BYLAWS OF THE MEDICAL STAFF

OF

ST. VINCENT HEALTHCARE

Bylaws 9/2013

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PREAMBLE

St. Vincent Healthcare is a not-for-profit corporation organized under the laws of the State of Montana whose purpose is to serve as a general acute care hospital. These Bylaws provide for a single organized Medical Staff that has the overall responsibility for the quality of all medical care provided to patients and for the ethical conduct and professional practices of its members, as well as for accounting therefore to the Board of Directors as provided by Montana law. These Bylaws are intended to be a general statement of the principles of the Medical Staff, to be supplemented by and read in conjunction with the Appointment Policy, Rules and Regulations and policies of the Hospital. These Bylaws, the Appointment Policy and Rules and Regulations create a framework within which Medical Staff members can act with a reasonable degree of freedom and confidence.

ARTICLE I - DEFINITIONS:

"Accredited Residency" when used with respect to training obtained by a Physician means a postgraduate residency training program which has been either (i) approved by either (1) the Accreditation Council on Graduate Medical Education of the American Medical Association ("ACGME") and as listed as accredited in the Directory of Graduate Medical Education Programs published by the ACGME for the year the applicant's residency was completed, or (ii) accepted by the American Board of Medical Specialties or the Advisory Board for Osteopathic Specialists of the American Osteopathic Association as satisfying such Specialty Board's minimum requirements to permit a Physician to sit for its certifying examination, provided that such Physician in fact has so satisfactorily passed the examination and other criteria for such Specialty Board to receive certification therefrom. For the purposes of determining whether a residency satisfies the foregoing, a Physician will be deemed to have satisfied these requirements if the last full year of his/her residency training is from such an approved or accredited program or (2) the Board of Directors of the American Osteopathy Association and as listed in the Yearbook and Directory of Osteopathic Physicians, Osteopathic Postdoctoral Training Programs Section, as published by the American Osteopathic Association for the year the applicant's residency was completed.

"Advanced Practice Registered Nurse" or "Nurse Practitioner" means and refers to those registered nurses who have obtained additional, specialized education beyond the basic nursing education through the completion of an advanced degree in nursing from an accredited institution, who are licensed by the Montana Board of Nursing to practice professional nursing, who are certified by a nationally recognized professional organization as having a nursing specialty or otherwise meet the criteria for Advanced Practice Registered Nurses established by the Montana Board of Nursing and who are certified by the Board of Nursing as an Advanced Practice Registered Nurse. Advanced Practice Registered Nurses include certified nurse midwives, certified registered nurse anesthetists, clinical nurse specialists, and nurse practitioners.

"Allied Health Professionals" means and refers to those classes of health care professionals, other than Physicians, Dentists, and Podiatrists, whose skills and knowledge have been determined by the Board of Directors to be needed for the care of patients in the Hospital, who have been licensed or certified by their respective licensing or certifying agencies to provide such care or who provide limited care as Medical Assistants or registered nurses under the direct supervision of Members of the Medical Staff and who may be granted, on an individual basis, limited clinical privileges by the Board of Directors. Allied Health Professionals include employees of the Hospital, if an Advanced Practice Registered Nurse, a Physician Assistant, independent health

care providers, and employees of Members of the Medical Staff. Examples of Allied Health Professionals are Advanced Practice Registered Nurses, Psychologists, Physician Assistants, technologists, therapists, Medical Assistants and, if employed by Members of the Medical Staff, registered or licensed practical nurses. Nurses and other healthcare providers (except Advanced Practice Registered Nurses, Physician Assistants, Psychologists and those eligible for Medical Staff appointment) provided under contract to the Hospital by staffing agencies shall be treated as employees of the Hospital and credentialed through the Hospital's human resources department or other internal mechanisms.

"Appointment Policy" means the Appointment and Credentialing Policy adopted by the Board of Directors and as amended from time to time.

"Board of Directors" means the Board of Directors of St. Vincent Healthcare which is the governing body of the Hospital and which has overall responsibility for the conduct of the Hospital and shall include, where appropriate, a committee of the Board of Directors designated to act on behalf of the Board of Directors with respect to a particular function or duty.

"Board Certified" or "Board Certification" means the certification by a Specialty Board that a Practitioner has satisfactorily passed the examination and other criteria of such Specialty Board for such certification.

"Board Qualified" means that a Practitioner has met the minimum requirements of the applicable Specialty Board to sit for the examination of such Specialty Board but has not yet taken such examination or, if having taken such examination, has not yet received verification of passage.

"CEO" means the person appointed by the Board of Directors to serve as the chief executive officer of the Hospital.

"Chief Medical Officer" means the physician appointed by the Hospital to act as the chief administrative medical officer for the Hospital.

"Clinical Privileges" or "privileges" means the permission granted by the Board of Directors to a Practitioner (or, as applicable, to an Allied Health Professional) to render care or perform specific diagnostic, therapeutic, medical, dental or surgical procedures in the Hospital pursuant to the Appointment Policy.

"Credentialing" means the process of obtaining and verifying information provided by applicants for appointment and/or clinical privileges or from third party sources concerning the applicant's status, satisfaction of basic requirements of education, training, licensing or certification, insurance, any required affiliations or associations and similar information to determine whether threshold requirements have been met for the Medical Staff and Board of Directors' use in determining whether to grant appointment to the Medical Staff and/or grant clinical privileges.

"Dentist" means both a doctor of dental surgery and doctor of dental medicine who has a current license issued by the Montana State Board of Dentistry to practice dentistry.

"Department" means one of the divisions or departments into which the Medical Staff is divided according to professional specialty and to which all Members of the Medical Staff are assigned for governance, call scheduling and peer review purposes.

"Director of Medical Staff Services" means the person designated by the Hospital who has the administrative responsibility for processing and coordinating with Medical Staff departments and committees their review of applications for appointment or reappointment to the Medical Staff and requests for Clinical Privileges and applications for Clinical Privileges of Allied Health Professionals.

"Ex-Officio" means participate as a member of a committee or other body by virtue of an office or position held by such member and, unless otherwise expressly provided, means service on such committee or body without voting rights.

"Hospital" means St. Vincent Healthcare and the hospital facilities and ancillary buildings located at 1233 North 30th Street, Billings, Montana constituting St. Vincent Healthcare.

"Joint Commission" means The Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations, or its successor.

"Locum/Contract Staff" means staff that is granted clinical privileges to provide temporary coverage for another practitioner or to fill an urgent patient need.

"Medical Assistants" means and refers to those dependant health care professionals who (i) provide medical services as employees of and under the direct supervision of Physicians, Dentists or Podiatrists who are presently appointed to the Medical Staff, (ii) may or may not be licensed or certified as healthcare providers and (iii) are individually authorized by the Board of Directors to assist such Medical Staff Members in the provision of healthcare as specifically delineated. Medical Assistants include certified surgical techs, obstetrical techs, O.R. techs, dental techs, dental hygienists, and such other healthcare providers as are approved by the Medical Executive Committee and the Board of Directors.

"Medical Executive Committee" means the Executive Committee of the Medical Staff.

"Medical Staff" means the collective body of all Physicians, Podiatrists, and Dentists who are appointed thereto by the Board of Directors and who may be granted Privileges to treat patients at the Hospital.

"Medical Staff Bylaws" or "Bylaws" mean these Bylaws of the Medical Staff.

"Medical Staff President" means the person elected to serve as president of the Medical Staff while serving in such capacity.

"Medical Staff Year" means the period from January 1 through December 31.

"Member" means any Physician, Podiatrist or Dentist who has a current Medical Staff appointment and who may have Clinical Privileges granted by the Board to practice at the Hospital.

"Patient Contacts" means (i) patient registrations at the Hospital, either on an inpatient or outpatient basis, for which practitioner is responsible, or (ii) formal admissions to the Hospital (either inpatient or outpatient) by a Member, or (iii) performance of an inpatient or outpatient procedure or surgery, or (iv) consultation when requested by the attending Physician as evidenced by an appropriate entry into the medical record of the patient, or (v) emergency department patient visits by the Member (consultations, examination or treatment pursuant to emergency call as evidenced by an appropriate entry into the medical record of the patient).

"Physician Assistants" means and refers to those healthcare professionals who provide medical services as employees of and under the direct supervision of Members of the Medical Staff or as employees of the Hospital and who have satisfied the requirements for certification as a physician assistant under Montana law by the Montana State Board of Medical Examiners.

"Physicians" mean both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s") who have a current license issued by the Montana State Board of Medical Examiners to practice medicine and surgery.

"Podiatric Clinical Residency" when used with respect to training obtained by a Podiatrist means a clinical residency in podiatric medicine or surgery of not less than one (1) year which is approved by the Council on Podiatric Medical Education of the American Podiatric Association and which was sponsored by and conducted in an institution such as a hospital or conducted by a college of podiatric medicine accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

"Podiatrist" means a doctor of podiatric medicine who has a current license issued by the Montana Board of Medical Examiners to practice podiatry.

"Practitioner" means any appropriately licensed Physician, Podiatrist or Dentist inquiring about an application for Medical Staff appointment or applying for or exercising Clinical Privileges at the Hospital.

"Rules and Regulations" means the Rules and Regulations adopted by the Medical Staff from time to time and approved by the Board of Directors governing patient care within the Hospital.

"Specialty Board" means (i) as to Physicians, that certifying agency or board relating to a medical specialty (or subspecialty) recognized or authorized by the American Board of Medical Specialties or the Advisory Board for Osteopathic Specialists of the American Osteopathic Association to issue certificates of special recognition of physicians' training and expertise in a specialty or subspecialty, (ii) as to Podiatrists, the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (if the Podiatrist has limited his/her practice to non-surgical procedures) or the American Board of Multiple Specialties in Podiatry, and (iii) as to Dentists, that certifying board recognized by the Council on Dental Education and Licensure of the American Dental Association, or the American Board of Oral and Maxillofacial Surgery.

"Supervising Physician" means the Medical Staff Member who is either the employer of or otherwise responsible for the direct supervision of an Allied Health Professional who is not permitted by licensure to practice independently, as acknowledged by such supervising Member.

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

ARTICLE II - APPOINTMENT TO THE MEDICAL STAFF

2.1 GENERALLY

Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements applicable to the category of the Medical Staff to which appointment has been granted or is sought in accordance with the Appointment Policy and as set forth in such credentialing criteria or policies as are adopted from time to time by the Board of Directors, and in such standards as are set forth in these Bylaws, the Rules and Regulations, and rules and regulations of the applicable clinical Departments of the Medical Staff as are approved by the Board of Directors, in effect at the time of appointment or granting of privileges and as amended from time to time. The Bylaws, the Appointment Policy, the Rules and Regulations, rules and regulations of clinical Departments and credentialing criteria are intended to be dynamic and evolving as medical science and the standards of the Hospital, Medical Staff and operations of the Hospital change from time to time. All individuals practicing medicine, dentistry or podiatry in the Hospital, unless excepted by specific provisions of these Bylaws or the Appointment Policy, must first have been appointed to the Medical Staff. The specific qualifications for appointment and reappointment and granting of clinical privileges in general shall be established by the Board of Directors and set forth in these Bylaws and the Appointment Policy, as amended from time to time.

2.2 QUALIFICATIONS TO BE APPOINTED TO THE MEDICAL STAFF

2.2-1 APPOINTMENT TO THE MEDICAL STAFF OTHER THAN THE HONORARY STAFF:

Only Physicians, Dentists and Podiatrists seeking appointment to the Medical Staff, other than the Honorary Staff category, who satisfy the following basic requirements shall be qualified for consideration for appointment to the Medical Staff:

(a) have a current unrestricted license to practice medicine, dentistry or podiatry. For those practitioners solely practicing in a telemedicine role, see section 3.7.

(b) possess current, valid professional liability insurance coverage in such form, with such insurers and in such amounts as are satisfactory to the Board of Directors;

(c) If a physician is applying for a new appointment, he or she must have:

Completed an accredited residency in the specialty or subspecialty in which the applicant principally seeks clinical privileges and also

(i) Be board certified in the applicant's primary specialty; or

(ii) If not a member of the Medical Staff prior to February 1, 2007 or did not continuously remain a Member of the Medical Staff the following requirements are in force:

1. Have satisfied the requirements of the appropriate Specialty Board and be board certified within five (5) years of completion of his/her Accredited Residency or Fellowship;

2. If the applicant is not board qualified, or more than five (5) years have elapsed from the end of his/her residency or fellowship, the applicant will not be eligible for appointment.

(d) IF A PHYSICIAN APPLYING FOR REAPPOINTMENT he or she must:

(i) Be Board Certified in Member's primary specialty except for those Members of the Medical Staff first appointed prior to February 1, 2007 and who have remained Members since initial appointment who shall be exempt from such Board Certification requirement; or

(ii) If not a member of the Medical Staff prior to February 1, 2007 or did not continuously remain a Member of the Medical Staff he or she must:

1. If more than five (5) years has elapsed since completion of residency or fellowship training program, or more than three (3) years from the time of initial appointment; the applicant will not be eligible for reappointment.

2. Maintain continuous Board certification in his/her primary area of specialty. If Board Certification expires during the appointment period, appointment will automatically cease at that time unless;

a. Member has made a good faith attempt to recertify prior to the expiration of their board; and

b. Member submits a plan to become recertified within twelve (12) months of expiration of his/her board and the Medical Executive Committee and the Board of Directors accepts the plan. This extension may be granted for no more than twelve (12) months.

