Only when sections are making formal recommendations to a department shall a report be required from the section chair documenting the section-specific position.
NOTE: Section meetings shall not be staffed by representatives of the Medical Staff Office. Attendance shall not be taken, nor shall any rigid agenda be followed.

5.A.3. Qualifications, Selection and Tenure of Department Chairs, Department Vice-Chairs and Section Chairs:

(a) Each department chair, department vice-chair and section chair shall meet all qualifications outlined in Section 4.A.2 and shall be willing and able to discharge the functions of his/her office and be either board certified or have been determined to possess equivalent qualifications by the Medical Executive Committee. Exceptions to the board certification requirements can be made by the Legacy Board upon recommendation by the Medical Executive Committee.

(b) Department chairs shall be elected by the department members and approved by the Legacy Board. Department Vice-Chairs shall be appointed by the Department Chairs and approved by the Legacy Board.

(c) Department chairs may be removed from office by the Legacy Board after a vote of at least two-thirds ($\frac{2}{3}$) of the Medical Executive Committee acting on its own initiative, but only after a joint conference with the Legacy Board. Department chairs may also be removed from office by the Legacy Board after a vote of at least two-thirds ($\frac{2}{3}$) of the department.

(d) Department chairs, department vice-chairs and section chairs shall serve two year terms of office and may succeed themselves.

(e) Section chairs shall be elected by the members of the section by majority vote of those voting.

5.A.4. Functions of Departments:

(a) Each department chair shall recommend to the Credentials Committee written criteria for the assignment of clinical privileges within the department and each of its sections. Such criteria shall be consistent with and subject to the bylaws, policies, rules and regulations of the Medical Staff and Hospital. These criteria shall be effective when approved by the Legacy Board. Clinical privileges shall be based upon demonstrated competence, training and experience within the specialties covered by the department.

(b) Each department (or section) shall monitor and evaluate medical care on a retrospective, concurrent and prospective basis in all major clinical activities of the department or section. This monitoring and evaluation shall at least include:

1. the identification and collection of information about important aspects of patient care, treatment and services provided in the department;
2. the identification of the indicators used to monitor the quality and appropriateness of the important aspects of care; and
3. evaluation of the quality and appropriateness of care.

(c) Each department (or section) shall recommend, subject to approval and adoption by the Medical Executive Committee and the Legacy Board, objective criteria that reflect current knowledge and clinical experience. These criteria shall be used by each department or section or by Hospital’s quality assessment program to monitor and evaluate patient care, treatment and services. When important problems in patient care
and clinical performance or opportunities to improve care are identified, each department or section shall document the actions taken and evaluate the effectiveness of such actions.

(d) Each relevant department (and section) shall also conduct a comprehensive review to examine justification of surgery performed, whether tissue was removed or not, and to evaluate the acceptability of the procedure chosen for the surgery. Specific consideration shall be given to the agreement or disagreement of the pre-operative and post-operative (including pathological) diagnoses. Written reports shall be maintained reflecting the results of all evaluations performed and actions taken.

(e) In discharging these functions, each department and section shall report after each meeting, when appropriate, to the appropriate utilization and/or quality management committee detailing its analysis of patient care, treatment and services and to the Credentials Committee whenever further investigation and action are indicated, involving any individual member of the department. Copies of these reports shall be filed with the Medical Executive Committee and the Legacy CEO.

(f) Departments shall hold executive committee meetings at least semi-annually.

5.A.5. Functions of Department Chairs:

Each department chair shall:

(a) be responsible for the clinically related activities within the department;
(b) be a member of the Medical Executive Committee;
(c) continually assess and improve the quality and appropriateness of treatment and services provided within the department;
(d) continually monitor the professional performance of all members in the department who have delineated clinical privileges and report thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;
(e) recommend to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department;
(f) recommend a sufficient number of qualified and competent individuals to provide patient care, treatment and services;
(g) be responsible for the integration of the department/service into the primary functions of Hospital;
(h) be responsible for the coordination and integration of interdepartmental and intradepartmental services;
(i) be responsible for the development and implementation of policies and procedures that guide and support the provision of patient care, treatment and services;
(j) maintain quality control programs and appoint ad hoc committees or working groups as necessary to carry out quality improvement activities;
(k) recommend to the Credentials Committee clinical privileges for each member of the department;
(l) be responsible for the evaluation of all provisional appointees and report thereon to the Credentials Committee;
(m) make recommendations to the Credentials Committee regarding the qualifications and competence of department or service personnel who are not LIPs and who provide patient care, treatment and services in the department;
(n) assist Hospital, in accordance with the provisions of these bylaws, with respect to the granting of locum tenens privileges within the department and with the evaluation of requests for temporary privileges;
(o) be responsible within the department for the enforcement of Hospital and Medical Staff bylaws, policies, rules and regulations;
(p) be responsible for implementation within the department of actions taken by the Legacy Board and the Medical Executive Committee;
(q) report and recommend to Hospital management when necessary with respect to matters affecting patient care, treatment and services in the department, including personnel, space and other resources, supplies, special regulations, standing orders and techniques;
(r) assist Hospital management in the preparation of annual reports and such budget planning pertaining to the department as may be required by the Legacy CMO, the Legacy CEO or the Legacy Board;
(s) assess and recommend to Hospital management off-site sources for needed patient care, treatment and services not provided by the department or Hospital;
(t) be responsible for the orientation and continuing education of all members in the department; and
(u) delegate to a vice chair of the department such duties as appropriate.

5.A.6. Clinical Vice Presidents of Service:

A Legacy employed or contracted Clinical Vice President of service may not hold the position of Department Chair. Clinical Vice Presidents shall work collaboratively with Department Chairs.

ARTICLE 6
COMMITTEES

6.A. MEDICAL STAFF COMMITTEES

6.A.1. Standing Committees:

The Medical Staff shall have five standing committees:
(a) Medical Executive Committee
(b) Credentials Committee
(c) Adult Quality Council
(d) Randall Children’s Hospital Quality Council
(e) Peer Review Coordination Committee

6.A.2. Additional Committees:

The Medical Staff and Medical Executive Committee may designate additional committees for specific purposes, on a permanent or temporary basis.

6.A.3. Committee Members:
Committee members may include individuals who are not members of the Medical Staff. The Legacy CEO and Legacy CMO shall be ex officio members of all Medical Staff committees.

6.A.4. Legacy Committees:

The Medical Staff shall have representation and actively participate on the following Legacy system-wide committees:
(a) Blood Transfusion Committee
(b) Clinical Ethics Committee
(c) Continuing Medical Education Committee
(d) Epidemiology (Infection Control) Committee
(e) Graduate Medical Education Committee
(f) Medical Staff Health Committee
(g) Integrated Network Cancer Committee
(h) Pharmacy/Therapeutics Committee

6.B. MEDICAL EXECUTIVE COMMITTEE

6.B.1. Composition:

(a) The Medical Executive Committee shall be comprised of the following seventeen (17) individuals:
   (1) President of the Medical Staff;
   (2) President-elect of the Medical Staff;
   (3) Immediate Past President of the Medical Staff;
   (4) Chair of the Credentials Committee;
   (5) Randall Children’s Hospital Chairman;
   (6) Randall Children’s Hospital Chairman-Elect;
   (7) Chair of Adult Quality Council;
   (8) Chair of Randall Children’s Hospital Quality Council;
   (9) Chairs of each Department;
   (10) Informatics Liaison; and
   (11) Two Members-at-large

(b) The President of the Medical Staff shall make recommendations to the Medical Executive Committee for appointment of the two Members-at-large and Informatics Liaison. Members-at-large and Informatics Liaison shall serve two year terms of office.

(c) The Informatics Liaison shall either be the Chief Medical Informatics Officer or a Physician Informaticist.

(d) Department Vice-Chairs are invited to attend the Medical Executive Committee meeting and can vote if the Department Chair is not present.

(e) The President of the Medical Staff shall serve as Chair of the Medical Executive Committee.

6.B.2. Duties:

The Medical Executive Committee shall perform the following duties:
(a) Represent and act on behalf of the Medical Staff, subject to such limitations imposed by
these bylaws;
(b) Coordinate the activities and general policies of the various departments;
(c) Receive and act upon committee reports;
(d) Implement policies of the Medical Staff not otherwise the responsibility of the
departments;
(e) Provide liaison between the Medical Staff and the Legacy CEO;
(f) Ensure that the Medical Staff is kept abreast of the accreditation program and informed of
the accreditation status of Hospital;
(g) Be accountable to the Legacy Board for the medical care of patients admitted to or
receiving treatment at Hospital;
(h) Review the report of the Credentials Committee on all applicants and make
recommendations for Medical Staff membership, assignments to departments and
delineation of clinical privileges;
(i) Take all reasonable steps to ensure professionally ethical conduct and competent clinical
performance for all members with clinical privileges;
(j) Perform such other functions as are necessary for the effective operation of the Medical
Staff;
(k) Report at the annual Medical Staff meeting; and
(l) Determine minimum continuing education requirements for Medical Staff members, if so
required.

6.B.3. Meetings:

The Medical Executive Committee shall meet as often as necessary to fulfill its responsibility
and maintain a permanent record of its proceedings and actions. Special meetings of the Medical
Executive Committee may be called at any time by the President of the Medical Staff.

6.C. CREDENTIALS COMMITTEE

6.C.1. Purpose:

The Credentials Committee organizes, administers, and directs Hospital’s credentialing program.
The Credentials Committee ensures that credentialing activities are in compliance with
Hospital’s credentialing policies, accrediting body standards, and applicable laws.

6.C.2. Reporting:

The Credentials Committee shall report to the Medical Executive Committee. Most often,
reporting shall be as needed, regarding applicants for Medical Staff appointment and Medical
Staff members eligible for reappointment. The Credentials Committee may need to make
additional reports, when necessary, such as when questions regarding a Physician’s competence
and qualifications arise. Additionally, the Credentials Committee is expected to interact with
and report to each department chair as necessary.

6.C.3. Selection and Tenure:
The President of the Medical Staff shall make recommendations to the Medical Executive Committee for appointment of the chair and members of the Credentials Committee and the Medical Executive Committee shall act on such recommendations. The Credentials Committee shall be comprised of no more than seven individuals. The chair shall be a member Active Staff. The chair shall serve a three year term of office and committee members shall serve one year renewable terms of office.

6.C.4. Accountability and Functions:

The Credentials Committee shall:
(a) create and maintain, on behalf of the Legacy Board, a fully documented credentialing policies and procedures manual, complete with all forms and other criteria for clinical privileges used in the credentialing process;
(b) ensure that all new applicants for Medical Staff appointment and existing Medical Staff members receive summaries of policies that may affect their practice at Hospital;
(c) monitor the processing of all applications for appointment, reappointment, and clinical privileges to ensure that applicable policies and procedures are followed; and
(d) maintain accurate and complete documentation concerning the entire credentialing process, including establishment, maintenance, storage, security and retrieval of credentials files, credentials committee minutes, and other documents pertaining to the processing of individual applications for appointment and clinical privileges and to the credentialing program in general.

6.D. ADULT QUALITY COUNCIL

6.D.1. Purpose:

Adult Quality Council provides organizational direction and oversight for Hospital’s adult Quality Improvement Initiatives and facilitates and provides direct support for adult Quality Improvement Initiatives based on directions derived from Legacy’s strategic plan and the Medical Quality & Credentialing Committee.

6.D.2. Reporting:

Adult Quality Council shall report to the Medical Executive Committee.

6.D.3. Selection and Tenure:

The President of the Medical Staff shall make recommendations to the Medical Executive Committee for appointment of the chair of Adult Quality Council and the Medical Executive Committee shall act on such recommendation. The chair shall be a member of the Active Staff. The chair shall serve a three year term of office. Committee members include key Physician and administrative leadership.

6.D.4. Duties:

The Adult Quality Council provides resources necessary to reach Hospital’s quality vision, regularly monitors quality indicators and identifies and presents trends in any of those indicators
to the attention of the Medical Executive Committee, the Medical Quality & Credentialing Committee and the Legacy Board when they cross pre-established thresholds, or otherwise warrant attention or action by those bodies, reviews policies which impact the quality of patient care, supports and guides process improvement teams and recognizes and celebrates continuous quality improvement efforts.

6.E. RANDALL CHILDREN’S HOSPITAL QUALITY COUNCIL

6.E.1. Purpose:

Randall Children’s Hospital Quality Council provides organizational direction and oversight for Hospital’s pediatric Quality Improvement Initiatives and facilitates and provides direct support for pediatric Quality Improvement Initiatives based on directions derived from Legacy’s strategic plan and the Medical Quality & Credentialing Committee.

6.E.2. Reporting:

Randall Children’s Hospital Quality Council shall report to the Medical Executive Committee.

6.E.3. Selection and Tenure:

The President of the Medical Staff shall make recommendations to the Medical Executive Committee for appointment of the chair of Randall Children’s Hospital Quality Council and the Medical Executive Committee shall act on such recommendation. The chair shall be a member of the Active Staff. The chair shall serve a three year term of office. Committee members include key Physician and administrative leadership.

6.E.4. Duties:

Randall Children’s Hospital Quality Council provides resources necessary to reach Hospital’s quality vision, regularly monitors quality indicators and identifies and presents trends in any of those indicators to the attention of the Medical Executive Committee, the Medical Quality & Credentialing Committee and the Legacy Board when they cross pre-established thresholds, or otherwise warrant attention or action by those bodies, reviews policies which impact the quality of patient care, supports and guides process improvement teams and recognizes and celebrates continuous quality improvement efforts.

6.F. PEER REVIEW COORDINATION COMMITTEE

6.F.1. Purpose:

To provide standard process, uniform reporting and a means of effective resolution of clinical practice issues related to all patient interactions.

6.F.2. Reporting:

The Peer Review Coordination Committee shall report to the Credentials Committee.
6.F.3. Selection and Tenure:

(a) The Peer Review Coordination Committee shall be comprised of representatives from each department. The President of the Medical Staff shall make recommendations to the Medical Executive Committee for appointment of the Chair and committee members. Committee members shall serve two year terms of office and may succeed themselves if reappointed by the Medical Staff President or the Chair. The Chair may succeed himself/herself if reappointed by the Medical Staff President.

(b) The Peer Review Coordination Committee shall have representation from Legacy’s Quality and Patient Safety Department and administrative support from Medical Staff Services.

6.F.4. Duties:

(a) Identify triggers for focused reviews;
(b) Ensure the review process is “standard and fair”;
(c) Create a process for consistent, educational and compassionate throughput/output;
(d) Involve the Medical Staff member being reviewed;
(e) Identify a communication path for committee receipt of information;
(f) Define critical elements of professional practice evaluation and peer review; and
(g) Examine reviewable/reportable events involving Medical Staff members.

6.F.5. Peer Review Definition:

An organized effort to evaluate and analyze medical care services delivered to patients and to assure the quality and appropriateness of these services through the generation of constructive feedback and valid reporting. Peer Review refers to activities that analyze the professional behavior, judgment and ability of individuals, as distinguished from Quality Assessment, which evaluates the collective performance of systems and groups. Combined, peer review and quality assessment form the basis for total quality management and continual improvement.

6.F.6. Criteria for Referral to the Peer Review Coordination Committee:

(a) Conflict of interest;
(b) Excess delay in peer review being completed;
(c) Technical expertise to review the case is not available;
(d) Section, program or department is unsure how to proceed;
(e) Resource for all sections doing peer review;
(f) Professional practice evaluation for initial privileges; and
(g) Focused review as indicated.

