BYLAWS
RULES AND REGULATIONS
OF THE
MEDICAL STAFF

St. Mary's Regional Medical Center
Lewiston, Maine

Amended and Restated by Medical Staff
06.17.2024

Revisions: See Endnotes for History of Revisions

Bylaws of the Medical Staff of
St. Mary's Regional Medical Center

RECITALS:

WHEREAS, St. Mary's Regional Medical Center is a nonprofit corporation organized under the laws of the State of Maine; and

WHEREAS, its purpose is to serve as a regional medical center providing patient care, education and research; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the Medical Center and must accept and discharge this responsibility, subject to the ultimate authority of the Medical Center Board, and that the cooperative efforts of the Medical Staff, the Chief Executive Officer and the Board are necessary to fulfill the Medical Center's obligation to its patients;

THEREFORE, the Physicians practicing in this Medical Center hereby organize themselves into a Medical Staff in conformity with these bylaws.

These Medical Staff Bylaws, once adopted by the Medical Staff and approved by the Board, shall be equally binding on the Medical Center Board and the Medical Staff.

DEFINITIONS

1. ALLIED HEALTH PROFESSIONAL means a non-physician, licensed, certified or registered by a state licensing board, but whose patient care activities may require that his/her authority to perform specified patient care services be supervised by, or subject to a collaborative agreement with, a member of the active Medical Staff.

2. BOARD means the governing Board of the Medical Center.

3. CHIEF EXECUTIVE OFFICER means the individual appointed by the Board to act in its behalf in the overall management of the Medical Center.

4. CHIEF MEDICAL OFFICER means the individual described in Section 10.8.1.

5. CHIEF OPERATING OFFICER means the individual appointed for day-to-day management of the Medical Center.

6. CHIEF QUALITY OFFICER means the individual appointed by the Medical Center to provide quality assurance and quality improvement support services to the Medical Staff in maintaining and improving clinical functions toward the maintenance of quality patient care for patients served by the Medical Center.

7. EXECUTIVE COMMITTEE means the Executive Committee of the Medical Staff unless specific reference is made to the Executive Committee of the Board.

8. MEDICAL CENTER means St. Mary's Regional Medical Center.

9. MEDICAL STAFF means all physicians who are privileged to attend patients in the Medical Center.

10. PHYSICIAN means a doctor of medicine, osteopathy, dentistry, or podiatric medicine.

11. PRACTITIONER means a Physician or an Allied Health Professional.

12. REGULAR NOTICE means the usual manner in which practitioners are notified of meetings or activities (e.g., correspondence left in their personal mailboxes, 1st class mail).

13. SPECIAL NOTICE means written notification given either by personal delivery or by certified or registered mail with return receipt requested, restricted delivery. Notice is deemed received upon actual receipt or refusal to accept document by personal delivery.

ARTICLE 1: NAME

1.1 Name. The name of this organization shall be the Medical Staff of St. Mary's Regional Medical Center.

ARTICLE 2: PURPOSES

2.1 Purpose. The purposes of this organization are:

2.1.1 To strive to ensure that all patients admitted to or treated in any of the facilities, departments, or services of the Medical Center shall receive care consistent with available resources at the Medical Center;

2.1.2 To insure a high level of professional performance of all Practitioners authorized to practice in the Medical Center through the appropriate delineation of the clinical privileges that each Practitioner may exercise in the Medical Center and through an ongoing review and evaluation of each Practitioner's professional performance in the Medical Center;

2.1.3 To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;

2.1.4 To initiate and maintain rules and regulations for self-government of the Medical Staff; and

2.1.5 To provide a means whereby issues concerning the Medical Staff and the Medical Center may be discussed by the Medical Staff with the Board and the Chief Executive Officer.

ARTICLE 3: MEDICAL STAFF MEMBERSHIP

3.1 Nature of Medical Staff Membership. Membership on the Medical Staff of St. Mary's Regional Medical Center is a privilege that shall be extended only to professionally competent Physicians who continuously meet the qualifications, standards and requirements set forth in these bylaws.

3.2 Qualifications for Membership.

3.2.1 Physicians licensed to practice in the State of Maine.

3.2.2 Physicians whose offices are located within a reasonable distance of the Medical Center to be able to provide continuous care of their patients.

3.2.3 Physicians who can document their background, experience, training and demonstrated current[8] competence, their adherence to the ethics of their profession, their good reputation, and their ability to work with others with sufficient adequacy to assure the Medical Staff and the Board that any patient treated by them or on their behalf in the Medical Center will be given a high quality of care.

3.2.4 Only those Physicians who are qualified, prepared, and eligible for an approved specialty board certification will qualify for Medical Staff membership (when a specialty board exists in their field).

3.2.4.1 An approved medical specialty shall mean one approved by a specialty board recognized by the:

3.2.4.1.1 American Board of Medical Specialties and the Accreditation Council on Graduate Medical Education (ACGME), or

3.2.4.1.2 Canadian Medical Association; or

3.2.4.1.3 Royal College of Physicians and Surgeons of Canada; or the Royal College of Physicians and General Medical Council of the United Kingdom; or the Intercollegiate Specialty Board of the United Kingdom, which includes the Royal College of Surgeons of England, the Royal College of Physicians and Surgeons of Glasgow, the Royal College of Surgeons of Edinburgh, and the Royal College of Surgeons in Ireland; or

3.2.4.1.4 American Dental Association*; or*

3.2.4.1.5 Committee on Post-Doctoral Training of the American Osteopathic Association; or

3.2.4.1.6 American Podiatric Medical Association.

3.2.4.2 The Physician applicant's qualifications shall be sufficient to satisfy the requirement in effect on the date of the application for examination and subsequent certification in his/her approved medical specialty. A Physician already certified in one of these approved medical specialties at the time of application shall not be affected by subsequent changes and requirements for the number of years in a residency program or other certification requirements.

