MEDICAL STAFF
BYLAWS

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ARTICLE I – NAME .................................................................................................................................................... 3

ARTICLE II - MEMBERSHIP .......................................................................................................................................................................................... 4
  2.1 NATURE OF MEDICAL STAFF MEMBERSHIP ................................................................................................................................. 4
  2.2 REQUIREMENTS FOR QUALIFICATIONS OF MEMBERSHIP ........................................................................................................... 4
    2.2-1 GENERAL QUALIFICATIONS ........................................................................................................................................ 4
    2.2-2 WAIVER OF ACCREDITED RESIDENCY TRAINING PROGRAM AND/OR BOARD CERTIFICATION REQUIREMENTS: .... 5
  2.3 NONDISCRIMINATION .................................................................................................................................................. 6
  2.4 RESPONSIBILITIES AND REQUIREMENTS OF MEDICAL STAFF MEMBERS ................................................................. 6
  2.5 DUES ........................................................................................................................................................................ 7

ARTICLE III - CATEGORIES OF APPOINTMENT ................................................................................................................................. 7
  3.1 CATEGORIES ......................................................................................................................................................... 7
  3.2 ACTIVE STAFF ................................................................................................................................................... 7
    3.2-1 QUALIFICATIONS FOR ACTIVE STATUS ..................................................................................................................... 7
    3.2-2 PREROGATIVES OF ACTIVE STATUS ................................................................................................................... 8
    3.2-3 OBLIGATIONS OF ACTIVE STATUS .................................................................................................................... 8
  3.3 PROVISIONAL STAFF ................................................................................................................................................ 8
    3.3-1 QUALIFICATIONS FOR PROVISIONAL STATUS .............................................................................................................. 8
    3.3-2 PREROGATIVES OF PROVISIONAL STATUS .............................................................................................................. 9
    3.3-3 OBLIGATIONS OF PROVISIONAL STATUS: ................................................................................................................ 9
    3.3-4 OBSERVATION AND FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) OF PROVISIONAL STAFF MEMBERS .......................................................... 9
    3.3-5 TERM OF PROVISIONAL STAFF STATUS .................................................................................................................. 10
    3.3-6 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS ...................................................................................... 10
  3.4 COURTESY STAFF ............................................................................................................................................. 11
    3.4-1 QUALIFICATIONS FOR COURTESY STAFF ............................................................................................................. 11
    3.4-2 PREROGATIVES OF COURTESY STATUS .................................................................................................................. 11
  3.5 HONORARY AND RETIRED STAFF ............................................................................................................................ 13
  3.6 MODIFICATION OF MEMBERSHIP ............................................................................................................................ 13
  3.7 LIMITATION OF PREROGATIVES ............................................................................................................................ 13
  3.8 INDEPENDENT ALLIED HEALTH PROFESSIONALS ........................................................................................................ 13
    3.9-1 QUALIFICATIONS OF IAHP’S ........................................................................................................................................ 13
    3.9-2 PREROGATIVES OF IAHP’S ........................................................................................................................................... 14
    3.9-3 OBLIGATIONS OF IAHP’S ............................................................................................................................................ 14
    3.9-4 APPLICATION FOR APPOINTMENT, CLINICAL PRIVILEGES, AND REAPPOINTMENT AS IAHP .................................................................................. 15
    3.9-5 CORRECTIVE ACTION AND HEARING PROCESS FOR IAHP’S ............................................................................................. 15
  3.10 DEPENDENT ALLIED HEALTH PROFESSIONALS ...................................................................................................... 15
    3.10-1 GENERAL .................................................................................................................................................. 15
    3.10-2 QUALIFICATIONS OF DAHP’S ........................................................................................................................................ 15
    3.10-3 PREROGATIVES OF DAHP’S ....................................................................................................................................... 16
    3.10-4 APPLICATION .................................................................................................................................................. 16
    3.10-5 EMPLOYER RESPONSIBILITY ........................................................................................................................................... 16
ARTICLE VII - HEARINGS

7.1 INITIATION OF HEARING
7.2 HEARING PREREQUISITES
7.3 HEARING PROCEDURE
7.4 HEARING OFFICER OR COMMITTEE REPORT AND FURTHER ACTION
7.5 ADVERSE ACTION REPORT

ARTICLE VIII - OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF
8.2 DUTIES OF OFFICERS

ARTICLE IX - CLINICAL SERVICES
ARTICLE X - COMMITTEES ................................................................................................................................................... 46

10.1 DESIGNATION ............................................................................................................................................................ 46
10.2 GENERAL PROVISIONS ................................................................................................................................................... 47
10.2-1 TERMS OF COMMITTEE MEMBERS .......................................................................................................................... 47
10.2-2 REMOVAL ................................................................................................................................................................. 47
10.2-3 VACANCIES ............................................................................................................................................................... 47
10.2-4 CONTINUATION OF COMMITTEE TERMS .................................................................................................................. 47
10.3 MEDICAL EXECUTIVE COMMITTEE .............................................................................................................................. 47
10.3-1 COMPOSITION .......................................................................................................................................................... 47
10.3-2 DUTIES ................................................................................................................................................................. 48
10.3-3 MEETINGS ............................................................................................................................................................... 49
10.4 CREDENTIALS COMMITTEE ........................................................................................................................................... 49
10.4-1 COMPOSITION .......................................................................................................................................................... 49
10.4-2 DUTIES ................................................................................................................................................................. 49
10.4-3 MEETINGS ............................................................................................................................................................... 50
10.6 CONTINUOUS QUALITY IMPROVEMENT COMMITTEE ................................................................................................. 50
10.6-1 COMPOSITION .......................................................................................................................................................... 50
10.6-2 DUTIES ................................................................................................................................................................. 50
10.6-3 MEETINGS ............................................................................................................................................................... 50
10.7 BYLAWS COMMITTEE .................................................................................................................................................... 51
10.7-1 COMPOSITION .......................................................................................................................................................... 51
10.7-2 DUTIES ................................................................................................................................................................. 51
10.7-3 MEETINGS ............................................................................................................................................................... 51
10.8 INFECTION CONTROL COMMITTEE ............................................................................................................................ 51
10.8-1 COMPOSITION .......................................................................................................................................................... 51
10.8-2 DUTIES ................................................................................................................................................................. 51
10.8-3 MEETINGS ............................................................................................................................................................... 52
10.9 CONTINUING EDUCATION COMMITTEE .................................................................................................................. 52

ARTICLE XI - MEETINGS ......................................................................................................................................................... 52

11.1 MEETINGS OF THE MEDICAL STAFF .......................................................................................................................... 52
11.1-1 SCHEDULE OF MEETINGS ....................................................................................................................................... 52
11.1-2 AGENDA ....................................................................................................................................................................... 52
11.1-3 SPECIAL MEETINGS .................................................................................................................................................... 53
11.2 COMMITTEE AND SERVICE MEETINGS .......................................................................................................................... 53
11.2-1 REGULAR MEETINGS ................................................................................................................................................... 53
11.2-2 SPECIAL MEETINGS .................................................................................................................................................... 53
11.3 QUORUM ........................................................................................................................................................................ 53
11.3-1 STAFF MEETINGS ........................................................................................................................................................... 53
11.3-2 COMMITTEE MEETINGS ........................................................................................................................................... 53
11.4 MANNER OF ACTION ........................................................................................................................................................... 53
11.5 MINUTES ........................................................................................................................................................................ 54
11.6 ATTENDANCE REQUIREMENTS ...................................................................................................................................... 54
11.6-1 REGULAR ATTENDANCE ........................................................................................................................................... 54
11.6-2 SPECIAL ATTENDANCE ............................................................................................................................................... 54
11.7 CONDUCT OF MEETINGS ................................................................................................................................................ 54

ARTICLE XII - CONFIDENTIALITY, IMMUNITY AND RELEASES .......................................................................................... 54

12.1 AUTHORIZATION AND CONDITIONS .......................................................................................................................... 54
12.2 CONFIDENTIALITY OF INFORMATION ........................................................................................................................... 55
12.3 IMMUNITY FROM LIABILITY ........................................................................................................................................... 55
DEFINITIONS AND USAGE

1. Legacy Silverton Health means Legacy Silverton Health dba Legacy Silverton Medical Center and its affiliated clinics.

2. LEGACY SILVERTON HEALTH BOARD or GOVERNING BOARD means the Board of Directors of Legacy Silverton Health. Each recommendation by the Medical Executive Committee made under these Bylaws shall be submitted to the Legacy Silverton Health Board. The Legacy Silverton Health Board shall review the recommendation and determine whether to accept, modify, or reject the recommendation of the MEC. Notwithstanding anything to the contrary in these Medical Staff Bylaws, the Legacy Silverton Health Board shall then submit its privileging and credentialing recommendations to the Legacy Health Medical Quality and Credentialing Committee for consent. In the event the Legacy Health Board does not consent to a recommendation of the Legacy Silverton Health Board, the Legacy Health Medical Quality and Credentialing Committee shall refer the recommendation along with the reasons for referral, back to the Legacy Silverton Health Board for further consideration and action. If necessary, the Legacy Health Medical Quality and Credentialing Committee and the Legacy Silverton Health Board shall engage in a collaborative discussion to resolve any differences. In no event shall the Legacy Health Medical Quality and Credentialing Committee take action unless such action is recommended by the Legacy Silverton Health Board.

3. MEDICAL STAFF means the formal organization through which all physicians who have been granted membership on the medical staff of Legacy Silverton Health carry out the functions of the medical staff.

4. PHYSICIAN means an individual with an M.D. or D.O. degree who is licensed to practice medicine in the state of Oregon, pursuant to ORS Chapter 677.

5. DENTIST means an individual with a DDS or DMD degree who is licensed to practice dentistry in the state of Oregon.

6. SPECIAL NOTICE means written notification by certified or registered mail, return receipt requested, dated the day of mailing and addressed to the affected provider at either the office or home address stated on their most recent application for staff appointment or such other address as contained in the hospital files relating to that person, or personal hand delivered written notification to the affected provider dated the day of delivery. Special notice shall be deemed to have been given as of the date appearing on the face of the notice.

7. MEDICAL EXECUTIVE COMMITTEE (MEC) means a group of active members of the medical staff chosen to represent and coordinate all activities and policies of the medical staff.
8. MEDICAL STAFF YEAR means the twelve month period commencing on January 1 of each year and ending on December 31.

9. PROVIDERS means, unless otherwise expressly defined, any appropriately licensed medical professionals permitted by law and by Legacy Silverton Health to provide patient care services, and who have applied for, or are exercising, clinical privileges that allow them to provide patient care services independently.

10. ADMINISTRATOR means the chief executive officer of Legacy Health.

11. GOOD STANDING means the medical staff member is in compliance with the requirements and responsibilities of medical staff membership.

12. EX OFFICIO means a person who serves as a member of a body or committee by reason of holding another office or position. An ex officio member of a body or committee shall not vote on matters before the body or committee.

13. NURSE PRACTITIONER means an advanced practice registered nurse who is certified by the state of Oregon as a nurse practitioner.

14. CERTIFIED NURSE MIDWIFE means a nurse midwife certified by the state of Oregon as a certified nurse midwife.

15. CERTIFIED NURSE ANESTHETIST means an advanced practice registered nurse who is certified by the state of Oregon as a certified nurse anesthetist.

16. ALLIED HEALTH PROFESSIONAL (AHP)
   There are two classes of Allied Health Professionals (AHPs) eligible for practice at Hospital:

   (a) Independent AHP
   (b) Dependent AHP

INDEPENDENT ALLIED HEALTH PROFESSIONAL (IAHP) means a licensed individual other than a licensed physician who is permitted by law and by Legacy Silverton Health to provide patient care services independently with an appropriate level of supervision by or in coordination with a physician member of the medical staff.

DEPENDENT ALLIED HEALTH PROFESSIONAL (DAHP) means a health care professional who is an employee of a physician member of the medical staff or who is employed by or contracted to Legacy Silverton Health and performs a portion of his or her professional responsibilities within the hospital. DAHP's must remain under the control and general supervision of physician members of the medical staff to insure adequate overall patient protection. DAHPs currently include but are not limited to Physician Assistants and Registered Nurse First Assistants.
AHP's are not members of the medical staff and accordingly have none of the prerogatives of medical staff members.
ARTICLE I – NAME ~ The name of this organization is the Medical Staff of Legacy Silverton Health.

ARTICLE II - MEMBERSHIP

2.1 NATURE OF MEDICAL STAFF MEMBERSHIP
Membership on the medical staff of Legacy Silverton Health is a privilege extended to certain providers for specified intervals of time and is not a right of any provider. Every provider who seeks or enjoys staff appointment must continuously meet and demonstrate to the satisfaction of the medical staff and the governing body the qualifications, standards and requirements set forth in these bylaws, and applicable Oregon State Law. (Board approved 5/27/15)

2.2 REQUIREMENTS FOR QUALIFICATIONS OF MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS
Applicants for membership on the medical staff shall:
(a) Be currently licensed by the State of Oregon in the Member’s area of expertise for privileges applied for or granted;
(b) Document the provider's background, experience and training and possess demonstrated competence, including current knowledge, judgment and technique in the provider’s specialty area and for all privileges applied for or granted;
(c) Be free of or have under adequate control any significant physical or mental behavioral impairment that interferes with or presents substantial probability of interfering with patient care, the exercise of privileges, the assumption and discharge of responsibilities or cooperative working relationships; and
(d) Physicians (MD, DO or DPM) must be a graduate of an approved medical, osteopathic or podiatric school;
(e) For Nurse Practitioners, appropriate graduate nursing education in a nationally accredited graduate nursing program to the expanded specialty in which privileges are being requested
(f) For Nurse Midwives, a midwifery training program accredited by the American College of Nurse-Midwives-Division of Accreditation
(g) For Nurse Anesthetists, graduation from an accredited Nurse Anesthesia program accredited by the AANA Council on Accreditation of Nurse Anesthesia Educational Program
(h) Physicians (MD, DO or DPM) must have completed a residency program in his/her specialty as approved by the Accreditation Council for Graduate Medical Education (ACGME), or be Board certified by Medical Specialty Board as approved by the American Board of Medical Specialists(ABMS), or have graduated from medical school before 1977;
(1) After January 1, 2010, newly appointed Physicians (MD, DO, or DPM) granted privileges and/or membership must be Board Certified or Board Eligible in the specialty in which they are privileged;
   a. If not Board Certified upon granting of privileges and/or membership, Physicians (MD, DO, or DPM) will obtain and present documented verification of completion of Board certification within five (5) years of initial appointment regardless of when residency was completed. Failure to
b. Physicians (MD, DO, or DPM) shall maintain Board certification to be eligible for continued membership and/or continuation of privileges. Should recertification not be attained, the Physician shall have two years from loss of certification to re-attain board Certification or membership and/or privileges shall be automatically lost.

c. Nurse Practitioners, including Nurse Midwives, board certification in the appropriate specialty is required within five (5) years of completing specialty training.

d. Nurse Anesthetist, board certification by the National Board Certification & Re-certification of Nurse Anesthetists is required.

e. Allied Health Professionals, whether Independent or Dependent, must be nationally certified by their respective organization.

