ST. JAMES HEALTHCARE
MEDICAL STAFF BYLAWS, RULES, AND REGULATIONS
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1 Added Policies & Procedures February 2013
ARTICLE I
DEFINITIONS

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

1. "Administrative Medical Staff Coordinator" refers to that individual who performs the clerical functions of the Medical Staff. This designated person may be required to take minutes at various Medical Staff, section, and committee meetings and other such duties consistent with his/her position.

2. "Board" means the Board of Directors of St. James Healthcare, Inc., which has the overall responsibility for the conduct of the hospital.

3. "Chairperson" shall be interpreted to mean that individual who has been designated to act as the head of a committee.

4. "Chief" shall be interpreted to mean that individual who has been designated to act as the head of the section.

5. "Chief Executive Officer" means the principal administrator of the hospital or his/her designee.

6. "Committee" means a group of individuals designated to consider, investigate, report, and/or act on matters of a certain kind. When performing peer review, quality assurance, or quality improvement activities on behalf of the Medical Staff, Sections are committees.2

7. "Medical Executive Committee" means the Medical Executive Committee of the Medical Staff unless specifically written "Executive Committee of the Board of Directors;"

8. "Leave of Absence" shall be defined as a greater than 90-day absence from the practice of medicine at St. James Healthcare.

9. "Medical Staff" means all physicians and dentists who are given membership and/or privileges to treat patients in the hospital.

10. "Member" means any physician or dentist who has been granted Medical Staff appointment and/or clinical privileges by the Board of Directors to practice at the hospital.

11. "Peer Review" refers to that review and if indicated, critique of aspects of clinical practice of one Medical Staff Member by another Medical Staff Member. In so far as possible, such peer review shall be by a member practicing the same specialty as the member whose work is being reviewed. However, if a Medical Staff Member is the only member providing care in a particular specialty or, if other Medical Staff members in that particular specialty are unwilling or unable to conduct a required review, the Peer Review shall be conducted by another Medical Staff Member or Members in related (in so far as possible) or unrelated areas of expertise.

12. "Peer Review Committee" – is a special professional review committee with peer review privilege, but is further defined as any committee formed to evaluate the professional practice or behavior of a medical staff member and which could result in a change in a medical staff member’s privileges or membership. Although the committee may have non-physician members, only members of the active staff may vote.3

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2 Revision(s) made June 2012
3 Added Definition June 2012
(13) “Peer Review Protected/Privilege” – is defined by statute as the proceedings of a Professional Review Committee protected from disclosure. This is to be distinguished from a peer review committee.4

(14) "Physicians" shall be interpreted to include both doctors of medicine and doctors of osteopathy.

(15) "Primary Clinical Section" shall designate that Clinical Section in which a Medical Staff member conducts the majority of his/her practice.

(16) "Proctor" shall refer to that Medical Staff member with expertise in the clinical privileges being granted to a Provisional Medical Staff member or Allied Health Professional,5 or to new provisional clinical privileges being granted to a Medical Staff member or Allied Health Professional6. The duties of a proctor include evaluating the competence and conduct of Provisional Medical Staff members or Allied Health Professionals7 and reporting to the Section Chief, or evaluating and monitoring the performance and reporting to the Section Chief regarding new clinical privileges for Medical Staff members or Allied Health Professional8.

(17) “Professional Review Committee” – means any other medical staff or health care facility committee which performs utilization review, medical ethics, quality assurance, or other quality improvement activities and the proceedings of which are protected by peer review privilege.1

(18) “Section” means the administrative division of medical services which classify and group care and treatment activities by the specialties of members who have been granted privileges in such specialties.

(19) A “Sentinel Event” is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes the loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

(20) "Special notice" means written notification sent by certified mail with return receipt requested or by personal delivery with signed acknowledgment receipt.

(21) Words used in the Bylaws shall be read as the masculine and 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.

4 Added Definition June 2012
5 Revision(s) made July 2009
6 Revision(s) made July 2009
7 Revision(s) made July 2009
8 Revision(s) made July 2009
ARTICLE II
CATEGORIES OF THE MEDICAL STAFF

The Medical Staff of St. James Healthcare is a self-governing body made up of qualified members chosen as described in these Bylaws. All members shall be assigned to a specific Section, but shall be eligible for clinical privileges in other sections as applied for and recommended pursuant to these Bylaws. All appointments to the Medical Staff shall be to one of the following categories.

ARTICLE II - PART A: ACTIVE STAFF

(a) The Active Staff shall consist of those physicians and dentists who regularly attend, admit, or are involved in the treatment of patients at the hospital and who are located close enough to the hospital to provide timely and continuous care to their patients in the hospital.

(b) Each member of the Active Staff shall agree to assume all the functions and responsibilities of appointment to the Active Staff, including emergency service care, consultation, and teaching assignments. Active Medical Staff members shall provide care for those patients who present to the hospital without an attending physician to care for them.

(c) When an Active Medical Staff member has become 60 years of age, or when he/she has been a member of the Active Medical Staff of St. James Healthcare for 30 years or more, he/she may elect to not be available to provide care for those patients who present to the hospital without an attending physician to care for them. Requests for such exceptions to the requirements of paragraph (b) above shall be made in writing to the President of the Medical Staff.

(d) Full-time Emergency Department physicians shall be members of the Active Staff.

(e) Active staff members shall be entitled to vote, hold office, serve on Medical Staff committees, and serve as Chairpersons of such committees.

ARTICLE II - PART B: COURTESY STAFF

(a) The Courtesy Staff shall consist of physicians and dentists who provide diagnostic or therapeutic services to patients at St. James Healthcare and who are otherwise qualified for Active Medical Staff appointment, but who only occasionally practice in the hospital and who only care for a limited number of patients (inpatients, outpatients, or patients in the Emergency Department) per year.

(b) Courtesy Staff members shall provide care to no more than twelve (12) patients (total of all inpatients, outpatients, and patients in the Emergency Department) per year at St. James Healthcare. The ordering of diagnostic studies does not constitute an outpatient contact. If the number of patients attended by a member of the Courtesy Staff exceeds twelve (12) in a given calendar year, he/she shall be automatically advanced to the Active Medical Staff for the remainder of the Medical Staff year and shall be expected to fulfill all the requirements for Active Staff membership.

(c) Emergency Department physicians who work less than 100 hours per month shall be members of the Courtesy Staff and shall be exempted from the twelve (12) patients per year limitation.

(d) Physicians who reside out-of-state (where the individual is tax domiciled for federal tax purposes), yet provide long term coverage (beyond the temporary privileges granted to locum tenens under Article VI - Part F: Section 4) to fulfill an important patient care, treatment or service need shall be members of the Courtesy Staff and shall be exempted from the twelve (12) patients per year limitation.9

(e) Courtesy Staff shall have no staff committee responsibilities, may not vote, and may not hold office. They are encouraged, but not required, to attend Medical Staff and Section meetings.

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9 Added Paragraph October 2014
Members of the Medical Staff who have Courtesy Staff privileges and who have been practicing at St. James Healthcare prior to 1995 and who have cared for inpatients, outpatients, and Emergency Department patients according to the Bylaws established prior to 1995, shall be allowed to continue to do so. They shall be expected to provide continuous and timely care to any inpatients, outpatients, and Emergency Department patients whom they attend at St. James Healthcare, following the rules established by Article II, Parts A and B; Article VI, Parts A and B; Article VI, Part C, Sections 1 and 2; and Article VII, Part A, Section 2.

ARTICLE II - PART C: CONSULTING STAFF

(a) The Consulting Staff shall consist of physicians and dentists qualified for staff appointment, who act only as Consultants. Consulting Staff may not admit, but may be involved in the diagnosis and treatment of inpatients and contribute to the administration of clinical departments (e.g., for such purposes as consultation on upgrading of facilities) with an Active Staff member.

(b) Consulting Staff shall be assigned to a clinical Section, shall have no staff committee responsibilities, may not vote, and may not hold office. They are encouraged, but not required, to attend Medical Staff and Section meetings.

ARTICLE II - PART D: AFFILIATE STAFF10

(a) The Affiliate Staff Members shall consist of those Practitioners who: 1) satisfy the general qualifications for appointment, including completion of an Accredited Residency and Board Certification as set forth in these Bylaws as applicable to the Practitioner; and 2) do not wish to establish a practice in the Hospital.

(b) 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 patients under the care of other Members of the Medical Staff.

(c) 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 or Departments of 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 education programs. Affiliate Staff Members 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.

ARTICLE II - PART E: VISITING STAFF

(a) The Visiting Staff shall consist of physicians and dentists who may attend to outpatients in specialty clinics established by the Hospital Administration to provide services not otherwise available in the Butte service area. Visiting Staff may not admit, but may be involved in the diagnosis and treatment of inpatients as consultants.

(b) Visiting Staff shall be assigned to a clinical Section, shall have no staff committee responsibilities, may not vote, and may not hold office. They are encouraged, but not required, to attend Medical Staff and Section meetings.

10 Added Affiliate Staff Category June 2012
ARTICLE II - PART F: HONORARY STAFF

(a) The Honorary Staff shall consist of Medical Staff members who have retired from active hospital practice or other physicians or dentists who are of outstanding reputation, not necessarily residing in the community.

(b) Persons appointed to the Honorary Staff shall not be eligible to admit or attend patients, to vote, to hold office, or to serve on standing medical staff committees, but may be appointed to special committees. They may, but are not required to, attend any Medical Staff meetings.
ARTICLE III
STRUCTURE OF THE MEDICAL STAFF

ARTICLE III - PART A: GENERAL

ARTICLE III - PART A: Section 1. Medical Staff Year:
For the purpose of these Bylaws the Medical Staff year commences on the first day of January and ends on the 31st day of December each year.

ARTICLE III - PART A: Section 2. Dues:
(a) All persons appointed to the Medical Staff shall pay annual staff dues to the hospital's Medical Staff account as may be required by the majority vote of the Medical Staff. Disbursements from this account may be made by either the Medical Staff President or the Medical Staff Secretary/Treasurer at the direction of the Medical Executive Committee. A report on this account, if it exists, will be made annually by the Secretary/Treasurer at the December meeting of the Medical Executive Committee and at the annual meeting of the Medical Staff.

(b) A change in the Medical Staff dues will require a majority vote of a quorum of the Medical Staff members at the meeting. If a quorum is not present for the vote, the vote shall be done by mail, fax or electronically. Passage will require an affirmative vote by more than 50% of the Medical Staff members voting, as long as a Medical Staff Meeting quorum of members vote. 11

ARTICLE III - PART B: OFFICERS
The officers of the Medical Staff shall be the President, Vice President, Immediate Past President, and Secretary-Treasurer. Officers must be members of the Active Staff at the time of nomination and election and must continue so during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

ARTICLE III - PART B: Section 1. The President
The President shall:

(a) act as the Chief of Staff and thus the Chief Medical Officer of the hospital, in coordination and cooperation with the Chief Executive Officer in matters of mutual concern involving the hospital.

(b) call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff.

(c) appoint committee Chairpersons and members, in accordance with the provision of these Bylaws, to all standing and special Medical Staff Committees, except the Medical Executive Committee.

(d) serve as Chairperson of the Medical Executive Committee.

(e) serve ex officio on all Medical Staff Committees other than the Medical Executive Committee, without vote.

(f) represent the views, policies, needs, and grievances of the Medical Staff and report on the medical activities of the staff to the Board of Directors and to the Chief Executive Officer.

(g) provide liaison on medical matters with the Chief Executive Officer and the Board of Directors as needed.

(h) receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance improvement activities of the medical staff to include Ongoing Professional Practice Evaluation and the quality of medical care12.

11 Added Paragraph June 2012
12 Revision(s) made July 2009
(i) appoint volunteer Medical Staff members to the hospital Utilization Review Committee and other hospital committees as required and appropriate.

(j) report to the Medical Staff at each regular meeting upon actions taken by the Medical Executive Committee since the previous report.

(k) serve as an ex-officio non-voting member of the Board of Directors in order to provide communication and collaboration among the Board of Directors, the Chief Executive Officer, and the Medical/Dental Staff.

(l) perform other duties as directed in the Bylaws and/or Rules and Regulations.

**ARTICLE III - PART B: Section 2. Vice President:**

The Vice President shall:

(a) assume all the duties and have the authority of the President of the Medical Staff in the event of the President's temporary inability to perform due to illness, absence from the community, or unavailability for any other reason.

(b) serve on the Medical Executive Committee.

(c) automatically succeed the President of the Medical Staff when the President fails to serve for any reason.

(d) act as the parliamentarian at each Medical Executive Committee and Medical Staff meeting. (The Administrative Medical Staff Coordinator shall bring the Robert's Rules of Order to each Medical Executive Committee and Medical Staff meeting.)

(e) serve on the St. James Healthcare Board of Directors' Quality Improvement Council or its successor.

(f) perform such duties as are assigned by the President.

**ARTICLE III - PART B: Section 3. Secretary-Treasurer:**

The Secretary-Treasurer shall:

(a) be responsible for keeping accurate and complete minutes of all Medical Staff and Medical Executive Committee meetings.

(b) collect and deposit Medical Staff dues, if any, and maintain appropriate records of the same. Make disbursements as directed by the Medical Executive Committee and report on the account, annually, at the December meeting of the Medical Executive Committee and the annual meeting of the Medical Staff.

(c) call meetings on order of the President of the Medical Staff, attend to all correspondence, and perform such other duties as pertain to the office of Secretary-Treasurer.

**ARTICLE III - PART B: Section 4. Immediate Past President:**

The Immediate Past President shall:

(a) serve on the Medical Executive Committee with voting privileges.

(b) perform such additional or special duties as shall be assigned by the President of the Medical Staff or the Medical Executive Committee.
ARTICLE III - PART B: Section 4.1. At-Large Medical Executive Committee Members:

(a) There shall be two at-large Medical Executive Committee members, each serving for two years with one at-large member being elected each year.

(b) At-large Medical Executive Committee members shall serve on the Medical Executive Committee and shall follow the "line of succession" as outlined in Article III, Part B, Section 9: “Temporary Vacancies in Offices.”

(c) Members-at-Large must be a member of the Active Staff.

ARTICLE III - PART B: Section 5. Election of Officers:

(a) The Medical Executive Committee, acting as a Nominating Committee, shall prepare a slate of nominees for each office and at-large seat on the Medical Executive Committee to be filled. Nominations for officers of the Medical Staff shall be presented by the Nominating Committee and from the floor for consideration by the Medical Staff at least four weeks prior to the scheduled date of election. The candidates who receive a majority vote of those Medical Staff members eligible to vote and present at the meeting at the time the vote is taken shall be elected. The vote shall be by written secret ballot.

(b) One member-at-large of the Medical Executive Committee shall be elected each year and shall serve a two-year term on the Medical Executive Committee. Each officer shall serve from the start of the next Medical Staff year for a term of one (1) year or until a successor has been elected. Any officer may be reelected for an indefinite number of terms. Officers shall take office on the first day of January following their election.

(c) Each member-at large shall serve from the start of the next Medical Staff year for a term of two (2) years or until a successor has been elected. Any member-at-large may be reelected for an indefinite number of terms. Members-at-large shall serve on the Medical Executive Committee on the first day of January following their election.

(d) In any election, if there are three (3) or more candidates for an office and no candidate receives a majority, there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until one (1) candidate obtains a majority.

ARTICLE III, PART B: Section 6. Conflict of Interest:

Conflict of interest shall be defined as that situation in which a member of the Medical Staff is a relative of an individual whose work is being questioned or investigated, is in direct economic competition with said individual, or is professionally associated with such individual.

ARTICLE III - PART B: Section 7. Removal of Leaders:

The Medical Executive Committee, by a two-thirds (2/3) vote of the Medical Executive Committee, may remove any Medical Staff leader for conduct deemed unprofessional or detrimental to the quality of patient care. Notice of the meeting at which such action takes place shall have been given in writing to such leader at least ten (10) days prior to the date of such meeting. The leader shall be afforded the opportunity to speak prior to the taking of any vote on such removal. The removal shall be effective when the vote is taken and upon notification of the affected individual. The Chief Executive Officer shall be immediately informed of any such removal action. Confidentiality, as provided for elsewhere in these bylaws, shall be maintained when the Medical Executive Committee reports to the Medical Staff.

13 Revision(s) made October 2011
14 Revision(s) made July 2009
15 Revision(s) made to this Section July 2009
Leaders are defined as follows:
1. Officers
2. Members at Large
3. Chief of Sections

**ARTICLE III - PART B: Section 8. Permanent Vacancies in Office:**
If there is a vacancy in the office of the President of the Medical Staff prior to the expiration of the President's term, the Vice President shall assume the duties and authority of the President for the remainder of the unexpired term. Permanent vacancies in the offices of Vice President, Secretary-Treasurer, and at-large members of the Medical Executive Committee will be filled by election by the Medical Staff, utilizing the same procedures as with annual elections. This election shall take place at any regular or special meeting of the Medical Staff. Vacancies in Section Chief offices and Committee Chairperson offices shall be filled utilizing the procedures set forth in these Bylaws for the appointment of said individuals.

**ARTICLE III - PART B: Section 9. Temporary Vacancies in Office:**
(a) If the President of the Medical Staff is temporarily unavailable and there is an immediate need for action, the role of President and the responsibilities pertaining to the office shall be assumed by the Vice President of the Medical Staff. Similarly, the Secretary-Treasurer, the longest-tenured at-large Medical Executive Committee member, followed by the shorter tenured at-large member, followed by the Immediate Past President shall comprise the line of succession. The duties of the Immediate Past President outlined in Article III, Part B, Section 4 shall not supersede the requirements of this paragraph.

(b) In the event of a conflict of interest, the same succession will be followed.

**ARTICLE III - PART C: MEETINGS OF THE MEDICAL STAFF**

**ARTICLE III - PART C: Section 1. Annual Staff Meeting:**
The last Medical Staff meeting before the end of the staff year shall be the annual meeting at which officers and any members at-large of the Medical Committee for the ensuing year shall be elected.

**ARTICLE III - PART C: Section 2. Staff Meetings and Agenda:**
The Medical Staff shall hold regular quarterly meetings on the Tuesday following the second Monday of the months of February, May, September, and December or on dates set by the President of the Medical Staff for the purpose of reviewing and evaluating Section and Committee reports and recommendations and to act on any other matters placed on the agenda by the President.

**ARTICLE III - PART C: Section 3. Special Staff Meetings:**
Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, a majority of the membership of the Medical Executive Committee, or a petition signed by not less than one-fourth (1/4) of the voting staff. In the event that it is necessary for the staff to act on a question without being able to meet, the voting staff may be presented with the question by mail and their votes returned to the President by mail. Such a vote shall be valid so long as the question is voted on by a majority of the staff eligible to vote.

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16 Revisions made to this paragraph September 2018
ARTICLE III - PART C: Section 4. Quorum:

A. Medical Executive Committee Meetings: the presence of one-third (1/3) of the persons eligible to vote shall constitute a quorum for any regular business or special meetings of the Medical Staff. In the event that a medical staff member’s privileges, membership status, disciplinary action, etc., is voted on, the presence of the super majority of two-thirds (2/3) of the persons eligible to vote shall constitute a quorum.

B. Section & Committee Meetings: The presence of one-fourth of the total membership of the Committee or Section eligible to vote at any regular or special meeting (but in no event less than two (2) members) shall constitute a quorum for all actions.

C. General Medical Staff Meetings and/or Special Medical Staff Meetings: The presence of one-fourth of the total membership of the Active Medical Staff eligible to vote at any general or special meeting shall constitute a quorum for all actions. If a quorum does not exist at the time of a vote, such vote shall not be valid.

ARTICLE III - PART D: SECTION AND COMMITTEE MEETINGS:

ARTICLE III - PART D: Section 1. Section Meetings:
Members of each Section shall meet as a Section at least monthly at a time set by the Chief of the Section to review and evaluate the clinical work of the Section; to consider the findings of Ongoing Performance Practice Evaluation, monitoring and evaluation activities; and to discuss any other matters concerning the section. The Section Chief shall set the agenda for the meeting and its general conduct.

ARTICLE III - PART D: Section 2. Committee Meetings:
All Committees shall meet at least quarterly, unless otherwise specified in these Bylaws, at a time set by the Chairperson of the Committee. The Chairperson shall set the agenda for the meeting and its general conduct.

ARTICLE III - PART D: Section 3. Special Section and Committee Meetings:
A special meeting of any Committee or Section may be called by or at the request of the appropriate Chairperson or Chief, by the President of the Medical Staff, or by a petition signed by not less than one-third of the voting members of the Section or Committee.

In the event that it is necessary for a Committee or Section to act on a question without being able to meet, the voting members may be presented with the question, in person or by mail, and their vote returned to the Chairperson or Chief of the Committee or Section. Such a vote shall be binding so long as the question is voted on by a majority of the Committee or Section members eligible to vote.

ARTICLE III - PART D: Section 4. Quorum:
The presence of one-fourth of the total membership of the Committee or Section eligible to vote at any regular or special meeting (but in no event less than two (2) members) shall constitute a quorum for all actions. In the case of the Medical Executive Committee, the presence of one-third (1/3) of the persons eligible to vote shall constitute a quorum for any regular or special meeting. If a quorum does not exist at the time of a vote, such vote shall not be valid.

ARTICLE III - PART D: Section 5. Minutes:
Minutes of each meeting of each Committee and each Section shall be prepared and shall include a record of the attendance of members, of the recommendations made, and of the votes taken on each matter. The presiding officer shall sign the minutes and copies thereof shall be promptly forwarded to the Medical Executive Committee. Each Committee and each Section shall maintain a permanent file of the minutes of each of its meetings.

17 Revisions made to this Section in July 2009
18 Paragraph added June 2012
ARTICLE III – PART D: Section 6. Peer Review:

A. Professional standards review, utilization review, peer review, medical ethics review, quality assurance, or quality improvement committee activities utilized exclusively in connection with quality assessment or improvement activities, including the professional training, supervision, or discipline of a medical practitioner, are performed by the following respective St. James Healthcare Medical Staff Committees:

1. The Medical Executive Committee;
2. The Medical Staff
3. The Medicine Section and Sub Sections;
4. The Surgery section and Sub Sections;
5. The Pediatric Section and Sub Sections;
6. The Radiology and Radiation oncology Committee;
7. The Pharmacy and Therapeutics Committee;
8. The Infection Control Committee;
9. The Trauma Committee;
10. The Emergency Care Committee;
11. The Pediatric Section and Sub Sections;
12. Any Special Committee or Ad Hoc authorized and appointed by the MEC or the Medical Staff President as provided for in the Medical Staff Bylaws.

B. To the fullest extent allowed by law, including but not limited to Montana Code Annotated §§ 50-16-201, et seq., and § 37-2-201:

1. All written reports, notes, transcripts, or records or oral reports or proceedings created by or at the request by one of the foregoing committees used exclusively for quality assessment or improvement activities, including the professional training, supervision, or discipline of a medical practitioner are (a) confidential and privileged, and (b) are not discoverable or admissible in evidence in any judicial proceeding or other non-peer review privileged committee proceeding.

2. All proceedings, records, and health care information data are confidential and privileged to the committee and the members of the committee. No committee member may disclose any data to anyone outside of the committee process except as otherwise allowed or required by the St. James Healthcare Medical Staff Bylaws.

Committee members are not liable in damages to any person for any action taken or recommendation made within the scope of the functions of the foregoing committees if the committee member acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts known to the member after reasonable effort to obtain the facts of the matter for which the action is taken or a recommendation is made.

ARTICLE III - PART E: PROVISIONS COMMON TO ALL MEETINGS:

ARTICLE III - PART E: Section 1. Notice of Meetings:
Notice of all meetings of the Medical Staff and regular meetings of Sections and Committees shall be posted on the Medical Staff bulletin board and delivered in person or by mail to each Medical Staff member at least five (5) days in advance of such meetings. Such notice shall state the date, time, and place of the meeting.

19 Added Section 6: Peer Review – June 2012
**ARTICLE III - PART E: Section 2, Attendance Requirements:**

(a) Medical Staff members are encouraged to attend all applicable Committee meetings but, except as set forth in (b) and (c) of this section, shall not be required to do so as a condition of continued appointment.

(b) Any Medical Staff member whose clinical work is scheduled for special discussion so deemed by the Section Chief or Committee Chairperson at a Section or Committee meeting shall be notified by Special Notice, listing all actions and Medical Records to be discussed and citing these Subsections (c) and (d). Such special notice shall be provided within a reasonable length of time. Attendance by the member shall be mandatory except as provided for in Subsection (d).