ARTICLE 7
CONFLICT OF INTEREST

(a) In any instance where an officer, department chair, section chair, committee chair, or a member of any Medical Staff committee has or reasonably could be perceived as having a conflict of interest or a bias in any matter involving another member of the Medical
Staff that comes before the individual, such individual shall first declare the conflict and shall not vote on the matter. However, the individual may be asked, and may answer, any questions concerning the matter.

(b) The existence of a potential conflict of interest or bias on the part of any member of a department, section, or committee may be called to the attention of the department chair, the section chair, or the committee chair by any other member with knowledge of such.

(c) A department chair and/or section chair shall have a duty to delegate review of applications for appointment, reappointment, clinical privileges, and/or questions that may arise to another member of the department or section if the department chair and/or section chair has a conflict of interest with the individual under review or could be reasonably perceived to be biased in the review of the matter.

ARTICLE 8
MEDICAL STAFF MEETINGS

8.A.1. Medical Staff Meetings:

(a) The Medical Staff shall meet at least once a year, such meeting to be designated as the annual meeting of the Medical Staff, which shall be held during the last quarter of each Medical Staff year. Notice for the annual meeting shall be given to each Medical Staff member by e-mail, mail, or in person at least seven days in advance of such meeting. Such notice shall state the date, time and place of the meeting. When sent via e-mail, notice shall be deemed delivered on the date the e-mail is sent to a Medical Staff member at his/her e-mail address on file with the Medical Staff Office. When mailed, notice shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to a Medical Staff member at his/her address on file with the Medical Staff Office. The attendance of any individual at any meeting shall constitute a waiver of that individual’s notice of said meeting.

(b) The primary objective of the annual meeting shall be to report on the activities of the Medical Staff and to conduct other business as may be on the agenda. Written minutes of all meetings shall be prepared and recorded.

8.A.2. Special Meetings of the Medical Staff:

The President of the Medical Staff may call a special meeting of the Medical Staff at any time. The President of the Medical Staff shall call a special meeting within twenty (20) days after receipt of a written request for such a meeting signed by not less than one-eighth (1/8) of the members of the Medical Staff or upon a resolution by the Medical Executive Committee. Such request or resolution shall state the purpose of the meeting. The President of the Medical Staff shall designate the time and place of any special meeting. Notice for a special meeting shall be given to each Medical Staff member by e-mail, mail, or in person at least seven days in advance of such meeting.

8.A.3. Regular Meetings:

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution.
8.A.4. Special Meetings of Committees, Departments and Sections:

A special meeting of any committee, department or section may be called by or at the request of the chair thereof or by the President of the Medical Staff with at least two weeks’ prior notice. Committee, department or section members are expected to attend special meetings.

8.A.5. Quorum and Action:

The quorum requirement for meetings shall be as follows:

(a) Medical Staff Meetings: One-tenth (1/10), but not fewer than three, of those eligible to vote.
(b) Medical Executive Committee and Credentials Committee Meetings: One-half (½) of the voting members of the respective committee.
(c) Committee, Department and Section Meetings: One-tenth (1/10) but not fewer than three, of those eligible to vote.

The action of a majority of its members present at a meeting at which a quorum is present shall be the action of the committee, department or section.

8.A.6. Attendance Requirements:

(a) Members of the Medical Staff are encouraged to attend all relevant meetings. Meeting attendance shall not be used by the Credentials Committee in evaluating Medical Staff members at the time of their reappointment.
(b) Members of the Medical Executive Committee and Credentials Committee are expected to attend at least one-half (½) of the meetings held.
(c) Special Attendance Requirements or Conferences:

(1) Whenever a Medical Staff or department educational program is prompted by findings of quality assessment/improvement activities, the individual whose performance prompted the program shall be notified of the time, date and place of the program, the subject matter to be covered, and its special applicability to the individual’s practice. The individual shall be required to be present.
(2) Whenever a pattern of suspected deviation from standard clinical or professional practice is identified the Legacy’s CMO, the President of the Medical Staff or the applicable department chair may require the individual to confer with him/her or with a standing or ad hoc committee considering the matter. The individual shall be given special notice of the conference at least five days prior to the conference, including the date, time and place, a statement of the issue involved, and a statement that the individual’s appearance is mandatory. Failure of the individual to appear at any such conference, unless excused by the Medical Executive Committee upon showing good cause, constitutes the individual’s relinquishment of all clinical privileges. The individual may petition the Medical Executive Committee for reinstatement of those clinical privileges upon showing good cause for the initial absence and relinquishment.
8.A.7. Participation by Legacy CEO:

The Legacy CEO and any representative assigned by the Legacy CEO may attend any committee, department, or section meetings of the Medical Staff.


The latest edition of Robert’s Rules of Order shall prevail at all meetings of the Medical Staff, Medical Executive Committee, Credentials Committee, departments and committees unless waived, except that the chair of any meeting may vote.

8.A.9. Minutes:

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

ARTICLE 9

PRACTITIONER RIGHTS

(a) Each Medical Staff member has the right to an audience with the Medical Executive Committee. In the event a Medical Staff member is unable to resolve a difficulty working with his/her respective department chair or section chair, that individual may, upon presentation of a written notice, meet with the Medical Executive Committee to discuss the issue.

(b) Any Medical Staff member has the right to initiate a recall election of a Medical Staff officer and/or department chair. A petition for such recall shall be presented, signed by at least one-fourth (¼) of the members of the Active Staff. Upon presentation of such valid petition, the Medical Executive Committee shall schedule a special Medical Staff meeting for purposes of discussing the issue and, if appropriate, entertaining a no-confidence vote.

(c) Any Medical Staff member may call a special meeting of the Medical Staff. Upon presentation of a petition signed by not less than one-fourth (¼) of the members of the Active Staff, the President of the Medical Staff shall schedule a special Medical Staff meeting for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted.

(d) Any Medical Staff member may raise a challenge to any rule or policy established by the Medical Executive Committee. In the event a rule, regulation or policy is felt to be inappropriate, any Medical Staff member may submit a petition signed by one-fourth (¼) of the members of the Active Staff. When such petition has been received by the Medical Executive Committee, it shall:
(1) Provide the petitioners with information clarifying the intent of such rule, regulation or policy; and/or
(2) Schedule a meeting with the petitioners to discuss the issue.
(e) Any department or section may request a meeting when a majority of the members of the department or section believes that the department or section has not acted appropriately. This provision does not pertain to issues involving disciplinary action, denial of request for appointment or clinical privileges, or any other matter relating to individual credentialing actions.

ARTICLE 10
VOTING

10.A.1. Manner of Voting:

Unless otherwise provided for in these bylaws, a vote on a matter presented to the Medical Staff, or a department, section or committee thereof, may be conducted by e-mail, voice, fax, mail, or other method approved by the Medical Executive Committee prior to the vote. E-mail, fax and mail voting may be used in lieu of a vote at the annual meeting or a special meeting of the Medical Staff. Each Medical Staff member shall provide the Medical Staff Office with a current e-mail address by which the Medical Staff may contact the member.

10.A.2. Ballots:

Ballots shall be distributed to all members of the Medical Staff entitled to vote and shall specify the method and date by which ballots are to be cast. Such dates shall be at least twenty-one (21) days after ballots are distributed. A member may request a written ballot in lieu of an electronic ballot. To be valid, a ballot shall be signed and dated by the member, or submitted electronically with the member’s name, and returned by the date established by the Medical Executive Committee.

10.A.3. Approval:

Unless otherwise provided for in these bylaws, the election of an officer, amendment to these bylaws or approval of a matter presented to the Medical Staff requires the affirmative vote of a majority of the Medical Staff who cast ballots. Voting results shall be communicated to the Medical Staff via e-mail, fax or mail.

ARTICLE 11
INITIAL APPOINTMENT

11.A: QUALIFICATIONS FOR APPOINTMENT

11.A.1. General:

(a) Appointment to the Medical Staff 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 and in such policies as are adopted from time to time by the Legacy Board. All LIPs practicing in Hospital, unless excepted by specific provisions of these bylaws, shall first be appointed to the Medical Staff.
All processes described in this Article shall be subject to the confidentiality provisions described in Section 17.A.

11.A.2. Specific Qualifications:

(a) Only LIPs who satisfy the following conditions shall be eligible for appointment to the Medical Staff:

(1) have a current, active, license (by order of the Oregon Medical Board or other appropriate licensing board) to practice in the State of Oregon;

(2) where applicable to their practice, have a current unrestricted Drug Enforcement Administration (DEA) registration;

(3) are located (office and residence) close enough to Hospital to fulfill their Medical Staff responsibilities and to provide timely and continuous care to their hospitalized patients, in accordance with those specific requirements as approved by the Legacy Board;

(4) possess current, valid professional liability insurance coverage in amounts required by Hospital and state law and regulation;

(5) have successfully completed an appropriate residency training program as set forth below unless such requirement is waived by the Legacy Board after consideration of the specific education, training, experience, and competence of the individual in question:

   (i) for Physicians, a residency training program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in the specialty in which the applicant seeks clinical privileges,

   (ii) for Podiatrists, a residency training program accredited by the Council on Podiatric Medical Education;

   (iii) for Dentists, a residency program accredited by the American Dental Association Commission on Dental Accreditation;

   (iv) for Nurse Practitioners, appropriate graduate nursing education in a nationally accredited graduate nursing program specific to the expanded specialty in which privileges are being requested.

   (v) for Certified Nurse Midwives, a midwifery training program accredited by the American College of Nurse Midwives – Division of Accreditation.

   (vi) for Psychologists, an internship and post-graduate training appropriate for state licensure, and have training and experience specific to the privileges being requested.

(6) are board certified by the appropriate specialty board unless such requirement is waived by the Legacy Board after considering the specific education, training, experience, and competence of the individual in question.
(i) for Physicians and Dentists (except general dentists), board certification in primary specialty is required within five years of completion of a residency program in primary specialty (board certification in general dentistry is not offered).

(ii) for Podiatrists, board certification in primary specialty is required within six years of completion of a residency program in primary specialty.

(iii) for Nurse Practitioners, including Certified Nurse Midwives, board certification in appropriate specialty is required within five years of completing specialty training.

(iv) for Psychologists, board certification is not required.

This requirement shall be applicable only to those individuals who apply for initial Medical Staff appointment and clinical privileges on or after the date these bylaws are adopted.

(7) can document their:

(i) background, experience, training, and demonstrated competence,

(ii) adherence to the ethics of their profession,

(iii) good reputation and character,

(iv) ability to safely and competently exercise the clinical privileges requested, and

(v) ability to work harmoniously with others sufficiently to convince Hospital that all patients treated by them at Hospital shall receive quality care and that Hospital and the Medical Staff shall be able to operate in an orderly manner; and

(8) have never been convicted of a felony crime.

(b) The qualifications set forth in paragraphs (1), (2), (3), (4), (5), (6), (7) and (8) above are deemed to be threshold criteria for appointment to the Medical Staff. Individuals who have an application for licensure and professional liability insurance pending shall be deemed to have satisfied the threshold criteria for the purpose of the pre-application process.

11.A.3. Waiver of Accredited-Residency Training Program and/or Board Certification Requirements:

(a) Sections 11.A.2 (a)(5) above outlines the accredited-residency training program requirement that must be satisfied for the granting of Medical Staff appointment and clinical privileges at Hospital. This requirement was established by the Medical Staff and Hospital and represents the benchmark standard that is expected of, and shall be applied to, all individuals who seek appointment and clinical privileges to practice at Hospital. Any individual may request that an exception be made and that the residency training requirement be waived. When such a request is made, the individual requesting the waiver shall bear the burden of demonstrating that his/her education and training are equivalent to, or exceed, the accredited residency training program requirement. The Legacy Board may grant a waiver after considering the findings of the Credentials
Committee and Medical Executive Committee, or other committee designated by the Legacy Board, regarding specific qualifications of the individual in question. The findings shall include a statement concerning what is in the best interest of patients, Hospital and the community served by Hospital.

(b) Section 11.A.2(a)(6) above outlines the board certification requirement that must be satisfied for the granting of Medical Staff appointment and clinical privileges at Hospital. This requirement was established by the Medical Staff and Hospital and represents the benchmark standard that is expected of, and shall be applied to, all individuals who seek appointment and clinical privileges to practice at Hospital. Any individual may request that an exception be made and that the board certification requirement be waived. When such a request is made, the individual requesting the waiver shall bear the burden of demonstrating that his/her education, training, experience, and competence are equivalent to, or exceed, the board certification requirement. The Legacy Board may grant a waiver after considering the findings of the Credentials Committee and Medical Executive Committee, or other committee designated by the Legacy Board, regarding the specific qualifications of the individual in question. The findings shall include a statement concerning what is in the best interests of patients, Hospital and the community served by Hospital. A waiver of the board certification requirement shall be limited to the current appointment or reappointment period unless otherwise designated by the Board.

(c) In the event the Legacy Board determines not to grant a waiver, the individual requesting the exception shall not be entitled to a hearing as set forth in these bylaws and shall be deemed to be ineligible to request appointment or clinical privileges.

(d) If the Legacy Board grants a waiver to an individual, that waiver shall not be deemed to set a precedent for any other applicant or appointee.

11.A.4. No Entitlement to Appointment:

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in Hospital merely by virtue of the fact that such individual:

(a) is licensed to practice a profession in this or any other state;
(b) is a member of any particular professional organization;
(c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;
(d) resides in the geographic service area of Hospital; or
(e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

11.A.5. Nondiscrimination Policy:

No individual shall be denied appointment or clinical privileges on the basis of sex, race, creed, religion, color, national origin, handicap, disability, solely because of the school of medicine to which the individual belongs, or on the basis of any criteria unrelated to the delivery of quality patient care at Hospital, to professional qualifications, or to Hospital’s purposes, needs, and capabilities.
11.B: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

11.B.1. Information:

(a) Applications for appointment to the Medical Staff shall be in writing, and shall be submitted on forms approved by the Legacy Board, upon recommendation of the Credentials Committee. These forms shall be obtained from the Medical Staff Office.

(b) The application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant’s professional qualifications, including:

1. the names and complete addresses of at least three LIPs licensed in the same professional discipline as the applicant with recent personal knowledge of the applicant’s current ability to practice. References must include relevant training and experience, current professional competence, and any effects of health status for privileges being requested. These references may not all be from individuals associated or about to be associated with the applicant in professional practice or personally related to the applicant. At least one reference shall be from the same specialty area as the applicant;

2. the names of any and all hospitals or other institutions at which the applicant has worked or trained;

3. information as to whether the applicant’s Medical Staff appointment or clinical privileges have ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, or not renewed at any other hospital or health care facility or if any such action is pending or under review;

4. information as to whether the applicant has ever voluntarily or involuntarily withdrawn his/her application for appointment, reappointment, and clinical privileges, or resigned from the Medical Staff before final decision by a hospital’s or health care facility’s governing board;

5. information as to whether the applicant’s license to practice any profession in any state, or DEA registration is or has ever been voluntarily or involuntarily suspended, modified, terminated, restricted, relinquished, revoked, subjected to probationary or other conditions or is currently being challenged. (The submitted application shall include a list or copy of all the applicant’s current licenses to practice, as well as copies of DEA registration, medical or dental school diploma, and certificates from all post graduate training programs completed);

6. information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company, and the amount and classification of such coverage, and whether said insurance coverage covers the clinical privileges the applicant or appointee seeks to exercise at Hospital;
(7) information concerning the applicant’s professional liability litigation experience, specifically information concerning pending matters, closed matters, final judgments, or settlements: (i) the substance of the allegations, (ii) the findings, (iii) the ultimate disposition, and (iv) any additional information concerning such proceedings or actions as the Credentials Committee Chair or the Credentials Committee, or the Legacy Board, may deem appropriate;

(8) a consent to the release of information from the applicant’s present and past professional liability insurance carriers;

(9) information concerning any professional misconduct proceedings involving the applicant in this state, any other state or any country, whether such proceedings are closed or still pending;

(10) information concerning the suspension, termination or revocation for any period of time of the right or privilege to participate in Medicare, Medicaid, any other government sponsored program, or any private or public medical insurance program, and information as to whether the applicant is currently under investigation;

(11) current information regarding the applicant’s ability to exercise the privileges requested and to perform the duties and responsibilities of appointment;

(12) information as to whether the applicant has ever been named as a defendant in a criminal action and/or convicted of a crime with details about any such instance, and an authorization and consent to release of information to perform a criminal background check to verify such information;

(13) a complete chronological listing of the applicant’s professional and educational appointments, employment, or positions;

(14) information on the citizenship and/or visa status of the applicant;

(15) the signed Medicare/Tricare acknowledgement statement;

(16) the applicant’s signature; and

(17) such other information as the Credentials Committee or the Credentials Committee Chair, or the Legacy Board, may require.