(1) After April 5, 2013, newly appointed AHP’s granted privileges must be nationally certified or qualified.

a. If not nationally certified upon granting of privileges, AHP’s will obtain and present documented verification or completion of national certification within one year of initial appointment regardless of when they completed their training. Failure to complete this requirement shall result in automatic loss of privileges.

b. AHP’s shall maintain national certification to be eligible for continuation of privileges. Should recertification not be attained, the AHP shall have one year from loss of certification to re-attain national certification or privileges shall be automatically lost.

c. Physicians (MD, DO or DPM) who are in their final year of residency training in a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME) may be considered for temporary privileges under section 5.4 or the Medical Staff bylaws as a Locum Tenens or a Temporary Emergency Department Physician;

(d) Follow the requirements of Article IV of these Bylaws for Appointment and Reappointment to the Medical Staff.

2.2-2 WAIVER OF ACCREDITED RESIDENCY TRAINING PROGRAM AND/OR BOARD CERTIFICATION REQUIREMENTS:

Section 2.2-1 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.

2.3 NONDISCRIMINATION ~ Medical staff membership or particular clinical privileges shall not be denied on the basis of sex, race, creed, color, national origin, age, or solely because of the school of medicine to which the provider belongs. The basis for denial may include any other criteria related to the delivery of quality patient care in the hospital, professional qualification, community need, and/or for the hospital's purposes, need and/or capabilities.

2.4 RESPONSIBILITIES AND REQUIREMENTS OF MEDICAL STAFF MEMBERSHIP
Acceptance of staff membership, including temporary privileges, shall constitute the staff member's agreement to:

(a) abide by the ethics of the provider’s profession, avoid acts or omissions constituting unprofessional conduct, and comply with federal and state laws and regulations;
(b) provide patients with care at the generally recognized professional level of quality and efficiency;
(c) abide by the medical staff bylaws and medical staff rules and regulations and other established standards, policies, and rules of the hospital when approved by the medical staff including, but not limited to, the Provider Code of Conduct.
(d) accept and appropriately discharge such medical staff committee and Legacy Silverton Health assignments and obligations for which the provider is responsible by appointment, election or otherwise, including peer review, quality assurance review, and service on hearing panels;
(e) prepare and complete medical records in a timely and legible fashion for all patients in whose care the provider is involved and in accordance with the Legacy Silverton Health Medical Staff Rules and Regulations.
(f) make prior arrangements with another appropriate provider to provide appropriate professional care for any patient in the hospital or clinic, or patient who may be admitted to the hospital for whom the provider is the attending physician when the provider is otherwise unable to attend the provider’s patients;
(g) notify the Medical Staff Office promptly of these conditions: any change in licensure, professional liability insurance coverage, and any restriction, denial or surrender of the provider’s hospital privileges or membership elsewhere; any professional liability claim, criminal charge, or any drug or alcohol charge; any revocation, suspension or voluntary relinquishment of the provider’s DEA number; any adverse determination by the Oregon Medical Professional Review Organization, the commencement of a formal investigation, or the filing of charges by any federal or state agency against the provider, unless such information is exempt from disclosure by law;
(h) work cooperatively with medical staff members, nurses, hospital administration, and others so as not to adversely affect patient care or disrupt the operation of the hospital;
(i) continuously maintain and provide written evidence to the Medical Staff Office of professional liability insurance specific to privileges requested with minimum limits of
at least $1 million per occurrence and $3 million in the aggregate. Applicants to the Medical Staff shall furnish evidence of insurance coverage with the application for membership, at reappointment, and whenever there is a change, renewal, or expiration of the most recently submitted insurance face sheet. Providers shall notify the Medical Staff Office in writing of termination or change of insurance coverage within one week of receiving notice of such termination or change;

(j) exhaust available procedures and remedies provided in these bylaws and statutes and rules before resorting to judicial action;

(k) provide a health care service which is consistent with the purposes, philosophy, methods, resources and capabilities of Legacy Silverton Health, and for which Legacy Silverton Health has a current need;

(l) appear as required for any committee meetings or hearings that involve the provider's clinical work.

2.5 DUES ~ In February of each year, all medical staff providers shall be billed for annual dues as determined by the Medical Staff. If no payment is received within 30 days, a reminder notice will be sent. If payment is not received within 60 days, the Member will be notified by the Medical Staff Treasurer and reminded that their privileges are at risk for suspension pending payment of dues.

ARTICLE III - CATEGORIES OF APPOINTMENT

3.1 CATEGORIES ~ The categories of the medical staff shall include the following: active, courtesy, affiliate and honorary. At the time of appointment, the member's staff category shall be determined.

3.2 ACTIVE STAFF

3.2-1 QUALIFICATIONS FOR ACTIVE STATUS ~ The active staff shall consist of physicians (MD or DO) who:

(a) meet the General Qualifications for membership set forth in Section 2.2;

(b) regularly admit patients to or otherwise are involved in the care of patients in the hospital’s facilities; or demonstrate by way of other substantial involvement in the activities of the medical staff or hospital a genuine concern and interest in medical staff and hospital functions;

(c) must have an office within a 20 mile radius of Legacy Silverton Medical Center in order to provide timely and appropriate continuity of patient care;

(d) except for good cause, as determined by the Medical Executive Committee, have completed at least one year of satisfactory performance on the provisional staff; and

(e) perform a sufficient number of procedures, or manage a sufficient number of cases, or have sufficient patient care contact to permit the Credentials Committee to assess the member's current competency and quality for all privileges. The 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 the hospital.

3.2-2 PREROGATIVES OF ACTIVE STATUS ~ Except as otherwise provided, the prerogatives of an active medical staff member shall be to:

(a) admit patients and exercise such clinical privileges as are granted pursuant to Article V;
(b) attend and vote on matters presented at general and special meetings of the medical staff and of the service and committees of which the provider is a member; and
(c) hold Medical Staff office and serve as a voting member of committees to which the provider is duly appointed or elected by the medical staff or duly authorized representative thereof.

3.2-3 OBLIGATIONS OF ACTIVE STATUS ~ An active staff member must:

(a) serve on appropriate medical staff committees;
(b) reasonably participate as requested in the quality review, risk management, and utilization management activities as may be required of the medical staff;
(c) satisfy the meeting attendance and special appearance requirements as found in these bylaws;
(d) upon request, serve in a rotational manner on the emergency room "call list" and other call lists as determined by the Medical Executive Committee. When on call, the active staff member must be available in a timely manner to evaluate a patient and provide necessary treatment. Physicians who live further than 20 miles from the hospital and have on-call responsibilities must provide a written plan, acceptable to the Medical Executive Committee, for the care of patients who require urgent evaluation and management at the hospital.

Active staff in specialties with fewer than three (3) physicians will be required to take emergency department call a minimum of seven (7) days per month.
(e) perform proctoring as required by the chairman of the services in which the provider has privileges and as delineated in Section 3.3-4 (b).
(f) pay medical staff dues.

3.3 PROVISIONAL STAFF

3.3-1 QUALIFICATIONS FOR PROVISIONAL STATUS ~ The provisional staff shall consist of members who:

(a) meet the general qualifications for membership as set forth in Section 2.2;
(b) are applying for active or courtesy staff;
(c) perform a sufficient number of procedures, or manage a sufficient number of cases, or have sufficient patient care contact to permit the Credentials Committee to assess the member's current competency and quality for all privileges.
3.3-2 PREROGATIVES OF PROVISIONAL STATUS ~ A provisional staff member may:

(a) admit patients and/or exercise such clinical privileges as are granted pursuant to Article V; and
(b) attend meetings of the medical staff and the service of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

Provisional staff members are not eligible to hold office in the medical staff organization, but may serve on committees.

3.3-3 OBLIGATIONS OF PROVISIONAL STATUS ~ A provisional staff member must:

(a) serve on appropriate medical staff committees as appointed;
(b) participate as requested in the quality review, risk management and utilization management activities as may be required of the medical staff;
(c) satisfy the special appearance requirements as found in these bylaws;
(d) upon request, serve in a rotational manner on the emergency room "call list" and other call lists as determined by the Medical Executive Committee. When on call, the provisional staff member must be available in a timely manner to examine a patient to determine whether the patient has an emergency medical condition or provide treatment, within the capabilities of the hospital, necessary to stabilize a patient who has an emergency medical condition;
(e) arrange appropriate proctoring of requested privileges as required by the Medical Executive Committee.
(f) pay medical staff dues.

3.3-4 OBSERVATION AND FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) OF PROVISIONAL STAFF MEMBERS

(a) Monitoring:
(1) During the term of provisional appointment, the person receiving the provisional privileges shall be monitored by the chief of the service in which provider has clinical privileges, and by the Peer Review Committees as to provider’s clinical competence, general behavior, and conduct. Monitoring shall include all aspects of medical care.

Surgeries and deliveries will be directly and concurrently proctored by a member of the active medical staff as assigned by the chief of the appropriate service.

The Chief of Service shall design a proctoring/FPPE program that reflects the education and experience of the applicant. The proctoring/FPPE program will be reviewed by the appropriate Peer Review Committee and will become part of the recommendation for provisional appointment. Monitoring of other aspects of medical care will be performed by the Credentials Committee and the MEC. The Peer Review Committee shall review the performance of the provisional staff member during the proctoring/FPPE programs.
and may, at its discretion, require extended proctoring of some or all of the admissions, surgeries, deliveries, and medical care provided by a member of the provisional staff. The MEC may, at its discretion, require proctoring of some or all of the admissions and medical care provided by a member of the provisional staff.

It is the responsibility of the provisional staff member to obtain a proctor prior to performing deliveries, surgeries, or, if required, for other admissions. No more than 60% of the applicant’s cases shall be proctored by their associate(s) or partner(s), unless previously approved by the MEC. Provisional clinical privileges shall be adjusted to reflect clinical competence at the end of the provisional period or sooner if warranted.

(2) Independent Allied Health Professionals who have successfully completed their provisional period may serve as proctors for other Independent Allied Health Professional with like privileges. Independent Allied Health Professionals may not proctor physicians. In the case of Certified Nurse Midwives, 60% of the applicant’s cases shall be proctored by a physician member of the active medical staff.

(b) Principles That Govern the Proctor:
The following principles shall govern the conduct of the proctor who monitors a staff member with provisional privileges:

(1) Their only responsibility shall be to Legacy Silverton Health and Legacy Health administration and the Medical Staff. Their duty is to observe and report. They shall not be compensated monetarily by the patient. They shall have no special relationship with the patient that could give rise to an obligation or duty on their part to assist or protect the patient. The proctor may, however, call in consultants, intervene, or solicit others to intervene in the conduct of a case when, in their judgment, it is necessary in the best interest of patient care.

(2) In selected cases, the proctor may wish to assist the provisional staff member in an operation or procedure. In this instance, the proctor may be compensated in the usual fashion. The patient shall be notified of the arrangement for the proctor’s participation. The proctor’s duties and responsibilities to the patient shall be limited to those ordinarily devolving upon a surgical assistant in like cases. The proctor may, however, call in consultants, intervene, or solicit others to intervene in the conduct of a case when, in their judgment, it is necessary in the best interest of patient care.

3.3-5 TERM OF PROVISIONAL STAFF STATUS ~ A member shall remain on the provisional staff for a period of one year, unless that status is extended by the MEC for an additional period of up to two (2) years.

3.3-6 ACTION AT CONCLUSION OF PROVISIONAL STAFF STATUS

(a) If the provisional staff member has satisfactorily demonstrated their ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued medical staff membership, the member shall be eligible for placement in the active, courtesy or IAHP staff, as appropriate, upon recommendation of the Credentials
Committee and the Medical Executive Committee; this recommendation will be forwarded to the Governing Board.

(b) In all other cases, the Credentials Committee shall make its report to the MEC which, in turn, shall make its recommendation to the Governing Board regarding continued provisional status, modification or termination of clinical privileges or termination of medical staff membership. In the case of continued provisional status beyond three (3) years, modification or termination of clinical privileges, or termination of medical staff membership, the member is entitled to the hearing rights of Article VII.

3.4 COURTESY STAFF

3.4-1 QUALIFICATIONS FOR COURTESY STAFF ~ The courtesy medical staff shall consist of members who:

(a) meet the General Qualifications as set forth in Section 2.2; and
(b) do not regularly care for patients at Legacy Silverton Medical Center or are not regularly involved in medical staff functions as determined by the medical staff; and
(c) are members in good standing of the active or provisional medical staff of another Oregon-licensed hospital, with the exception of Teleradiologists who must be members in good standing of the active or provisional medical staff of another hospital within the United States; and
(d) perform a sufficient number of procedures, or manage a sufficient number of cases, or have sufficient patient care contact to permit the appropriate Medical Staff Committee to assess the member's current competency and quality for all privileges; and
(e) possess adequate clinical and professional expertise; and
(f) May admit patients; and
(g) If the courtesy physician does not reside and have an office within 20 miles, then the courtesy physician must co-admit with a member of the active medical staff in order to provide timely and appropriate continuity of patient care in the event that the courtesy physician is not readily available. The co-admitting physician will be written in the admitting orders.