3.2.4.3 After September 2, 1992, any physician who is not board certified upon application and who fails, to obtain board certification within 5 years of his/her specialty residency graduation date shall not be appointed or reappointed.

3.2.4.4 If there is a compelling reason a Practitioner should remain on the staff although he/she has not passed his/her specialty boards or his/her specialty board certification is withdrawn or expires, he/she has the right to appeal to the Executive Committee of the Medical Staff for exception to the board certification provision. The Executive Committee's recommendation in this regard will be forwarded to the Board for final action.

3.2.5 The Physician applicant must document the successful completion of the required number of years for a full specialty residency program approved by the:

3.2.5.1 Accreditation Council for Graduate Medical Education (ACGME), or

3.2.5.2 Canadian Medical Association, or

3.2.5.3 Royal College of Physicians and Surgeons of Canada, or the Royal College of Physicians

and General Medical Council of the United Kingdom; or the Intercollegiate Specialty Board of the United Kingdom, which includes the Royal College of Surgeons of England, the Royal College of Physicians and Surgeons of Glasgow, the Royal College of Surgeons of Edinburgh, and the Royal College of Surgeons in Ireland; or

3.2.5.4 American Dental Association, or

3.2.5.5 Committee on Post-Doctoral Training of the American Osteopathic Association,[6] or

3.2.5.6 American Podiatric Medicine Association, or

3.2.5.7 Other equal postdoctoral medical training programs. The burden of proof of equal training will be upon the applicant.

3.2.6 The Physician must document his/her physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that he/she will provide care for patients at the generally recognized professional level of quality, in an efficient manner, considering patients' needs, the available Medical Center facilities and resources, and according to applicable law.

3.2.7 Physicians must provide evidence of professional liability insurance coverage in an amount determined by the Board, with such coverage to be in effect upon appointment to the Medical Staff in the form of an insurance policy issued by a company with a certificate of authority from the Maine Superintendent of Insurance to issue such insurance coverage within the State of Maine.

3.3 Effect of Other Affiliations. No Physician shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Medical Center merely by virtue of the fact that he/she is duly licensed to practice medicine or dentistry in this or any other state, or that he/she is a

member of any professional organization, or that he/she had in the past, or presently has, such privileges at another hospital.

3.4 Nondiscrimination. Medical staff membership or particular clinical privileges shall not be denied based on sex, age, race, creed, religion, veteran status, disability, color, sexual orientation[14] or national origin.

3.5 Basic Responsibilities of Staff Membership. Each member of the Medical Staff shall:

3.5.1 Abide by the Ethical and Religious Directives for Catholic Health Facilities and by the Principles of Medical Ethics of the American Medical Association and American Dental Association, whichever is applicable, as the same are appended to and made a part of these bylaws.

3.5.2 Provide his/her patient with care of the generally professionally accepted level of quality in the community and in a reasonably economical and efficient manner.

3.5.3 Abide by the Medical Staff and Medical Center bylaws, rules and regulations and by all other reasonable standards, policies and rules of the Medical Center and Board.

3.5.4 Diligently discharge such staff, department, service, committee, and Medical Center functions for which he/she is responsible by appointment, election or otherwise.

3.5.5 Prepare and complete, according to medical staff or medical center policy, medical and other required records for all patients he/she admits or in any way provides care to in the Medical Center.

3.5.6 Provide for continuous quality care for his/her patients.

3.5.7 Actively participate in quality assessment, peer review and performance improvement activities.

3.5.8 Review the Medical Center's conflict of interest policy biannually and disclose any conflicting or financial interests as defined in the

policy (as amended), in providing patient care or when participating in the decision to acquire or recommending the acquisition of supplies, capital equipment, services or operating systems. Such disclosure shall be made to the person to whom such a recommendation is made.[11]

3.5.9 Comply with all applicable State and Federal laws.

3.5.10 Perform, or arrange for another qualified practitioner to perform a physical examination and medical history no more than Thirty (30) days before or Twenty-Four (24) hours after a patient is admitted to the Medical Center, in accordance with such requirements or procedures as may be set forth in Medical Center or Medical Staff rules, regulations, policies or procedures.

3.6 Conditions and Duration of Appointment.

3.6.1 All initial appointments, and modifications of appointment pursuant to 6.5, shall be for a period extending for two years from the month of appointment.

3.6.2 Reappointments to any category of the Medical Staff shall be for not more than two years.

3.6.3 Initial appointments and reappointments to the Medical Staff shall be made by the Board. The Board shall act on appointments, reappointments, or revocation of appointments only after receipt and review of required information and verification(s), and there has been a recommendation from the Medical Staff as provided in these bylaws. In the event of unwarranted delay by the Medical Staff, the Board may act without such recommendation based on documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.

3.6.3.1 For the purposes of this section, unwarranted delay generally means 100 days from the date that the duly completed application has been received by the Medical Staff.

3.6.3.2. When acting in the event of an unwarranted delay, the Board must base its decision upon the same kind of information as is usually considered by the Medical Staff.

3.6.4 Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board, according to these bylaws.

3.6.5 Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of their obligation to provide continuous care and supervision of his/her patients, to abide by the Medical Staff and Medical Center bylaws, rules and regulations, to accept committee assignments, to participate in quality and peer review activities and to accept consultation assignments.

