PROVIDENCE
St. Patrick Hospital

BYLAWS OF THE MEDICAL STAFF

ARTICLE I
MEDICAL STAFF APPOINTMENT and REAPPOINTMENT

Section 1. Appointment

Appointment and reappointment to membership on the Medical Staff is a privilege which shall be extended only to professionally competent physicians, dentists, and podiatrists who continuously meet the qualifications, standards and requirements set forth in these Bylaws and Policies of the Medical Staff. All members have delineated clinical privileges that define the scope of patient care services they may provide independently in the hospital. All members and others with delineated clinical privileges are subject to medical staff bylaws and policies and are subject to review as part of the organization's performance improvement activities.

Section 2. Ethical Requirements

Each staff appointee will conduct himself/herself in accordance with the healing mission of the medical profession as generally perceived. All staff members, while attending patients at this hospital, are required to abide by the "Ethical and Religious Directives for Catholic Health Facilities."

Section 3. Term of Appointment

Appointment to the staff will be made by the Governing Body for not more than a two-year period.

Section 4. Resignation or Termination of Appointment

Resignation or termination, in good standing, of medical staff appointment is contingent on the member's request for resignation and fulfillment of all medical record requirements and obligations pertaining to the patients he/she has attended at the hospital and contingent on the Governing Body's granting this request. The request must be made at least 30 days prior to date of resignation/termination.

Appointment of any staff member may be terminated by the Governing Body following an investigation under the direction of the Executive Committee and as defined in these bylaws.

Section 5. Appointment to Medical Staff Categories

Applicants for initial appointment to the Medical Staff and clinical privileges shall be reviewed in accordance with established policies of the Medical Staff. This includes review and recommendation by the practitioner's department chair, the Credentials Committee, and the Executive Committee. Final determination shall be made by the Governing Body. Applicants for reappointment to the Medical Staff and clinical privileges shall undergo the same general process as in initial appointment as delineated in applicable Medical Staff policies and procedures.

All appointments and reappointments to the Medical Staff will be to one of the following categories of the Medical Staff: Active, Affiliate, or Non-Resident Consulting. All Members shall be granted clinical privileges in one or more specific Departments. As a general rule, Medical Staff Members may apply for and be granted privileges in a single Department. However, if a Medical Staff Member has completed residencies in multiple specialties encompassing more than one Department, that Member is board certified or board eligible in those specialties, and that Member intends to actively practice in those specialties, the Member may apply for appointment to more than one Department. Additionally, Medical Staff Members may be eligible for clinical privileges in other Departments as applied for and recommended pursuant to these bylaws and related policies.

Appointees to the Medical Staff, in addition to meeting the basic responsibilities of Medical Staff

Members set forth in these bylaws, will, as needed, actively participate in proctoring and other quality assessment and improvement activities, including peer review, required of the Medical Staff, participate in emergency and other specialty coverage, such as emergency and town call, and fulfill other Medical Staff duties, responsibilities and functions.

Section 6. Active Category

An Active Category Member must meet the following criteria:

A. Regularly admit patients, or otherwise be regularly involved in the care of patients of the Hospital. "Regularly" means at least 24 Patient Contacts for each 12-month period. In a specialty without an active Hospital practice such as, but not limited to, allergy and dermatology, a Practitioner may qualify for Active Category membership through demonstrated active participation in the activities of the Medical Staff and the Hospital.
B. Support the activities and principles of the Hospital.
C. Fulfill all Committee appointments and assignments.
D. Take emergency and town call in his/her specialty and in accordance with emergency and town call policy.

An Active Category Member may:

A. Exercise such clinical privileges as granted by the Governing Body.
B. Vote and hold office.
C. Be a Committee member.

Section 7. Non-Resident Consulting Category

A Non-Resident Consulting Category member must meet the following criteria:

A. Admit patients to, or otherwise be involved in the care of patients of the Hospital.
B. Reside outside a 30-mile radius of Missoula County.
C. Designate for each admission, an Active Category Member who will accept and exercise responsibility for care of the patient.
D. Have been granted Non-Resident Consulting Category membership by the Governing Body following review of a recommendation by the Executive Committee.

A Non-Resident Consulting Category Member may:

A. Exercise such clinical privileges as granted by the Governing Body.
B. Be excused from emergency and town call.

Section 8. Honorary Category

An Honorary Category Member must meet the following criteria:

A. Are former active medical staff members.
B. Be retired from active medical practice and of outstanding ability and reputation.
C. Have no clinical privileges and no call responsibility.
D. Have been accorded the honor of permanent, emeritus staff membership by the Governing Body upon recommendation of the Executive Committee.
E. Support the activities and principles of the Hospital.

An Honorary Category Member may:

A. Attend General Medical Staff meetings.
B. Vote.
C. Be a Committee member.

Section 9. Affiliate Category

Affiliate Category Members are those who do not intend to have a practice within St. Patrick Hospital

(SPH) but wish to belong to the Medical Staff for educational or collegial purposes or to promote continuity of patient care through referrals and collaboration with Medical Staff members who have admitting and clinical privileges at SPH.

An Affiliate Category Member must meet the following criteria:

A. Maintain a valid Montana State license.
B. Meet all requirements for initial appointment to Medical Staff, except for Board eligibility or certification.
C. Meet reappointment requirements which must include NPDB query, and two peer evaluations.
D. Have been granted Affiliate Category Membership by the Board following review of a recommendation by the Executive Committee.
E. Agree to accept patients discharged from SPH who have no identified physician for medically necessary follow-up, per current Emergency and Town Call Policy.

An Affiliate Category Member may:

A. Refer patients to SPH for medical care for out-patient or in-patient services.
B. Order diagnostic tests on patients not admitted to SPH.
C. Order outpatient treatments consisting of infusions or transfusions
D. Visit patients with whom the Affiliate Category Member has a current professional relationship and review those patients' medical records.
E. Observe procedures, with the consent of the Medical Staff member performing the procedure.
F. Serve as a committee member at SPH, excepting the Executive Committee. However, the Chair of the Department of Family Medicine may be a member of the Executive Committee.
G. Vote at any committee meeting where he/she is a member, as well as at General Medical Staff meetings.

An Affiliate Category Member may not:

A. Admit patients to SPH.
B. Document in the permanent clinical records of patients within SPH.
C. Order any lab tests or other diagnostic tests for patients who are currently admitted to SPH (Inpatient and outpatient areas, including, but not limited to ER, Day Surgery, and Endoscopy).
D. Provide any medical care, treatment or services for hospital patients (in or out) at SPH.
E. Interfere with the clinical care and management of patients who are currently admitted to SPH.
F. Participate in emergency call.

ARTICLE II
CLINICAL PRIVILEGES

Section 1. Medical Staff Clinical Privileges

Every Medical Staff appointee is granted specific clinical privileges by the Governing Body and is entitled to exercise only those privileges specifically granted. The Governing Body may include review, consultation or other conditions relating to privileges as recommended by the Executive Committee. The organization, based on recommendations by the organized medical staff and approval by the Governing Body, develops criteria that will be considered in the decision to grant, limit, or deny a requested privilege. Medical Staff appointment and clinical privileges are granted for not longer than a two-year period.