(e) IF A PODIATRIST APPLYING for new appointment to the Medical Staff, he or she must:

Have completed a Podiatric Clinical Residency in surgery or medicine applicable to the primary specialty in which the applicant principally seeks Clinical Privileges and also:

(i) Be board certified in the applicant's primary specialty; or

(ii) If not a member of the Medical Staff prior to February 1, 2007 or did not continuously remain a Member of the Medical Staff the following requirements are in force:

1. Have satisfied the requirements of the appropriate Specialty Board and be board certified within five (5) years of completion of his/her Accredited Residency or Fellowship;

2. If the applicant is not board qualified, or more than five (5) years have elapsed from the end of his/her residency or fellowship, the applicant will not be eligible for appointment.

(f) IF A PODIATRIST APPLYING FOR REAPPOINTMENT:

(i) Be Board Certified in Member's primary specialty except for those Members of the Medical Staff first appointed prior to February 1, 2007 and who have remained Members since initial appointment who shall be exempt from such Board Certification requirement; or

(ii) If not a member of the Medical Staff prior to February 1, 2007 or did not continuously remain a Member of the Medical Staff he or she must:

1. If more than five (5) years has elapsed since completion of residency or fellowship training program, or more than three (3) years from the time of initial appointment; the applicant will not be eligible for reappointment.

2. Maintain continuous Board certification in his/her primary area of specialty. If Board Certification expires during the appointment period, appointment will automatically cease at that time unless;

a. Member has made a good faith attempt to recertify prior to the expiration of their board; and

b. Member submits a plan to become recertified within twelve (12) months of expiration of his/her board and the Medical Executive Committee and the Board of Directors accepts the plan. This extension may be granted for no more than twelve (12) months.

(g) IF A DENTIST IS APPLYING for appointment:

(i) Be board certified in the applicant's primary specialty; or

(ii) If not a member of the Medical Staff prior to February 1, 2007 or did not continuously remain a Member of the Medical Staff the following requirements are in force:

1. Have satisfied the requirements of the appropriate Specialty Board and be board certified within five (5) years of completion of his/her Accredited Residency or Fellowship;

2. If the applicant is not board qualified, or more than five (5) years have elapsed from the end of his/her residency or fellowship, the applicant will not be eligible for appointment.

(h) IF A DENTIST APPLYING FOR REAPPOINTMENT:

(i) Be Board Certified in Member's primary specialty except for those Members of the Medical Staff first appointed prior to February 1, 2007 and who have remained Members since initial appointment who shall be exempt from such Board Certification requirement; or

(ii) If not a member of the Medical Staff prior to February 1, 2007 or did not continuously remain a Member of the Medical Staff he or she must:

1. If more than five (5) years has elapsed since completion of residency or fellowship training program, or more than three (3) years from the time of initial appointment; the applicant will not be eligible for reappointment.

2. Maintain continuous Board certification in his/her primary area of specialty. If Board Certification expires during the appointment period, appointment will automatically cease at that time unless;

a. Member has made a good faith attempt to recertify prior to the expiration of their board; and

b. Member submits a plan to become recertified within twelve (12) months of expiration of his/her board and the Medical Executive Committee and the Board of Directors accepts the plan. This extension may be granted for no more than twelve (12) months.

(i) have not been convicted of, pleaded guilty to a charge of, or entered a plea of no contest to a charge of, a felony which reasonably relates to the ability of the Practitioner to exercise the Clinical Privileges sought to be granted, whether or not sentence was imposed;

(j) have not been excluded or debarred from any government funded program of healthcare, such as, but not limited to, the Medicare or Medicaid programs or TRICARE (formerly CHAMPUS);

(k) comply with the requirements set forth in the Bylaws for appointment to the staff category to which appointment is sought;

(l) can document their:

(i) relevant background, current experience, training, continuing medical education, medical/clinical knowledge, demonstrated current

competence, patient care, practice-based learning and improvement, and systems-based practice,

(ii) professionalism and adherence to the ethics of their profession,

(iii) good character and reputation, and that such reputation and nature of their practice is not contrary to the mission or tenets of the Hospital, and would not subject the Hospital to embarrassment, conflict, disruption or otherwise not be in the best interest of the Hospital;

(iv) ability to perform, with or without an accommodation, the essential functions required for the Clinical Privileges requested without posing a direct threat to the health or safety of the Practitioner, patients or others;

(v) communicative skills, including their ability to speak and write legibly the English language, to the extent necessary to communicate effectively and be able to provide medical services as may be needed by any patient at the Hospital; and

(vi) ability to work harmoniously with others,

with sufficient adequacy to assure the Board of Directors that any patient treated or examined by the applicant will receive high-quality medical care and that the orderly administration of the Hospital will not be adversely affected;

(m) conform to the Medical Staff Development Plan, if any, as well as the Bylaws, Appointment Policy and the Medical Staff Rules and Regulations;

(n) would not conflict with any contract in which the Hospital has granted to any Practitioner or group the exclusive right to exercise the Clinical Privileges requested by the applicant;

(o) agrees, if appointed, to conform to the Ethical Religious Directives set forth in Section 2.4; and

2.2-2 HONORARY STAFF APPOINTMENT

To be considered for appointment to the Honorary Staff, Physicians, Dentists, or Podiatrists must satisfy the following conditions:

(a) have retired from active practice at the Hospital, or;

(b) are Physicians, Dentists or Podiatrists of outstanding reputation, not necessarily residing in the community.

2.3 NO AUTOMATIC ENTITLEMENT TO APPOINTMENT OR REAPPOINTMENT

No Practitioner shall be entitled to appointment, or reappointment, to the Medical Staff or a specific category of the Medical Staff and no Practitioner shall be entitled to the exercise of particular Clinical Privileges in the Hospital merely by virtue of the fact that such Practitioner:

(a) is licensed to practice a profession in the State of Montana or any other state;

(b) is a member of any particular professional organization;

(c) resides in the geographic service area of the Hospital as defined by the Board of Directors; or

(d) satisfies the threshold requirements or qualifications for appointment set forth in Section 2.2 or for reappointment as set forth herein.

2.4 ETHICAL RELIGIOUS DIRECTIVES.

The Hospital is a member of Sisters of Charity of Leavenworth Health System, Inc., and as such follows the Ethical and Religious Directives for Catholic Healthcare Services (2001) as revised from time to time by the National Conference of Catholic Bishops, approved by the National Conference of Catholic Bishops and promulgated by the Diocese of Great Falls/Billings, Montana (the "Ethical Religious Directives"). All Practitioners and Allied Health Professionals practicing within the Hospital are expected to and must agree to conform with and abide by such Ethical Religious Directives in the care and treatment of all patients for whom they may provide care, treatment, or consultation. Each applicant to the Medical Staff and each applicant for Clinical Privileges shall be provided with a copy of such Ethical Religious Directives and shall be expected to include with any application for appointment or reappointment to the Medical Staff or for Clinical Privileges a written pledge signed by such applicant agreeing to abide by and conform with such Ethical Religious Directives.

2.5 PROCEDURE FOR APPOINTMENT.

All applications for appointment to the Medical Staff, requests for Clinical Privileges (including additional privileges) and applications for reappointment shall be in writing or in other approved format submitted to the CEO or his/her designee in accordance with the Appointment Policy. Applications shall contain complete information concerning the applicant's education, training and experience, privileges requested, licensure, practice and previous hospital experience, any unfavorable history regarding licensure and hospital privileges and such other information as the Board of Directors may require as set forth in the Appointment Policy. When all questions on the application have been determined to have been answered and preliminary information submitted, such applications shall be processed for verification by the Director of Medical Staff Services and thereafter the application and accompanying information shall be forwarded by the Director of Medical Staff Services to the appropriate Department chairperson(s), the Credentials Committee of the Medical Staff, and the Medical Executive Committee for evaluation and recommendation to the Board of Directors (or Committee thereof, if applicable) in accordance with such specific procedures as may be established by the Board of Directors as set forth in the Appointment Policy. The Board of Directors shall act on all recommendations from the Medical Executive Committee as to the approval and appointment of all applicants to the Medical Staff, including

reappointments, rejection of any application for initial appointment or reappointment, granting of clinical privileges and termination of privileges or dismissal from the Medical Staff. The Medical Staff acknowledges the ultimate responsibility and authority of the Board to establish the conditions of appointment, the qualifications therefore, the ability of the Board of Directors to waive any specific requirement where deemed in the best interests of the Hospital as may be appropriate to be enable the Hospital to provide care to its patients, and the procedure for seeking appointment or reappointment which shall be set forth in the bylaws of the Hospital or Appointment Policy or as the Board shall otherwise determine.

ARTICLE III - CATEGORIES OF THE MEDICAL STAFF

3.1 APPOINTMENT TO A CATEGORY

All appointments to the Medical Staff shall be made by the Board of Directors and shall be to one of the categories of the Medical Staff described in this Article. Appointment shall initially be made on a provisional basis for up to eighteen (18) months. Each Member shall be appointed to a primary Department which shall be the Department most pertinent to the Clinical Privileges requested by the Member, but a Member may, upon written request from such Member, be appointed to one or more additional Departments of the Medical Staff**.** Such request shall be made by a letter delivered to the CEO or his/her designee and shall specify the reasons for seeking membership in the additional Department(s). Reasons for additional Department membership include, among others, program planning and development, medical education or performance of Clinical Privileges which are generally performed by members of such requested Department. However, appointment to a second (or any) Department shall not be a prerequisite to be eligible for Clinical Privileges, if qualified and eligible pursuant to the credentialing policies of the Board of Directors, in other Departments as applied for and recommended pursuant to the Appointment Policy. Such request for additional Department membership shall be subject to satisfaction of the additional Department's rules and regulations for appointment (other than completion of a particular residency) and must receive a favorable review and recommendation by the Medical Executive Committee which shall consider such request to ensure appropriateness of appointment to the additional Department and that the organization and governance of the Medical Staff is not adversely affected. Appointment shall otherwise be in accordance with the Appointment Policy.

The Medical Staff shall be divided into the following categories: Provisional, Active, Courtesy, Consulting, Telemedicine, Affiliate, and Honorary. All initial appointments to the Medical Staff are to the Provisional Staff until proctoring is completed except applicants who wish appointment to the Telemedicine or Affiliate Staffs only may be appointed directly to those categories. The qualifications, responsibilities, prerogatives, and methods of advancement are outlined in the following sections.

3.2 PREROGATIVES AND RESPONSIBILITIES APPLICABLE TO ALL CATEGORIES:

3.2-1 PREROGATIVES GENERALLY:

Except as specifically set forth for a category of the Medical Staff below, if appointed to the Medical Staff, Practitioners shall:

(a) be entitled to admit or attend patients or otherwise participate in the treatment and care of patients within the limits of the Clinical Privileges granted to them except that (i) Dentists may not admit patients unless the Dentist can demonstrate

that a Physician Member of the Active or Courtesy Staff has assessed the proposed anesthesia and/or medical problems which may be presented by the procedure proposed to be performed, a Physician Member of the Active or Courtesy Staff has assumed responsibility for the care of any medical problem that may be present or may arise during hospitalization that is outside the lawful scope of the Dentist's practice or Clinical Privileges and a Physician Member of the Active or Courtesy Staff has performed a history and physical on the patient, (ii) A podiatrist may admit a patient as identified in Rules and Regulations.

(b) be entitled to attend and vote on matters presented at general and special meetings of the Medical Staff, its Departments and committees except that Podiatrists shall have no right to vote; and

(c) be entitled to submit nominations for, and be eligible to hold, Medical Staff office and serve as a voting member of the Medical Staff, its Departments and committees to which appointed except that Podiatrists may not make nominations for or hold any Medical Staff office which requires medical training or experience beyond that which they can demonstrate.

(d) Except in an emergency, an appropriate history and physical examination pertinent to the admitting diagnosis on all patients must be performed and be present in the medical record within twenty-four (24) hours of admission and in all events must be completed and be present in the medical record before any diagnostic or therapeutic procedures are performed. A recorded history and physical examination taken by a qualified Member, Resident, or Allied Health Professional within thirty (30) days of the patient's admission (or readmission) to the Hospital may be used in the patient's Hospital medical record provided that: an interval admission note is recorded documenting an examination for any changes in the patient's condition; all additions to the history and any changes in the physical findings subsequent to the original report are completed and present in the medical record within twenty-four (24) hours after admission or before any diagnostic or therapeutic procedures are initiated, whichever comes first.

3.2-2 RESPONSIBILITIES GENERALLY:

Except as specifically set forth for a category of the Medical Staff below, if appointed to the Medical Staff, Practitioners shall satisfy all of the responsibilities to the Medical Staff, including:

(a) responsibility within the Member's areas of professional competence and Clinical Privileges for the daily care and supervision within generally recognized standards of care of the Member's patients in the Hospital for whom the Member is providing services, or arranges for another appropriately qualified Member of the Medical Staff for such care and supervision;

(b) participating in the care or treatment of patients within the Member's areas of professional competence and Clinical Privileges to whom such Member is referred for consultation or assistance;

(c) designating another Member having appropriate Clinical Privileges as his/her alternate or designee to provide coverage for the Practitioner's patients in the Hospital when the Practitioner is not otherwise available to provide care to his or her patients;

(d) caring for unassigned patients as directed by the Member's Department chairperson;

(e) abiding by the ethical principles of the Member's profession;

(f) preparing and completing in a timely, accurate, complete and legible manner the medical and other required records as to the care provided by the Member for all patients the Member admits or in any way provides care in the Hospital;

(g) participating in quality improvement and patient monitoring activities;

(h) paying Medical Staff dues as established by Medical Executive Committee;

(i) maintaining in force professional liability insurance in not less than the minimum amounts as may be established by the Board of directors upon the advice of the Medical Executive Committee;

(j) maintaining in good standing the Member's license to practice medicine and surgery, dentistry, and podiatry as applicable, in the State of Montana; and

(k) complying with these Bylaws, the Rules and Regulations and the rules and regulations of the Department to which the Member is appointed and fulfilling all of the obligations required of such Department's members.