(c) The Chief of the applicable Section 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. If, after meeting with the individual, the President of the Medical Staff or the Medical Executive Committee feels that no good cause exists for failure of the individual to attend the mandatory meeting, such failure shall constitute violation of Bylaws of Medical Staff. Similarly, if the individual refuses to meet with the President of the Medical Staff or the Medical Executive Committee within a reasonable time [seven (7) days], the individual shall be deemed to have violated the Bylaws of the Medical Staff. 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 Chief of the individual's Section or by the Medical Executive Committee if the Section Chief 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.

(d) Persons appointed to the Consulting and Courtesy Staff categories of the Medical Staff may attend and participate in Section meetings, but shall not be required to do so as a condition of continued staff membership.

**ARTICLE III - PART E: Section 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.

**ARTICLE III - PART E: Section 4, Voting:**

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

(b) If a quorum is not present, or if a quorum is present and a majority of those present so choose, an action item may be submitted for a vote in accordance with (c) below.

(c) The action item will be presented to the Medical Staff who are eligible to vote by mail, fax, or electronically. The ballot will include an explanation of the action item and have a return date of at least 14 days after the ballot was sent. The ballots will be counted by the Medical Staff Coordinator and verified by the respective meeting chairperson, and passage will be subject to the respective quorum and majority requirements.

(d) The method for voting on Bylaws, Rules & Regulations, and Medical Staff Policies & Procedures is found in Article XI, Part A, Section 1 & 2.

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20 Added paragraph (b), (c), & (d) June 2012
ARTICLE IV
CLINICAL SECTIONS

ARTICLE IV - PART A:  CLINICAL SECTIONS

ARTICLE IV - PART A:  Section 1. List of Clinical Sections:
The following clinical sections are established:

(a) Medicine Section
   (1) Medicine and its subspecialties
   (2) Family/General Practice
   (3) Emergency Medicine
   (4) Psychiatry

(b) Surgery Section
   (1) Anesthesia
   (2) Dentistry
   (3) Ear, Nose, and Throat
   (4) Family/General Practice
   (5) General Surgery
   (6) Gynecology
   (7) Neurosurgery
   (8) Obstetrics
   (9) Ophthalmology
   (10) Orthopedics
   (11) Plastic Surgery
   (12) Thoracic and Vascular Surgery
   (13) Urology
   (14) Pathology
   (15) Other Surgical Specialties

(c) Pediatric Section
   (1) Pediatrics
   (2) Family/General Practice

(d) Radiology/Radiation Oncology Section
   (1) Radiology
   (2) Radiation Oncology

ARTICLE IV - PART A:  Section 2. Section Membership and Voting:
Members of the Medical staff may elect to be in a Section related to their area of training and shall be permitted to vote or hold office in only one (1) clinical Section. Family/General Practice members shall be assigned to the Medicine Section unless they notify the Medical Executive Committee, in writing, with copies to the Chief of Medicine and the Chief of the selected Section. In no instance shall a member be allowed to vote in more than one Section in any one calendar year.

ARTICLE IV - PART A:  Section 3. Functions of Sections:

(a) Each clinical Section Chief shall recommend to the Medical Executive Committee written criteria for the assignment of clinical privileges within the Section. Such criteria shall be consistent with and subject to the Bylaws, Rules, and Regulations of the Medical Staff. Clinical privileges shall be based upon demonstrated competence, training, and ability to perform the privileges requested within the specialty covered by the Section.

(b) Each Section shall monitor and evaluate the appropriateness of medical care and patient outcomes on a retrospective and concurrent basis, and shall have the option to present cases. Such
presentations shall include cases involving deaths or complications, Performance Improvement measures Ongoing Professional Practice Evaluation (OPPE), and such other cases believed to be important, such as those involving patients currently in the hospital with unsolved clinical problems.

(c) Each relevant Section shall also conduct a review to examine appropriateness of the procedure performed whether tissue was removed or not, and to evaluate the acceptability of the procedure. Specific consideration shall be given to the agreement or disagreement of the preoperative and postoperative (including pathological) diagnoses. Written records shall be maintained reflecting evaluations performed and actions taken.

(d) In discharging these functions, each Section shall report to the Medical Executive Committee any analysis of patient care with recommendations regarding any further action which might be mandated by its findings. Minutes of all Section meetings will be forwarded to the Medical Executive Committee.

ARTICLE IV - PART A: Section 4, Section Chiefs:

(a) The Chief of each Section shall be a member of the Active Staff and will be certified by an appropriate specialty Board or will have affirmatively established comparable competence proven through the credentialing process. To possess competence comparable to Board Certification, the Medical Staff will identify knowledge and skills expected of a Board-Certified individual and will determine that the Section Chief has such knowledge and skills. This knowledge and skill will be determined by the Medical Executive Committee after review of credentials, education, training, and experience.

(b) The Chief and Assistant Chief of each Section shall be elected by the voting membership of each Section for a one-year term. The Assistant Chief shall assume all the duties of the Section Chief in the event of the Section Chief's absence or temporary inability to perform. The Assistant Chief's tenure shall coincide with that of the Chief of the Section.

(c) Removal of a Chief during a term of office may be initiated by a two-thirds vote of all Active Staff members in the Section or by a two-thirds vote of all members of the Medical Executive Committee.

ARTICLE IV - PART A: Section 5, Function of Section Chiefs:

Each Section Chief shall:

(a) be responsible, personally or through delegation, for coordinating and integrating inter- or intra-Sectional services as provided by the Section.

(b) be responsible for all clinically related activities of the Section.

(c) be responsible for administrative activities within the Section.

(d) be a member of the Medical Executive Committee.

(e) delegate to the Assistant Chief and other members of the Section such duties as appropriate.

(f) recommend criteria for clinical privileges in the Section.

(g) assess and recommend to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the section or the organized medical staff.

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21 Revision(s) made July 2009
22 Revision(s) made July 2009
23 Revision(s) made July 2009
24 Revision(s) made to this paragraph October 2010
25 Revision(s) made July 2009

Revised September 2018
(h) integration of the section into the primary functions of the organized medical staff.\textsuperscript{27}

(i) Recommending space and other resources needed by the section.\textsuperscript{28}

(j) Designated responsibilities for the Radiology Section Chief:\textsuperscript{29}
   1) Determines the qualifications of the radiology staff who use equipment and administer procedures.
   2) Approves the Nuclear Services Director’s specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff.
   3) Supervises ionizing radiology services.

(k) be responsible, personally or through delegation for continuously assessing and improving the performance of the care and services provided by the Section by:
   1) enforce and implement within the Section actions taken by the Medical Executive Committee and the Medical Staff.
   2) establish, implement, and ensure the effectiveness of teaching, education, and research programs in the Section.
   3) conduct continuing review of the ongoing\textsuperscript{30} professional performance of all individuals who have delineated clinical privileges in the Section and report thereon to the Medical Executive Committee as part of the reappointment process and at such other times as may be indicated.
   4) Review all documentation relevant to the appointment/reappointment and delineation of clinical privileges processes for each member of the applicable Section for accuracy and completeness and submit a written report to the Medical Executive Committee after such review, indicating the acceptability (or lack thereof) of the presented material supporting the Section member's appointment or reappointment and clinical privileges.
   5) appoint proctors or act as proctor for monitoring the performance and conduct of those Provisional Medical Staff members of the applicable Section or the new provisional clinical privileges of Medical Staff members as related to the applicable clinical Section and provide reports to the Medical Executive Committee as outlined in Article VI, Part D, Section 2.
   6) Report and recommend to hospital management, when necessary, with respect to matters affecting patient care in the Section.
   7) oversees continuous assessment, development, improvement, and implementation of policies and procedures that guide and support the provision of care, treatment, and services.
   8) recommends a sufficient number of qualified and competent persons to provide care, treatment, and services.
   9) determines qualifications and competence of all persons in the Section who are not licensed independent practitioners and who provide patient care, treatment, and services.
   10) ensures orientation and continuing education of all persons in the Section.
   11) Performs\textsuperscript{31} other such activities he/she deems appropriate.

\textsuperscript{26} Revision(s) made July 2009
\textsuperscript{27} Revision(s) made July 2009
\textsuperscript{28} Revision(s) made July 2009
\textsuperscript{29} Added new paragraph (j) June 2012
\textsuperscript{30} Revision(s) made July 2009
\textsuperscript{31} Revision(s) made July 2009
ARTICLE V
COMMITTEES OF THE MEDICAL STAFF

ARTICLE V - PART A: APPOINTMENT:

ARTICLE V - PART A: Section 1. Chairpersons:

(a) The President of the Medical Staff, unless otherwise provided in these Bylaws, shall appoint all Committee Chairpersons, during the first two weeks of the new Staff year.

(b) Committee Chairpersons will be appointed for an initial term of one (1) year, but may be reappointed for any number of consecutive yearly terms, unless otherwise provided in these Bylaws.

ARTICLE V - PART A: Section 2. Members:

(a) Members of each Committee, except as otherwise provided for in these Bylaws, shall be appointed yearly by the President of the Medical Staff, not more than fourteen (14) days after the end of the Medical Staff year, with no limitation in the number of terms they may serve. All appointed members may be removed and vacancies filled at the discretion of the President of the Medical Staff.

(b) The President of the Medical Staff or his/her designee shall be a member, ex-officio, without vote, on all Committees.

(c) The Chief Executive Officer or his/her designee may attend Committee meetings, except the Physician Health Committee.

ARTICLE V – PART A: Section 3: Reports and Recommendations

All committees shall report to the Medical Executive Committee any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of Medical Staff Bylaws, Rules and Regulations, or unacceptable conduct on the part of any member of the Medical Staff, for consideration and appropriate action by the Medical Executive Committee.

ARTICLE V - PART B: MEDICAL EXECUTIVE COMMITTEE

ARTICLE V - PART B: Section 1. Composition:

(a) The Medical Executive Committee shall consist of the officers of the Medical Staff, the Chief of each clinical Section, and the two (2) members elected at-large from the Active Staff. The Chief Executive Officer (CEO) of the hospital or his designee may attend meetings of the Medical Executive Committee on an ex officio basis and participate in its discussion, but without vote.

(b) One Medical Executive Committee member-at-large shall be elected at each annual Medical Staff meeting and shall serve for a term of two years. At-large members shall be eligible for reelection.

(c) The President of the Medical Staff shall be Chairperson of the Medical Executive Committee.

ARTICLE V - PART B: Section 2. Duties:

The Medical Executive Committee shall:

(a) represent and act on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws. These limitations specifically apply to Bylaws amendments and changes in the Rules and Regulations. A simple majority vote of the Medical Staff, if indicated, will constitute approval by the Medical Staff.

(b) coordinate the activities and general rules and regulations of the various Sections.
receive and act upon reports of Medical Staff Committees, Sections, and other assigned activity groups, as specified in these Bylaws, and will make recommendations concerning them to the Chief Executive Officer and the Board of Directors, including:

1. the process used to review credentials and delineate privileges.
2. The delineation of privileges for each practitioner privileges through the medical staff process.
3. Medical Staff membership.

(d) implement rules and regulations of the Medical Staff.

(e) provide liaison among Medical Staff, the Chief Executive Officer, and the Board of Directors.

(f) keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the hospital.

(g) during the entire length of hospital service, ensure that patients receive appropriate quality of care, treatment, and services from a licensed independent practitioner or an Allied Health Professional under their supervision who has been credentialed through the Medical Staff and aid the Section Chiefs in enforcing Medical Staff rules in the best interest of patient care.

(h) review and recommend action concerning questions of clinical competence, patient care, safety, and treatment, case management, or inappropriate behavior of any Medical Staff member or applicant, including recommendation of medical staff membership termination or termination or restriction of clinical privileges. Due process as described in the Bylaws will apply.

(i) May request evaluations of any person who holds privileges through the medical staff process in instances where there is doubt about that person’s ability to perform the privileges requested.

(j) be responsible to the Board of Directors for the implementation of the Performance Improvement Plan as it affects the Medical Staff and the quality of medical care.

(k) review the Bylaws, Rules, and Regulations of the Medical Staff and associated documents at least once a year and recommend such changes thereto as may be necessary or desirable.

(l) act as Nominating Committee for the election of staff officers.

(m) review Medical Record completion and enforce the Rules and Regulations regarding timely medical record completion by members of the Medical Staff.

ARTICLE V - PART B: Section 3. Meetings, Reports, and Recommendations:

(a) The Medical Executive Committee shall meet at least once each month or more often if necessary to transact pending business. The Secretary will be responsible for maintaining reports and minutes of all meetings, which reports shall include the minutes of the various Committees and Sections of the staff. A report of the monthly meeting of the Medical Executive Committee shall be made to the Medical Staff at each staff meeting.

(b) Recommendations of the Medical Executive Committee shall be transmitted to the Board of Directors with a copy to the Chief Executive Officer. The President of the Medical Staff shall attend Board of Director’s Meetings and applicable Committees.

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32 Revision(s) made October 2011
33 Revision(s) made July 2009
34 Revision(s) made July 2009
(c) Should there be issues of conflict between the medical staff and the Medical Executive Committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy, or an amendment thereto, the medical staff member(s) may communicate with the St. James Healthcare’s Board of Directors or the Medical Executive Committee to voice their concerns, provided that there has first been an attempt to resolve the difference with the Medical Executive Committee directly. Nothing in the foregoing is intended to prevent medical staff members from communicating with the St. James Healthcare’s Board of Director’s or a rule, regulation, or policy adopted by the organized medical staff or the Medical Executive Committee.35

(d) Between meetings of the Medical Executive Committee, the President of the Medical Staff, or if absent, the Vice President, shall be empowered to act in situations of urgent or confidential concern where not prohibited by these Bylaws.

ARTICLE V - PART C: COMMITTEE ON PHYSICIAN HEALTH

ARTICLE V - PART C: Section 1 - Purpose: The Medical Staff recognizes that providers are individuals who have dedicated their lives to helping others and who many now be in need of help and recognizes that providing this help is a primary goal of the Physician Health Committee. This Committee will follow a non-punitive approach in which it and the Medical Staff work as advocates for, rather than adversaries of, the provider, while protecting patients and others from harm. These Bylaws and the Medical Staff also recognize that if there is a problem, necessary action must be taken for the protection of patients and the provider.

ARTICLE V - PART C: Section 2 - Composition: The Physician Health Committee will be composed of at least two Medical Staff members including at least one psychiatrist, if possible. The President of the Medical Staff shall select these two (or more) members, appointing one to serve as Chairperson. Additional special Committee members will be members of the Medical Staff and may be added from time to time as special circumstances warrant. If possible, the members of the Physician Health Committee should not also be serving as Medical Staff Officers or on the Medical Executive Committee. The composition of the Physician Health Committee will be widely circulated to hospital and medical personnel and other interested parties to ensure timely access for providers.

ARTICLE V - PART C: Section 3 - Confidentiality: The proceedings of this committee shall be held in strict confidence and not disclosed except: a) as required by applicable law; or b) to ensure compliance with these bylaws; or c) to protect patients, hospital staff, and other staff members from harm; or d) to ensure the quality and continuity of patient care.1

ARTICLE V - PART C: Section 4 - Meetings: The Physician Health Committee shall meet as often as necessary to discharge its duties, but at least yearly. Special meetings of the Physician Health Committee may be called by its Chairperson upon request by any of the permanent or special members, other staff Committee Chairpersons, Section Chiefs, the President of the Medical Staff, the Chief Executive Officer, or the Board of Directors.1

ARTICLE V - PART C: Section 5 - Duties, Responsibilities, and Procedures:

(a) The Physician Health Committee, in the discharge of its duties, will avail itself of the help and advice of the Montana Professional Assistance Program and the Nurses’ Assistance Program. One of the Committee’s initial duties will be to ensure, at least annually, that these programs are still available and functioning.

(b) The Physician Health Committee will advise the Medical Executive Committee, the Chief Executive Officer, or the Board of Directors1 about questions pertaining to its area of expertise, which may arise in the processing of new applications for Medical Staff appointment.

35 Revision(s) made December 2011
(c) The Committee shall oversee a program to identify and facilitate the rehabilitation of providers who may have alcohol abuse, drug abuse, and mental and/or physical problems.

(d) The Committee shall evaluate the accuracy of allegations of impairment.

(e) The Committee shall take such action as may be necessary to protect the provider’s patients, other hospital patients, other members of the hospital community, and the hospital, and as may be necessary to facilitate the provider’s rehabilitation.

(f) The Committee shall coordinate with the hospital a hospital program to educate Hospital Staff, Medical Staff and Allied Health Professional Staff regarding prevention of impaired conditions.

(g) The Committee shall, after each meeting, make a report of its actions to the Medical Executive Committee and the Board of Directors taking care to ensure the confidentiality of the providers who might have come under its purview by referring to such physicians by code rather than by name. If, in its opinion, the Medical Executive Committee feels, after reviewing the report of the Committee on Physician Health, that a particular provider may pose imminent danger or harm to hospital patients, it (the Medical Executive Committee) may require disclosure of the provider’s name for the purpose of taking such steps as necessary to prevent patient harm and provided for elsewhere in these Bylaws.

Appended to these Bylaws shall be a suggested protocol, which, while not binding, may serve as a guide for the Committee on Physician Health in the discharge of its duties.

ARTICLE V - PART D: PHARMACY AND THERAPEUTICS COMMITTEE

ARTICLE V - PART D: Section 1. Composition:
The Pharmacy and Therapeutics Committee shall consist of at least two (2) Medical Staff members. One representative from Pharmacy and one (1) representative each from Patient Care Services and Hospital Management appointed by the Chief Executive Officer, may attend. Other medical staff members may be asked to attend as needed on an ad hoc basis.

ARTICLE V - PART D: Section 2. Duties:
The Pharmacy and Therapeutics Committee shall:

(a) review the appropriateness of empiric and therapeutic use of drugs through the analysis of individual or aggregate patterns of drug practice, including review of the minutes of the Medication Usage Committee.

(b) develop and recommend to the Medical Executive Committee policies and procedures relating to the selection, procurement, storage, distribution, ordering and transcribing, preparing and dispensing, administration, and monitoring of effectiveness of drugs and diagnostic testing materials.

(c) review all significant untoward drug reactions and significant medication errors.

(d) maintain a formulary or drug list and review at a minimum of at least annually.

(e) review the appropriateness, safety, and effectiveness of the prophylactic, empiric, and therapeutic use of antibiotics in the hospital.

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36 Revision(s) made July 2009
37 Revision(s) made July 2009
38 Revision(s) made July 2009
39 Revision(s) made July 2009
40 Revision(s) made July 2009
(f) establish regulations concerning research in the use of recognized drugs and evaluate clinical data concerning new drugs requested for use in the hospital.

(g) establish policies and protocols for safe drug use where appropriate, including hazardous and investigational drugs.

(h) Evaluate the medication management system for improvements based upon new technology, internal and external data, and practices that enhance patient safety.

ARTICLE V - PART D: Section 3. Meetings, Reports, and Recommendations:

The Pharmacy and Therapeutics Committee shall meet as often as necessary to transact its business, but at least quarterly; 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.

ARTICLE V - PART E: INFECTION CONTROL COMMITTEE

ARTICLE V - PART E: Section 1. Composition:

(a) The Infection Control Committee is a multi-disciplinary committee that oversees the program for the surveillance, prevention, and control of infection. Committee membership includes representatives from the Medical Staff, Nursing, Administration, and the person(s) directly responsible for the management of infection surveillance prevention and control program (i.e., Infection Control Officer, Infection Control Coordinator, Employee Health Nurse, and the Microbiology Section of the Laboratory). The Medical Staff has committee representation from the Infection Control Officer, at least one (1) Medical Staff member, and at least one (1) pathologist.

(b) The Chairman of the Infection Control Committee shall be a physician appointed by the Chief of Staff.

(c) The Infection Control Committee, or its designee, shall have the authority to institute any surveillance, prevention, and control measures or studies when there is reason to believe that any patient, visitor or personnel may be in danger.

(d) This statement of authority is to be reviewed and authenticated every two years by the Hospital Administration and the Medical Staff.

ARTICLE V - PART E: Section 2. Duties:

The Infection Control Committee shall:

(a) be responsible for the surveillance of hospital infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, including, but not limited to, the testing of hospital personnel for carrier status, the disposal of infectious materials, isolation procedures, sterilization procedures, and the supervision of infection control in all phases of the hospital's activities, including the inpatient, outpatient, service/diagnostic, and support services areas.

(b) establish a system for documenting all hospital infections, including infections among patients and hospital personnel, to provide a basis for studying infection sources.

(c) monitor and incorporate relevant standards and guidelines for infection control and prevention, and monitor the bacteriological and virological services available to the hospital.

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41 Revision(s) made July 2009
42 Revision(s) made July 2009
43 Revision(s) made July 2009
(d) establish an infection control/prevention program based on infection control risk analysis activities and ensure a continuing education program for Medical Staff members and hospital personnel on infectious disease control and prevention.

(e) evaluate the effectiveness of the infection control program at least annually.

ARTICLE V - PART E: Section 3. Meetings, Reports, and Recommendations:
The Infection Control Committee shall meet at least quarterly; shall maintain a permanent record of its findings, proceedings, and actions.

ARTICLE V - PART F: TRAUMA COMMITTEE

ARTICLE V - PART F: Section 1. Composition:

(a) The Trauma Committee shall consist of members of the Medical Staff with voting privileges who are appointed by the Trauma Medical Director, including the Medical Director of the Emergency Department, and all trauma surgeons, one (1) orthopedic surgeon, one (1) radiologist, one (1) anesthesia provider, and one (1) Emergency Department physician. The multi-disciplinary team shall include non-physician members: the Trauma Coordinator, representatives from each air and ambulance service and the fire department, one (1) nursing supervisor, Radiology Director, ED Director, Critical Care Supervisor, and at least one representative from Hospital Administration, who will be non-voting members.

(b) The Trauma Medical Director shall be a Board-Certified General Surgeon with demonstrated competency in trauma care. The Trauma Medical Director is the chairperson of the Trauma Committee.

ARTICLE V - PART F: Section 2. Duties:
The purpose of the Trauma Committee will be to provide oversight and leadership to the entire trauma program. The major foci will be:

(a) performance improvement,

(b) compliance with the Montana Trauma Plan: Area Trauma Hospital standards of care, and

(c) education and outreach programs with appropriate groups for injury prevention.

ARTICLE V - PART F: Section 3. Meetings, Reports, and Recommendations:

(a) The Trauma Committee shall meet monthly; shall maintain a permanent record of its findings, proceedings, and actions.

(b) The Trauma Committee shall also report to the Medical Executive Committee.

ARTICLE V - PART G: EMERGENCY CARE COMMITTEE

ARTICLE V - PART G: Section 1. Composition:
The Emergency Care Committee shall consist of at least one (1) representative from each of the clinical Sections as needed and shall include representation from anesthesiology and the emergency physicians’ group. A representative from the County Disaster and Emergency Services organization may be invited to attend at the discretion of the Chairperson of the Committee. A representative from Nursing Service and Hospital Management appointed by the Chief Executive Officer may attend.

44 Revision(s) made July 2009
45 Revision(s) made June 2015
ARTICLE V - PART G: Section 2. Duties:
The Emergency Care Committee shall:

(a) monitor and evaluate the appropriateness and quality of patient care provided in the Emergency Department.

(b) review and recommend appropriate procedures and policies concerning the Emergency Department and outpatient services.

(c) develop and integrate maximum and efficient utilization of other hospital facilities and services together with the emergency care and outpatient services.

(d) promote cooperation between the Emergency Department physician and the patient's physician.

(e) encourage and facilitate the integration of the St. James Healthcare Emergency Department in the overall scheme of the local, regional, and state Emergency Medical Services System. This shall specifically apply to the development of Advanced Life Support and Advanced Trauma Support in the pre-hospital phase of patient care and generally to the provision of quality pre-hospital medical and trauma care.

(f) train and continually educate all Emergency Department personnel.

ARTICLE V - PART G: Section 3. Meetings, Reports, and Recommendations:
The Emergency Care Committee shall meet as often as necessary to transact its business, but at least quarterly; shall make a permanent record of its findings, proceedings, and actions.

ARTICLE V - PART H: BYLAWS COMMITTEE

ARTICLE V - PART H: Section 1. Composition:
The Bylaws Committee shall consist of at least five (5) members from the Active Staff. One representative from Hospital Management may attend.