The extent of privileges granted to each Medical Staff appointee is based on criteria developed by the

department. Factors include the individual's education, training, experience, current competence, references, peer recommendations, information pertaining to the quality of care the individual provides, a query to the National Practitioner Data Bank, appropriateness of the privileges requested and other relevant information. At initial appointment, these items will be verified and reviewed by the appropriate department chair, the Credentials Committee, and the Executive Committee who will forward a final recommendation to the Governing Body for approval. Completed applications for privileges will be acted upon within 180 days. Additional information regarding this process is contained in the Processing Application Policy of the Medical Staff.

Members requesting reappointment to the medical staff and renewal of privileges must satisfy eligibility requirements including completion of medical records, completion of continuing medical education requirements, and continuous satisfaction of all qualifications and criteria for appointment and clinical privileges. In addition, the member must have had sufficient verifiable patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. The reappointment request will be reviewed by the appropriate department chair and the Executive Committee, which will forward a final recommendation to the Governing Body for approval. Additional information regarding this process is contained in the Reappointment Factors and Conditions Policy.

Section 2. Request for Clinical Privileges

Application for Medical Staff appointment must contain a request for the specific clinical privileges desired by the applicant. The applicant has the burden of establishing qualifications and current competency in the clinical privileges requested. The application must be made on a hospital approved form.

Requests for changes in clinical privileges other than at the time of application for reappointment will be in accordance with medical staff policy.

Section 3. Temporary and Locum Tenens Privileges

Requests for Temporary Privileges will only be granted in two instances and in accordance with Medical Staff Policy:

A. When a new physician applicant to the Medical Staff or a new applicant for Allied Health Privileges has a complete, clean application and is awaiting review and approval of the Credentials Committee, Medical Staff Executive Committee and/or Governing Body. This request must be approved by the Chief Acute Services Officer, and either the President of the Medical Staff or the appropriate clinical department chair, and the Chair of the Credentials Committee.

B. To fulfill an important patient care need. This request must be approved by the Chief Acute Services Officer, and either the President of the Medical Staff or the Chairperson of the applicable clinical department.

Temporary Privileges will not be granted simply for the convenience of the Hospital Administration or Medical Staff and will not exceed a period of ninety (90) days.

Locum Tenens Privileges will only be granted in accordance with Medical Staff Policy.

Section 4. Emergency and Disaster Privileges

In case of emergency, defined as a condition in which serious permanent harm would result 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 danger, any physician, dentist or podiatrist member of the staff, to the degree permitted by license and regardless of privileges or staff category, will be permitted and assisted to do everything possible to save the life of a patient, using every facility of the hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such physician,

dentist, or podiatrist must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or are not requested, the patient shall be assigned to an appropriate member of the staff.

In the case of a disaster when the hospital Emergency Management Plan has been activated and the hospital's Medical Staff is unable to handle immediate patient care needs, any licensed independent practitioner presenting himself/herself to the hospital who is not a member of the medical staff who presents a valid picture identification such as a driver's license or passport may be considered for disaster privileges.

Prior to the granting of disaster privileges, the practitioner must complete an Emergency/Disaster Privileges form and his/her professional license must be verified via online web database. In the extraordinary circumstance that primary source verification of licensure cannot be completed prior to the volunteer being assigned duties, it will be completed as soon as possible.

The volunteer staff will be assigned to a SPH manager or designee who will provide oversight of the professional practice and care provided by the volunteer staff via observation and collaboration of care. Based upon information obtained regarding the professional practice of volunteer staff, the organization will make a decision within seventy-two (72) hours related to the continuation of disaster privileges initially granted. Disaster privileges will automatically terminate when the emergency situation no longer exists as determined by SPH's Emergency Operations Plan and the practitioner is notified by the hospital.

Section 5. Telemedicine privileges

For telemedicine physicians providing telemedicine services under an agreement, the medical staff may rely upon the credentialing and privileging decisions of the distant-site hospital or telemedicine entity with which the hospital has entered into an agreement. The credentialing and privileging process of the distant site hospital or entity will conform to current regulatory standards, and details of this process will be part of the agreement with St. Patrick Hospital.

ARTICLE III
EXECUTIVE COMMITTEE OF THE MEDICAL STAFF

Section 1. Executive Committee Role and Responsibility

The organized medical staff delegates authority to the medical staff Executive Committee to carry out medical staff responsibilities. The Executive Committee carries out its work within the context of the Hospital's functions of governance, leadership and performance improvement. The Executive Committee has the primary authority for activities related to self governance of the medical staff and for performance improvement of the professional services provided by physicians and licensed independent practitioners.

In the same way delegated authority to the Medical Executive Committee is established through these Medical Staff Bylaws, removal of this delegated authority from the Medical Executive Committee is also established.

Section 2. Communication

Effective communication among the Medical Staff, Hospital Administration and the Governing Body is essential. The Executive Committee serves as liaison between the Medical Staff and the president of the Medical Staff, between the Medical Staff and Hospital Administration, between the Medical Staff and the Governing Body and between departments of the Medical Staff. The Executive Committee is responsible for making recommendations to the Governing Body for its approval. The Executive

Committee receives and acts on reports and recommendations from Medical Staff departments and committees.

Section 3. Composition of the Executive Committee

The Executive Committee will include physicians and will be composed of, at least, the following individuals:

A. President
B. President-Elect
C. Past President
D. At-Large-Delegates (3 or more)
E. Secretary
F. Credentials Committee Chair
G. Department Chairs
H. Peer Review Committee Chair

The Executive Committee may include other practitioners and any other individuals as determined by the organized medical staff.

The Hospital CEO or his/her designee attends Executive Committee meetings on an ex-officio basis without a vote.

Section 4. Responsibilities of the Executive Committee

The Executive Committee will have, at least, the following responsibilities:

A. Coordinate Medical Staff activities,
B. Oversee quality improvement activities,
C. Create, eliminate or consolidate committees as appropriate,
D. Recommend all Medical Staff bylaw changes to the General Medical Staff,
E. Address concerns, complaints and issues relating to members of the Medical Staff and initiate investigations or corrective action when indicated,
F. Receive and act upon reports and recommendations from Medical Staff committees and departments,
G. Make recommendations or provide reports to the Governing Body, regarding Hospital employed physicians and physician contracts, Medical Staff and Allied Health Professional appointment, reappointment, clinical privileges and quality of care,
H. Perform any additional responsibilities delegated to it by the Governing Body,
I. Review and make changes or additions in Medical Staff policies,
J. Review and recommend to the Governing Body changes or additions to Medical Staff bylaws.

Section 5. Meetings, Reports and Recommendations of the Executive Committee

The Executive Committee will meet as needed but at least ten times each year. It will report and make recommendations as needed to Administration, the Medical Staff and its Departments and Committees. Further, it will routinely report and make recommendations to the Community Ministry Board.

Section 6. Conflict and Dispute Resolution

Should there be issues of conflict between the medical staff and the 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) (by a petition of at least 20%) may communicate with the Community Ministry Board or the Medical Executive Committee to voice their concerns, provided that there has first been an attempt to resolve differences with the Executive Committee directly. Nothing in the foregoing is intended to prevent medical staff members from communicating with the Community Ministry Board on a rule, regulation, or policy adopted by the organized medical staff or the Executive Committee. Details of

the process for conflict and dispute resolution shall reside in the Leadership Group Conflict Management Policy.