3.7 Provisional Status.

3.7.1 **Initial Appointments.** Except as otherwise determined by the Board, all initial appointments to any category of the Medical Staff shall be provisional. Each provisional appointee's performance shall be evaluated by the Chief Medical Officer of the Medical Staff, or by a member of the Medical Staff or a committee of Medical Staff appointed by the Chief Medical Officer, to determine his/her eligibility for regular staff membership in the staff category for which he/she was provisionally granted. Any initial appointment and renewals thereof shall remain provisional until the Chief Medical Officer or his/her designee makes a determination that:

3.7.1.1 the appointee meets all of the qualifications, has discharged all of the responsibilities, and has not exceeded or abused the prerogatives of the staff category to which he/she was provisionally appointed; and

3.7.1.2 the appointee has demonstrated his/her ability to exercise the clinical privileges provisionally granted to him/her.

3.7.2 **Modification in Staff Category and Privileges.** The Executive Committee may recommend to the Board that a change in staff category of a current staff member or the granting of additional privileges to a current staff member pursuant to Section 6.5 be made provisional according to the procedures provided in Section 3.7.1 for initial appointments.

3.7.3 **Duration and Renewal of Provisional Status.** Initial appointments to Provisional status shall be for at least a six-month period. Provisional status shall not extend for more than two (2) years. If the Chief Medical Officer of the Medical Staff or his/her designee fails within that period to make the determination required in Section 3.7.1 through 3.7.1.2, his/her staff status or particular clinical privileges, as applicable, shall automatically terminate. The appointee so affected shall be given Special Notice

of such termination and shall be entitled to the procedural rights afforded in Article 9.

3.7.4 **Evaluation of Provisional Appointees.** The person/committee responsible for evaluation of the provisional appointee shall review all pertinent information, including, but not be limited to, an assessment of patient care, documentation skills, and interpersonal relationships with peers demonstrated by the appointee during the provisional period. A Focused Professional Practice Evaluation ("FPPE"), as determined by the Executive Committee, will be part of the assessment of any new medical staff member or medical staff member granted a new privilege. The person/committee responsible for evaluation of the appointee shall make a written report and recommendation to the Chief Medical Officer of the Medical Staff or to his/her designee before the expiration of any provisional appointment or reappointment.

3.7.5 **Restricted from Holding Office.** Provisional appointees may not hold office in any department unless the restriction is waived by the Board after recommendation of the Executive Committee.

3.8 Leave of Absence.

3.8.1 **Definition.** An absence of greater than 60 days shall be considered due cause for leave-of-absence processing.

3.8.2 **Written Request.** Voluntary leave of absence from patient care responsibilities and privileges, and from Medical Staff membership functions, shall be obtained by a staff member by submitting a written request to the Executive Committee.

The request shall state the time required and the reason for the leave. The time shall not exceed one year in length.

3.8.3 **Conditions and Limitations.** The Executive Committee shall determine the conditions and limitations of the leave. A Medical Staff member shall not exercise patient care privileges during his/her leave. Consideration of medical records completion, meeting attendance, emergency room coverage, and patient care shall be among the items included in the Executive Committee's

determination. If the member on leave has his/her staff membership appointment due for consideration while on leave, the reappointment process shall be delayed until the member is ready for resumption of his/her privileges.

3.8.4 **Absence without Leave.** An absence greater than 60 days without a submitted written request will be considered due cause for termination of staff membership, privileges, and prerogatives without right of hearing or appellate review. A request for staff membership subsequently from a staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointment.

3.8.5 **Termination of Leave.** If the leave-of-absence is 90 days or longer, at least 30 days before the termination of the leave, or at any earlier time:

3.8.5.1 The staff member shall ask for reinstatement of his/her privileges by submitting a written request to the Executive Committee.

3.8.5.2 The staff member shall submit a written summary of his/her relevant activities during the leave should the Executive Committee request it.

3.8.6 **Failure to Request Reinstatement.** Failure to request reinstatement without good cause, or failure to provide a requested summary of activities as above stated before termination of the leave, will result in automatic termination of staff membership, privileges, and prerogatives without right of hearing or appellate review. A request for staff membership subsequently from a staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointment.

3.8.7 **Executive Committee Action.** The Executive Committee shall make a determination regarding the reinstatement of the member's privileges and prerogatives. If such recommendation is negative, the member shall be entitled to the procedural rights afforded in Article 9.

ARTICLE 4: CATEGORIES OF THE MEDICAL STAFF

4.1 Categories. The Medical Staff shall be divided into active, courtesy, consulting, senior-active and honorary categories. All categories of staff, except honorary, shall be appointed to a specific department.

4.2 Active Medical Staff.

4.2.1 **Qualifications.** The active Medical Staff shall consist of Physicians who:

4.2.1.1 Regularly use the Medical Center;

4.2.1.2 Meet the basic qualifications set forth in Sections 3.1 through 3.2.7.

4.2.2 **Prerogatives.** The prerogatives of an active Medical Staff member shall be to:

4.2.2.1 Admit patients to the Medical Center.

4.2.2.2 Exercise such clinical privileges as are granted to him/her pursuant to Article 7.

4.2.2.3 Vote on all matters presented at general and special meetings of the Medical Staff and of committees of which he/she is a member.

4.2.2.4 Hold office on the Medical Staff.

4.2.3 **Responsibilities.** Each member of the active staff shall:

4.2.3.1 Meet the basic responsibilities set forth in Section 3.5.

4.2.3.2 Serve on Medical Staff committees.

4.2.3.3 Retain responsibility within his/her area of professional competence for the daily care and

supervision of each patient in the Medical Center for whom he/she is providing services, or arrange a suitable alternative for such care and supervision.

4.2.3.4 Actively participate in patient assessment activities and quality maintenance activities required of the staff in supervising provisional appointees of his/her same profession and in discharging other staff functions as may from time to time be required.

