MEDICAL STAFF RULES AND REGULATIONS

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July 29, changed “Silverton Hospital” and “the hospital” to “Silverton Health”; “practitioner” to “provider”; “he/she” to “provider”; “his/hers” to “their”.
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## ARTICLE I

### DEFINITIONS
The following definitions shall apply to terms used in these Rules and Regulations:

(a) “Board” means the Board of Trustees of Silverton Health, who has overall responsibility for the operation of Silverton Health.

(b) “Emergency” means a condition which could result in serious or permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that harm or danger.

(c) “Executive Committee” means the Executive Committee of the Medical Staff unless specifically written “Executive Committee of the Board”.

(d) “Medical Staff” means all providers who are given privileges to treat patients within Silverton Health.

(e) “Patients” means inpatients or outpatients.

(f) “Physicians” shall be interpreted to include both doctors of medicine and doctors of osteopathy.

(g) “Provider” means physicians and independent and dependent allied health professionals.

(h) “Preceptor” means provider who has privileges for treating patients within Silverton Health and is serving in a supervisory teaching role.

(i) “Preceptee” means provider who is involved in procedures under the supervision of a Preceptor as outlined in Article XIV.
ARTICLE II TREATMENT OF PATIENTS

Patients may be treated only by providers who have submitted proper credentials and been granted privileges to practice within Silverton Health by the Governing Board.

Disaster Privileges: Temporary privileges may be granted to providers in the event of an emerging incident event and as directed by the Incident Command Center. Emerging Incident Events include events that have potential to negatively impact the ability to provide services, such as, but not limited to, mass casualty incidents, earthquakes, bioterrorism, civil disturbance, fire, evacuation, hazardous material spill and/or utility failure. Primary source verification of licensure, certification, or registration which reasonably supports a favorable determination begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer provider presents to the organization. In the extraordinary circumstance that primary source verification can not be completed within 72 hours (for example, no means of communication or a lack of resources), it is expected that it is to be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. The Incident Commander shall be responsible to make a decision within 72 hours (based on information obtained) regarding whether or not the professional practice of the volunteer provider shall be continued with responsibilities as assigned. (Board approved 7/30/08)

Primary source verification of the following shall be done: valid, current license issued by the State of Oregon or completion of the Oregon Medical Board out-of-state physician form or membership of the National Disaster Medical System (NDMS), photo identification, current professional liability insurance, and current hospital affiliations. In cases where the complete verification process cannot be accomplished immediately, the Administrator or designee may grant temporary privileges upon presentation of any of the following: current hospital photo identification card, current state medical license and a valid picture identification issued by a state, federal or regulatory agency, identification of membership in the NDMS, or presentation by current hospital staff or Medical Staff members with personal knowledge regarding the provider’s identity. The provider will be paired with a Member. (Board approval 2/23/05)

Self-Treatment or Treatment of Immediate Family Members: Consistent with the “American Medical Association Code of Ethics, Opinion 8.19 – Self-Treatment or Treatment of Immediate Family Members”, providers (physicians, IAHP’s and DAHP’s) generally should not treat, prescribe for, or render care to themselves or members of their household, or any other immediate family member, at Silverton Hospital or any Silverton Health clinic. Immediate family members shall be defined as spouse, grandparents, parents, siblings, children, grandchildren and in-law equivalents.

As noted in the aforementioned AMA opinion, it would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.
If a provider renders care for themselves or a family member, complete documentation of relevant history, physical examination, and medical decision making should be provided. If a concern arises regarding the appropriateness of a situation involving self-treatment or treatment of immediate family members, the matter may be referred for review to at least two members of the Medical Executive Committee (MEC). If upon review of the medical record, the MEC members determine the provider’s relationship with the patient may be adversely affecting said care, the provider will be required to refer the case to another provider. (Board approved 4/29/15)

ARTICLE III HOSPITAL ADMISSION

ATTENDING PHYSICIAN: At Silverton Health every patient shall have a physician who will be designated as the “attending physician” for that admission. This will be the admitting physician unless changed by written orders on the chart. The attending physician has final authority on any matters of patient care and will be charged with the responsibility for the release of the patient. Any other physicians who are involved in the patient’s care will be so designated through requests for consultation or referral.

CONSULTING PHYSICIAN: A consulting physician is entitled to examine the patient and to obtain the necessary medical history from the patient or relatives. His advice should be recorded within 24 hours on the chart. A consultation shall include examination of the patient and pertinent records and a written opinion signed by the consultant which is made a part of the record. When an operative procedure is involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

Consultations are requested at the discretion of the Attending Physician under the following circumstances:

(1) Where the diagnosis is obscure after ordinary diagnostic procedures have been completed, or
(2) Where there is strong medical doubt as to the choice of therapeutic measures to be utilized, or
(3) In unusually complicated situations where the specific skills of other medical staff members may be needed, or
(4) Upon the request of the patient or family.

A consultation does not in and of itself constitute a transfer of care. A transfer of care must be clearly delineated with written documentation. (Board approved 5/28/08)

REFERRAL PHYSICIAN: Referral of a patient for medial care will be designated as referral for a specific problem only or for total care while in the hospital. If the referral is for total care, the physician accepting the referral would be designated the “attending” physician.

ARTICLE IV STANDING ORDERS

Standing orders shall be formulated by conference between Nursing and Medical providers. Final approval must come from either the medicine or surgery department, as appropriate.

ARTICLE V MEDICAL RECORDS

(Board approved Oct 30, 2013)
5.15.1 Proper use of Legacy's electronic health record (EHR) has the potential to improve the quality of care for patients, reduce medical errors, promote best practices, and decrease the cost of care. However, the improper use of the EHR can potentially result in medical errors and patient harm. The purpose of these rules is to set forth the expectations for the proper use of the EHR in order to ensure patient safety and high quality health care. For the purposes of this document the LHS EHR is considered to include any software, hardware or network which stores or transmits patient level data; is used for computerized practitioner order entry (CPOE); or the acquisition or interpretation of clinical diagnostic data. Practitioners are also expected to be aware of and follow all HIPAA requirements which may apply to the use of the LHS EMR, as well as the transmission of HIPAA protected information by other means, which includes but is not limited to the use of non-secure e-mail, hard copy documents including patient lists and fax transmissions.

Practitioners will actively and meaningfully use the EHR for all patients for whom they care. Practitioners will document all patient encounters in the EHR in a prompt and timely manner, and in all cases within the time frames required by law and as set forth in these Rules and Regulations.