3.3 PROVISIONAL STAFF

3.3-1 QUALIFICATIONS:

The Provisional Staff shall consist of those Practitioners who are initially appointed to the Medical Staff generally during the first eighteen (18) months of appointment and who satisfy the general qualifications for appointment, including completion of an Accredited Residency and Board Certification as set forth in these Bylaws and in the Appointment Policy, as applicable to the Practitioner.

3.3-2 PREROGATIVES:

Provisional Staff Members shall have all of the prerogatives granted to all Members generally as set forth in Section 3.2-1, except they shall:

(a) have only the right to attend, in a non-voting capacity, meetings of the Medical Staff; and

(b) not be entitled to submit nominations for, or be eligible to hold, a Medical Staff office or serve as a Department or committee Chairperson, but may serve on Medical Staff committees if appointed.

3.3-3 RESPONSIBILITIES:

Provisional Staff Members shall satisfy all of the responsibilities of appointment to the Medical Staff as set forth in Section 3.2-2.

Participate actively in the Emergency Department Call Program, unless otherwise excused from such participation by departmental approval.

3.4 ACTIVE STAFF

3.4-1 QUALIFICATIONS:

The Active Staff shall consist of those Practitioners who:

(a) regularly admit patients to the Hospital or regularly consult in the care and treatment of patients in the Hospital such that the Member will have twenty-four (24) Patient Contacts during their appointment period (failure to have such number of Patient Contacts shall automatically result in a change to the Consulting or Courtesy Staff); and

(b) have satisfactorily completed an initial evaluation period as a member of the Provisional Staff.

3.4-2 PREROGATIVES:

Active Staff Members shall have all of the prerogatives granted to all Members generally as set forth in Section 3.2-1.

3.4-3 RESPONSIBILITIES:

Active Staff Members shall satisfy all of the responsibilities of appointment to the Medical Staff set forth in Section 3.2-2 and shall also:

(a) serve on committees established by the Medical Executive Committee; and

(b) Participate actively in the Emergency Department Call Program, unless otherwise excused from such participation by departmental approval.

3.5 COURTESY STAFF

3.5-1 QUALIFICATIONS:

The Courtesy Staff shall consist of those Practitioners who:

(a) have satisfactorily completed an initial evaluation period as a member of the Provisional Staff;

(b) have fewer than twenty-four (24) Patient Contacts during their previous two (2) year appointment period in either another category or as a member of the Courtesy Staff (in the event a Member has more than twenty-four (24) Patient Contacts in a two-year appointment term, the Member will be moved to Active Staff); or

(c) are members of the active or equivalent medical staff category at another Montana licensed hospital.

3.5-2 PREROGATIVES:

Courtesy Staff Members shall have all of the prerogatives granted to all Members generally as set forth in Section 3.2-1, except they shall:

(a) have only the right to attend, in a non-voting capacity, meetings of the Medical Staff, its Departments and Committees;

(b) not be eligible to hold or submit nominations for Medical Staff Office or serve as Chairperson of a Department or Medical Staff committee but may serve on committees, if appointed; and

(c) not have the right to have more than twenty-four (24) Patient Contacts during their appointment term.

3.5-3 RESPONSIBILITIES:

(a) Courtesy Staff Members shall satisfy all of the responsibilities of appointment to the Medical Staff as set forth in Section 3.2-2.

(b) Participate actively in the Emergency Department Call Program, unless otherwise excused from such participation by departmental approval.

3.6 CONSULTING STAFF

3.6-1 QUALIFICATIONS:

The Consulting Staff shall consist of those Practitioners who:

(a) satisfy the general qualifications for appointment, including completion of an Accredited Residency and Board Certification as set forth in these Bylaws and in the Appointment Policy as applicable to the Practitioner;

(b) practice in a specialty area where (i) the standard of practice does not generally require admitting privileges, but does involve provision of assistance, including surgical assistance, to other Medical Staff Members with such other Members'

patient care in a consulting capacity when requested, or (ii) there is a Hospital need for services in such specialty area (as determined by the Board of Directors) but the practice involves minimal, if any, regular Hospital activity; and

(c) have satisfactorily completed an initial evaluation period as a member of the Provisional Staff.

3.6-2 PREROGATIVES:

The Consulting Staff shall have all of the prerogatives granted to all Members generally as set forth in Section 3.2-1 except they shall:

(a) not be entitled to admit patients to the Hospital and their practice shall be limited to providing consultations or surgical assistance to and at the request of other Medical Staff Members for matters appropriate to their Clinical Privileges;

(b) only be entitled to attend, in a non-voting capacity, meetings of the Medical Staff, and of the Department in which he/she is a member; and

(c) not be eligible to hold, or make nominations for, Medical Staff office, or serve as a Department or Committee Chairperson but may serve on Medical Staff committees, if appointed.

3.6-3 RESPONSIBILITIES:

Consulting Staff Members shall satisfy all of the responsibilities of appointment to the Medical Staff set forth in Section 3.2-2 except that:

(a) their responsibility for patient care shall be limited to consulting with or providing surgical assistance to other Members of the Medical Staff with regard to the care of specific patients when requested by other Medical Staff Members, or when required under provisions of these Bylaws, the Rules and Regulations, or other Medical Staff or Department policies defining those circumstances where consultation is required; and

(b) they shall not be required to participate on emergency department call schedules or care for unassigned patients.

3.7 TELEMEDICINE STAFF

3.7-1 QUALIFICATIONS:

The Telemedicine Staff shall consist of those Physicians who satisfy the general qualifications for appointment, including completion of an Accredited Residency and Board Certification as set forth in these Bylaws and in the Appointment Policy as applicable to the Practitioner except that they shall either hold a current unrestricted license issued by the Montana State Board of Medical Examiners to practice medicine if located within the State of Montana or, if not so located in Montana, either (i) hold such license if required by such board or a telemedicine license for those practitioners solely practicing in a telemedicine role, as applicable to the Practitioner, in the State of

Montana, except for those applying to the Telemedicine Staff category if not required by Montana law or the Montana State Board of Medical Examiners as set forth in Section 3.6; or (ii) if not required by such board to hold a Montana license, hold a current unrestricted license issued by the Physician's home state's applicable licensing body.

3.7-2 PREROGATIVES:

Telemedicine Staff Members shall have all of the prerogatives granted to all Members generally as set forth in Section 3.2-1 except they:

(a) shall not be eligible to vote, hold a Medical Staff office or submit nominations for office, serve as Chairpersons of Departments, Sections or Medical Staff committees but may attend meetings of the Medical Staff or its Departments or committees, and

(b) shall not be entitled to admit patients but may only exercise the specific Clinical Privileges granted to them, including writing clinical notes with respect to patients for whom they have responsibility but may not write orders.

3.7-3 RESPONSIBILITIES.

Telemedicine Staff Members shall satisfy all the responsibilities of appointment to the Medical Staff set forth in Section 3.2-2 except:

(a) their responsibility for the care and treatment of patients in the Hospital shall be limited to the scope of their Clinical Privileges as a consultant;

(b) their obligation to maintain the Member's license to practice medicine shall comply with Section 3.7-1; and

(c) they shall not be obligated to pay Medical Staff dues, or participate in emergency department call schedules or provide care to unassigned patients.

3.8 AFFILIATE STAFF

3.8-1 QUALIFICATIONS:

Affiliate Medical Staff Members shall consist of those Practitioners who:

(a) satisfy the general qualifications for appointment, including completion of an Accredited Residency and Board Certification as set forth in these Bylaws and in the Appointment Policy as applicable to the Practitioner; and

(b) do not wish to establish a practice at the Hospital.

3.8-2 PREROGATIVES AND RESPONSIBILITIES:

Affiliate Staff Members shall not have any of the prerogatives or responsibilities granted to or imposed upon other Members of the Medical Staff and shall have no Clinical Privileges and are not permitted to admit, treat or provide medical care to patients of the

Hospital, to write orders or otherwise make entries into the medical records of Hospital patients. Affiliate Staff Members are permitted to refer patients to the Hospital for diagnostic services and shall be afforded visitation rights for their private patients who are Hospital inpatients under the care of other Members of the Medical Staff.

Affiliate Staff Members may, but are not required to, attend Medical Staff and committee meetings, but are not eligible to vote for or serve as Medical Staff officers, Chairpersons of Departments or Medical Staff committees or as members of standing or special Medical Staff committees unless specifically appointed to such committees. Affiliate Staff Members may attend Hospital and Medical Staff educational programs. Affiliate Medical Staff shall pay such fees, Medical Staff dues and assessments as may be established from time to time by the Medical Executive Committee and approved by the Board of Directors.

3.9 ***HONORARY STAFF***

3.9-1 QUALIFICATIONS:

The Honorary Staff need not satisfy any of the qualifications applicable to other Members of the Medical Staff and shall consist of those Practitioners who do not actively practice at the Hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long standing service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct. Honorary Staff Members are not required to maintain professional liability insurance coverage.

3.9-2 PREROGATIVES AND RESPONSIBILITIES:

The Honorary Staff shall not have any of the prerogatives or responsibilities granted to other Members of the Medical Staff, shall not admit patients to the Hospital or exercise Clinical Privileges in the Hospital, and shall not be eligible to vote or to submit nominations for or hold Medical Staff office, or serve as Chairpersons of Departments or Medical Staff committees, but Members of the Honorary Staff may be invited to attend meetings of the Medical Staff and to serve as members of committees if appointed and may participate in Medical Staff and Hospital educational activities.

3.10 **EMERITUS STATUS**

3.10.1 QUALIFICATIONS:

This status shall be reserved for Practitioners who

(a) previously participated actively on the medical staff but no longer meet the eligibility requirements for, or choose not to pursue, active status;
(b) have reached the minimum age of 60, unless approved by the practitioner’s department, and provide evidence of acceptable health status;
(c) are in the process of retirement from their practice.

3.10.2 PREROGATIVES:

A member with Emeritus Status shall

(a) have the right to attend, in a non-voting capacity, meetings of the Medical Staff, its Departments and Committees;
(b) not be entitled to submit nominations for, or be eligible to hold, a Medical Staff office or serve as a Department or committee Chairperson, but may serve on Medical Staff committees if appointed;
(c) exercise only such clinical privileges as are granted by the governing board, and not as an attending physician for procedures;
(d) not admit patients, but may review a patient's medical record and make recommendations to the admitting physician;
(e) not be required to maintain board certification;
(f) be appointed to this category for one (1) year and participate in annual reviews.

3.10.3 RESPONSIBILITIES:

Appointees to this category shall:

(a) not be required to participate in Emergency Department Call Program;
(b) maintain in force professional liability insurance in not less than the minimum amounts as may be established by the Board of directors upon the advice of the Medical Executive Committee;
(c) maintain in good standing the Member's license to practice medicine and surgery, dentistry, and podiatry as applicable, in the State of Montana; and
(d) comply with these Bylaws, the Rules and Regulations and the rules and regulations of the Department to which the Member is appointed and fulfill all of the obligations required of such Department's members.

3.11 LOCUM/CONTRACT STAFF

3.1.1 QUALIFICATIONS:

Locum/Contract Medical Staff Members shall consist of those Practitioners who:

(a) satisfy the general qualifications for appointment, including completion of an Accredited Residency and Board Certification as set forth in these Bylaws and in the Appointment Policy as applicable to the Practitioner;
(b) provide care through a locum or contract agreement; and
(c) not required to meet the geographic requirements.

3.1.2 PREROGATIVES AND RESPONSIBLITIES:

Locum/Contract Staff Members shall not have any of the prerogatives or responsibilities granted to or imposed upon other Members of the Medical Staff and shall have Clinical Privileges limited to the locum/contract agreement.

Locum/Contract Staff Members may, but are not required to, attend Medical Staff and committee meetings. Locum/Contract Staff Members are not eligible to vote for or serve as Medical Staff officers, Chairpersons of Departments or Medical Staff committees or as members of standing or special Medical Staff committees unless specifically appointed to such committees. Locum/Contract Staff Members may attend Hospital and Medical Staff educational programs. Locum/Contract Medical Staff shall pay such fees and assessments as may be established from time to time by the Medical Executive Committee and approved by the Board of Directors.

Locum/Contract Staff Members shall participate in provisional monitoring of three (3) cases if the period of membership is less than six (6) months and twelve (12) cases if greater than six (6) months.

Locum/Contract Staff Members with no activity over a twelve (12) month period will be processed as a voluntary resignation.

Locum/Contract Staff Members are responsible for participation in emergency call as specified by their department.

3.12 MODIFICATION OF MEDICAL STAFF CATEGORY.

A Member of the Medical Staff may, if qualified, request a change in category by submitting a request therefore in writing to the CEO or his/her designee and such request will be processed in the same manner as applications for reappointment are processed. The Member may be requested, if applicable, to complete such applications (or short forms) as deemed appropriate.