4.2.3.5 Attend Medical Staff meetings to the satisfaction of attendance requirements set forth in Article 13.6.

4.2.3.6 Perform all on-call emergency service care and consultation assignments.

4.2.3.7 Pay dues.

4.3 Courtesy Medical Staff

4.3.1 **Qualifications.** The courtesy Medical Staff shall consist of Physicians who:

4.3.1.1 Qualify for staff membership but only occasionally use the Medical Center.

4.3.1.2 Serve in an active staff capacity at another hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations

4.3.2 **Prerogatives.** The prerogatives of a courtesy staff shall be to:

4.3.2.1 Admit patients to the Medical Center.

4.3.2.2 Exercise such clinical privileges as are granted to him/her pursuant to Article 7.

4.3.2.3 Attend meetings without right to vote or hold office.

4.3.3 **Responsibilities.** Each member of the courtesy staff shall:

4.3.3.1 Meet the basic responsibilities set forth in Section 3.5.

4.3.3.2 Pay dues.

4.4 Consulting Medical Staff.

4.4.1 **Qualifications.** The consulting Medical Staff shall consist of physicians in active practice who because of outstanding ability, special training or recognition of eminence in their special fields of practice can assist the staff at St. Mary's Regional Medical Center.

4.4.2 **Prerogatives.** The prerogatives of a consulting Medical Staff member shall be to:

4.4.2.1 Provide consultation services to patients and active staff members at the Medical Center.

4.4.2.2 Exercise such privileges as are granted to him/her pursuant to Article 7.

4.4.2.3 Attend meetings without the right to vote or hold office.

4.4.3 **Responsibilities.** Each member of the consulting staff shall be required to:

4.4.3.1 Meet the basic responsibilities set forth in Section 3.5.

4.5 Senior-Active Medical Staff.

4.5.1 **Qualifications.** Prior to January 1, 2023 members of the Active Medical Staff had the option of becoming members of the Senior-Active Medical Staff at the age of sixty-two (62) years, or after having completed twenty-five (25) years of duty on the Active Medical Staff. Active Medical Staff members who exercised that option prior to January 1, 2023 may continue to retain Senior-Active Status. Effective January 1, 2023 Active

Medical Staff members shall no longer have the option of becoming members of the Senior-Active Medical Staff.

4.5.2 **Prerogatives.** The prerogatives of a senior-active Medical Staff member shall be to:

4.5.2.1 Admit patients to the Medical Center.

4.5.2.2 Exercise such clinical privileges as are granted to him/her pursuant to Article 7.

4.5.2.3 Vote on all matters presented at general and special meetings of the Medical Staff and on committees of which he/she is a member.

4.5.2.4 Hold office on the Medical Staff.

4.5.2.5 Accept committee work or emergency service assignments, only at their pleasure.

4.5.3 **Responsibilities.** Each member of the senior-active staff shall:

4.5.3.1 Meet the basic responsibilities set forth in Section 3.5.

4.5.3.2 Retain responsibility within his/her area of professional competence for the daily care and supervision of each patient in the Medical Center for whom he/she is providing services, or arrange a suitable alternative for such care and supervision.

4.5.3.3 Actively participate in patient assessment activities and quality maintenance activities required of the staff in supervising provisional appointees of his/her same profession and in discharging other staff functions as may from time to time be required.

4.5.3.4 Attend Medical Staff meetings to the satisfaction of attendance requirements set forth in Article 13.6.

4.6 Honorary Medical Staff

4.6.1 **Qualifications.** The honorary Medical Staff shall consist of Physicians who:

4.6.1.1 Are not active in the Medical Center or who are honored by emeritus positions. These may be Physicians who have retired from active Medical Center practice or who are of outstanding reputation, not necessarily residing in the community.

4.6.2 **No Prerogatives and Responsibilities.** Honorary staff members shall not be eligible to admit or treat[8] patients, to vote, hold office or to serve on standing Medical Staff committees.

4.7 **Locum Tenens Staff.** The Locum Tenens staff shall consist of physicians and allied health professionals, who meet the qualifications for membership specified in these Bylaws, respectively appointed for the specific purpose of providing coverage in various disciplines where the number of appointed staff is insufficient to meet patient care needs. Locum Tenens shall be appointed for a one year term, with a possible one year renewal, no longer than necessary to meet the identified patient care needs, and in no event longer than two (2) years. Appointment or reappointment as a Locum Tenens staff member shall follow the appointment or reappointment provisions established elsewhere in these Bylaws.

Physicians appointed to the Locum Tenens staff shall not be required to meet the Medical Staff meeting attendance requirements, nor be required to pay dues and assessments (but shall pay any initial applicable application fee), nor be eligible to vote or to hold office, but may be appointed to committees or assigned other responsibilities by staff officers or the Department Chair. Locum Tenens appointees are encouraged to attend educational conferences and appropriate staff meetings. Physicians appointed to the Locum Tenens staff may be changed to Active, Courtesy, Consulting, or Allied Health Professional staff providing they meet the

requirements of that category. In such case, the applicant would be subject to the provisions of these Bylaws regarding provisional status.

ARTICLE 5: THE ALLIED HEALTH PROFESSIONAL STAFF

5.1 Purpose. The medical staff has the option to create and maintain an allied health professional staff to improve patient care.

5.2 Qualifications. Applicants shall hold all licenses and certifications required by law and be of good standing in their professional fields. Allied Health Professional staff membership is limited to persons with acceptable credentials in the following categories:

Category	**Responsible to Dept/Service Chair of Independent Practitioners**
Audiologist	Surgery (or his/her designee)
Speech Therapist and Speech Pathologist	Surgery (or his/her designee)
Physicist (Masters level or above)	Radiology
Psychologist	Psychiatry
Veterinarian	Medicine (or his/her designee)
Optometrist	Surgery (or his/her designee)
Certified Nurse Midwife	
Certified Nurse Practitioner	Surgical Nurse & Technician
Dependent Practitioners	
Certified Registered Nurse Anesthetist	
Physician Assistant	

Commented [JMK1]: I have tried to revise this chart, but am unable to do so. Apparently there is some formatting involved that I am unable to change in this veriosn of the document. The chart should be revised to provide that PAs with less than 4,000 clinical hours remain dependent while those with more than 4,000 hours no longer require supervision or a collaborative agreement.