A Practitioner will be granted access to the EHR after completing appropriate training and, or demonstrating current competence. Basic competence is defined as the role-specific ability of any Practitioner to perform his or her usual work flows in the care of the patient, including the specific components outlined below.

Periodic upgrades in EHR technology, structure or process may necessitate that Practitioners complete additional education and training in order to remain competent in use of the EHR. EHR training deemed necessary by Legacy Heath for the safe and efficient operation of the EHR system will be reviewed and approved by the MEC. EHR training approved by the MEC is mandatory for designated practitioners.

Computer Practitioner Order Entry

All clinicians will use Computer Practitioner Order Entry (CPOE) for entering orders into the EHR. Verbal orders (including telephone orders) will only be accepted in urgent situations when immediate access to CPOE is not feasible and orders are needed to promptly address changes in the patient’s condition. All verbal orders must be dated, timed and authenticated as required by law and these Rules & Regulations.

Problem List Maintenance

An accurate and up to date Problem List in the EHR is essential for ensuring safe and high quality patient care. Practitioners will update the active Problem List, within the scope of their clinical expertise:
- at each face to face outpatient clinical encounter,
- upon admission to the hospital, with each transfer between levels of care and upon discharge from the hospital, and
- prior to any invasive procedure.

The Problem List is for the acute and/or chronic active problems of the patient.

Medication Management

 Practitioners are ultimately responsible for the quality of the medication list, and will update the active Medication List, within the scope of their clinical expertise, or leverage the work done by
other members of the healthcare team:
- at each face to face outpatient clinical encounter,
- upon admission to the hospital, with each transfer between levels of care and upon discharge from the hospital, and
- prior to any invasive procedure.
All medications, including PRN medications available for current use, chronic OTC medications, vitamins, supplements, homeopathic remedies, and medications prescribed for chronic use by non-Legacy practitioners, should be on the Medication List. Updating the Medication List also specifically includes the timely removal of duplicate medications or those which will no longer be prescribed.

Epic in Basket including Results Review and Patient Notification

Practitioners will utilize the online results retrieval in the EHR and communicate results to patients or fellow clinicians or both in a timely manner.

Failure to Properly Use the EHR

After formal notice from the Medical Staff for failure to properly use the EHR and an opportunity to come into compliance, a Medical Staff appointee’s admitting and clinical privileges (elective and emergency) shall be automatically relinquished, for failure to comply. Clinical privileges shall be reinstated once the appointee meets the requirements established by Legacy Clinical Informatics for EHR training and demonstration of competency and agrees in writing to properly use the EHR as set forth in these Rules. Failure to complete training, demonstrate competency and agree to properly use the EHR within sixty (60) days from the date privileges were relinquished shall constitute an automatic relinquishment of all admitting and clinical privileges and voluntary resignation from the Medical Staff.

5.2 CHART PREPARATION: The attending provider shall be responsible for the preparation of the medical record (chart) for Silverton Health files. When the consulting provider assumes the majority of care of the patient, that provider shall be deemed to have become the attending provider and assumes responsibility for the discharge summary and final diagnoses.

5.3 HISTORY AND PHYSICAL: Refer to Bylaws ARTICLE V – CLINICAL PRIVILEGES, HISTORY AND PHYSICAL (H&P) for applicable requirements.

5.4 EMERGENCY DEPARTMENT: Records must be completed within 72 hours of discharge from the Emergency Department. A summary of clinically relevant information for continuity of care of the Emergency Medicine patient must be completed within 24 hours of discharge from the Emergency Department.

5.5 OBSTETRICAL RECORDS: The current obstetrical record must include, in addition to requirements for medical records, a complete prenatal record. The prenatal record may be a durable, legible copy of the attending Provider’s office record transferred to the medical record prior to admission and will fulfill the requirements of the history and physical. If the prenatal record reflects an examination of the patient within 7 days of the hospital admission, no interval note will be required. An interval admission note must be written, signed, timed and dated and include pertinent additions to the patient’s history and any subsequent changes in the physical findings. If a prenatal record is not available, the provider must record a complete history and physical examination report at the time of admission.
Prior to a Cesarean Section, a Provider must record a complete history and physical examination.

5.6 **OPERATIVE REPORTS:**

5.6-1 An operative or other high risk procedure report is written or dictated upon completion of the operative or other high risk procedure and before the patient is transferred to the next level of care. If the provider performing the operation or high risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.

5.6-2 The operative or other high risk procedure report includes the following information:
   (a) The name(s) of the licensed independent providers(s) who performed the procedure and his or her assistant(s)
   (b) The name of the procedure performed
   (c) A description of the procedure
   (d) Findings of the procedure
   (e) Any estimated blood loss
   (f) Any specimens(s) removed
   (g) The postoperative diagnosis

5.6-3 When a full operative or other high risk procedure report cannot be entered immediately into the patient’s chart after the operation or procedure, a progress note is entered in the chart before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis. A full report must be dictated within 24 hours of procedure.

5.7 **PROGRESS NOTES:** Notes recording the progress of the patient are required at least daily by the admitting provider and/or attending provider in sufficient detail to give a clear picture of the patient’s condition or needs. Progress notes shall give a pertinent chronological report of the patient’s course in the hospital. *(Board approved 1/27/15)*

5.8 **DISCHARGE DIAGNOSES AND SUMMARIES:** A discharge summary shall be dictated or written within 96 hours of discharge. A discharge summary is not required when a patient is seen for minor problems or interventions, including uncomplicated spontaneous vaginal deliveries staying less than 72 hours, uncomplicated tubal ligations, uncomplicated newborns, observation visits, and other uncomplicated stays of less than 48 hours, regardless of inpatient or outpatient status. In these cases, a final progress note may be substituted for the discharge summary, provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care. Discharge summaries or notes are not required for uncomplicated same-day surgery visits.

5.8-1 When indicated, a discharge summary shall include the following:
   a. The reason for hospitalization
   b. The procedures performed
   c. The care, treatment, and services provided
   d. The patient’s condition and disposition at discharge
   e. Information provided to the patient and family
   f. Provisions for follow-up care
   g. When a patient is transferred to a different level of care within the hospital, and
caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used.

5.9 TREATMENT ORDERS:

5.9-1 Orders for treatment or testing shall be entered directly into the Electronic Health Record, or in writing. An order shall also be considered to be entered if dictated to a Registered Nurse, Registered Pharmacist, or in the case of diagnostic tests, to radiology or laboratory personnel, or cardio-pulmonary personnel. Orders for physical, occupational, and speech therapy and clinical nutrition may be dictated to the respective professionals.