(c) The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, shall be evaluated as a criteria for appointment, reappointment, and the granting of clinical privileges. However, the mere presence of verdicts, settlements, or claims shall not, in and of themselves, be sufficient to deny appointment or particular clinical privileges. The evaluation shall consider the extent to which verdicts, settlements, or claims evidence a pattern of care that raises questions concerning the individual’s clinical competence, or whether a verdict, settlement, or claim in and of
itself, represents such deviation from standard medical practice as to raise overall questions regarding the applicant’s clinical competence, skill in the particular clinical privilege, or general behavior.

11.B.2. Basic Responsibilities and Requirements for Applicants and Appointees:

As a condition of consideration of an application for Medical Staff appointment or reappointment, or clinical privileged, and as a condition of continued Medical Staff appointment or clinical privileges, if granted, every applicant and appointee shall:

(a) provide appropriate continuous care and supervision to all patients within Hospital for whom the individual has responsibility;

(b) make, continuously throughout appointment prior arrangements with a Medical Staff member with similar clinical privileges to provide medical coverage in case of the LIPs illness or unavailability.

(c) abide by all bylaws, policies, and rules and regulations of the Medical Staff, Hospital and Legacy then in effect, without regard to whether or not appointment to the Medical Staff and/or clinical privileges are granted;

(d) accept committee assignments and such other reasonable Medical Staff duties and responsibilities as shall be assigned;

(e) provide, with or without request, new or updated information to the Medical Staff Office, as it occurs, that is pertinent to any question on the application form;

(f) maintain the confidentiality of the peer review processes;

(g) appear, if requested, for personal interviews in regard to the application;

(h) agree that any misrepresentation or misstatement in, or omission from the application, whether intentional or not, may constitute cause for immediate cessation of the processing of the application and no further processing shall occur. In the event that appointment is granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may be deemed to constitute automatic relinquishment of clinical privileges and Medical Staff appointment. In either situation, there shall be no entitlement to any hearing or appeal rights as set forth in these bylaws;

(i) use Hospital and its facilities sufficiently to allow Hospital, through assessment by appropriate committees and department chairs, to evaluate in a continuing manner the current competence of the appointee, or to provide adequate information from other facilities as requested by Hospital to evaluate current competence;

(j) refrain from fee splitting or other illegal inducements relating to patient referral;
(k) refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

(l) refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;

(m) seek consultation whenever necessary;

(n) promptly notify the Legacy CEO, or a designee, and the President of the Medical Staff of any change in eligibility for payments by third-party payers or for participation in Medicare, including any sanctions imposed or recommended by the federal Department of Health and Human Services, and/or the receipt of a Quality Improvement Organization citation and/or quality denial letter concerning alleged quality problems in patient care;

(o) abide by generally recognized ethical principles applicable to the applicant’s or appointee’s profession;

(p) participate in the quality monitoring and evaluation activities of clinical departments;

(q) complete in a timely manner the medical and other required records for all patients as required by the Medical Staff rules and regulations, these bylaws, and other applicable policies of Hospital and/or Legacy;

(r) work cooperatively and professionally with Medical Staff appointees, Medical Staff leadership, Hospital management, allied health practitioners, medical assistants, nurses, and other Hospital personnel;

(s) promptly pay any applicable Medical Staff dues and assessments, in accordance with these bylaws;

(t) participate in continuing education programs appropriate to privileges requested or held;

(u) authorize the release of all information necessary for an evaluation of the individual’s qualifications for initial or continued appointment, reappointment, and/or clinical privileges;

(v) sign the acknowledgement and/or other documentation required by the Medicare Prospective Payment System;

(w) agree that the hearing and appeal procedures set forth in these bylaws shall be the sole and exclusive remedy with respect to any professional review action taken at Hospital;

(x) agree not to sue Hospital, Legacy, the Medical Staff, or anyone acting by or for Hospital, Legacy, and its Medical Staff for any matter relating to the application for appointment, reappointment, or clinical privileges, or relating to the evaluation of the applicant’s qualifications on any matter related to appointment, reappointment, or clinical privileges;
extend absolute immunity to Hospital, its Medical Staff, Legacy, and all individuals acting by or for Hospital and/or its Medical Staff and Legacy for all matters relating to appointment, reappointment, and clinical privileges or the individual’s qualifications for the same; and

if the individual institutes legal action notwithstanding the provisions of subparagraphs (w) and (x), and does not prevail, he/she shall reimburse Hospital, Legacy, and any Medical Staff members named in the action for all costs incurred in defending such legal action, including reasonable attorney’s fees.

11.B.3. Burden of Providing Information:

(a) The applicant shall have the burden of producing information deemed adequate by Hospital for proof of identity and a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.

(b) The applicant shall have the burden of providing evidence that all the statements made and information given on the application are true and correct.

(c) Until the applicant has provided all information requested by Hospital, the application for appointment or reappointment shall be deemed incomplete and shall not be further processed. If information provided in the initial application for appointment changes during the course of an appointment, the appointee has the burden to provide information about such change to the Credentials Committee Chair sufficient for the Credentials Committee Chair’s review and assessment.

11.B.4. Grant of Immunity and Authorization to Obtain/Release Information:

The following statements, which shall be included on the application form and which form a part of these bylaws, are express conditions applicable to every Medical Staff applicant, appointee to the Medical Staff, and individuals having or seeking clinical privileges at Hospital. By applying for appointment, reappointment, or clinical privileges, the applicant expressly accepts these conditions, whether or not appointment or clinical privileges are granted, during the processing and consideration of the application, during the time of any appointment or reappointment, and after the expiration, resignation, relinquishment, revocation, or other termination of appointment.

(a) Immunity:

To the fullest extent permitted by law, the applicant or appointee releases from any and all liability, extends absolute immunity to, and agrees not to sue Hospital, Legacy, their authorized representatives, and appropriate third parties, 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;
(3) proceedings for suspension or reduction of clinical privileges or for revocation of Medical Staff appointment, or any other disciplinary sanction;

(4) precautionary suspension;

(5) hearings and appellate reviews;

(6) medical care evaluations;

(7) utilization reviews;

(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; and/or

(10) any other matter that might directly or indirectly relate to the applicant’s or appointee’s competence, to patient care, or to the orderly operation of this or any other hospital or health care facility.

(b) Authorization to Obtain Information:
The applicant or appointee specifically authorizes Hospital and its authorized representatives to consult with any third party who may have information bearing on the individual’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 relevant to such questions. The individual also specifically authorizes said third parties to release said information to Hospital and its authorized representatives upon request. The applicant or appointee specifically authorizes Hospital and its authorized representatives to perform a criminal background check and shall execute an authorization and consent to release of information to such effect.

(c) Authorization to Release Information:
The applicant or appointee specifically authorizes Hospital and its authorized representatives to release such information to other hospitals, health care facilities and their agents, who solicit such information for the purpose of evaluating the applicant’s or appointee’s professional qualifications pursuant to a request for appointment and/or clinical privileges.

11.C: PROCEDURE FOR INITIAL APPOINTMENT

11.C.1. Pre-Application Review Process:

(a) An application for appointment to the Medical Staff shall be processed only for those individuals who:

(1) meet the threshold criteria for appointment to the Medical Staff set forth in Section 11.A.2 (unless granted a waiver by the Legacy Board);

(2) desire to provide care and treatment to patients for conditions and diseases for which Hospital has facilities and personnel;

(3) indicate an intention to utilize Hospital facilities as required by the staff category to which they seek appointment; and
(4) are not seeking clinical privileges that are currently subject to an exclusive contract, unless the individual or the group with whom the individual is employed or contracted has been or is to be awarded such contract.

(b) An individual requesting appointment shall be notified of the threshold criteria for appointment and shall be required to attest that he/she meets the threshold criteria for appointment at the time of the request.

(c) Those individuals who attest that they can meet the threshold criteria for Medical Staff appointment shall be given an application. Individuals who fail to meet the threshold criteria shall not be given an application and shall be so notified. If, during processing of the application, information is obtained that establishes that the individual does not meet the threshold criteria, processing shall be discontinued and the individual shall be notified of such action.

(d) An individual who does not meet the threshold criteria for Medical Staff appointment and who has not been granted a waiver by the Legacy Board shall not be given an application and shall not be entitled to a hearing as provided in these bylaws.

11.C.2. Submission of Application:

(a) A completed application form for Medical Staff appointment with copies of all required documents must be returned within two weeks of receipt of same if the individual desires further consideration. The application must be accompanied by payment of the processing fee in order to be considered complete.

(b) The Medical Staff Office shall review the application to determine that all questions have been answered, all references and other information or materials deemed pertinent have been received and that all pertinent information, including, but not limited to, applicant’s current licensure, applicant’s specific relevant training and applicant’s current competence, has been verified with primary sources. As part of the process of reviewing the application, the Medical Staff Office shall determine whether the application shall be processed in accordance with Section 11.C.5. Thereafter, the Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate section and department chair.

(c) An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified, and the processing fee has been received. An application shall become incomplete if the need arises for new, additional or clarifying information at any time during the evaluation period. Any application that continues to be incomplete thirty (30) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references.

(d) In addition to verifying all pertinent information in the application, the Medical Staff Office shall query the NPDB and the OIG List of Excluded Individuals/Entities and the results of such queries shall be evaluated prior to making a recommendation on Medical Staff appointment and/or clinical privileges.
(e) For those individuals who meet the threshold criteria, the Medical Staff Office shall transmit the complete application and all supporting information to the appropriate section and department chair.

(f) The Medical Staff Office shall post or circulate the name of any applicant who satisfies the threshold criteria and submits a complete application so that each Medical Staff member may have an opportunity to submit to the Medical Executive Committee, in writing, information bearing on the applicant’s qualifications for Medical Staff appointment or clinical privileges. In addition, any current Medical Staff member shall have the right to appear in person before the Medical Executive Committee to discuss in private and in confidence any concerns the appointee may have about the applicant.

11.C.3. Verification of Identity:

(a) The credentialing process for initial appointment and/or grant of privileges includes the following mechanism to ensure that the individual requesting and exercising privileges is the same individual identified in the credentialing documents.

(1) Applicants for Medical Staff appointment and/or clinical privileges, including those granted temporary privileges, shall obtain a Legacy Photo Identification Badge prior to entering a clinical area or seeing a patient. Before issuing a Photo Identification Badge, the Legacy employee or representative shall view a valid, government-issued photo identification (e.g., driver’s license, passport, etc.) to confirm that the individual is the applicant identified in the credentialing documents. Confirmation of the verification shall be documented and forwarded to the Medical Staff Office.

   (i) If the photo identification equipment is unavailable for any reason, a Temporary Identification Badge shall be obtained as described below.

   (ii) A permanent Legacy Photo Identification Badge shall be obtained prior to the expiration of the Temporary Identification Badge.

(2) Applicants for locum tenens privileges, or for temporary privileges who are not also applicants to the Medical Staff, shall obtain a Temporary Identification Badge prior to entering a clinical area or seeing a patient. Before issuing a Temporary Identification Badge, the Legacy employee or representative shall view a valid, government-issued photo identification (e.g., driver’s license, passport, etc.) to confirm that the individual is the applicant identified in the credentialing documents. Confirmation of the verification shall be documented and forwarded to the Medical Staff Office.

(3) Electronic copies of photos obtained for Legacy Photo Identification Badges shall be forwarded to the Medical Staff Office and made available for access by Legacy staff on the Legacy Intranet and for other appropriate purposes.

11.C.4. Section and Department Chair Procedure:
(a) The chair of each section and department in which the applicant seeks clinical privileges shall provide the Credentials Committee or the Chair of the Credentials Committee with a written report concerning the applicant’s qualifications for appointment and requested clinical privileges. The section and department chairs have the right to meet with the applicant to discuss any aspect of the application, qualifications, and requested clinical privileges.

(b) The section chair and department chair, or the individual within the section or department to which the chair has assigned this responsibility, shall evaluate the applicant’s education, training, and experience, and may make inquiries with respect to the same to the applicant’s past or current department chair(s), residency training director, and others who may have knowledge about the applicant’s education, training, experience, and ability to work with others.

(c) The section and department chair shall be available to the Credentials Committee or the Chair of the Credentials Committee to answer any questions that may be raised with respect to that chair’s report and findings.

11.C.5. Processing Applications When No Questions Are Raised and All Information is Appropriate and in Order:

(a) Applications, which are deemed complete, may be processed in an expedited manner as set forth in this section. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process:

(1) the applicant has a current challenge or a previously successful challenge to licensure or registration;

(2) Hospital has determined that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant;

(3) the applicant has had involuntary limitation, reduction, denial or loss of clinical privileges or involuntary termination of membership at another organization; and

(4) questions have been raised about the applicant by the section or department chair.

(b) The Chair of the Credentials Committee, acting on behalf of the Credentials Committee, shall, after receiving the report from each appropriate section and department chair and information contained in references given by the applicant and from other available sources, examine evidence of the applicant’s character, professional competence, qualifications, prior behavior, and ethical standing and shall determine whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the clinical privileges requested.

(c) As part of the process of making its recommendation, the Credentials Committee Chair may meet with the applicant to discuss the applicant’s application, qualifications, and clinical privileges requested.
(d) The Chair of the Credentials Committee shall prepare a report and forward the same to the Medical Executive Committee. The report shall recommend provisional department assignment. All recommendations to appoint, including provisional appointment, shall specifically recommend the clinical privileges to be granted.

(e) If the Chair of the Credentials Committee has any questions about the applicant’s qualifications or current clinical competence, the Chair shall refer the matter to the entire Credentials Committee and the routine credentialing process, as set forth below, shall be followed.

(f) The Medical Executive Committee, shall review the recommendation made by the Chair of the Credentials Committee. If the Medical Executive Committee concurs with the favorable recommendation, the recommendation shall be forwarded to the Medical Quality & Credentialing Committee for action. If the Medical Executive Committee has any questions about the applicant, the questions shall be noted and the matter shall be referred to the entire Credentials Committee for further action.

(g) The Medical Quality & Credentialing Committee reviews and evaluates the qualifications and competence of the applicant and renders its decision. If it concurs with the favorable recommendation, the status or privileges requested are granted. If the Medical Quality & Credentialing Committee’s decision is adverse to the applicant, the matter is referred back to the Medical Executive Committee for further evaluation.

(h) A report regarding all applicants who are granted an appointment and clinical privileges shall be forwarded to the Legacy Board for consideration.