ARTICLE V - PART H: Section 2. Duties:

(a) The Bylaws Committee shall review the Bylaws of the Medical Staff and associated documents at least annually and recommend amendments thereto to the Medical Executive Committee. This review shall include, but not be limited to, the Medical Staff Rules and Regulations and appointment and reappointment application forms. In addition, the Committee shall receive and consider all recommendations for changes in these documents by the Medical Executive Committee or the Medical Staff. The Bylaws Committee shall also assist with interpretations of the Bylaws and Rules and Regulations when requested to do so by the President of the Medical Staff, the Medical Executive Committee, or the Board of Directors.

(b) Annual review and revision of approved abbreviation list function: At least annually and more often, if necessary, review and revise the list of approved abbreviations allowed to be used in the Medical Record.

ARTICLE V - PART H: Section 3. Meetings, Reports, and Recommendations:
The Bylaws Committee shall meet as often as necessary to fulfill its duties, but at least annually, shall maintain a permanent record of its activities.

ARTICLE V - PART I: CREATION OF STANDING COMMITTEES
The Medical Executive Committee shall perform any function required to be performed by these Bylaws, which is not assigned to a standing or special Committee.

46 Revisions made October 2011
ARTICLE V - PART J: SPECIAL COMMITTEES
Special Committees may be created and their members and Chairperson shall be appointed by the President of the Medical Staff as required. Such Committees shall confine their activities to the purpose for which they were appointed, and shall report to the Medical Executive Committee after each meeting.
ARTICLE VI - PART A: QUALIFICATIONS FOR APPOINTMENT

ARTICLE VI - PART A: Section 1. General:  

(a) A practitioner requesting medical staff appointment and/or privileges shall initially be sent a Pre-Application Questionnaire packet that outlines the threshold criteria for appointment and applicable clinical privileges. The Pre-Application Questionnaire explains the review process and request for application form, which requests proof that the threshold criteria for appointment can be met by the practitioner. Each practitioner has the responsibility to report any and all information about investigations, relinquishment or loss or privileges, sanctions, or limitations on licensure from any applicable state licensing agency or board.

Once the pre-application has been processed and finalized, it is reviewed by the President of the Medical Staff and the Chief of the Section. A final written approval is given or not given, in accordance to the paragraphs below, to the Medical Staff Office to send an initial application packet to the applicant.

An Initial Application packet for appointment to the Medical Staff shall only be sent to those individuals who, according to the Medical Staff Bylaws, are eligible for appointment to the Medical Staff; who meet established threshold criteria; and who indicate an intention to utilize the hospital as required by the staff category to which they desire appointment.

Practitioners who fail to meet the threshold criteria shall not be given an Initial Application Packet and shall be so notified in writing by the President of the Medical Staff and/or his/her designee. A practitioner who does not meet the established threshold criteria is not entitled to the procedural rights set forth in the Fair Hearing Process which is outlined in the Medical Staff Bylaws.

If the President of the Medical Staff and/or Chief of the Section deny the pre-application, the denial will require a 2/3 (two/thirds) vote of the Medical Executive Committee.

(b) Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in these Bylaws as are adopted from time to time. When an individual has completed an accredited training program and is in the Board Certification Pathway, that individual will be given a maximum of two years from the time they have completed the accredited training program, to attain Board Certification (when a certifying Board is available), unless a longer time period is defined by that Board. The Board Certification must be recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association Boards (AOA), or the American Dental Association. If, at the end of this period, Board Certification has not been obtained, then that individual’s membership and privileges will be revoked. The applicant must provide ongoing evidence of certification process throughout the certification provisional period in accordance with the American Board of Medical Specialties, the American Osteopathic Association Boards, the American Dental Association or the Maintenance of Certification pathway. The applicant will maintain in provisional status until certification is obtained. An applicant for appointment to the Medical/Dental Staff may apply for specific privileges in their specialty at the time of application for appointment. All individuals practicing medicine and dentistry in this hospital, unless accepted by specific provisions of these Bylaws, must first have been appointed to the Medical Staff. Appointments to the Medical Staff, whether initial or reappointment, must be approved by appropriate professional review Committees of the Medical Staff, and by the Board of Directors pursuant to these Bylaws.  

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47 Added new Paragraph (a) June 2012
48 Changes made to this Paragraph October 2010
(c) All other applicants must be Board Certified by a Board recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association Boards (AOA), or the American Dental Association, or show evidence of the certification or recertification process, as a condition of medical staff membership. The applicant must provide ongoing evidence of the certification or recertification process throughout the certification or recertification provisional period in accordance with the American Board of Medical Specialties, the American Osteopathic Association Boards, the American Dental Association or the Maintenance of Certification pathway. The applicant will maintain in provisional status until certification or recertification is obtained.49

(d) All members must be Board Certified. The Board Certification must be recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association Boards (AOA), or the American Dental Association... If the Board Certification has lapsed, that member will be given a maximum of 2 years to attain Board Certification, unless a longer time period is defined by that Board. The applicant must provide ongoing evidence of the recertification process throughout the recertification provisional period in accordance with the American Board of Medical Specialties, the American Osteopathic Association Boards, the American Dental Association or the Maintenance of Certification pathway.50

(e) Practitioners, such as General Dentists, whose degree and training do not have certifying boards, can apply for membership and medical staff privileges at St. James Healthcare. Dental specialists must have passed and maintained their specialty certifying board membership in order to apply for membership and medical staff privileges at St. James Healthcare.51

**ARTICLE VI - PART A: Section 2. Specific Qualifications:**

Only physicians and dentists who satisfy the following conditions shall be qualified for appointment to the Medical Staff:

(a) are currently licensed to practice in the state of Montana.

(b) are located within the geographic service area from the Hospital in order to provide timely and continuous care for their patients. An exception to this rule will be made for Consulting and Visiting Staff members. An exception is also made for Emergency Department contract physicians.

(c) possess current and valid professional liability insurance coverage in amounts recommended by the Medical Staff and approved by the Board of Directors.

(d) can document their:

1. current licensure, relevant training or experience, current competence, and ability to perform the requested privileges52.
2. adherence to the ethics of their profession.
3. good reputation and character, including the applicant’s mental and emotional stability.
4. ability to work harmoniously with others sufficiently to convince the hospital that all patients treated by them in the hospital will receive quality care and that the hospital and its Medical Staff will be able to operate in an orderly manner. Honest disagreement and strident argument and discussion shall not be proscribed; however, unprofessional conduct, including, but not limited to, verbal abuse, physical intimidation, harassment, and/or violence shall not be tolerated.
5. Board Certification as noted in Article VI, Part A, Section 1.

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49 Paragraph added October 2010
50 Paragraph added October 2010
51 Paragraph added February 2013
52 Revision(s) made July 2009
The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing a valid picture identification issued by a state or federal agency (e.g., driver's license or passport).

**ARTICLE VI - PART A: Section 3. No Entitlement to Appointment:**
No individual shall be entitled to appointment to the Medical Staff or to exercise particular clinical privileges in the hospital merely by virtue of the fact that such individual:

(a) is licensed to practice a profession in this or any other state,

(b) is a member of any particular professional organization, or

(c) has had in the past, or currently has, Medical Staff appointment in this or another hospital.

**ARTICLE VI - PART A: Section 4. Non-Discrimination Policy:**
No individual shall be denied appointment on the basis of gender, age, race, creed, religion, color, or national origin.

**ARTICLE VI - PART A: Section 5. Ethical and Religious Directives:**
All Medical Staff members and others exercising clinical privileges in the hospital shall, in their care of hospital inpatients and outpatients, abide by the terms of the Ethical and Religious Directives for Catholic Health Facilities promulgated by the National Conference of Catholic Bishops. No activity prohibited by said Directives shall be engaged in by any Medical Staff member or other person exercising clinical privileges in the hospital.

**ARTICLE VI - PART B: CONDITIONS OF APPOINTMENT**

**ARTICLE VI - PART B Section 1. Initial Provisional Appointment:**

(a) All initial appointments to the Medical Staff, regardless of the category of the staff to which the appointment is made, and all initial clinical privileges shall be provisional for a period of twelve (12) months from the date of appointment. During the term of this provisional appointment, the individual receiving the provisional appointment shall be evaluated by the Chief of the Section or Sections in which the individual has clinical privileges and by the relevant Committees of the Medical Staff as to the individual’s clinical competence, general behavior, conduct in the care of patients, and other considerations as defined in Article VII, Part A, Section 2 of these Bylaws. Provisional clinical privileges shall be adjusted to reflect clinical competence at the end of the provisional period, or sooner, if warranted. Continued appointment after the provisional period shall be conditioned on an evaluation of the factors to be considered for reappointment. A provisional Active Staff member’s knowledge and skill will be determined by review of at least three (3) cases per quarter of the initial provisional year by the Section Chief and a peer practitioner. Case review for provisional Allied Health Professionals, Courtesy, Consulting and Visiting staff will be determined in accordance of paragraph “d” below.\(^{53}\)

(b) All provisional Active Staff members shall be permitted to participate in discussions at Medical Staff meetings, but shall not be entitled to make motions, vote, hold staff office, or serve as Chairpersons of staff Committees.

(c) At the time of initial appointment, each new member of the Medical Staff shall be assigned to one or more clinical Sections. The clinical Section in which a practitioner treats the majority of his/her patients shall be designated the primary clinical Section for that particular staff member.

(d) The Chief of each Section to which a Provisional Member has been assigned shall have primary responsibility for evaluating the provisional member's clinical competence and conduct in his/her Section. However, the Section Chief may delegate the responsibility to conduct concurrent and retrospective evaluations to a Proctor (Medical Staff member with expertise in the clinical privileges

\(^{53}\) Revision(s) made December 2011
to be monitored) assigned to this task. The number and types of cases to be reviewed shall be determined by each clinical Section, but shall encompass a spectrum of cases broad enough to allow adequate evaluation of a provisional member's clinical competence and conduct.

(e) Section Chiefs shall report to the Medical Executive Committee regarding Provisional Medical Staff Members' clinical competence and conduct. The Medical Executive Committee shall proceed as provided for in Article VI, Part D, Section 3.

(f) The Section Chief may recommend extension of the provisional period for a period of up to an additional twelve (12) months—not to exceed a total of two years—if the Provisional Medical Staff member has treated an inadequate number of patients or if there remain questions regarding his/her clinical competence and conduct during the provisional period.

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

ARTICLE VI - PART C: Section 1. Information:
Applications for appointment to the Medical Staff shall be in writing and shall be submitted on forms approved by the Board of Directors and recommended by the Medical Executive Committee. These forms shall be obtained from the Medical Staff Office, who shall notify the President of the Medical Staff that an application form has been dispensed. The application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications including:

(a) the names and complete addresses of at least three (3) physicians, dentists, or other practitioners, as appropriate, who have had recent extensive experience in observing and working with the applicant and who can provide adequate information pertaining to the applicant's present professional competence and character. Said references may not be associated or about to be associated with the applicant in professional practice or personally related to the applicant. At least one (1) reference shall be from the same specialty area as the applicant.

(b) the names and complete addresses of the Chairpersons of each Department or Section of any and all hospitals or other institutions at which the applicant has worked or trained (i.e., the individuals who served as Chairpersons at the time the applicant worked in the particular department or section). If the number of hospitals in which the applicant has worked is great or if fifteen (15) years have passed since the applicant worked at a particular hospital, the Section Chief may take into consideration the applicant's good faith effort to produce this information.

(c) information as to whether the applicant's Medical Staff appointment or clinical privileges have ever been relinquished, denied, revoked, suspended, reduced, or not renewed at any other hospital or health care facility (voluntarily or involuntarily).

(d) information as to whether the applicant has ever withdrawn an application for appointment, reappointment and clinical privileges, or resigned from the Medical Staff before final decision by a hospital's or health care facility's government agency.

(e) information as to whether the applicant's membership in local, state, or national professional societies, or license to practice any profession in any state, or Drug Enforcement Administration license has ever been suspended, modified, or terminated (voluntarily or involuntarily). The submitted application shall include a copy of all the applicant's current licenses to practice, as well as a copy of his/her Drug Enforcement Administration license, medical or dental school diplomas, and certificates from all postgraduate training programs completed.

(f) information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company, and the amount and classification of such coverage.
(g) information concerning applicant's malpractice claims experience.
(h) a consent to the release of information from the applicant's present and past professional liability insurance carriers.
(i) information on the applicant's physical and mental health, including a consent to release of information from the applicant's past and present personal health care providers.
(j) information as to whether the applicant has ever been named as a defendant in a criminal action and details about any such instance.
(k) information on the citizenship and visa status of the applicant.
(l) the applicant's signature.
(m) a consent to the release of general information.
(n) a valid picture ID issued by a state or federal agency (e.g., driver's license or passport).
(o) such other information as the Medical Staff may require.

**ARTICLE VI - PART C: Section 2. Undertakings:**
The following undertakings shall be applicable to every Medical Staff applicant and member for staff appointment or reappointment as a condition of consideration of such application and as a condition of continued Medical Staff appointment if granted:

(a) an obligation upon appointment to the Medical Staff to provide continuous care and supervision to all hospital inpatients, outpatients, and Emergency Department patients for whom the individual has responsibility.
(b) an agreement to abide by the Bylaws, Rules, and Regulations of the Medical Staff, as shall be in force from time to time during the time the individual is appointed to the Medical Staff.
(c) an agreement to accept Committee assignments and such other reasonable duties as shall be assigned to the applicant after appointment.
(d) an agreement to provide the Section Chief new or updated information as it occurs, that is pertinent to any question on the application form.
(e) a statement that the applicant has received and had an opportunity to read a copy of the Bylaws, Rules, and Regulations of the Medical Staff as are in force at the time of his or her application and that the applicant has agreed to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment to the Medical Staff or clinical privileges are granted.
(f) a statement of the applicant's willingness to appear for personal interview in regard to the application.
(g) a statement that any intentional misrepresentation or misstatement in, or omission from the application, shall constitute cause for automatic and immediate rejection of the application resulting in denial of appointment and clinical privileges. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may result in summary dismissal from the Medical Staff.
(h) a statement that the applicant will:
   (1) refrain from fee splitting or other inducements relating to patient referral.

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54 Revision(s) made July 2009

Revised September 2018
(2) refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised.

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

(4) seek consultation whenever necessary.

(5) abide by generally recognized ethical principles applicable to the applicant's profession.

(6) provide continuous timely care for the applicant's hospital inpatients, outpatient, and Emergency Department patients.

(7) agree to abide by the terms of the Ethical and Religious Directives for Catholic Health Facilities promulgated by the National Conference of Catholic Bishops in the care of hospital inpatients and/or outpatients and to perform no activity prohibited by said Directives in the care of hospital inpatients and/or outpatients.

Each applicant for Medical Staff appointment and reappointment shall specifically agree in writing to these undertakings as part of the application.

**ARTICLE VI - PART C: Section 3. Burden of Providing Information:**

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

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

(c) Until the applicant has provided all information required by the credentialing process herein detailed, the application for appointment or reappointment will be deemed incomplete and will not be further processed. Should information provided in the initial application for appointment change during the course of an appointment year, the member has the burden of providing information about such change to the Section Chief.

**ARTICLE VI - PART C: Section 4. Authorization to Obtain Information:**

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

(a) Immunity: To the fullest extent permitted by law, the individual releases from any and all liability, and extends absolute immunity to the Medical Staff, the hospital and their authorized representatives, and any third parties as defined in subsection (d) below, with respect to any acts, communications, or documents, recommendations, or disclosures involving the individual, concerning the following:

   (1) applications for appointment or clinical privileges, including temporary privileges.
   (2) evaluations concerning reappointment or changes in clinical privileges.
   (3) proceedings for suspension or reduction of clinical privileges or for revocation of Medical Staff appointment, or any other disciplinary sanction.
   (4) summary suspension.
   (5) hearings and appellate reviews.
   (6) medical care evaluations.
   (7) other activities relating to the quality of patient care or professional conduct.

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55 Revision(s) made July 2009
(8) matters or inquiries concerning the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ability to perform requested privileges, ethics, or behavior.

(9) any other matter that might directly or indirectly relate to the individual's competence, to patient care, or to the orderly operation of this hospital.

The foregoing shall be privileged to the fullest extent permitted by law. Such privilege shall extend to the Medical Staff, the hospital and their authorized representatives, and to any third parties as defined in subsection (d) below.

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

(c) Authorization to Release Information: The individual specifically authorizes the Medical Staff, the hospital, and their authorized representatives to release such information to other hospitals, health care facilities, and their agents, who solicit such information for the purpose of evaluating the applicant's professional qualifications pursuant to the applicant's request for appointment or clinical privileges.

(d) Definitions:

(1) As used in this section, the terms, "the Medical Staff, the hospital, and their authorized representatives" means the hospital corporation and any of the following individuals who have any responsibility for obtaining or evaluating the individual's credentials, or acting upon the individual's application or conduct in the hospital; the members of its Board of Directors and their appointed representatives; the Chief Executive Officer or designees; other hospital employees; consultants to the hospital; the hospital's attorney and his/her partners, associates, or designees; and all members of the Medical Staff who have any responsibility for obtaining or evaluating the individual's credentials, or acting upon the individual's application or conduct in the hospital.

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

ARTICLE VI - PART D: PROCEDURE FOR INITIAL APPOINTMENT

ARTICLE VI - PART D: Section 1. Submission of Application:

(a) The application for Medical Staff appointment shall be submitted by the applicant to the Medical Staff Office, who shall notify the President of the Medical Staff and the Section Chief that an application has been received and from whom. It must be accompanied by payment of such processing fees as may be recommended by the Medical Staff. After receiving all references and

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other information or materials deemed pertinent, and after verifying the information provided in the application with primary sources, the Section Chief or a designee shall determine the application to be complete.

(b) An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified. An application shall become incomplete if the need arises for new, additional, or clarifying information anytime during the evaluation. Any application that continues to be incomplete 90 days after the applicant has been notified of the additional information required shall be deemed to be withdrawn unless due to extenuating circumstances found reasonable to the Medical Executive Committee. It is the responsibility of the applicant to provide that the application is complete, including adequate responses from references. If the application remains incomplete for 12 months from the time it is received in the Medical Staff Office, the applicant will be required to reapply for membership and privileges by completing another initial application packet. An incomplete application will not be processed.  

(c) Completed applications shall be processed within 120 days after receipt of the application by the Administrative Medical Staff Coordinator. This process may include, but will not be limited to, submitting queries to primary sources:

1) the National Practitioner Data Bank (NPDB)

2) the American Medical Association (AMA) or the American Osteopathic Association (AOA)

3) the American Board of Medical Specialties (ABMS)

4) the Federation of State Medical Boards (FSMB)

5) Criminal background investigative check


7) State licensure

8) Drug Enforcement Agency (DEA)

9) Specialty Boards

10) State Medical/Dental Boards

11) Educational Commission for Foreign Medical Graduates (ECFMG), where applicable

12) Malpractice insurance companies, past and present

13) All educational references

14) All personal references

15) All hospital and other facility references

16) Citizenship and/or Visa status

17) Malpractice litigation history and legal proceedings affecting applicant

60 Added 2nd to the last sentence in Paragraph (b) June 2012

61 Revision(s) made July 2009
Photo identification, lists of privileges requested, and a competency questionnaire will be sent with above requests (see Initial Application for Medical Staff Membership and Clinical Privileges.

The Medical Executive Committee shall be responsible for assuring that completed applications are processed within this time frame. If an unavoidable delay occurs in the processing of a completed application, the President of the Medical Staff shall be responsible for notifying the applicant, in writing, of the delay and the reasons for the delay. Copies of this letter shall be forwarded to the Medical Executive Committee, the Chief Executive Officer, the Board of Directors1, and to the individual, Committee, or Section responsible for the delay.

ARTICLE VI - PART D: Section 2. Section Chief Procedure:
The appropriate Section Chief shall provide the Medical Executive Committee with a report concerning the applicant's qualifications for appointment and written findings supporting the proposed delineation of the applicant's clinical privileges. As part of the process of making this report, the Section Chief has the right to meet with the applicant to discuss any aspect of the application, qualifications, and requested clinical privileges.

(a) The Section Chief, or the individual(s) or committee within the Section to which the Chief has assigned this responsibility, shall evaluate the applicant's education, training, and experience and make inquiries with respect to the same to the applicant's past or current Section Chief(s), and/or the Residency Training Director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

ARTICLE VI - PART D: Section 3. Medical Executive Committee Procedure:
The Medical Executive Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the Committee, including the report and findings from the Chief of each clinical Section in which privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for the clinical privileges requested.

As part of the process of making its recommendation, the Medical Executive Committee may require a physical and/or mental examination of the applicant by a physician or physicians satisfactory to the Medical Executive Committee and shall require that the results be made available for the Committee's consideration. The results of such physical and/or mental examination shall also be provided to the applicant. Any costs incurred for such examination shall be borne by the individual concerned. Failure of the applicant to procure such an examination within a reasonable time after being requested to do so in writing by the Medical Executive Committee shall constitute a voluntary withdrawal of the application for appointment and clinical privileges, and all processing of the application shall cease.

(a) The Medical Executive Committee shall have the right to require the applicant to meet with the Medical Executive Committee to discuss any aspect of the applicant's application, qualifications, or clinical privileges, requested.

(b) The Medical Executive Committee may use the expertise of the Section Chief, or any member of the Section, or an outside consultant, if additional research is required into the applicant's qualifications.

(c) If, after considering the report of the clinical Section Chief concerned, the Medical Executive Committee's recommendation for appointment is favorable, the Medical Executive Committee shall recommend provisional Section assignment and provisional privileges. All recommendations to appoint, including provisional appointment, must specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions.

(d) If action by the Medical Executive Committee is delayed longer than 120 days, the President of the Medical Staff shall send a letter to the applicant, with a copy to the Medical Executive Committee and the Chief Executive Officer, explaining the reasons for the delay.
ARTICLE VI - PART D: Section 4. Medical Executive Committee Recommendations:

(a) Upon receipt of favorable recommendations from the Medical Executive Committee that the applicant be granted appointment and the requested clinical privileges, the Board of Directors may:
   (1) appoint the applicant and grant clinical privileges as recommended; or
   (2) reject the recommendation.

(b) If the Board of Directors determines to reject the favorable recommendations of the Medical Executive Committee, it may refer the matter back to the Medical Executive Committee for further research, investigation, and recommendation. If the Board of Director’s determination remains unfavorable to the applicant, that determination, with the reasons therefore, shall be sent to the Chief Executive Officer who shall promptly give Special Notice to the individual, advising the individual of his/her right to a hearing and appeal as set forth elsewhere in these Bylaws. If the applicant waives his/her procedural rights or if there is no reply to the Special Notice within a reasonable time as set forth in the Special Notice, the application shall be deemed to have been withdrawn.

(c) If the Medical Executive Committee’s recommendation is unfavorable, the unfavorable recommendation shall be forwarded to the Chief Executive Officer who shall promptly give Special Notice to the individual advising the individual of his/her right to a hearing and appeal as set forth elsewhere in these Bylaws.

ARTICLE VI - PART E: CLINICAL PRIVILEGES – APPOINTMENT, REAPPOINTMENT, REQUESTS FOR ADDITIONAL PRIVILEGES AND/OR EXPANDING PRIVILEGES:

ARTICLE VI - PART E: Section 1. General:

(a) Medical Staff appointment/reappointment confers only the right to exercise those clinical privileges specifically recommended by the Medical Executive Committee and approved by the Board of Directors. This includes reasonable access to existing hospital resources necessary to exercise those clinical privileges.

(b) The clinical privileges recommended by the Medical Staff shall be based upon the following:

   (1) the applicant’s current licensure, relevant training and experience, current competence, ability to perform the requested privileges\textsuperscript{62}, and references.

   (2) adequate levels of professional liability insurance coverage.

   (3) any previously successful or currently pending challenges to any licensure or registration, or voluntary/involuntary relinquishment of such licensure or registration, information concerning any voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital.

   (4) other relevant information, including a written report and findings by the Chief of each of the clinical Sections in which such privileges are sought.

   (5) The applicant shall have the burden of establishing qualifications for and competence to exercise the clinical privileges requested.

   (6) At the time of request from any Medical Staff member to expand or add a new privilege, the National Practitioner Data Bank (NPDB) shall be queried.

\textsuperscript{62} Revision(s) made July 2009
ARTICLE VI - PART E:  Section 2. Clinical Privileges for Dentists:

(a) The scope and extent of surgical procedures that a dentist may perform at the hospital shall be delineated and recommended in the same manner as other clinical privileges.

(b) Surgical procedures performed by dentists shall be under the overall supervision of the Chief of Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician member of the Medical Staff before dental surgery shall be scheduled for performance, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) Oral surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination, may assess the medical risks of the procedure on the patient, and may treat the patient as appropriate, if they have privileges to do so. "Oral surgeons" shall be interpreted to refer to licensed dentists who have successfully completed a postgraduate program in oral surgery accredited by a nationally recognized accrediting body approved by the United States Office of Education.