ARTICLE IV
LEADERSHIP OF THE MEDICAL STAFF

Section 1. Officers and Chairpersons of the Medical Staff

Medical Staff Leadership includes elected officers and appointed chairpersons of Medical Staff Departments and Committees. These individuals are considered a part of the Hospital leadership. Officers of the Medical Staff are:

A. President
B. President-elect
C. Immediate Past-President
D. Secretary
E. Delegates-At-Large

Officers and Chairpersons will have and fulfill duties as specified in Medical Staff Policy. Only those Medical Staff Members who satisfy the following criteria will be eligible to serve as Officers and Department or Committee Chairpersons:

A. Be appointed as Active Category Members and maintain such appointments during their term of office.
B. Have no pending recommendations to revoke, reduce or restrict their Medical Staff membership or clinical privileges. Failure to maintain such status will immediately create a vacancy in the office involved.
C. Be certified by an appropriate specialty board, or have affirmatively established comparable competence through the credentialing process.
D. Be a doctor of medicine or osteopathy, or if permitted by state law, a doctor of dental surgery or dental medicine.

Section 2. Nominations, Elections, Appointments and Terms of Office

A. The Nominating Committee shall nominate at least one candidate for the following year for the offices of President-elect and Secretary and for the At-large position on the Executive Committee. The names of the candidates will be submitted to the Medical Staff at the annual meeting of the General Staff. Additional nominations may be made from the floor by Active Staff members at the annual meeting.

B. Election of officers for the following year will occur by mailed or e-mailed ballot during the months of November or December and will be determined by a plurality of the mailed or e-mailed ballots returned within the specified time.

C. Officers will assume the duties of their offices on the first day of January following the annual meeting at which they were elected and will serve through the last day of December of that year.

D. In the event that the office of President is vacated, the President-elect shall serve out the President's term and the office of President-elect shall remain vacant until the next annual election of officers. Should the office of President-elect be vacated other than by succession to the presidency, or should the office of Secretary be vacated, the offices may be filled by election at any regular or special meeting of the Medical Staff.

E. The President, President Elect, Immediate Past-President, and Secretary's term of office will be for one year. Should they agree to serve, officers may be nominated for and re-elected to a second consecutive term. During his/her term of office, the President serves as a member of the hospital Governing Body. Department and Committee chairpersons may serve longer at the discretion of the President. The Delegates-at-Large will have terms of three years or until a successor is elected.

Section 3. Vacancies and Removal of Officers or Department and Committee Chairpersons

Upon receipt of a petition seeking recall of an Officer, signed by not less than one-third of the Medical Staff Active Category members, the President will call a special meeting of the General Staff Active members to be held within thirty (30) days of receipt of the petition. If two-thirds of the eligible voters present vote for recall, the office or position will be declared vacant.

Any elected representative who, during the course of his/her tenure, fails to maintain Active Medical Staff membership is automatically removed from office excepting chair of Hospital Inpatient/Outpatient Liaison Committee.

An appointed individual who, during the course of his/her tenure, fails to maintain Active Medical Staff membership, is malfeasant in office, conducts himself/herself in a manner detrimental to the interests of the hospital or fails or is unable to fulfill the requirements of the position, may be removed by the person authorized to have appointed that individual.

The term of any individual elected or appointed to a vacated office or chair will coincide with the intended term of the individual he has replaced.

If there is a vacancy in the office of President prior to the expiration of the President's term, the President-Elect will assume the duties and authority of the President for the remainder of the unexpired term. If there is a vacancy in any other office, the President will appoint another individual meeting criteria set forth herein to serve out the remainder of the unexpired term.

ARTICLE V
MEETINGS OF THE MEDICAL STAFF

Section 1. General Staff Meetings

General Medical Staff meetings will be held quarterly. Notice of all meetings of the General Staff will be posted on the Medical Staff bulletin board and delivered to members either in person or by mail (including electronic mail).

The President of the Medical Staff will establish the agenda and conduct any regular or special General Staff meetings. Once the quorum requirements have been met, a simple majority of voters present at the time of the vote will be needed to take an action. At least 20 members with Active or Honorary membership must be present to establish a quorum. If the vote is conducted by mail (including electronic mail) or phone, at least 25% of members eligible to vote must do so to establish a quorum.

Section 2. Department and Committee Meetings

Each Department will meet as needed but no less than four times per year at times set by the Chair of the Department. Members will review and evaluate information collected concerning the clinical work of the Department, consider the findings of ongoing performance improvement, monitoring and evaluation activities, and discuss any other matters concerning the Department.

Committees will meet as needed. Members review and evaluate information collected covering the care of patients and make recommendations for performance improvement.

In the event a Committee or Department must act on a question when it is not feasible to call a meeting, all voting Members may be presented with the question, in person, by mail (including electronic mail), or by telephone call and their votes returned to the Chair. Such a vote will be binding so long as the question is voted on by a majority of the Committee or Department members eligible to vote.

Those present, eligible and voting will constitute a quorum for all Committee and Department actions. Eligible voters include all Medical Staff members appointed to a Department or Committee.

Section 3. Provisions Common to All Meetings

Agendas for General Staff, Department and Committee meetings will be developed by the respective Chair.

Minutes of each General Medical Staff, Department and Committee meeting will be prepared. These will include those in attendance, findings, proceedings, and actions. Minutes of meetings will be maintained by Hospital Administration. Minutes of Departments and Committees will be provided to the Executive Committee.

All Active and Affiliate status medical staff members will be required to attend 50% of the General Medical Staff meetings annually. This meeting attendance will be tracked as a component of Ongoing Professional Practice evaluation and will become a required element for reappointment. A member may receive credit for a missed meeting if he reviews the minutes in Medical Staff Services within 90 days of the meeting and signs an attestation stating he has done so. All members who have not met the 50% annual attendance requirement in the two years prior to the date their reappointment applications are sent out will be assessed a reappointment fee of $250. This fee must be received in order for the reappointment application to be processed.

Confidentiality of meeting proceedings, including minutes and reports, is essential. All information collected or prepared for the purpose of achieving and maintaining quality patient care is confidential and will not be provided to anyone other than authorized individuals and as defined in Medical Staff Policy.

ARTICLE VI
DEPARTMENTS OF THE MEDICAL STAFF

Section 1. Organization of Departments

Medical Staff Departments include: Anesthesiology, Emergency Medicine, Family Medicine, Medicine, Obstetrics, Pathology, Pediatrics, Psychiatry, Radiology and Surgery.

Each Department is responsible for the promotion of quality care at the Hospital and peer review of Members and Allied Health Professionals rendering care.

Sections or subcommittees will be established by the Departments following approval of the Executive Committee. Sections and subcommittees will be directly responsible to the related Department.

Department Chairs are appointed by the President of the Medical Staff. Chairs are responsible for the supervision and satisfactory discharge of the functions of the Department. Chairs will be certified by their appropriate specialty board or have comparable competence established by the Credentials Committee.