Appropriate Department Chair or designee	Appropriate Department Chair or designee
Anesthesiology	Appropriate Department Chair or designee Surgery (or his/her designee)

5.2.1. **Specific Qualifications for Certain Physician Assistants**. Physician Assistants with less than 4,000 hours of documented clinical practice must have a Maine Board of Licensure in Medicine or Maine Board of Osteopathic Licensure approved Collaborative Practice Agreement with a member of the Active, Senior-Active or Courtesy Staff in good-standing.

5.2.2. **Physcian Assistant Collaborative Practice Agreement**. A Collaborative Practice Agreement means a document agreed to by a physician assistant and a Physician that describes the scope of practice for the physician assistant as determined by the Medical Center and describes the decision-making process for a health care team including communication and consultation among health care team members. It shall meet all applicable requirements of a Collaborative Practice Agreement, as set forth in the applicable rules of the Maine Board of Licensure in Medicine or the Maine Board of Osteopathic Licensure.

5.3 Procedure for Appointment and Granting Privileges. Applications for membership and delineation of privileges for Allied Health Professionals shall be reviewed and voted upon in the same manner as designated in Articles 6 and 7 of these bylaws. Clinical privileges granted to Allied Health Professional staff members shall be based on their training, experience, and demonstrated competence and judgment. The scope of supervised practice, where required, for the Allied Health Professional staff member shall be within the limits of the professional qualifications and training of the individual Practitioners and according to federal and state regulations that apply to their specific profession. Allied Health Professionals shall be individually assigned to departments appropriate to their professional training and shall be subject to the same terms and

conditions of appointment as specified in Sections 3.5 through 3.8 for Medical Staff appointments.

5.4 Corrective Action. Allied Health Practitioners shall be subject to corrective action under these Bylaws. However,corrective action regarding employed Allied Health Professionals, including termination or suspension of employment shall be governed by Medical Center personnel practices and the Allied Health Professional's employment agreement. All Allied Health Professionals shall be subject to the Automatic Suspension provisions (Section 8.12) and the Confidentiality, Immunity and Release provisions (Article 14) of these bylaws.

Commented [JMK2]: I am not sure this is the case, but I would recommend that an Allied Health Practitioner's employment agreement contain an agreement that the practitioner resigns his/her clinical privileges upon termination of the agreement for any reason.

5.5 Prerogatives. The members of the Allied Health Professional staff shall:

5.5.1 Exercise privileges granted under a Collaborative Practice Agreement, if required, under supervision, if required, or under the direction of a member of the Medical Staff and consistent with the limitations stated in Section 7.4. Privileges granted shall be exercised according to Medical Center policies and Medical Staff rules and regulations.

5.5.2 Not be considered members of the Medical Staff, but may, by invitation only, attend staff meetings. They may attend scientific meetings when designated.

5.5.3 Serve as non-voting advisory members of Medical Staff committees when requested.

5.5.4 Not admit patients to the Medical Center.

5.6 Responsibilities Each Allied Health Professional shall:

5.6.1 Meet the same basic responsibilities as required by Section 3.5 for Medical Staff members.

5.6.2 Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Medical Center for whom he/she is providing services, or arrange a suitable alternative for such care and supervision.

5.6.3 Wear identification badges indicating their titles in words, not abbreviations.

5.7 Dependent Practitioners. Those practitioners of the Allied Health Professional Staff included in Section 5.2 under the heading "Dependent Practitioners", with the exception of certain physician assistants who are subject to Collaborative Practice Agreements, shall be under the active supervision of a member of the active Medical Staff and must act in rendering patient care only at the direction of said member or another active staff member designated by the primary supervising Physician. The following provisions apply to any Dependent Practitioner:

Commented [JMK3]: While not related to the PA issue, do you still want to require this for NPs who have completed their intital, required, two (2) years of physician supervision? IN other words, would you want to move those NPs to the independent category?

5.7.1 The supervising or collaborating Physician must accept full responsibility and accountability for the conduct of the Dependent practitioner within the Medical Center.

Commented [JMK4]: I note that previously the licensure rules requiring PA supervision held the supervising physician liable. That liability has been eliminated in the current rule.

5.7.2 The supervising or collaborating Physician must accept responsibility to acquaint the Dependent Practitioner with the applicable bylaws and rules and regulations of the Medical Staff and of the department to which the Dependent Practitioner is assigned.

5.7.3 The privileges accorded the Dependent Practitioner shall automatically cease upon termination of the Medical Staff appointment of the employer, where applicable.

5.7.4 The privileges accorded the Dependent Practitioner shall terminate automatically upon curtailment of the supervising or collaborating physician's clinical privileges.

5.7.5 The privileges accorded the Dependent Practitioner shall terminate automatically upon the loss by the Dependent Practitioner of licensure or by action of the Medical Staff and Board.

5.7.6 It shall be the obligation of the Dependent Practitioner to inform the Medical Affairs Office as to the identity of his/her supervising or collaborating physician and any alternative supervising or collaborating physician and as to any changes in the status of

his/her supervising or collaborating or alternative supervising or collaborating physician.

5.7.7 The supervising or collaborating physician shall provide the Medical Affairs Office with a letter attesting to the supervisory or collaborating relationship, and may resign from such relationship at his/her discretion. Resignation from such supervisory or collaborative relationship shall be forwarded in writing to the Medical Affairs Office noting the effective date of the discontinuation of the supervisory or collaborative relationship, in advance of such resignation.