5.9-2 Any order received verbally, including by telephone, shall be entered by the person receiving the order with the name of the provider indicated. The provider must authenticate the order and must maintain communication until order entry is completed.

5.10 DOCUMENTATION OF ENTRIES: All entries in the patient’s medical record must be dated, timed, and authenticated.

5.11 PROCEDURE FOR INCOMPLETE RECORDS

5.11-1 HEALTH INFORMATION MANAGEMENT PROCEDURES: A medical record shall be deemed incomplete when the provider responsibilities delineated in the preceding sections of this Article have not been completed. The Manager of Health Information Management, or designee, will provide notice of incomplete records at seven (7) days and fourteen (14) days. The Manager of Health Information Management (or designee) will work collaboratively with providers to facilitate chart completion.

5.11-2 CORRECTIVE ACTION:

a. Subject to appeal, limited administrative suspension shall be imposed by the medical executive committee when a provider’s responsibility for completion of a given chart is not completed within twenty-one (21) days of notification. A provider placed on limited administrative suspension shall receive special notice in writing of the suspension, stating the stipulations thereof, and the requirements for removal.

b. When a provider has an illness or scheduled absence from the area, this period of time will not be used for calculating incomplete charts if the provider’s medical records are current the week preceding the absence. The provider is obligated to notify the Medical Staff Office in advance of such absences.

c. When a chart is determined to be incomplete due to circumstances outside of the provider’s control, it will not be considered the responsibility of the provider.

d. A provider may appeal limited administrative suspension to the medical executive committee within 48 hours of notification of suspension by providing a written explanation of why specific incomplete medical records should not be considered the responsibility of the provider. An ad hoc committee consisting of the medical staff president, president elect, and service chief or their designees, shall consider the information provided and make a determination as to whether limited administrative suspension should be imposed.

e. A provider under limited administrative suspension:

1. May continue to care for their own previously admitted inpatients
2. May operate on previously scheduled patients
3. May not admit medical patients
4. May not schedule further surgeries
5. May not work a shift in the Emergency Department, and must arrange other coverage.
6. May not take Emergency Department backup call, and if scheduled must arrange other coverage.
7. May not perform deliveries or newborn care, and must arrange other coverage for any obstetrical or newborn responsibilities.
8. Call coverage arrangements must be submitted in written or electronic form to the Medical Staff Office within 48 hours of notification of limited administrative suspension.

f. Three administrative suspensions in one rolling year shall be deemed a voluntary resignation from the medical staff. Providers may reapply to the staff, but must follow all the procedures for a new application. A provider may appeal voluntary resignation to the medical executive committee by providing a written explanation of why specific incomplete medical records should not be considered the responsibility of the provider. An ad hoc committee consisting of the medical staff president, president elect, and service chief or their designees, shall consider the information provided and make a determination as to whether voluntary resignation should be accepted.

ARTICLE VI EDUCATION OF SILVERTON HEALTH PERSONNEL

All Medical Staff and Allied Health Practitioners shall cooperate with Health administration to offer education to Silverton Health hospital personnel by supervising and teaching as requested.

ARTICLE VII EMERGENCY DUTY

Medical staff members shall be responsible for Emergency Department back-up service and for admission of patients without a physician on staff. Rotational call lists will be maintained for Med. Peds, OB, and other specialties as determined by the Medical Staff. If a patient’s problem is beyond the provider’s scope of practice, consults may be requested.

If clinical indicated, patients (a) seen in the Emergency Department by the on-call physician or (b) referred by the Emergency Department to the on-call physician will be scheduled for at least one follow up visit, regardless of the patient’s ability to pay, for the problem which precipitated the initial visit to the Emergency Department. This obligation ends if the patient does not contact the physician’s office within two (2) weeks of the Emergency Department visit to request an appointment. Further aftercare may be referred elsewhere at the discretion of the physician.

There will be these exceptions to this call requirement:

1. Members whose office is more than 20 miles from the hospital, or
2. Members 60 years of age or older.
3. Upon written request, the Medical Executive Committee may excuse any staff member from this requirement.
4. Members in specialties with fewer than three (3) physicians will be required to take emergency department call a minimum of seven (7) days per month. (Board approved
ARTICLE VIII  SCREENING EXAMINATIONS

A. EMERGENCY DEPARTMENT PATIENTS

Every patient presenting to the Emergency Department will have a screening examination performed by the ED physician or a provider with appropriate medical staff privileges; or in the case of suture or staple removal by an RN qualified by training and in accordance with ED policy and procedure. (Board approved 2/27/08) Obstetrical patients presenting for evaluation of labor or obstetrical problems will have a screening exam performed by a physician or allied health provider with appropriate medical staff privileges, or an RN qualified by training and in accordance with Medical Staff and Silverton Health Policy. The purpose of the examination is to determine whether an emergency medical condition exists.

ARTICLE IX  SURGERY

A. Privileges

1. Surgery privileges will be granted to members of the medical staff consistent with their qualifications as provided in the Bylaws.

2. New physicians joining the staff shall a) have documentation of having performed the surgical procedures in question or b) have a letter of recommendation from the previous hospitals where he/she has worked to certify competence.

3. Surgical privileges will be reviewed by the Credentials Committee at the time of reappointment.

B. Anesthesia

1. Anesthesia privileges will be granted as provided in the Bylaws to anesthesiologists and Certified Registered Nurse Anesthetists (CRNA) who by special training have the ability to perform accepted procedures commonly employed to render the patient insensible to pain for the performance of surgical and obstetrical procedures, support life functions during the period of anesthesia, provide appropriate pre-anesthesia and post-anesthesia management, and provide consultation relating to other forms of patient care such as emergency CPR and intubation.

2. Anesthesia care for elective surgery should be available as arranged by Silverton Health administration and at all times for emergent cases.

3. Pre-anesthesia evaluation of the patient will be made by the provider responsible for anesthesia services and will include the patient’s previous drug history, allergies, anesthetic history, and potential anesthetic problems.

4. The provider responsible for anesthesia services will monitor and record all events taking place during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous
fluids, and blood or blood fractions. (Revised to meet CRNA guidelines)

5. When a general anesthesia is administered, the provider will record within 48 hours, post-anesthetic visits that include at least one visit after administration of anesthesia with specific reference to presence or absence of anesthetic complications.

6. A written, signed, informed consent will be obtained prior to the use of any general or major block anesthetic except in cases when the patient’s life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient.

C. Scheduling

1. Elective surgeries will be scheduled through the operating room supervisor. Individual surgeons may be granted a reserved block of time by the surgery department if their volume justifies this courtesy. Unscheduled time will be released 72 hours prior to use and filled on a first-come-first-served basis.