11.C.6. Credentials Committee Procedure:

(a) Except as expressly provided in Section 11.C.5, all other applications for initial appointment and clinical privileges shall be processed as set forth in Sections 11.C.6 - 11.C.8.

(b) The Credentials Committee shall examine evidence of the applicant’s character, professional competence, qualifications, prior behavior, and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including the report and findings from the chair of each clinical department in which privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the clinical privileges requested.

(c) As part of the process of making its recommendation, the Credentials Committee may meet with the applicant to discuss the applicant’s application, qualifications, and clinical privileges requested.

(d) The Credentials Committee may use the expertise of the section or department chair, or any member of the department, or an outside consultant, if additional information is required regarding the applicant’s qualifications.
(e) If, after considering the report of the clinical section and department chair concerned, the Credentials Committee’s recommendation for appointment is favorable, the Credentials Committee shall recommend provisional department assignment. All recommendations to appoint, including provisional appointment, shall specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions as deemed appropriate by the committee.

(f) If the recommendation of the Credentials Committee is delayed longer than ninety (90) days after receipt of the section or department chair’s report, the Chair of the Credentials Committee shall send a letter to the applicant, with a copy to the Medical Executive Committee, and to the Legacy CEO, explaining the reasons for the delay.

11.C.7. Credentials Committee Report:

(a) Not later than ninety (90) days from its receipt of the application and all required and requested information, the Credentials Committee shall send its recommendation and written findings in support thereof to the Medical Executive Committee. The completed application and all supporting documentation shall accompany the Credentials Committee’s recommendations and findings. Each recommendation shall state one of the following:
   (1) that the applicant be appointed to the Medical Staff;
   (2) that the applicant’s application be deferred for further consideration; or
   (3) that the applicant be rejected for Medical Staff appointment.

(b) When the Credentials Committee recommends appointment to the Medical Staff, it shall also make a specific recommendation regarding the clinical privileges to be granted, and any limitations or conditions on the appointment or the privileges.

(c) The Chair of the Credentials Committee shall be available to the Medical Executive Committee (and to the Legacy Board) to answer any questions that may be raised with respect to the Credentials Committee’s recommendation.

11.C.8. Medical Executive Committee Procedure:

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:
   (1) adopt the findings and recommendation of the Credentials Committee;
   (2) refer the matter back to the Credentials Committee for further consideration and preparation of responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or
   (3) set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Credentials Committee’s recommendation.

(b) If the recommendation of the Medical Executive Committee is favorable to the applicant, it shall transmit its recommendation through the Legacy CEO to the Legacy Board, including the findings and recommendation of the Credentials Committee. All
recommendations to appoint shall also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges.

(c) If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing pursuant to these bylaws, it shall be forwarded to the Legacy CEO who shall promptly notify the applicant in writing, certified mail, return receipt requested. The Legacy CEO shall then hold the application until after the applicant has exercised or waived the right to a hearing as provided in these bylaws, after which the Legacy CEO shall forward the recommendation of the Medical Executive Committee, together with the complete application and all supporting documentation, to the Legacy Board for further action.

(d) Upon receipt of a favorable recommendation from the Medical Executive Committee that the applicant be granted appointment and the requested clinical privileges, the Legacy Board (or its designated committee) may:
   (1) appoint the applicant and grant clinical privileges as recommended; or
   (2) refer the matter back to the Medical Executive Committee or to another source inside or outside Hospital for additional research or information; or
   (3) reject the recommendation. If the Legacy Board determines to reject the favorable recommendation, it shall first discuss the matter with the Chair of the Medical Executive Committee. If the Legacy Board’s determination remains unfavorable to the applicant, that determination and the reasons in support thereof, shall be sent to the Legacy CEO, who shall promptly notify the applicant in writing, certified mail, return receipt requested. The Legacy Board shall make no final decision until the applicant has exercised or waived the right to a hearing and appeal as outlined in these bylaws.

(e) The affected individual shall be notified in writing of the Legacy Board’s decision and, if applicable, the reasons for such decision no later than thirty (30) days after the meeting.

11.D: PROVISIONAL STATUS

11.D.1. Duration of Initial Provisional Appointment:

(a) All initial appointments to the Medical Staff (regardless of the category of the staff to which the appointment is made) and all initial clinical privileges shall be provisional for a period of six months from the date of initial appointment. The duration of this provisional period may be extended by the Credentials Committee after consulting with the appropriate section and/or department chair. In no case, shall the duration of the provisional period extend more than twenty-four (24) months from the date of initial appointment.

(b) All grants of increased clinical privileges to existing Medical Staff appointees are also provisional for a period of six months from the date the increased clinical privileges were granted. The duration of this provisional period may be extended by the Credentials Committee after consulting with the appropriate section and/or department chair. In no
case shall the duration of the provisional period extend more than twenty-four (24) months from the date the increased clinical privileges were granted.

(c) The terms of provisional appointment shall be recommended by the Credentials Committee, after consulting with the appropriate section or department chair.

(d) During provisional appointment, the individual shall be evaluated by the chair of the section or department in which the individual has clinical privileges, and by the relevant committees of the Medical Staff and Hospital, as to the individual’s clinical competence and general behavior and conduct in Hospital.

(e) Provisional clinical privileges may be modified or removed to reflect demonstrated clinical competence during or at the end of the provisional period. The modification or removal of provisional clinical privileges shall not constitute grounds for a hearing or appeal.

(f) Continued appointment and/or clinical privileges after the provisional period shall be conditioned on the individual’s demonstrated competency in the privileges granted and an evaluation of the factors to be considered for reappointment as set forth in Section 13.A.3.

11.D.2. Duties of Provisional Appointees:

(a) Appointment to the Medical Staff shall require that each appointee assume such reasonable duties and responsibilities, as the Legacy Board or the Medical Staff shall require.

(b) During the provisional period, an appointee must demonstrate all of the qualifications, may exercise all of the prerogatives, and must fulfill all of the obligations attendant to his/her staff category.

(c) Each appointee must cooperate in a focused evaluation of his/her professional practice during the provisional period.

(d) Failure of the provisional appointee during the provisional period to (i) cooperate in a focused professional practice evaluation, (ii) admit, treat, or attend to the number of patients established by the Credentials Committee (sufficient to permit observation and assessment), or, (iii) during the provisional period, to fulfill all requirements of appointment relating to meeting attendance, completion of medical records, or cooperation with monitoring or proctoring conditions, as outlined in these bylaws, may result in modification or removal of provisional appointment or clinical privileges or both and render the provisional appointee ineligible to apply for reappointment.
ARTICLE 12
CLINICAL PRIVILEGES

12.A: CLINICAL PRIVILEGES

12.A.1. General:

(a) Medical Staff appointment or reappointment as such shall not confer any clinical privileges or right to practice at Hospital.

(b) Each individual appointed to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Legacy Board.

(c) The grant of clinical privileges shall carry with it acceptance of the obligations of such privileges, including emergency service and other rotational obligations to fulfill Hospital’s responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.

(d) Clinical privileges shall be voluntarily relinquished only in a manner that provides for the orderly transfer of such obligations.

(e) The clinical privileges recommended to the Legacy Board shall be based upon consideration of the following:

(1) the applicant’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism;
(2) the applicant’s education, training, experience, demonstrated current competence and judgment, references, utilization patterns, and ability to perform the privileges requested;
(3) the applicant’s ability to meet all current criteria for the requested clinical privileges;
(4) availability of a Medical Staff member with similar clinical privileges to provide medical coverage in case of the applicant’s illness or unavailability;
(5) adequate levels of professional liability insurance coverage with respect to the clinical privileges requested;
(6) Hospital’s available resources and personnel;
(7) any previously successful or currently pending challenges to any licensure or registration, or the voluntary relinquishment of such licensure or registration;
(8) any information concerning professional review actions, voluntary or involuntary termination of Medical Staff appointment, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and
(9) other relevant information, including a written report and findings by the chair of each of the clinical departments in which such privileges are sought.

(f) The applicant shall have the burden of establishing qualifications for and competence to exercise the clinical privileges requested.
(g) The reports of the chair of the section and clinical department in which privileges are sought shall be forwarded to the Credentials Committee or Chair of the Credentials Committee, depending upon whether any questions are raised, and processed as a part of the initial application for Medical Staff appointment.

12.A.2. Clinical Privileges for Dentists and Oral Surgeons:

(a) The scope and extent of surgical procedures that a Dentist or an Oral Surgeon may perform in Hospital shall be delineated and recommended in the same manner as other clinical privileges.

(b) Surgical procedures performed by Dentists or Oral Surgeons shall be under the overall supervision of the Chair of the Department of Surgery. A medical history and physical examination of the patient shall be made and recorded by a Physician who holds an appointment to the Medical Staff before dental surgery shall be scheduled for performance, and a designated Physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) Oral Surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee or Chair of the Credentials Committee.

(d) The Dentist or Oral Surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient’s record. Dentists may write orders within the scope of their license and consistent with the Medical Staff rules and regulations, and in compliance with Hospital, Legacy, and Medical Staff bylaws.

12.A.3. Clinical Privileges for Podiatrists:

(a) The scope and extent of surgical procedures that a Podiatrist may perform in Hospital shall be delineated and recommended in the same manner as other clinical privileges and in accordance with such policies governing Podiatrists as may be adopted by the Legacy Board from time to time.

(b) Surgical procedures performed by Podiatrists shall be under the overall supervision of the Chair of the Department of Surgery. A medical history and physical examination of each inpatient shall have taken place and been recorded in the medical record by a Physician who holds an appointment to the Medical Staff before podiatric surgery shall be performed, and a designated Physician shall be responsible for the medical care of the patient throughout the period of hospitalization. Podiatrists may be granted the privilege to complete history and physicals for all podiatric outpatients, provided that appropriate medical consultation is obtained whenever necessary, to assure optimum standards of patient care and anesthesia safety. Discharge of the patient shall be on written order of the Podiatrist.
(c) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination as well as all appropriate elements of the patient’s record. Podiatrists may write orders which are within the scope of their license, consistent with the Medical Staff rules and regulations, and in compliance with Hospital, Legacy, and Medical Staff bylaws.

12.A.4. Clinical Privileges After Age 70:

The Credentials Committee shall specifically consider the mental and physical capabilities of each appointee who has attained the age of 70 years and who has clinical privileges at Hospital. These individuals shall be reappointed on an annual basis. Recommendations by the Credentials Committee for continued clinical privileges for appointees who have attained the age of 70 shall be based upon an evaluation of the individual’s current knowledge, skills, conduct, and ability to perform the privileges requested.

12.A.5. Clinical Privileges for New Procedures:

Whenever a Medical Staff appointee requests clinical privileges to perform a new procedure or service not currently being performed at Hospital (or a significant new technique to perform an existing procedure), the following process shall be followed:

(a) A review pursuant to the new procedure/technology procedure shall be done and shall include review and input from representatives of the appropriate Sections and/or Departments or specialties involved. Input from Administration shall be solicited to determine the capability of Hospital to perform or support the proposed procedure or technology. After completion of these reviews, the matter and a recommendation regarding privilege criteria including the minimum education, training, and experience necessary to perform the procedure or technique in question and the extent of monitoring or supervision that is required, if indicated, shall be referred to the Credentials Committee to determine whether the matter is a new procedure or service (or technique). The Credentials Committee shall forward a report and a recommendation to the Medical Executive Committee.

(b) If the matter is a new procedure or service (or technique), the matter shall then be referred to the Medical Executive Committee which shall make a recommendation to the Legacy Board which shall make a determination whether the new procedure or service (or technique) is one that will be offered to patients and, if so, shall act upon any recommendations regarding privilege criteria. One factor to be considered in reaching this determination is whether Hospital has the capabilities to perform the procedure in question.

(c) Once the foregoing steps are accomplished, specific requests from Medical Staff appointees who wish to perform the procedure in question shall be handled in accordance with Section 12.D.

12.B: CLINICAL PRIVILEGES THAT CROSS SPECIALTY LINES
Whenever a Medical Staff appointee requests clinical privileges that may be exercised by individuals in more than one specialty, the following process shall be followed:

(a) The appointee shall first be informed by the Legacy CEO that his/her request shall not be processed until the steps outlined in this section have been completed and a determination is made regarding the appointee’s eligibility to request the clinical privileges in question.

(b) The Credentials Committee shall then investigate the matter and prepare a report and recommendation for the Medical Executive Committee and the Legacy Board (or its designated committee). Specifically, the Credentials Committee shall conduct research and consult with experts, both those on the Medical Staff (e.g., appropriate department chairs, individuals on the Medical Staff with special interest and/or expertise in the privileges in question) and those outside Hospital (e.g., other hospitals, residency training programs, specialty societies).

(c) The Credentials Committee shall then develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the clinical privileges in question, and (2) the extent of monitoring and supervision required. These recommendations may or may not permit individuals from different specialties to request the privileges at issue. The Credentials Committee shall forward its recommendations to the Medical Executive Committee, which shall review the matter and forward its recommendations to the Legacy Board (or its designated committee) for final action.

(d) The Legacy Board (or its designated committee) shall then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question.

(e) Once the foregoing steps are completed, specific requests from eligible Medical Staff appointees who wish to exercise the privileges in question shall be handled in accordance with Section 12.D.

12.C: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

12.C.1. Temporary Clinical Privileges for Applicants:

Temporary privileges shall not routinely be granted to applicants. Only those applicants who meet the conditions outlined in Section 11.C.5. are eligible to receive temporary privileges. Temporary admitting and clinical privileges may only be granted by the Legacy CEO after there is a favorable recommendation made by the Chair of the Credentials Committee regarding the applicant’s application for Medical Staff appointment and clinical privileges. In exercising such privileges, the applicant shall act under the supervision of the chair or appropriate designee of the section and department in which the applicant has requested primary privileges. Temporary privileges for new applicants may be granted for a limited period of time, not to exceed 120 days.

12.C.2. Temporary Clinical Privileges for Non-Applicants:
(a) A request for temporary privileges must be accompanied by payment of any processing fee, and must be submitted at least five days in advance of exercising such privileges. A request for locum tenens privileges must be submitted at least three weeks in advance of exercising such privileges and requires completion of an application and clinical privilege form. An individual must meet all of the qualifications set forth in Section 11.A.2 in order to be granted temporary privileges.

(b) Temporary privileges may be granted to fulfill an important patient care, treatment or service need.

(c) Hospital shall verify appropriate information regarding the individual’s licensure, DEA registration, current clinical competence and professional liability insurance coverage and shall query and evaluate the reports from the NPDB and the OIG List of Excluded Individuals/Entities before making a final decision to grant temporary privileges.

(d) Prior to temporary privileges being granted, the individual must agree in writing to be bound by all of the bylaws, policies, and rules and regulations of the Medical Staff, Hospital, and Legacy then in force.

(e) Temporary privileges may be granted by the Legacy CEO only after there is a favorable recommendation from the President of the Medical Staff, or from the applicable department chair or the chair of the Credentials Committee as designees of the President of the Medical Staff. In exercising the temporary privileges, the individual shall act under the supervision of the appropriate department chair.

(f) Temporary privileges shall be granted for a specific period of time as warranted by the situation. In no situation should the grant of temporary privileges be for a period exceeding 120 days.