(d) The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. Dentists may write orders within the scope of their license and consistent with the Medical Staff Bylaws, Rules, and Regulations.

ARTICLE VI - PART E:  Section 3. Interns and Residents:
Interns and residents in training in the hospital shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to exercise only those privileges set out in training protocols developed by the Chief of the appropriate Section and the Program Director, and approved by the Medical Executive Committees and the Board of Directors. An Active staff practitioner will be designated as a sponsor. 63

ARTICLE VI - PART F:  PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

ARTICLE VI - PART F:  Section 1. Temporary Clinical Privileges for Applicants:
Temporary privileges are granted only to meet an important patient care need. Temporary privileges for new applicants may be granted only when the application is complete and awaiting review and approval by the organized Medical Staff including but not limited to the following items are present and verified64:

(a) current licensure
(b) relevant training/experience
(c) proof of current competencies and ability to perform the privileges requested
(d) a query and evaluation of the National Practitioner Data Bank information
(e) no current or previously successful challenges to licensure or registration
(f) no subjection to involuntary termination of medical staff membership at another organization
(g) no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
(h) DEA license certification
(i) malpractice insurance (professional liability) in the amounts set by the Board of Directors
(j) character and ethical standing

After consulting with the President of the Medical Staff or authorized designee, the Chief Executive Officer or authorized designee may grant temporary admitting and clinical privileges to an applicant for Medical Staff appointment or a properly-qualified Allied Health Professional for consecutive 60-day periods with a maximum of 120 days. The applicant shall be required to sign an acknowledgment to be bound by the Medical Staff Bylaws, Rules and Regulations then in force. In exercising such privileges, the

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63 Added sentence June 2015
64 Revision(s) made July 2009

Revised September 2018
applicant shall act under the supervision of the Chief or appropriate designee of the Section in which the applicant has requested primary privileges.

**ARTICLE VI - PART F: Section 2. Temporary Clinical Privileges for Specific Patients:**

Temporary admitting and clinical privileges, when requested by the attending physician who will prepare a statement of need\(^1\), for care of a specific patient or patients may be granted by the Chief Executive Officer with the concurrence of either the Chief of the Section concerned or the President of the Medical Staff to a physician who has evidence of current licensure and competence, provided that the Chief Executive Officer shall first obtain such individual's signed acknowledgment to be bound by the Medical Staff Bylaws, Rules, and Regulations then in force. Such privileges shall be restricted to the specific patients for which they are granted and, if they are not members of the Medical Staff, to the treatment of not more than six (6) patients in any one year, after which the individual shall be required to apply for appointment to the Medical Staff and for clinical privileges before being permitted to attend additional patients.

If a non-applicant has had temporary clinical privileges granted for more than one 60-day period within a biennium, this non-applicant will be required to complete similar information as is required of other staff members during the reappointment process.

**ARTICLE VI - PART F: Section 3. Special Requirements:**

The appropriate Section Chief may impose special requirements of supervision and reporting on any individual granted temporary clinical privileges. Temporary privileges may be immediately terminated by the Chief Executive Officer upon notice by the President of the Medical Staff or by the Chief of the applicable Section of any failure by the individual to comply with such special conditions.

**ARTICLE VI - PART F: Section 4. Locum Tenens:**

(a) The Chief Executive Officer may grant an individual serving as a locum tenens for a member of the Medical Staff or Allied Health Professional Staff temporary admitting and/or clinical privileges to attend patients of that member for a period of time.\(^6\) This shall be done in the same manner and upon the same conditions as set forth in Section 1 of this part, provided that the Chief Executive Officer shall first obtain such individual's signed acknowledgment that he or she has received and had an opportunity to read copies of the Medical Staff Bylaws, Rules, and Regulations which are then in force and that he or she agrees to be bound by the terms thereof in all matters.

(b) The individual serving as a locum tenens must also complete a request for clinical privileges form and must have in force and effect a current license to practice; a current DEA license, if applicable; and professional liability insurance in an amount and terms required by the Board of Directors.

(c) The individual serving as a locum tenens may exercise privileges for a maximum of 120-days, consecutive or not, anytime during the 24-month period following the date they are granted, subject to the following conditions:\(^6\)

1) the individual must notify the Medical Staff Office prior to each time that he or she will be exercising these privileges; and
2) along with this notification, the individual must inform the Medical Staff Office of any change that has occurred to any of the information provided on the initial application for locum tenens privileges.

**ARTICLE VI - PART F: Section 5. Termination of Temporary Clinical Privileges:**

(a) The Chief Executive Officer may, at any time, after receiving a recommendation from the President of the Medical Staff or the Chief of the Section responsible for the individual's supervision, terminate an individual's temporary clinical privileges. Clinical privileges shall then be terminated when the

\(^{65}\) Revised Sentence October 2014
\(^{66}\) Revised Paragraph October 2014
physician's inpatients are discharged from the hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual, a summary termination of temporary clinical privileges may be imposed by the Chief Executive Officer, Section Chief, or President of the Staff, and such termination shall be immediately effective.

(b) The appropriate Section Chief, or in his or her absence, the President of the Medical Staff, shall assign to a Medical Staff member with appropriate clinical privileges, responsibility for the care of such terminated individual's patients until they are discharged from the hospital, giving consideration where possible to the wishes of the patient in the selection of the new attending.

(c) Temporary members of the medical staff of any of the foregoing medical staff categories will be processed under the category of what they applied for67.

ARTICLE VI - PART G: EMERGENCY CLINICAL PRIVILEGES

(a) For the purpose of this section, an "emergency" is defined as a condition, which could result in serious or permanent harm to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that harm or danger.

(b) In an emergency, a physician or dentist who is not currently a member of the Medical Staff may be permitted by the hospital to exercise clinical privileges to act in such emergency using all necessary facilities of the hospital, including calling for any necessary or desirable consultation.

(c) Similarly, in an emergency involving a particular patient, a physician or dentist currently a member of the Medical Staff may be permitted by the hospital to act in such emergency by exercising clinical privileges not specifically assigned to him/her.

(d) When the emergency situation no longer exists, such physician or dentist must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or not requested, the President of the Medical Staff shall assign the patient to a staff member with appropriate clinical privileges. The wishes of the patient shall be considered in the selection of a substitute physician.

ARTICLE VI – PART H: DISASTER PRIVILEGES

Disaster privileges may be granted only when the following two conditions are present: disaster plan has been activated and the organization is unable to handle the immediate patient needs.

(a) The Chief Executive Officer or Medical Staff President or his or her designee(s) has (have) the option to grant disaster privileges.

(b) The responsible individual(s) is (are) not required to grant privileges to any individual and is (are) expected to make such decisions on a case-by-case basis at his or her discretion.

(c) The Chief Executive Officer, in consultation with available medical staff member(s), or Medical Staff President or his or her designee(s) who grant disaster privileges will determine the mechanism (for example, direct observation, mentoring, and clinical record review) to oversee the professional performance of volunteer practitioners who receive disaster privileges.68

(d) In order for volunteers to be considered eligible to act as licensed independent practitioners, the organization obtains for each volunteer practitioner, at a minimum, a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport), and at least one of the following:

(1) A current license to practice in a United States or Canadian jurisdiction.

67 Revision(s) made July 2009
68 Revision(s) made July 2009
(2) Primary source verification of the license.

(3) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), or Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VH) or other recognized state or federal organizations or groups.

(4) Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).

(5) Identification by current hospital or medical staff member(s) who possess(es) personal knowledge regarding volunteer’s ability to act as a licensed independent practitioner during a disaster.

(e) If not immediately available, primary source verification of licensure begins as soon as the emergent situation is under control, and is completed 72 hours from the time the volunteer practitioner presents to the organization.

NOTE: In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.  

(f) The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

(g) Individuals who are granted disaster privileges will be provided with appropriate identification.

ARTICLE VI - PART I: PRIVILEGES FOR PROCTORS AND INSTRUCTORS

(a) The Chief Executive Officer, after consulting with the Section Chief, may grant privileges to proctor and instruct. A physician, wishing to proctor and instruct at St. James Healthcare, must request these privileges prior to the scheduling of the cases to be proctored or instructed. This physician must be sponsored and supervised by an Active Medical Staff member with privileges in the specialty in which the procedure will be taught.

(b) Although the State of Montana does not require licensure for visiting instructors, Section 37-3-1-103(1)(b), MCA, states:

“This chapter does not require a license with respect to any of the following acts: (b) the rendering of services in this state by a physician lawfully practicing medicine in another state or territory. However, if the physician does not limit the services to an occasional case or if he has any established or regularly used hospital connections in this state or maintains or is provided with, for his regular use, an office or other place for rendering the services, he must possess a license to practice medicine in this state.”

69 Revision(s) made July 2009
70 Revision(s) made July 2009
71 Revision(s) made July 2009
(c) The Montana State Board of Medical Examiners must be notified when a physician/proctor is sponsored and they require a copy of the instructor's curriculum vitae and a copy of his/her current license in the state in which he/she practices.

(d) The following items must be supplied to the Administrative Medical Staff Coordinator and be verifiable: a request to proctor, a Consent to Release Information, a curriculum vitae, proof of malpractice coverage (Certificate of Insurance) in amounts acceptable by the St. James Healthcare Board of Directors, a valid state license (not necessarily Montana’s), a valid DEA license, copies of Specialty Board Certificates, and the names, address and phone numbers of hospitals where this physician has Active Staff privileges in the area that is being proctored or taught. 72

(e) Upon receipt of the above information by the Administrative Medical Staff Coordinator and the State Board of Medical Examiners, the information will be reviewed and a determination made.

(f) The physician proctor shall be granted privileges only for the procedures to be proctored or taught for a period of one year. 73

ARTICLE VI – PART J: TELEMEDICINE PRIVILEGES

(a) St. James Healthcare may use the credentialing and privileging information from the distant site if all the following requirements are met:

(1) The distant site is Joint Commission-accredited.

(2) The practitioner is privileged at the distance site for those services to be provided at St. James Healthcare.

(3) St. James Healthcare has evidence of an internal review of the practitioner’s performance of these privileges and sends to the distant site information that is useful to assess the practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by the Joint Commission that result for the telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at St. James Healthcare. NOTE: This occurs in a way consistent with any organizational policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law.

(b) The medical staffs at both St. James Healthcare and the distant sites recommend the clinical services to be provided by the licensed independent practitioners through a telemedicine link at their respective sites and the clinical services offered are consistent with commonly accepted quality standards.

(c) All telemedicine providers must submit a current Montana license, proof of current malpractice/ professional liability insurance coverage in the amounts approved by the Board of Directors, and proof of their affiliation with the distant JCAHO-accredited site to the St. James Healthcare Medical Staff Office before privileges are granted.

72 Revision(s) made July 2014
73 Revision(s) made July 2014
ARTICLE VII
ACTIONS AFFECTING MEDICAL STAFF MEMBERS

ARTICLE VII - PART A: PROCEDURE FOR REAPPOINTMENT

ARTICLE VII - PART A: Section 1. Application:

(a) Each current member who is eligible to be reappointed to the Medical Staff shall be responsible for completing the reappointment application form. The reappointment application shall be submitted to the Medical Staff Office at least four (4) months prior to the expiration of the staff member’s then current appointment period. Any unexcused or unreasonable failure to submit an application by that time will result in automatic expiration of the member’s appointment and clinical privileges at the end of the then current Medical Staff Year.

(b) Reappointment, if granted, shall be for a period of not more than two years, with approximately one-half of the staff appointed in even-numbered years and the other half in odd-numbered years.

ARTICLE VII - PART A: Section 2. Factors to be Considered:

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

1. ethical behavior, clinical competence, clinical judgment in the treatment of patients, current competence, training and experience, current licensure, and ability to perform requested privileges.

2. attendance at Medical Staff, Section, and Committee meetings and participation in staff duties.

3. compliance with the Medical Staff Bylaws, Rules, and Regulations including, but not limited to, provision of timely, continuous care to hospital inpatients, outpatients, and Emergency Department patients.

4. conduct at the hospital, including cooperation with Medical Staff and hospital personnel as it relates to patient care.

5. capacity to satisfactorily treat patients as indicated by the results of the Medical Staff’s Performance Improvement activities or other reasonable indicators of continuing qualifications.

6. documentation of a minimum of 50 hours CME’s, per two year reappointment cycle, must be included as part of the reappointment packet and submitted to the Medical Staff Office along with the reappointment application.

7. previously successful or currently pending challenges to any licensure or registration (State, Drug Enforcement Administration, etc.) or the voluntary or involuntary relinquishment of such licensure or registration.

8. voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital.

9. involvement in a professional liability action in which a final court judgment or settlement was reached.

10. indication that the Medical Staff member continues to meet all the other qualifications for Medical Staff membership as detailed in Article VI, Part A, Section 2 of these Bylaws.

ARTICLE VII - PART A: Section 3. Section Chief Procedure:

(a) No later than three months prior to the end of the current appointment period, the Chief Executive Officer shall send to the Chief of each section a current list of all members who have clinical

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74 Revision(s) made July 2009
75 Revision(s) made June 2015
privileges in that Section, together with a description of the clinical privileges each holds, accompanied by copies of their applications.

(b) The Chief shall include in each written report, when applicable, the reasons for any changes recommended in staff category, in clinical privileges, or for non-reappointment for those who applied for changes and for those who did not.

(c) Criteria for evaluating requests for increase or decrease of clinical privileges shall be based upon Article VI, Part E: Section 1 and the following:

(1) relevant recent training,
(2) observation of patient care provided,
(3) review of the records of patients treated in this or other hospitals.
(4) results of the Medical Staff's Performance Improvement Activities.
(5) other reasonable indicators of the individual's qualifications for the privileges in question such as peer review recommendations.

ARTICLE VII - PART A: Section 4. Medical Executive Committee Procedure:

(a) The Medical Executive Committee, after receiving the report from the Section Chief, shall review all pertinent information available for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing appointment period.

(b) As part of the process of making its recommendation, the Medical Executive Committee may require that an individual currently seeking reappointment procure a physical and/or mental examination by a physician or physicians satisfactory to the Medical Executive Committee and the affected individual either as part of the reapplication process or during the appointment period to aid it in determining whether clinical privileges should be granted or continued. The results of such examination shall be available to the Medical Executive Committee for consideration. The results of such physical and/or mental examination shall also be provided to the applicant. Any costs incurred for such examination shall be borne by the individual concerned. Failure of an individual seeking reappointment to procure such an examination within 45 days after being requested to do so in writing by the Medical Executive Committee shall constitute a voluntary relinquishment of all Medical Staff and clinical privileges until such time as the Medical Executive Committee has received the examination results and has had 45 days to evaluate them and make a recommendation thereon.

(c) The Medical Executive Committee shall have the right to require the staff member to meet with the Committee to discuss any aspect of the individual's reappointment application, qualifications, or clinical privileges requested.

(d) The Medical Executive Committee may use the expertise of the Section Chief, or any member of the Section, or an outside consultant, if additional research is required into the member's qualifications for reappointment.

ARTICLE VII - PART A: Section 5. Medical Executive Committee Recommendations:

(a) Upon receipt of favorable recommendations from the Medical Executive Committee that the individual be granted reappointment and the requested clinical privileges, the Board of Directors may:
(1) reappoint the individual and grant clinical privileges as recommended, or
(2) reject the recommendations.

(b) If the Board of Directors determines to reject the favorable recommendations of the Medical Executive Committees, it should first discuss the matter with the Chairperson of that Committee, or it

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76 Revision(s) made July 2009
may refer the matter back to that Committee for further research, investigation, and recommendation. If the Board of Director's determination remains unfavorable to the individual, that determination with the reasons therefore shall be sent to the Chief Executive Officer, who shall promptly give Special Notice to the Medical Staff member, advising said member of his/her right to a hearing and appeal as set forth elsewhere in these Bylaws.

(c) If the Medical Executive Committee’s recommendation is also unfavorable, the unfavorable recommendation shall be forwarded to the Chief Executive Officer who shall promptly so notify the individual by Special Notice. The individual shall then have an opportunity to exercise the right to a hearing and appeal as provided in these Bylaws.

ARTICLE VII - PART B: PROCEDURES FOR REQUESTING ADDITIONAL CLINICAL PRIVILEGES

ARTICLE VII - PART B: Section 1. Application for Additional Clinical Privileges:
Whenever, during the term of an appointment to the Medical Staff, additional clinical privileges are desired, the staff member requesting additional privileges shall apply in writing to the Medical Staff Office. The application shall state in detail the specific additional clinical privileges desired and the member’s relevant recent training and experience, which justify additional privileges. Thereafter, it will be processed in the same manner as an application for initial clinical privileges if the request is made during the term of appointment, or as part of the reappointment application if the request is made at that time.

ARTICLE VII - PART B: Section 2. Factors to be Considered:
Recommendations for additional clinical privileges made to the Board of Directors shall be based upon:

(a) relevant recent training and experience.

(b) observation of patient care provided.

(c) review of the records of patients treated in this or other hospitals.

(d) results of the Medical Staff's Performance Improvement activities.

(e) other reasonable indicators of the individual's continuing qualifications for the privileges in question.

The recommendation for such additional privileges may carry with it such requirements for supervision or consultation.

The recommendation for such additional privileges shall designate the time period for which such additional privileges are provisional and shall also designate the proctoring Medical Staff member. The appropriate Section Chief shall appoint the proctoring Medical Staff member.

ARTICLE VII - PART C: PROCEDURE FOR OTHER QUESTIONS INVOLVING MEDICAL STAFF MEMBERS:

ARTICLE VII - PART C: Section 1. Grounds for Action:
Whenever, on the basis of information and belief, the President of the Medical Staff, the Chief of a Clinical Section, the Chairperson or a majority of any Medical Staff Committee, the Chairperson of the Board of Directors, or the Chief Executive Officer has cause to question:

(a) the clinical competence of any Medical Staff member or Allied Health Professional; or

(b) the care or treatment of a patient or patients or management of a case by any Medical Staff member or Allied Health Professional; or

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77 Revision(s) made July 2009
78 Revision(s) made July 2009
(c) the known or suspected violation by a Medical Staff member or Allied Health Professional of applicable ethical standards or the Medical Staff Bylaws, Policies, Rules, and Regulations, including, but not limited to, the Performance Improvement Programs; or

(d) behavior or conduct on the part of any Medical Staff member or Allied Health Professional that is considered lower than the standards of the Medical Staff or disruptive of the ability to provide quality care to the patients.

That person shall address a written request for an investigation of the matter to the President of the Medical Staff making specific reference to the activity or conduct, which gave rise to the request. The President of the Medical Staff, after receiving the written request for investigation of the matter, may:

(a) Refer the matter to the Committee on Physician Health.

(b) Confer with the Medical Executive Committee to determine whether an Ad Hoc Committee should be formed to investigate the matter.

**ARTICLE VII - PART C: Section 2, Investigative Procedure:**

After being informed by the President of the Medical Staff, the Medical Executive Committee shall immediately investigate the matter, appoint a subcommittee to do so, or appoint an Ad Hoc Investigating Committee consisting of up to three persons, all holding appointment to the Medical Staff. This Committee shall not include partners, associates, or relatives of the individual being investigated, or any individual who is in direct economic competition with the individual being investigated.

(a) The Medical Executive Committee, its subcommittee, or the Ad Hoc Investigating Committee shall have available to it the full resources of the Medical Staff and the hospital to aid in its work, as well as the authority to use outside consultants, if needed. The Committee may also require a physical and mental examination of the individual being investigated, by a physician or physicians satisfactory to the Committee and shall require that the results of such examination be made available for the Committee's consideration. The results of such physical and/or mental examination shall also be provided to the member. Any costs incurred for such examination shall be borne by the individual concerned.

(b) The individual being investigated may have an opportunity to meet with the Investigating Committee before it makes its report. This interview shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. A summary of such interview shall be made by the Investigating Committee and included with its report to the Medical Executive Committee.

(c) If a subcommittee or Ad Hoc Investigating Committee is used, the Medical Executive Committee may accept, modify, or reject the recommendation it receives from that Committee.

**ARTICLE VII - PART C: Section 3, Procedure Thereafter:**

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

(1) that no action is justified.
(2) to issue a written warning.
(3) to issue a letter of reprimand.
(4) to impose terms of probation.
(5) to impose a requirement for consultation.
(6) to reduce clinical privileges.
(7) to recommend revocation of staff appointment.
(8) to take other action as it deems necessary or appropriate, including summarily suspending or terminating medical staff membership and/or clinical privileges.

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79 Revision(s) made July 2009
80 Revision(s) made July 2009
81 Revision(s) made July 2009
(b) If the action of the Medical Executive Committee does not entitle the individual to a hearing, the action shall take effect immediately. A report of the action taken and reasons therefore shall be made to the Board of Directors through the Chief Executive Officer and the action shall stand unless modified by the Board of Directors.

(c) Any recommendation by the Medical Executive Committee that would entitle the affected individual to the procedural rights provided in these Bylaws shall be forwarded to the Chief Executive Officer who shall promptly notify the affected individual by Special Notice. The Chief Executive Officer shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing as provided in these Bylaws. Thereafter, the Chief Executive Officer shall forward the recommendation of the Medical Executive Committee, together with all supporting information, to the Board of Directors. The Chairperson of the Medical Executive Committee shall be available to the Board of Directors to answer any questions that may be raised with respect to the recommendation.

(d) In the event the Board of Directors determines to consider modification of the action of the Medical Executive Committee and such modification would entitle the individual to a hearing, it shall so notify the affected individual through the Chief Executive Officer.

ARTICLE VII - PART D: SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

ARTICLE VII - PART D: Section 1. Grounds for Summary Suspension:

(a) The President of the Medical Staff (or an appropriate designee), on request by: a member of the Medical Staff, the Chief Executive Officer or designee, a member of the Medical Executive Committee, a Section Chief, the Chairperson of the Committee on Physician Health, or the Board of Directors, shall have the authority to summarily suspend any portion or all of the clinical privileges of a Medical Staff member or other individual whenever failure to take such action may result in an imminent danger to the health of any individual. Such suspension shall not imply any final finding of responsibility for the situation that caused the suspension.

For purposes of Summary Suspension, the following individuals, in order of priority, shall be deemed appropriate designees of the President of the Medical Staff if he or she is unavailable: 82

(1) Vice President of the Medical Staff
(2) Chief of the Section involved
(3) Immediate Past President of the Medical Staff
(4) Secretary/Treasurer of the Medical Executive Committee
(5) Other Section Chiefs
(6) Member-at-Large of the Medical Executive Committee with the longer tenure
(7) Member-at-Large of the Medical Executive Committee with the shorter tenure

If none of these persons is available to make a decision regarding summary suspension, the Chief Executive Officer has the authority to summarily suspend an individual's clinical privileges.

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

(c) The President of the Medical Staff or a designee from the Medical Executive Committee shall immediately by Special Notice inform the member of the summary suspension, detailing the conduct or actions that caused concern for imminent danger to the health of an individual. In conjunction with this notice, the hospital Chief Executive Officer shall be notified of the summary suspension.

82 Revision(s) made July 2009
Special Notice shall also inform the member of his right to a prompt meeting with the Medical Executive Committee and of rights as to the hearing and appeals process83.

(d) **ARTICLE VII - PART D: Section 2. Medical Executive Committee Procedure:**
The Medical Executive Committee shall investigate the matter following the procedures outlined elsewhere in this Article and meet within seven (7) days of the imposition of the summary suspension. The affected member or Allied Health Professional84 shall be allowed to question the summary suspension at this meeting. Since this meeting is not a hearing, none of the procedural rules of a hearing shall apply. If the action of the Medical Executive Committee is other than lifting the suspension, the affected member shall be entitled to a hearing and appeal as detailed in this Article.

**ARTICLE VII - PART D: Section 3. Care of Suspended Individual's Patient:**

‘(a) Immediately upon the imposition of a summary suspension, the appropriate Section Chief or, if unavailable, the President of the Medical Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's patients still in the hospital at the time of such suspension until such time as they are discharged. The wishes of the patient shall be considered in the selection of a substitute member.

‘(b) It shall be the duty of the President of the Medical Staff and the Section Chief to cooperate with the Chief Executive Officer in enforcing all suspensions.