3.4-2 PREROGATIVES OF COURTESY STATUS ~ A courtesy staff member may:

(a) admit patients to the hospital with the limitations of Section 3.4-1 (b), and exercise such clinical privileges as are granted pursuant to Article V; and
(b) attend meetings of the medical staff and the service of which the provider is a member; including open committee meetings and educational programs, but shall have no right to vote at such meetings.
(c) will pay medical staff dues.
(d) upon request, may serve in a rotational manner on the emergency room "call list" and other call lists as determined by the Medical Executive Committee. When on call, the courtesy staff member must be available in a timely manner to examine a patient to determine whether the patient has an emergency medical condition or provide treatment, within the capabilities of the hospital, necessary to stabilize a patient who has an emergency medical condition;
Courtesy medical staff members shall be eligible to hold office in the medical staff organization, and may also be appointed to serve on committees.

3.4-3 LIMITATIONS OF COURTESY STATUS ~ Courtesy staff members who admit or regularly care for 15 patients, in a 12-month period, at the hospital may upon review of the credentials committee or medical executive committee, be obligated to seek appointment to the active medical staff category.

3.5 AFFILIATE STAFF

3.5-1 GENERAL QUALIFICATIONS ~ The Affiliate Staff shall consist of members who:

(a) meet the General Qualification as set forth in Section 2.2; and
(b) will not be granted hospital privileges and may not practice, admit patients, perform consults, exercise clinical privileges or write orders at Hospital.

(c) refer patients to members of the Active Staff
(d) order diagnostic or therapeutic services at Hospital
(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 peer review

may include, but is not limited to, physicians and nurse providers who provide patient care in a facility or clinic that is directly administered by the Hospital; and

3.5-2 PREROGATIVES OF THE AFFILIATE MEDICAL STAFF ~ An affiliate staff member may:

(a) attend continuing education conferences; and
(b) attend the Medical Staff meeting; and
(c) attend Committee and Service meetings; and
(d) serve on hospital medical staff committees, hold office or have the right to vote; or
(e) visit their patients in the hospital, but may not write orders on the chart;
(f) serve on outpatient medical staff committees; and
(g) will pay medical staff dues.

3.5-3 OBLIGATIONS OF AFFILIATE STATUS ~ An Affiliate staff member

(a) may participate in the emergency room “call list” to see patients discharged from the hospital or ED that require outpatient follow-up; and
(b) do not need to participate in the proctoring or provisional status requirements. (Board approved 4/28/2004)
(c) 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.

### 3.6 HONORARY AND RETIRED STAFF

The honorary medical staff shall consist of providers who have retired from active practice at Legacy Silverton Health or who are of outstanding reputation, not necessarily residing in the community.

Honorary staff members may attend staff and service meetings, open committee meetings, and educational programs. They may not admit patients, exercise clinical privileges in the hospital, or vote or hold office in the medical staff organization. They may serve on committees, with or without vote at the discretion of the Medical Executive Committee. Honorary staff members do not have to pay dues.

### 3.7 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a member under Section 4.5-1 (f), the MEC may recommend a change in the medical staff category of a member consistent with the requirements of the bylaws.

### 3.8 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitations by special conditions attached to a particular membership by other sections of these bylaws and by the medical staff rules and regulations.

### 3.9 INDEPENDENT ALLIED HEALTH PROFESSIONALS

Independent Allied Health Professionals (IAHP) will consist of providers other than physician medical staff members who are permitted by the Governing Board to provide certain patient care services independently. Persons in this category must, depending on their licensure and approved privileges, either remain under the control and general supervision of, or work in coordination with, specified physician members of the medical staff to ensure overall patient care and management.

#### 3.9-1 QUALIFICATIONS OF IAHP’S

Each IAHP must meet the requirements of applicable state law, these medical staff bylaws, the medical staff Rules and Regulations, and satisfy the basic qualifications required for medical staff membership including, without limitation:

1. be currently licensed by the State of Oregon to practice the IAHP's profession;
2. document the IAHP's background, experience, and training, and possess documented competence, including current knowledge, judgment, and technique in and for all privileges applied for or held;
3. be free of or have under adequate control any significant physical or mental or
behavioral impairment that interferes with or presents substantial probability of interfering with patient care, the exercise of privileges, the assumption and discharge of responsibilities, or cooperative working relationships;
(d) be a graduate of a school approved by the IAHP's licensing board;
(e) continuously maintain and provide written evidence to the Medical Staff Office of professional liability insurance with minimum limits of at least $1 million per occurrence and $3 million in the aggregate. Applicants to the Medical Staff shall furnish evidence of insurance coverage with the application for membership, at reappointment, and whenever there is a change, renewal, or expiration of the most recently submitted insurance face sheet. Providers shall notify the Medical Staff Office in writing of termination or change of insurance coverage within one week of receiving notice of such termination or;

The Governing Board may, in consultation with the medical staff, establish additional qualifications required of members of any category of IAHP.

3.9-2 PREROGATIVES OF IAHP'S
(a) may provide patient care services within the limits of their professional skills, abilities, and licensure. The degree of participation of IAHP's in patient care shall be determined according to protocol or privileges recommended to and/or approved by the Governing Board;
(b) may attend open meetings of the medical staff, open meetings of the service of which that person may be a member, open committee meetings, and educational programs, and shall have the right to vote at such meetings.
(c) may, as a condition of continued privileges, be required to attend meetings involving the clinical review of patient care in which they participated, and be subject to the provisions of section II.6-2, Special Attendance.

3.9-3 OBLIGATIONS OF IAHP'S
(a) Exercise independent judgment in their areas of competence provided that a member of the active medical staff shall have the ultimate responsibility for the patient's general medical care;
(b) IAHPs may not independently admit or discharge patients, but may be granted privileges to co-admit with a physician member of the medical staff according to protocol or privileges approved by the Governing Board;
(c) Participate directly in the management and care of patients and depending upon licensure, protocol, or approved privileges, either coordinate with or act under the general supervision or direction of a member of the medical staff;
(d) Record reports and progress notes on the patient record and orders for treatment to the extent established in the rules and regulations of the medical staff, provided that such orders are within the scope of privileges granted, licensure or other credentials;
(e) Be subject to a period of provisional status as generally set forth in Article 3.3, and be subject to proctoring as set forth in Article 3.3-4;
(f) Be subject to the responsibilities generally set forth in Article 2.4; and
(g) Pay staff dues as required in Article 2.5.
3.9-4 APPLICATION FOR APPOINTMENT, CLINICAL PRIVILEGES, AND REAPPOINTMENT AS IAHP

(a) Application for appointment, clinical privileges, and reappointment as an IAHP shall be generally processed in accordance with the procedures set forth in the medical staff bylaws for appointment, delineation of privileges, and reappointment as set forth in Article IV and V.
(b) All IAHP's, irrespective of employment relationship, shall be credentialed under these bylaws.

3.9-5 CORRECTIVE ACTION AND HEARING PROCESS FOR IAHP'S ~ Corrective action and the appeals process for a hearing for IAHP's shall be generally processed in accordance with the procedures set forth in the medical staff bylaws, Articles VI and VII.

3.10 DEPENDENT ALLIED HEALTH PROFESSIONALS

3.10-1 GENERAL ~ Dependent Allied Health Professionals (DAHP) are not members of the medical staff and accordingly have none of the privileges of staff members. Persons in this group must remain under the control and general supervision of physician members of the medical staff to insure adequate overall patient care and management. DAHP's shall consist of employees of a physician with medical staff privileges or individuals employed by or contracted to Legacy Silverton Health. They include, but are not limited to, registered physician assistants and surgical assistants.

3.10-2 QUALIFICATIONS OF DAHP'S ~ Each DAHP must meet the requirement of applicable state law, these medical staff bylaws, the medical staff Rules and Regulations, and satisfy the basic qualifications required for medical staff membership including, without limitation:

(a) be currently licensed by the State of Oregon to practice the DAHP's profession if applicable;
(b) document the DAHP's background, experience, and training, and possess documented competence, including current knowledge, judgment, and technique in and for all privileges applied for or held;
(c) be free of or have under adequate control any significant physical or mental or behavioral impairment that interferes with or presents substantial probability of interfering with patient care, the exercise of privileges, the assumption and discharge of responsibilities, or cooperative working relationships;
(d) be a graduate of a school approved by the DAHP's licensing board;
(e) maintain professional liability insurance in such amounts as may be required by the Governing Board.

The Governing Board may, in consultation with the medical staff, establish additional qualifications required of members of any category of DAHP.
3.10-3 PREROGATIVES OF DAHP’S

(a) DAHP’s may provide patient care services within the limits of their professional skills, abilities, and licensure. The degree of participation of DAHP’s in patient care shall be determined according to protocol or privileges recommended by the MEC and approved by the Governing Board;

(b) DAHP’s may attend open meetings of the medical staff, open meetings of the service of which that person may be a member, open committee meetings, and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

(c) DAHP’s may, as a condition of continued privileges, be required to attend meetings involving the clinical review of patient care in which they participated, and be subject to the provisions of section 11.6-2, Special Attendance.

3.10-4 APPLICATION ~ The Dependent Allied Health Practitioner shall apply for privileges. The employer shall present a written statement of the clinical duties and responsibilities of said individual to the credentials committee for its approval. Application for privilege to use a DAHP shall be generally processed in accordance with the procedures set forth in these bylaws for delineation of privileges. The application must be approved prior to utilizing said individual within the hospital. The employer shall complete and deliver such forms as may be requested by the Credentials Committee.

3.10-5 EMPLOYER RESPONSIBILITY ~ The employer of the DAHP shall assume full responsibility and be fully accountable for the conduct of said individual. It is the full responsibility of the employer of the DAHP to acquaint such individual with the appropriate rules and regulations of the medical staff and Legacy Silverton Health as well as the appropriate members of the medical staff and Legacy Silverton Health personnel with whom said individual shall have contact at Legacy Silverton Medical Center or any of the Legacy Silverton Health affiliated clinics.

3.10-6 EMPLOYMENT TERMINATION ~ The clinical duties and responsibilities of a DAHP within Legacy Silverton Health shall terminate if the medical staff appointment of the employing physician or the employment and/or the contract with Legacy Silverton Health is terminated for any reason, or if the employer's clinical privileges are curtailed to the extent that the professional services of said individual within Legacy Silverton Health are no longer necessary or permissible to assist the employer.

3.10-7 REMOVAL PROCEDURES ~ Legacy Silverton Health retains the right either through the administrator or upon recommendation of the Credentials Committee to suspend or terminate any or all of the privileges, prerogatives, or functions of any category of DAHP without recourse on the part of such person or others to the hearing procedures of these bylaws.

When a DAHP is to be terminated or any prerogatives curtailed, the employer and the individual shall be notified in writing by the administrator of the reasons for such action and be awarded an opportunity for review by the Credentials Committee. The Credentials Committee, which shall be composed of members not in direct economic competition with
the provider, can recommend accepting, rejecting, or modifying the decision to curtail or terminate subject to review and final decision by the Governing Board.

3.11  TELEMEDICINE STAFF

3.11-1 QUALIFICATIONS FOR TELEMEDICINE STAFF ~ The telemedicine medical staff shall consist of a provider who:

(a) has contracted with or is an employee or principal of an entity that has a contractual relationship with or has otherwise been engaged by Legacy Silverton Health to provide medical services and/or to provide medico-administrative services for Legacy Silverton Health;
(b) provides diagnostic or treatment services from the distant site to Legacy Silverton Health patients at the originating site via telemedicine devices. Telemedicine devices include interactive audio, video, imaging, or data communications (other than telephone or electronic mail communications) between physicians regarding patients;
(c) meets the General Qualifications as set forth in Section 2.2. Legacy Silverton Health Governing Board may choose to rely on the credentialing and privileging decisions made by a distant site hospital when granting privileges to telemedicine providers, if there is a written agreement that complies with all specific requirements; (Board approved 5/27/15) and
(d) is a member in good standing at the distant site hospital or entity which is Joint Commission accredited, and participates in the Medicare program. (Board approved 5/27/15) ; and
(e) performs a sufficient number of services, or has cases for Legacy Silverton Health and/or other facilities, to permit the appropriate Medical Staff Service Committee to assess the member's current competency and quality for privileges granted.

3.11-2 PREROGATIVES OF TELEMEDICINE STATUS ~ The telemedicine staff members:

(a) may render tele-medicine medical services to patients at Legacy Silverton Health in accordance with the agreement or other arrangement with Legacy Silverton Health and hospital or clinic-based provider group having clinical privileges within Legacy Silverton Health;
(b) may exercise only those Clinical Privileges granted to him/her consistent with these Bylaws; and
(c) will pay dues; and
(d) will comply with the terms and conditions of any contractual or other arrangement with Legacy Silverton Health for the providing of services Legacy Silverton Health and acknowledge that the hearing rights specified in these Bylaws shall not be available nor will they apply to the Provider as acknowledged by the Provider in their application for membership.
(e) may attend meetings of the medical staff and the service of which the provider is a member; including open committee meetings and educational programs
(f) may participate in the call list for emergency medical coverage

3.11-3 LIMITATIONS OF TELEMEDICINE STATUS ~ Telemedicine staff members may
not:

(a) admit patients; or
(b) hold any office in the medical staff organization; or
(c) vote; or
(d) serve on Medical Staff Committees;

ARTICLE IV - APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL

By applying to the medical staff for appointment or reappointment, the applicant acknowledges responsibility to first review these bylaws and agrees that throughout any period of membership that person will comply with the responsibilities of medical staff membership and with the bylaws and rules and regulations of the medical staff as they exist and as they may be modified from time to time. Appointment to the medical staff shall confer on the appointee only such clinical privileges granted in accordance with these bylaws.

4.2 DURATION OF APPOINTMENT AND REAPPOINTMENT

Appointments to the medical staff and grants of clinical privileges shall be for a period of no more than two (2) years. The specific staggering of reappointments shall be in a manner established by the Medical Staff Office.