Section 2. Functions of Departments

Each Department, through its Chair, will recommend to the Credentials Committee written criteria for the

granting of clinical privileges within the Department. Such criteria will be consistent with and subject to the bylaws, policies of the Medical Staff, the Hospital and its Governing Body.

Each Department, through its Chair, will be responsible for:

A. Clinically related activities of the department.
B. Administratively related activities of the department, unless otherwise provided by the Hospital.
C. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.
D. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department.
E. Recommending clinical privileges for each member of the department.
F. Assessing and recommending to the relevant hospital authority offsite sources for needed patient care, treatment and services not provided by the department or the organization.
G. The integration of the department into the primary functions of the hospital.
H. The coordination and integration of interdepartmental and intradepartmental services.
I. The development and implementation of policies and procedures that guide and support the provision of care, treatment and services.
J. The recommendations for a sufficient number of qualified and competent persons to provide care, treatment and service.
K. The determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment and services.
L. The continuous assessment and improvement of the quality of care, treatment and services.
M. The maintenance of quality control programs.
N. The orientation and continuing education of all persons in the department.
O. Recommendations for space and other resources needed by the department.

ARTICLE VII
COMMITTEES OF THE MEDICAL STAFF

Section 1. Organization of Committees

Committees of the Medical Staff include the Executive Committee and other committees as defined in Medical Staff Policy. The Executive Committee may establish, dissolve or change committee structure, duties or composition, as needed, to better accomplish Medical Staff functions.

Section 2. Committee Membership

Medical Staff committees are established to perform one or more of the Medical Staff functions required by these Bylaws. Committees may include Active, Affiliate and Honorary Members. Non-voting members may include, when appropriate, Allied Health Professionals, Hospital management, and representatives of nursing, quality management, medical records, pharmacy, case management or other departments. All committee chairs are appointed by the President of the Medical Staff.

Except as otherwise provided for in these bylaws, members of each committee will be appointed yearly by the Committee Chair not more than 30 days after the end of the year. There will be no limitation in the number of terms members may serve. Appointed members may be removed and vacancies filled at the discretion of the Committee Chair.

ARTICLE VIII
COLLEGIAL INTERVENTION AND INVESTIGATIONS

Section 1. Collegial Intervention

These Bylaws encourage the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review.

Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of staff members and pursuing counseling, education, and related steps, such as the following:

A. Advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
B. Proctoring, monitoring, consultation, and letters of guidance;
C. Sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

The relevant Medical Staff leader(s) will determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation of collegial efforts is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response will be maintained in that individual's file along with the original documentation.

Collegial intervention efforts are encouraged, but are not mandatory, and will be within the discretion of the appropriate Medical Staff leaders and Hospital management.

This meeting is not a hearing, and none of the procedural rules for hearings will apply. No party involved will have the right to be represented by legal counsel at this meeting. Recording of this meeting via the use of any device will not be allowed.

The relevant Medical Staff leader(s), in conjunction with the CEO, will determine whether to direct that a matter be handled in accordance with another policy. Medical Staff leaders may also direct these matters to the Executive Committee for further action.

Section 2. Investigations

A. Initial Review:
    1) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue, regarding:
        a. the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;
        b. the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws and policies of the Hospital or the Medical Staff; and/or
        c. conduct by any member of the Medical Staff that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others, the matter may be referred to the President of the Medical Staff, the chair of the department, the chair of a standing committee (e.g., Professional Wellness Committee), the CEO or his/her designee, or the Chair of the Governing Body.

2) The person to whom the matter is referred will make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, will forward it in writing to the Executive Committee.
3) No action taken pursuant to this Section will constitute an investigation.

B. Initiation of Investigation:
1) When a question involving clinical competence or professional conduct is referred to, or raised by, the Executive Committee, the Executive Committee will review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (such as the Code of Conduct or the Professional Wellness policy) or to proceed in another manner. In making this determination, the Executive Committee may discuss the matter with the individual. An investigation will begin only after a formal determination by the Executive Committee to do so.
2) The Executive Committee will inform the individual that an investigation has begun. Notification may be delayed if, in the Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff. The Executive Committee may delegate this to an individual, such as an officer or other medical staff leader.
3) The Governing Body may also determine to commence an investigation and may delegate the investigation to the Executive Committee, a subcommittee of the Governing Body, or an ad hoc committee.
4) The President of the Medical Staff will keep the CEO fully informed of all action taken in connection with an investigation.

C. Investigative Procedure:
1) Once a determination has been made to begin an investigation, the Executive Committee will investigate the matter itself or request that a committee of the medical staff such as the Credentials Committee, the Peer Review Committee or the Professional Wellness Committee conduct the investigation, or appoint an individual or ad hoc committee to conduct the investigation. Any ad hoc committee will not include partners, associates, or relatives of the individual being investigated but may include individuals not on the Medical Staff. Whenever the questions raised relate to clinical competence of the individual under review, the ad hoc committee will include a peer of the individual (e.g., physician, dentist or podiatrist).
2) The committee conducting the investigation ("investigating committee") will have the authority to review relevant documents and interview individuals. It will also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and investigating committee that:
   a. the clinical expertise needed to conduct the review is not available on the Medical Staff; or
   b. the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or
   c. the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.
3) The investigating committee may require a physical and/or mental examination of the individual by health care professional(s) acceptable to it. The individual being investigated will execute a release allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee.

4) The individual will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated. At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview will be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The individual being investigated will not have the right to be represented by legal counsel at this meeting.

5) The investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it will inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

6) At the conclusion of the investigation, the investigating committee will prepare a report with its findings, conclusions, and recommendations.

7) In making its recommendations, the investigating committee will strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:
   a. relevant literature and clinical practice guidelines, as appropriate;
   b. all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s); and
   c. any information or explanations provided by the individual under review.

D. Recommendation:

1) The Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Executive Committee may:
   a. determine that no action is justified;
   b. issue a letter of guidance, counsel, warning, or reprimand;
   c. impose conditions for continued appointment;
   d. impose a requirement for monitoring or consultation;
   e. recommend additional training or education;
   f. recommend reduction of clinical privileges;
   g. recommend suspension of clinical privileges for a term;
   h. recommend revocation of appointment and/or clinical privileges; or
   i. make any other recommendation that it deems necessary or appropriate.

2) A recommendation by the Executive Committee that would entitle the individual to request a hearing will be forwarded to the CEO, who will promptly inform the individual by special notice. The CEO will hold the recommendation until after the individual has completed or waived a hearing and appeal.

3) If the Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Governing Body.