**ARTICLE VII - PART E: OTHER ACTIONS**

**ARTICLE VII - PART E: Section 1. Failure to Complete Medical Records:**
A completed medical record has the history and physical exam report, operative procedure report, consultations, and discharge summary, all orders, and progress notes completed and signed within thirty (30) days after patient discharge. Privileges shall be voluntarily relinquished if the medical records are not completed within this period.85

**ARTICLE VII - PART E: Section 2. Action by State Licensing Agency:**
Action by the appropriate state licensing board or agency revoking or suspending an individual's professional license, or loss or lapse of state license to practice for any reason, shall result in voluntary relinquishment of all hospital clinical privileges as of that date, until the matter is resolved and the license restored. In the event the individual's license is restricted, the clinical privileges that would be affected by the license restriction shall be voluntarily relinquished.

**ARTICLE VII - PART E: Section 3. Failure to be Adequately Insured:**
If at any time a member or Allied Health Professional’s liability insurance coverage lapses, falls below the required minimum as determined by the Board of Directors, is terminated, or otherwise ceases to be in effect (in whole or in part), the member's or Allied Health Professional's clinical privileges shall be voluntarily relinquished as of that date until the matter is resolved and adequate professional liability insurance coverage is restored86.

**ARTICLE VII - PART E: Section 4: Failure to Pay Dues:**
All Active and Active Provisional medical Staff members are required to pay annual dues, the amount and due date to be determined by the Medical Executive Committee at its January meeting and approved by the Medical Staff. Failure to pay will constitute voluntary relinquishment of clinical privileges87.

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83 Revision(s) made July 2009  
84 Revision(s) made July 2009  
85 Revision(s) made July 2009  
86 Revision(s) made July 2009  
87 Revision(s) made July 2009
ARTICLE VII - PART E: Section 5. Procedure for Leave of Absence:

(a) Individual members of the Medical Staff may, for good cause, be granted leaves of absence by the Board of Directors upon recommendation by the Medical Executive Committee for a definitely-stated period of time not to exceed two (2) years leave of absence shall be defined as a greater than 90-day absence from the practice of medicine at St. James Healthcare. (Medical Staff members are requested, but not required, to notify the Chief of Staff or the Medical Staff Office if an absence of 30 to 90 days is contemplated.) Absence for longer than one (1) year shall constitute voluntary resignation of Medical Staff appointment and clinical privileges unless an exception is recommended by the Medical Executive Committee and is approved by the Board of Directors. During the time of the leave of absence, the Medical Staff membership of the individual is preserved for as long as the current appointment period is valid, but he/she shall not exercise his/her clinical privileges. He/she shall be excused from meeting attendance requirements and from Committee and other Medical Staff duties and responsibilities.88

(b) Requests for leaves of absence shall be made to the President of the Medical Staff or the Medical Executive Committee and shall state the beginning and ending dates of the requested leave. The Medical Executive Committee shall then forward the request to the Board of Directors with comment or recommendation as indicated89.

(c) If the leave of absence is 180 days or less, the Medical Staff member may resume clinical practice at the hospital upon filing a written statement with the President of the Medical Staff summarizing his/her activities undertaken during the leave of absence. The Medical Staff member shall also provide such other information as may be requested by the Medical Executive Committee at that time. If the leave of absence is 181 days or more, he/she shall be required to complete and submit a "Request for Reappointment" application to the Medical Executive Committee, who shall forward the request to the Board of Directors with comment or recommendation as indicated. The "Request for Reappointment" application should include a summary of activities undertaken during the leave of absence. Additional information may be requested from the Medical Staff member by the Medical Executive Committee or the Board of Directors as indicated.90

(d) In acting upon the request to resume clinical practice, the Board of Directors, upon recommendation of the Medical Executive Committee, may limit or modify the clinical privileges of the Medical Staff member. If limitations or modifications are imposed, the member has a right to initiate the hearing and appeals procedures of Article VII of these Bylaws.91

ARTICLE VII - PART F: CONFIDENTIALITY AND REPORTING

(a) Actions taken and recommendations made pursuant to this Article shall be treated as confidential in accordance with such policies regarding confidentiality as may be adopted by the Medical Staff. In addition, reports of actions taken pursuant to these Bylaws shall be made by the Chief Executive Officer to such governmental agencies as may be required by law.

(b) All records and other information generated in connection with and/or as a result of professional review activities shall be confidential. Such information shall not be disseminated to anyone other than a representative of this hospital or Medical Staff, nor be used in any way except that provided herein, or except if otherwise required by law or authorized by the practitioner. Any breach of confidentiality by an individual or Committee member may result in a professional peer review action, and/or may result in appropriate legal action to ensure that confidentiality is preserved.

88 Revision(s) made July 2009
89 Revision(s) made July 2009
90 Revision(s) made July 2009
91 Revision(s) made July 2009
ARTICLE VII - PART G: PEER REVIEW PROTECTION
All minutes, reports, recommendations, communications, and actions made or taken pursuant to these Bylaws are deemed to be covered by the provisions of any federal or state statute providing protection to peer review or related activities. Furthermore, those individuals, Committees, and panels charged with making reports, findings, recommendations, or investigations pursuant to these Bylaws shall be considered to be acting on behalf of the hospital and its Board of Directors when engaged in such professional review activities, and thus shall be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.
ARTICLE VIII
HEARING AND APPEAL PROCEDURES

ARTICLE VIII - PART A: INITIATION OF HEARING
An applicant or an individual holding a Medical Staff appointment shall be entitled to a hearing whenever the Medical Executive Committee or the Board of Directors has made a recommendation unfavorable to him/her regarding those matters enumerated in Part B, Section 1 of this Article. The purpose of the hearing is to determine the true facts of an allegation, to determine if those facts warrant an adverse decision against the individual, and to recommend a course of action to the Medical Staff or Board of Directors. According the hearing shall be conducted in as informal a manner as possible, subject to the rules and procedures of these Bylaws.

ARTICLE VIII - PART B: THE HEARING

ARTICLE VIII - PART B: Section 1. Grounds for Hearing:
No recommendation or action other than those hereinafter enumerated shall constitute grounds for a hearing:

(a) denial of initial Medical Staff appointment.
(b) denial of requested advancement in Medical Staff category.
(c) denial of Medical Staff reappointment.
(d) revocation of Medical Staff appointment.
(e) denial of requested initial clinical privileges.
(f) denial of requested increased clinical privileges.
(g) decrease of clinical privileges.
(h) suspension of clinical privileges.
(i) imposition of mandatory concurring consultation requirement.

ARTICLE VIII - PART B: Section 2. Notice of Recommendation:
When a recommendation is made which, according to these Bylaws, entitles an individual to a hearing prior to a final decision of the Board of Directors on that recommendation, the affected individual shall promptly be given a Special Notice by the Chief Executive Officer. This Special Notice shall contain:

(a) a statement of the recommendation made and the specific reasons for it as outlined elsewhere in this Article.
(b) notice that the individual has the right to requesting a hearing on the recommendation within thirty (30) days of receipt of the notice.

ARTICLE VIII - PART B: Section 3. Request for Hearing:
Such individual shall have thirty (30) days following the date of the receipt of such notice within which to request a hearing. The request shall be made in writing to the Chief Executive Officer. In the event the affected individual does not request a hearing within the time and in the manner herein above set forth, the individual shall be deemed to have waived the right to such hearing and to have accepted the action involved. The action shall become effective immediately upon final Board of Directors action.
ARTICLE VIII - PART B: Section 4. Notice of Hearing and Statement of Reasons:

(a) The President of the Medical Staff and the Chief Executive Officer shall schedule the hearing and shall give Special Notice to the person who requested the hearing. The notice shall include:

1. the time, place, and date of the hearing.
2. a proposed list of witnesses who will give testimony or evidence at the hearing in support of the Medical Executive Committee or the Board of Directors.
3. the names of the Hearing Panel members/Hearing Officer, if known.
4. A statement of the specific reasons for the recommendation as well as the list of records and information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or revised at any time, even during the hearing, so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing. The individual and his or her counsel shall have sufficient time, up to fifteen (15) days, to study this additional information and rebut it.

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

ARTICLE VIII - PART B: Section 5. Witness List:
The individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on the affected individual's behalf within ten (10) days after receiving notice of the hearing. The witness list of either party may, in the discretion of the Presiding Officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The Presiding Officer shall have the authority to limit the number of witnesses.

ARTICLE VIII - PART B: Section 6. Hearing Panel or Officer:

(a) Hearing Panel:

1. When a hearing is requested, the Chief Executive Officer, acting for the Board of Directors and after considering the recommendations of the President of the Medical Staff (and that of the Chairperson of the Board of Directors, if the hearing is occasioned by a Board of Directors determination) shall appoint a Hearing Panel which shall be composed of not less than three (3) members. The Panel shall be composed of Active Medical Staff members who are impartial peers and who shall not have actively participated in consideration of the current problem.
2. The Hearing Panel shall not include any individual who is in direct economic competition with the affected person or any such individual who is professionally associated with or related to the affected person. Such appointment shall include designation of a Chairperson or the Presiding Officer. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel.

(b) Presiding Officer:

1. In lieu of a Hearing Panel Chairperson, the Chief Executive Officer may appoint an attorney at law as Presiding Officer. Such Presiding Officer must not act as a prosecuting officer, or as an advocate for either side at the hearing. The Presiding Officer, if appointed, must be acceptable to the individual being heard, the Hearing Panel, and the Board of Directors.
2. If no Presiding Officer has been appointed, the Chairperson of the Hearing Panel shall serve as the Presiding Officer, and shall be entitled to one (1) vote.
3. The Presiding Officer (or Hearing Panel Chairperson) shall:
   (i) act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross-examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.
   (ii) maintain decorum throughout the hearing.
   (iii) determine the order of procedure throughout the hearing.
(iv) have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions, which pertain to matters of procedure and to the admissibility of evidence.

(v) act in such a way that all information relevant to the continued appointment or clinic privileges of the person requesting the hearing is considered by the Hearing Panel in formulating its recommendations.

**ARTICLE VIII - PART B: Section 7. Failure to Appear:**

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions pending, which shall then become final and effective immediately.

**ARTICLE VIII - PART B: Section 8. Postponements and Extensions:**

Postponements and extensions of time beyond any time limit set forth in these Bylaws may be requested by anyone, but shall be permitted only by the Hearing Panel, its Chairperson, or the entity which appointed the Hearing Panel on a showing of good cause.

**ARTICLE VIII - PART C: HEARING PROCEDURE:**

**ARTICLE VIII - PART C: Section 1. Rights of Both Sides:**

At a hearing, both sides shall have the following rights:

(a) to call and examine witnesses to the extent available.

(b) to introduce exhibits.

(c) to cross-examine any witness on any matter relevant to the issues and to rebut any evidence.

(d) to be represented by counsel who may examine witnesses and present the case. Both sides shall notify the other of the name of that counsel at least ten (10) days prior to the date of the hearing.

(e) to call and examine any individuals requesting a hearing who do not testify in their own behalf as if under cross-examination.

**ARTICLE VIII - PART C: Section 2. Admissibility of Evidence:**

The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. The Presiding Officer will admit any relevant evidence if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities and the Hearing Panel may request such a memorandum to be filed following the close of the hearing. The Hearing Panel may interrogate the witnesses, call additional witnesses, or request documentary evidence if it deems it appropriate.

**ARTICLE VIII - PART C: Section 3. Official Notice:**

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

**ARTICLE VIII - PART C: Section 4. Record of Hearing:**

The Hearing Panel shall maintain a record of the hearing by either a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. The Hearing Panel may, but shall not be required to, order that oral evidence shall be taken
only on oath or affirmation administered by such person designated by such body and entitled to notarize documents in the State of Montana.

ARTICLE VIII - PART D: HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS:

ARTICLE VIII - PART D: Section 1. Burden of Proof:
At any hearing conducted under this Article, the following rules governing the burden of proof shall apply:

(a) The Board of Directors or the Medical Executive Committee, depending on whose recommendation prompted the hearing initially, shall first come forward with evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to come forward with evidence.

(b) When a hearing relates to an initial application for Medical Staff appointment under Article VI of these Bylaws, the applicant has the burden of proving by the more convincing evidence that he or she is qualified for or entitled to Medical Staff appointment. In all other matters, the body whose action occasioned the hearing has the burden of proving by the more convincing evidence that the recommended action be implemented.

ARTICLE VIII - PART D: Section 2. Basis of Decision:
The decision of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

(a) oral testimony of witnesses.

(b) memorandum of points and authorities presented in connection with the hearing.

(c) any information regarding the individual who requested the hearing so long as that information has been admitted into evidence at the hearing and the individual who requested the hearing had the opportunity to comment on and, by other evidence, refute it.

(d) any and all applications, references, and accompanying documents.

(e) other documented evidence, including medical records.

(f) any other evidence that has been admitted.

ARTICLE VIII - PART D: Section 3. Attendance by Panel Members:
All members of the Hearing Panel shall be expected to be present at all sessions of the Panel.

ARTICLE VIII - PART D: Section 4. Adjournment and Conclusion:
The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the participants without Special Notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

ARTICLE VIII - PART D: Section 5. Deliberations and Recommendation of the Hearing Panel:
Within twenty (20) days after final adjournment of the hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons justifying the recommendation made, and shall deliver such report to the Chief Executive Officer.

ARTICLE VIII - PART D: Section 6. Disposition of Hearing Panel Report:
The Hearing Panel shall deliver its report and recommendation to the Chief Executive Officer who shall forward it, along with all supporting documentation, to the Board of Directors for further action. The Chief Executive Officer shall also send a copy of the report and recommendation, return receipt requested, to the individual who requested the hearing. If the hearing has been conducted by reason of an adverse
recommendation by the Medical Executive Committee, the Chief Executive Officer shall deliver a copy of the report of the Hearing Panel to that Committee for informational purposes.

**ARTICLE VIII - PART E: APPEAL**

**ARTICLE VIII - PART E: Section 1. Time for Appeal:**
Within ten (10) days after notice of the Hearing Panel’s recommendation, either party may request an appellate review. The request shall be in writing, and shall be delivered to the President of the Medical Staff, the Medical Executive Committee, and the Chief Executive Officer either in person or by certified mail, return receipt requested, and shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within ten (10) days as provided herein, both parties shall be deemed to have accepted the recommendation and it shall thereupon be considered by the Board of Directors for final action as the Board of Directors, in its discretion, may determine.92

**ARTICLE VIII - PART E: Section 2. Grounds for Appeal:**
The grounds for appeal shall be that:

(a) there was substantial failure to comply with these Bylaws so as to deny due process or a fair hearing; or

(b) the recommendations by the Hearing Panel were made arbitrarily, capriciously, or with prejudice; or

(c) the recommendations of the Hearing Panel were not supported by substantial evidence.

**ARTICLE VIII - PART E: Section 3. Time, Place, and Notice:**
Whenever an appeal is requested as set forth in the preceding sections, the Chairperson of the Board of Directors shall, within ten (10) days after receipt of such request, schedule, and arrange for an appellate review. The Board of Directors shall cause the affected individual to be given notice of the time, place, and date of the appellate review. The date of appellate review shall be not less than twenty (20) days, nor more than forty (40) days, from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from a member who is under a suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than fourteen (14) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chairperson of the Board of Directors for good cause.93

**ARTICLE VIII - PART E: Section 4. Nature of Appellate Review:**

(a) The Chairperson of the Board of Directors shall appoint a Review Panel composed of not less than three (3) persons, either members of the Board of Directors or others including, but not limited to, reputable persons outside the hospital, or any combination of the same, to consider the record upon which the recommendation before it was made.94

(b) The Review Panel may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that any opportunity to admit it at the hearing was denied, and then only at the discretion of the Review Panel.

(c) Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the Review Panel or Board of Directors may allow each party or their representatives to appear personally and make oral argument. The Review Panel shall recommend final action to the Board of Directors.95

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92 Revision(s) made July 2009
93 Revision(s) made July 2009
94 Revision(s) made July 2009
95 Revision(s) made July 2009

Revised September 2018
(d) The Board of Directors may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation. In the event the Board of Directors determines to modify or reverse the recommendation of the Review Panel and such action would entitle the affected individual to a hearing in accordance with these Bylaws, it shall so notify the affected individual through the Chief Executive Officer, and shall take no final action thereon until the individual has exercised or has waived the procedural rights so provided.\(^96\)

**ARTICLE VIII - PART E: Section 5. Final Decision of the Board of Directors:**

Within thirty (30) days after receipt of the Review Panel’s recommendation, the Board of Directors shall render a final decision in writing and shall deliver copies thereof to the affected individual and to the President of the Medical Staff, in person or by certified mail, return receipt requested\(^97\).

**ARTICLE VIII - PART E: Section 6. Further Review:**

Except where the matter is referred for further action and recommendation in accordance with Section 4 of this Part, the final decision of the Board of Directors following the appeal shall be effective immediately and shall not be subject to further review. Provided, however, if the matter is referred for further action and recommendation, such recommendations shall be promptly made to the Board of Directors in accordance with the instructions given by the Board of Directors. This further review process and the report back to the Board of Directors shall in no event exceed thirty (30) days in duration except as the parties may otherwise stipulate\(^98\).

**ARTICLE VIII - PART E: Section 7. Right to One Appeal Only:**

No applicant, Medical Staff member or Allied Health Professional shall be entitled as a matter of right to more than one appellate review on any single matter, which may be the subject of an appeal. In the event that the Board of Directors ultimately determines to deny initial Medical Staff or Allied Health Professional appointment or reappointment, or to revoke or terminate the Medical Staff or Allied Health Professional appointment and/or clinical privileges as significant circumstances / facts warrant review, as determined by the Medical Executive Committee, that individual may not again apply for Medical Staff or Allied Health Professional appointment or clinical privileges at this hospital unless the Board of Directors provides otherwise. However, nothing in these Bylaws shall restrict the right of the applicant to reapply for appointment to the Medical Staff or restrict the right of a staff member to apply for reappointment and clinical privileges as circumstances and facts warrant\(^99\).

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\(^96\) Revision(s) made July 2009  
\(^97\) Revision(s) made July 2009  
\(^98\) Revision(s) made July 2009  
\(^99\) Revision(s) made July 2009
ARTICLE IX
ALLIED HEALTH PROFESSIONALS

ARTICLE IX - PART A: ALLIED HEALTH PROFESSIONALS

ARTICLE IX - PART A: Section 1. General:
Allied Health Professionals are not members of the Medical Staff and, accordingly, have none of the membership rights or responsibilities of Medical Staff members and specifically do not have the same hearing and due process rights as those accorded to the Medical Staff. The due process rights of Allied Health Professionals are limited to those outlined in Article IX Part C of these Bylaws.

The Medical Staff has the responsibility of assuring that the quality of care at this hospital meets generally recognized standards and also has the responsibility of ensuring insofar as possible that no harm comes to patients who receive treatment at this hospital. The Medical Staff and its Sections and Committees shall review the credentials and activities of Allied Health Professionals and make recommendations to the Board of Directors regarding Allied Health Professionals including recommendations regarding their scope of practice.

ARTICLE IX - PART A: Section 2. Qualifications of Allied Health Professionals:
Each Allied Health Professional must hold a current license, certificate, or such other credentials as may be required by Montana State Law and these Medical Staff Bylaws, Rules, and Regulations; and must satisfy the basic qualifications required for appointment, including professional liability insurance coverage and current competence in a discipline which the Board of Directors has determined to allow Allied Health Professionals to practice in the hospital.

ARTICLE IX - PART A: Section 3. Prescribing and Dispensing Drugs by Allied Health Professionals:
Allied Health Professionals shall have prescriptive authority, pursuant to applicable state and federal laws, and pursuant to applicable sections of the St. James Healthcare Bylaws, Rules, and Regulations. Granting of this privilege will be considered upon presentation of proper certification of prescriptive authority by the appropriate Montana Professional Licensing Board or authority and current DEA license, to the Administrative Medical Staff Coordinator.

ARTICLE IX - PART A: Section 4. Scope of Practice:
An individual Allied Health Professional’s scope of practice shall be defined by their clinical privileges, recommended by the Medical Executive Committee and approved by the Board of Directors.

ARTICLE IX - PART A: Section 5. Application for Clinical Privileges
Application for clinical privileges as an Allied Health Professional shall be processed in accordance with established procedures to verify education, training, skills, current clinical competence in the areas of requested clinical privileges and any other area that might be necessary to ascertain suitability granting of clinical privileges and as may change from time to time.

ARTICLE IX - PART A: Section 6. Attendance at Medical Staff Functions:
Allied Health Professionals may attend, without vote, appropriate Committee or Section meetings as determined by the Committee Chairperson or Section Chief of that Section. Such individuals may be invited by the President of the Medical Staff to attend Medical Staff meetings, but they shall not be allowed to vote.

100 The AHP entire section was re-written in October 2010
ARTICLE IX - PART A: Section 7: Loss or Curtailment of Supervising Physician of Allied Health Professional

The clinical privileges of an Allied Health Professional within the hospital shall terminate immediately if the Medical Staff appointment/reappointment, or clinical privileges, of the Allied Health Professional’s supervising physician is terminated for any reason.

ARTICLE IX – PART B: REAPPOINTMENT OF ALLIED HEALTH PROFESSIONALS:

ARTICLE IX – PART B: Section 1: Reappointment:

Reappointment of Allied Health Professionals, shall be processed in accordance with established procedure to verify education, training, skills, current clinical competence, and any other area that might be necessary to ascertain suitability for reaffirmation of clinical privileges and as may change from time to time. Except in extenuating circumstances acceptable to the Medical Executive Committee and the Board of Directors, if the application for reappointment is incomplete and such incompleteness continues beyond 60 days, then the reapplication shall be considered to have not been made and the clinical privileges of the Allied Health Professional shall be terminated.

ARTICLE IX - PART C: REMOVAL PROCEDURES:

ARTICLE IX – PART C: Section 1: General:

The Board of Directors has the right, either of its own volition or upon recommendation of the Medical Executive Committee to the Board of Directors, to suspend or terminate any or all of the clinical privileges, prerogatives, or functions of an Allied Health Professional without recourse on the part of such person to the hearing procedures of these Bylaws.

Allied Health Professionals who are to be terminated or have their clinical privileges modified, shall be notified by the Chief Executive Officer of the reasons for such action and, if they so request within thirty (30) days, shall be entitled to have such action reviewed by the Medical Executive Committee. At any review meeting, the professional shall be allowed to be present and to fully participate, except that he or she shall not be allowed to vote. The Medical Executive Committee can recommend to the Board of Directors to accept, reject, or modify the decision, but the final determination shall be at the discretion of the Board of Directors.
ARTICLE X
REQUIREMENTS FOR COMPLETION OF HISTORY AND PHYSICAL EXAMINATIONS

A. History and Physical Report: A History and Physical Report may be completed no more than thirty (30) days before each admission to inpatient services. Any history of physical examination performed prior to admission must be updated within 24 hours after admission. Inpatients and outpatients undergoing invasive or therapeutic procedures aside from routine lab procedures and diagnostic radiological procedures must have a History and Physical Examination Report completed and recorded on the chart prior to the performance of the procedure. Any history and physical examination performed prior to the date of the invasive or therapeutic procedure must be updated by the provider performing the invasive or therapeutic procedure on the day of and prior to initiation of such procedure.\textsuperscript{101}

Outpatients undergoing invasive or therapeutic procedures aside from routine laboratory procedures and diagnostic radiological procedures must have a History and Physical Examination Report completed and recorded on the chart prior to performance of the procedure. A History and Physical Examination Report shall be completed no more than thirty (30) calendar days prior to outpatient procedures. Any history of physical examination performed more than 24 hours prior to the outpatient admission must be updated prior to the outpatient procedure. The medical record shall be considered delinquent if these standards are not met. A complete History and Physical Report has the following components:\textsuperscript{102}:

1. Chief complaint.
2. History of present illness.
3. Past medical history (including allergies, medications, clotting disturbances, and habits).
4. Family History.
5. System Review:
6. Appropriate physical examination:
7. Course of action planned during the hospital stay.
8. Impression/Diagnosis.

ARTICLE XI
RULES AND REGULATIONS OF THE MEDICAL STAFF

ARTICLE XI – PART A: RULES AND REGULATIONS OF THE MEDICAL STAFF

(a) Medical Staff Rules and Regulations shall implement more specifically the general principles outlined in these Bylaws. All Rules and Regulations of the Medical Staff (General and Sectional) shall be voted upon by the Medical Staff. In no way shall the Medical Staff Rules and Regulations be used to circumvent or abridge the effect and intent of these Bylaws.

(b) Medical Staff Rules and Regulations will be kept with the Bylaws and will be reviewed annually by the Medical Staff Bylaws Committee to assure that the Rules and Regulations reflect current medical and surgical practice in the hospital.