4.3 PROVIDERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

4.3-1 QUALIFICATIONS AND SELECTION ~ A provider who is or who will be providing specified professional services pursuant to a contract or employment with Legacy Silverton Health must meet the same appointment qualifications, must be evaluated for appointment, reappointment and clinical privileges in the same manner and must fulfill all of the obligations of the provider’s category as any other applicant or staff member.

4.3-2 EFFECT OF CONTRACT EXPIRATION OR TERMINATION ~ Upon termination or expiration of a written exclusive contract to provide medical services, the provider’s appointment to the staff and clinical privileges will be voluntarily relinquished. Upon termination or expiration of all other contracts, the provider’s appointment or clinical privileges will not be affected except to the extent such issues are governed by the terms of the provider’s contract.

4.3-3 APPLICABILITY OF CORRECTIVE ACTION AND FAIR HEARINGS PROCEDURES
A provider providing contractual professional services is obligated to fulfill the obligations of the provider’s appointed staff category, and therefore is subject to the grounds for corrective action as any other staff member. As such, the provider has the right to the fair hearings procedure found in Article VII of these bylaws. Matters of an administrative nature
or those other issues addressed by the terms of the contract do not entitle the practitioner to the Article VII fair hearings process.

4.4 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

4.4-1 APPLICATION FORM ~ An application shall be recommended by the Credentials Committee, MEC, and finally to the Governing Board. The application shall require detailed information which shall include, but not be limited to, information concerning:

(a) the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current Drug Enforcement Agency (DEA) registration and experience, and continuing medical education information related to the clinical privileges to be exercised by the applicant;
(b) peer references familiar with the applicant's professional competence and ethical character;
(c) requests for membership categories, services, and clinical privileges;
(d) past or pending professional corrective action, licensure limitations, or related matters;
(e) malpractice claims history;
(f) physical and mental health status; and
(g) a certificate of professional liability insurance in such amounts as may be required by the Governing Board.

Each application for initial appointment to the medical staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant is sent an application form, after review of the pre-application form by the Credentials Committee, the applicant shall also be given a copy of these bylaws and the medical staff rules and regulations.

4.4-2 EFFECT OF APPLICATION ~ In addition to the matters set forth in Section 4.1, by applying for appointment to the medical staff each applicant:

(a) attests to the correctness and completeness of all information furnished by the applicant;
(b) agrees to abide by these bylaws and rules and regulations of the medical staff;
(c) signifies willingness to appear for interviews in connection with the application;
(d) authorizes the hospital, the Credentials Committee, Medical Executive Committee and the appropriate service to consult with members of the medical staff and with others who may have information bearing on the applicant's professional qualifications, ethical standing, and competence;
(e) consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
(f) acknowledges those provisions in these medical staff bylaws for release and immunity from civil liability
(g) consents to the disclosure to appropriate licensing boards or other organizations as
required by law, any information regarding the applicant's professional or ethical standing that the hospital or medical staff may have, and releases the medical staff and the hospital from liability for so doing to the fullest extent permitted by law;

(h) agrees to cooperate openly and fully in an impartial physical or mental examination; and

(i) pledges to provide continuous care for his/her patients.

4.4-3 BURDEN OF PRODUCING INFORMATION ~ In connection with all applications for appointment, reappointment, advancement or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. This burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the MEC, which may select the examining physician after conferring with the provider being reviewed. No application is complete or deemed received, until all requested information is provided.

4.4-4 APPOINTMENT PROCESS ~ Upon request for an application, a pre-application will be sent to the requester. The completed pre-application will be reviewed by the Credentials Committee and a decision will be made as to whether or not a Medical Staff application will be sent to the applicant. The completed applications shall be submitted to the Manager of Medical Staff Services. Upon receipt of the completed signed application, the Medical Staff Office will seek to verify its content and collect additional information as follows:

(a) verification of licensure or status from the Oregon Board of Medical Examiners or the appropriate licensing board, and from all current or past states of licensure;

(b) all information held by the Secretary of the Department of Health and Human Services or the agency designated by the secretary, pursuant to the Health Care Quality Improvement Act of 1986, as amended, and the regulations adopted pursuant thereto; and

(c) copies of certificates or letters confirming completion of an accredited medical school and residency training program.

(d) verification from the primary source, whenever feasible, of all information about the applicant's experience and current competence provided by the applicant.

After receipt of the completed application, verification of its contents and receipt of additional information, the Medical Staff Office shall transmit the application and all supporting materials to the Credentials Committee.

4.4-5 CREDENTIALS COMMITTEE ACTION ~ The Credentials Committee shall review the completed application and evaluate the supporting documentation and any other relevant information.

The Credentials Committee may elect to interview the applicant and seek additional information. Within 90 days after receipt of all necessary information, the credentials committee shall transmit to the Medical Executive Committee a report and its recommendations as to appointment and, if appointment is recommended, as to membership category, service affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also recommend that
the MEC defer action on the application.

4.4-6 MEDICAL EXECUTIVE COMMITTEE ACTION ~ At its next regular meeting after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practical, the MEC shall consider the report and any other relevant information. The MEC may request additional information, return the matter to the Credentials Committee for further investigation, and/or elect to interview the applicant. On behalf of the MEC, the Medical Staff President shall forward to the Governing Board, a written report and recommendation as to medical staff appointment and, if appointment is recommended, as to membership category, service affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may also defer action on the application. The reason for each recommendation shall be stated.

4.4-7 RECOMMENDATION TO DEFER THE APPLICATION ~ When the recommendation of the Credentials Committee or the MEC is to defer the application for further consideration, it must be followed within ninety [90] days by either a subsequent recommendation for provisional appointment with the specified clinical privileges, or a recommendation that the application for staff membership be rejected. Deferral of an application for reappointment must not result in the extension of the existing appointment beyond a period of two years.

4.4-8 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(a) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the Administrator shall promptly forward it, together with supporting documentation, to the Governing Board.

(b) Adverse Recommendation: When a recommendation of the MEC is adverse to the applicant, the Administrator shall immediately inform the applicant by special notice. If the recommendation of the MEC would entitle the applicant to request a hearing pursuant to these bylaws, it shall be forwarded to the Administrator who shall promptly notify the applicant in writing, certified mail, return receipt requested. The Administrator 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 Administrator shall forward the recommendation of the MEC, together with the complete application and all supporting documentation, to the Governing Board for further action.

4.4-9 ACTION ON THE APPLICATION

(a) When the recommendation of the MEC is favorable to the provider, the Governing Board shall consider it at its next scheduled meeting. If the Governing Board’s decision is favorable to the applicant, the applicant will be notified of the Governing Board’s decision by the administrator within three weeks of the decision.

(b) If the Governing Board’s decision is adverse to the provider and would entitle the applicant to request a hearing pursuant to these bylaws, the administrator shall notify said provider within three weeks of the adverse decision by special notice, and such adverse decision shall be held in abeyance until the provider has exercised or has been deemed to have waived their rights under Article VII of these bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges when
none existed before.

4.5 REAPPOINTMENTS AND REQUESTS FOR MODIFICATION OF STAFF STATUS OR PRIVILEGES

4.5-1 APPLICATION OF REAPPOINTMENT

(a) At least 3 months prior to the expiration date of the current staff appointment (except for temporary appointments), a reapplication form shall be mailed or delivered to the provider. If an application for reappointment is not received at least 45 days prior to the expiration date, written notice shall be promptly sent to the provider advising that the application has not been received. At least 45 days prior to the expiration date, each provider shall submit to the Credentials Committee the completed application form for renewal of appointment to the staff for the coming year, and for renewal or modification of clinical privileges.

(b) The provider shall have furnished in writing on the application form for reappointment, complete information and all documents necessary to reappraise the provider at the time of reappointment, including, but not limited to, current licenses, health status changes, professional liability insurance coverage and experience, and other institutional affiliation and status, board certification status, disciplinary actions pending or completed, and documentation of CME hours completed since the time of previous appointment. If the provider is not board certified, 50 hours of AMA Category 1 CME shall be required during each two-year reappointment cycle. Surgical First Assists shall be required to have 25 CME hours during each two-year reappointment cycle. In all cases, documentation of completed CME hours must be submitted with application at time of reappointment.

Acceptable forms of documentation of CME may include copies of certificates, a list of courses and hours submitted with a statement attesting to the fact that these courses were attended, a copy of the renewal application for state board licensure listing CME activity, or a copy of a CME transcript from a provider’s specialty board. If a listing is provided without proof, proof of attendance and program must be submitted upon request.

(c) The provider must sign the reappointment application, and in so doing accept the same conditions as stated in Section 4.1 of this Article in connection with the initial application.

(d) As with the initial application, provider shall bear the burden of completing the application form and producing all information in the same manner as stated in Section 4.4-3 of this Article, in connection with the initial appointment.

(e) Upon receipt of the completed application the Medical Staff Office will seek verification of licensure status from the Oregon Medical Board, or the appropriate licensing board, and all information held by the Secretary of the Department of Health and Human Services or the agency designated by the Secretary, pursuant to the Health Care Quality Improvement Act of 1986, as amended, and the regulations adopted pursuant thereto.

(f) A provider who seeks a change in staff status or modification of clinical privileges may submit such a request at any time upon a form developed by the MEC, except that such
application may not be filed within one year of the time a similar request has been denied. This request must include specific requests for additions to or deletions from the clinical privileges presently held with any bases for changes.

4.5-2 EFFECT OF APPLICATION ~ The effect of an application for reappointment or modification of staff status or privileges is the same as that set forth in Section 4.4-2.

4.5-3 STANDARDS AND PROCEDURES FOR REVIEW ~ When a provider submits the first application for reappointment, and every two years thereafter, or when the member submits an application for modification of staff status or clinical privileges, the provider shall be subject to an in-depth review generally following the procedures set forth in Sections 4.4, in addition to reviewing the information found in the provider's credentials file.

4.6 BASIS OF RECOMMENDATIONS

Each recommendation concerning the reappointment of the provider and the clinical privileges to be granted upon reappointment shall be based upon such provider's:

(a) demonstrated current competence, professional performance, and judgment; and
(b) clinical and/or technical skills as indicated in part by the results or conclusions drawn by quality assessment and improvement activities; and
(c) sanctions imposed or pending, voluntary terminations of medical staff memberships or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and
(d) previously successful and currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration; and
(e) participation as a staff official, committee member or chairman, and in on-call coverage rosters; and
(f) timely, accurate, and legible preparation and completion of medical records; and
(g) physical and mental health; and
(h) ethics and conduct; and
(i) continuing medical education, attendance at medical staff meetings and participation in medical staff affairs, compliance with these bylaws and rules and regulations of the medical staff; and
(j) cooperation with hospital personnel, use of the hospital's facilities for patients, relations with other providers; and
(k) peer recommendations; and
(l) other reasonable indicators of continuing qualifications, such a board certification.

4.6-1 FAILURE TO FILE REAPPOINTMENT APPLICATION ~ Failure without good cause to file a completed application for reappointment in a timely manner shall result in the automatic suspension of the provider's admitting privileges and expiration of other practice privileges and prerogatives at the end of the current staff appointment. (Board Approved 9/24/2008) If the provider fails to submit a completed application for reappointment within 60 days of the due date, the provider shall be deemed to have resigned membership in the
medical staff.

In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

4.7 LEAVE OF ABSENCE

4.7-1 LEAVE STATUS ~ At the discretion of the MEC, a medical staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the MEC stating the approximate period of leave desired, which may not exceed 1 year. During the period of the leave, the provider shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical staff. If the provider is under investigation, the investigation shall be completed before the provider is granted a leave of absence, unless the leave is for an emergency situation.

4.7-2 TERMINATION OF LEAVE ~ At least 30 days prior to the termination of the leave of absence, or at any earlier time, the provider may request reinstatement of privileges by submitting written notice to that effect to the MEC. The provider shall submit a summary of relevant activities during the leave, if the MEC so requests. The MEC shall make a recommendation concerning reinstatement of the provider’s privileges and prerogatives, and the procedures provided in Sections 4.1 through 4.4-10 shall be followed.

4.7-3 FAILURE TO REQUEST REINSTATEMENT ~ Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A provider whose membership is automatically terminated shall be entitled to the procedural hearing rights provided in Article VII for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable. A request for medical staff membership subsequently received from a provider so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE V - CLINICAL PRIVILEGES

5.1-1 EXERCISE OF PRIVILEGES ~ Except as otherwise provided in these bylaws, a provider providing clinical services at Legacy Silverton Health shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the rules and regulations of the clinical service and the authority of the service chief and the medical staff.

Medical staff privileges may be granted, continued, or modified only upon recommendation of the medical staff, only for reasons directly related to quality of patient care and/or other provisions of the medical staff bylaws, and only following the procedures outlined in these bylaws.
Privileges for providers providing contractual services are governed by Section 4.3.

5.1-2 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.

5.1-3 HISTORY AND PHYSICAL (H&P) – A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, nurse practitioner or physician assistant who is credentialed and privileged to perform an H&P. As a minimum, the H&P must contain the following elements for both inpatients and outpatient procedures requiring an H&P:

1. Patient’s name, age, gender
2. Chief complaint
3. History of present problem
4. Relevant social history
5. Past medical history
6. Previous surgeries
7. Allergies
8. Current medications
9. Review of systems
10. Physical examination – vital signs, heart, lungs, affected organ(s)
11. Diagnosis

The Oregon Uniform Prenatal Record may be used as the H&P for obstetric patients admitted for delivery, provided that all other H&P requirements are met. The Emergency Department record is not an acceptable H&P.

There must be a complete H&P, and an update, if applicable, in the medical record of every patient prior to surgery, or a procedure requiring anesthesia services, except in emergencies. In the case of emergencies, the H&P must be recorded immediately following the procedure and the provider must sign, date and time a statement of the emergency circumstances in the patient’s medical record.

When an H&P is not recorded in the medical record prior to any operative or invasive procedure, or any potentially hazardous diagnostic procedure, except in emergencies, the procedure will be postponed or cancelled.