2. Qualified operating room personnel will be on-call for emergency surgery. A published on-call schedule, including anesthesia services, will be available at the medical/surgical nurses’ station.

D. Assistants

For cases involving unusual hazard to life or physical function, the assistant shall be another qualified physician. Other cases, which are considered routine and uncomplicated, the operating surgeon may decide whether to use another physician or qualified operating room staff member. If there is a disagreement on the necessity of an assisting physician, the chairman of the surgery department will resolve the dispute.

E. Pathology

All tissues removed in the operating room must be sent to the Pathology Laboratory for gross and/or microscopic examination except as Surgery Department policy provisions provide exceptions.

F. Special availability for obstetric patients

All physicians, midwives, and anesthetists providing obstetrical services must be available to their patients within 30 minutes. If circumstances preclude this possibility, the provider must notify the OB charge nurse of their designated alternative provider.

ARTICLE X Residents and Students

A. Medical and Non-Physician Students, depending on licensure and clinical privileges, provide patient care services within limits of licensure with appropriate levels of supervision and/or in coordination with physician Members. Non-physician Members must have the ability to meet Medicare/Medicaid conditions of participation and JCAHO standards, and conditions of reimbursement to the Hospital for services.

Students may be allowed to participate in training with a Member Silverton Health under the
following guidelines:
1. Must be currently enrolled in an accredited medical school or applicable professional school. A letter from the school is required and must include:
   a. Name of preceptor;
   b. Proposed length of training period;
   c. Professional liability insurance as required of Members;
   d. Worker’s Compensation coverage.
2. May be an assistant at a procedure.
3. Must work only under the direct supervision of a Member or IAHP.
4. Patients must be made aware of, and consent to, student involvement in their care (i.e., surgery, diagnostic procedure, making rounds, etc.)
5. The supervising Member must cosign all orders within 24 hours. Orders written by the student in the absence of the Member must be confirmed by the Member over the phone to the charge nurse.
6. Must wear a name badge at all times.
7. May write progress notes in the patient chart with co-signature of preceptor.
8. Will comply with “Visitors in OR” policy.

B. Residents who are participating in patient care under affiliation agreements adhere to the following guidelines:

1. Must hold a valid limited license or current license issued by the Oregon Medical Board.
2. Must be currently enrolled in an accredited residency program.
3. May only work under supervision of a Member.
4. May participate in call coverage for a Member but may not assume primary patient responsibility. Member must be within 30 minutes of the hospital for direct, on-sight patient care and must be immediately available by phone. Must wear a name badge at all times.

ARTICLE XI CRITERIA FOR PRECEPTOR PROGRAM

A. Preceptor/preceptee training shall be allowed at Silverton Health.

B. Written criteria for privileging for any procedure that involves a preceptor-training program shall be developed by the Credentials Committee prior to initiation of a preceptor-training program.

C. Prior to the initiation of any preceptor-training program for an individual provider, a written plan will be submitted to the Credentials Committee for approval, then to the Executive Committee of the Medical Staff for approval, and subsequently to the Governing board of Trustees for approval before it is initiated. The plan shall include the names of the preceptor(s), the preceptee, the time period during which the training program will be occurring, and the procedure that will be taught.

If any member of the Medical Staff is presenting a minority report then a conference committee comprised of the Executive Committee of the Board of Trustees and the Executive Committee of the Medical Staff will meet in order to facilitate a full review of the issues. The Executive Committee of the Board of Trustees shall then formulate a report and a recommendation, which shall be presented to the Board of Trustees.
D. Guidelines for the Preceptor
   1. Any physician member of the medical staff can be the preceptor.
   2. The preceptor must have privileges for the procedure being taught.
   3. The preceptor is responsible for the diagnosis, the procedure, and the pre-and-post-
      procedure care.
   4. The procedure must be scheduled in the name of the preceptor, and the preceptor must
      be listed as the physician of record.

E. If a preceptor program needs to be developed, the Credentials Committee will appoint an ad
   hoc Preceptor Training Review Committee (PTRC) of at least two members to develop
   criteria for credentialing for that procedure. The committee shall be composed of active
   members of the medical staff who are providers having similar training and experience and
   holding similar privileges to those privileges being requested by the preceptee. If it is not
   possible to include providers that have similar privileges on the PTRC, then at least one
   committee member should be a medical staff member with privileges for that procedure.
   When appropriate, effort should be taken to include input from outside Silverton Health into
   the preceptor-training program.

F. A signed authorization on the procedure consent form must be obtained which indicates the
   physician of record (preceptor) and the physician performing the procedure (preceptee).
   This wording is suggested for the consent:

   "I approve of ______________________________ performed by ______________________________
   under the supervision of Dr. ______________________________.”

G. The preceptee must present his/her training experience to the Credentials Committee for
   approval before being recommended to the Governing Board for provisional privileges for
   that procedure.

ARTICLE XII  ALLIED HEALTH PROVIDERS

Section A.  CERTIFIED NURSE MIDWIVES

Certified Nurse Midwife (CNM) is a provider currently licensed by the Board of Nursing as a
Nurse Midwife Nurse Practitioner.

CNM’s may make written application for appointment to the IAHP staff by following the Silverton
Health Bylaws and meeting the following additional provisions:

- Must reside and have an office within 20 mile radius of Silverton Health in order to provide
  timely and appropriate continuity of patient care;
- 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 in insurance coverage within one week of receiving notice of such
termination or change;
- Have written protocols of practice that have been approved by the Surgical Service Chief
  and Credentials Committee;
- Have approved statement of collaboration and cooperation from "collaborating physicians"
as defined below, and;
- Possess prescriptive privileges from the Oregon Board of Nursing;
- Complete a period of provisional status and monitoring as delineated by the Medical Staff
  Bylaws and Rules and Regulations

1. Formal Relationship with Collaborating Physician

   a. CNMs must have a formal relationship with collaborating physicians for clinical
      privileges granted. Each physician must provide a letter to the Credentials Committee
      that details this relationship and includes arrangements for call coverage at all times.

   b. The collaborating physician must be a member of the active medical staff with
      appropriate obstetrical privileges. (Board approved 7/29/15) The collaborating physician works
      cooperatively with the CNM and provides consultation and backup for complications of
      patients managed by the CNM.

   c. The physical presence of the on-call collaborating physician is not required, but the
      physician must be available within 30 minutes for direct, on-site, patient care. The
      Credentials Committee must approve backup physicians for collaborating physician.
      Physicians acting as backup to the collaborating physician must be members of the
      medical staff with appropriate obstetrical privileges. (Board approved 7/29/15)