3.13 LIMITATION OF PREROGATIVES.

The prerogatives set forth under each Medical Staff category specified herein are general in nature and may be subject to limitation by special conditions attached to the appointment of any specific Practitioner, or to any other limitation contained in these Bylaws, the Appointment Policy, the Rules and Regulations, and other rules and policies of the Medical Staff, the individual Departments, or the Hospital. Any such limitation is subject to waiver by the Board of Directors in individual cases.

ARTICLE IV - STRUCTURE OF THE MEDICAL STAFF.

4.1 GENERAL

4.1-1 MEDICAL STAFF YEAR:

For the purpose of these Bylaws the Medical Staff Year commences on the 1st day of January and ends on the 31st day of December of each year.

4.1-2 DUES:

Unless otherwise excepted, all Practitioners appointed to the Medical Staff shall pay Medical Staff dues and special assessments, if any, in such amounts and subject to such exemptions or classifications as may be established from time to time by the Medical Executive Committee.

4.2 DEPARTMENTS

4.2-1 ORGANIZATION OF CLINICAL DEPARTMENTS.

The Medical Staff shall be divided into clinical Departments. Each Department shall be organized as a separate component of the integrated Medical Staff and shall have a Chairperson and Vice-Chairperson selected and entrusted with the authority, duties and responsibilities specified in Section 4.2-7. Departments may be further organized into Sections.

4.2-2 DESIGNATION OF DEPARTMENTS.

The Medical Staff shall be divided into ten (10) Departments: Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, OB/GYN, Orthopedics, Pathology, Pediatrics, Radiology and Surgery.

4.2-3 CREATION OF AND DISSOLUTION OF DEPARTMENTS.

(a) Standards for Creation.

Additional Departments to those designated in Section 4.2-2 may be created by the Medical Executive Committee with the approval of the Board of Directors when there is:

(1) A demonstrated need, related to the provision of quality medical care, for the creation of a new Department;

(2) A sufficient number of Active Staff Members who will exercise Privileges in the proposed Department to ensure that the proposed Department can undertake and fulfill the responsibilities of Department status, including continuing monitoring and evaluation of the quality of medical care rendered within the Department;

(3) A written request to establish a new Department which has been submitted to the Medical Executive Committee; and

(4) A Chairperson and a Vice-Chairperson selected for the Department who will fulfill the obligations of such offices as herein provided.

(b) Dissolution of Department.

If the Medical Executive Committee determines that an existing Department no longer fulfills the reason for its creation and no longer satisfies the conditions in 4.2-3(a) it shall,

upon approval of the Board of Directors, dissolve the Department and assign its members to another Department.

4.2-4 ASSIGNMENT TO DEPARTMENTS.

A Medical Staff Member shall be assigned membership in one Department, and may also be granted Clinical Privileges in other Departments. The exercise of Privileges within each Department shall be subject to such Department's rules and regulations and to the authority of the Chairperson of such Department.

4.2-5 FUNCTIONS OF DEPARTMENTS.

The primary responsibility delegated to each Department shall be to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Department.

To carry out this responsibility, each Department shall:

(a) Recommend to the Credentials Committee, through its Chairperson, written criteria for the assignment of Clinical Privileges for procedures typically performed by Practitioners practicing those specialties within the Department and each of its sections. Such criteria shall be consistent with and subject to these Bylaws, the Rules and Regulations and the policies of the Medical Staff and the Hospital. These criteria shall be effective when approved by the Board of Directors.

(b) Establish guidelines for the granting of Privileges within the Department and submit recommendations to the Credentials Committee regarding the specific privileges each Medical Staff Member or applicant may exercise. Granting of Privileges shall be based upon demonstrated competence, training, experience and compliance with the criteria established for such Privileges.

(c) Conduct or participate in, and make recommendations regarding the need for, continuing education programs;

(d) Assure adherence to these Bylaws, the Rules and Regulations, and other relevant Hospital policies and procedures, sound principles of clinical and surgical practice, and other standards designed to promote quality medical care for members of the Department and other providers assigned thereto;

(e) Coordinate the patient care provided by the members of the Department and other providers assigned thereto with nursing and ancillary patient care services and with administrative support services;

(f) Submit written reports (including findings and actions) to the Medical Executive Committee on a regular basis concerning the quality of care provided in the Department and such other matters as may be requested from time to time by the Medical Executive Committee;

(g) Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it;

(h) Assist Hospital management in establishing procedures for addressing intra-departmental activities, including cooperative utilization of Hospital facilities with other departments for the purpose of improving patient care and efficiency; and

(i) Establish schedules for taking emergency calls by Members of the Department.

4.2-6 MEETINGS OF DEPARTMENTS.

A Department shall meet at least quarterly, either as a whole Department or through its Sections or committees, to carry out those responsibilities assigned to it and to function in accordance with the rules, regulations, and policies of the Department. The Chairperson of the Department shall preside at Department meetings.

4.2-7 DEPARTMENT CHAIRPERSONS AND VICE-CHAIRPERSONS.

(a) Qualifications.

Each Department Chairperson and Vice-Chairperson shall (i) be an Active Staff Member, (ii) be qualified by experience within the Department and by administrative ability to supervise the functions of the Department, (iii) be willing and able to discharge the functions of the Department Chairperson, and, (iv) be Board Certified unless a Member of the Medical Staff prior to February 1, 2007 (and continuously a Member since).

(b) Selection.

Department Chairpersons and Vice-Chairpersons shall be selected by the President of the Medical Staff, subject to the approval of two-thirds of the Active Medical Staff by their vote in the manner herein prescribed and the approval of the Board of Directors, or, in extraordinary circumstances where immediate action is necessary to protect the interests of the Hospital, may be appointed temporarily by the President of the Medical Staff alone.

(c) Removal

A Department Chairperson may be removed from his/her office for the same reasons as outlined in Section 4.4-2(c) by majority vote of the Medical Executive Committee.

(d) Term.

Each Department Chairperson shall serve a term of two (2) years coinciding with the Medical Staff Year beginning on January 1 following his/her selection. If practical, one-half (1/2) of the Department Chairpersons will be appointed on alternate years to provide for continuing experience. A Department Chairperson may be selected for successive terms.

(e) Responsibilities.

Each Department Chairperson shall have responsibility for the organization and administration of the Department, including, without limitation:

(1) Accounting to the Medical Executive Committee and the Medical Staff as a whole for all professional, clinical, and Medical Staff administrative activities within the Department;

(2) Monitoring and assessing, on an ongoing basis, the professional performance of Medical Staff Members and other providers who exercise Privileges within the Department, including the rendering of reports on each such Member or Allied Health Professional at the time of reappointment or reappraisal and on the monitoring of Provisional Staff Members;

(3) Recommending to the Medical Staff the criteria to be utilized in granting Privileges within the Department and recommending Clinical Privileges to be granted each member of the Department granted privileges in the Department and determining the qualifications and competence of Allied Health Professionals who provide patient care services within the Department;

(4) Assessing and improving on an ongoing basis the quality of care and services provided, maintaining quality control programs as appropriate and ensuring that the findings, conclusions, recommendations and actions taken to improve organizational performance are communicated to appropriate Medical Staff Members;

(5) Appointing committees, as needed, to conduct Department functions, including, without limitation, appointment, reappraisal, and quality improvement activities;

(6) Participating in budgetary planning, recommending space and other resources for the Department, as required, and supervising and assisting in preparation of reports required of the Department;

(7) Appointing a Chairperson for each duly established Section of the Department;

(8) Integrating the Department into the primary functions of the Medical Staff and the Hospital;

(9) Coordinating and integrating interdepartmental and intradepartmental services;

(10) Developing and implementing policies and procedures that guide and support the provision of patient care services in the Department;

(11) Recommending a sufficient number of qualified and competent persons to provide patient care services in the Department;

(12) Making available orientation and continuing education to Members in the Department; and

(13) Assessing and recommending to Hospital administrative off-site sources for needed patient care services not provided by the Department.

4.3 SECTIONS.

4.3-1 CREATION AND DISSOLUTION OF SECTIONS

A clinical Section is a sub-unit within a clinical Department which contains a recognized specialty or subspecialty practice area and two or more Members whose practice is limited or primarily limited to such specialty or subspecialty. A clinical Section may be created if it is a section recognized by the American Board of Medical Specialties and if the Department determines that there exists within the Department such a defined specialty that the Department as a whole may not satisfy the needs of such members. No section shall be created unless approved by the Department, the Medical Executive Committee and the Board of Directors. If the Department or Medical Executive Committee determines that an existing section no longer fulfills these qualifications it shall dissolve the Section, subject to the approval of the Board of Directors.

4.3-2 FUNCTIONS OF SECTIONS.

(a) Each Section Chairperson shall develop and recommend to the Department Chairperson written criteria for the assignment of Clinical Privileges for the performance of those procedures properly within the specialty or subspecialty comprising the Section, but such Section shall have no responsibility for performing any credentialing function with respect to the granting of Privileges to any applicant or Member.

(b) Each Section shall develop and recommend to the Department Chairperson clinical indicators for quality improvement review and the section shall participate in the performance of quality improvement in cooperation with Hospital administration.

(c) Each Section shall develop and recommend to the Department Chairperson suggested requirements for continuing medical education.

(d) Each Section shall monitor and evaluate its medical care on a retrospective, concurrent and prospective basis in all major clinical activities of the section. For the purposes hereof, concurrent review means review while the patient is still in the Hospital but shall not imply review while a procedure is being performed on a patient or proctoring of the treating Practitioner. This monitoring shall include those same matters, if appropriate, enumerated in Section 4.2-5.

(e) Each Section shall meet at least quarterly, shall maintain minutes thereof and shall transmit written reports after each meeting to the Department Chairperson and report at the next Department meeting of its activities. Copies of these reports shall be filed with the Department, Medical Executive Committee and the Board of Directors.

4.3-3 SECTION CHAIRPERSONS

(a) Selection.

Each Section Chairperson shall be selected by the Chairperson of the appropriate Department, subject to the approval of the Medical Executive Committee. Each Section Chairperson shall be (i) an Active Staff Member, (ii) qualified by experience within the Section and by administrative ability to supervise the functions of the Section, (iii) willing and able to discharge the functions of the Section Chairperson and (iv) Board Certified unless a member of the Medical Staff prior to February 1, 2007 (and continuously a Member since).

(b) Removal.

The Section Chairperson may be removed from his/her office for the same reasons outlined in Section 4.4-2(c) by a majority vote of the Medical Executive Committee.

(c) Term.

Each Section Chairperson shall serve a term of (2) two years coinciding with the Medical staff Year beginning on January 1 following his/her selection.

(d) Responsibilities.

Each Section Chairperson shall have the following responsibilities, including, without limitation:

(1) Making findings as to the qualifications for reappointment when requested by the Chairperson of the Department; and

(2) Assuring that a permanent record is maintained of the Section's proceedings with respect to quality review activities, recommendations and actions and that these are reported to the Chairperson of the Department at least quarterly;

4.4 OFFICERS

4.4-1 OFFICERS OF THE MEDICAL STAFF.

The officers of the Medical Staff shall be:

1. President of the Medical Staff.
2. President-elect of the Medical Staff.
3. Immediate Past President of the Medical Staff.

4.4-2 QUALIFICATIONS.

(a) Qualifications

Each officer must be a member in good standing of the Active Staff at the time of his/her nomination and election and must remain a member in good standing of the Active Staff during his/her term of office. The termination of Active Staff status of any officer of the Medical Staff shall result in automatic termination of his/her status as an officer of the Medical Staff.

(b) Election and Term.

Officers shall be elected by the Active Staff of the Medical Staff in the manner herein provided, except that the President-elect of the Medical Staff shall automatically succeed to the office of President of the Medical Staff if qualified and the current President shall then succeed to the office of the Immediate Past President. Approval of nominees will be determined by the vote of two-thirds (2/3) of the Active Staff entitled to vote and voting in the manner determined by the Medical Executive Committee as provided during the Annual Meeting. All officers shall serve a term of one (1) year, coinciding with the Medical Staff Year beginning on January 1 next following their election to office.

(c) Removal.

Officers may be removed by (i) the vote of three-fourths (3/4) of the entire Medical Executive Committee or (ii) a vote of three-fourths (3/4) of the Members of the Active Medical Staff present and voting at any general or special meeting called for that purpose at which a quorum is present or as otherwise provided for voting on Medical Staff matters as provided in Section 5.4, subject to the approval of the Board of Directors. If the President of the Medical Staff is removed from that office, he/she shall be ineligible to hold the office of Immediate Past President of the Staff. An officer may be removed from office under any of the following circumstances:

(i) Failure of the officer to carry out the duties and responsibilities of the office, including failure to attend at least 50% of Medical Executive Committee meetings; or

(ii) Summary suspension of the officer's Medical Staff appointment or Clinical Privileges in accordance with Article 4 of the Appointment Policy; or

(iii) Automatic suspension of the officer's Medical Staff appointment and/or Privileges in accordance with Article 4 of the Appointment Policy, other than for failure to complete medical records, or

(iv) Final adverse action has been taken regarding the officer's Medical Staff appointment or Privileges in accordance with Article 4 of the Appointment Policy;

(v) Suffering from a physical or mental infirmity that renders the officer incapable of fulfilling the duties of the office, with or without reasonable accommodation; or

(vi) conduct detrimental to the interests of the Hospital;

(vii) other just cause.