The H&P may be handwritten or transcribed, but always must be placed within the patient’s
medical record within 24 hours of admission or registration, or prior to surgery or a
procedure requiring anesthesia, whichever comes first. If a complete H&P has been
completed within 30 days before admission or registration, a durable, legible copy of the
H&P is transferred to the medical record. The practitioner is responsible for performing and
documenting the H&P and any update to the H&P that is necessary. Legacy Silverton
Health is responsible for placing the dictated H&P in the chart.

When a medical history and physical examination has been completed within 30 days
before admission or registration, an updated medical record entry must be completed and
documented in the patient’s medical record within 24 hours after admission or registration.
The examination must be conducted by a licensed provider who is credentialed and
privileged to perform an H&P. In all cases, the update must take place prior to surgery or a
procedure requiring anesthesia services. The update note must document an examination
for any changes in the patient’s condition since the patient’s H&P was performed that might
be significant for the planned course of treatment. The physician or qualified licensed
individual uses his/her clinical judgment, based upon his/her assessment of the patient’s
condition and co-morbidities, if any, in relation to the patient’s planned course of treatment
to decide the extent of the update assessment needed as well as the information to be
included in the update note in the patient’s medical record.

If, upon examination, the licensed provider finds no change in the patient’s condition since
the H&P was completed, provider may indicate in the patient’s medical record that the H&P
was reviewed, the patient was examined, and that “no change” has occurred in the patient’s
condition since the H&P was completed. Any changes in the patient’s condition must be
documented by the provider in the update note and placed in the patient’s medical record
within 24 hours of admission or registration, but prior to surgery or a procedure requirement
anesthesia services. Additionally, if the provider finds that the H&P done before admission
is incomplete, inaccurate, or otherwise unacceptable, the provider reviewing the H&P,
examining the patient, and completing the update may disregard the existing H&P, and
conduct and document in the medical record a new H&P within 24 hours after admission or
registration, but prior to surgery or a procedure requiring anesthesia.

The attending provider may include in the medical record an H&P performed by another
physician if it is clinically complete and relevant to the current patient care. However, the
attending Provider must cosign the H&P report submitted by another physician, and add an
interval admission note which must be written, signed, timed and dated by the attending
Provider and include pertinent additions to the patient’s history and any subsequent
changes in the physical findings. When performance, documentation, and authentication
are split among qualified providers, the provider who authenticates the H&P will be held
responsible for its contents.

5.2    DELINEATION OF PRIVILEGES IN GENERAL

5.2-1 REQUESTS ~ Each application for appointment and reappointment to the medical
staff must contain a request for the specific clinical privileges desired by the applicant. A
request by a provider for modification of clinical privileges may be made at any time, but
such requests must be supported by documentation of training and/or experience
supportive of the request.

5.2-2 BASIS FOR PRIVILEGES DETERMINATION ~ Requests for clinical privileges shall be evaluated on the basis of activities currently performed in the hospital or its clinics, and activities or its clinics that may be presented for consideration by the Legacy Silverton Health administration and medical staff, with final approval granted by the governing board; the provider’s education, training, experience, demonstrated professional competence and judgment, clinical performance, and the documented results of patient care and other quality review and monitoring which the medical staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a provider exercises clinical privileges. The provider’s physical and mental health status shall be compatible with the privileges requested.

5.3 PROVISIONAL PERIOD

5.3-1 GENERAL ~ All grants of initial clinical privilege are subject to the requirements of the provisional period as outlined in Sections 3.3-4 to 3.3-6 of these bylaws. At the conclusion of the provisional period, the chief of the service with which the provider has affiliation, and any other persons designated to observe the provider during the provisional period, shall submit to the appropriate Peer Review Committee a report stating that the applicant appears to meet all of the qualifications for practice in that department, has discharged all the responsibilities of staff membership and has not exceeded or abused the prerogatives of the category to which the appointment was made. The chief of the service shall then present to the Credentials Committee for review and recommendation to the Medical Executive Committee. The medical staff president shall present recommendations to the Governing Board for final approval of Advancement off of Provisional.

5.4 TEMPORARY CLINICAL PRIVILEGES

5.4-1 CONDITIONS ~ Temporary clinical privileges may be granted only in the circumstances and under the conditions described in Section 5.4-2; only to an appropriately licensed provider, only when the information available including, at a minimum, information obtained from the Secretary of Health and Human Services, or their designee, through the National Practitioner Data Bank (NPDB) pursuant to the Health Care Quality Improvement Act of 1986, as amended, and the regulations adopted pursuant thereto, and Oregon Medical Board, or other appropriate licensing boards substantially supports a favorable determination regarding the requesting provider’s qualifications, ability and judgment to exercise the privileges requested, and only after the provider has satisfied the professional liability insurance requirements of these bylaws and rules and regulations. Special requirements of consultation and reporting may be imposed by the Credentials Committee. Under all circumstances, the provider requesting temporary privileges must agree in writing to abide by these bylaws and related manuals, rules and regulations of the medical staff and those of the hospital in all manners relating to the provider’s activities for Legacy Silverton Health.

5.4-2 CIRCUMSTANCES ~ On written recommendation of the president of the medical
staff, the Administrator may grant temporary privileges in the following circumstances:

(a) Pendency of application:

1. to an applicant for staff membership, but only after receipt of a completed application for staff appointment, including a request for specific temporary privileges, consultation with the president of the medical staff, and verification of the qualifications for membership required by these bylaws.

2. temporary privileges may be granted in this circumstance for an initial period of 90 days with subsequent renewals not to exceed the pendency of the application. Any such renewal shall be made upon written recommendation of, and may be made only when the information available continues to support a favorable determination regarding the provider’s application for membership and privileges. Under no circumstances may they be initially granted or renewed if the application is still pending because the applicant has not responded to a request for clarification or for a matter of additional information.

(b) Care of specific patients - To a provider for the care of a specific patient, after receipt of a request for the specific privileges desired. Temporary privileges of this nature may not be granted for more than [4] patients in any twelve month period after which the provider must apply for staff appointment, and are restricted to the specific patients for which they are granted. In urgent situations, where the health and wellbeing of a patient so requires, the administrator, in consultation with a member of the MEC, may grant temporary privileges for the case of a specific patient. The administrator will then promptly obtain the information as set forth in 5.4-1.

(c) Locum Tenens - To a provider who will be serving as a locum tenens for a staff member, but only after receipt of a complete application for appointment as locum tenens, including a request for specific privileges. The locum tenens may not exceed 120 days in duration.

(d) Temporary Emergency Department Physician- May be granted to a provider who is in their final year of residency training in Internal Medicine, Family Practice, Emergency Medicine as defined in section 2.2-1(f), but only after receipt of a complete application for appointment as temporary Emergency Department Physician including a request for specific privileges, and within the limits proposed by the Credentials Committee. The temporary Emergency Department Physician privileges will expire in 60 consecutive days.

5.4-3 TERMINATION

(a) Temporary privileges may be terminated by the President of the medical staff, the MEC, the service chief or designee in which the provider holds privileges, or the administrator. 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 President of the medical staff or the applicable service chief, and such termination
shall be immediately effective. The appropriate service chief 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 Legacy Silverton Medical Center, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

(b) The granting of any temporary admitting and clinical privileges is a courtesy on the part of Legacy Silverton Health 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.

5.4-4 EMERGENCY PRIVILEGES

(a) In the case of an emergency, in which serious harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger and any delay in administering treatment could add to that danger, any provider of the medical staff is authorized to the degree permitted by his/her license and regardless of the service affiliation and staff category, or privileges, to do everything possible to help save the patient's life. The provider shall make every reasonable effort to communicate promptly with the service chief concerning the need for emergency care and assistance by practitioners with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the service chief with respect to further care of the patient.

(b) In the event of an emergency, any person shall be permitted to do whatever is reasonably necessary to help a patient. Such persons shall promptly yield with the patient's consent such care to a qualified provider when it becomes reasonably available.

5.5 REQUEST FOR MODIFICATION OF PRIVILEGES

(a) After the provisional period, any provider may request a modification of privileges, including a request to eliminate certain privileges.

(b) All requests to modify privileges must be submitted in writing to the Credentials Committee, together with information supporting the basis for the modification request.

(c) The Credentials Committee shall submit a report to the MEC within 30 days after receipt of all information deemed necessary by the Credentials Committee, making a recommendation to allow or deny the request based on a reappraisal of the provider at the time of the request. Thereafter, it shall be processed in the same manner as an application for initial clinical privileges.
ARTICLE VI - OTHER ACTIONS

6.1 OTHER QUESTIONS INVOLVING MEDICAL STAFF APPOINTEES

6.1-1 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 Legacy Health, Legacy Silverton Health 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 Legacy Silverton Health or disruptive to the orderly operation of Legacy Silverton Health or its Medical Staff, including the inability of the appointee to work harmoniously with others;

the President of the Medical Staff, service chief, Chair of the Credentials Committee, or Administrator 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 MEC. If any of the inquiring individuals set forth in this provision believe it to be in the best interest of Legacy Silverton Health and the appointee concerned, they may, but are not required to, discuss the matter with the affected appointee.

6.1-1 INVESTIGATION

(a) The MEC, upon receipt of a concern as outlined above, will review and decide if any further action is necessary. If the concern contains sufficient information to warrant a recommendation without a further investigation, the MEC, at its discretion, may make such a recommendation, with or without a personal interview with the individual being investigated.

(b) If further action is to be taken, the MEC shall determine whether to discuss the matter with the individual concerned, or begin an investigation. The MEC may then decide whether to conduct the investigation itself, or may assign the task to an appropriate medical staff officer, medical staff service, Conduct Committee, or ad-hoc committee of the medical staff.

(c) The affected provider may be requested to meet with the investigator(s) to make a presentation in the provider’s own behalf. If so requested, the investigator(s) may require the affected provider to attend and participate in an investigatory interview after reasonable notice. Failure to do so without good cause shall result in immediate summary suspension until such time as the provider participates in the interview. Any appearance before the investigator(s) shall not constitute a hearing, shall be informal in
nature and none of the procedural rules, hereinafter set forth with respect to hearings shall apply.

(e) As part of the investigation, the investigator(s) may, when indicated, require the provider to procure an impartial physical or mental examination. Failure to do so without good cause shall result in immediate suspension of medical staff appointment and clinical privileges until such time as the examination is obtained. The provider who will conduct the examination shall be named by the investigator(s) and fees for the examination shall be paid by Legacy Silverton Health.

(f) The investigator(s) shall proceed with the investigation in a prompt manner and shall provide a report of the investigation to the MEC. The MEC will meet following the conclusion of the investigation and may accept, modify, or reject the recommendation it receives from the investigator(s).

6.1-2 ACTION BY THE MEDICAL EXECUTIVE COMMITTEE

(a) In acting after the investigation, the MEC 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) If the recommendation would entitle the appointee to a hearing, the recommendation will be forwarded to the Administrator who shall promptly notify the affected individual by certified mail, return receipt requested. The Administrator shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing, after which the Administrator shall forward the recommendation of the MEC, together with all supporting information, to the Governing Board. The President of the Medical Staff, or his/her designee shall be available to the Governing Board to answer any questions that may be raised with respect to the recommendation.

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

(e) Any action taken by either the MEC or the Governing Board as a result of an investigation shall be communicated to and shall be valid at all Legacy hospitals.
6.1-3 ACTION BY THE GOVERNING BOARD ~ Within a reasonable period after receipt of the recommendation of the MEC, the Governing Board shall act thereon. Such action may be to affirm, to modify by increasing or reducing the corrective action recommended, or to reject the recommendation. If the Governing Board finds that the information provided by the MEC is not sufficiently complete to make an informed recommendation/decision, it may request additional information from the MEC or the provider. The Medical Staff President shall notify the MEC and the provider of the action and the basis for the Governing Board's decision.

6.1-4 REAPPLICATION AFTER GOVERNING BOARD ACTION ~ If the Governing 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 Legacy Silverton Health for a period of five years unless the Legacy Board provides otherwise.

6.2 SUMMARY RESTRICTION OR SUSPENSION

6.2-1 CRITERIA FOR INITIATION

The President of the Medical Staff, the service chief, the Chair of the Credentials Committee, the Administrator (or designee), or the Governing 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 Legacy Silverton Medical Center. Such summary 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.

Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give notice to the provider, the Medical Staff President, and the Administrator. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the provider’s patients, with their consent, shall be promptly assigned to another provider by the service chief or by the president of the medical staff. The wishes of the patient will be considered in choosing a substitute provider.

6.2-2 MEDICAL EXECUTIVE COMMITTEE ACTION

Any individuals who exercise authority to summarily suspend clinical privileges as a precaution shall immediately report this action to the MEC. 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 Administrator so that the
Administrator and the MEC may consider whether the suspension should be lifted.

6.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the provider’s privileges or membership may be suspended or limited as described, which action shall be final without a right to hearing or further review, except where a bona fide dispute exists as to whether the circumstances have occurred:

6.3-1 LICENSURE

(a) Revocation and Suspension: Whenever a provider’s license or other legal credential authorizing practice in this state is revoked or suspended, medical staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

(b) Restriction: Whenever a provider’s license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the provider has been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(c) Probation: Whenever a provider is placed on probation by the applicable licensing or certifying authority, the provider’s membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its terms.

6.3-2 CONTROLLED SUBSTANCES

(a) Whenever a provider’s DEA certificate is revoked, limited, or suspended, the provider shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

(b) Probation: Whenever a provider’s DEA certificate is subject to probation, the provider’s right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

6.3-3 MEDICAL RECORDS

Providers are required to complete medical records within such reasonable time as may be prescribed by the MEC. Refer to Rules and Regulations Article V. (Board approved October 30, 2013)

6.3-4 FAILURE TO APPEAR

Failure to appear at meetings when requested at the discretion of the chair or presiding officer, when a provider’s practice or conduct is scheduled for discussion at a regular service, or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least 7 days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at three (3) consecutive
meetings with respect to which the provider was given such notice, unless excused by the 
MEC upon a showing of good cause, shall be deemed voluntary relinquishment of medical 
staff membership and privileges.