2. Responsibilities

   a. Patient criteria for independent hospital obstetrical care by CNM’s shall be all normal
      patients (singleton, vertex presentation, over 36 weeks) within a 37-week risk score of
      less than 5 as defined by the attached OHSU risk factor scoring guidelines. Patient
      criteria for normal newborns shall be those normal, stable infants weighing at least 5.5
      lbs.

   b. The CNM evaluates all patients for the development of deviations from normal and is
      responsible for notifying the collaborating physician of any deviations from normal.
      Intrapartum and postpartum patients or newborns developing deviations from normal
      require consultation with the collaborating physician, or require transfer to physician
      management. The type of management for each case is dependent upon the severity of
      the deviation and the level of intervention required. This decision should be arrived at
      mutually, though final authority for this decision will rest with the collaborating physician.
      Because the CNM has an ongoing relationship with the woman, the CNM may continue
      to be involved in the care of these patients.

   c. Additional privileges may include performing 3rd or 4th degree lacerations and c-
      section first assist if justified by training and experience and approved by the Credentials
      Committee.

3. Clinical Privileges

   The Medical Executive Committee will make recommendations to the Governing Board
regarding the scope and extent of procedures that a Certified Nurse Midwife may perform within the scope of CNM practice standards, the collaborative agreement with the collaborating physicians, and the privileges granted, the CNM may perform core privileges as delineated on the privilege request form.

Section B. CERTIFIED NURSE PRACTITIONER

A. Certified Nurse Practitioner (CNP) is a provider currently licensed by the Oregon State Board of Nursing as a Nurse Practitioner in a given specialty.

B. CNP's may make written application for appointment to the IAHP staff by following the Silverton Health Bylaws and meeting the following additional provisions:

1. Must reside and have an office within 20 mile radius of Silvertown hospital in order to provide timely and appropriate continuity of patient care;

2. 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 in insurance coverage within one week of receiving notice of such termination or change;

3. Have written protocols of practice that have been approved by the Medicine Service Chief and Credentials Committee;

4. Have approved statement of collaboration and cooperation from "collaborating physician(s)" as defined below, and;

5. Possess prescriptive privileges from the Oregon State Board of Nursing;

6. Complete a period of provisional status and monitoring as delineated by the Medical Staff Bylaws and Rules and Regulations

C. Formal Relationship with Collaborating Physician

1. CNPs must have a formal relationship with collaborating physicians for clinical privileges granted. Each physician must provide a letter to the Credentials Committee that details this relationship and includes arrangements for call coverage at all times.

2. The collaborating physician must be a member of the medical staff with privileges appropriate to the CNP, and must have completed the provisional monitoring requirements. (Board approved 7/29/15) The collaborating physician works cooperatively with the CNP and provides consultation and backup for complications of patients managed by the CNP.

3. The physical presence of the on-call collaborating physician is not required, but the
physician must be available within 30 minutes for direct, on-site, patient care. The Credentials Committee must approve backup physicians for collaborating physician. Physicians acting as backup to the collaborating physician must be members of the medical staff with privileges appropriate to the CNP. (Board approved 7/29/15)

D. Responsibilities

1. Patient criteria for independent care by CNP’s shall be those patients who fall within the nurse practitioner’s scope of practice for which they are educationally prepared and for which competency has been established and maintained.

2. The CNP evaluates all patients for the development of deviations from normal and is responsible for notifying the collaborating physician of any deviations from normal and shall require consultation with the collaborating physician, or require transfer to physician management. The type of management for each case is dependent upon the severity of the deviation and the level of intervention required. This decision should be arrived at mutually, though final authority for this decision will rest with the collaborating physician. Because the CNP has an ongoing relationship with the patient, the CNP may continue to be involved in the care of these patients.

E. Clinical Privileges

The Medical Executive Committee will make recommendations to the Governing Board regarding the scope and extent of procedures that a Certified Nurse Practitioner may perform. Within the scope of CNP practice standards, the collaborative agreement with the collaborating physicians, and the privileges granted, the CNP may perform core privileges as delineated on the privilege request form.

Section C. PSYCHOLOGIST

A. Clinical psychologist means a provider licensed under ORS Chapter 675 who has successfully completed an approved doctoral degree from a regionally accredited training program. Clinical psychologists are members of the Independent Allied Health Professional Staff (IAHP) as delineated in Article 3.9 of the Medical Staff Bylaws.

B. Psychologists may make written application for appointment to the IAHP staff by following the provisions of Article IV of the Silverton Health Bylaws and meeting the following additional provisions:

1. Be a PhD or PsyD

2. 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 in insurance coverage within one week of receiving notice of such termination or change.

C. Responsibilities

Clinical psychologists may participate in patient care and perform psychological testing,
evaluation, counseling or other activities within the scope of his/her clinical privileges at the request of the attending physician when written in the “Physician Orders”.

D. Clinical Privileges

The scope and extent of the privileges that a clinical psychologist may perform, will be delineated by the Credentials Committee and recommended by the Medical Executive Committee for approval by the Governing Board as delineated in Article V of the Medical Staff Bylaws.

a. Clinical Psychologists may not admit patients to the hospital;
   b. May provide counseling, psychological testing and evaluation and other activities within the scope of his/her clinical privileges;
   c. May document notes in the patient’s hospital chart but may not write orders.

Section D.  PODIATRISTS

A. Podiatrist means a provider licensed under ORS Chapter 677 who has successfully completed a four (4) year program at an accredited school of Podiatric Medicine and received a degree as a Doctor of Podiatric Medicine.

B. Podiatric Medicine is the diagnosis and treatment of conditions affecting the human foot and ankle and their governing and related structures, including the local manifestations of systemic conditions by all appropriate systems and means.

C. Podiatric Surgery is a specialty within Podiatric Medicine that includes the diagnosis, medical and surgical management and adjunctive treatment of all diseases, defects, injuries of the foot, ankle and related structures of the leg.

D. Podiatrists are members of the Independent Allied Health Professional Staff (IAHP) as delineated in Article 3.9 of the Medical Staff Bylaws.