12.C.3. Special Requirements:

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

12.C.4. Termination of Temporary Clinical Privileges:

(a) The Legacy CEO may, at any time after consulting with the President of the Medical Staff, the Credentials Committee Chair, or the chair of the department responsible for the individual’s supervision, terminate temporary admitting privileges. Clinical privileges shall then be terminated when the individual’s inpatients are discharged from Hospital. However, where it is determined that the care or safety of such patients may be endangered by continued treatment by the individual granted temporary privileges, a termination of temporary clinical privileges may be imposed by the Legacy CEO, the department chair, or the President of the Medical Staff, and such termination shall be immediately effective.

(b) The appropriate department chair or the President of the Medical Staff shall assign to a Medical Staff appointee responsibility for the care of such terminated individual’s patients until they are discharged from Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.
(c) The granting of any temporary admitting and clinical privileges is a courtesy on the part of Hospital and any or all may be terminated if a clinical question or concern is raised. Neither the granting, denial or termination of such privileges shall entitle the individual concerned to any of the procedural rights provided in these bylaws.

12.D: PROCEDURES FOR REQUESTING INCREASE IN CLINICAL PRIVILEGES

12.D.1. Application for Additional Clinical Privileges:

(a) Whenever, during the term of appointment, additional clinical privileges are desired, the appointee requesting increased privileges shall apply in writing to the Medical Staff Office. The application shall state in detail the specific additional clinical privileges desired and the appointee’s relevant recent training and experience which justify the additional privileges. If the appointee meets the relevant threshold criteria for the clinical privileges in question, this application shall be transmitted by the Medical Staff Office to the appropriate department chair. Thereafter, it shall be processed in the same manner as an application for initial clinical privileges including licensure check and queries and reports from the NPDB and the OIG List of Excluded Individuals/Entities.

(b) Whenever a Medical Staff appointee requests clinical privileges to perform a new procedure or service not currently being performed at Hospital (or a significant new technique to perform an existing procedure), the process set forth in Section 12.A.6 shall be followed.

12.D.2. Factors to be Considered:

(a) Recommendations for additional clinical privileges shall be based upon:

(1) relevant recent training;
(2) observation of patient care provided;
(3) review of the records of patients treated in this or other hospitals;
(4) results of Hospital’s quality improvement activities;
(5) appointee’s ability to meet the qualifications and criteria for the clinical privileges requested; and
(6) other reasonable indicators of the individual’s continuing qualifications for the privileges in question.

(b) The recommendation for such increased privileges may carry with it such requirements for supervision or consultation or other conditions, for such periods of time as are thought necessary.

12.E EMERGENCY CLINICAL PRIVILEGES

12.E.1. Individual Patient Emergencies:

(a) For the purpose of this section, an “emergency” is defined as a condition which could result in serious or permanent harm to a patient and in which any delay in administering treatment would add to that harm or danger.
(b) In such an emergency, any LIP who is currently appointed to the Medical Staff may be permitted by Hospital to exercise clinical privileges to the extent permitted by his/her license, regardless of that individual’s department status or specific grant of clinical privileges.

(c) When the emergency situation no longer exists, the patient shall be assigned by the appropriate department chair or the President of the Medical Staff to an appointee with appropriate clinical privileges. The wishes of the patient shall be considered in the selection of a substitute appointee.

12.E.2. Disaster Privileges for LIPs During Activation of Hospital Emergency Incident Command System (HEICS) Due to an External or Internal Incident or Emergency:

(a) Members of the Medical Staff: Members of the Medical Staff may, at the direction of HEICS Medical Staff Director, exercise clinical privileges to the extent permitted by his/her license regardless of the LIP’s department status or specific grant of clinical privileges.

(b) Non-Member Volunteers: LIPs without Medical Staff membership and clinical privileges at Hospital may be granted disaster privileges by the Legacy CEO, the Legacy CMO, Hospital Administrator, Medical Staff President or HEICS Medical Staff Director to practice only when (1) the HEICS has been activated and (2) Hospital unable to meet immediate patient needs without additional assistance.

(c) Disaster privileges may not exceed the limits of the LIP’s licensure and should be specific to the LIP’s specialty and for the primary function of stabilizing and triaging patients. Whenever possible, the LIP with disaster privileges should act under the supervision of a current Medical Staff member of the same specialty.

(d) Disaster privileges are time-limited and expire at the time that HEICS determines that an emergency situation no longer exists, or sooner if there is no longer a need for the additional assistance, as determined by the HEICS Medical Staff Director.

(e) Disaster privileges may be terminated at any time by the Legacy CEO, the Legacy CMO, Hospital Administrator, Medical Staff President or the HEICS Medical Staff Director, for any reason, without recourse to a hearing or any other appeal procedure and without any other rights.

(f) When a LIP who is not a member of the Medical Staff seeks disaster privileges:

1. The LIP shall complete an application for disaster privileges.
2. The LIP shall provide two forms of identification:
   (i) a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport), and
   (ii) at least one of the following:
       (A) A current Hospital picture ID card that clearly identifies professional designation.
       (B) A current license to practice.
(C) Primary source verification of the license.
(D) Identification certifying that the LIP is a member of the Medical Reserve Corps, a Disaster Medical Assistance Team, Emergency System for Advance Registration of Volunteer Health Professionals or other recognized state or federal organization.
(E) Identification certifying that the LIP has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity.
(F) Identification by a current Hospital employee or Medical Staff member(s) who possesses personal knowledge regarding volunteer’s ability to act as a LIP during a disaster. If possible, the ID document should be photocopied and attached to the “Application for Disaster Privileges.”

(3) A photocopy of the “Application for Disaster Privileges” shall be maintained in Hospital’s Emergency Operations Center for the duration of the incident. The original application and any attachments shall be forwarded as quickly as practical to the Site Medical Staff Office.

(4) Medical Staff Office personnel or designees shall proceed with credentials verification as soon as the immediate situation is under control or within seventy-two (72) hours from the time the volunteer LIP presents to Hospital. If, due to extraordinary circumstances, verification does not occur within seventy-two (72) hours, Hospital documents the reason it could not be performed, evidence of the LIP’s demonstrated ability to provide adequate care, treatment or services, and evidence of Hospital’s attempt to perform primary source verification. Primary source verification of licensure is not required if the volunteer LIP has not provided care, treatment and services under the disaster privileges.

(5) Hospital shall make a decision (based on information obtained regarding the professional practice of the volunteer LIP) within seventy-two (72) hours related to the continuation of the disaster privileges initially granted.

(6) If any concerns are identified during the verification process, Medical Staff Office personnel shall communicate that information immediately to the HEICS Incident Commander or Medical Staff Director and the Legacy CEO or designee and Medical Staff President. Disaster privileges may be terminated at any time in accordance with subsection (e) above.

(7) The appropriate individual shall notify the Medical Staff Office of the date and reason for termination of any disaster privileges prior to the end of the emergency situation, including those terminated because there is no longer a need for assistance.

(8) The Medical Staff shall oversee the professional practice of a volunteer LIP who receives disaster privileges by means of direct observation, mentoring, and/or clinical record review – Medical Staff determined.

(9) The Medical Staff Office will maintain a permanent file for each LIP granted disaster privileges.

12.F: TELEMEDICINE
It is the policy of the Medical Staff to permit safe and effective telemedicine services pursuant to these bylaws. The types of services to be provided by telemedicine shall be approved by the Legacy Board based on a recommendation from the Medical Executive Committee.

12.F.1 Definition and scope:

Telemedicine practitioners are those who prescribe, render a diagnosis, or otherwise provide or direct clinical treatment to a patient at Hospital utilizing electronic or other communication technologies that provide or support clinical care from a distance.

Telemedicine does not include those electronic services provided incident to standard clinical privileges held at Hospital or electronic consultations between practitioners as long as the consultant is only giving advice as a professional courtesy and is not providing patient care orders or otherwise directing the patient’s care.

Telemedicine shall only be practiced at Hospital by LIPs who have been approved by the Legacy Board for delineated clinical privileges following a recommendation from the Medical Executive Committee, based on the following criteria which are in addition to all other credentialing and membership criteria.

12.F.2. Qualifications:

(a) A LIP or group of LIPs wishing to provide telemedicine services must provide the Medical Staff written confirmation of one of the following:

(1) A contractual relationship with Hospital.
(2) A contractual relationship with the holder of an exclusive contract for a clinical service at Hospital. The holder of the exclusive contract must provide in-person back-up twenty-four (24) hours a day, seven days a week, if needed.
(3) Sponsorship and a continuous relationship with a member of the Medical Staff in the same specialty who supports the LIP in providing telemedicine services. The sponsor must provide in-person back-up twenty-four (24) hours a day, seven days a week, if needed.

(b) In addition, a LIP or group of LIPs wishing to provide telemedicine services must arrange for review and written confirmation to the Medical Staff from Legacy Information Resources and Hospital Administration that the arrangements for technical and operational integration, access, and maintenance meet all Legacy standards including but not limited to HIPAA regulations and contingency planning for downtime.

(c) Termination of the contractual or sponsorship relationship referred to above, or failure to maintain compliance with Legacy technical standards shall be considered a voluntary relinquishment of all clinical privileges related to telemedicine, and in the case of LIPs with privileges solely related to telemedicine, a voluntary resignation of Medical Staff membership. Such an event, in and of itself, shall not be considered a reportable event to the NPDB or a state licensing board.
(d) Applicants to provide approved telemedicine services shall be required to be members of the Medical Staff and are subject to all membership and privilege criteria. Membership and privilege criteria related to geographic location of residence and primary office and call coverage are fulfilled by compliance with the contractual or sponsorship relationship described in Section 12.F.2.A.

(1) Clinical privileges shall be specifically delineated and may not include any clinical services not associated with the provision of telemedicine services, unless the applicant also meets geographic and call coverage requirements.

(2) Hospital may perform primary source verification of credentialing elements and/or may use credentialing information from another facility where the applicant holds his/her primary affiliation and similar clinical privileges in accordance with regulatory and accreditation requirements.

It shall be the sole responsibility of the telemedicine applicant (or any group with which he/she is affiliated) to ensure that written confirmation of primary source verification is provided for any items relied upon either through completion of the facility verification form or directly from the primary source and delivered to Hospital.

(e) Occasional time-limited uses of telemedicine to meet other patient care needs that cannot be met by members of the Medical Staff may be handled by the use of temporary privileges.

ARTICLE 13
REAPPOINTMENT

13.A: PROCEDURE FOR REAPPOINTMENT

All terms, conditions, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

13.A.1. Qualifications:

(a) To be eligible to apply for reappointment, an individual must have, during the previous appointment term:

(1) completed all medical records;
(2) provided information regarding participation in continuing education related to the clinical privileges to be exercised by the individual;
(3) satisfied all Medical Staff responsibilities and fulfilled all duties assigned by the President of the Medical Staff;
(4) satisfied the Patient Contact requirement for the particular staff category to which the appointee is seeking reappointment; and
(5) continued to meet all qualifications and criteria for Medical Staff appointment and the clinical privileges requested as outlined in the bylaws, policies, rules and regulations of the Medical Staff, Hospital and Legacy, including the qualifications outlined in Section 11.A.2.
(b) To be eligible to apply for renewal of clinical privileges, an individual must have performed sufficient procedures, treatments, or therapies in the previous appointment term to enable the appropriate department chair and the Credentials Committee to assess the appointee’s current clinical competence for the privileges requested. Any individual seeking reappointment who has minimal activity level at Hospital shall cause to be submitted a copy of his/her confidential quality improvement profile from his/her primary hospital and/or such other information as may be requested before the individual’s reappointment application shall be considered complete and processed further. When insufficient peer review information is available for any appointee including those individuals in specialties that do not require use of Hospital facilities or treatment of hospitalized patients, the appointee shall provide peer recommendations in the same professional discipline as the appointee who have personal knowledge of the appointee’s current ability to practice. References must include relevant training and experience, current competence, and any effects of health status on privileges being requested.

13.A.2. Application:

(a) Each current appointee who is eligible to be reappointed to the Medical Staff shall be responsible for completing a reappointment application form and for paying a reappointment processing fee in an amount is determined by the Credentials Committee and approved by the Legacy Board.

(b) The reappointment application shall be furnished to the appointee by the Medical Staff Office at least five months prior to the expiration of the appointee’s current appointment period. The completed reappointment application shall be submitted to the Medical Staff Office at least three months prior to the expiration of the appointee’s current appointment period. Failure to submit an application at least two months prior to the expiration of the appointee’s current term shall result in automatic expiration of the appointee’s appointment and clinical privileges at the end of the then current term of appointment. The Medical Staff Office shall verify information provided by the appointee and query the NPDB and the OIG List of Excluded Individuals/Entities in the same manner described in Section 11.C.2(c).

(c) The reappointment application shall be considered incomplete and shall not be processed unless the appointee is current with respect to the payment of Medical Staff dues and assessments.

(d) Reappointment, if granted by the Legacy Board, shall be for a period of not more than two years. The specific staggering of reappointments shall be in a manner established by the Medical Staff Office.

13.A.3. Factors to be Considered:

Each recommendation concerning reappointment of an individual currently appointed to the Medical Staff shall be based upon such appointee’s:
(a) ethical behavior, clinical competence, and clinical judgment in the treatment of patients;
(b) attendance at Medical Staff, departmental and committee meetings and participation in staff duties, as required;
(c) compliance with the bylaws, policies, and rules and regulations of the Medical Staff, Hospital and Legacy;
(d) behavior at Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of Hospital, and general attitude toward patients, Hospital and its personnel;
(e) use of Hospital’s facilities for patients, taking into consideration the individual’s comparative utilization patterns;
(f) current information regarding the appointee’s ability to exercise the privileges requested and to perform the duties and responsibilities of appointment;
(g) capacity to satisfactorily treat patients as indicated by the results of Hospital’s quality improvement activities or other reasonable indicators of continuing qualifications;
(h) satisfactory completion of such continuing education requirements as may be imposed by law, Hospital, or applicable accreditation agencies;
(i) current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments, and settlements;
(j) current licensures, including currently pending challenges to any license or registration;
(k) voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;
(l) relevant findings from Hospital’s quality improvement activities; and
(m) other reasonable indicators of continuing qualifications.

13.A.4. Department Chair Procedure:

(a) Prior to the end of the current appointment period, the Medical Staff Office shall notify the section and department chair of each section and department when files are available for appointees who have clinical privileges in that department, who need to be reappointed. The files shall contain a checklist or summary describing all verifications and information obtained, together with a description of the clinical privileges held and requested, accompanied by copies of the applications, all of which shall be reviewed and evaluated by the section chair with a report prepared for the department chair’s review.

(b) No later than thirty (30) days after notification of the availability of the applications, the section and department chairs shall provide the Credentials Committee or the Chair of the
Credentials Committee, depending upon whether questions are raised, a written report concerning each individual seeking reappointment. The chairs shall include in each written report, when applicable, the reasons for any changes recommended in staff category, in clinical privileges, or for non-reappointment. The chair of the section or department concerned shall be available to the Credentials Committee or the Chair of the Credentials Committee to answer any questions that may be raised with respect to any such report.

13.A.5. Processing Applications When No Questions Are Raised and All Information is Appropriate and in Order:

(a) Applications which are deemed complete from individuals seeking reappointment and renewal of clinical privileges may be processed in an expedited manner as set forth in this section. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process:
   (1) Since the time of last appointment/reappointment review, the appointee has a current challenge to licensure or registration;
   (2) Since the time of last appointment/reappointment review, Hospital has determined that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the appointee;
   (3) The appointee has had involuntary limitation, reduction, denial or loss of clinical privileges or involuntary termination of membership at another organization; and
   (4) Questions are raised about the applicant by the section or department chair.