5.8 Independent Practitioners. Those practitioners of the Allied Health Professional Staff included in Section 5.2 under the heading "Independent Practitioners" shall be supervised by the Chair of a specified professional department of the Medical Staff (through a service, when applicable) or by a physician designated by the Chair.

Commented [JMK5]: This should read "subject to the direction of" or similar language, since, by licensure requirement they are nottechincally subject to "supervisions."

5.9 Limitation. The Medical Staff shall limit its recommendations for appointment to membership on the Allied Health Professional staff to that number of persons that it considers most advantageous in the rendering of good medical care.

ARTICLE 6: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

6.1 General Procedure. The Medical Staff, acting through the Executive Committee and other Medical Staff committees and officers, shall investigate and consider each application for appointment or reappointment to any staff status and each request for modification of staff status and shall adopt and transmit recommendations thereon to the Board. The Executive Committee shall also perform these same investigation, evaluation and recommendation functions concerning any professional who seeks to exercise privileges as a member of the Allied Health Professional staff. The specific steps in the appointment and reappointment process shall be documented in a Appointment and Reappointment Plan developed and approved by the Executive Committee, approved by the Board, and appended to these bylaws.

6.2 Application for Initial Appointment.

6.2.1 **Application Form.** All applications for appointment to the Medical Staff shall be in writing, submitted on the prescribed form and signed by the applicant.

6.2.2 **Content.** The application shall require detailed information concerning the applicant's professional qualifications, including, but not necessarily limited to:

6.2.2.1 **Acknowledgment and Agreement.** The application form shall include a statement that the applicant has received and read the bylaws of the Medical Center and the bylaws, rules and regulations of the Medical Staff and that he/she agrees to be bound by the terms thereof if he/she is granted membership and/or clinical privileges in all matters relating to consideration of the application without regard to whether or not the application is granted.

6.2.2.2 **Qualifications.** Detailed information concerning the applicant's qualifications, including information in satisfaction of the basic qualifications specified in Sections 3.1, 3.2 or 5.2, as is applicable, and of any additional qualifications specified in these bylaws for the particular staff status to which the applicant requests appointment, including, but not limited to:

i) verification of active Maine license
ii) verification of Board certification
iii) verification of professional liability claims history
iv) query of National Practitioner Data Bank

6.2.2.3 **Requests.** Specific requests stating the staff status and clinical privileges for which the applicant wishes to be considered.

6.2.2.4 **References.** A letter of reference from the immediate chief of service for whom he/she worked or trained under and two other persons familiar with his/her work who can provide adequate references concerning the applicant's professional competence and ethical character.

6.2.2.5 **Professional Sanctions.** Information about whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced or not renewed at any other hospital or healthcare institution or whether any proceeding is pending or has been instituted which, if decided adversely to the applicant, could result in any of the foregoing. The applicant shall further provide information about whether any of the following have ever been voluntarily or involuntarily limited, restricted, suspended, revoked denied or otherwise adversely affected or disciplined:

6.2.2.5.1 Hospital staff membership and membership/fellowship in local, state or national professional organizations;

6.2.2.5.2 specialty board certification;

6.2.2.5.3 License and privileges to practice any profession in any jurisdiction; or

6.2.2.5.4 Drug Enforcement Agency (DEA) registration.

If any such actions were ever taken or instituted or are pending, the particulars thereof shall be included.

6.2.2.6 **Professional Liability Insurance.** For all Practitioners, a statement that the applicant carries at least the minimum amount of professional liability insurance coverage as required by Section 15.3 and

information concerning the applicant's malpractice claims history and experience during the past five years, including a consent to the release of information from his/her present and past malpractice insurance carrier(s) and a waiver of any privilege relating thereto.

6.2.2.7 **Notification of Release and Immunity Provisions.** Statements notifying the applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions of Section 6.3 and Article 14 regarding Confidentiality, Immunity and Releases.

6.2.2.8 **Administrative Remedies.** A statement whereby the professional agrees that, when an adverse ruling is made with respect to his/her staff status and/or clinical privileges, he/she will exhaust the administrative remedies afforded by these bylaws before resorting to legal action.

6.2.2.9 An official photo, such as a passport or driver's license photo.

6.3 Effect of Application. By applying for appointment to the Medical Staff, each applicant thereby signifies:

6.3.1 Willingness to appear for interviews regarding the application.

6.3.2 Authority of Medical Center representatives to consult with members of Medical Staffs of other hospitals or healthcare organizations with which the applicant has been associated and with others who may have information bearing on his/her competence, character, physical and mental health, emotional stability, and ethical qualifications.

6.3.3 Consent to the inspection by Medical Center representatives of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the

clinical privileges he/she requests, and of his/her moral and ethical qualifications for staff membership.

6.3.4 Consent to release from any liability all individuals and organizations who provide information to the Medical Center in good faith and without malice concerning the applicant's competence, ethics, character, including physical and mental health and emotional stability and other qualifications for staff appointment and clinical privileges including otherwise privileged or confidential information.

6.4 Reappointment Process

6.4.1 **Information Form for Reappointment.** The Chief Executive Officer or his/her designee shall, at least ninety days before the expiration date of the present staff's appointment, provide such person with a reappointment form. Each such person who desires reappointment shall, at least sixty days before such expiration date, send his/her reappointment form to the Chief Executive Officer or his/her designee. Special Notice from the Chief Executive Officer or his/her designee, will be given when a Practitioner fails to submit a timely and complete reappointment form. If after Special Notice and without good cause the Practitioner fails to return a completed reappointment form, it shall be considered a voluntary resignation from staff status and shall result in automatic termination of staff status and all clinical privileges at the expiration of such person's current term. Such action shall not be deemed to be adverse to the applicant. Notwithstanding the foregoing, voluntary resignations do not vitiate an otherwise lawful obligation to (1) report to the National Practitioner Data Bank: (ii) complete medical records: or (iii) to proceed with a quality assurance investigation or peer review.