(c) Medical Staff Rules and Regulations shall be divided into "general" and "sectional" rules and regulations:

(1) General - shall contain such Rules and Regulations as are pertinent to the entire Medical Staff and Allied Health Professionals. These Rules and Regulations shall include, but not be limited to, such areas as medical records, standing and stop orders, continuing medical education, etc.

\textsuperscript{101} Revision(s) made July 2009
\textsuperscript{102} Revision(s) made July 2009
(2) **Sectional** - shall contain Rules and Regulations that apply to specific areas of the hospital such as Pediatrics, the Emergency Department, Surgery, ICU/CCU, Telemetry Unit, etc. Each clinical Section (or appropriate Committee) shall annually review the Sectional Rules and Regulations pertinent to it for compliance with hospital policies and government regulations, and for continuing quality medical care at the hospital.

All proposed changes and method for voting on these Rules & Regulations are in accordance to Article XI: Part A, Section 2. Changes in Rules and Regulations & Policies and Procedures – Article XI.

**ARTICLE XI: AMENDMENTS**

**ARTICLE XI: PART A, Section 1: BYLAWS AMENDMENTS - ARTICLES I - X:**

All proposed amendments to these Bylaws initiated by the Bylaws Committee or Medical Staff shall, as a matter of procedure, be referred to the Medical Executive Committee. The Medical Executive Committee shall report on them either favorably or unfavorably at a regular meeting of the Medical Staff or at a special meeting called for such purposes. Any proposed amendment to the Bylaws will be presented to the Medical Staff who are eligible to vote by mail, fax, or electronically. The ballot will include an explanation of the proposed changes and have a return date of at least 14 days after the ballot was sent. The ballots will be counted by the Medical Staff Coordinator and verified by the President of the Medical Staff or designee, and passage will require an affirmative vote by 2/3 (two/thirds) of the Medical Staff Members voting as long as a Medical Staff Meeting quorum of members vote. Bylaw changes adopted by the Medical Staff shall become effective following approval by the Board of Directors, which approval shall not be withheld unreasonably. If approval is withheld, the reasons for doing so shall be specified by the Board of Directors in writing to the President of the Medical Staff and the Bylaws Committee. The Medical Staff Bylaws are not unilaterally amended.

**ARTICLE XI: PART A, Section 2, CHANGES IN RULES & REGULATIONS & POLICIES AND PROCEDURES - ARTICLE XI**

All proposed changes to these Rules & Regulations and Policies and Procedures are initiated by the Bylaws Committee or Medical Staff and shall be referred to the Medical Executive Committee. The Medical Executive Committee shall report on them either favorably or unfavorably at a regular meeting of the Medical Staff or at a special meeting called for such purposes. Any proposed amendment to the Rules & Regulations and Policies and Procedures will be presented to the Medical Staff who are eligible to vote by mail, fax, or electronic mail. The ballot will include an explanation of the proposed changes and have a return date of at least 14 days after the ballot was sent. The ballots will be counted by the Medical Staff Coordinator and verified by the President of the Medical Staff or designee, and passage will require an affirmative vote by more than 50% of the Medical Staff Members voting as long as a Medical Staff Meeting quorum of members vote.

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103 Added Paragraph February 2013
104 Revisions made ARTICLE XI - Amendments June 2012
ARTICLE XII
ADOPTION

ARTICLE XII, PART A: ADOPTION

(a) These Bylaws are adopted and made effective upon vote of the Medical Staff and approval of the Board of Directors, superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each individual exercising clinical privileges in the hospital shall be taken under and pursuant to the requirements of these Bylaws.

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

Adopted by the Medical Staff on:

June 12, 2015

Approved by the Board of Directors on:

June 12, 2015
GENERAL

MEDICAL STAFF MS-001
RULES AND REGULATIONS

Reappointment/Reappraisal
The St. James Healthcare Medical Staff, through its organized structure has a responsibility to monitor, oversee and make appropriate recommendations to the governing body of St. James Healthcare regarding the quality and safety of professional services provided by individuals with clinical privileges. Biannually, members of the Medical Staff and Allied Health Professionals are considered for reappointment and reappraisal of clinical privileges. Reappointment and/or the renewal or revision of clinical privileges is based on a reappraisal of the individual at the time of reappointment and/or the renewal or revision of clinical privileges. Such renewal of privileges and/or membership may not exceed a period of two years.

The reappraisal includes information concerning:

2. Ability to perform requested privileges.
5. Outcomes pertaining to clinical and/or technical skills, as reviewed through the Performance Improvement activities of the Medical Staff.
6. Whether provider’s practice is currently subject to review by outside agencies or by other health care facilities.
7. Current evidence of adequate professional liability insurance.
8. Participation in continuing education.
9. Medical record deficiencies or delinquency.
10. Malpractice claims history.
11. Medication and blood usage.
13. Operative and other procedure review.
14. Computer printouts of all the practitioner’s procedure performed in the hospital for the most recent past two years available.
15. Information which ensures that the practitioners do not practice outside their scope of privileges.

PROCEDURE:

1. During the second quarter of the appropriate year of reappointment, the Medical Staff Reappraisal/Reappointment form will be sent to each physician and allied health professional.

2. The form will be returned to the Administrative Medical Staff Coordinator and prepared for the appropriate Section meeting. If no response has been received after a period of 60 days from the mailing of the application for reappointment, a second letter will be sent by certified mail to the applicant requesting immediate return of application (within 14 days) or it will be considered that the applicant no longer wishes affiliation with St. James Healthcare.

3. The appropriate Section Chief or designee will review the pertinent information regarding the reappointment, non-reappointment, and/or clinical privileges of reappointment. If a change in clinical privileges is recommended, the reason for such recommendations shall be stated and documented. The form will then be transmitted to the Medical Executive Committee.

Revision(s) made July 2009
4. The Medical Executive Committee will review all pertinent information regarding the reappointment, non-reappointment, and/or clinical privileges of reappointment. If a change in clinical privileges is recommended, the reasons for such recommendation shall be stated and documented and forwarded to the Medical Executive Committee.

5. The Medical Executive Committee will review all pertinent information and make written recommendation to the Board of Directors, through the Chief Executive Officer regarding the reappointment, non-reappointment, and/or clinical privileges of reappointment. If a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented.

6. As a part of the Hospital's Performance Improvement Program, opportunities to improve care will be addressed and important problems in patient care will be identified and resolved. Monitoring is based on the rise of objective criteria that reflect current knowledge, clinical experience, and relevant literature. Conclusions, recommendations, actions taken, and results of actions taken are identified and reported. Educational opportunities will be identified that will support and increase quality patient care.

7. The Medical Staff Bylaws identify appropriate action, including a fair hearing, when the review of credentials and the recommendations regarding reappointment are adverse to the applicant.
   
   a. Initial appointment is for a provisional period, as specified in the Medical Staff Bylaws, and follows the same procedure as noted above.

8. Records and statistical information are stored within the hospital for the statutes of limitation.

9. The Medical Staff of St. James Healthcare has elected to adopt an electronic credentialing program. The program in effect shall be followed for delineation of privileges, appointment, and reappointment.
GENERAL

MEDICAL STAFF MS-002
RULES AND REGULATIONS

Protocol for the Physician Health Committee
In response to Article V, Part D, Section 5, Paragraph C, the following protocol has been developed:

The Medical Staff recognizes that impaired providers are individuals who have dedicated their lives to helping others and are now in need of help and recognizes that providing this help to impaired staff members is a primary goal of the Physician Health Committee. This Physician Health Committee will follow a non-punitive approach in which it and the Medical Staff work as advocates for, rather than adversaries of, the member while protecting patients and others from harm. The Bylaws and the Medical Staff also recognize that if there is a problem, necessary action must be taken for the protection of patients and the provider\textsuperscript{109}.

For all purposes except to ensure compliance with these Bylaws and to protect patients, hospital staff, and other staff members from harm, and to ensure quality and continuity of patient care, the proceedings of the Physician Health Committee will be held in strict confidence. Reports to the Medical Executive Committee should replace the provider’s name with a code. The identity of persons reporting to the Physician Health Committee or informants about the possible impairment of a staff member should be held in strictest confidence and should not be released to the impaired provider\textsuperscript{110}.

The Physician Health Committee shall meet yearly or as often as necessary to discharge its duties. Special meetings of the Physician Health Committee may be called by its Chairperson upon request by any of the permanent or special members, other staff Committee Chairpersons, Section Chiefs, the President of the Medical Staff, the Chief Executive Officer, or the Board of Directors.

The Physician Health Committee will advise the Medical Executive Committee, the Chief Executive Officer, or the Board of Directors about questions pertaining to its area of expertise, which may arise in the processing of new applications for appointment. The Physician Health Committee, in the discharge of its duties, will avail itself of the help and advice of the appropriate Professional Assistance Program. One of the Physician Health Committee’s initial duties will be to ensure, at least annually, that this program is still available and functioning\textsuperscript{111}.

The manner in which the Physician Health Committee discharges its duties will necessarily depend upon the manner in which its attention is drawn to the needs of a possibly impaired provider. The Physician Health Committee will evaluate all referrals regarding provider’s impairment. If the Physician Health Committee finds that no impairment exists, the complaint will be dismissed. If the Physician Health Committee finds that impairment does exist, with the assistance of the appropriate Professional Assistance Program, the Physician Health Committee will proceed as follows\textsuperscript{112}:

If the Physician Health Committee has received “official” notice of impairment of a provider from a staff Committee, the President of the Medical Staff, the Chief Executive Officer, or the Board of Directors, it will meet, formulate a plan of action as circumstances dictate, and designate one of its members to approach the possibly-impaired provider with available information and to offer assistance. The Physician Health Committee should then make a report to the Committee or individual making the “official” request for investigation or intervention. This report needs only to indicate that the matter has been recognized and is being resolved. A fuller report needs to be made to the Medical Executive Committee and to the Board of Directors without identifying the impaired provider\textsuperscript{113}.

\textsuperscript{109} Revision(s) made July 2009
\textsuperscript{110} Revision(s) made July 2009
\textsuperscript{111} Revision(s) made July 2009
\textsuperscript{112} Revision(s) made July 2009
\textsuperscript{113} Revision(s) made July 2009
If provider impairment is brought to the attention of the Physician Health Committee or one of its members through "unofficial" channels (concerned fellow staff member; hospital personnel; the member's friend; family; or the impaired member him/herself), the Physician Health Committee shall meet (by telephone is not precluded) and formulate a plan. The plan may vary as circumstances dictate, from watchful waiting to direct immediate confrontation and offer of assistance\textsuperscript{114}.

Regardless of the manner in which the suspected impairment is reported to the Physician Health Committee, there must be an evaluation of the credibility of the complaint, allegation, or concern by the Physician Health Committee\textsuperscript{115}.

If the provider refuses assistance, and if, in the opinion of the Physician Health Committee, the possibility exists of danger to the health and well-being of patients, other staff members, or hospital personnel, the Chairman of the Physician Health Committee will notify the President of the Medical Staff and the Chief Executive Officer. The individual provider so suspected of being impaired shall be apprised of this notification, if possible before notification of the President of the Medical Staff and the Chief Executive Officer. The matter then can be resolved as indicated by circumstances under other portions of the Bylaws of the Medical Staff\textsuperscript{116}.

If the impaired provider\textsuperscript{117} accepts the assistance of the Physician Health Committee, he/she must:

(a) agree to be responsible for all cost of diagnosis/treatment incurred.
(b) sign a waiver of provider/patient\textsuperscript{118} privileges with respect to diagnosis/treatment required pursuant to the plan of the Physician Health Committee. These reports from treating physician should be made directly to the Physician Health Committee and should be held in strictest confidence. Various nondisclosure laws such as Confidentiality of Alcohol and Drug Abuse Patient Record (part of Federal Law) would restrict release of such documents without a specific written release.
(c) acknowledge that by coming under the purview of the Physician Health Committee, he/she agrees to follow the plan formulated by the Physician Health Committee and the appropriate Professional Assistance Program, the matter then comes under the jurisdiction of the Bylaws of the Medical Staff and whatever corrective action is necessary will be recommended by the Physician Health Committee to the Medical Executive Committee.

It must be recognized by the Physician Health Committee that when a provider who is experiencing a mental/emotional disturbance, which has not impaired professional performance, seeks help with said mental/emotional disturbance, neither the provider nor the Physician Health Committee is obligated to inform anyone, and this protocol is not operative. All persons involved in these deliberations need be always aware that if a provider suffers from an emotional disturbance, it does not necessarily follow that his/her professional performance is impaired\textsuperscript{119}.

If the impaired provider accepts the help of the Physician Health Committee, the Physician Health Committee may recommend, but not be limited to recommending\textsuperscript{120}:

(a) continued practice by the impaired provider with careful oversight by the Physician Health Committee or a designated representative to ensure that no harm comes to patients, hospital personnel, or the impaired provider himself/herself\textsuperscript{121}.
(b) restriction of certain clinical privileges.
(c) the provider voluntarily agreeing not to admit or otherwise care for patients at St. James Healthcare for a designated time. The agreement that the impaired provider makes with the Physician Health

\textsuperscript{114} Revision(s) made July 2009
\textsuperscript{115} Revision(s) made July 2009
\textsuperscript{116} Revision(s) made July 2009
\textsuperscript{117} Revision(s) made July 2009
\textsuperscript{118} Revision(s) made July 2009
\textsuperscript{119} Revision(s) made July 2009
\textsuperscript{120} Revision(s) made July 2009
\textsuperscript{121} Revision(s) made July 2009
Committee or its designee does not constitute voluntary or involuntary relinquishment of Medical Staff
privileges. He/she would simply not be admitting, consulting upon, and otherwise caring for
hospital inpatients during the time of the agreement. Any inpatients under the care of the impaired
provider at the time of signing of the agreement would be assigned to the care of another Medical
Staff member by the Chairperson of the Physician Health Committee or the President of the
Medical Staff after taking the patient's wishes into consideration.\textsuperscript{122}

(d) voluntary formal leave of absence from practice at the hospital.

(e) physical exam, psychiatric exam, substance abuse evaluation, and appropriate treatment by
physicians or entities acceptable to both the impaired member and the Physician Health
Committee. The treating physicians or entities must make at appropriate intervals and especially at
the end of the treatment period reports to the Physician Health Committee. The Physician Health
Committee will utilize these reports and other communications when it makes its recommendation
to the Medical Executive Committee and the Hospital Board of Directors.

(f) periodic reevaluation and/or retesting of the impaired provider\textsuperscript{123} mental/physical status including
blood and urine testing. This is especially important during the "reentry into practice" phase of
his/her rehabilitation.

After an impaired provider\textsuperscript{124} has undergone appropriate treatment and is ready to reenter practice, the
Physician Health Committee may recommend to the Medical Executive Committee and the Hospital
Board of Directors that whatever limitations of privileges or practice restriction have been imposed be
lifted and the provider\textsuperscript{125} be allowed to reenter practice at the hospital. However, it must be remembered
that fulfillment of any contracts with the Physician Health Committee by an impaired provider\textsuperscript{126} does not
automatically entitle the practitioner to reinstatement of any staff privileges which may have been affected
by his/her impaired condition. Reinstatement is at the discretion of the Hospital Board of Directors.

The Physician Health Committee will report its activities to the appropriate\textsuperscript{127} Professional Assistance
Program. It is the responsibility of the appropriate\textsuperscript{1} Professional Assistance Program to report to its
licensing Board\textsuperscript{128}.

"Impaired provider;" “impaired member,” or “impaired physician or dentist” is a physician or non-physician
member who, because of physical illness, psychiatric illness, or substance abuse, has impairment of
his/her clinical judgment or ability and who may be unable to provide appropriate patient care or may
otherwise constitute a direct and immediate threat to the health and safety of patients, hospital personnel,
or other staff members.

"Substance abuse" refers to the inappropriate use of illegal drugs, alcohol, or over-the-counter drugs or
prescription drugs while a member is "on call" or otherwise directly responsible for the care of hospital
inpatients or outpatients. While not to be used as the only indicator of substance abuse, blood and/or
urine concentration of alcohol or other altering-altering drugs in concentration deemed significant by the
United States Department of Health and Human Resources during such a time is clear evidence of
substance abuse. For clarity and to prevent controversy, a blood alcohol level greater than 0.030 gm/dl at
such a time will be considered significant. If, with reasonable certainty, blood or urine concentration of a
specimen collected at a time when the member is not "on call" or otherwise directly responsible for patient
care can be extrapolated to give probable levels at a time when the member was "on call" and directly
responsible for patient care, then this also would be clear evidence of substance abuse.

\textsuperscript{122} Revision(s) made July 2009
\textsuperscript{123} Revision(s) made July 2009
\textsuperscript{124} Revision(s) made July 2009
\textsuperscript{125} Revision(s) made July 2009
\textsuperscript{126} Revision(s) made July 2009
\textsuperscript{127} Revision(s) made July 2009
\textsuperscript{128} Revision(s) made July 2009
GENERAL

MEDICAL STAFF MS-003
RULES AND REGULATIONS

ADMISSION AND DISCHARGE OF PATIENTS

1. **Admission Diagnosis:** No patient shall be admitted to the hospital until a provisional diagnosis has been stated. At the time admission orders are given to the admitting nurse, the attending physician will give the patient's diagnosis(es) and anticipated surgery, if any, in order to initiate the Utilization Review assignment of "length of stay."

2. **Admission Privileges:** A patient may be admitted to the hospital only by a member of the Active Medical/Dental Staff. The official admitting policy of the hospital shall govern all practitioners.

3. **Care by an Allied Health Professional:** Patients being admitted to receive the care of an Allied Health Professional shall be admitted by the sponsoring physician member of the Active Medical Staff or a Certified Nurse Midwife with admitting privileges. The Active Medical Staff member shall assume overall responsibility for the care of the patient throughout the hospital stay. If provided for by licensure or scope of care, the Allied Health Professional may be responsible for recording Patient Care Orders, Progress Notes, History and Physical, Discharge Summary, Consultations, or Operative Reports, and make other notations in the patient records, but during his/her provisional period the attending physician must authenticate each. Patient care orders will be carried out before authentication. All Allied Health Professionals, except Certified Registered Nurse Anesthesia providers, must have a non provisional Active Staff member assigned to them for supervision. The provisional Certified Registered Nurse Anesthesia providers must be proctored by a non provisional Active Staff Anesthesiologist or a non provisional Certified Registered Nurse Anesthesia provider.

4. **Admissions by Dental Staff:** The Dental Staff shall conform in general to the Rules and Regulations of the Medical Staff with the following additions.
   
   (a) Patients admitted for dental service shall be admitted on the Surgical Service and shall be the responsibility of that service.
   
   (b) An adequate history and physical by a physician member of the Active Medical Staff shall be required on each patient before surgery. This medical supervision shall continue until the dismissal of the patient.
   
   (c) Complete records, both dental and medical, shall be required on each patient and shall be a part of the hospital records.
   
   (d) An oral surgeon with credentials for patient management is able to do such without assistance from Medical Staff member as delineated in the bylaws.

5. **Danger to Patients:** Practitioner’s admitting private patients shall be responsible for giving such information as may be necessary to assure protection of other patients from those who are a source of danger. Suspected infections should be identified and delineated to such extent as possible by the attending physician on admission.

6. **Orders for Treatment/Requests for Consultation:** All orders for treatments or requests for consultation shall be in writing. Telephone orders, verbal orders, or requests for consultations are to be authenticated, as set forth in the Medical Staff Bylaws. An order for treatment, diagnostic tests, and so forth, or request for consultation shall be considered to be in writing if dictated to registered nurses, Pharmacists, dieticians, speech therapists, occupational therapists, Care Management, physical therapists, and respiratory therapists. All standing orders will be reviewed annually and signed by the physician. A physician is responsible for contacting his own consultant except in the case of an emergency, at which time a member of the nursing staff may be asked to contact the consultant. Consultation of Trauma Team shall follow trauma protocol.

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129 Revision(s) made July 2009
7. **Care and Treatment of Patient**: A member of the Active Medical Staff shall be responsible for the medical care and treatment of each of their patient(s) in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Medical Staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

8. **Patient Assignment**

(b) **Patients Presenting to Emergency Department**: A patient presenting to the Emergency Department with a problem that, in the opinion of the Emergency Department nurses and/or the Emergency Department physician, requires intervention, will be seen by the Emergency Department physician with the appropriate attending physician being notified as indicated by circumstances, following as much as possible the wishes of the patient and/or family. In case of the patient and/or family not having a choice and the patient needing admission to the hospital, selection of an attending physician shall be made from the appropriate rotating roster of Medical Staff members for unassigned patients. The following procedure will be followed to define an unassigned patient:

1. Patients are assigned if there is evidence of an ongoing doctor-patient relationship as evidenced by:
   - The patient’s verbal history
   - Hospital medical records
   - In-hand prescriptions

2. Patients are unassigned if:
   - None of the above exist
   - Fired from a physician’s practice with a letter sent from the physician to the patient. Physician must provide documentation to the Emergency Department upon request.
   - The patient’s primary care practitioner does not have admission privileges at St. James Healthcare.
   - Patient has not seen the primary care provider for the past three years.

3. The primary medical indication for admission of the unassigned patient shall be the determining factor used by the Emergency Department physician to decide which “unassigned physician” on call is contacted for the admission.

4. The Emergency Department physician has the final say. This does not, however, preclude discussion between the Emergency Department physician and the on-call physician contacted. Any such discussion shall, however, be conducted in a professional and polite manner.

5. Once the “unassigned” patient is admitted to the “unassigned physician” on call, the patient is no longer unassigned for the purposes of that hospital admission.

(c) **Medical Screening Examination**: Each patient presenting to the Emergency Department will have a screening medical examination. This screening medical examination shall be completed by an individual who is credentialed through the Medical Staff. All patients being admitted must be seen by a physician.

(d) **Call List for Unassigned Patients**: Rotating rosters shall be prepared at the direction of the Medical Executive Committee and shall be posted in the Emergency Department and distributed to all involved Medical Staff members. The Sections may direct how the rotating roster will be set up for their Section members by a vote at a Section meeting. There will be a rotational call list prepared when there are two separate practices for a particular specialty.
(e) **Non-Emergent Problems**: A patient who comes to the Emergency Department for a non-emergent problem may be seen by the Emergency Department physician on duty or the patient's attending physician, depending on patient/family choice with a 30-minute limitation on patient waiting for attending physician. If 30 minutes expire, the patient will be asked whether he/she wants to be seen by the Emergency Department physician or other physician of his/her choice. If physician cannot be contacted within ten (10) minutes, the Emergency Department physician will see the patient.

9. **Call Coverage**: Each member of the Medical Staff shall name a physician to take his call should he/she be out of town or unable to be located. This list will be available in the Emergency Department.

10. **Laboratory Work Prior to Admission**: Any laboratory work performed within one (1) week prior to admission may be entered into the patient hospital record and accepted as part of the basic medical evaluation of the patient. Easily legible copies or the original may be accepted.

11. **Admissions to Intensive Care Unit and Cardiac Care Unit**: If any question as to the validity of admission to or discharge from the Intensive or Cardiac Care Units should arise, that decision is to be made through consultation with the Chief of Surgery Section and/or Chief of Medicine Section.

12. **Need for Continued Hospitalization after Specific Periods of Stay**: The attending practitioner is required to document the need for continued hospitalization after specific periods of stay (per disease category) as identified by the Utilization Review Committee of this hospital.

   (a) An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.

   (b) The estimated period of time the patient will need to remain in the hospital.

   (c) Plans for post-hospital care.

Upon request of the Utilization Review Committee, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient hospitalized thirty (30) days or longer, including an estimate of additional days of stay and the reason therefore. Failure of compliance with this policy will be brought to the attention of the Medical Executive Committee for action.

13. **Discharge of Patients**: Patients shall be discharged only upon written order of the attending physician. An exception to this rule is that, as part of the disaster plan and during a disaster, the physician designated to dismiss patients may do so with the approval of the hospital administration and without the approval of the attending physician. For medical/legal reasons, if it should be necessary for a patient to leave the hospital, the physician will write a discharge order. If the patient returns within the same date, an order to readmit the patient will be written on the physician's order sheet, and the same medical record will be utilized. If the patient returns on a later date, this will constitute a new admission.