E. Podiatrists may make written application for appointment to the IAHP staff by following the provisions of Article IV of the Silverton Health Medical Staff Bylaws and meeting the following additional provisions:

1. Be a graduate of a podiatric medical college accredited by the American Podiatric Medical Association (APMA) and the Council on Podiatric Medical Education (CPME);
2. Have successfully completed a post-graduate residency training program approved by the APMA and the CPME;
3. Be Board qualified or Board certified by the American Board of Podiatric Orthopedics and Primary Care Orthopedics and/or the American Board of Podiatric Surgery;
4. Must reside and have an office within 20 mile radius of Silverton hospital in order to provide timely and appropriate continuity of patient care;
5. 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 in insurance coverage within one week of receiving notice of such termination or change;

F. Responsibilities

1. Podiatrists may admit patients to the Hospital, for outpatient and inpatient admissions, in collaboration with a physician who is a member of the Active Medical Staff and who shall be responsible for the non-surgical aspects of the patient’s care throughout the hospital stay. The Podiatrist shall arrange for the collaborating physician. (Board approved 7/29/15) The physical presence of the collaborating physician is not required, but the physician must be available within 30 minutes for direct, on-site, patient care.

2. The podiatrist shall be responsible for the Podiatric care for the patient, including the podiatric history and physical examination, as well as all appropriate elements of the patient’s record.

3. The podiatric H&P must be performed and recorded in the medical record by the Podiatrist prior to any surgical procedure.

4. Patients brought to the Hospital for podiatric surgery who have a significant medical problem must have a pre-hospital history and physical (H&P) by a medical physician who is on the active medical staff of an Oregon hospital, and the H&P shall be recorded in the hospital’s medical record prior to surgery.

G. Clinical Privileges

The scope and extent of podiatry problems, and the extent of procedures a podiatrist may perform, will be delineated by the Credentials Committee and recommended by the Medical Executive Committee for approval by the Governing Board as delineated in Article V of the Medical Staff Bylaws.

1. Podiatrists who perform surgical procedures on patients must have graduated from an approved 12 or 24 month Podiatric Surgical Residency and be Board eligible or Board certified by the ABPS.

2. Surgical procedures that are performed by podiatrists will be under the overall supervision of the Chief of Surgical Services.

3. Podiatrists may write orders within the scope of his licensure and consistent with Medical Staff Bylaws.

Section E. CERTIFIED REGISTERED NURSE ANESTHETIST

Certified Registered Nurse Anesthetist (CRNA) is a provider currently licensed by the Oregon State Board of Nursing as a Nurse Anesthetist.
1) CRNA’s may make written application for appointment to the IAHP staff by following the Silverton Health Bylaws and meeting the following additional provisions:

- Must reside and have an office within 20 mile radius of Silverton hospital in order to provide timely and appropriate continuity of patient care;
- 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 in insurance coverage within one week of receiving notice of such termination or change;
- Complete a period of provisional status and monitoring as delineated by the Medical Staff Bylaws and Rules and Regulations

2) Collaboration with Medical Staff Members

- CRNAs are part of the Surgery Service for quality monitoring purposes, credentialing and other medical staff concerns;

3) Responsibilities

- CRNAs will be responsible to provide general, regional, spinal and epidural anesthesia, as well as deep sedation to patients in Silverton Hospital, within the scope of privileges granted by the Governing Board.
- CRNAs will be responsible for completing the relevant parts of the medical record, including the anesthesia record, and pre/post-anesthesia evaluation.
- CRNAs are responsible for recognizing their limits of knowledge and experience and for consulting with a physician member of the Hospital medical staff as appropriate.

4) Clinical Privileges

- The Medical Executive Committee will make recommendations to the Governing Board regarding the scope and extent of procedures that a Certified Registered Nurse Anesthetist may perform. Within the scope of CRNA practice standards and the privileges granted, the CRNA may provide anesthesia services and perform other related activities.
- CRNAs may write orders within the scope of their licensure and consistent with Medical Staff Bylaws and prescriptive privileges granted.

ARTICLE XIII - Physician Wellness and Non-Disciplinary Assistance (Board approved 10/30/13)

The medical staff maintains zero tolerance for the abuse of alcohol, drugs or controlled substances ("Intoxicants") by any provider while responsible for patient care in Silverton Hospital or any of its hospital-owned clinics.

Any Silverton Health personnel who observe behavior, emotional or physical condition, or appearance of a provider at a Silverton Health facility that raises a question of impairment while responsible for patient care should immediately notify the nursing supervisor, or clinic manager. Upon receipt of the concern, the nursing supervisor or clinic manager will notify the appropriate Medical Staff Department Chair or Medical Staff President or their designee from the MEC (the "Investigator").
The following steps will be taken if a provider exhibits a behavior, emotional or physical condition, or appearance that raises a reasonable likelihood that, (a) patient care or safety may be compromised, (b) Silverton Health operations may be disrupted, or (c) the community’s confidence in Silverton Health may be impaired. Examples of behavior, physical condition or appearance that may give rise to implementing this language include, but are not limited to, slurred or incoherent speech, uncharacteristic moodiness or aggression, and/or lack of coordination in fine or gross motor skill, i.e., handling of instruments, writing, walking, etc.

The Investigator will proceed to the location of the provider in question to investigate the concern. Awaiting arrival of the Investigator, the Nursing Supervisor or clinic manager may have the prerogative to hand off patient care by the provider in question to another qualified provider. As part of the investigation, the provider and/or the Investigator may request appropriate lab tests to determine evidence of chemical impairment. Should testing be warranted, the Investigator will escort the provider to the testing site.

If, in the Investigator’s opinion, the provider is considered to be impaired, alternative medical coverage for patients of the provider shall be arranged by the Investigator. The provider shall be directed to leave the premises. If necessary, transportation safety for the provider will be addressed prior to departure.

If the Investigator is someone other than the Medical Staff President, the Investigator will provide documentation of the incident to the Medical Staff President. Documentation will include name of provider, date and time of the incident; name of patient(s) involved; individual reporting the incident and circumstances leading to Investigator’s notification; specific complaint; Investigator’s evaluation; provider designated to assume patient care responsibilities; any transportation arrangements made for the impaired provider; and name(s) of any additional staff present.

The Medical Staff President will convene a meeting to discuss the incident within ten days, or as soon as feasible. Participants will include the provider, Investigator, appropriate Department Chair, Medical Staff President and any others deemed necessary by the attendees. Documentation will remain in the provider credentialing file maintained by the Medical Staff Office. If the Medical Staff President and Department Chair determine there is a reasonable suspicion of impairment, the provider may be referred for evaluation by an expert in substance abuse or other appropriate field (i.e., behavioral or physical health). If evaluation by the expert determines there is substance abuse by the provider, the provider shall be referred to the Oregon Health Professional Services Program (HPSP) for further evaluation, treatment, and monitoring in collaboration with Silverton Health.

Upon receipt of a second complaint, the above process will be used except that the appropriate lab testing shall be required of the provider by the Investigator, and evaluation by an expert in substance abuse or other appropriate field will also be required.