4) In the event the Governing Body considers a modification to the recommendation of the Executive Committee that would entitle the individual to request a hearing, the CEO will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

5) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal will be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

Section 3. Precautionary Suspension or Restriction of Clinical Privileges

A. Grounds for Precautionary Suspension or Restriction:

1) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital, the President of the Medical Staff, the chair of a clinical department, the CEO, the Governing Body Chair, or the Executive Committee will each have the authority to (i) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (ii) suspend or restrict all or any portion of an individual's clinical privileges. If either situation extends greater than 30 days, the matter will be reported to the National Practitioner Data Bank.
2) A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Executive Committee that would entitle the individual to request a hearing.
3) Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It will not imply any final finding of responsibility for the situation that caused the suspension or restriction.
4) A precautionary suspension or restriction will become effective immediately upon imposition, will immediately be reported in writing to the CEO and the President of the Medical Staff, and will remain in effect unless it is modified by the CEO or Executive Committee.
5) The individual in question shall be provided a brief written description of the reason(s) for the precautionary suspension, including the names and medical record numbers of the patient(s) involved (if any), within three days of the imposition of the suspension.

B. Executive Committee Procedure:
1) The Executive Committee will review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the orderly operation of the Hospital, depending on the circumstances.
2) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Executive Committee will determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Executive Committee will also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).
3) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

C. Care of Patients:
1) Immediately upon the imposition of a precautionary suspension or restriction, the

President of the Medical Staff will assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment will be effective until the patients are discharged. The wishes of the patient will be considered in the selection of a covering physician.

2) All members of the Medical Staff have a duty to cooperate with the President of the Medical Staff, the department chair, the Executive Committee, and the CEO in enforcing precautionary suspensions or restrictions.

Section 4. Automatic Relinquishment of Privileges

A. Failure to Complete Medical Records:
Failure to complete medical records will result in relinquishment of privileges as required by applicable policy.

B. Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

1) Any action taken by any licensing governing body, professional liability insurance company, and court or government agency regarding any of the matters set forth below must be promptly reported to the Medical Staff Office.

2) An individual's appointment and clinical privileges will be automatically relinquished if any of the following occur:

a. Licensure: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's license.

b. Controlled Substance Authorization: Revocation, suspension or the placement of conditions or restrictions on an individual's DEA or state controlled substance authorization. If the DEA certification has expired, the member is automatically divested of ability to prescribe controlled substance.

c. Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.

d. Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

e. Criminal Activity: Indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another.

3) An individual's appointment and clinical privileges will be automatically relinquished, without entitlement to a hearing, if the individual fails to satisfy any of the applicable threshold qualifications.

4) Automatic relinquishment will take effect immediately upon notice to the Hospital and continue until the matter is resolved, if applicable. If an individual engages in any patient contact at the Hospital after the occurrence of an event that results in automatic relinquishment, without notifying the Hospital of that event, then the relinquishment will be deemed permanent.

5) Failure to resolve the underlying matter leading to an individual's clinical privileges being automatically relinquished in accordance with paragraphs (B)(1), (B)(2) or (B)(3) above, within 90 days of the date of relinquishment will result in automatic resignation from the Medical Staff.

6) Requests for reinstatement will be reviewed by the relevant department chair, the Chair of the Credentials Committee, the President of the Medical Staff, and the CEO. If all these individuals make a favorable recommendation on reinstatement,

the Medical Staff member may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, Executive Committee, and the Governing Body for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Executive Committee, and Governing Body for review and recommendation.

C. Failure to Provide Requested Information:
Failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges, in response to a written request from the Credentials Committee, the Executive Committee, the CEO, or any other committee authorized to request such information, will result in automatic relinquishment of all clinical privileges until the information is provided to the satisfaction of the requesting party.

D. Failure to Attend Special Conference:
1) Whenever there is a concern regarding clinical practice or professional conduct involving any individual, the department chair or the President of the Medical Staff may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff.
2) The notice to the individual regarding this conference will be given by special notice at least three days prior to the conference and will inform the individual that attendance at the conference is mandatory.
3) Failure of the individual to attend the conference will be reported to the Executive Committee. Unless excused by the Executive Committee upon a showing of good cause, such failure will result in automatic relinquishment of all or such portion of the individual's clinical privileges as the Executive Committee may direct. Such relinquishment will remain in effect until the matter is resolved.

ARTICLE IX
HEARINGS AND APPELLATE REVIEW

Section 1. Exhaustion of Remedies and Definitions

If an adverse recommendation is made with respect to an individual's staff membership, staff status, or clinical privileges at any time, regardless of whether he is an applicant or a medical staff member, the individual must exhaust the intra-organizational remedies afforded by this bylaw before resorting to formal legal action challenging the decision, the procedures used to arrive at it, or asserting any claim against the hospital or participants in the decision process. The exclusive procedure for obtaining judicial review will be by petition for Writ of Mandate pursuant to pertinent sections of the Montana Code Annotated.

Except as otherwise provided in these bylaws, the following definitions shall apply under this article:

A. "Body whose decision prompted the hearing" refers to the Executive Committee in all cases where the Executive Committee or authorized officers, members or committees of the medical staff took the action or rendered the decision which resulted in a hearing being requested. This refers to the Governing Body in all cases where the Governing Body or authorized officers, directors or committees of the Governing Body took the action or rendered the decision which resulted in a hearing being requested.
B. "Notice" refers to a written communication delivered personally to the required addressee or sent by United States Postal Service, first-class postage prepaid, certified or registered mail, return receipt requested, addressed to the required addressee at his or its address as it appears in the records of the hospital.
C. "Petitioner" refers to the individual who has requested a hearing pursuant to medical staff bylaw.
D. "Date of receipt" of any notice or other communication is the date such notice or

communication was delivered personally to the required addressee. If delivered by mail, the notice or communication is deemed received 48 hours after being deposited, postage prepaid, in the United States mail in compliance with this bylaw.

Section 2. Grounds for Hearing

Grounds for a hearing are as follows:

A. An individual is entitled to request a hearing whenever the Executive Committee makes one of the following recommendations:
   1) Denial of initial appointment to the Medical Staff;
   2) Denial of reappointment to the Medical Staff;
   3) Revocation of appointment to the Medical Staff;
   4) Denial of requested clinical privileges;
   5) Revocation of clinical privileges;
   6) Suspension of clinical privileges for more than 30 days (other than precautionary suspension);
   7) Mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or
   8) Denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.

B. No other recommendations will entitle the individual to a hearing.

C. If the Governing Body makes any of these recommendations without an adverse recommendation by the Executive Committee, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Executive Committee. When a hearing is triggered by an adverse recommendation of the Governing Body, any reference in this Article to "the Executive Committee" will be interpreted as a reference to "the Governing Body."

Section 3. Actions Not Grounds for Hearing

None of the following actions will constitute grounds for a hearing, and they will take effect without hearing or appeal, provided that the individual will be entitled to submit a written explanation to be placed into his or her file:

A. Issuance of a letter of guidance, counsel, warning, or reprimand;
B. Imposition of conditions, monitoring, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval);
C. Termination of temporary privileges;
D. Automatic relinquishment of appointment or privileges;
E. Imposition of a requirement for additional training or continuing education;
F. Precautionary suspension;
G. Denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to professional competence or conduct;
H. Determination that an application is incomplete;
I. Determination that an application will not be processed due to a misstatement or omission; or
J. Determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

Section 4. Requests for Hearing

Request for Hearing: The petitioner has thirty (30) days following the date of receipt of the notice of proposed adverse recommendation to request a hearing by a Hearing Panel. This request is affected by notice to the President of the staff with a copy to the President of the Hospital. In the event the petitioner does not request a hearing he will be deemed to have accepted the recommendation, decision, or action

involved and it thereupon becomes the final recommendation of the Medical Staff. The final recommendation is considered by the Governing Body within sixty (60) days of the recommendations for adverse action, but is not to be binding on the Governing Body.