In addition, the Board of Directors may remove an officer in extraordinary circumstances where such removal is necessary to protect the interests of the Hospital.

4.4-3 VACANCIES.

Vacancies in Medical Staff offices, other than that of President of the Medical Staff, shall be filled by the Medical Executive Committee. The President-elect of the Medical Staff, if qualified, shall automatically succeed to the office of President of the Medical Staff in case of a vacancy in that office or upon the completion of the term of the President of the Medical Staff. Should the office of Immediate Past President or President-elect become vacant and a replacement be appointed by the Medical Executive Committee to fill a vacancy of the Immediate Past President or President-elect, that appointment shall be subject to confirmation by a vote of 2/3rd of the attending or responding Active Staff members of the Medical Staff voting at a meeting of the Medical Staff held as soon as practical or by other method provided for voting as provided in Section 5.4.

Vacancies in office occur upon death, disability, resignation or removal of the officer, such officer's loss of appointment to the Medical Staff, or by reason of the succession of the officer to another office.

4.4-4 DUTIES OF PRESIDENT OF THE MEDICAL STAFF.

The President of the Medical Staff shall serve as the chief administrative officer and principal official of the Medical Staff. As such, the President shall be responsible for implementing the general responsibilities of the Medical Staff, including, without limitation:

(a) Aiding and coordinating Medical Staff activities and providing day-to-day liaison on medical matters with the activities and concerns of the Board of Directors, administration of the Hospital, nursing and other patient care services;

(b) Being accountable to the Board of Directors and Medical Staff, in conjunction with the Medical Executive Committee and the respective Departments, for the safety, quality, efficiency, and performance improvement activities of patient care services delegated to and provided by the Medical Staff;

(c) Developing and implementing, in coordination with the Chairpersons of the respective Departments, continuing education programs, utilization review, and methods for credentials review, delineation of privileges, and monitoring of patient care within Departments;

(d) Communicating and representing the views, opinions, concerns, grievances and recommendations of the Medical Staff to the Board of Directors, the President of the Hospital, and other officials of the Medical Staff;

(e) Assuming responsibility for the enforcement of these Bylaws, the Rules and Regulations and policies of the Medical Staff, for implementation of appropriate sanctions where indicated and for the Medical Staff's compliance with procedural safeguards as provided in the Appointment Policy in all instances where appropriate;

(f) Participating in Hospital planning and collaborating in decision making activities;

(g) Assuring that the scope of services and goals provided by each Department are defined and written;

(h) Calling and presiding at all general and special meetings of the Medical Staff and of the Medical Executive Committee;

(i) Serving as Chairperson of the Medical Executive Committee, and as an ex officio member of all other Medical Staff committees with the right to vote, except as to the Quality Improvement Committee where he/she shall have no right to vote;

(j) Approving appointments by the committee Chairpersons of members of all committees of the Medical Staff, except the Medical Executive Committee;

(k) Serving as a non-voting member of the Board of Directors;

  (i) Receiving and interpreting the policies of the Board of Directors to the Medical Staff and reporting to the Board of Directors on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care;

(l) Being a spokesperson for the Medical Staff in external professional and public relations;

(m) Performing such other functions as may be assigned to him/her by these Bylaws, the Medical Staff or the Medical Executive Committee;

(n) Assisting the Hospital in maintaining Joint Commission accreditation; and

(o) Recommending or appointing, as applicable, Members of the Medical Staff to Hospital committees and committees of the Board of Directors or joint committees on which Members of the Medical Staff area asked to serve.

4.4-5 DUTIES OF PRESIDENT-ELECT.

The President-elect of the Medical Staff shall serve as a member of the Medical Executive Committee and shall be required to assist the President of the Medical Staff and to perform such duties as may be assigned to him/her by the President of the Medical

Staff and by the Medical Executive Committee. The President-elect will be responsible for authenticating the Credentials Committee's recommendation sheets for appointment and reappointment. In the absence of the President of the Medical Staff, the President-elect shall assume the responsibilities, exercise the authority, and perform the duties assigned to the President of the Medical Staff until the President of the Medical Staff returns. Upon the occurrence of a vacancy in the office of the President of the Medical Staff, the President-elect shall automatically succeed to that office. The President-elect will serve as the Treasurer for Medical Staff funds.

4.4-6 DUTIES OF IMMEDIATE PAST PRESIDENT.

The Immediate Past President of the Medical Staff shall be a member of the Medical Executive Committee for one year and shall serve as an advisor to the President of the Medical Staff and perform those functions delegated to him/her by the President of the Medical Staff and by the Medical Executive Committee.

4.5 COMMITTEES OF THE MEDICAL STAFF

4.5-1 DESIGNATION

There shall be a Medical Executive Committee and such other standing and special committees of the Medical Staff responsible to the Medical Executive Committee as may from time to time be deemed necessary and desirable by the Medical Staff. The Medical Executive Committee may, by resolution and with the approval of the Board of Directors, establish or abolish committees of the Medical Staff to perform one or more of the required functions of the Medical Staff.

4.5-2 COMMITTEE CHAIRPERSONS.

With the exception of the Medical Executive Committee, the Chairperson of each standing or special committee shall be appointed by the current President-Elect with respect to new appointments commencing on January 1 of the next ensuing year subject to approval by the Board of Directors. The current President of the Medical Staff shall fill vacancies occurring during the Medical Staff Year, subject to the approval of the Board of Directors. The President of the Medical Staff shall serve as Chairperson of the Medical Executive Committee. All committee Chairpersons shall be members of the Active Staff.

4.5-3 MEMBERSHIP.

(a) Eligibility.

Members of the Active, Consulting and Courtesy Staffs shall be eligible for appointment to any standing or special committee of the Medical Staff, except for the Medical Executive Committee whose members must be members of the Active Staff. Where specified in these Bylaws, or where the Medical Executive Committee deems it appropriate to the functions of a committee of the Medical Staff, members of other categories of the Medical Staff, and representatives from various services of the Hospital, including, without limitation, administration, shall be eligible for service on specific committees of the Medical Staff.

(b) Selection.

Unless otherwise provided in these Bylaws, Medical Staff Members of any Medical Staff committee, other than the Medical Executive Committee, shall be appointed by the Chairperson of such committee with the approval of the President of the Medical Staff.

(c) President of the Hospital as ex-officio member.

Unless otherwise provided in these Bylaws, the President of the Hospital or his/her designee shall serve as an ex officio member of all Medical Staff committees.

(d) Term.

Each Medical Staff committee member shall serve a term of two (2) years, coinciding with the Medical Staff Year beginning on January 1 next following his/her appointment. If practical, members shall be appointed with staggered terms to allow for a continuation of experienced voting members. Committee members may be reappointed as often as the individual or entity responsible for such reappointment may deem advisable.

(e) Minutes.

Each committee shall maintain a permanent record of all its proceedings and recommendations, and shall report to the Medical Executive Committee of its findings and recommendations in connection with its functions promptly after each meeting.

4.5-4 REQUIREMENTS FOR MEDICAL STAFF COMMITTEE SERVICE.

All members of the Active Staff are encouraged to participate in designated committee activities. Failure to participate when requested, without good cause, may be grounds for denial of reappointment to the Medical Staff.

4.5-5 BYLAWS COMMITTEE.

(a) Composition.

The Bylaws Committee shall consist of at least five (5) members of the Active Staff who shall be selected from different Departments if feasible.

(b) Responsibilities.

The Bylaws Committee shall be responsible for the performance of the following functions:

(1) Conducting regular review and revisions of these Bylaws, the Appointment Policy and the Rules and Regulations and making recommendations with respect thereto to the Medical Executive Committee; acting as a consultant for procedures and forms promulgated in connection with these Bylaws, the Appointment Policy and the Rules and Regulations to reflect current practices within the Medical Staff and the Hospital, and to comply with

changes in applicable law, regulations, and accreditation and professional standards.

(2) Conducting a review of all proposed amendments to these Bylaws, the Appointment Policy and the Rules and Regulations and submitting recommendations based on such review and evaluation to the Medical Executive Committee;

(3) Interpreting the provisions of these Bylaws and adjudicating any unresolved issues in relation thereto, including the resolution of the parliamentary disputes arising under these Bylaws; and

(4) Performing such other duties as may be assigned to it by the Medical Executive Committee.

(c) Meetings.

The Bylaws Committee shall meet as frequently as necessary to perform its functions, and at least annually.

4.5-6 CANCER COMMITTEE

(a) Composition:

The Cancer Committee shall consist of:

(1) at least five (5) Physician Members from the following specialties: Diagnostic radiology, pathology, general surgery, medical oncology, and radiation oncology. If possible, one member from each of such specialties shall be selected;

(2) at least one (1) non-Physician member selected from the Hospital Cancer program administrator, oncology nursing, social services, cancer registry and quality improvement;

(3) Additional Physician or non-Physician members may include members of: Cardiovascular/Thoracic Surgery, ENT Surgery, Family Medicine, Urology, Neurosurgery, Gynecology, Orthopedic, Hospice, palliative care, clinical research, nutrition, pharmacy, spiritual care/services, mental health, American Cancer Society, and a member of the community;

The Cancer Committee chairperson shall be a Physician Member who may also fulfill the role of one of the required medical specialties set forth in (1). The Cancer Liaison Physician shall be a member of the committee and fulfill the role of one of the required medical specialties.

(ii) Responsibilities:

The Cancer Committee shall be responsible for performance of the following functions:

(1) Being accountable for all cancer program activities at the Hospital;

(2) Designating one coordinator for each of the four areas of cancer committee activity: cancer conference, quality control of the cancer registry data, quality improvement, and community outreach. The Cancer Liaison Physician shall coordinate the community outreach activities;

(3) Developing and evaluating annual goals and objectives for clinical, community outreach, quality improvement, and programmatic endeavors related to cancer care on an annual basis;

(4) Establishing the cancer conference frequency, format, and multidisciplinary attendance requirements for cancer conferences on an annual basis and ensure that the required number of cases are discussed at cancer conference and that at least 75 percent of the cases discussed at cancer conferences are presented prospectively. The committee shall monitor and evaluate the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective case presentation on an annual basis;

(5) Completing site-specific analysis that includes comparison and outcome data and disseminates the results of the analysis to the Medical Staff;

(6) Reviewing 10 percent of the analytic caseload to ensure that American Joint Committee on Cancer staging is assigned by the Cancer Liaison Physician and recorded on a staging form in the medical record on at least 90 percent of eligible analytic cases;

(7) Reviewing 10 percent of the analytic caseload to ensure that ninety (90) percent of cancer pathology reports include the scientifically validated data elements outlined in the College of American Pathologists protocols;

(8) Providing a formal mechanism to educate patients about cancer-related clinical trials;

(9) Monitoring community outreach activities on an annual basis;

(10) Completing and documenting the required studies that measure quality and outcomes;

(11) Implementing two improvements that directly affect patient care;

(12) Establishing subcommittees or workgroups as needed to fulfill cancer program goals; and

(13) Performing such other duties as may be assigned to it by the Medical Executive Committee.

(iii) Meetings:

The Cancer Committee will meet quarterly and shall report to the Medical Executive Committee as required.

4.5-7 CREDENTIALS COMMITTEE.

(a) Composition:

The Credentials Committee shall consist of a sufficient number of members of the Active Staff to ensure representation of the major clinical and Hospital-based specialties. In addition, the President of the Hospital or his/her designee, an administration representative or his/her designee, the Chief Medical Officer and the Director of Medical Staff Services shall serve as ex officio members. The designated administrative representative shall have the right to vote.

(b) Responsibilities:

The Credentials Committee shall be responsible for the initial assessment and continuing review of applicants for appointment and reappointment to the Medical Staff and granting of Clinical Privileges to Practitioners and, as applicable, Allied Health Professionals, including the following:

(1) Reviewing and evaluating the credentials and qualifications of each applicant for initial appointment, reappointment or modification of appointment to the Medical Staff and for delineated privileges of such applicants and Allied Health Professionals, and obtaining and considering the recommendations of the appropriate Departments.

(2) Recommending criteria for specific Clinical Privileges after receiving reports and recommendations from appropriate Department chairpersons, consultants or others with appropriate expertise;

(3) Submitting reports through the Chairperson of the Credentials Committee to the Medical Executive Committee in accordance with the procedures set forth in the Appointment Policy regarding the Credentials Committee review and evaluation of the qualifications of each applicant for Medical Staff appointment, for Department affiliation, and for delineated privileges for Practitioners and Allied Health Professionals;

(4) Establishing policies for the assignment of Allied Health Professionals to Departments;

(5) Reviewing policies, Rules and Regulations and policies of the Medical Staff or of the Hospital relating to the appointment or credentialing of appointees to the Medical Staff and recommending changes as may be necessary or desirable to the Medical Executive Committee;

(6) Investigating, reviewing, and reporting on matters concerning the professional or ethical conduct of any Practitioner or Allied Health Professional

applying for appointment or reappointment or as may be assigned or referred to the Credentials Committee by the Medical Executive Committee;

(7) Reviewing annually and making recommendations on each Department's/Section's Clinical Privileges list which is assessed by the Department/Section in order to determine whether sufficient facilities (space, equipment, staffing and financial resources) are available (or will be available within a specified time) to support each Privilege; and

(8) Performing such other duties as may be assigned to it by the Medical Executive Committee.