6.4.2 **Content of Reappointment Form.** The reappointment form shall be a prescribed form and shall require and, when completed, shall contain medical staff membership and privilege information

necessary to maintain as current the Medical Center's file including, without limitation, information about:

6.4.2.1 Continuing licensure, training, education and experience that qualifies the reappointment applicant for the status and/or privileges sought on reappointment.

6.4.2.2 Current physical/mental health, emotional stability and substance abuse problems that may adversely affect patient care.

6.4.2.3 The name and address of any other health care organization or practice setting where the reappointment applicant provided clinical services during the preceding period.

6.4.2.4 Membership, awards or other recognitions conferred, granted or revoked by any professional health care societies, institutions or organizations.

6.4.2.5 Whether the applicant's staff status and/or clinical privileges have been revoked, suspended, reduced or not renewed at this or any other hospital or health care institution or whether any proceeding is pending or has been instituted which, if decidedly adversely to the applicant, would result in any of the foregoing. The applicant shall further provide information about whether any of the following have been voluntarily or involuntarily limited, restricted, suspended, revoked, denied or otherwise adversely affected or disciplined:

6.4.2.5.1 membership/fellowship in local, state or national professional organizations;

6.4.2.5.2 specialty board certification and/or recertification;

6.4.2.5.3 license to practice any profession in any jurisdiction; or

6.4.2.5.4 Drug Enforcement Agency (DEA) registration.

If any such actions were taken or instituted or proposed to be imposed since the applicant was initially appointed or last reappointed to staff status, the particulars thereof shall be included.

6.4.2.6 Details about malpractice claims experience.

6.4.2.7 An Ongoing Professional Practice Evaluation ("OPPE") as determined by the Executive Committee.

6.4.2.8 Other specific information about the reappointment applicant's professional ethics, qualifications and ability as the Board or the Executive Committee may reasonably require of all applicants for reappointment.

6.4.2.9 Any request for modification of staff status or privileges that the reappointment applicant may desire to make.

6.5 Requests for Modification of Appointment. A Medical Staff member or Allied Health Professional may, either in connection with reappointment or at any other time, request modification of his/her staff status, department assignment or privileges by submitting a written application to the Chief Executive Officer on the prescribed form. Such application shall be processed in the same manner as provided in Section 6.4 for reappointment.

ARTICLE 7: CLINICAL PRIVILEGES

7.1 Clinical Privileges Restricted. Every Practitioner practicing at the Medical Center, by virtue of Medical Staff membership or otherwise, shall in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the Board, except as provided

in Sections 7.2 and 7.3 of this Article 7. Despite the clinical privileges granted to a Practitioner, each Practitioner shall obtain consultation when necessary or appropriate for patient care or when required by medical staff or department rules or regulations.

7.2 Delineation of Privileges.

7.2.1 **Requests.** Every application for appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. All initial or additional clinical privileges granted shall be subject to the Medical Staff Focused Professional Practice Evaluation policy, as it may be amended from time-to-time. A request pursuant to Section 6.5 for a modification of privileges must be supported by documentation of training and/or experience supportive of the request. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests.

7.2.2 **Bases for Privileges Determinations.** Requests for clinical privileges shall be evaluated based on the Practitioner's licensure, education, training, experience, demonstrated professional competence, judgment, physical and mental health status, references and other relevant information. The bases for privileges determinations to be made in connection with periodic reappointment or otherwise shall include, but not necessarily be limited to, the following:

7.2.2.1 results of practitioner-specific[13] quality assessment and performance improvement activities,

7.2.2.2 review of the records of patients treated in the Medical Center or other healthcare facilities; and

7.2.2.3 review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care.

This review may also include direct observation of care provided. This information shall be added to and maintained in the Medical

Center's credential file established for a Medical Staff member or Allied Health Professional.

7.2.3 **Procedure.** All requests for clinical privileges shall be evaluated and granted, modified, or denied pursuant to the procedures outlined in Article 6 and Appendix B.[1]

7.3 Special Conditions for Privileges

7.3.1 **Special Conditions for Privileges of Dentists.** Privileges granted to dentists shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the chief of surgery. History and physicals shall be done by a qualified oral surgeon, doctor of osteopathy, doctor of medicine, or an appropriate Allied Health Professional.

7.3.2. Special Conditions for Privileges of Podiatrists. The scope and extent of surgical procedures that a podiatrist may perform in the Medical Center shall be delineated and recommended to the Board in the same manner as all other clinical privileges. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chief of the Surgical Service. The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination as well as all appropriate elements of the patient's record. The podiatrist may write orders within the scope of his or her license consistent with the Medical Staff Bylaws, Rules and Regulations.

7.4 Special Conditions for Privileges of Allied Health Professionals. Requests to exercise privileges by Allied Health Professionals shall be processed, evaluated, granted or denied, in the manner specified in Section 7.2. An Allied Health Professional may, subject to any licensure requirements or other legal limitations and subject to the requirement of Section 7.1 be entitled to exercise only those clinical privileges specifically granted to him/her by the Board, and exercise independent judgment within the areas of his/her professional competence.