Notice of Time and Place for Hearing: The CEO will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will contain a statement of the recommendation and the general reasons for it; a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and a copy of this Article. The hearing will 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.

Notice of Hearing and Statement of Reasons: The CEO will schedule the hearing and provide notice of the following:

A. The time, place, and date of the hearing;
B. A proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;
C. The names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and
D. A statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the petitioner's qualifications and the petitioner has had a sufficient opportunity, up to 30 days, to review and rebut the additional information.

Section 5. Hearing Panel, Presiding Officer, and Hearing Officer

The CEO, after consulting with the President of the Medical Staff, will appoint a Hearing Panel in accordance with the following guidelines:

A. The Hearing Panel will consist of at least three members, one of whom will be designated as Chair.
B. The Panel may include any combination of any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level, and/or physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital). At least one physician should be included.
C. Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Panel.
D. Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Panel.
E. The Panel will not include any individual who is in direct economic competition with the petitioner.
F. The Panel will not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

In lieu of a Hearing Panel Chair, the CEO may appoint a Presiding Officer who may be an attorney. The Presiding Officer will not act as an advocate for either side at the hearing. If no Presiding Officer has been appointed, the Chair of the Hearing Panel will serve as the Presiding Officer and will be entitled to one vote. The Presiding Officer will:

A. Allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination
B. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or

abusive or that causes undue delay

C. Maintain decorum throughout the hearing
D. Determine the order of procedure
E. Rule on all matters of procedure and the admissibility of evidence
F. Conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present
G. The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure
H. The Presiding Officer may participate in the private deliberations of the Hearing Panel and is a legal advisor to it, but will not be entitled to vote on its recommendations

As an alternative to a Hearing Panel, the CEO, after consulting with the President of the Medical Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the petitioner. If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" will be deemed to refer to the Hearing Officer.

Any objection to any member of the Hearing Panel, or the Hearing Officer, or the Presiding Officer, will be made in writing, within ten days of receipt of notice, to the CEO. A copy of such written objection must be provided to the President of the Medical Staff and must include the basis for the objection. The President of the Medical Staff will be given a reasonable opportunity to comment. The CEO will rule on the objection and give notice to the parties. The CEO may request that the Presiding Officer make a recommendation as to the validity of the objection.

The Presiding Officer, Hearing Officer, and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.

Section 6. Pre-Hearing Procedures

A. Provision of Relevant Information:
   1) Prior to receiving any confidential documents, the petitioner must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The petitioner must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.
   2) Upon receipt of the above agreement and representation, the petitioner will be provided with a copy of the following:
      a. copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the petitioner's expense;
      b. reports of experts relied upon by the Executive Committee;
      c. copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
      d. copies of any other documents relied upon by the Executive Committee.

      The provision of this information is not intended to waive any privilege under the state peer review protection statute.
   3) The petitioner will have no right to discovery beyond the above information. No information will be provided regarding other practitioners on the Medical Staff.
   4) Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, will be submitted in writing in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

5) Evidence unrelated to the reasons for the recommendation or to the petitioner's qualifications for appointment or the relevant clinical privileges will be excluded.
6) Neither the petitioner, nor any other person acting on behalf of the petitioner, may contact Hospital employees whose names appear on the Executive Committee's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the employees about their willingness to be interviewed. The Hospital will advise the petitioner once it has contacted such employees and confirmed their willingness to meet. Any employee may agree or decline to be interviewed by or on behalf of the petitioner.

B. Pre-Hearing Conference: The Presiding Officer will require the petitioner or a representative (who may be counsel) for the petitioner and for the Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing will last no more than 4 hours, with each side being afforded approximately 2 hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 4 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

C. Stipulations: The parties and counsel, if applicable, will use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

D. Provision of Information to the Hearing Panel: The following documents will be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference, (without the need for authentication); and (c) stipulations agreed to by the parties.

E. Record of Hearing: A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the Hospital. Copies of the transcript will be available at the petitioner's expense. Oral evidence will be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

F. Witness List: At least 15 days before the pre-hearing conference, the petitioner will provide a written list of the names of witnesses expected to offer testimony on his or her behalf. The witness list will include a brief summary of the anticipated testimony. The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

Section 7. Rights of Both Sides and the Hearing Panel at the Hearing

A. At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:
1) to call and examine witnesses, to the extent they are available and willing to testify;
2) to introduce exhibits;
3) to cross-examine any witness on any matter relevant to the issues;
4) to have representation by counsel who may be present but not examine, and cross-examine witnesses or present the case;
5) to submit a written statement at the close of the hearing; and
6) to submit proposed findings, conclusions and recommendations to the Hearing

Panel.

B. If the petitioner does not testify, he or she may be called and questioned.

C. The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

D. Admissibility of Evidence: The hearing will not be conducted according to rules of evidence. Evidence will not be excluded merely because it is hearsay. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

E. Post-Hearing Statement: Each party will have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

F. Persons to be Present: The hearing will be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the CEO or the President of the Medical Staff.

G. Postponements and Extensions: Postponements and extensions of time may be requested by anyone, but will be permitted only by the Presiding Officer or the CEO on a showing of good cause.

H. Presence of Hearing Panel Members: A majority of the Hearing Panel will be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she will read the entire transcript of the portion of the hearing from which he or she was absent.

I. Hearing Conclusion, Deliberations, and Recommendations: The Executive Committee will first present evidence in support of its recommendation. Thereafter, the burden will shift to the petitioner to present evidence. Consistent with the burden on all individuals to demonstrate satisfaction, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel will recommend in favor of the Executive Committee unless it finds that the petitioner has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

J. Deliberations and Recommendation of the Hearing Panel: Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel will conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel will render a recommendation, accompanied by a report, which will contain a concise statement of the basis for its recommendation.

K. Disposition of Hearing Panel Report: The Hearing Panel will deliver its report to the CEO. The CEO will send a copy of the report to the petitioner. The CEO will also provide a copy of the report to the Executive Committee.

Section 8. Hearing Procedure

The hearing is intended to be akin to an administrative law proceeding limiting the range of technical procedural arguments that an attorney for the petitioner might make against the Medical Staff leaders. The role of the attorneys is limited to consultation in order to prevent the Medical Staff hearing, an

informal discussion of colleagues, from turning into a trial.

A. Pre-Hearing Conference: It is the duty of the petitioner and the Governing Body whose decision prompted the hearing or their representatives to meet in advance of the date for the hearing for the purpose of simplification and identification of issues to be decided at the hearing and any other matters that might aid in expeditious consideration and determination of the matter and to handle all procedural issues and objections in advance of the hearing and establish limitations on the overall allotment of time for each side to present its case. The petitioner is not entitled to discovery.