ARTICLE VII - HEARINGS

7.1 INITIATION OF HEARING

7.1-1 GROUNDS FOR HEARING
The following recommendations shall, if made or proposed to be made by the MEC, be 
grounds for hearing upon timely and proper request by the affected provider:

(a) denial of Medical Staff reappointment;
(b) revocation of medical staff appointment and clinical privileges;
(c) denial of requested initial clinical privileges;
(d) denial of requested additional clinical privileges;
(e) decrease in clinical privileges (after the period of provisional appointment);
(f) suspension of clinical privileges (for greater than 30 days);
(g) imposition of a requirement for 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).

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

7.1-4 NOTICE OF RIGHT TO REQUEST HEARING
In all cases in which the MEC has or may recommend, or the Governing Board may take, 
those actions constituting grounds for hearing, the affected provider shall be given special 
notice of their right to request a hearing. This special notice shall:

(a) advise the practitioner of the recommendation or action and the general reasons for it;
(b) a copy outlining the rights of the provider in the hearing as provided in these Bylaws;
(c) specify that the provider has thirty (30) days after receiving the notice within which to 
submit a written request for a hearing to the Administrator who will promptly deliver the 
request to the Governing Board;
(d) state that failure to request a hearing within the specified time period and in the proper 
manner will result in loss of all rights to a hearing on the matter that is the subject of the 
notice and that the provider will be deemed to have accepted the action taken;
(e) state that any higher authority required or permitted under these bylaws to act on the 
matter will not be bound by its recommendation or action, but may take any action, 
whether more or less severe, where it deems warranted by the circumstances; and
(f) state that the individual has the right to be represented by counsel at the hearing
7.2 HEARING PREREQUISITES

7.2-1 HEARING COMMITTEE

When a proper request for hearing is received, the Administrator of Legacy Silverton Health shall promptly deliver the request to the Governing Board. Upon receipt of the hearing request, the Governing Board after conferring with the president of the medical staff, 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 Legacy Silverton Health, 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. 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.

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. If no Presiding Officer has been appointed, a Chair of the Hearing Panel shall be appointed by the Administrator to serve as the Presiding Officer, and shall be entitled to one vote. The Presiding Officer may be advised by legal counsel to Legacy Silverton Health with regard to the hearing procedure.

Pursuant to ORS 441.055, upon agreement of all of the following: (1) physician whose practice is being reviewed (2) the MEC (3) and the Governing Board, the Governing Board shall appoint a hearing committee from a list of persons consisting of representatives of the Oregon Medical Board.

7.2-2 NOTICE OF TIME AND PLACE FOR HEARING

The Governing Board shall after appointment of the hearing officer or committee, schedule a hearing and notify the affected provider of the time, place and date. A hearing shall be scheduled on a date not less than 30 days from the date appearing on the face of the notice.

7.2-3 CONTENT OF HEARING NOTICE

The notice of hearing shall be prepared by the Administrator and shall state in concise language, (1) the criteria, bylaws or other requirements relied on in the applicable recommendation, decision or act; (2) the name of the hearing officer or the composition of the hearing committee; (3) the time, place and date of the hearing; (4) notification that the right to the hearing may be forfeited if the provider fails without good cause to appear; (5) notification that in the hearing, the affected provider has the right to representation by an attorney or other person of the provider's choice at the provider's expense; (6) notification that the provider has the right to have a record made of the proceedings, copies of which
may be obtained by the provider upon payment of any reasonable charges associated with
the preparation thereof; (7) notification that the provider or representative has the right to
call, examine and cross-examine witnesses; (8) notification that the provider or
representative has the right to present evidence determined to be relevant by the presiding
officer, regardless of its admissibility in a court of law; (9) notification that the provider or
representative has the right to submit a written statement at the close of the hearing; (10)
notification that upon completion of the hearing the provider or representative involved has
the right to receive the written recommendation of the hearing officer or committee,
including a statement of the basis of the recommendations, and shall receive a written
decision of the hospital, including a statement of the basis of the decision; (11) the name of
the person to contact for access to the record on which the adverse recommendation was
based; (12) the names of witnesses then contemplated; and (13) the name of the person
appointed to present the evidence of the proponents of the adverse recommendation, if
any.

7.2-4 CHALLENGE OF HEARINGS OFFICER OR COMMITTEE MEMBER

A provider who has requested a hearing may challenge the impartiality of a hearings officer
or hearings committee member for demonstrated bias or direct economic competition and
for no other cause. Challenges shall be in writing, stating the grounds for challenge, and
delivered to the President of the medical staff, or his designee, and the Administrator within
three (3) days after the provider has been notified of the identity of the hearings officer or
committee members. The President of the medical staff or designee shall decide
challenges, within five days of the receipt of the challenge. All parties shall be notified, in
writing, of the President's decision and the name(s) of the replacement(s), if any.

7.3 HEARING PROCEDURE

7.3-1 PERSONAL PRESENCE

Failure of the provider to appear at the hearing without good cause shall constitute a waiver
of the right to a hearing and a voluntary acceptance of the recommendations or actions
involved.

7.3-2 PRESIDING OFFICER

The presiding officer or chair of the hearing committee shall preside over the hearing. The
presiding officer or chair shall act to insure that decorum is maintained and that all persons
who participate in the hearing have a reasonable opportunity to be heard, and to present
oral and documentary evidence.

7.3-3 REPRESENTATION

The affected provider shall be entitled to have an attorney or other person of the provider's
choice present to advise, and actively participate with, the provider at the provider's own
expense. The MEC shall be entitled to have an attorney and shall appoint a
representative(s) to represent the interests of the MEC and the medical staff, to present
evidence, and to examine witnesses. The name of such representative(s) shall be given to
the affected provider.
7.3-4 RIGHTS OF THE PARTIES
The parties to the hearing and/or their representatives shall have the right to: (a) call and examine witnesses, (b) present evidence determined to be relevant by the presiding officer, (c) cross-examine on any matter determined to be relevant by the presiding officer. If the provider does not testify in the provider's own behalf, the provider may be called and examined as if under cross-examination, (d) obtain a copy of the hearing record upon payment of any reasonable charges associated with its preparation.

The Administrator of Legacy Silverton Health shall do whatever is reasonably necessary to have records of the hospital that are relevant and necessary to the issues at hearing produced and witnesses, who are employees of the hospital, appear and testify at the hearing upon request of either party. A witness refusal to testify shall not be a reason to end the proceeding unless the parties so agree.

7.3-5 PROCEDURE AND EVIDENCE
The hearing need not be conducted according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons might customarily rely on in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. The hearing officer or committee is also entitled to consider all other relevant information that can be considered under these bylaws in connection with credential matters. Each party shall be entitled prior to or during the hearing to submit memoranda concerning any issue of law or fact and those memoranda shall be part of the hearing record. Oral evidence shall be taken only on oath or affirmation.

7.3-6 SCOPE OF REVIEW AND BURDEN OF PROOF
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. 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.

7.3-7 HEARING RECORD
An accurate record of the hearing must be kept. The hearing officer or chair of the hearing committee may select a method to be used for making a record, such as a court reporter, electronic recording unit, detailed transcription or minutes of the proceedings. If the hearing committee does not elect to use a court reporter, the provider may arrange for a court reporter at the provider's own expense, but shall consent to Legacy Silverton Health's
right of access to any such transcription with Legacy Silverton Health to bear one-half the
cost of producing the record and the entire cost of Legacy Silverton Health’s copy. The
hearing record shall also contain all exhibits or other documentation considered, written
statements or memoranda submitted by the parties and correspondence between the
parties or between the hearing committee and the parties if any during the hearing process.

7.3-8 POSTPONEMENT
Request for postponement of a hearing may be granted by the hearing officer or chair of
the hearing committee only upon showing of good cause, and only if the request is made
as soon as is reasonably practical.

7.3-9 PRESENCE OF THE HEARING COMMITTEE AND VOTE
The entire hearing committee must be present throughout the hearing and deliberations
unless the committee member reviews the written transcript of the proceeding and exhibits
presented during his/her absence.

7.3-10 RECESSES AND ADJOURNMENT
The hearing officer or chair of the hearing committee may recess and reconvene the
hearing for the convenience of the participants or for the purpose of obtaining new or
additional evidence or consultation. The hearing must be reconvened in a timely manner
and in any event the recess must not exceed 10 days except by consent of the affected
provider. Upon conclusion of the presentation of oral and written evidence and argument,
the hearings shall be closed. The hearing officer or committee shall, at a time convenient,
conduct the deliberations outside the presence of the parties. Upon conclusion of the
deliberations, the hearing shall be adjourned. The adjournment shall be not later than 10
days after the hearing is closed.

7.3-11 EX-PARTE COMMUNICATIONS
Once a hearing officer or hearing committee is appointed, neither party may discuss any
matter related to the hearing with the hearing officer or any member of the committee
outside of the hearing procedure except in the presence or with the consent of the other
party.

If an ex-parte communication is received by any member it must be immediately reported to
the other members of the committee, and reported to all parties except if it is made or given
in the presence or with the written consent of the other party.

Such communication shall not be considered or received as evidence until rebuttal or
argument is presented by the parties during the hearing process and then admissibility is
solely at the discretion of the presiding officer.

7.4 HEARING OFFICER OR COMMITTEE REPORT AND FURTHER ACTION

7.4-1 HEARING OFFICER OR COMMITTEE REPORT
Within 10 days after adjournment of the hearing, the hearing officer or committee shall
make its written report and recommendations and shall assemble the report along with the record and any other documentation in the matter. The materials shall be sent to the Governing Board, with a copy of the report and recommendations to the provider by special notice, and an informational copy to the MEC.

7.4-2 ACTION BY GOVERNING BOARD

Within 30 days after receipt of the hearing officer or committee report, the Governing Board shall act upon the recommendation(s) of the hearing officer or hearing committee. It may either affirm, modify, or reject the decision of the hearing officer or hearing committee. If the decision of the Governing Board is in accord with the last recommendation of the hearing officer or committee, then the Administrator shall give written notice of the decision to the provider. If the action of the Governing Board has the effect of changing the hearing officer's or committee's last recommendation, the matter shall be referred to a joint review committee as provided in part 7.7-3 below. The Governing Board shall inform the parties of its decision and the basis thereof, by special notice.

7.4-3 JOINT REVIEW COMMITTEE

In the event the decision of the Governing Board differs from that of the hearing committee, the Governing Board decision shall not be final until the matter shall be referred to the joint review committee for consideration. The joint review committee shall consist of six members, the Governing Board shall appoint three Governing Board members and the president of the medical staff shall appoint three members not in direct economic competition with the provider from the active medical staff. Within 30 days after receiving the matter referred to it under this article, the joint review committee will consider the matter. Within 15 days after the joint review committee has considered the matter it shall prepare and submit its recommendations to the Governing Board with a copy to the affected provider.

(a) Matter to be considered by the joint review committee: The affected provider may submit written statements covering any matters raised at any step in the hearing process. The Administrator shall submit the statement to the joint review committee and other parties within 20 days after the matter is sent to the joint review committee, except if the joint review committee waives the time limit. The proponents of the challenged action may also submit a written statement covering any matters raised at any step in the hearing process within 20 days after the matter is sent to the joint review committee.

(b) Oral statements: The joint review committee at its sole discretion may allow the parties of their representatives to personally appear and make oral statements in favor of their positions. Any such appearances and statements shall not constitute a hearing under the procedural rules provided for hearings under these bylaws. Any party appearing may be required to answer questions by any member of the joint review committee.

(c) Consideration of new or additional matters: New or additional evidence not raised in the original hearing or otherwise reflected in the record may be introduced during the joint review committee only under unusual circumstances and only at the sole discretion of the joint review committee, if the party requesting consideration of the new or additional
The requesting party shall submit to the Governing Board for submission to the joint review committee, a written description of the new or additional evidence, as soon as the party becomes aware of the evidence.

7.4-4 FINAL ACTION BY GOVERNING BOARD

Within 45 days after receipt of the joint review committee's recommendations, the Governing Board shall make its final decision in the matter and send special notice thereof to the MEC and to the affected provider. No provider shall be entitled to more than one hearing pursuant to Article VII of these bylaws.

7.5 ADVERSE ACTION REPORT

7.5-1 PRIOR NOTICE TO AFFECTED PROVIDER

If the final action of the Board is an action for which an Adverse Action Report form must be submitted to the Oregon Medical Board, or the appropriate licensing agency pursuant to the Health Care Quality Improvement Act of 1986, as amended, and the regulations adopted pursuant thereto, the Administrator shall provide the provider with an exact copy of the Adverse Action Report which Legacy Silverton Health intends to submit to the Oregon Medical Board, or appropriate licensing agency, together with the Privacy Act Notification and an explanation of all codes used in completing the form at least five days prior to submission to allow resolution of any dispute.

7.5-2 DISPUTES CONCERNING ADVERSE ACTION REPORT

If a provider disputes the content of the report the provider shall immediately, in writing, inform the Administrator, or designee who, after conferring with the president of the medical staff regarding the report's contents, shall within 48 hours ultimately decide upon the final content of the report. When the Administrator or president of the medical staff will be absent from Legacy Silverton Health, or otherwise unavailable to act on the disputed contents of an Adverse Action Report, they shall appoint designees to act during their unavailability. If the Adverse Action Report is revised following this procedure, a new Adverse Action Report shall be prepared and an exact copy provided to the provider by special notice prior to sending the Adverse Action Report to the Oregon Medical Board or the appropriate licensing board.

7.5-3 SUBMISSION TO THE BOARD OF MEDICAL OR DENTAL EXAMINERS

Regardless of whether a dispute regarding an Adverse Action Report has been resolved, the Administrator or designee shall submit the Adverse Action Report to the National Practitioner Data Bank and the Oregon Medical Board or appropriate licensing board, within 15 days from the date the decision is approved by the Administrator in writing.