14. **Patients Leaving Against Medical Advice (AMA)**: Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

15. **Floor and Room Assignment of Patients**: Floor and room assignment of patients will be made by the Nursing Supervisor through the Admissions Office. It is understood that when deviations are made from assigned areas, the Nursing Supervisor will correct these assignments at the earliest possible moment. If a patient is transferred, the attending physician shall be notified.
16. **Protocol for Patients Needing Psychiatric or Substance-Abuse Service**: Since St. James Healthcare does not provide inpatient psychiatric or substance-abuse services, the Medical Staff’s role in the care and/or appropriate referral of patients who are emotionally ill, who become emotionally ill while in the hospital, or who suffer the results of alcoholism or drug abuse and need additional care, is delineated in the St. James Healthcare Administrative Policies regarding:

   (a) Patient Transfers
   (b) OBRA Anti-Dumping 1987
   (c) Transferring Patients to Mental Health Facilities
   (d) Violent/Suicidal Patients.

17. **Physicians Notified of Death of Patient**: When a patient dies in this hospital, the attending\(^{130}\) physician shall be notified at the time of death.

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\(^{130}\) Revision(s) made July 2009
GENERAL

THE MEDICAL STAFF MS-004
RULES AND REGULATIONS

MEDICAL RECORDS:

B. **Abbreviated History and Physician Exam:** May be recorded (for non-inpatients undergoing minimally-invasive diagnostic or therapeutic procedures [minimally invasive is defined as those requiring local anesthetic], which require outpatient nursing observation). An abbreviated history and physical exam has the following components131:

1. History of present illness.
2. Abbreviated past medical history.
3. Abbreviated systems review.
4. Indications for the procedure contemplated.
5. Current medications and allergies.
6. Past surgical and/or anesthesia complications.
7. Course of action planned during the hospital stay
8. Impression/diagnosis.

C. **Operative Reports:** The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately. The medical record shall be considered delinquent if this standard is not met. The operative reports dictated or written after procedure record will contain:

1. Preoperative diagnosis.
2. Primary surgeon and assistant(s).
3. Description of findings.
4. Technical procedures used and description.
5. Specimens removed.
7. Estimated blood loss.

D. **Verbal/Telephone Orders:** Each verbal order is dated and is identified by the name of the licensed practitioner with appropriate privileges who gives the order and the qualified individual who receives it. Qualified individuals are registered nurses, pharmacists, dietitians, speech therapists, occupational therapists, care management, physical therapists, and respiratory therapists.132. Verbal/telephone orders are to be authenticated (signed) within 48 hours133 by the practitioner responsible for the patient, except for orders for restraint that are to be authenticated (signed) within 24 hours.

E. **Discharge Summaries:** Discharge Summaries are to be completed (dictated) within the 30-day completion requirement for the entire record. The components of a Discharge Summary are:

1. Final diagnoses (principal diagnosis and additional diagnoses identified during the hospital stay).
2. Operative procedures performed.
3. Admitting diagnosis or reason for the admission.
4. Pertinent findings, which may include laboratory, x-ray, physical.

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131 Revision(s) made July 2009
132 Revision(s) made July 2009
133 Revision(s) made July 2009
5. Medical and/or surgical treatment which include the patient's response, complications (hospital infection or other complication), and consultations.
6. Patient's condition on discharge (stated in measurable terms so that a comparison can be made with the admitting condition).
7. Discharge instructions (physical activities, medication, diet, follow-up care).
8. Where patient discharged to: home, other hospital, nursing home, home health, other.

F. **Quality of Medical Records**: The quality of the medical record depends in part on timeliness, accuracy, meaningfulness, authentication, and legibility of the informational content. A record may be considered delinquent if the Medical Executive Committee determines the medical record does not fulfill the standards of quality.

G. **Transfer of Patient Care to Second Physician**: If the first physician states immediately in the Progress Notes that the total care of the patient is transferred to the second physician, then the second physician is responsible for the History and Physical Report. However, if twenty-four (24) hours elapse before the second physician can assume the care of the patient, the first physician is responsible for the History and Physical Report.

H. **Reproduced Office Records**: Reproduced office records that are to be entered in the hospital medical records shall be on hospital-size paper of permanent type and legible enough to reproduce. A reproduction of office records meeting these requirements shall be acceptable. All of these shall include dates.

I. **Progress Notes**: Legible pertinent Progress Notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Each of the patient's clinical problems should be clearly identified in the Progress Notes. Progress Notes shall be written at least daily on critically-ill patients and on those where there is difficulty in diagnosis or management of the clinical problems.

J. **Consultations**: Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion, and recommendations. This report shall be made a part of the patient's medical record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation. A request for consultation signed by the physician requesting the consultation shall include a brief statement of information regarding the patient (e.g., the diagnosis, special conditions affecting the report of the consultant, and the specific information which is expected from the consultant). The request should be directed to a specific physician or service in general.

    *Requests for Consultation*: Any physician requesting a consultation is personally responsible for contacting the consultant and defining the parameters. Request for consultation may take the following forms:

1. Consultation - the physician will see and evaluate the patient and document the assessment on the consultation form.
2. Consult and write orders - the physician will see and evaluate the patient, document the assessment on the consultation form, and write orders for treatment and diagnostic modalities.

    *Time Limit for Consultation*: Consultation must be answered in a timely fashion (within 24 hours).

K. **Obstetric Record**: The current obstetric record shall include a complete History and Physical Report. The History and Physical may be the original copy of the attending physician's office prenatal record transferred to the hospital before admission. Pertinent additions to the History and subsequent changes in physical findings will be added on admission. This will include patients requiring Cesarean Section.
L. **Dates and Authentication**: All clinical entries in the patient's medical record shall be accurately dated and authenticated. Orders and progress notes shall have the time recorded.

M. **Symbols and Abbreviations**: Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations should be kept on file in the Medical Record Department. Copies are provided at each Nursing Station.

N. **Release of Medical Information**: Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

O. **Removal of Medical Records**: Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the hospital and shall not otherwise be taken away without permission of the Chief Executive Officer. In cases of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or another. Unauthorized removal of records from the hospital is grounds for suspension of the practitioner's privileges for a period to be determined by the Medical Executive Committee of the Medical Staff.

P. **Access to Medical Records**: Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. The Medical Executive Committee shall be notified of all such projects of the Medical Staff. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

Q. **Routine or Standing Orders**: A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, and signed by the practitioner. The Routine or Standing Orders shall be reviewed and signed annually by the physician.

R. **Readmission for Same Condition**: If a patient is readmitted within seven (7) days' time for the same condition, the previous History and Physical examination, with an interval note stating the condition of the heart and lungs, will suffice.

S. **Emergency Department Records**: Emergency Department records are to be completed at the time care is rendered.

T. **Completion of Medical Records**: In the event there are incomplete records for a physician who has left, died, or is no longer on the Medical Staff, his/her records will be completed by the President of the Medical Staff or his appointee.

U. **Privacy Practice and Organized Health Care Arrangement**: All members of St. James Healthcare’s Medical Staff are required to abide by the terms of the Notice of Privacy Practices prepared and distributed to patients as required by the federal patient privacy regulations.

V. **Failure to Complete Medical Records**: 134

   a. Medical Records Department will tabulate the number of delinquent records every other week notifying each Medical Staff member of the number of delinquent records. The Medical Record Department will notify the President of the Medical Staff of any Medical Staff member with any delinquent records. The Medical Records Department will notify the Medical Staff member at least 14 days before medical records are delinquent. Any Medical Staff member that has not completed his/her medical records within 30 days of discharge of

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134 Revisions made to this section June 2012
a patient will be fined $200.00. If the records are not completed within 45 days, an additional fine of $500.00 will be levied. If the records are not completed within 60 days, the Medical Staff member will receive a certified letter from the Medical Staff President notifying him/her that admitting, consulting, and procedure performance (both inpatient and outpatient) privileges shall be voluntarily relinquished. This relinquishment shall continue until all records of the Medical Staff member are no longer delinquent. As per the Montana Code Annotated, the voluntarily relinquishment or privileges will be forward to the Montana State Medical Examiners. The Medical Staff member may provide a written reason for the failure to complete medical records to the Medical Executive Committee for review and action.

b. For failure to complete medical records in a timely manner, a Practitioner’s clinical privileges (except with respect to his/her patients already in the Hospital and his/her rights to admit patients, to perform surgeries or procedures already scheduled, and to consult with respect to patients,) shall after written warning of delinquency, be automatically relinquished and shall remain relinquished until medical records are complete. In cases of emergencies, the President of the Medical Staff or his/her designee may provide exceptions to this policy on a case-by-case basis. Due consideration will be given to those Practitioners who are on vacation or who are ill.

c. The money received from the fines will be donated to the St. James Healthcare Medical Staff’s Bank Account.

d. If the fines are not paid by the time of the next reappointment, the Medical Staff member will not be in good standing and the Medical Executive Committee could potentially not approve the Medical Staff member’s request for reappointment.
GENERAL

MEDICAL STAFF MS-005
RULES AND REGULATIONS

GENERAL CONDUCT OF CARE

A. Consent Form: A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission by the Admissions Clerk.

B. Informed Consent Form for Surgery: An informed consent must be obtained from the patient, or from his legal representative, prior to surgery, for all surgical procedures, except in emergencies. This consent must be dated, timed, and witnessed. If an informed consent cannot be obtained in an emergency situation, it should be documented as to why the informed consent cannot be obtained.

C. Legibility of Orders: The practitioner's orders must be written clearly, legibly, and completely. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood by the nurse.

D. "Blanket" Orders: The use of "Renew," "Repeat," "Continue" or "Resume Previous Orders" is not acceptable.

E. Orders Canceled at Surgery: All previous orders are canceled when patients go to surgery.

F. Stop Orders:
   1. In acute care patients, all IV therapeutic antibiotics will be stopped after ten (10) days, unless the physician has requested a different specific duration or stop date. The physician will be notified in writing on the chart twenty-four (24) hours prior to the impending stop of IV therapeutic antibiotics.
   2. For Transitional Care Unit (TCU) patients, all therapeutic antibiotics, (PO, IV, and IM) will be stopped after ten (10) days, unless the physician has requested a different specific duration or stop date. The physician will be notified in writing and by phone twenty-four (24) hours prior to the impending stop of the antibiotics.

G. Drug Enforcement Administration (DEA) License: If a practitioner’s DEA license expires, that practitioner will not be allowed to write orders for controlled substances covered under that certification until a copy of the license and/or primary source verification is supplied to the Administrative Medical Staff Coordinator.

H. Drugs and Medications: All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital Formulary Service of A.M.S. Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

I. Drugs Brought to Hospital by Patient: Drugs brought into the hospital by patients shall not be administered. The only exception to this rule will be drugs not available in the Hospital Formulary, which are identified and are specifically ordered by the physician. Drugs not used during a patient's hospitalization should be packaged and sealed, then either given to the patient's family or stored and returned to the patient at the time of discharge.

J. Anesthesia Record: A signed and dated postoperative notation describing the presence or absence of anesthesia-related complications will be completed prior to discharge.

K. Consult Indicated: The patient's physician is responsible for requesting consultation when indicated. If an indicated consult is not obtained, the matter may be subject to consideration by the Medical Staff.
L. **Care Questioned by Nursing Staff**: If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of his/her Nursing Supervisor who, in turn, may refer the matter to the Vice President of Clinical/Patient Services or an appropriate designee). If warranted, the matter may be brought to the attention of the Chief of the Section wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the Chief of the Section may request a consultation.

M. **Availability of Physician and Coverage of In-Hospital and Emergency Department Patients**: The purpose of these recommendations is to codify physician responsibility to respond to patient care needs when the physician is not physically present in the hospital. The recommendations include, but are not limited to, telephone response; physician in-person response to the patient care area; weekend, holiday, and vacation call coverage; and consultation availability. Unless otherwise stated, times given are approximate and refer to situations that are immediately threatening to the patient's life or health.

N. **Timely Continuous Care**: The members of the Medical Staff of St. James Healthcare shall provide timely continuous care to any hospital inpatients for whom they are the primary physician. If a member of the Medical Staff is the primary physician for an inpatient at St. James Healthcare and he/she anticipates that he/she will become unavailable, then he/she shall arrange for another member of the Medical Staff to provide coverage. Covering physicians are expected to respond to patients’, nursing staff, and Administrative concerns about care of a particular patient's problem with the same timeliness expected of the primary physician.

O. **Unavailability**: In the event that the member of the Medical Staff who is primarily responsible for the care of a patient becomes unavailable as defined in these Rules, other physician members of the Medical Staff involved in the care of that particular patient will assume primary responsibility for the care of that particular patient. In the event that a physician is unavailable to provide emergent bedside patient care, the following procedures shall go into effect:

1. The Emergency Department physician on duty shall be asked to see the patient immediately and to provide necessary care to preserve life and limb until the primary attending physician or an appropriate covering physician is physically present to provide care.

2. Nursing Supervisor is to be notified. He/she shall interrupt a busy phone if that is the problem causing the unavailability. If, after retrying backup phone numbers and other telecommunication modalities, the Nursing Supervisor is unable to locate the primary physician or a covering physician, the first available physician from the following list shall be contacted in the order listed to either assume or direct care for that patient’s immediate problem or to ask another member of the Medical Staff to do so:

   (a) President of the Medical Staff.
   (b) Vice President of the Medical Staff or the Chief of the Section involved.
   (c) Chief of the Section involved or the Vice President of the Medical Staff.
   (d) Other Section Chiefs.
   (e) Secretary/Treasurer of the Medical Executive Committee.
   (f) Member-at-Large of the Medical Executive Committee with the longer tenure.
   (g) Member-at-Large of the Medical Executive Committee with the shorter tenure.
   (h) Immediate Past President of the Medical Staff.
   (i) The Chief Executive Officer or representative.

P. **Phone Availability**: Medical staff phone response time is 10 minutes to all departments except Recovery Room, which is five (5) minutes
**Response Time**
Emergency Department for Medical Staff members on the appropriate call list – 30 minutes

**Q. Availability to Patient Care Area:** Availability to the patient care areas shall be 30 minutes after the physician has been notified that there is a problem immediately threatening MORTALITY or MORBIDITY to the patient for whom the physician is the primary physician.

**R. Discharge of Attending Physician by Patient:** In the event that a hospital patient discharges as attending his/her physician and does not have a preference for another physician or if his/her preferred replacement physician is unavailable or is otherwise unable to provide care for the patient, the President of the Medical Staff or his designee will be contacted to arrange for a replacement physician.

**S. Preoperative Laboratory and Diagnostic Studies for Outpatients Requiring General Anesthesia:** Outpatients who receive a general anesthetic require the same laboratory and diagnostic studies as inpatients who receive a general anesthetic, as defined in the Preoperative Minimum Laboratory Testing (General, Spinal, Epidural, or Peripheral Anesthesia) Guidelines (OR-112). These may be accomplished in the outpatient area or physician's office prior to the time of the scheduled case.

**T. Preoperative Laboratory and Diagnostic Studies for Outpatients Requiring Local Anesthesia or Moderate Sedation:** Patients receiving local anesthesia or moderate sedation must sign an Operative Consent Form prior to surgical intervention and, further, they must have a written history and physical examination documented on their chart.

**U. Preoperative Workup for Emergency Procedures:**

1. **Emergency Procedure:** When a patient is in an emergent condition (an immediate threat to the life or health of the patient) and immediate treatment is required to prevent catastrophic disability, immediate surgical treatment may be required. Physician's documentation as to the state of the emergency must be on the chart. If the emergent condition does not allow written consent, treatment may be administered without the necessity of written and signed consent. Blood must be drawn prior to commencing the procedure and must be sent to the laboratory for results. Blood work may also be waived by the physician with consultation and approval by anesthesiology, if the patient's emergent condition so dictates. This must be documented on the chart.

2. **Urgent Procedure:** Patient requires rapid, but no immediate intervention. Urgent procedures include most emergencies and imply that the procedure will be performed within several hours. These patients will require preoperative laboratory work, history and physical examination, and informed operative consent.

**V. Pediatric Age:** The pediatric patient will be any person less than 18 years of age.
GENERAL

MEDICAL STAFF MS-006
RULES AND REGULATIONS

PROCEDURE IN THE EVENT OF PATIENT EXPOSURE TO PHYSICIANS’ BLOOD

1. Any report of such an event will be kept in the strictest confidence. If it is an incident report or any other manner of report, it will be communicated directly to the Chairman of the Infection Control Committee (ICC).

2. If the Chairman of the ICC feels that there is no data to substantiate the report of exposure after interviewing the parties involved, the issue will be dropped.

3. If the Chairman of the ICC feels the potential for exposure does exist, a committee of three people will convene to determine whether or not that concern is substantial enough to be acted on. This Committee would consist of the physician involved, the Chief of the appropriate Section, and the Chairman of the ICC. If two out of three of these members feel there is reason to proceed, the testing as described below will be done. If any member of the Committee feels the patient's rights have been infringed by the majority opinion of the Committee, the disagreement will be arbitrated by the President of the Medical Staff. If there is concern about exposure of the patient to physician's blood, the testing and counseling for the patient will be the same as it would be for the physician. It is recognized in nearly all these instances that there is simultaneous exposure of both parties. In any event, the procedures for counseling the patient and/or the physician will be the same.

4. If blood testing is performed, the reports will be reviewed by the Chairman of the ICC to determine whether there exists any potential for harm of the patient by the exposure. These results will be communicated to the patient by the Chairman of the Infection Control Committee, as they are communicated to any physician who is exposed to patients’ blood or body fluids.

5. In the event the Chairman of the Infection Control Committee is the physician involved, the pathologist or another physician member of the ICC of the physician's choosing can take his place. In the event the President of the Medical Staff is involved, the Vice-President of the Medical Staff will take his place on the reviewing Committee. In the event that the Chief of the appropriate Section is the physician involved, the Assistant Chief of the appropriate Section will take his place on the reviewing Committee. If the physician involved is concerned about the particular individual who is Chairman of the Infection Control Committee being involved, the pathologist or any other physician member of the Infection Control Committee would be designated by the physician involved as a member of the reviewing Committee.

6. Any failure by the physician involved in the exposure to cooperate with the above procedures to assure the safety of the patients under our care, would be reported immediately to the Medical Executive Committee. The Medical Executive Committee would be responsible for deciding further action, if any.
GENERAL

MEDICAL STAFF MS-007
RULES AND REGULATIONS

REVIEW OF PATIENT-CARE POLICIES

The Medical Staff of St. James Healthcare will utilize, review, implement, and effect necessary changes to certain Policies developed by the Hospital Administration, as they affect patient care. These include, but are not limited to:

1. Restraints,
   a. Medical/Surgical, V-A 28.1
   b. Behavioral, V-A 28.2
2. Living Will/Advanced Directives, V-A 19,
3. Organ Donation
   a. Organ Tissue Donation, V-A 1
   b. Organ Donation after Cardiac Death, V-A 24
4. Sedation/Analgesia (Moderate Sedation), V-A 38
5. EMTALA, V-A 23,
6. Autopsy, V-A 50
7. Herbal Products V-J 33
8. Sentinel Events, I-I 4
GENERAL

MEDICAL STAFF MS-008
RULES AND REGULATIONS

PROVISIONAL PERIOD AND PROCTORING

1. The provisional period for each new Medical Staff member and the provisional period for the exercise of any new or increased clinical privileges by an established Medical Staff member shall be monitored by a proctor appointed by the Section Chief of the appropriate Clinical Section.

2. Proctors shall report to the Section Chief as directed by in the Medical Staff Bylaws on the appropriate form approved by the Medical Staff. If a proctor does not wish to utilize the provided form, he/she shall provide in his/her written report all of the information that would be provided by executing the appropriate form.

3. The number of charts/cases to be reviewed for provisional period is to be determined by the Clinical Sections. If a Clinical Section has not determined that number of charts/cases to be reviewed for a provisional period, 12 charts/cases or 10% of the charts/cases for the provisional period shall be reviewed.

4. If a Active Provisional Medical Staff Member or a Active Medical Staff Member with provisional new or additional clinical privileges has not accumulated 12 charts/cases (or the number designated by the Clinical Section) during the designated Provisional Period (one year unless otherwise specified by the Clinical Section), the Provisional Period shall be extended as determined by the Clinical Section and the Medical Executive Committee. Case/chart review for Provisional Allied Health Professionals, Courtesy, Consulting and Visiting staff will be determined in accordance with Article VI – Part B Section 1, Paragraph d, Initial Provisional Appointment of these Bylaws.
GENERAL

MEDICAL STAFF MS-009
RULES AND REGULATIONS

CHARTS SENT FOR OUTSIDE REVIEW

If a Section Chief or Clinical Section, or MultiSpecialty Peer Review Committee, as an Adhoc Committee of the Medical Executive Committee, is unable to make a recommendation to the Medical Executive Committee regarding credentialing or proper disposition of a problem with the management of a particular case, the Section Chief may recommend to the Medical Executive Committee that a patient's chart or charts be sent for review by an outside reviewer expert in the area questioned. The Medical Executive Committee will then determine if the chart (or charts) do(es) indeed need outside review. If the chart is deemed to need outside review, the Section Chief may then send the relevant material for that outside review. All reports by the outside reviewer will be addressed to the Section Chief and/or the Medical Executive Committee.135

135 Revised Paragraph October 2014
GENERAL

MEDICAL STAFF MS-010
RULES AND REGULATIONS

SEXUAL HARASSMENT AND THE MEDICAL STAFF

The Federal Equal Employment Opportunity Commission has declared that sexual harassment constitutes illegal discrimination under Title VII of the Civil Rights Acts of 1964. It is the position of St. James Healthcare Medical Staff that sexual harassment of or by Medical Staff members and Allied Health Professionals (independent or dependent) has no place and will not be tolerated in this hospital.

By authentication of having received and read the Bylaws, all practitioners are aware of the Medical Staff's position regarding sexual harassment and know that adequate procedures are in effect to facilitate prompt reporting of specific acts of sexual harassment that may occur in the hospital. Prompt action will be taken on all complaints made. Practitioners shall be defined as all individuals who are not employed by the hospital, but have been granted privileges to practice or provide services in St. James Healthcare or on hospital-affiliated business, including, but not limited to physicians, dentists, and specified professional personnel.

Sexual harassment undermines an individual's integrity and human dignity. St. James Healthcare's Medical Staff prohibits all sexual harassment, including, but not limited to prohibiting persons connected with the Hospital from making unwelcome sexual advances, requesting sexual favors, or engaging in other verbal, physical, non-verbal, and non-physical conduct of a sexual nature, whereby an individual's submission to or rejection of such conduct is made an explicit or implicit condition of employment or care; or is used as the basis of an employment decision affecting the individual; or where such conduct has the purpose or effect of interfering with an individual's job performance or care, or creates an intimidating, hostile, or offensive environment.

The key idea to help people decide if a behavior is or is not sexual harassment is the word “unwelcome.” If any individual finds behaviors or comments offensive or is made the object of unwelcome sexual attention:

1. If reasonable, the complainant is encouraged to inform the individual doing the harassment that he/she believes the conduct of that individual is sexual harassment and unwelcome. If the complainant is unable or unwilling to approach the individual doing the harassment, then the complainant should do as follows:

   A. If the complainant is an employee: A report should be filed by the individual in accordance with St. James Healthcare Sexual Harassment Policy.

   B. If the complainant is a patient or practitioner: A written, signed, report should be filed in accordance with the Procedure for Questions Involving Medical Staff Members (in the Medical Staff Bylaws).
GENERAL

MEDICAL STAFF MS-011
RULES AND REGULATIONS

DISRUPTIVE BEHAVIOR AND THE MEDICAL STAFF

St. James Healthcare Medical Staff believes that all individuals within the Hospital shall be treated courteously, respectfully, and with dignity. To that end, the Hospital expects all practitioners to conduct themselves in a professional and cooperative manner in the Hospital.

By authentication of having received and read the Bylaws, all practitioners are aware of the Medical Staff’s position regarding disruptive behavior and know that adequate procedures are in effect to facilitate prompt reporting of acts of disruptive behavior that may occur in the hospital. Prompt action will be taken on all complaints made. 136

Problems may arise when a practitioner’s behavior is so disruptive to Hospital operations that the positive value of the practitioner’s clinical skills is outweighed by the negative impact of his/her behavior(s). That a practitioner’s behavior is unusual, unorthodox, or different is not a sufficient basis to justify disciplinary action; however, when the practitioner’s behavior has a significant negative impact on patient care, this will not be tolerated. Unacceptable disruptive conduct can include, but is not limited to, attacks leveled at other practitioners/healthcare providers which are personal, irrelevant, or go beyond the bounds of fair professional comment; comments written, illustrations drawn, or other material placed in a patient’s medical records or other official documents, impugning the quality of care in the Hospital or attacking other practitioners, healthcare providers, or Hospital policy; non-constructive criticism, addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or to impute stupidity or incompetence; participation on a Medical Staff Committee or Section meeting in a disruptive or unprofessional manner; and/or imposing medical idiosyncratic requirements on other healthcare providers which have nothing to do with appropriate patient care, but serve only to burden the healthcare providers with unnecessary procedures.