(b) The Chair of the Credentials Committee, acting on behalf of the Credentials Committee, shall, after receiving the report from each appropriate section and department chair, review all pertinent information available, including all information provided from other committees of the Medical Staff and from management, for the purpose of making a recommendation for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing appointment period.

(c) The Chair of the Credentials Committee shall have the right to require any appointee to meet with him/her to discuss any aspect of the individual’s reappointment application, qualifications, or clinical privileges requested.

(d) If, after considering the report of the appropriate section and department chair, the Chair of the Credentials Committee’s recommendation is favorable, he or she shall recommend reappointment and the specific clinical privileges to be granted, and this recommendation shall be forwarded to the Medical Executive Committee.

(e) If the Chair of the Credentials Committee has any questions about the appointee’s qualifications or current clinical competence, the Chair shall refer the matter to the entire Credentials Committee and the routine credentialing process, as set forth below shall be followed.

(f) The Medical Executive Committee shall review the recommendation made by the Chair of the Credentials Committee. If the Medical Executive Committee concurs with the
favorable recommendation, the recommendation shall be forwarded to the Medical Quality & Credentialing Committee for action. If the Medical Executive Committee has any questions about the appointee, the questions shall be noted and the matter shall be referred to the entire Credentials Committee for further action.

(g) The Medical Quality & Credentialing Committee reviews and evaluates the qualifications and competence of the appointee and renders its decision. If it concurs with the favorable recommendation, the status or privileges requested are granted. If the Medical Quality & Credentialing Committee’s decision is adverse to the appointee, the matter is referred back to the Medical Executive Committee for further evaluation.

(h) A report regarding all appointees who are granted reappointment and clinical privileges by the expedited process shall be forwarded to the Legacy Board for consideration.

13.A.6. Credentials Committee Procedure:

(a) Except as expressly provided in Section 13.A.5, all other applications for reappointment and clinical privileges shall be processed as set forth in Sections 13.A.6 - 13.A.8.

(b) The Credentials Committee, after receiving the reports from each department chair, shall review all pertinent information available, including all information provided from other committees and from Hospital management, for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing appointment period.

(c) The Credentials Committee shall have the right to require the appointee to meet with the committee to discuss any aspect of the individual’s reappointment application, qualifications, or clinical privileges requested.

(d) The Credentials Committee may use the expertise of the department chair, or any member of the department, or an outside consultant, if additional information is required regarding the appointee’s qualifications for reappointment.

(e) If, after considering the report of the clinical department chair concerned, the Credentials Committee’s recommendation is favorable, it shall recommend reappointment and the specific clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions, as appropriate.

13.A.7. Medical Executive Committee Procedure:

(a) The Credentials Committee shall forward its written findings and recommendations to the Medical Executive Committee in time for the Medical Executive Committee to consider the individual’s reappointment at its regularly scheduled meeting before the expiration of the appointee’s appointment period. The completed application and all supporting documentation shall accompany the Credentials Committee’s findings and recommendation. Where non-reappointment, non-promotion of an eligible current appointee, or a change in clinical privileges is recommended, the reason for such recommendation shall be stated. The Chair of the Credentials Committee shall be
available to the Medical Executive Committee (or to the Legacy Board) to answer any
questions that may be raised with respect to the recommendation.

(b) At its next regular meeting after receipt of the written findings and recommendation of
the Credentials Committee, the Medical Executive Committee shall:

(1) adopt the findings and recommendation of the Credentials Committee;
(2) refer the matter back to the Credentials Committee for further consideration and
preparation of responses to specific questions raised by the Medical Executive
Committee prior to its final recommendation; or
(3) set forth in its report and recommendation clear and convincing reasons, along
with supporting information, for its disagreement with the Credentials
Committee’s recommendation.

c) If the recommendation of the Medical Executive Committee is favorable, it shall transmit
its recommendations through the Legacy CEO to the Legacy Board, including the
findings and recommendations of the Credentials Committee. All recommendations to
reappointment shall also specifically recommend the clinical privileges to be granted,
which may be qualified by any probationary or other conditions or restrictions relating to
such clinical privileges.

d) Any recommendation by the Medical Executive Committee that would entitle the
affected individual to the procedural rights provided in these bylaws shall be forwarded
to the Legacy CEO who shall promptly notify the affected individual by certified mail,
return receipt requested. The Legacy CEO shall then hold the recommendation until after
the individual has exercised or has waived the right to a hearing as provided in these
bylaws, after which time the Legacy CEO shall forward the recommendation of the
Medical Executive Committee, together with all supporting documentation to the Legacy
Board. The Chair of the Medical Executive Committee shall be available to the Legacy
Board to answer any questions that may be raised with respect to the recommendation.

e) In the event the Legacy Board determines to consider modification of the action of the
Medical Executive Committee and such modification would entitle the individual to a
hearing in accordance with these bylaws, it shall notify the affected individual, through
the Legacy CEO, and shall take no final action until the individual has exercised or has
waived the procedural rights provided in these bylaws.

(f) The affected individual shall be notified in writing of the Legacy Board’s decision and, if
applicable, the reasons for such decision no later than thirty (30) days after the meeting.

13.A.8. Meeting with Affected Individual:

If, during the processing of an individual’s reappointment, it becomes apparent to the Credentials
Committee or its Chair that the committee is considering a recommendation that would deny
reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical
privileges, the Chair of the Credentials Committee may notify the individual of the general tenor
of the possible recommendation and ask if the individual desires to meet with the committee
prior to any final recommendation by the 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; however, the individual shall not be permitted to bring an attorney. This interview shall not constitute a hearing and none of the procedural rules provided in these bylaws with respect to hearings shall apply. Minutes of the discussion in the meeting shall not be kept. However, the committee shall indicate as part of its report to the Medical Executive Committee and the Legacy Board whether such a meeting occurred, and shall include a summary of the meeting.

ARTICLE 14
OTHER ACTIONS AFFECTING MEDICAL STAFF APPOINTEES

14.A: PROCEDURES FOR OTHER QUESTIONS INVOLVING MEDICAL STAFF APPOINTEES

14.A.1. Initial Procedure:

Whenever a concern or question is raised regarding:

(a) the clinical competence or clinical practice of any Medical Staff appointee;
(b) the care or treatment of a patient or patients or management of a case by any Medical Staff appointee;
(c) the known or suspected violation by any Medical Staff appointee of applicable ethical standards or the bylaws, policies, rules or regulations of Hospital, Legacy or the Medical Staff, including, but not limited to Hospital’s quality improvement, risk management, and utilization review programs; and/or
(d) behavior or conduct on the part of any Medical Staff appointee that is considered lower than the standards of Hospital or disruptive to the orderly operation of Hospital or its Medical Staff, including the inability of the appointee to work harmoniously with others; the President of the Medical Staff, department chair, Chair of the Credentials Committee, or Legacy CEO shall make sufficient inquiry to satisfy themselves that the concern or question raised is credible, after which it shall be submitted in writing to the Medical Executive Committee. If any of the inquiring individuals set forth in this provision believe it to be in the best interest of Hospital and the appointee concerned, they may, but are not required to, discuss the matter with the affected appointee.

14.A.2. Initiation of Investigation:

(a) When a concern or question involving clinical competence or behavior/conduct is referred to the Medical Executive Committee, that committee shall meet as soon as possible and shall determine either to discuss the matter with the individual concerned, or to begin an investigation. The individual shall not discuss the matter with the complainant, unless authorized by the Legacy CEO. The Medical Executive Committee may also, by formal resolution, initiate an investigation on its own motion. If the Legacy Board wishes to begin such an investigation, it shall also formally resolve to do so, but may delegate the actual investigation.
(b) The President of the Medical Staff shall promptly notify the Legacy CEO in writing of all such requests and investigations, and shall keep the Legacy CEO fully informed of all action taken in connection therewith.

(c) If the concern contains sufficient information to warrant a recommendation without a further investigation, the Medical Executive Committee, at its discretion, may make such a recommendation, with or without a personal interview with the individual being investigated.

14.A.3. Investigative Procedure:

(a) If the concern does not contain sufficient information to warrant a recommendation, the Medical Executive Committee shall immediately investigate the matter, appoint a subcommittee to do so, request the Credentials Committee to investigate, or appoint an ad hoc investigating committee consisting of up to three persons, who may or may not hold appointments to the Medical Staff. This ad hoc investigating committee shall not include partners, associates, relatives, competitors or referral sources of the individual being investigated.

(b) The Medical Executive Committee, its subcommittee, the Credentials Committee, or the ad hoc investigating committee shall have available to it the full resources of the Medical Staff and Hospital, as well as the authority to use outside consultants, if needed. The committee may also require a physical and mental examination of the individual being investigated by a physician or physicians satisfactory to the committee, and shall require that the results of such examination be made available for the committee’s consideration.

(c) The individual being investigated shall have an opportunity to meet with the investigating committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it) the individual shall be informed of the general nature of the evidence supporting the question being investigated and shall be invited to discuss, explain, or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in these bylaws with respect to hearings, including the right to counsel, shall apply. A summary of such interview shall be made by the investigating committee and included with its report to the Medical Executive Committee.

(d) If a subcommittee, the Credentials Committee, or ad hoc investigating committee is used, the Medical Executive Committee may accept, modify, or reject the recommendation it receives from that committee.

(e) Prior to its recommendation, the Medical Executive Committee may allow the individual being investigated an opportunity to present to the Medical Executive Committee. There is no right or entitlement of the individual being investigated to such a presentation, the presentation shall not constitute a hearing, and none of the procedural rules provided in these bylaws with respect to hearings, including the right to counsel, shall apply. The Medical Executive Committee, at its sole discretion, may place any conditions on the individual’s presentation.
14.A.4. Procedure Thereafter:

(a) In acting after the investigation, the Medical Executive Committee may:

(1) determine that no action is justified;
(2) issue a written warning;
(3) issue a letter of reprimand;
(4) impose terms of probation;
(5) impose a requirement for consultation;
(6) recommend reduction of clinical privileges;
(7) recommend suspension of clinical privileges for a term;
(8) recommend revocation of Medical Staff appointment; or
(9) make such other recommendations as it deems necessary or appropriate.

(b) Any recommendation by the Medical Executive Committee that would entitle the individual being investigated to the procedural rights provided in these bylaws shall be forwarded to the Legacy CEO who shall promptly notify the affected individual by certified mail, return receipt requested. The Legacy CEO shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing, after which the Legacy CEO shall forward the recommendation of the Medical Executive Committee, together with all supporting information, to the Legacy Board (or its committee). The Chair of the Medical Executive Committee, or his/her designee shall be available to the Legacy Board (or its committee) to answer any questions that may be raised with respect to the recommendation.

(c) If the action of the Medical Executive Committee does not entitle the individual to a hearing, the action shall take effect immediately without action of the Legacy Board and without the right of appeal to the Legacy Board. A report of the action taken and reasons therefor shall be made to the Legacy Board through the Legacy CEO, and the action shall stand unless modified by the Legacy Board.

(d) In the event the Legacy Board determines to consider modification of the action of the Medical Executive Committee and such modification would entitle the individual to a hearing in accordance with these bylaws, it shall so notify the affected individual, through the Legacy CEO, and shall take no final action thereon until the individual has had an opportunity to exercise the right to a hearing and appeal as provided in these bylaws.

(e) Any action taken by either the Medical Executive Committee or the Legacy Board as a result of an investigation shall be communicated to and shall be valid at all Legacy hospitals.

14.B: PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES

14.B.1. Grounds for Precautionary Suspension:

(a) The President of the Medical Staff, the chair of a clinical department, the Chair of the Credentials Committee, the Legacy CEO (or designee), or the Legacy Board Chair, shall
each have the authority to suspend all or any portion of the clinical privileges of a Medical Staff appointee or other individual whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual or to the orderly operations of Hospital. Such precautionary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that may be taken with respect to the suspended individual but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.

(b) Such precautionary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Legacy CEO, the President of the Medical Staff, and the Chair of the Credentials Committee, and shall remain in effect unless or until modified by the Legacy CEO or the Medical Executive Committee.

14.B.2. Medical Executive Committee Procedure:

(a) Any individuals who exercise authority under Section 14.B.1 to suspend clinical privileges as a precaution shall immediately report this action to the Medical Executive Committee to take further action in the manner specified in Section 14.B.

(b) A review of the matter resulting in precautionary suspension shall be completed within a reasonable time period or reasons for the delay shall be transmitted to the Legacy CEO so that the Legacy CEO and the Medical Executive Committee may consider whether the suspension should be lifted. In any event, the Medical Executive Committee shall take such further action as is required in the manner specified under Section 14.B.

14.B.3. Care of Suspended Individual’s Patients:

(a) Immediately upon the imposition of a precautionary suspension, the appropriate department chair or, if unavailable, the President of the Medical Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual’s patients still in Hospital. The assignment shall be effective until such time as the patients are discharged. The wishes of the patient shall be considered in the selection of the assigned appointee.

(b) It shall be the duty of all Medical Staff appointees to cooperate with the President of the Medical Staff, the department chair concerned, the Medical Executive Committee, and the Legacy CEO in enforcing all suspensions.

14.C: OTHER ACTIONS

A member shall be notified of any action taken against his/her Medical Staff appointment or clinical privileges pursuant to Section 14.C. Such actions shall not constitute grounds for a hearing or appeal.

14.C.1. Failure to Complete Medical Records:
The admitting and clinical privileges (elective and emergency) of any individual shall be deemed to be automatically relinquished for failure to complete medical records in accordance with applicable regulations governing the same, after notification by the medical records department of such delinquency. Such relinquishment shall continue until all the records of the individual’s patients are no longer delinquent and the appointee’s clinical privileges have been formally reinstated by the Legacy CEO. Failure to complete the medical records that caused relinquishment of clinical privileges within sixty (60) days from the relinquishment of such privileges shall constitute an automatic relinquishment of all clinical privileges and resignation from the Medical Staff.

14.C.2. Action by State Licensing Agency:

Action by the appropriate state licensing board or agency revoking or suspending an individual’s professional license, or loss or lapse of state license to practice for any reason, shall result in automatic relinquishment of all clinical privileges as of that date, until the matter is resolved, and an application for reinstatement of privileges is approved by the Credentials Committee and the Legacy Board. In the event the individual’s license is only partially restricted, the clinical privileges that would be affected by the license restriction shall be similarly restricted.

14.C.3. Failure to be Adequately Insured:

If at any time an appointee’s professional liability insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect (in whole or in part), the appointee’s clinical privileges that would be affected shall be automatically relinquished or restricted as applicable as of that date until the matter is resolved, adequate professional liability insurance coverage is restored and the appointee’s clinical privileges have been formally reinstated by the Legacy CEO.

14.C.4. Failure to Provide Requested Information:

If at any time an appointee fails to provide required information pursuant to a formal request by the Credentials Committee, the Medical Executive Committee, the Medical Staff President or designee, or the Legacy CEO, the appointee’s clinical privileges shall be automatically relinquished until the required information is provided to the satisfaction of the requesting party. For purposes of this section “required information” shall refer to (1) physical or mental examinations as specified elsewhere in these bylaws; (2) information necessary to explain an investigation, professional review action, or resignation from another facility or agency; (3) information pertaining to professional liability actions involving the appointee; or (4) other information necessary to ensure an appointee’s compliance with the bylaws, policies, and rules and regulations of the Medical Staff, Hospital and Legacy.