7.5-4 SEPARATE REPORTING FORM

A separate report of the adverse action(s) shall be reported to the appropriate licensing board, in a format different from the form used to report to the National Practitioner Data Bank.
ARTICLE VIII - OFFICERS

8.1 OFFICERS OF THE MEDICAL STAFF

8.1-1 IDENTIFICATION
The officers of the medical staff shall be the president, vice president, immediate past president, and secretary-treasurer.

8.1-2 QUALIFICATIONS
Officers must be members of the active medical staff at the time of their nominations and election, and must remain active members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

8.1-3 NOMINATIONS
(a) The election year shall be every two years. The Medical Staff shall appoint a nominating committee not later than 60 days prior to the November staff meeting or at least 45 days prior to any special election. The nominating committee shall consist of the current president, the vice president and 3 members chosen by vote of the active Medical Staff. The nominating committee shall nominate one or more nominees for each position on the MEC. The nominations of the committee shall be reported to the medical staff at least 30 days prior to the November meeting.

(b) Except as provided in Section 8.1-5, further nominations may be made for any office by any voting member of the medical staff, provided that the name of the candidate is
submitted in writing to the chair of the nominating committee, is endorsed by the signature of at least 10% of other members who are eligible to vote, and bears the candidate's written consent. These nominations shall be delivered to the chair of the nominating committee as soon as reasonably practicable, but at least 20 days prior to the date of election.

If any nominations are made in this manner, the voting members of the medical staff shall be advised by notice delivered or mailed at least 10 days prior to the meeting. Nominations from the floor will be recognized if the nominee is present and consents.

8.1-4 ELECTIONS

The vice president, secretary-treasurer, and chairs of Credentials Committee, CQI Committee, and the service chiefs shall be elected at the November meeting of the medical staff. Voting shall be by voice vote or by secret written ballot, and authenticated sealed mailed ballots may be counted. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the MEC shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

8.1-5 TERM OF ELECTED OFFICE

Each officer shall serve a two-year term, commencing on the first day of the medical staff year following the officer's election. Each officer shall serve in each office until the end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be removed from that office. At the end of that officer's term, the president shall automatically assume the office of immediate past president and the vice president shall automatically assume the office of president.

8.1-6 RECALL OF OFFICERS

Except as otherwise provided, recall of a medical staff officer may be initiated by the MEC or shall be initiated by a petition signed by at least one-third of the members of the medical staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the medical staff members eligible to vote for medical staff officers who actually cast votes at the special meeting in person or by mail ballot.

8.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies, other than that of the president, shall be filled by appointment by the MEC until the next regular election. If there is a vacancy in the office of president, then the vice president shall serve out that remaining term and shall immediately appoint an ad hoc nominating committee to decide promptly upon nominees for the office of vice president. Such nominees shall be reported to the MEC and to the medical staff. A special election to fill the position shall occur at the next
regular staff meeting. If there is a vacancy in the office of vice president, that office need not be filled by election, but the MEC shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of president.

8.2 DUTIES OF OFFICERS

8.2-1 PRESIDENT OF MEDICAL STAFF

The president shall serve as the chief officer of the medical staff. The duties of the president shall include, but not be limited to:

(a) enforcing the medical staff bylaws and rules and regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
(b) calling, presiding at, and being responsible for the agenda of all meetings of the medical staff;
(c) serving as chair of the MEC;
(d) serving as an ex officio member of all other staff committees without vote, unless the president’s membership in a particular committee is required by these bylaws;
(e) interacting with the administrator in all matters of mutual concern within the hospital;
(f) appointing, in consultation with the MEC, committee members for all standing and special medical staff, liaison, or multi-disciplinary committees, except where otherwise provided by these bylaws and, except where otherwise indicated, designating the chairs of these committees;
(g) representing the views and policies of the medical staff to the Governing Board and to the administrator;
(h) attending the regular meetings of the Board; report on the medical staff activities and quality of care issues and activities to the Board; receive and interpret the polices of the Board to the medical staff;
(i) being a spokesperson for the medical staff in external professional and public relations; and
(j) performing such other functions as may be assigned to the president by these bylaws, the medical staff, or by the MEC.

8.2-2 VICE PRESIDENT OF THE MEDICAL STAFF [PRESIDENT ELECT]

The vice president shall assume all duties and authority of the president in the absence of the president. The vice president shall be a member of the MEC, the Bylaws Committee, and of the joint conference committee, and shall perform such other duties as the president may assign, or as may be delegated by these bylaws or by the MEC.

8.2-3 IMMEDIATE PAST PRESIDENT OF THE MEDICAL STAFF

The immediate past president shall be a member of the MEC and a member of the Joint Conference Committee, and shall perform such other duties as may be assigned by the president or delegated by these bylaws, or by the MEC.

8.2-4 SECRETARY-TREASURER

The secretary-treasurer shall be a member of the MEC. The duties shall include, but not
be limited to:

(a) receiving, disbursing, and safeguarding all funds of the medical staff; and
(b) performing such other duties as ordinarily pertain to the office or as may be assigned
from time to time by the president or the MEC.

ARTICLE IX - CLINICAL SERVICES

9.1 ORGANIZATION OF CLINICAL SERVICES

The medical staff shall be divided into clinical services, which shall be organized as
separate components of the medical staff. Each service shall have a chief of service
selected and entrusted with the authority, duties, and responsibilities specified in Section
9.5

9.2 CURRENT CLINICAL SERVICES

The current clinical services are:
(a) Medicine – including intensive care, pediatrics, emergency services, pathology,
diagnostic imaging, blood utilization, pharmacy and therapeutic support services;
(b) Surgery – including Endoscopy services, and anesthesia); and
(c) Ob/Newborn – including obstetrics and Family Birth Center newborn nursery.
(d) Outpatient – including all clinical outpatient services of Legacy Silverton Health

9.3 ASSIGNMENT TO SERVICES

Every provider shall have affiliations with the services, which reflect the provider’s
professional training and experience. A provider may be granted clinical privileges in one
or more services and the provider’s exercise of privileges within the jurisdiction of any
service is always subject to the rules and regulations of that service and the authority of the
chief.

9.4 FUNCTIONS OF THE SERVICE

The general functions of each service shall include:

(a) Monitoring overall patient care for the purpose of analyzing and evaluating the quality
of care provided to patients within the service. The service shall routinely collect
information about important aspects of patient care provided in the service,
periodically assess this information, and develop objective criteria for use in evaluating
patient care.

(b) Establishing a Peer Review Committee (PRC) to monitor and evaluate medical care
on a retrospective, concurrent, and prospective basis for providers providing care
within the service. The peer review plan as approved by the medical staff will be the basis of the peer review process of the committee. The PRC’s will meet at least four times annually.

Each PRC shall be composed of at least four members of the active or affiliate medical staff, who will be selected each November by the incoming service chief, and appointed to a two-year term, by the incoming service chief. At least two members of each PRC will be Family Practitioners and other members will represent the major specialty areas in the service. The outpatient services peer review committee shall be composed of members who are subject to the outpatient peer review process. The outpatient services PRC shall pertain exclusively to the peer review of clinical outpatient services delivered at a Legacy Silverton Health facility.

The PRC shall make recommendations on a quarterly basis to the Credentials Committee concerning staff status, monitoring of provisional staff members, and clinical privileges, including reappointment, and termination of the provisional staff status. The chief of service shall report monthly to the MEC the activities and recommendations of the PRC, and as needed to the credentials committee and other committees of the medical staff as appropriate.

(c) coordinating patient care provided by the service members with nursing and ancillary patient care services, and making recommendations to the medical staff for maintaining and improving the quality of care provided in the service.

(d) taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.

(e) formulating recommendations for services rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval of the MEC and the Medical Staff.

(f) coordinating with the Credentials Committee to establish minimal requirements for the clinical privileges that may be exercised within this service.

9.5 SERVICE CHIEFS

9.5-1 QUALIFICATIONS

Each service shall have a service chief who shall be a member of the active medical staff and shall qualify by training, experience, and demonstrated ability in at least one of the clinical areas covered by the service.

9.5-2 SELECTION

Service Chiefs shall be nominated by the Medical Staff Nominating Committee and elected by the medical staff.
9.5-3 TERM OF OFFICE

Each Service Chief shall serve a two year term which coincides with the medical staff year or until a successor is chosen, unless the chief shall resign or be removed from office or lose medical staff membership or clinical privileges in that service. Service chiefs shall be eligible to succeed themselves.

9.5-4 REMOVAL

After election to office, removal of service chiefs from office may occur for cause by a two-thirds vote of the medical staff members who cast votes at a Medical Staff meeting.

9.5-5 DUTIES

A service chief has these specific responsibilities and authority:

(a) designate a qualified temporary chief to assume all responsibility and authority of the chief in the service chief's temporary absence;
(b) participate on a continuous basis in managing the service through cooperation and coordination with the nursing and other patient care services, hospital management and the president of the medical staff on all matters affecting patient care;
(c) implement within the service actions taken by the medical staff, MEC, and the Governing Board;
(d) maintain through the peer review committee a continuing review of patient care and professional performance of providers with clinical privileges or specified services in the service, and present written reports to the medical staff, to the MEC and to other staff or hospital committees when appropriate or required;
(e) coordinate with the PRC to monitor providers with provisional privileges and supervise proctoring of these providers, and report such activities to the Credentials Committee as appropriate.
(f) review data/information forwarded from the various medical committees charged with quality review, risk management, or utilization management activities;
(g) prepare and transmit to appropriate committees as required by the medical staff bylaws or other relevant protocols recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to providers in the service.
(h) take appropriate action when important problems in patient care and clinical performance, or opportunities to improve care, are identified.

ARTICLE X - COMMITTEES

10.1 DESIGNATION

Medical staff committees shall include but not be limited to, 1) the medical staff meeting as a committee of the whole, 2) meetings of services, 3) meetings of committees established under this Section, and 4) meetings of special or ad hoc committees created by the MEC (pursuant to this section). The committees described in this Section shall be the standing committees of the medical staff. Special or ad hoc committees may be created by the MEC.
to perform specified tasks. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the president, subject to consultation with and approval by the MEC. Medical staff committees shall be responsible to the MEC.

10.2 GENERAL PROVISIONS

10.2-1 TERMS OF COMMITTEE MEMBERS

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

10.2-2 REMOVAL

If a member of a committee ceases to be a member in good standing of the medical staff, or loses employment or a contract relationship with Legacy Silverton Health, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the MEC.

10.2-3 VACANCIES

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

10.2-4 CONTINUATION OF COMMITTEE TERMS

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

10.3 MEDICAL EXECUTIVE COMMITTEE

10.3-1 COMPOSITION

The MEC shall consist of the following persons:
(a) The officers of the medical staff;
(b) The service chiefs;
(c) The chairman of the Continuous Quality Improvement Committee and the Credentials Committee;
(d) The Director of the Emergency Department;
(e) The immediate Past-President;
(f) The Administrative Director of the hospital or designee as an ex-officio member; and
(f) When an IAHP is being considered for corrective action or an adverse decision for appointment, an additional appointee from the IAHP's profession shall be named as a temporary voting member. Such person need not be a member of the IAHP's staff.

47
of Legacy Silverton Health.

10.3-2 DUTIES
The duties of the MEC shall include, but not be limited to:

(a) receiving reports and recommendations from the Credentials Committee, CQI Committee, and service chiefs, and receiving recommendations for corrective action as delineated in 6.1-2.

(b) coordinating and implementing the professional and organizational activities and policies of the medical staff;

(c) receiving reports and approving recommendations from medical staff services, committees, and assigned activity groups as delegated by the Medical Staff;

(d) recommending actions to the Governing Board on matters of a medical-administrative nature;

(e) establishing the structure of the medical staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assurance activities and mechanisms of the medical staff, termination of medical staff membership and fair hearing procedures, as well as other matters relevant to the operation of an organized medical staff;

(f) evaluating the medical care rendered to patients of Legacy Silverton Health;

(g) participating in the development of all medical staff, hospital and clinic policy, practice, and planning;

(h) reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members, and making recommendations to the Governing Board regarding staff appointments and reappointments, clinical privileges, and corrective action;

(i) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in medical staff corrective or review measures when warranted;

(j) taking reasonable steps to develop continuing medical education activities and programs for the medical staff;

(k) designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the medical staff and approving or rejecting appointments to those committees by the president of the medical staff;

(l) reporting to the medical staff at each regular staff meeting and recommending actions as appropriate;

(m) assisting in the obtaining and maintenance of accreditation;

(n) developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster;

(o) appointing such special or ad hoc committees as may seem necessary or appropriate to assist the MEC in carrying out its functions and those of the medical staff; and

(p) reviewing the quality and appropriateness of services provided by contract physicians;

(q) acting for the organized Medical Staff between meetings of the organized medical staff; and

(r) In cases of a documented need for an urgent amendment to rules and regulations or bylaws necessary to comply with State law or regulation, or Federal law or regulation, the MEC shall provisionally adopt, and the governing board may
provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff shall be immediately notified of the provisional amendment by the MEC. At the next medical staff meeting, the medical staff shall review and comment on the provisional amendment with formal readings and a vote as described in ARTICLE XIII of the Bylaws. If there is conflict over the provisional amendment and resolution cannot be reached, the process for resolving conflict between the organized medical staff and the medical executive committee shall be implemented. If necessary, a revised amendment is then submitted to the governing board for action.

10.3-3 MEETINGS

The MEC shall meet as often as necessary, but at least quarterly, and shall maintain a record of its proceedings and actions.

10.4 CREDENTIALS COMMITTEE

10.4-1 COMPOSITION

The Credentials Committee shall consist of at least six members of the active Medical Staff to assure representation from major specialty services. The members shall be nominated by the nominating committee and elected by the active Medical Staff at the November meeting. Membership shall include the President, Credentials Chair, Immediate Past-President, President-elect, Service Chiefs, and one (1) member-at-large. The member-at-large will serve a four (4) year term to help ensure continuity and experience.

When an IAHP is being considered for corrective action or an adverse decision for appointment, an additional appointee from the provider’s profession shall be named as a temporary voting member. Such person need not be a member of the IAHP staff of Legacy Silverton Health.