Where reasonable, the concerned healthcare practitioner/provider is encouraged to inform the practitioner or the practitioner’s Section Chief, the President of the Medical Staff, or the Chief Executive Officer, that he/she believes the conduct of that individual is disruptive.

If the concerned healthcare practitioner/provider is unable or unwilling to approach the practitioner or the aforementioned parties, or is not satisfied with the response from the aforementioned parties, then a written, signed report should be filed in accordance with the Procedure for Questions Involving Medical Staff Members (in the Medical Staff Bylaws).

136 Revised Paragraph October 2013
ORDERING OF DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Physicians and other licensed providers may order diagnostic testing on outpatients at St. James Healthcare. Examples include (but are not limited to) laboratory testing, radiology exams, pathology specimen evaluation, electrocardiograms, echocardiograms, fitness testing and therapy evaluation.\(^\text{138}\)

Physicians and other providers licensed in the State of Montana may order non-invasive and non-injectable therapeutic intervention on outpatients at St. James Healthcare. Examples included (but are not limited to) physical, occupational and speech therapy and tetanus toxoid.

In order to assure quality improvement, peer-review and to protect patients, only physicians and other Montana licensed providers who are credentialed by the medical staff, may order therapeutic interventions which require injection, infusion and/or invasive modality. Examples include (but are not limited to) injectable antibiotics, chemotherapy and blood transfusions.

\(^{137}\) Medical Staff MS-012 Added to Rules and Regulations October 2010

\(^{138}\) Revisions made to this paragraph June 2012
SURGERY SECTION
RULES AND REGULATIONS

1. **Surgical Consent:**
   A written, signed informed surgical consent shall be obtained prior to any operative procedure except in those situations where the patient's life is in jeopardy and suitable signatures cannot be obtained due to the patient's condition. In emergency situations involving a minor or an unconscious patient, in which consent for surgery cannot be immediately obtained from the parents, guardian, or next of kin, the circumstances should be fully explained on the patient's medical record. If time permits, a consultation may be desirable before the emergency operative procedure is undertaken. A telephone consent may be obtained according to hospital policy. The consent is valid for 30 days. 139

2. **Pre-Operative Testing:**
   Preoperative minimum laboratory work will be done and will be noted on the chart prior to surgery for all patients having a surgical procedure under general, regional, or monitored anesthesia care with the following exceptions:
   A. Emergency cases in which life or health would be endangered.
   B. Emergency cases in which it is impossible to get a voided or catheterized urine specimen preoperatively.
   C. Cases scheduled under local anesthesia.
   D. If an infant cannot provide a urine specimen, the urinalysis should be obtained as soon as possible post-operatively.
   E. EKGs at St. James Healthcare must be done prior to surgery, in order to be read and confirmed. 140
   F. Blood Bank: Type-and-screens and type-and cross matches should be done within the 72 hours prior to surgery.
   G. The patient is unable to cooperate for preoperative testing. 141

   Preoperative minimum laboratory testing is reviewed and approved by Surgery Section. 142

3. **Tissue or Foreign Bodies Removed at Surgery:**
   All tissues or foreign bodies removed at surgery, with the exception of those listed below, will be sent to the hospital pathologist who shall make such examination as he considers necessary. The exceptions are:
   A. Myringotomy tubes. These may be given to the family at their request.
   B. Foreign bodies, i.e. rocks, coins, IUDs, etc. These may be given to the patient or their family after they have been properly recorded.
   C. Skin scars, at the option of the physician. Scars from surgeries that might possibly harbor other disease such as recurrent neoplasm should be sent.
   D. Surgical appliances such as orthopedic screws, plates, etc.
   E. Placentas that are grossly normal and have been removed in the course of operative or non-operative obstetrics.
   F. Cataracts.
   G. Bone, cartilage, and adjacent structures taken incidental to other operative procedures.
   H. Clots from aneurysms.
   I. Bullets and other foreign objects removed from patients who may have been injured during a criminal activity should be kept by the operating surgeon and given directly, in person, to the police. Bullets should be grasped by the base to avoid marking them.
   J. Pacemakers.
   K. Teeth.

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139 Revised October 2013
140 Revised October 2013
141 Added Sentence October 2013
142 Revised October 2013
4. **General Rules – First Assistant:**

   A. It is the responsibility of the operating surgeon, considering the patient's clinical condition and the surgical procedure, to determine the need for a surgical assistant.
   
   B. The first assistant may be a Medical Staff Member or an Allied Health Professional credentialed to first assist.
   
   C. When an assistant is required, the assistant must be in the hospital and ready to begin the operation with the surgeon before the anesthetic is to be initiated.
   
   D. The assistant will remain at the operating table in assistance until all but the subcutaneous tissues and skin have been closed, except if called away by an emergency. Upon resolution of the emergency, the assistant will return.
   
   E. The name of the assistant will be given to the Director of Surgery or the Surgery Secretary when a case is scheduled or as soon as possible thereafter.
   
   F. Surgeons must be in the operating room and ready to commence operation at the time scheduled. Start time will be defined as when the patient is anesthetized and ready to be positioned. Only in extenuating circumstances will the operating room be held longer than ten (10) minutes after the time scheduled. If the surgeon is late three times in a six-week period, the following actions will occur:
      
      1) Verbal warning by Director of Surgery
      2) Written warning from Director of Surgery
      3) Letter from Director of Surgery and/or Chief of Surgery informing surgeon that the surgeon shall not be allowed to perform or schedule 8:00 a.m. cases for two weeks.
   
   G. For patients with life-threatening conditions or medical complications, surgeons should request appropriate consultation from specialists on the Medical Staff.
   
   H. Clinical privileges in surgery for dentists and oral surgeons are outlined in the Bylaws.

5. **Trauma Call**
   
   General surgeons are required to take trauma call; exceptions can be granted on an individual basis through Surgery Section.

6. **Emergency/After Hours Surgery Cases:**
   
   Only Class I, Class II, Class III, and Class IV cases may be done after normal surgery hours.

7. **Anesthesia-Related Rules and Regulations:**

   A. Type of Anesthesia: Anesthesia providers will determine the appropriate type of anesthesia in consultation with the operating surgeon. Conflicts will be referred to the Chief of Surgery.

8. **Procedure-Specific Rules:**

   A. Pacemaker Insertion:
      1) The surgeon is responsible to dictate and/or record the cut down and location of the vein.
      2) The internist is responsible to dictate and/or record the guidance and location of the electrode into the ventricle.

   B. Uterine curettage or endometrial biopsy: If a uterine curettage or endometrial biopsy is contemplated and there is a possibility of a viable pregnancy, consultation with a gynecologist is required.

   C. Obstetric record: A current obstetric record shall include a complete history and physical. The attending physician must update the history and physical on admission.

   D. Early termination of pregnancy will require:
1) **Consultation:** Two consultants, in addition to the attending physician, must confirm that they have examined the patient and agree with the proposed procedure as medically necessary to preserve the patient's life. These consultations shall be written or typed.

2) **Discussion with Hospital Administrator:** The attending physician must discuss the proposed procedure with the hospital administrator, establishing the fact that the patient's life can be saved only by terminating the pregnancy.

3) **Permits required:** Therapeutic Abortion Form and Informed Surgical Consent Form.

9. **Autopsies**
   Development of criteria for autopsies shall be performed by the Surgery Section.

10. **ICU/CCU Admission and Discharge**
    Establishes criteria for admission and discharge of patients from the unit, including a methodology to address when patient load exceeds patient capacity.

   A. Admission to the ICU/CCU is dependent upon the need for intensive and specialized nursing care. A "Do not resuscitate" order or an Advance Directive does not automatically prohibit admission to the ICU/CCU. Criteria for admission is:

   1) Monitoring and assessment of biophysical parameters (i.e., temperature, cardiac function, respiratory function, and cerebral function more frequently than every four hours).
   2) Continuous monitoring of biophysical parameters with a high potential for requiring immediate nursing intervention.
   3) Patients requiring pharmacologic interventions to manage cardiac dysrhythmias, vaso-active infusions, sedation, or barbiturate anesthesia/paralyzing medications.
   4) Patients requiring acute interventions to manage respiratory status, circulating blood volume, or cardiac rate or rhythm.
   5) Patients requiring the following monitoring modalities: arterial pressure monitoring, Swan-Ganz monitoring, or intracranial pressure monitoring.

    In the event that patient needs exceed unit capacity, the attending physician of the new admission contacts the unit for candidates for transfer from the unit. The physician then contacts the attending physician of the discharge candidate to discuss and prioritize bed availability.

   B. Discharge from the ICU/CCU is appropriate when:

   1) The patient's neuro-vital signs, blood pressure, cardiac or respiratory status is maintained without intravenous medications or mechanical interventions.
   2) There is an absence of arterial and/or Swan-Ganz monitoring lines or intracranial pressure monitoring.
   3) The need for monitoring and evaluation of the patient's biophysical parameters is every four hours or greater.

11. **ICU/CCU Pediatric Patients**
    All patients under the age of 12 years who are admitted to the ICU/CCU shall be seen in consultation by a Pediatrician.

12. **ICU/CCU Notification of Test Results**
    The physician ordering tests will be notified of abnormal or clinically significant lab values. If the ordering physician is different from the attending physician, the attending physician will also be notified.

13. **ICU/CCU Patients Admitted from Emergency Department**
    Patients admitted to the ICU/CCU from the Emergency Department must be seen by the attending physician within 6 hours of admission to the unit or earlier as dictated by the patient's condition.
14. **ICU/CCU Conflicting Orders**
   If conflicting orders are written, the physicians writing the orders will be notified and will be responsible for resolving the conflict and writing revised orders.

15. **ICU/CCU Sudden Change in Patient's Condition**
   If there is a sudden change in the patient's condition, the attending physician will be notified and queried regarding notification of the consulting physician.
MEDICINE SECTION RULES AND REGULATIONS

1. **Blood and Blood Product Review**
   Blood and blood product review shall be performed by the Medicine Section.

2. **ICU/CCU Admission and Discharge**
   Establishes criteria for admission and discharge of patients from the unit, including a methodology to address when patient load exceeds patient capacity.
   
   A. Admission to the ICU/CCU is dependent upon the need for intensive and specialized nursing care. A "Do not resuscitate" order or an Advance Directive does not automatically prohibit admission to the ICU/CCU. Criteria for admission is:
      
      1) Monitoring and assessment of biophysical parameters (i.e., temperature, cardiac function, respiratory function, and cerebral function more frequently than every four hours).
      
      2) Continuous monitoring of biophysical parameters with a high potential for requiring immediate nursing intervention.
      
      3) Patients requiring pharmacologic interventions to manage cardiac dysrhythmias, vaso-active infusions, sedation, or barbiturate anesthesia/paralyzing medications.
      
      4) Patients requiring acute interventions to manage respiratory status, circulating blood volume, or cardiac rate or rhythm.
      
      5) Patients requiring the following monitoring modalities: arterial pressure monitoring, Swan-Ganz monitoring, or intracranial pressure monitoring.
   
   In the event that patient needs exceed unit capacity, the attending physician of the new admission contacts the unit for candidates for transfer from the unit. The physician then contacts the attending physician of the discharge candidate to discuss and prioritize bed availability.

   B. Discharge from the ICU/CCU is appropriate when:
      
      4) The patient's neuro-vital signs, blood pressure, cardiac or respiratory status is maintained without intravenous medications or mechanical interventions.
      
      5) There is an absence of arterial and/or Swan-Ganz monitoring lines or intracranial pressure monitoring.
      
      6) The need for monitoring and evaluation of the patient's biophysical parameters is every four hours or greater.

3. **ICU/CCU Pediatric Patients**
   All patients under the age of 12 years who are admitted to the ICU/CCU shall be seen in consultation by a Pediatrician.

4. **ICU/CCU Notification of Test Results**
   The physician ordering tests will be notified of abnormal or clinically significant lab values. If the ordering physician is different from the attending physician, the attending physician will also be notified.

5. **ICU/CCU Patients Admitted from Emergency Department**
   Patients admitted to the ICU/CCU from the Emergency Department must be seen by the attending physician within 6 hours of admission to the unit or earlier as dictated by the patient's condition.
6. **ICU/CCU Conflicting Orders**
   If conflicting orders are written, the physicians writing the orders will be notified and will be responsible for resolving the conflict and writing revised orders.

7. **ICU/CCU Sudden Change in Patient's Condition**
   If there is a sudden change in the patient’s condition, the attending physician will be notified and queried regarding notification of the consulting physician.
MEDICAL STAFF MSPP-001
POLICY & PROCEDURE

PURPOSE: To outline a policy and procedure for the use of a History and Physical from a provider who is not credentialed and privileged at St. James Healthcare.

SCOPE: All members of the medical staff and Allied Health Professionals privileged through the medical staff process.

CLINICAL SECTION: All Clinical Sections

POLICY: A provider who is authorized/privileged by St. James Healthcare, (as permitted by state law and organization policy) and familiar with the organization’s policy for the defined minimal content of the H & P must:

- review the history and physical examination document;
- determine if the information is compliant with minimal content defined in the Medical Staff Bylaws;
- obtain missing information through further assessment;
- update information and findings as necessary, which shall include, but are not limited to:
  - inclusion of absent or incomplete required information
  - a description of the patient’s condition and course of care since the history and physical examination was performed
  - a signature and date on any document with updated or reviewed information as an attestation that it is current
MEDICAL STAFF MSPP-002  
POLICY & PROCEDURE

PURPOSE: To provide guidelines for Focused Professional Practice Evaluation (FPPE) which allows the Medical Staff and the hospital to substantiate current competence for practitioners initially granted privileges or who apply for new privileges at St. James Healthcare.

SCOPE: All members of the medical staff and Allied Health Professionals privileged through the medical staff process.

CLINICAL SECTION: All Clinical Sections

POLICY:

Focused Professional Practice Evaluation (FPPE), will provide the basis for obtaining organization-specific information that substantiates current competence for practitioners initially granted privileges or who apply for new privileges at St. James Healthcare.

1. Definitions
   A. Practitioner – For the purpose of this policy, the term “practitioner” means any medical staff member or allied health professional (AHP) who applies for and receives clinical privileges at St. James Healthcare.
   
   B. Evaluating – For the purpose of this policy, FPPE is a focused evaluation to confirm an individual practitioner’s current competence, either at initial granting of privileges as a current member of the medical or AHP staff or when new privileges are requested. The hospital’s medical staff has elected to use the six general competencies as defined by the American Board of Medical Specialties (ABMS) as a general framework for evaluation of practitioners. The six competencies include:

   1) Patient care and Procedural Skills – Provide care that is compassionate, appropriate and effective treatment for health problems and to promote health.
   2) Medical knowledge – Demonstrate knowledge about established and evolving biomedical, clinical and cognate sciences and their application I patient care.
   3) Practice-based learning and improvement – Able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence and improve their practice of medicine.
   4) Interpersonal and communication skills – Demonstrate skills that result in effective information exchange and teaming with patients, their families and professional associates (e.g. fostering a therapeutic relationship that is ethically should, uses effective listening skills with non-verbal and verbal communication; working as both a team member and at times as a leader).
   5) Professionalism – Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to diverse patient populations.
   6) Systems-based practice – Demonstrate awareness of and responsibility to larger context and systems of healthcare. Be able to call on system resources to provide optimal care (e.g. coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professions or sites).

2. Medical Staff Oversight
   A. The Section Chair is responsible for overseeing the FPPE process for all applicants assigned to his/her Section. The Section Chair may delegate the review; however, has primary responsibility as assigned by the Medical Staff Bylaws. Evaluations are part of the quality files, with the Section Chair recommending removal of the FPPE process upon successful completion. All identified
quality issues are referred through routine quality review processes and are protected as such under peer review protection guidelines.

B. The Medical Executive Committee assumes the responsibility of monitoring compliance with this policy. It accomplishes this oversight through receiving quarterly status reports from the Section Chairs related to the progress of all practitioners required to be evaluated, as well as any issues or problems involved in implementing this policy.

3. Review
Selection of criteria for review will be determined by the Section Chair and is dependent on the privileges requested. The appropriate methods to determine current competency will be part of the recommendation for granting of privileges by the Section Chair and will be reviewed and approved by Medical Executive Committee and recommended to the Board of Directors.

4. Sources of Data
A. FPPE data may include (but is not limited to):
   1) Personal interaction with the practitioner
   2) Detailed medical record review
   3) Interviews of hospital staff interacting with the practitioner
   4) Chart audits based on medical staff-defined criteria by non-medical staff personnel
   5) Quantros and/or Risk Management reports

B. The data obtained by the evaluator will be recorded on the appropriate retrospective evaluation form for consistency.

5. FPPE Period
Evaluation will begin when a practitioner is informed of the appointment to the medical staff, AHP staff, or upon being granted a new privilege. The evaluation period may be extended for a period not to exceed 24 months from the granting of privilege(s) that require evaluation, as defined by Medical Staff Bylaws.

6. Results and Recommendations
At the end of the FPPE period, the Section Chair shall provide a summary report to the Medical Executive Committee. After review, the Medical Executive Committee provides a recommendation to the Board of Directors.

7. Responsibilities
A. Reviewer – A reviewer must be a member in good standing of St. James Healthcare’s Medical or AHP staff and must have privileges in the area relative to the privileges to be evaluated. In the absence of a suitable reviewer, an appropriate external reviewer may be utilized. The reviewer shall:
   1) Use appropriate methods and tools approved by the Medical Executive Committee.
   2) Assure the confidentiality of the evaluation results and forms and deliver the completed forms to the Medical Staff Office for review by the applicable Section Chair.
   3) If the practitioner being evaluated lacks sufficient cases to complete the evaluation process in the prescribed timeframe, the reviewer should report this to the Section Chair.
   4) If at any time during the evaluation period concerns are identified about the practitioner’s competency to perform specific clinical privileges or care related to specific patients, the Section Chair should be notified.

B. Section Chairs – Each medical staff Section Chair shall:
   1) Assign of reviewers as reflected above.
   2) Review treatment records of the patient(s) if, at any time during the FPPE period, the Section Chair is notified of concerns and:
      a) Review the case for possible referral for peer review, and/or
b) Recommend to the Medical Executive Committee that
   ● Additional or revised evaluation requirements be imposed upon the practitioner
   ● Corrective action is undertaken pursuant to applicable corrective action procedures

3) Review both case-specific and aggregate data and provide the Medical Executive Committee with an interpretation of the practitioner's performance and whether it is acceptable, in need of further data to complete the evaluation, or unacceptable.

C. Medical Executive Committee
   1) Receive and review the recommendations of the Section Chairs.
   2) Make recommendations for extension or completion of FPPE to the Board of Directors.
   3) Perform annual review and analysis of the process.

8. Procedure
   The specific steps needed to perform the FPPE process are outlined below:

   A. Evaluation Assignments
      Prior to privileges being granted by the Board of directors, the Medical Staff President and Section Chairs make and confirm evaluation assignments to members from appropriate specialties.

      1) Initiation of Evaluation. The Section Chair and Medical staff Coordinator inform the evaluator and the practitioner of the FPPE plan at orientation and activation of privileges.

      2) Distribution of Evaluation Forms. The Medical Staff Coordinator distributes evaluation forms to the evaluator prior to or at the time the privileges are activated.

      3) Completion of Evaluation Forms. The evaluator submits completed evaluation forms to the Medical Staff Office quarterly for the duration of the proctoring period.

      4) Review of Evaluation Forms. The Medical Staff Coordinator collects evaluation forms as needed during the evaluation period and alerts the Section Chair that they are ready for review.

      5) Recommendation. At the end of the initial evaluation period or volume (unless substantial concerns are raised earlier requiring immediate action), the Section Chair provides to the Medical Executive Committee an overall assessment of evaluation data and recommendation to end or extend evaluation or terminate privileges.

      6) Written Response.
         a. If at any time during the initial FPPE procedure there is evidence of negative findings by the evaluation process, the practitioner shall be notified by the Section Chief in writing or in person, of the findings and given the opportunity to provide a written response to the findings. Upon receipt of the provider's written response, if the negative findings are not upheld by the Section Chief and the Medical Executive Committee, the evaluation form(s) will not be incorporated into the practitioner's quality file which is maintained in the Medical Staff Office.

         b. If the negative findings are upheld, the written response will be placed in the provider's quality file that is maintained in the Medical Staff Office.

   B. Final Recommendation and Decision
      At its next scheduled meeting, the Medical Executive Committee reviews the evaluation data and Section Chair's recommendation and submits a final recommendation to the Board of Directors.
MEDICAL STAFF MSPP-003
POLICIES & PROCEDURES

PURPOSE: To provide guidelines for Ongoing Professional Practice Evaluation (OPPE) which allows the Medical Staff and the hospital to identify professional practice trends that impact on quality of care and patient safety.

SCOPE: All members of the medical staff and Allied Health Professionals privileged through the medical staff process.

CLINICAL SECTION: All Clinical Sections

POLICY:
OPPE is used to assess the competence of medical staff members and Allied Health Professional staff members who are privileged through the medical staff process. Data is collected and analyzed for review. Criteria for review may include, but is not limited to:

- Review of operative and other clinical procedures performed and their outcomes
- Length of stay patterns
- Morbidity and mortality data
- Practitioner’s use of consultants
- Other relevant criteria as determined by the organized medical staff

The medical staff is responsible for ensuring that OPPE is consistently implemented and that clearly defined indications are uniformly applied.

PROCEDURE:
Continuing review of patient care and the professional performance of practitioners is the responsibility of the Section Chiefs as delineated in the Medical Staff Bylaws.

The organized medical staff has a leadership role in performance improvement activities to improve quality of care, treatment and services as well as patient safety. This is accomplished through the mechanisms of the hospital’s and medical staff’s committees, which include, but is not limited to: patient care improvement committee; patient safety committee; ethics committee; and any other organization-wide performance improvement activities, the results of which may provide information as it relates to the performance of a practitioner with privileges.

The hospital’s medical staff has elected to use the six general competencies as defined by the American Board of Medical Specialties (ABMS) as a general framework for evaluation of practitioners. The six competencies include:

1) Patient care and Procedural Skills – Provide care that is compassionate, appropriate and effective treatment for health problems and to promote health.
2) Medical knowledge – Demonstrate knowledge about established and evolving biomedical, clinical and cognate sciences and their application I patient care.
3) Practice-based learning and improvement – Able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence and improve their practice of medicine.
4) Interpersonal and communication skills – Demonstrate skills that result in effective information exchange and teaming with patients, their families and professional associates (e.g. fostering a therapeutic relationship that is ethically should, uses effective listening skills.
with non-verbal and verbal communication; working as both a team member and at times as a leader).

5) Professionalism – Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to diverse patient populations.

6) Systems-based practice – Demonstrate awareness of and responsibility to larger context and systems of healthcare. Be able to call on system resources to provide optimal care (e.g. coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professions or sites).

All OPPE’s will be reviewed by the Section Chief and reported to the Medical Executive Committee to determine whether there are any performance improvement initiatives that need to be addressed further related to organizational processes or clinical practices.

All reviews shall be considered a part of the confidential peer review activity of the medical staff and allied health professional staff and are intended to enhance the quality and safety of patient care, and as such is entitled to peer review protection and privilege.

The choice of the methods may include, but are not limited to:

1. Periodic chart review
2. Direct Observation
3. Evaluation of diagnostic and treatment techniques
4. Discussion with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nursing and administration personnel.

The written results of OPPE will become a part of the practitioner’s quality file, which is maintained in the Medical Staff Office and will be included in the decision to maintain existing privileges, revise existing privileges or to revoke an existing privilege prior to or at the time of renewal.

Written Response.

a. If at any time during the OPPE procedure there is evidence of negative findings by the evaluation process, the practitioner shall be notified by the Section Chief in writing or in person, of the findings and given the opportunity to provide a written response to the findings. Upon receipt of the provider’s written response, if the negative findings are not upheld by the Section Chief and the Medical Executive Committee, the evaluation form(s) will not be incorporated into the practitioner’s quality file which is maintained in the Medical Staff Office.

b. If the negative findings are validated, the practitioner will be returned to the Focused Professional Practice Evaluation (FPPE) period until it is deemed by the Section Chief and the Medical Executive Committee that improvement of the provider has been adequately reviewed and documented. Once the decision is made by the Section Chief and the Medical Executive Committee that the practitioner has improved and is deemed adequate, the practitioner will return to the OPPE process and will be notified in writing.

c. If the negative findings are upheld, the written response will be placed in the provider’s quality file that is maintained in the Medical Staff Office.

Results of OPPE’s are to be communicated in writing to the practitioner.