The State of Oregon’s Health Professionals’ Service Program (HPSP) makes available assistance to health professional licensees who are unable to practice with professional skills and safety due to a substance abuse disorder, a mental health disorder, or both of the disorders. Medical Staff and Silverton Health personnel will be educated about this state-wide confidential, non-disciplinary program, illness and impairment recognition issues specific to providers; signs and symptoms of substance abuse disorders; mental health disorders and relapse; the value of self-referral by a provider; evaluation of the credibility of a complaint; allegation, or concern; referral to the appropriate professional resources for assessment, diagnosis, treatment and support of the condition or concern to facilitate recovery and return to
work; maintenance of the confidentiality of the provider seeking referral or assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened; effective workplace supervision; monitoring of the provider and the safety of patients until the rehabilitation or other process is complete; and comprehensive aftercare.

When a licensee self-refers, HPSP will work with the licensee to develop an individualized monitored agreement and will keep the licensee’s enrollment confidential as long as the licensee is in compliance with his/her HPSP monitoring agreement.

Monitoring of licensees who have not self-referred will be conducted by the Silverton Health Medical Staff Provider Conduct Committee. The monitoring process will include initiating appropriate actions when a provider fails to complete the required rehabilitation program.

ARTICLE XIV – Health Screenings (Board approved 10/30/13)

Health screenings to determine competency may be required based on concerns resulting from direct observation and/or questionable trends identified through standard quality monitors currently in place, such as peer review and Ongoing Professional Practice Evaluations. Health screenings for the purpose of determining competency will not be required based solely on age of the provider.

ARTICLE XV – PROVIDER CODE OF CONDUCT
(The following was Board approved 10/27/10)

PURPOSE: To ensure optimum patient care by promoting a safe, cooperative, and professional healthcare environment.

Appropriate Behavior: Medical staff members cannot be subject to discipline for appropriate behavior. Examples of appropriate behavior include, but are not limited to, the following:

- Criticism communicated in a reasonable manner and offered in good faith with the aim of improving patient care and safety;
- Encouraging clear communication;
- Expressions of concern about a patient’s care and safety;
- Expressions of dissatisfaction with policies through appropriate grievance channels or other civil non-personal means of communication;
- Constructive criticism conveyed in a respectful and professional manner, without blame or shame for adverse outcomes;
- Professional comments to any professional, managerial, supervisory, or administrative staff, or members of the Board of Directors about patient care or safety provided by others;
- Active participation in medical staff and hospital meetings (i.e., comments made during or resulting from such meetings can not be used as the basis for a complaint under this Code of Conduct, referral to the Medical Executive Committee, economic sanctions, or the filing of an action before a state or federal agency);
- Membership on other medical staffs; and
- Seeking legal advice or the initiation of legal action for cause.

Inappropriate Behavior: Inappropriate behavior by medical staff members is discouraged. Persistent inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.” Examples of inappropriate behavior
include, but are not limited to, the following:

- Belittling or berating statements;
- Use of profanity or disrespectful language;
- Inappropriate comments written in the medical record;
- Blatant failure to respond to patient care needs or staff requests;
- Deliberate refusal to return phone calls, pages, or other messages concerning patient care or safety;
- Intentionally condescending language; and
- Intentionally degrading or demeaning comments regarding patients and their families; nurses, physicians, hospital personnel and/or the hospital.

**Disruptive Behavior:** Disruptive behavior by medical staff members is prohibited. Examples of disruptive behavior include, but are not limited to, the following:

- Physically threatening language directed at anyone in the hospital including other medical staff members, nurses, any hospital employee, administrator or member of the Board of Directors;
- Physical contact with another individual that is threatening or intimidating;
- Throwing instruments, charts or other things;
- Threats of violence or retribution;
- Sexual harassment; and,
- Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation.

**Interventions:** Interventions should initially be non-adversarial in nature, if possible, with the focus on restoring trust, placing accountability on and rehabilitating the offending medical staff member, and protecting patient care and safety. The medical staff supports tiered, non-confrontational intervention strategies, starting with informal discussion of the matter with the appropriate section chief or department chairperson. Further interventions can include an apology directly addressing the problem, a letter of admonition, a final written warning, or corrective action pursuant to the medical staff bylaws, if the behavior is or becomes disruptive. The use of summary suspension should be considered only where the medical staff member’s disruptive behavior presents an imminent danger to the health of any individual. At any time rehabilitation may be recommended. If there is reason to believe inappropriate or disruptive behavior is due to illness or impairment, the matter may be evaluated and managed confidentially according to the established procedures of the medical staff’s Medical Executive Committee.

**DEFINITIONS:**

**Appropriate Behavior:** Any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized medical staff, or to engage in professional practice including practice that may be in competition with the hospital. Appropriate behavior is not subject to discipline under these bylaws.

**Disruptive Behavior:** Any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.

**Harassment:** Conduct toward others based on their race, religion, gender, gender identity, sexual orientation, nationality or ethnicity, which has the purpose or direct effect of unreasonably interfering with a person’s work performance or which creates an offensive, intimidating or
otherwise hostile work environment.

**Inappropriate Behavior:** Conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.”

**Medical Staff Member:** Physicians and others granted membership and/or privileges on the Medical Staff and, for purposes of this Code, includes individuals with temporary clinical privileges.

**Sexual Harassment:** Unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person’s work performance or which creates an offensive intimidating or otherwise hostile work environment.

**PROCEDURE:** Complaints about a member of the medical staff regarding allegedly inappropriate or disruptive behavior should be in writing, signed and directed to the President of the medical staff or, if the President of the medical staff is the subject of the complaint, to the Vice President of the medical staff, and include to the extent feasible:

1. The date(s), time(s) and location of the inappropriate or disruptive behavior;
2. A factual description of the inappropriate or disruptive behavior;
3. The circumstances which precipitated the incident;
4. The name and medical record number of any patient or patient’s family member who was involved in or witnessed the incident;
5. The names of other witnesses to the incident;
6. The consequences, if any, of the inappropriate or disruptive behavior as it relates to patient care or safety, or hospital personnel or operations; and
7. Any action taken to intervene in, or remedy, the incident, including the names of those intervening.

At the discretion of the President of the medical staff (or Vice President if the President of the medical staff is the subject of the complaint), the duties here assigned to the President of the medical staff can, from time to time, be delegated to another elected member of the medical staff (“designee”).

Written acknowledgement of the complaint will be provided to the person lodging the complaint.