When deemed reasonably necessary, the Medical Executive Committee shall carry out these responsibilities between meetings of the Credentials Committee.

(c) Meetings:

The Credentials Committee shall meet as often as necessary to carry out its functions, but at least monthly.

4.5-8 INTENSIVE CARE COMMITTEE.

(a) Composition

(1) The Intensive Care Committee shall consist of all participating Intensivists, the Director of Trauma Services, the Chief Operating Officer, the Vice President of Patient Care Service, the Director of Critical Care, the Chief Medical Officer and a representative from the Pharmacy. Other Members of the Medical Staff may be invited on an as needed basis.

(2) The Chairperson of the Intensive Care Committee shall be a member of the Active Staff whose professional training, experience and credentials document knowledge of and special interest or experience in Critical Care.

(b) Responsibilities.

The Intensive Care Committee shall be responsible for the following functions:

(1) Monitoring the clinical performance for the intensive care unit.

(2) Developing a system for reporting, identifying and analyzing the quality aspects of clinical practice that focuses around improvements in patient outcomes;

(3) Developing written policies defining criteria of clinical practice and flow in the Intensive Care Unit; and

(4) Performing such other duties as may be assigned to it by the Medical Executive Committee.

(c) Meetings

The Intensive Care Committee will meet as needed but not less than quarterly and shall report on its activities and recommendations to the Vice President Patient Care Services as well as the Medical Executive Committee.

4.5-9 INFECTION CONTROL COMMITTEE.

(a) Composition.

(1) The Infection Control Committee shall consist of at least five (5) members of the Medical Staff from appropriate departments, the President of the Hospital or his/her designees, and at least one (1) representative each from Pharmacy, Performance Excellence, Laboratory and Occupational Health. The Employee Health Representative shall be asked to attend on an as needed basis.

(2) The Chairperson of the Infection Control Committee shall be a member of the Active Staff whose professional training, experience and credentials document knowledge of and special interest or experience in infection control.

(b) Responsibilities.

The Infection Control Committee shall be responsible for the following functions:

(1) Developing a Hospital-wide infection control program and maintaining surveillance over the program;

(2) 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;

(3) Developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;

(4) Developing written policies defining special indications for isolation requirements;

(5) Coordinating action on findings from the Medical Staff's review of the clinical use of antibiotics;

(6) Acting upon recommendations related to infection control received from the President of the Medical Staff, the Medical Executive Committee, the Departments and other committees;

(7) Reviewing sensitivities of organisms specific to the Hospital; and

(8) Performing such other duties as may be assigned to it by the Medical Executive Committee.

(c) Meetings.

(1) The Infection Control Committee shall meet as often as necessary to carry out its functions, but at least bi-monthly, and

(2) Shall report on its activities and recommendations to the Vice President Patient Health Services and to the Board of Directors as well as to the Medical Executive Committee.

4.5-10 MEDICAL EXECUTIVE COMMITTEE.

(a) Composition.

The Medical Executive Committee shall be chaired by the President of the Medical Staff and shall consist of the following members:

(1) President of the Medical Staff;

(2) President-elect of the Medical Staff;

(3) Immediate Past President of the Medical Staff.

(4) Chairpersons from the Departments of Medicine, Surgery, Pediatrics, OB-GYN, Orthopedics, Anesthesia, Family Practice, Emergency Medicine, Pathology and Radiology;

(5) Chairpersons of the Credentials, Operating Room and Intensive Care Unit Committees; and

(6) The President of the Hospital or his/her designee, the Chief Medical Officer and the Chairperson of the Board of Directors who shall serve as ex officio members without vote;

No member of the Active Staff shall be ineligible for membership on the Medical Executive Committee solely because of his or her professional discipline or specialty.

(b) Responsibilities.

The Medical Executive Committee shall represent the Medical Staff, assume responsibility for the effectiveness of all medical activities of the Medical Staff, act on matters of concern and importance to the Medical Staff, and act as the authorized delegate of the Medical Staff between Medical Staff meetings in regard to general and specific functions of the Medical Staff. The Medical Executive Committee is delegated the primary authority over activities related to the functions of self governance of the Medical Staff and over activities related to the functions of performance improvement of the professional services provided by providers with Clinical Privileges. In that regard, the Medical Executive Committee shall have responsibility, without limitation, for:

(1) Receiving and acting upon reports and recommendations from Medical Staff committees, Departments, and assigned activity groups; receiving and

reviewing reports from the graduate medical education program director as to the Hospital's residency and other education programs and reports thereon to the Board of Directors;

(2) Implementing approved policies of the Medical Staff;

(3) Recommending to the Board of Directors on all matters relating to: medical staff structure, mechanisms used to review credentials and to delineate Clinical Privileges, individuals for medical staff appointment and delineated Privileges for each eligible provider;

(4) Aiding and fulfilling the accountability of the Medical Staff to the Board of Directors for the quality of the overall medical care rendered to patients within the Hospital;

(5) Initiating and pursuing formal investigation and corrective action when warranted, in accordance with the provisions of the Appointment Policy and making recommendations to the Board of Directors regarding the mechanisms by which Medical Staff appointment and Clinical Privileges may be terminated and for fair hearing procedures.

(6) Serving as a liaison between the Medical Staff and the Board of Directors and administration of the Hospital, including considering and recommending action to the Board of Directors and administration of the Hospital on all medical-administrative matters.

(7) Undertaking all steps necessary to provide that the Hospital meets or exceeds the requirements for accreditation, licensure, and certification imposed by relevant entities and authorities, including, without limitation, Joint Commission, Medicare, and the Montana State Board of Health.

(8) Evaluating and recommending proposed steps and policies to provide that variations from relevant accreditation standards are noted and corrected by the Medical Staff, the Board of Directors, and Hospital administration.

(9) Providing for the preparation of all Medical Staff meeting programs, either directly or through delegation to a program committee or other designee.

(10) Requiring participation of the Medical Staff in organizational performance improvement and patient safety activities and evaluating the quality of ancillary services, including equipment, space, and operating policies and practices of all such services and making appropriate recommendations regarding such services to the President of the Hospital and the Board of Directors. The services to be so evaluated shall include, without limitation, anesthesiology, radiology, pathology, pharmacy, rehabilitative services, respiratory therapy, and all special care units of the Hospital.

(11) Advising the Board of Directors as to minimum coverage limits for professional liability insurance;

(12) Reviewing and recommending approval of these Bylaws, the Appointment Policy, Rules and Regulations and policies and amendments thereto;

(13) Recommending the amount of dues assessment annually at the annual Medical Staff meeting;

(14) Recommending to Hospital administration the amount of stipends to be paid to the Medical Staff officers and any other expenditures on an annual basis; and

(15) In the absence of a Credentials Committee, the Medical Executive Committee shall carry out the responsibilities of the Credentials Committee.

(c) Meetings.

(1) The Medical Executive Committee shall meet at least (10) ten times per year and shall keep a permanent record of all proceedings and actions at its meetings. A quorum shall consist of at least fifty percent (50%) of the current voting members of the committee.

(2) The minutes of the Medical Executive Committee shall be made available to any Member of the Medical Staff upon request, except that peer review information, credentialing information and provider health information that may be part of the Medical Executive Committee minutes shall be extracted and shall not be made so available.

4.5-11 MEDICAL STAFF QUALITY IMPROVEMENT COMMITTEE

(a) Composition:

The Medical Staff Quality Improvement Committee shall consist of at least five (5) members of the Medical Staff from the following specialties: General Medicine, a Medical Subspecialty, Pediatrics, Orthopedics, Family Practice, Surgery, OB/GYN, Emergency Medicine and Anesthesiology and the Chief Medical Officer. If reasonably possible, one member from each specialty shall be selected. Physicians from other specialties may be invited to the meetings of the Committee as needed.

(b) Responsibilities:

The Medical Staff Quality Improvement Committee will be responsible for evaluating and improving Practitioner and Allied Health Professional performance. The goals of the committee are:

(1) Improving patient outcomes;

(2) Encouraging the pursuit of excellence;

(3) Increasing efficiency of the Practitioner and Allied Health Professional performance evaluation;

(4) Supporting Medical Staff educational goals; and

(5) Ensuring the efficient use of Practitioner and Allied Health Professional and quality staff measurement resources.

In support of such goals the Quality Improvement Committee shall:

(1) establish a planned and systematic process for monitoring, evaluating, and improving the quality and appropriateness of the care and treatment of patients served by Members of the Medical Staff and Allied Health Professionals and the clinical performance of all individuals with Clinical Privileges. This monitoring and evaluation shall be conducted not less frequently than as required by Joint Commission or, if more frequently, as required by state or federal law (including applicable regulations) and shall include:

(i) the identification and collection of information about important aspects of patient care provided by the Medical Staff and Allied Health Professionals;

(ii) the identification of the indicators used to monitor the quality and appropriateness of the important aspects of care;

(iii) the periodic assessment of patient care information to evaluate the quality and appropriateness of care, to identify opportunities to improve care, and to identify important problems in patient care. Patient care reviews shall include all clinical work performed by the Medical Staff and Allied Health Professionals.

(iv) recommend for approval of the Medical Executive Committee plans for maintaining quality patient care within the Hospital. These plans 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,

4. monitor the results of quality improvement activities throughout the Hospital; and

5. coordinate quality improvement activities;

(v) submit regular written confidential reports to the Medical Executive Committee on the quality of medical care provided and on peer review activities conducted and such other matters within the duties of the Committee as may be requested from time to time by the Medical Executive Committee;

(vi) evaluate the appropriateness of blood transfusions;

(vii) develop proposed policies and procedures for the screening, distribution, handling and administration of blood and blood components;

(viii) meet regularly for the purpose of receiving, reviewing and considering findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care provided to patients and the results of the Department's other review and educational activities, and the purpose of preparing and receiving reports on other Department and Staff functions;

(ix) evaluate the appropriateness of operative, other invasive and noninvasive procedures, including selection of the procedure, preparation of the patient, performance of the procedure and patient monitoring, post-procedure care and post-procedure patient education;

(x) receive, evaluate and recommend practices related to infection control issues; and

(xi) receive and take action to improve prevention and control activities and to reduce nosocomial infections.

(c) Meetings:

The Medical Staff Quality Improvement Committee shall meet as often as needed to satisfy its functions.

4.5-12 NOMINATING COMMITTEE.

(a) Composition.

The Nominating Committee shall consist of the officers of the Medical Staff and the President of the Hospital or his/her designee, who shall be an ex officio member without vote. The President-elect shall serve as Chairperson of the Nominating Committee.

(b) Responsibilities.

The Nominating Committee shall be responsible for identifying nominees for offices of the Medical Staff and for Department Chairpersons for submission to the Active Staff for approval. The positions for which the Nominating Committee shall submit recommendations shall be:

(1) President-elect of the Medical Staff.

(2) Immediate Past President in the event the office becomes vacant during the term of such office.

(3) Department Chairpersons.

(c) Procedures.

(1) In order to identify nominees for the positions listed in Section 4.5-13, the Nominating Committee shall meet annually in August to compile a list of nominees for each position.

(2) The Nominating Committee shall notify each Active Staff Member of its nominees for the positions to be elected by October 1.

(3) Nominations from the general Medical Staff shall be entertained with the consent of the nominee if submitted to the Nominating Committee by October 20 and if accompanied by supporting signatures of at least twelve (12) members of the Active Staff eligible to vote.

4.5-13 OPERATING ROOM COMMITTEE

(a) Composition:

The Operating Room Committee shall consist of a minimum of (1) representative from each specialty group that performs procedures in the Hospital operating rooms and two (2) members of the Anesthesiology Department. Members shall serve two-year terms. In addition, the Executive Vice President/Chief Operating Officer of the Hospital shall serve as an ex officio member without vote. The Chairperson of the committee shall also serve as the Medical Director of the Perioperative Services.

(b) Responsibilities:

The Operating Room Committee will have the following responsibilities:

(1) Providing leadership in the operations and efficiencies of the Operating Room to the Medical Staff. The Chairperson of the Operating Room will be responsible for communicating operational needs and assessments to Hospital administration and the Medical Staff;

(2) Reviewing and assigning new and amended block requests for those surgeons who have secured block time;

(3) Evaluating block utilization data for block efficiency and overall performance;

(4) Monitoring and making recommendations regarding operating room staffing;

(5) Develop in coordination with Hospital administration policies, procedures and protocols for the operating rooms, pre-op and recovery areas to provide guidance for the effective operation of these facilities as well as the implementation and assurance of compliance with pertinent regulatory agencies and applicable laws; and

(6) Performing such other duties as may be assigned to it by the Medical Executive Committee.

(c) Meetings:

The Operating Room Committee shall meet as often as necessary to carry out its functions but at least quarterly.

4.5-14 PHARMACY AND THERAPEUTICS COMMITTEE.

(a) Composition.

(1) The Pharmacy and Therapeutics Committee shall consist of at least four (4) members of the Medical Staff, the President of the Hospital or his/her designee, the Chief Medical Officer, the Chief Medical Officer and one (1) representative each from Pharmacy, Dietary, and Nursing Services who shall serve without vote.

(2) If possible, the Chairperson shall appoint at least one (1) member from each major Department to serve as a member of the Committee.

(b) Responsibilities.