10.4-2 DUTIES

The Credentials Committee shall:

(a) review and evaluate the qualifications of each provider applying for initial appointment, reappointment, or modification of clinical privileges, and obtain and consider the recommendations of the appropriate services;

(b) submit required reports and information on the qualifications of each provider applying for membership or particular clinical privileges including recommendations for appointment, membership category, service affiliation, clinical privileges and special conditions to the MEC;

(c) investigate matters referred by the president of the MEC, peer review committees, other committees of the medical staff, or any member of the medical staff regarding the qualifications, conduct, professional character or competence of any applicant or
provider. The Credentials Committee may, at its discretion, request the provider who is being investigated to appear before the committee. The Committee will submit its findings and recommendations to the MEC; and

(d) submit periodic reports to the MEC on its activities and the status of pending applications.

10.4-3 MEETINGS
The Credentials Committee shall meet at least quarterly, and as often as necessary at the call of its chair. The Committee shall maintain a record of its proceedings and actions and shall report to the MEC.

10.6 CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

10.6-1 COMPOSITION
The CQI Committee shall consist of such members as may be designated by the president of the Medical Staff including, at least one representative from the nursing service and from administration. The chairman of the committee will be nominated by the nominating committee and be elected bi-annually by the active Medical Staff at the November meeting.

10.6-2 DUTIES
The duties of the CQI committee shall include continuous quality improvement activities and utilization review, as well as perform the following duties:

(a) recommend for approval of the MEC plans for maintaining quality patient care within Legacy Silverton Health. These may include mechanisms to:

1. establish systems to identify potential problems in patient care;
2. set priorities for action on problem correction;
3. refer priority problems for assessment and corrective action to appropriate departments or committees and/or to outside consultants;
4. monitor the results of CQI activities throughout Legacy Silverton Health; and
5. coordinate CQI activities;

(b) submit regular confidential reports to the MEC on the quality of medical care provided and on quality review activities conducted.

(c) conduct utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services. The committee shall communicate the results of its studies and other pertinent data to the MEC and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety;

(d) establish a utilization review plan which shall be approved by the Medical Staff;

(e) obtain, review, and evaluate information and raw statistical data obtained or generated by the hospital's case management system.
10.6-3 MEETINGS

The committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to the MEC and Governing Board, except that routine reports to the Governing Board shall not include peer evaluations related to individual members.

10.7 BYLAWS COMMITTEE

10.7-1 COMPOSITION

The bylaws committee shall consist of at least three members of the medical staff, including the vice president of the Medical Staff who shall serve as committee chair. The other members of the committee will be appointed bi-annually by the vice-president of the Medical Staff.

10.7-2 DUTIES

The duties of the bylaws committee shall include:

(a) conducting an annual review of the medical staff bylaws, as well as the rules and regulations and forms promulgated by the Medical Staff;
(b) submitting recommendations to the Medical Staff for changes in these documents as necessary to reflect current medical staff practices; and
(c) receiving and evaluating for recommendation to the Medical Staff suggestions for modification of the items specified in subdivision (a).

10.7-3 MEETINGS

The bylaws committee shall meet as often as necessary at the call of its chair, but at least annually. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Staff.

10.8 INFECTION CONTROL COMMITTEE

10.8-1 COMPOSITION

The Infection Control Committee shall consist of such members as may be designated by the president of the Medical Staff, and representatives from nursing service, administration, laboratory and other relevant services as the Medical Staff deems necessary. The chairman and committee members shall be appointed bi-annually by the president of the Medical Staff.

10.8-2 DUTIES

The duties of the Infection Control Committee shall include:

(a) developing a hospital-wide infection control program and maintaining surveillance over the program;
(b) developing a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;
(c) developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;
(d) developing written policies defining special indications for isolation requirements;
(e) coordinating action on findings from the medical staff's review of the clinical use of antibiotics;
(f) acting upon recommendations related to infection control received from the president of the medical staff, the MEC, departments and other committees;
(g) reviewing sensitivities or organisms specific to the facility.

10.8-3 MEETINGS
The Infection Control Committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its findings, proceedings and actions, and shall make reports of its activities and recommendations to the Medical Staff.

10.9 CONTINUING EDUCATION COMMITTEE
The physician appointed bi-annually by the president of the Medical Staff shall be responsible for the hospital based educational activities of the Medical Staff.

ARTICLE XI - MEETINGS

11.1 MEETINGS OF THE MEDICAL STAFF

11.1-1 SCHEDULE OF MEETINGS
There shall be no fewer than nine Medical Staff meetings annually.

11.1-2 AGENDA
The order of business at a meeting of the medical staff shall be determined by the president and MEC. The agenda shall include, insofar as feasible:

(a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;
(b) administrative reports from the president, the MEC, the services and committees, the Governing Board chairman, and the Administrator;
(c) election of officers when required by these bylaws;
(d) reports by responsible officers, committees, and services on the overall results of patient care audits and other quality review, evaluation and monitoring activities of the staff, and on the fulfillment of other required staff functions;
(e) old business; and
(f) new business.
11.1-3 SPECIAL MEETINGS

Special meetings of the medical staff may be called at any time by the president or the MEC, or shall be called upon the written request of 10% of the members of the active medical staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the MEC within 30 days after receipt of such request. No later than 10 days prior to the meeting, notice shall be mailed or delivered to the members of the staff which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

11.2 COMMITTEE AND SERVICE MEETINGS

11.2-1 REGULAR MEETINGS

Except as otherwise specified in these bylaws, the chairs of committees, services may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice. The services will hold meetings at least every quarter. The service peer review committee will meet at least four times annually.

11.2-2 SPECIAL MEETINGS

A special meeting of any medical staff committee or service may be called by the chair thereof, the MEC, or the president, and shall be called by written request of one-third of the current members, eligible to vote, but not less than six members.

11.3 QUORUM

11.3-1 STAFF MEETINGS

The presence of 50% of the total members of the active medical staff at any regular or special meeting in person or through written ballot shall constitute a quorum for the purpose of amending these bylaws or the rules and regulations of the medical staff or for the election or removal of staff officers.

11.3-2 COMMITTEE MEETINGS

A quorum of 50 percent of the voting members shall be required to call the meeting to order and for voting action at committee meetings with assigned members. Abstentions shall not affect the quorum. For other committees and services, a quorum shall be the voting members present.

11.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Committee action may be conducted by telephone or e-mail conference which shall be deemed to
constitute a meeting for the matters discussed in that telephone or e-mail conference. Valid action may be taken without a meeting by a committee if it is acknowledged in writing, setting forth the action so taken, which is signed by at least two-thirds of the members entitled to vote.

11.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. The original of the minutes shall be signed by the presiding officer of the meeting and forwarded to the MEC to be retained in the medical staff office, with a copy retained by the appropriate committee. Any minutes, (including the original and copies), which are privileged under ORS 41.675, as provided for in Article 12 Section 12.2, shall be marked: "Privileged and Protected under ORS 41.675."

11.6 ATTENDANCE REQUIREMENTS

11.6-1 REGULAR ATTENDANCE

All members of the medical staff are encouraged to attend medical staff, committee, and service meetings as assigned in order to be involved in the responsibilities and decisions of the medical staff.

11.6-2 SPECIAL ATTENDANCE

At the discretion of the chair or presiding officer, when a provider’s practice or conduct is scheduled for discussion at a regular service, or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least 7 days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at three (3) consecutive meetings with respect to which the provider was given such notice, unless excused by the MEC upon a showing of good cause, shall be deemed voluntary relinquishment of medical staff membership and privileges.

11.7 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order, however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

ARTICLE XII - CONFIDENTIALITY, IMMUNITY AND RELEASES

12.1 AUTHORIZATION AND CONDITIONS

By applying for clinical privileges within Legacy Silverton Health, an applicant:

(a) authorizes representatives of the hospital and the medical staff to solicit, provide, and
act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

(b) authorizes persons and organizations to provide information concerning such provider to the medical staff;

(c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the medical staff or the hospital who acts in accordance with the provisions of this Article; and

(d) acknowledges that the provisions of this Article are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of clinical privileges at this hospital.

12.2 CONFIDENTIALITY OF INFORMATION

Any information in connection with training, supervision, or discipline of physicians or in connection with a grant, denial, restriction, or termination of clinical privileges, including, without limitation, written reports, notes and records of Legacy Silverton Health or the medical staff or any committee or representative of Legacy Silverton Health or its medical staff for the purpose of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, determining that health care services are professionally indicated, or were performed in compliance with the applicable standard of care, or establishing and enforcing guidelines to keep health care costs within reasonable bounds, is privileged. Such information shall not be disseminated to anyone other than a representative of Legacy Silverton Health or medical staff, nor be used in any way except as provided herein, or except as otherwise required by law or authorized by the provider. Such information shall be maintained in a confidential manner by the Manager of Medical Staff Services. Any such information required or permitted by these bylaws or law to be disseminated to the MEC, Administrative Director, or others, shall be marked: "Privileged and Protected Under ORS. 41.675."

12.3 IMMUNITY FROM LIABILITY

12.3-1 FOR ACTION TAKEN

Each representative of the medical staff and Legacy Silverton Health shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the medical staff or Legacy Silverton Health.

12.3-2 FOR PROVIDING INFORMATION

Each representative of the medical staff and Legacy Silverton Health and all third parties shall be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the medical staff or hospital concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at Legacy Silverton Health.
12.3-3 INDEMNITY

Legacy Silverton Health’s corporate Bylaws provide that it shall indemnify any director, officer, employee or agent of Legacy Silverton Health or any person who is or was serving at the request of Legacy Silverton Health as a member of a committee for liability incurred by such person in the exercise of their duties with respect to the hospital to the extent permitted by Oregon Law. Legacy Silverton Health shall not change this provision without thirty (30) days prior written notice to the medical staff.

12.3-4 INSURANCE

Legacy Silverton Health has insurance which according to the terms of the insurance policy covers medical staff members for peer review and similar activities required by these Bylaws. Legacy Silverton Health shall keep the medical staff apprised in writing of the terms of such insurance and any changes thereto.

12.4 ACTIVITIES AND INFORMATION COVERED

12.4-1 ACTIVITIES

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

(a) application for appointment, reappointment, or clinical privileges;
(b) corrective action;
(c) hearings and reviews;
(d) utilization reviews;
(e) other service, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
(f) peer review organizations, BME, and National Practitioners Data Bank (NPDB) or similar reports.

12.5 RELEASES

Each applicant or member shall, upon request of the medical staff or Legacy Silverton Health, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

12.6 CREDENTIALS FILE

12.6-1 CREDENTIALS FILE

There shall be one credentials file for each member of the medical staff and it shall be deemed confidential pursuant to ORS 41.675.
12.6-2 CONTENT:

(a) Applications, reapplication;
(b) Licenses, DEA Number;
(c) Evidence of education, experience, Board Certifications (if any);
(d) Reference and correspondence related to professional qualifications;
(e) Professional liability coverage and experience;
(f) All credentials material;
(g) National Practitioner Data Bank queries and responses;
(h) Quality or disciplinary documents (if any);
(i) Evidence of appropriate continuing medical education;
(j) Other documents and correspondence related to practice; and
(k) Other information and provider requests to be included.

12.6-3 ACCESS

Access to such records is limited to authorized persons with a need to know, i.e. medical staff officers, persons serving on committees, and medical staff administration personnel and staff, and only for the purposes of discharging authorized activities and responsibilities.

A provider may have access to their own credentials file, subject to the following conditions.

(a) The staff member must request access from the president of the medical staff or designee. Access will be granted within a reasonably short time after the request or the provider will be given the reason for denial.
(b) Review shall take place in the office where the records are maintained, during normal business hours, with a member of the medical staff office or administration present.
(c) Review is limited to those documents prepared or provided personally by the provider. All other information shall be disclosed only in written summary form. The summary shall contain the substance, but not the source of the information.
(d) In the event of a corrective action or a hearing, the provider shall have access to the information in the file to the extent required by Sec. 6.1-4(d) of the Bylaws.
(e) A provider may request copies of those documents available for review. The provider may be charged a fee for copying not to exceed the reasonable cost to copy the documents. A provider shall not remove, cancel, destroy, obliterate or change any document in the file.

12.6-4 CORRECTION, DELETION OR ADDITIONS TO INFORMATION IN FILE

A provider may request corrections, deletions or additions to information in the provider’s file.

The President shall review the request within a reasonable time and decide whether the request will be granted or denied. If granted, the appropriate action will be taken and the provider will be so notified. If the request is denied, the provider will be notified of the reasons for denial. The provider may request a review of the president's decision by the MEC. This review is not a hearing pursuant to Article VIII.
Notwithstanding the above, a provider has the right to add a short, reasonable, relevant, written statement to the provider's file to support or rebut any other information contained therein.

**ARTICLE XIII – VOTING**

**13.1. Manner of Voting:**

Unless otherwise provided for in these bylaws, a vote on a matter presented to the Medical Staff, or a clinical service 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.

**13.2. 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.

**13.3. Approval:**

Unless otherwise provided for in these bylaws, 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 XIV - 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 XV: REVIEW, REVISION, ADOPTION AND AMENDMENT OF THE BYLAWS

15.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.

15.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.

(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.
15.A.3. **Related Policies, Rules and Regulations:**

(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 14 shall be implemented.

(f) Neither the Medical Staff nor the Legacy Board may unilaterally amend such rules, regulations and policies.

15.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 XVI: 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.

**MEDICAL STAFF BYLAWS**

These Bylaws were unanimously recommended to the Silverton Hospital Board of Trustees by the Medical Staff on September 27, 1994.

These Bylaws were approved by the Silverton Hospital Governing Board on October 25, 1994 for implementation on January 1, 1995.

Revisions were made and approved by the Silverton Hospital Governing Board on October 30, 2002.

These Bylaws were reviewed and approved by the Governing Board of Trustees on January 30, 2008.

_________________________________________  __________________________
John Gilliam, MD, Medical Staff President       Date

_________________________________________  __________________________
William Winter, Administrative Director         Date

_________________________________________  __________________________
Gary Simon, Governing Board Chairman            Date