14.C.5. Criminal Activity:

Any Medical Staff appointee who has been convicted of any felony or of any misdemeanor involving violations of law pertaining to controlled substances, illegal drugs, or Medicare, Medicaid, or insurance fraud or abuse, or any appointee who pleads guilty or nolo contendere to charges pertaining to the same, shall automatically relinquish his/her Medical Staff appointment and all clinical privileges.
14.C.6. Medicare and Medicaid Participation:

Any Medical Staff appointee whose participation in the Medicare or Medicaid programs is terminated by either or both of those programs, or who is otherwise excluded or precluded from participation in either or both of those programs, shall automatically relinquish all clinical privileges as of the effective date of the termination, exclusion, or preclusion. If the appointee’s participation in those programs is not fully reinstated by the expiration of the appointee’s then current reappointment term, the appointee shall be deemed to have resigned from the Medical Staff at that time. It shall be the duty of all appointees to promptly notify Hospital of any action taken by either such program in this regard.

14.C.7. Procedure for Leave of Absence:

(a) Individuals appointed to the Medical Staff may, for good cause, be granted leaves of absence by the Legacy Board, for a definitely stated period of time not to exceed one year. Absence for longer than one year shall constitute voluntary resignation of Medical Staff appointment and clinical privileges, unless an exception is made by the Legacy Board upon recommendation of the Medical Executive Committee.

(b) Requests for leaves of absence shall be made to the President of the Medical Staff, and shall state the beginning and ending dates of the requested leave. The President of the Medical Staff shall transmit the request together with a recommendation to the Legacy CEO for action by the Legacy Board.

(c) At the conclusion of the leave of absence, the individual may be reinstated, upon filing a written statement with the Legacy CEO summarizing the professional activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by Hospital at that time. All this information shall be considered by the Credentials Committee and the Medical Executive Committee in arriving at a recommendation regarding reinstatement.

(d) If the leave of absence was for medical reasons, then the appointee must submit a report from his/her attending physician indicating that the appointee is physically and/or mentally capable of resuming a hospital practice and exercising the clinical privileges requested. The appointee shall also provide such other information as may be requested by Hospital at that time. After considering all relevant information, Hospital, the Credentials Committee and the Medical Executive Committee shall then make a recommendation to the Legacy Board for final action.

(e) In acting upon the request for reinstatement, the Legacy Board may approve reinstatement either to the same or a different staff category, and may limit or modify the clinical privileges to be extended to the individual upon reinstatement.

14.D: INFORMAL PROCEEDINGS

Nothing in these bylaws shall preclude collegial, educational, and/or informal efforts to address questions or concerns relating to an individual’s practice and conduct at Hospital, and these
bylaws specifically encourage voluntary structuring of clinical privileges to achieve a clinical practice mutually acceptable to the individual, the Credentials Committee, the Medical Executive Committee, Hospital, and the Legacy Board. All efforts of Hospital and the Medical Staff leaders in this regard are intended to be and are part of Hospital’s quality improvement and professional review activities.

ARTICLE 15
FAIR HEARING AND APPEAL PROCEDURES

15.A: INITIATION OF HEARING

15.A.1. Grounds for Hearing:

(a) An applicant or an individual holding a Medical Staff appointment shall be entitled to request a hearing whenever an unfavorable recommendation is made by the Medical Executive Committee or the Legacy Board regarding the following:

(1) denial of Medical Staff reappointment;
(2) revocation of Medical Staff appointment;
(3) denial of requested initial clinical privileges;
(4) denial of requested additional clinical privileges;
(5) decrease of clinical privileges (after the period of provisional appointment);
(6) suspension of clinical privileges (other than precautionary suspension) for more than thirty (30) days; or
(7) imposition of mandatory concurring consultation requirement (i.e., not only must the individual obtain a consult but must also reach agreement with the consult as to the course of treatment before that treatment can be pursued).

(b) No other recommendations except those enumerated in (a) of this section shall entitle the individual to request a hearing.

(c) The affected individual shall also be entitled to request a hearing before the Legacy Board enters a final decision, in the event the Legacy Board determines, without a similar recommendation from the Medical Executive Committee, to take any action set forth above.

(d) The hearing shall be conducted in as informal a manner as possible, subject to the rules and procedures set forth in these bylaws.

15.A.2. Actions Not Grounds for Hearing:

None of the following actions shall constitute grounds for a hearing, and shall take effect without hearing or appeal:

(a) the issue of a letter of warning, a letter of admonition, or a letter of reprimand;
(b) the imposition of terms of probation, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not reach agreement with the consult before the treatment is pursued);
(c) the granting, denial and termination of temporary privileges;
(d) the automatic relinquishment of clinical privileges as provided in these bylaws;
(e) the imposition of a requirement for additional training or continuing education;
(f) modification or removal of provisional clinical privileges; or
(g) denial of initial Medical Staff appointment for failure to meet threshold criteria for appointment.

15.B: THE HEARING

15.B.1. Notice of Recommendation:
When a recommendation is made which, according to these bylaws entitles an individual to a hearing prior to a final decision of the Legacy Board, the affected individual shall promptly be given notice by the Legacy CEO, in writing, certified mail, return receipt requested. The Legacy CEO shall provide this notice to the individual within ten (10) days from the date the recommendation was made. This notice shall contain:

(a) a statement of the recommendation made and the general reasons for it;
(b) notice that the individual has the right to request a hearing on the recommendation within thirty (30) days of receipt of this notice;
(c) a copy of this Article outlining the rights in the hearing as provided for in these bylaws; and
(d) notice that the individual has the right to be represented by counsel at the hearing.

15.B.2. Request for Hearing:
An individual shall have thirty (30) days following the date of the receipt of such notice within which to request the hearing. The request shall be in writing to the Legacy CEO. In the event the individual does not request a hearing within the time and in the manner required by these bylaws, the individual shall be deemed to have waived the right to the hearing and to have accepted the action involved. That action shall become effective immediately upon final Legacy Board action.

15.B.3. Notice of Hearing and Statement of Reasons:

(a) The Legacy CEO shall schedule the hearing and shall give written notice, certified mail, return receipt requested, to the individual who requested the hearing. The notice shall include:

(1) the time, place, and date of the hearing;
(2) a proposed list of witnesses, as known at that time, but which may be modified, who will give testimony or present evidence at the hearing in support of the Medical Executive Committee or the Legacy Board;

(3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and

(4) a statement of the specific reasons for the recommendation, as well as the list of patient records and information supporting the recommendation. This statement, and the list of supporting patient record numbers and other supporting information, may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing. The individual and counsel shall have sufficient time, up to thirty (30) days, to study this additional information and rebut it.

(b) The hearing shall begin as soon as practicable, but no sooner than thirty (30) days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by the parties.

15.B.4. Witness List:

(a) Within ten (10) days after receiving notice of the hearing, the individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or present evidence on his/her behalf.

(b) The affected individual’s witness list, as well as the witness list of the Medical Executive Committee or the Legacy Board, shall include a brief summary of the nature of the anticipated testimony. Both lists shall be finalized at the time of the pre-hearing conference. However, the witness list of either party may, thereafter, in the discretion of the Presiding Officer or Hearing Panel Chair, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The Presiding Officer shall have the authority to limit the number of witnesses, especially character witnesses or witnesses whose testimony is merely cumulative, as set forth in Section 15.B.5.

15.B.5. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

(1) When a hearing is requested, the Legacy CEO, acting for the Legacy Board and after considering the recommendations of the President of the Medical Staff (and that of the Chair of the Legacy Board, if the hearing is occasioned by a Legacy Board determination) shall appoint a Hearing Panel, which shall be composed of not less than three members. The Hearing Panel shall be composed of Medical Staff appointees who shall not have actively participated in the consideration of the matter involved at any previous level, or of physicians or laypersons not connected with Hospital, or any combination of such persons. Knowledge of the
matter involved shall not preclude any individual from serving as a member of the Hearing Panel.

(2) The Hearing Panel shall not include any individual who is in direct economic competition with the affected individual or any such individual who is professionally associated with or related to the affected individual. Such appointment shall include designation of a Chair or a Presiding Officer.

(3) In consideration of their time and service to the Medical Staff and the hearing process, the Hearing Panel members may be paid fair market value compensation. To avoid any allegation of a conflict of interest, the compensation shall be disclosed to all parties involved in the hearing process, including the individual requesting the hearing.

(b) Presiding Officer:

(1) In lieu of a Hearing Panel Chair, the Legacy CEO may appoint an attorney at law as Presiding Officer. Such Presiding Officer shall not act as a prosecuting officer, or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

(2) If no Presiding Officer has been appointed, a Chair of the Hearing Panel shall be appointed by the Legacy CEO to serve as the Presiding Officer, and shall be entitled to one vote.

(3) The Presiding Officer (or Hearing Panel Chair) shall:

(i) act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

(ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, abusive, or that causes undue delay;

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure throughout the hearing;

(v) 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;

(vi) act in such a way that all information relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the Hearing Panel in formulating its recommendations; and

(vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the panel wishes to be present.
(4) The Presiding Officer may be advised by legal counsel to Hospital with regard to the hearing procedure.

(c) Hearing Officer:

(1) As an alternative to the Hearing Panel described in paragraph (a) of this Section, the Legacy CEO, after consulting with the President of the Medical Staff (and Chair of the Legacy Board if the hearing was occasioned by a Legacy Board determination) may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Panel. The Hearing Officer shall preferably be an attorney at law.

(2) The Hearing Officer may not be in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he/she shall not represent clients in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the “Hearing Panel” or “Presiding Officer” shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

(3) If the individual requesting the hearing, the Medical Executive Committee, and the Chair of the Legacy Board agree, a request may be made to the Oregon Medical Board to appoint one or more physicians as a Hearing Committee, in accordance with ORS §441.055.

(4) The Hearing Panel shall not include any individual who is in direct economic competition with the affected individual or any such individual who is professionally associated with or related to the affected individual.

15.C: HEARING PROCEDURE

15.C.1. Discovery:

(a) There is no right to discovery in connection with the hearing. However, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

(1) copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at the individual’s expense;
(2) reports of experts relied upon by the Medical Executive Committee or the Legacy Board;
(3) redacted copies of relevant committee or department minutes (such provision does not constitute a waiver of the state peer review protection law); and
(4) copies of any other documents relied upon by the Medical Executive Committee or the Legacy Board.
(b) Prior to the hearing, on dates set by the Presiding Officer or agreed upon by counsel for both sides, each party shall provide the other party with the party’s proposed exhibits. All objections to documents or witnesses to the extent then reasonably known, shall be submitted in writing in advance of the hearing. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(c) Neither the affected individual, nor his/her attorney, nor any other person acting on behalf of the affected individual, shall contact Hospital employees appearing on the other party’s witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

15.C.2. Pre-Hearing Conference:

The Presiding Officer shall require counsel for the individual and for the Medical Executive Committee or the Legacy Board to participate in a pre-hearing conference for purposes of resolving all procedural questions in advance of the hearing. The Presiding Officer shall specifically require that:

(a) all documentary evidence/exhibits to be submitted by the parties be presented to each other prior to this conference and that any objections regarding the documents be made at this conference and resolved by the Presiding Officer;
(b) evidence unrelated to the reasons for the unfavorable recommendation or unrelated to the individual’s qualifications for appointment or the relevant clinical privileges be excluded;
(c) the names of all witnesses and a brief statement of their anticipated testimony be exchanged by the parties prior to this conference and that any objections regarding witnesses be made at this conference and resolved by the Presiding Officer;
(d) the time granted to each witness’ testimony and cross-examination be agreed upon, or determined by the Presiding Officer, in advance; and
(e) witnesses and documentation not provided and agreed upon in advance of the hearing may be excluded from the hearing.

15.C.3. Failure to Appear:

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the pending recommendations or actions, which shall then be forwarded to the Legacy Board for final action.

15.C.4. Record of Hearing:

The Hearing Panel shall maintain a record of the hearing by a stenographer present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by Hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual’s expense. 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.

15.C.5. Rights of Both Sides and the Hearing Panel at the Hearing:
(a) At a hearing both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer or Hearing Panel Chair:

(1) to call and examine witnesses to the extent available;
(2) to introduce exhibits;
(3) to cross-examine any witness on any matter relevant to the issues and to rebut any evidence;
(4) representation by counsel who may call, examine, and cross-examine witnesses and present the case. Both sides shall notify the other of the name of that counsel at least ten (10) days prior to the pre-hearing conference; and
(5) to submit a written statement at the close of the hearing.

(b) Any individual requesting a hearing who does not testify in his/her own behalf may be called and examined as if under cross-examination.

(c) The Hearing Panel may question the witnesses, call additional witnesses, and/or request documentary evidence.

15.C.6. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Hearsay evidence shall not be excluded merely because it constitutes hearsay. 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. The guiding principle shall be that the Legacy Board, which shall ultimately decide about the affected individual’s appointment and clinical privileges, shall have before it all information relevant to the individual’s qualifications for the appointment and/or clinical privileges.

15.C.7. Post-Hearing Memoranda of Points and Authorities:

Each party shall have the right to submit a memorandum in support of its position, and the Hearing Panel may request such a memorandum to be filed, following the close of the hearing.

15.C.8. Official Notice:

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

15.C.9. Postponements and Extensions:
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 Presiding Officer or the Legacy CEO on a showing of good cause.

15.D: HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

15.D.1. Order of Presentation:

The Medical Executive Committee or the Legacy Board, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

15.D.2. Basis of Decision:

(a) The Hearing Panel shall recommend in favor of the Medical Executive Committee or the Legacy Board unless it finds that the individual who requested the hearing has proved that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by substantial evidence.

(b) The recommendation of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

1. oral testimony of witnesses;
2. memorandum of points and authorities presented in connection with the hearing;
3. any information regarding the individual who requested the hearing so long as that information 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;
4. any and all applications, references, and accompanying documents;
5. other documented evidence, including medical records; and
6. any other evidence that has been admitted.

15.D.3. Adjournment and Conclusion:

The Presiding Officer may, without special notice, adjourn the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and/or questions by the Hearing Panel, the hearing shall be closed.

15.D.4. Deliberations and Recommendation of the Hearing Panel:

Within twenty (20) days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing memoranda, whichever is later), the Hearing Panel 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 basis for the Hearing Panel’s decision.
15.D.5. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report and recommendation to the Legacy CEO who shall forward it, along with all supporting documentation, to the Legacy Board for further action. The Legacy CEO shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing. The Legacy CEO shall also provide a copy to the Medical Executive Committee for its information.

15.E: APPEAL PROCEDURE

15.E.1. Time for Appeal:

Within ten (10) days after notice of the Hearing Panel’s recommendation, either party may request an appellate review. The request shall be in writing, and shall be delivered to the Legacy CEO either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) days as provided herein, both parties shall be deemed to have waived appellate review, and the Hearing Panel’s report and recommendation shall be forwarded to the Legacy Board for final action.

15.E.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure to comply with these bylaws and/or Hospital bylaws during or prior to the hearing, so as to deny a fair hearing; and/or
(b) the recommendations of the Hearing Panel were made arbitrarily, capriciously, or with prejudice; and/or
(c) the recommendations of the Hearing Panel were not supported by substantial evidence.

15.E.3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding sections, the Chair of the Legacy Board shall schedule and arrange for an appellate review. The affected individual shall be given notice of the time, place, and date of the appellate review. The appellate review shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

15.E.4. Nature of Appellate Review:

(a) The Chair of the Legacy Board shall appoint a Review Panel composed of not less than three persons, either members of the Legacy Board or others, including but not limited to reputable persons outside Hospital, to consider the record upon which the recommendation before it was made, or the Legacy Board may hear the appeal as a whole body.
(b) The Review Panel may in its discretion accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

(c) Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes. The Review Panel shall recommend final action to the Legacy Board.