The Pharmacy and Therapeutics Committee shall be responsible for the performance of the required functions of the Medical Staff related to the development and monitoring of pharmacy and therapeutics policies and practices within the Hospital, including:

(1) Reviewing the appropriateness of the use of medications through the analysis of individual or aggregate patterns of medication practice and intra-hospital distribution and handling and safe administration of medications and chemicals;

(2) Evaluating and making recommendations to the Pharmacy, Nursing Services, and the Medical Staff regarding the choice of medications to be made available within the Hospital, the stocking of medications within nursing units and services, and other matters concerning availability of medications within the Hospital;

(3) Developing and reviewing for adequacy, on an annual or more frequent basis, a formulary or medication list for utilization within the Hospital;

(4) Monitoring and evaluating possible unnecessary duplication in the stocking of medications, including availability of medications and combinations having substantially identical proportions of similar therapeutic ingredients;

(5) Reviewing and evaluating clinical data, and formulating recommendations concerning new medications or preparations requested for availability and use within the Hospital;

(6) Monitoring and reviewing all unexplained or untoward medication reactions;

(7) Reviewing, evaluating, and approving protocols and standards for the use of investigational or experimental medications and for research in the use of recognized medications within the Hospital;

(8) Documenting ongoing medication usage within the Hospital, including findings, conclusions, the actions recommended and undertaken and corrective measures specified; and

(9) Performing such other duties as may be assigned to it by the Medical Executive Committee.

(c) Dietary Responsibilities.

The term "therapeutics," as used in this Section 4.5-15 shall include all dietary and total parenteral responsibilities. The Pharmacy and Therapeutics Committee shall be responsible for reviewing special menus and approving the Hospital Dietary Manual.

(d) Meetings.

The Pharmacy and Therapeutics Committee shall meet as often as necessary to perform its required functions but at least quarterly.

4.5-15 PROVIDER HEALTH COMMITTEE

(a) Composition:

The Provider Health Committee shall consist of at least four (4) members of the Active Staff.

(b) Responsibilities:

The Provider Health Committee shall be responsible for the following functions:

(1) Establishing a program to identify, contact, and assist Practitioners and Allied Health Professionals who have become professionally impaired because of alcohol abuse, drug abuse, mental and/or physical problems;

(2) Evaluating the degree of impairedness of Practitioners and its likely effect on Hospital patients, employees, and the Members of the Medical Staff;

(3) Taking such action as may be necessary to protect the impaired Practitioner's patients, other Hospital patients, employees, Members of the Medical Staff, other members of the hospital community, and the Hospital, and to take such action as may be necessary to facilitate the impaired Practitioner's rehabilitation;

(4) Establishing a program to educate Medical Staff Members regarding prevention of impaired conditions; and

(5) Performing such other duties as may be assigned to it by the Medical Executive Committee.

(c) Meetings:

The Provider Health Committee shall meet as often as necessary to perform its functions.

4.5-16 TRAUMA COMMITTEE

(a) Composition.

(1) The Trauma Committee shall consist of at least seven (7) members of the Medical Staff from Trauma Surgery, Neurosurgery, Orthopedic Surgery, Anesthesia, Emergency Medicine and an Intensivist. Representatives from Radiology, Pediatrics, Rehabilitation and Forensics/pathology shall be invited to attend when a matter involving such patient care area is involved. Representatives (non-Physicians) from Advanced Practice Registered Nurses, Operating Room, Emergency Room, the Chief Medical Officer, Intensive Care Unit, Flight, administration, and Pediatrics shall be invited to attend but shall not be members of the committee.

(2) The Trauma Committee shall be chaired by the Trauma Director who shall meet the qualifications for such directorship as published by the American College of Surgeons and is appointed by the President of the Medical Staff in consultation with the CEO.

(b) Responsibilities

The Trauma Committee shall be responsible for the following functions:

(1) Providing direction and leadership for trauma related activities of the Medical Staff and coordination of trauma care and all trauma care-related activities within the Hospital consistent with the pursuit of excellence and adherence to the hospital criteria established by the American College of Surgeons Committee on Trauma.

(2) Implementing Montana and America College of Surgeons Committee on Trauma trauma care requirements as they develop.

(3) Identifying areas of need in trauma education, trauma performance improvement, and trauma patient safety and conducting and overseeing educational activities related to these needs and general trauma care.

(4) Facilitating and overseeing the creation and updating of all trauma policies, procedures and guidelines related to care delivery process and care

management guidelines utilizing evidence-based practice literature as well as expert assistance from nursing, medical/surgical specialties and subspecialties.

(5) Providing a forum for the delivery of focused and general trauma care peer review utilizing processes consistent with the Hospital's Patient First initiatives and national standards of care.

(6) Incorporating in all discussions current internal and regional trauma care outcome and summary trending reports as well as any potential uses of data sets and analyses provided by the Hospital Collector® Trauma Registry.

(7) Providing to Hospital administration recommendations relative to equipment, staffing, space, facility or process needs identified through the peer review, performance review, and registry analysis processes in conjunction with an annual review of the trauma program;

(8) Creating and supporting partnerships amongst providers of trauma care at the Hospital so as to work in a cohesive and cooperative fashion towards maintenance of the Level 2 Trauma Center verification awarded by survey by the American College of Surgeons Committee on Trauma every 3 years; and

(9) Performing such other duties as may be assigned to it by the Medical Executive Committee.

(c) Meetings

The Trauma Committee will meet generally monthly, but not less than 10 times per year.

4.5-17 UTILIZATION MANAGEMENT COMMITTEE

(a) Composition:

The Utilization Management Committee shall consist of at least four (4) but not more than seven (7) members of the Active Staff and the Chief Medical Officer.

(b) Responsibilities:

The Utilization Management Committee shall have the following duties:

(1) Promoting an understanding of utilization issues for all healthcare providers in the Hospital. Through this understanding it is expected that the Hospital will experience improved efficiency in resource utilization; and

(2) Performing functions pertaining to utilization review to meet all regulatory requirements such as, but not limited to, Joint Commission and Centers for Medicare and Medicaid Services.

(3) Performing such other duties as may be assigned to it by the Medical Executive Committee.

(c) Meetings:

The Utilization Management Committee shall meet as often as needed to fulfill its functions.

4.6 CONFLICT OF INTEREST

4.6-1 RECUSAL IF CONFLICT.

In any instance where an officer, or Department, Section or committee Chairperson, or member of any Medical Staff committee has or reasonably could be perceived to have a conflict of interest or to be biased in any matter involving an applicant to the Medical Staff or Medical Staff appointee that comes before such individual, or department, section or committee, or in any instance where any such individual, or Department, Section or committee member brought the complaint against that appointee, such individual or member shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time, although that individual, or Department, Section or committee member may be asked, and may answer, any questions concerning the matter before leaving. As a matter of procedure, the Chairperson of any body designated to make such a review shall inquire, prior to any discussion of the matter, whether any member has any conflict of interest or bias. The existence of a potential conflict of interest or bias on the part of any officer, or Department, Section or committee member may be called to the attention of the Chairperson by any individual with knowledge of the matter.

4.6-2 ASSIGNMENT OF REVIEW OF APPLICATIONS.

A Department Chairperson shall have a duty to delegate review of applications for appointment, reappointment or Clinical Privileges, or questions that may arise, to the Vice-Chairperson or another appropriate member of the Department, if the Chairperson has a conflict of interest with the individual under review, or could be reasonably perceived to be biased.

ARTICLE V - MEDICAL STAFF MEETINGS

5.1 ANNUAL MEETING.

5.1-1 BUSINESS TO BE TRANSACTED.

The Medical Staff shall hold a regular, annual meeting at which Medical Staff officers and Department Chairpersons for the following Medical Staff Year shall be elected unless the Medical Executive Committee shall select another method for voting on such officers and Department Chairpersons as provided in Section 5.4. This meeting shall be the last regularly scheduled Medical Staff meeting before the conclusion of the Medical Staff Year. The business to be conducted at such meeting shall include, without limitation:

(i) Presentation and consideration of reports and recommendations from the current officers of the Medical Staff and from any or all of such

committees of the Medical Staff as may be requested to make such reports.

(ii) Such other business as may be deemed appropriate or relevant by the Medical Executive Committee.

5.1-2 NOTICE.

Notice of the annual Medical Staff meeting shall be sent to each Active Staff member at the address of each such Member appearing on the records of the Medical Staff, and shall be posted at least twenty (20) days before such meeting. Such notice shall state the following, without limitation:

(i) The place, day, and hour of such meeting.

(ii) The matters to be discussed and upon which action is to be taken as the Medical Executive Committee may deem appropriate.

5.2 SPECIAL MEDICAL STAFF MEETINGS.

5.2-1 CALL OF SPECIAL MEETING.

A special meeting of the Medical Staff may be called at any time by the President of the Medical Staff, a majority of the Medical Executive Committee, or pursuant to a petition signed by not fewer than fifteen percent (15%) of the Active Staff and shall be called at the request of the Board of Directors. The person calling or requesting the special meeting shall state the purpose of the meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within thirty (30) days after receipt of such request. No business shall be conducted at a special meeting except that stated in the notice calling the meeting.

5.2-2 NOTICE:

Notice of any special meeting shall be posted at least five (5) days prior to the meeting. Notice shall also be mailed to each member of the Active Medical Staff at his/her address as it appears on the records of the Medical Staff at least seven (7) days prior to the meeting.

5.2-3 AGENDA:

The agenda at special Medical Staff meetings shall be as follows:

1. Reading of the notice calling the meeting
2. Transaction of the business for which the meeting was called.
3. Adjournment

5.3 QUORUM AT MEDICAL STAFF MEETINGS.

The presence of at least one-half (1/2) of the total membership of the Active Medical Staff shall constitute a quorum at the annual meeting or any special Medical Staff meeting called in accordance with Sections 5.1-2 or 5.2.

5.4 VOTING WITHOUT MEETING

In the event that it is necessary for the Medical Staff to act on a question without being able to meet or when otherwise deemed impractical by the Medical Executive Committee, the Active Staff may be presented with the question by mail, facsimile or electronic mail (including intranet website) appropriately sent to members of the Active Staff and their votes returned to the President of the Medical Staff or his/her designee in the same manner as the matter was sent to the Members by the deadline specified in the notice to the Active Staff. The method of soliciting and registering voting on a matter shall be set by the Medical Executive Committee. Such a vote shall be valid so long as the question is voted on by a majority of the Active Staff who submit their votes by the specified deadline, unless a greater percentage of votes are specified in these Bylaws as to a particular matter.

5.5 MINUTES.

Minutes of each annual Medical Staff meeting and any special Medical Staff meeting shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. Copies of the minutes shall be approved at the next Medical Staff meeting. All minutes shall be forwarded to the Medical Executive Committee and the Director of Medical Staff Services shall maintain a permanent file of the minutes of each meeting.

5.6 DEPARTMENT, SECTION AND COMMITTEE MEETINGS

5.6-1 REGULAR MEETINGS.

Regular meetings of Departments, Sections and committees shall be held with sufficient frequency to carry out their required functions and as otherwise required by these Bylaws. At Department and Section meetings, the Department or Section, as applicable, shall review and evaluate the clinical work of the Department or Section, consider the findings of ongoing quality assessment, monitoring and evaluation activities, and discuss any other matters concerning the Department or Section. Each Department, Section and committee shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof, after each meeting, to the Medical Executive Committee and the Board of Directors.

5.6-2 SPECIAL DEPARTMENT, SECTION AND COMMITTEE MEETINGS

(a) Calling Special Meetings

A special meeting of any Department, Section or committee may be called by or at the request of the appropriate Chairperson, the President of the Medical Staff, or by a petition signed by not fewer than one-fourth (1/4) of the members of the Department, Section or committee, as applicable.

(b) Acting Without Meeting

In the event that it is necessary for a Department, Section or committee to act on a question without being able to meet, the voting members may be presented with the

question in person, by mail, facsimile, electronic mail (e-mail or intranet website), and their vote returned to the Chairperson of the Department, Section or committee, as applicable, by the date set forth in the notice presenting such question. The method of soliciting and registering voting on a matter shall be set by the Chairperson of the Department, Section or committee. Such a vote shall be binding so long as the question is voted on by a majority of the Department, Section or committee eligible to vote and voting who submit their vote in the required manner by the established deadline, unless a vote of more than a majority is specified in these Bylaws as to a particular matter.

5.6-3 QUORUM

Members of the Department, Section or committee, except the Medical Executive Committee, present at a meeting and eligible to vote at any regular or special meeting shall constitute a quorum so long as no fewer than two members of the Active Staff are in attendance and participate. The presence of one-half (1/2) of the members of the Medical Executive Committee shall constitute a quorum. Except as otherwise specified, the action of a majority of the voting members present and voting at a meeting shall be the action of the Department, Section or committee. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

5.6-4 AGENDA

The agenda at any regular or special Department, Section, or committee meeting and its conduct shall be set by the Chairperson thereof and the agenda shall be made available to all members of such Department, section or committee, as the case may be, prior to the meeting.

5.6-5 MINUTES.

Minutes of each regular and special meeting of a committee, or Department shall be prepared and shall include evidence of decisions concerning care based upon medical care evaluation activities, a record of the attendance of members of the committee, Section or Department, and the vote taken on each matter. Copies of the minutes shall be submitted to the attendees for approval. Upon approval the minutes will be signed by the Chairperson. All minutes shall be forwarded to the Medical Executive Committee. The Director of Medical Staff Services shall maintain a permanent file of the minutes of each meeting.