A Conduct Committee, none of the members of which may be economic competitors of the medical staff member, consisting of the President or Vice President of the medical staff, or designee, and at least two additional elected members of the medical executive committee, one of whom shall be the medical staff member’s department chairperson, provided the chairperson is not the subject of the complaint, shall make such investigation as appropriate in the circumstances which may include seeking to interview the complainant, any witnesses and the subject of the complaint. The subject medical staff member shall be provided an opportunity to respond in writing to the complaint.

The Conduct Committee will make a determination of the authenticity and severity of the complaint. The ad hoc committee shall dismiss any unfounded complaint and may dismiss any complaint if it is not possible to confirm its authenticity or severity, and will notify both the complainant and the subject of the complaint of the decision reached.
In cases deemed by the Conduct Committee to be valid, the medical staff member subject of the complaint shall be provided a copy of this Code of Conduct and a copy of the complaint in a timely fashion, as determined by the organized medical staff, in a timely manner. The medical staff member will be notified that attempts to confront, intimidate, or otherwise retaliate against the complainant is a violation of this Code of Conduct and may result in corrective action against the medical staff member. (Sequence Amendment Board approved April 5, 2013)

If the Conduct Committee determines the complaint is well founded, the complainant and the subject of the complaint will be informed of the decision, and the complaint will be addressed as follows:

1. If this is the first incident of inappropriate behavior, the appropriate section chief, or chairperson of the offending medical staff member’s assigned department, shall discuss the matter with the offending medical staff member, and emphasize that the behavior is inappropriate and must cease. The offending medical staff member may be asked to apologize to the complainant. The approach during this initial intervention should be collegial and helpful.

2. Further isolated incidents that do not constitute persistent, repeated inappropriate behavior will be handled by providing the offending medical staff member with notification of each incident, and a reminder of the expectation the individual comply with this Code of Conduct.

3. If the Conduct Committee determines the offending medical staff member has demonstrated persistent, repeated inappropriate behavior, constituting harassment (a form of disruptive behavior), or has engaged in disruptive behavior on the first offense, a letter of admonition will be sent to the offending medical staff member, and, as appropriate, a rehabilitation action plan developed by the Conduct Committee, with the advice and counsel of the medical executive committee.

4. If, in spite of this admonition and intervention, disruptive behavior recurs, the Conduct Committee shall meet with and advise the offending medical staff member such behavior must immediately cease or corrective action will be initiated. This “final warning” shall be sent to the offending medical staff member in writing.

5. If after the “final warning” the disruptive behavior recurs, corrective action (including suspension or termination of privileges) shall be initiated pursuant to the medical staff bylaws of which this Code of Conduct is a part, and the offending medical staff member shall have all of the due process rights set forth in the medical staff bylaws.

6. If a single incident of disruptive behavior or repeated incidents of disruptive behavior constitute an imminent danger to the health of an individual or individuals, the offending medical staff member may be summarily suspended as provided in the medical staff bylaws. The medical staff member shall have all of the due process rights set forth in the medical staff bylaws.

7. If no corrective action is taken pursuant to the medical staff bylaws, a confidential memorandum summarizing the disposition of the complaint, along with copies of any written warnings, letters of apology, and written responses from the offending medical staff member, shall be retained in the medical staff member’s credentials file for two (2) years, and then must be expunged if no related action is taken or pending. Informal rehabilitation, a written apology, issuance of a warning, or referral to the MEC will not constitute corrective action.

8. At any time during this procedure the medical staff member has a right to personally retain and be represented by legal counsel.

Inappropriate or disruptive behavior which is directed against a medical staff member by a hospital network employee, administrator, board member, contractor, or other member of the hospital network community shall first be reported in writing by the medical staff member to the
Human Resource Director. Written complaints should include to the extent feasible:
1. The date(s), time(s) and location(s) of the inappropriate or disruptive behavior;
2. A factual description of the inappropriate or disruptive behavior;
3. The circumstances which precipitated the incident;
4. The name of any other person who was involved in or witnessed the incident;
5. The consequences, if any, of the inappropriate or disruptive behavior as it relates to patient care or safety, or hospital network personnel or operations; and
6. Any action taken to intervene in, or remedy, the incident, including the names of those intervening.

The Human Resource Director, in conjunction with the applicable Silverton Health policy/law, will assist in investigation and resolution of the employee behavior problem. The Human Resource Director shall report to Silverton Health Administration, who shall report to the governing board if appropriate, any claimed violation of applicable policy/law, and action and/or resolution. In addition the Human Resource Director shall provide counsel regarding appropriate reporting mechanisms if violation has occurred of any state or federal government agency or relevant accrediting body rule, regulation or law. In instances where the network president is involved, the Human Resource Director shall report findings directly to the Governing Board President.

In all cases the Human Resource Director shall provide feedback to the medical staff member who reported the incident noting adherence to due process outlined in this policy as well as appropriate hospital network policy/law; that investigation has been completed and action taken as appropriate to policy/law and/or the specific incident.

Abuse of Process: Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by medical staff members against complainants will give rise to corrective action pursuant to the medical staff bylaws. Individuals who falsely submit a complaint shall be subject to corrective action under the medical staff bylaws or hospital employment policies, whichever applies to the individual.

Promoting Awareness of Code of Conduct: The medical staff shall, in cooperation with Silverton Health, promote continuing awareness of this Code of Conduct among the medical staff and the Silverton Health community, by:
1. Sponsoring or supporting educational programs on disruptive behavior to be offered to medical staff members and Silverton Health employees;
2. Disseminating this Code of Conduct to all current medical staff members upon its adoption and to all new applicants for membership to the medical staff.
3. Encouraging the Medical Executive Committee to assist members of the medical staff exhibiting inappropriate or disruptive behavior to obtain education, behavior modification, or other treatment to prevent further infractions.
4. Informing the members and the Silverton Health staff of the procedures the medical staff and Silverton Health have put into place for effective communication to Silverton Health administration of any medical staff member’s concerns, complaints and suggestions regarding Silverton Health personnel, equipment, and systems.
ARTICLE XVI  ADOPTION

Rules and Regulations may be adopted, amended, or repealed at any regular meeting at which a quorum is present and without previous notice, or at any special meeting with notice, by a two-thirds vote of those present of the Active Medical Staff. Such changes shall become effective when approved by the Governing Board.

Revisions approved by the Governing Board effective October 30, 2002

Reviewed and approved by the Governing Board on January 30, 2008.

Approved:

____________________________________________ ________________  Date
Frank Golden, MD, Medical Staff President

____________________________________________ ________________  Date
William Winter, Administrative Director

___________________________________________ ________________  Date
Gary Simon, Governing Board Chair