B. Witnesses: A list of the witnesses, if any, expected to testify at the hearing on behalf of the professional review body will be provided to the petitioner prior to the hearing. A list of witnesses, if any, expected to testify at the hearing on behalf of the petitioner will be provided to the professional review body through the hospital president prior to the hearing. The witness list is amended when additional witnesses are identified. The physician and/or attorney may not contact individuals on the Hospital's witness list except as agreed to by hospital counsel or as directed by the hearing officer.

C. Representation: The hearings provided for in this bylaw are for the purpose of interprofessional resolution of matters bearing on conduct and professional competency. The petitioner is entitled to be accompanied by and represented at these hearings by an attorney or other person of the individual's choice. The body whose decision prompted the hearing appoints a representative from the Medical Staff or from the Governing Body (whichever body's decision prompted the hearing), or an attorney who presents its recommendation, decision, or action taken and the supporting materials and examined witnesses.

D. The Presiding Officer: The presiding officer at the hearing is a hearing officer as described below. The presiding officer acts to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. He is entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing. He has the authority and discretion, in accordance with this bylaw, to make all rulings on questions which, with reasonable diligence, could not have been raised prior to the hearing and which pertain to matters of law, procedure, or the admissibility of evidence. The hearing officer has authority to keep the hearing process an intraprofessional exchange rather than a forum for litigation tactics.

E. The Hearing Officer: At the request of the petitioner, the Executive Committee, or the Governing Body, the President or his designee may appoint a hearing officer to preside at the hearing. The hearing officer may be an attorney-at-law qualified to preside over the hearing and, preferably, with experience in medical staff matters. He must not act as a prosecuting officer, as an advocate for the hospital, Governing Body, Executive Committee, the Governing Body's whose action prompted the hearing, or the petitioner. If requested by the Hearing Panel, he may participate in the deliberations of such body and be a legal advisor to it, but is not entitled to vote.

F. Record of the Hearing: A record of the hearing shall be maintained by one of the following methods: a certified shorthand reporter present to make a record of the hearing, or an audio recording of the proceedings. The cost of any certified shorthand reporter shall be borne by the party requesting same. The Hearing Panel may, but is not required to, order that oral evidence be taken only on oath administered by any person designated by body and entitled to notarize documents in this state or by affirmation under penalty of perjury.

G. Rights of the Parties: At the pre-hearing conference, both sides have the right to challenge specific members of the Hearing Panel who, by reason of bias, should not serve on the committee. Challenged members will be replaced by the chairman of the Hearing

Panel. At the hearing, both sides will have the following rights: to call and examine witnesses, to introduce exhibits or other documents, to cross-examine or otherwise attempt to impeach any witness who testifies orally on any matter relevant to the issues, and otherwise to rebut any evidence. The petitioner may be called by the body or its representative whose decision prompted the hearing and examined as if under cross-examination. The petitioner is not entitled to discovery.

H. Burden of Going Forward and Burden of Proof: At any hearing involving any of the grounds for hearing specified herein, it is incumbent upon the petitioner, initially, to come forward with evidence in support of his position. In all other cases, the body whose decision prompted the hearing has the duty, initially, to come forward with evidence in support of such decision. Thereafter, the burden shifts to the petitioner to produce evidence in support of his position. The petitioner bears the ultimate burden of persuading the Hearing Panel, by a preponderance of the evidence provided at the hearing, that the reasons for the decision, assigned by the body whose decision prompted the hearing, lacked foundation in fact or that the action or decision recommended was otherwise arbitrary or unreasonable.

I. Miscellaneous Terms and Conditions: The rules of law relating to the examination of witnesses and presentation of evidence do not apply in any hearing. Any relevant evidence, including hearsay, is admitted by the presiding officer if it is the sort of evidence which responsible persons are accustomed to rely on in the conduct in a court of law. Each party is encouraged to submit a written statement prior to the meeting in support of his/her position. The Hearing Panel may request such a statement to be filed following the conclusion of the presentation of oral testimony. The Hearing Panel may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

J. Adjournment and Conclusion of Hearing: The presiding officer may adjourn the hearing and reconvene at the convenience of the participants. Upon conclusion of the presentation of oral and written evidence and argument, the hearing will be closed. The Hearing Panel will, following the end of the hearing and outside of the presence of any other person, conduct its deliberations and render a decision and accompanying report.

K. Committee Decision: The Hearing Panel recommends to the Governing body discipline as it believes warranted and based on evidence produced at the hearing. Evidence may consist of the following:

1) Oral testimony of witnesses.
2) Briefs or written statements presented in connection with the hearing.
3) Any material contained in the hospital or medical staff personnel files regarding the petitioner, which shall have been made a part of the hearing record.
4) Any and all applications, references, medical records, exhibits and other documents and records which shall have been made a part of the hearing record.
5) Any other evidence admissible hereunder.

L. Recommendation of the Hearing Panel: Within five (5) days after final adjournment of the hearing and committee decision, the Hearing Panel delivers a written recommendation which includes a report that contains findings of fact, sufficient in detail to enable the parties, any appellate review governing body, and the Governing body to determine the basis for the Hearing Panel's recommendation on each matter contained in the notice of charge. The recommendation and report is delivered to the Executive Committee, the President of the hospital and the Governing body. At the same time, a copy of the report and recommendation is delivered to the petitioner by registered or certified mail, return receipt requested.

M. At its next meeting the Governing body considers the recommendation of the Hearing

Panel and takes final action which may include: (1) affirming the Executive Committee's recommendation, (2) affirming the Hearing Panel's recommendation, (3) modifying the recommendation of either the Executive Committee or Hearing Panel, or (4) remanding the matter back to the Executive Committee for re-evaluation. Such action of the Governing body is final unless appealed in accordance with this Article.

Section 9. Appeals to the Governing Body

A. Time for Appeal: Within thirty (30) days after the date of receipt of the Hearing Panel's recommendation, either the petitioner, or the body whose decision prompted the hearing may request an appellate review by the Governing body. This request is delivered to the Hospital President in writing either in person, or by certified or registered mail, return receipt requested, and it must include a statement of the basis upon which the recommendation of the Hearing Panel should be modified or reversed. If an appellate review is not requested within this period, both sides are deemed to have accepted the action involved and it becomes the final recommendation of the Medical Staff. This final recommendation shall be considered by the Governing body within sixty (60) days, but is not binding on the Governing body.

B. Reasons for Appeal: The reasons for appeal from the hearing shall be:
   1) Substantial failure of any person to comply with the procedures required by these bylaws or applicable law in the conduct of the hearing and the rendering of the decision so as to deny petitioner a fair hearing;

   2) Lack of evidence to support the decision of the Hearing Panel;

C. Appeal Governing body: When an appellate review is requested, the Governing body may sit as the Appeal Governing Body or it may appoint an Appeal Governing Body which will be composed of Governing Body members. It will have at least four (4) members at least one being a physician. Knowledge of the matter involved does not preclude any person from serving as a member of the Appeal Governing Body.

D. Notice of Time and Place for Appellate Review Hearing: When appellate review is requested, the Governing Body, within thirty (30) days after the date of receipt of the appeal request, schedules and arranges for an appellate review hearing. The Governing Body gives both parties notice of the time, place, and date of the appellate review hearing. The date of appellate review must not be less than fifteen (15) days nor more than sixty (60) days from the date of receipt of the request. However, when a request for appellate review is from a petitioner who is under suspension which is then in effect, the appellate review will be held as soon as the arrangements may reasonably be made, not to exceed thirty (30) days from the date of receipt of the request for appellate review.