5.7 PROVISIONS COMMON TO ALL MEETINGS

5.7-1 NOTICE OF MEETINGS

Notice of all meetings of the Medical Staff and regular meetings of Departments, Sections and committees shall state the date, time and place of the meeting, shall be delivered, either in person, by mail, by electronic transmission (e-mail or intranet website) or by facsimile transmission, to each Member of the Active Staff at least seven (7) days in advance of such meetings, unless otherwise specifically stated in these Bylaws as to the meetings of a particular body. Notice may also be given by inclusion in Medical Staff or Department newsletters, annual or quarterly calendars of meetings or other

appropriate means. The attendance of any individual at any meeting shall constitute a waiver of that individual's notice of said meeting. Mailing, electronic transmission with acknowledgment of successful transmission or facsimile transmission with acknowledgement of successful transmission of such notice shall be deemed to constitute actual notice to the persons concerned. Notices shall be sent to the last mailing or electronic address or facsimile number on file with the Director of Medical Staff Services.

5.7-2 ATTENDANCE REQUIREMENTS

(a) Each Active Staff Member is expected to attend, and actively participate in, and each Affiliate**,** Courtesy, Consulting and Provisional Staff Member is encouraged to attend, all meetings of the Medical Staff and Department, Section and Medical Staff committees to which the Member has been appointed but such specific attendance will not be a prerequisite for reappointment to the Medical Staff.

(b) Any Medical Staff Member whose clinical competence is scheduled for discussion at any Medical Staff meeting shall be so notified and shall be expected to attend such meeting. If such individual is not otherwise required to attend the meeting, the President of the Medical Staff or his/her designee shall give the individual advance written notice, at least fourteen (14) days**,** of the time and place of the meeting at which attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the individual shall so state, shall be given by certified mail, return receipt requested, and the individual's attendance at the meeting at which the alleged deviation is to be discussed shall be mandatory.

(c) The Chairperson of the applicable Department shall notify the Medical Executive Committee of the failure of an individual to attend any meeting with respect to which notice was given that attendance was mandatory. Unless excused by the Medical Executive Committee upon showing of good cause, such failure shall constitute voluntary relinquishment of all or such portion of the individual's admitting privileges as the Medical Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved. In all other cases, if the individual shall make a timely request for postponement, supported by an adequate showing that the absence will be unavoidable, the presentation may be postponed by the chairperson of the individual's department, or by the Executive Committee if the department chairperson is the individual involved, until not later than the next regularly scheduled meeting. Otherwise, the pertinent clinical information shall be presented and discussed as scheduled.

5.7-3 RULES OF ORDER

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

5.7-4 ENTITLED TO ONLY ONE VOTE

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote. There shall be no proxy voting.

ARTICLE VI - HEARING AND APPEAL PROCEDURES

The Board of Directors has adopted the Appointment Policy which sets forth the circumstances under which applicants to the Medical Staff, Members of the Medical Staff and Allied Health Professionals shall be entitled to request a review and hearing of certain adverse actions taken against them concerning appointment, reappointment and the granting, restriction, suspension or revocation of Clinical Privileges or Medical Staff appointment, which procedures the Medical Staff has approved. The Appointment Policy details the rights, procedures and process of the Hospital and the Medical Staff with regard to matters affecting appointment and Clinical Privileges and shall control in all cases of ambiguity concerning such matters. Reference is hereby made to the Appointment Policy for such appeal and hearing rights.

ARTICLE VII - ALLIED HEALTH PROFESSIONALS

Allied Health Professionals shall not be eligible for membership in, nor appointed to, the Medical Staff. However, Allied Health Professionals may be assigned to certain Departments of the Medical Staff for purposes of participating in medical education and research and for the purposes of reviewing and monitoring the performance of their activities and functions. Allied Health Professionals shall apply for Privileges as provided in the Appointment Policy. Allied Health Professionals shall not be entitled to admit patients.

ARTICLE VIII - CONFIDENTIALITY, IMMUNITY, AND RELEASES

8.1 AUTHORIZATIONS AND CONDITIONS.

By applying for or exercising Privileges, or by providing specified patient care services within the Hospital, all Practitioners, without limitation:

(i) Authorize representatives of the Hospital and of the Medical Staff to solicit, procure, and act upon information bearing on their professional ability and qualifications.

(ii) Agree to be bound by the provisions of this Article and to waive all legal claims against any representative of the Hospital or of the Medical Staff who acts in accordance with the provisions of this Article.

(iii) Acknowledge that the provisions of this Article are express conditions to their applications for or acceptance of Medical Staff appointment, or to their exercise of Privileges or provision of specified patient services within the Hospital.

8.2 CONFIDENTIALITY OF INFORMATION.

Information with respect to any Practitioners and Allied Health Professionals submitted, collected or prepared by any representative of the Hospital or any other health care facility or organization or the Medical Staff, for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research, shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative of the Hospital or of the Medical Staff, nor used in any way except as provided herein, and such

confidentiality shall also extend to information of like kind that may be provided by third parties, which information shall not become part of any particular patient's file.

8.3 IMMUNITY FROM LIABILITY.

8.3-1 FOR ACTION TAKEN.

No representative of the Hospital or of the Medical Staff shall be liable in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as such a representative, if such representative acts in good faith and without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement or recommendation is warranted by such facts.

8.3-2 FOR PROVIDING INFORMATION.

No representative of the Hospital or of the Medical Staff and no third party shall be liable in any judicial proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of the Hospital or an approved representative of the Medical Staff or to any other hospital, organization of health professionals, or other health-related organization, concerning any Practitioner or Allied Health Professional who is or has been an applicant to or Member of the Medical Staff or who did or does exercise Privileges at the Hospital, provided that such representative or third party acts in good faith and without malice.

8.4 ACTIVITIES AND INFORMATION COVERED.

8.4-1 ACTIVITIES.

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures in connection with the Hospital or any other health-related institution's or organization's activities concerning, but not limited to:

(i) Applications for appointment to the Medical Staff or Clinical Privileges.

(ii) Periodic reappraisals for reappointment to the Medical Staff or Clinical Privileges.

(iii) Corrective action.

(iv) Hearings and appellate reviews.

(v) Performance improvement activities.

(vi) Utilization reviews.

(vii) Other Hospital, Department, Section or Committee activities related to monitoring and maintaining of quality patient care and appropriate professional conduct and any other peer review activities.

8.4-2 INFORMATION.

The acts, communications, reports, disclosures, and other information referred to in this Article may relate to a Practitioner's or Allied Health Professional's professional qualifications, clinical or surgical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

8.5 RELEASES.

All Practitioners and Allied Health Professionals shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice, and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under Montana law. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

8.6 CUMULATIVE EFFECT.

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

8.7 MEMBERS' AND ALLIED HEALTH PROFESSIONALS' ACCESS TO FILE.

8.7-1 ACCESS TO CREDENTIALING FILES.

To allow for a free flow of information necessary to adequately investigate an application to the Medical Staff, access of an individual practitioner to his/her Medical Staff file shall be limited to that information used by the Medical Staff, Administration, and/or Board of Directors in reaching an adverse decision or recommendation on appointment, reappointment or privileges subject to the following:

(i) A written request for access must be made by the Member or Allied Health Professional to the President of the Medical Staff;

(ii) The Member or Allied Health Professional may review, and receive a copy of only those documents provided by or addressed personally to the Member or Allied Health Professional;

(iii) The Member or Allied Health Professional shall be allowed access to any information in his/her credentials file other than that described in Section (b) only if, following a written request by the Member or Allied Health Professional, the President of the Medical Staff, the Medical Executive Committee or the Board of Directors grants permission for good cause;

(iv) If deemed in the best interest of the Hospital and the Medical Staff, such access may be in the form of a written summary. The written summary shall disclose the substance, but not the source, of the summarized information, and

(v) The review by the Member or Allied Health Professional shall take place in the Medical Staff Office or other designated location, during normal working hours, with an officer or designee of the Medical Staff present.

ARTICLE IX - GENERAL PROVISIONS

9.1 MEDICAL STAFF RULES AND REGULATIONS.

Subject to the approval of the Board of Directors, the Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. The Rules and Regulations shall relate to the proper conduct of Medical Staff organizational activities and to the level of practice that is to be required of Medical Staff Members and Allied Health Professionals in the Hospital. Recommended changes to the Rules and Regulations shall be submitted to the Bylaws Committee and the Medical Executive Committee for review and recommendation to the Board of Directors. Following review of changes or additions to the Rules and Regulations, the Medical Staff will be notified of proposed revisions and given a seven (7) day response period to provide feedback to the President of the Medical Staff. Any changes shall become effective when approved by the Board of Directors

9.2 DEPARTMENTAL RULES AND REGULATIONS.

Subject to the approval of the Medical Executive Committee and the Board of Directors, each Department shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these Bylaws, the Appointment Policy, the Rules and Regulations, or other policies of the Hospital.

9.3 FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with Medical Staff appointments or reappointments, the delineation of Privileges, corrective action, notices, recommendations, reports, and other matters shall be adopted by the Board of Directors after considering the advice of the Medical Executive Committee and Credentials Committee.

9.4 CONSTRUCTION OF TERMS AND HEADINGS.

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

9.5 TRANSMITTAL OF REPORTS.

Reports and other information that these Bylaws require the Medical Staff to transmit to the Board of Directors shall be deemed so transmitted when delivered to the President of the Hospital, unless otherwise specified.

9.6 AUTHORITY TO ACT.

Any Member or Members who act in the name of the Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

9.7 DIVISION OF FEES.

Any illegal division of professional fees by Members of the Medical Staff is forbidden and any such division of fees shall be for revocation of Medical Staff appointment and/or Clinical Privileges without any right to a hearing or appeal of such action.

ARTICLE X - REVIEW AND AMENDMENT OF BYLAWS, APPOINTMENT POLICY AND RULES AND REGULATIONS

A review of the Bylaws, the Appointment Policy and Rules and Regulations by the Bylaws Committee shall occur regularly but at least every other year. Proposed amendments to these Bylaws, the Appointment Policy and the Rules and Regulations shall be submitted to the Bylaws Committee for consideration. Proposed revisions and amendments to these Bylaws will be submitted to Members of the Active Staff at least fourteen (14) days prior to the date for voting thereon. Approval of the proposed revisions and amendments to these Bylaws, and the Appointment Policy shall require the affirmative vote of two-thirds of the votes submitted by the established deadline. Amendments so made shall be effective when approved by the Board of Directors. Medical Staff Members shall be apprised of any changes and given an opportunity to receive an updated version.

Amendments to the Rules and Regulations may be approved by the affirmative vote of two-thirds (2/3) of the Medical Executive Committee voting either at a meeting of the committee or pursuant to another method selected by the committee and will be effective when approved by the Board of Directors. The authority to approve amendments to the Rules and Regulations is hereby delegated to the Medical Executive Committee. The Medical Staff will be apprised of any changes and given an opportunity to receive an updated version.

ARTICLE XI - ADOPTION AND AMENDMENT

11.1 AMENDMENT BY THE MEDICAL EXECUTIVE COMMITTEE—CORRECTIVE ACTION

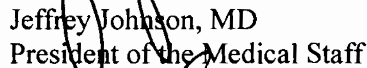
The Medical Executive Committee shall have the power to adopt such amendments to these Bylaws as are, in the committee's judgment, corrections, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board of Directors within sixty (60) days of adoption and notification by the Medical Executive Committee. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Medical Executive Committee or pursuant to another method for voting selected by the Medical Executive Committee. Immediately upon adoption, such amendments shall be sent to the Chief Executive Officer and distributed to the Medical Staff.

11.2 ADOPTION BY MEDICAL STAFF

These Bylaws shall be adopted at any general Medical Staff meeting or as otherwise provided for in these Bylaws, shall replace any previous Bylaws and shall be effective when approved by the Board of Directors; such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner.

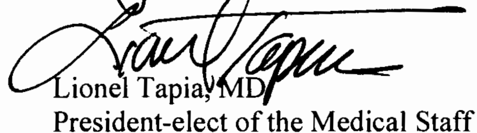
11.3 ADOPTION AND AMENDMENT BY THE BOARD OF DIRECTORS

The Board of Directors shall have the power to adopt amendments of these Bylaws by a majority vote of the members of the Board of Directors present at a meeting of the Board of Directors at which a quorum thereof is present in the event, and only in the event, that the Medical Staff shall fail, after notice from the Board of Directors and a reasonable period of time for response, to exercise its responsibility and authority as required by Article 10 and Section 11.2 to approve amendments which are required to comply with changes in Joint Commission Standards, state or federal law (including applicable agency regulations or judicial decisions or interpretations), Medicare Conditions of Participation, regulatory direction or where such amendments are reasonably required to reduce potential liability to the Hospital or Members of the Medical Staff.



Date: September 20, 2013

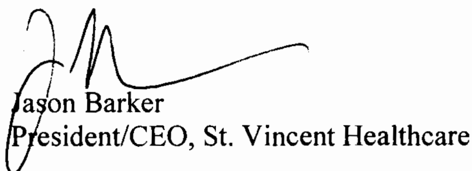
Jeffrey Johnson, MD
President of the Medical Staff



Date: September 20, 2013

Lionel Tapia, MD
President-elect of the Medical Staff

These Bylaws are hereby approved by the Board of Directors of St. Vincent Healthcare.



Date: September 20, 2013

Jason Barker
President/CEO, St. Vincent Healthcare