(d) The Legacy Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Legacy Board’s ultimate legal responsibility to grant appointment and clinical privileges. In the event the Legacy Board determines to modify or reverse the recommendation of the Review Panel in such a manner that the action would entitle the affected individual to another hearing in accordance with these bylaws, it shall so notify the affected individual through the Legacy CEO, and shall take no final action thereon until the individual has exercised or has waived the procedural rights provided in these bylaws.

15.E.5. Final Decision of the Legacy Board:

Within thirty (30) days after receipt of the Review Panel’s recommendation, the Legacy Board shall render a final decision in writing, including specific reasons, and shall deliver a copy thereof to the affected individual by certified mail, return receipt requested. A copy shall also be provided to the Medical Executive Committee for its information.

15.E.6. Further Review:

Except where the matter is referred for further action and recommendation in accordance with Section 15.E.4, the final decision of the Legacy Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred pursuant to Section 15.E.4 for further action and recommendation, such recommendation shall be promptly made to the Legacy Board in accordance with the instructions given by the Legacy Board. This further review process and the report back to the Legacy Board shall in no event exceed thirty (30) days except as the parties may otherwise stipulate.

15.E.7. Right to One Hearing and One Appeal Only:

No applicant or Medical Staff appointee shall be entitled to more than one hearing and one appellate review on any matter which may be the subject of an appeal. If the Legacy Board determines to deny initial Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current appointee, that individual may not apply for Medical Staff appointment or for those clinical privileges at Hospital for a period of five years unless the Legacy Board provides otherwise.
ARTICLE 16
MEDICAL HISTORY AND PHYSICAL EXAMINATIONS

All patients admitted to Hospital must have a medical history and physical examination (H&P) completed and documented by a LIP granted privileges to perform H&Ps or another qualified licensed practitioner authorized by the Medical Staff to perform H&Ps in accordance with the Medical Staff Rules and Regulations. The H&P must be appropriate for the patient’s procedure/treatment and completed and documented in accordance with federal and state law and the Medical Staff Rules and Regulations.

The H&P must be completed and documented no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but in all cases prior to surgery or a procedure requiring anesthesia services. If the H&P was completed within thirty (30) days before admission or registration, it must be updated, including any changes in the patient’s condition, within twenty-four (24) hours after admission or registration, but in all cases prior to surgery or a procedure requiring anesthesia services.

ARTICLE 17
CONFIDENTIALITY; PEER REVIEW PROTECTION

17.A: CONFIDENTIALITY AND REPORTING

(a) Actions taken, recommendations made and information shared pursuant to these bylaws shall be treated as confidential in accordance with applicable legal requirements, as well as such policies regarding confidentiality as may be adopted by Hospital and the Medical Staff. In addition, reports of actions taken pursuant to these bylaws shall be made by the Legacy CEO to such governmental agencies as may be required by law.

(b) Hospital shall maintain all information it receives from third parties in strict confidence, and the release of any such information shall be in accordance with applicable federal and state law, including, but not limited to, ORS §41.675 or the corresponding provisions of any subsequent state or federal law providing protection to peer review or related activities. No party shall disclose this information to any third party without the express written consent of the others.

(c) The Medical Staff and Hospital recognize that it is vital to maintain the confidentiality of records maintained by or on behalf of the Medical Staff (collectively, “Medical Staff Records”). Medical Staff Records include, but are not limited to, Medical Staff committee records and minutes and credentials, quality and peer review files of individual practitioners. Medical Staff members participate in peer review, performance improvement, quality assurance, utilization review, credentialing, education, training, supervision and discipline and privileging activities (collectively, “Peer Review Activities”) in reliance upon the confidentiality of and legal protections afforded to these activities. As such, Medical Staff Records are confidential, privileged and protected pursuant to ORS 41.675 & 41.685, RCW 4.24.240-260 & 70.41.200, the federal Health
Care Quality Improvement Act of 1986 and other applicable law and may be disclosed only in accordance with these bylaws or as otherwise authorized by law.

17.B: PEER REVIEW PROTECTION

All minutes, reports, recommendations, communications, and actions made or taken pursuant to these bylaws are deemed to be covered by the provisions of ORS §41.675 or the corresponding provisions of any subsequent federal or state law providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations, or investigations pursuant to these bylaws shall be considered to be acting on behalf of Hospital and Legacy when engaged in such professional review activities and thus shall be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986.

17.C: MEDICAL STAFF RECORDS

(a) Location and Security Precautions. All Medical Staff Records are maintained in the Medical Staff Office under the custody of the Medical Staff Coordinator. The Medical Staff Office shall be locked except during those times that office staff is present and able to monitor access in accordance with these bylaws. Medical Staff Records shall only be released from the Medical Staff Office in accordance with these bylaws.

(b) Manner of Access; Parties Entitled to Access.

(1) Requests for Access; Access Parameters. All requests for Medical Staff Records shall be directed to the Medical Staff Coordinator. Those requests which require notice to, or approval by, other individuals shall be forwarded to those persons by the Medical Staff Coordinator. Unless otherwise required by law or provided in these bylaws, persons granted access to Medical Staff Records shall be given a reasonable opportunity to review relevant records and take notes, but shall not be allowed to remove records from the Medical Staff Office or to make copies of records, except with the express permission of the Medical Staff President (or designee).

(2) Access by Persons Performing Authorized Hospital or Medical Staff Functions and Responsibilities. Medical Staff officers, committee members, members of the Board of Directors, the Legacy CEO or authorized representative, the Medical Staff Coordinator, and other persons participating in authorized Hospital or Medical Staff Peer Review Activities may have access to Medical Staff Records, other than their own files, to the extent necessary to perform such Peer Review Activities.

(3) Access by Member to His/Her Own Credentials File.

(i) A member may have access to his/her own credentials file, subject to the following conditions:
(A) The review shall take place in the Medical Staff Office, during normal business hours, with Hospital or Medical Staff personnel present.

(B) A member may review any documents in his/her credentials file which he/she prepared or provided personally (e.g., initial appointment application, application for reappointment, request for privileges, copies of licensure and certifications, or correspondence from himself or herself) or which were originally addressed to him/her.

(C) A member may request copies of documents available for review. The Medical Staff office may charge the member a reasonable fee for such copies.

(D) All other information may be disclosed only in written summary form. The summary shall contain the substance, but not the source, of the information.

(E) A member may not modify, remove, cancel, destroy or change any document or information in the file.

(ii) In the event of a hearing or appeal as set forth in these bylaws, the member may have access to all information in the file relevant to the hearing, appeal or underlying corrective action.

(4) Access By Persons or Organizations Outside Hospital or Medical Staff.

(i) Credentialing or Peer Review at Other Health Care Facilities.

(A) Medical Staff Records may be released in response to a written request from another health care facility or medical staff. Disclosure generally shall include verification of the member’s Medical Staff membership and clinical privileges and may include additional information from the file when the member has signed an acceptable authorization and release.

(B) If a member has been the subject of corrective action at Hospital, special care shall be taken. All responses to inquiries regarding that member shall be reviewed and approved by the Medical Staff Coordinator and/or Medical Staff President (or designee), with input from legal counsel.

(ii) Hospital Surveyors and Auditors. Hospital surveyors and auditors (e.g., Joint Commission, CMS) may review Medical Staff Records on Hospital premises in the presence of Hospital or Medical Staff personnel provided that: (1) no originals or copies may be removed from the premises; (2) access is granted with the concurrence of the Medical Staff President (or
(iii) Subpoenas. All subpoenas of Medical Staff Records shall be referred to the legal department. The legal department shall work with the Medical Staff Office to determine the appropriate response to the subpoena.

(iv) Other Requests. All other requests by persons or organizations outside Hospital or Medical Staff for information contained in the Medical Staff Records shall be forwarded to the Medical Staff President (or designee) for review and action.

(c) Credentials Files Changes. A member may request corrections, deletions and additions to information in his/her credentials file, subject to the following provisions:

(1) The request shall be made in writing to the Medical Staff President and shall include a reason for the action(s) requested.

(2) The Medical Staff President (or designee) shall review such request within a reasonable period of time and decide whether to grant or deny the request. The Medical Staff President (or designee) may make reasonable modifications to the member’s request. The member will be notified promptly, in writing, of the Medical Staff President’s decision.

(3) If granted, the appropriate action shall be taken and the member shall be so notified. If the request is denied, the member shall be notified of the reason(s) for denial. The member may request a review of the President’s decision by the Medical Executive Committee. This review is not a hearing as described in Section 15.B. and does not entitle a member to any due process rights to which he/she might otherwise be entitled under Section 15.B.

(4) In any case, a member has the right to add a short, relevant, written statement to his/her own credentials file to support or rebut any information contained therein.
ARTICLE 18
CONFLICT MANAGEMENT

(a) In the event of conflict between the Medical Executive Committee and the Medical Staff regarding a proposed or adopted Medical Staff bylaw, rule, regulation, policy, or other issue of significance to the Medical Staff, a written petition signed by at least five percent (5%) of the members of the Medical Staff shall be submitted to the President of the Medical Staff to trigger the conflict management process. The petition shall designate three members of the Active Staff to serve as the petitioners’ representatives.

(b) Upon presentation of a valid petition, the President of the Medical Staff shall convene a meeting between the petitioners’ representatives and an equal number of members of the Medical Executive Committee as he/she shall select.

(c) The representatives of the Medical Executive Committee and the petitioners shall exchange information relevant to the conflict and shall work in good faith to resolve their differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee and the safety and quality of patient care at Hospital. Resolution of the conflict shall require a vote of the majority of the representatives of the Medical Executive Committee and a majority of the petitioners’ representatives.

(d) Differences which remain unresolved at the conclusion of this process shall be submitted to the Legacy Board for its consideration in making a final decision with respect to the bylaw, rule, regulation, policy, or issue. Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Legacy Board on a bylaw, rule, regulation, policy, or issue. The Legacy Board shall determine the method of communication.

ARTICLE 19
REVIEW, REVISION, ADOPTION AND AMENDMENT OF THE BYLAWS

19.A.1. Medical Staff Responsibility:

The Medical Staff shall have the responsibility to formulate, review periodically, adopt and recommend to the Legacy Board Medical Staff bylaws and amendments thereto, which shall be effective when approved by the Legacy Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner.

19.A.2. Methods of Adoption and Amendment:

(a) Amendments to these bylaws may be proposed by a standing committee of the Medical Staff upon submission of a petition signed by at least five percent (5%) of the members of the Medical Staff.

(b) All proposed amendments shall be reviewed and discussed by the Medical Executive Committee prior to submission to a vote of the Medical Staff.
(c) An amendment shall be recommended to the Legacy Board upon the affirmative vote of a majority of the Medical Staff who cast ballots; provided, however, changes in Article 9 may be made only by a majority vote of all the Active Staff.

(d) The Medical Executive Committee may recommend amendments to the Legacy Board without a vote of the Medical Staff as are, in the committee’s judgment, technical or legal modifications or clarifications; reorganization or renumbering; or amendments needed because of punctuation, spelling or other errors of grammar or expression. The Medical Executive Committee shall notify the Medical Staff when it recommends such an amendment.

(e) Amendments become effective upon approval by the Legacy Board.

(f) Neither the Medical Staff nor the Legacy Board may unilaterally amend these bylaws.


(a) The Medical Executive Committee shall recommend to the Legacy Board policies, rules, and regulations that further define the general policies contained in these bylaws. Amendments to such rules, regulations, and policies may be recommended to the Legacy Board by the Medical Executive Committee after a majority vote of the Medical Executive Committee and shall be approved by the Legacy Board prior to becoming effective.

(b) Notwithstanding the role of the Medical Executive Committee to review and recommend amendments to the Medical Staff rules, regulations, and policies, a member of the Active Staff may propose amendments to such rules, regulations, and policies, upon submission of a petition signed by at least five percent (5%) of the members of the Medical Staff. An amendment shall be recommended to the Legacy Board upon the affirmative vote of a majority of the Medical Staff who cast ballots.

(c) When the Medical Executive Committee proposes to adopt a Medical Staff rule, regulation, policy, or amendment thereto, it shall notify the Medical Staff of such proposal and shall allow fourteen (14) days for the Medical Staff to comment on the proposal. When the Medical Staff proposes to adopt a Medical Staff rule, regulation, policy, or amendment thereto, it shall notify the Medical Executive Committee of such proposal and shall allow fourteen (14) days for the Medical Executive Committee to comment on the proposal.

(d) The Medical Executive Committee shall notify the Medical Staff when it adopts a rule, regulation, policy, or amendment thereto.

(e) In the event it becomes necessary to amend a Medical Staff rule, regulation or policy in order to comply with any law or regulation, the Medical Executive Committee shall have the authority to provisionally adopt and the Legacy Board may provisionally approve such amendment as may be required to comply with the law without prior communication to the Medical Staff. In such circumstances, the Medical Executive Committee shall immediately notify the Medical Staff, providing the basis for such urgent amendment with the written notice. The Medical Staff shall have the opportunity to comment on the provisional amendment. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendment shall remain in effect. If there is conflict over the provisional amendment, the conflict management process set forth in Article 18 shall be implemented.

(f) Neither the Medical Staff nor the Legacy Board may unilaterally amend such rules, regulations and policies.
19.A.4. Joint Conference Amendment:

If the Legacy Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee, the Medical Executive Committee is entitled to a joint conference between the officers of the Legacy Board and the officers of the Medical Staff. Such joint conference shall be for the purpose of further communicating the Legacy Board’s rationale for its contemplated action and to permit the officers of the Medical Staff to fully articulate the rationale for the Medical Executive Committee’s recommendation. Such a joint conference shall be scheduled by the Legacy CEO within two weeks after receipt of a request for same submitted by the President of the Medical Staff.

The Legacy Board shall consider the rationales presented at the joint conference in reaching its decision.
ARTICLE 20
ADOPTION

These bylaws are adopted and made effective upon approval of the Legacy Board, superseding and replacing any and all other Medical Staff bylaws, rules, regulations or policies pertaining to the subject matter herein.

ADOPTED BY THE LEGACY BOARD AFTER RECEIPT OF A RECOMMENDATION FROM HOSPITAL’S MEDICAL EXECUTIVE COMMITTEE ON SEPTEMBER 16, 2010.

Adopted by the Medical Staff:
/s/Leslie Root, MD, PhD  Date: 9/13/10
President of the Legacy Emanuel Hospital & Health Center Medical Staff

Approved by the Legacy Health Board:
/s/ Jeffrey Fullman, MD  Date: 9/16/10

Revised by the Medical Staff:
/s/Leslie Root, MD, PhD  Date: 12/13/10
President of the Legacy Emanuel Hospital & Health Center Medical Staff

Revised by the Legacy Health Board:
/s/ Jeffrey Fullman, MD  Date: 12/16/10

Revised by the Medical Staff:
/s/Leslie Root, MD, PhD  Date: 3/25/11
President of the Legacy Emanuel Hospital & Health Center Medical Staff

Revised by the Legacy Health Board:
/s/ Jeffrey Fullman, MD  Date: 3/31/11

Revised by the Medical Staff:
/s/ Leslie Root, MD, PhD  Date: 10/24/11
President of the Legacy Emanuel Hospital & Health Center Medical Staff

Revised by the Legacy Health Board:
/s/ Jeffrey Fullman, MD  Date: 1/17/13

Revised by the Medical Staff:
/s/ Frederic J. Cole, Jr, MD  Date: 11/3/14
President of the Legacy Emanuel Hospital & Health Center Medical Staff

Revised by the Legacy Health Board:
/s/ Jeffrey Fullman, MD  Date: 12/18/14