E. Appellate Review Hearing Procedure: The Appeal Governing Body convenes for the purpose of addressing the issues raised by the party appealing the recommendation of the Hearing Panel. Attendance at the hearing before the Appeal Governing Body shall be limited to the parties to the appeal, their counsel, if any, members of the hospital administration and the hospital's counsel. The party bringing the appeal shall have 45 minutes to present arguments for reversing or modifying the recommendation of the Hearing Panel; the other party shall have 45 minutes to respond; and the party bringing the appeal shall have 10 minutes to rebut. Either party may request additional time which the Appeal governing Body, in its sole discretion, may allow. The parties may not present witnesses nor may they submit new evidence. The Appeal governing Body shall have before it the record of proceedings before the Hearing Panel, including the Executive Committee findings and recommendations, the findings and recommendations of the Hearing Panel, the written statement submitted by the party appealing the recommendation of the Hearing Panel, and any other documents which the Appeal

governing body may request. The Appeal Governing body, in its discretion, may allow the parties to submit written briefs in advance of the hearing pursuant to a briefing schedule which the governing Body will establish. Following the hearing, the Appeal Governing Body shall issue a written decision affirming, modifying or reversing the Hearing Panel's recommendation. The decision of the Appeal Governing body shall be effective upon acceptance by the Governing Body.

F. Decision: The Governing Body may affirm, modify, or reverse the Hearing Panel's recommendation. The written decision of the Governing Body, including a statement of the basis for the decision, is provided to the petitioner and Hearing Panel and the Executive Committee. The document is delivered to the above parties by personal delivery or by certified or registered mail, return receipt requested.

Section 10. Exceptions to Hearing Rights

Exclusive Use Departments and Medical-Administrative Officers:

A. Exclusive Use Departments: The fair hearing rights do not apply to individuals whose application for Medical Staff membership and privileges was denied because the privileges he sought are granted only pursuant to an exclusive use contract. Such an applicant has the right, however, to request that the Governing Body review the denial, and the Governing Body has the discretion to determine whether to review this request and, if it decides to review the request, to determine if that person may personally appear before and/or submit a statement in support of his/her position to the Governing Body.

B. Medical-Administrative Officers: Fair hearing rights do not apply to individuals serving the hospital in a medical-administrative capacity. Removal from office of these persons is instead governed by the terms of their individual contracts and agreements with the hospital. However, hearing rights apply to the extent that medical staff membership status or clinical privileges, which are independent of the staff member's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights applicable to such decisions.

ARTICLE X
MEDICAL RECORD DOCUMENTATION

Section 1. CMS Requirement for History and Physical Examination Completion

A medical history and physical examination must be completed and documented by a practitioner (as defined by Centers for Medicare and Medicaid Services, "CMS") who has been approved to do so by the organization, in accordance with Montana State law and hospital policy. Patients receive a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. Medical histories and physicals completed within 30 days before registration or inpatient admission must be updated within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia. . The requirements for completing and documenting H&Ps are detailed in Medical Staff Policy MSP-MDS-004 "Medical Record Documentation."

ARTICLE XI
SCREENING EXAMINATIONS

Section 1. Medical Screening Examinations

Any person seeking evaluation and treatment in the Emergency Department is entitled to a medical screening exam. Someone acting on the person's behalf may also request medical care. The medical screening exam must be performed by an emergency physician, emergency physician assistant, an emergency nurse practitioner, or a designated, qualified Emergency Department registered nurse. Additionally, for purposes of the obstetrical service, the qualified medical personnel able to perform the medical screening exam may be a designated and trained labor and delivery registered nurse.

ARTICLE XII
POLICIES OF THE MEDICAL STAFF

Section 1. Purpose

Medical Staff policies are developed as necessary to implement Medical Staff Bylaws or otherwise support the purpose and function of the bylaws. Policies set standards of practice required of the Medical Staff and Allied Health Professionals and are an aid to evaluating performance. Polices have the same force and effect as Bylaws. The Executive Committee is empowered to act on behalf of the entire Medical Staff in the development of Policies. Bylaw changes require action by the general Medical Staff. Medical Staff Bylaws and policies will not conflict with the Bylaws of the Corporation.

Section 2. Policies

Policies may affect the entire Medical Staff or specific Departments of the Medical Staff. They may be recommended for adoption, amendment, or repeal by vote of the Executive Committee at any regular or special meeting. Governing Body approval is required.

Policies must be recommended to the Executive Committee. Medical Staff Policies may be recommended for adoption, amendment or repeal at any regular meeting of the Executive Committee provided proper Medical Staff notification has occurred. A majority vote of the eligible Members present will be required for recommendation to the Governing Body. Amendments to the Policies will become effective when approved by the Governing Body.

Section 3. Notification of Medical Staff

Prior to action by the Executive Committee which results in recommendation of changes of Medical Staff policies, reasonable efforts to notify all affected members of the Medical Staff will be made. Further, a two (2) week comment period prior to action by the Executive Committee will be allowed.

Section 4. Urgent Amendment

In case of a documented need for an urgent amendment to a policy necessary to comply with law or regulation, the Executive Committee may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the Executive Committee and will be provided a two (2) week comment period. If there is no conflict between the organized medical staff and the Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the Executive Committee is implemented. If necessary, a revised amendment is then submitted to the govern body for action.

ARTICLE XIII
AMENDMENTS TO THE BYLAWS

Section 1. Medical Staff Responsibility

The general Medical Staff has the responsibility for adopting and recommending to the Governing Body, bylaws and amendments thereto, which will be effective when approved by the Governing Body. Policies are reviewed and revised as necessary. Medical staff and Corporate By-laws will not conflict.

Section 2. Methods of Adoption and Amendment

Amendments to these bylaws may be proposed by the Executive Committee or by a petition signed by 25% of the Active members of the Medical Staff. Proposed bylaw changes must be recommended to the Medical Staff. Medical Staff bylaws may be adopted, amended or repealed at any regular meeting of the General Staff or by mailed or emailed ballot, notice having been given at a prior regular or special meeting or by written notice thirty (30) days in advance. A majority vote of the eligible Members present or mailed or emailed ballots returned will be required for adoption. Amendments or other changes to these Bylaws will become effective when approved by the Governing Body.

ARTICLE XIV
ADOPTION OF BYLAWS

These bylaws are adopted and made effective upon approval of the Governing Body, superseding and replacing any and all previous Medical Staff bylaws, and henceforth all activities and actions of the Medical Staff and of each Practitioner exercising clinical privileges at the Hospital will be taken under and pursuant to the requirements of these bylaws.

Adopted by the Medical Staff:

_____ February 25, 2020
Kevin Eichhorn, MD Date
President of Medical Staff

_____ February 25, 2020
K.C. Brewington, II, MD Date
Secretary of Medical Staff

Approved by the Governing Body:

_____ September 24, 2019
Joyce Dombrouski, MHA, RN, CENP, CPH Date
Secretary of Community Ministry Board