7.5 Temporary Privileges

7.5.1 **Circumstances.** Upon the written concurrence of the Chief Medical Officer of the Medical Staff and the Department Chair, the Chief Executive Officer may grant temporary privileges in the following circumstances:

7.5.1.1 **Pending Review/Approval.** After receipt of an application for appointment, including a request for specific temporary privileges, and according to the conditions specified in Section 7.5.2, an appropriately licensed applicant may be granted temporary privileges for an initial period of ninety (90) days, with subsequent renewal not to exceed ninety (90) days.[9]

7.5.1.2 **Care of Specific Patients.** Upon receipt of a written request, an appropriately licensed professional who is not an applicant for membership may be granted temporary privileges for the care of one or more specific patients. Such privileges shall be restricted to the treatment of not more than five patients in any one year by any Practitioner, after which such Practitioner shall be required to apply for the appropriate staff status before being allowed to attend additional patients. The Executive Committee, at its discretion, may grant exceptions or request that the professional apply for membership.

7.5.1.3 **Locum Tenens.** Upon receipt of a written request, an appropriately licensed professional may serve as a locum tenens and be granted temporary privileges as outlined under 7.5.1.1 for ninety (90) days with one subsequent 90-day renewal, if necessary.

7.5.2 **Conditions.** Temporary privileges shall be granted only when the information then available and verified [11] reasonably supports a favorable determination regarding the requesting Practitioner's or applicant's qualifications, judgment, professional competence and

ethical standing to exercise the privileges requested. Special requirements of consultation and reporting may be imposed by, and in the discretion of, the Chair of the Executive Committee. Before temporary privileges are granted, the Practitioner or applicant must acknowledge in writing that he/she has received and read the Medical Staff bylaws, rules and regulations and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges, and Practitioner or applicant has provided such information as may be requested by the Executive Committee with the following information:

i) verification of active Maine license
ii) verification of current professional liability insurance and claims history
iii) verification of competence and training
iv) query of National Practitioner Data Bank

Temporary privileges require:

v) verification of active Maine license
vi) verification of current professional liability insurance and claims history
vii) verification of competence and training
viii) query of National Practitioner Data Bank

7.5.3 **Termination.** The Chief Executive Officer may at any time upon reasonable notice under the circumstances and for any reason after consultation with the Chief Medical Officer of the Medical Staff and the Department Chair terminate any or all temporary privileges granted. Upon any such termination, the Practitioner's patient(s) then under his/her care in the Medical Center shall be assigned to another Practitioner by the appropriate Department Chair or, in his/her absence, the Chair of the Executive Committee. The wishes of the patient(s) shall be considered where feasible in selection of such substitute Practitioner.

7.5.4 **Rights.** No Practitioner shall be entitled to the procedural rights afforded by Article 9 because of his/her inability to obtain

temporary privileges or because of any termination or suspension of temporary privileges.

7.6 Emergency Privileges. For this section, an "emergency" means 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. In an emergency, any Physician member of the Medical Staff, to the degree permitted by his/her license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Medical Center necessary, including the calling for any consultation necessary or desirable. When an emergency no longer exists, or after seventy-two (72) hours (whichever occurs first)[9], such Physician must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he/she does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff. Emergency privileges are not renewable.[9]

7.7 Disaster Privileges. Disaster Privileges may be granted when the hospital emergency management plan has been activated. The CEO, Medical Staff Chief Medical Officer or their designee may grant disaster privileges through the identification and verification process delineated in the hospital's emergency management plan.

7.8 Telemedicine Privileges

7.8.1 Licensed independent Practitioners, or their employers, who provide medical information exchanged from distant sites to the Medical Center, via electronic communications, for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment and services shall have a contract with the Medical Center that describes the services to be provided. These Practitioners shall be credentialed and privileged in either of the following mechanisms:

i.) Verification of credentials and competence to render telemedicine services by the methods outlined in the Bylaws; or

ii.) Delegated credentialing verification using credentialing information from the distant site, if the distant site is a Joint Commission accredited hospital or ambulatory care organization, but maintaining the

credentialing decisions of the Medical Staff and Board. The remote Practitioner must be privileged at the distant site for those services to be provided to the Medical Center.

7.8.2 Telemedicine Practitioners shall not be eligible to vote or to hold Medical Staff office. Any licensed independent Practitioner granted Telemedicine privileges shall be under the medical and administrative supervision of the Medical Staff. Telemedicine privileges shall be subject to the provisional appointment provisions of the Bylaws.

7.8.3 The Medical Staff shall provide ongoing and focused professional practice evaluations of Practitioners exercising telemedicine privileges and shall provide the distant site with information that is useful in assessing the Practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum such information shall include: (1) information regarding adverse outcomes related to sentinel events considered reviewable by the Joint Commission that result from telemedicine services provided and (2) complaints about the distant site Practitioner from patients, licensed independent Practitioners, or staff at the Medical Center.

7.8.4 Upon termination of a telemedicine service agreement pursuant to which a Practitioner is providing services, or if the Practitioner's employment with the distant site is terminated, the Practitioner's telemedicine privileges shall terminate. Such termination shall not be subject to the fair hearing and appeal provisions set forth in the Bylaws

7.9 Residents.

Residents at the Medical Center shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. They may, however, provide patient care under the supervision of an Attending Doctor of Medicine or Osteopathy and subject to training protocols developed by their ACGME approved (or equivalent accreditation) residency program as accepted by the Medical Center. Medical Center acceptance of such training protocols shall include review by the Chief Medical Officer, and prior approval by the Medical Executive Committee and the Board. All Residents shall, as part of their orientation, review the Bylaws, Rules and Regulations of the Medical Staff.

ARTICLE 8: COMPLAINT RESOLUTION AND *FORMAL REVIEW*[8]

8.1 Complaint Resolution. The Executive Committee shall develop a complaint resolution process for addressing documented allegations or concerns regarding a practitioner that may avoid formal review[8]. The Executive Committee shall develop and approve a policy and procedure for conducting the complaint resolution process (CRP) and append such policy and procedure to these bylaws (see Appendix J).

8.1.1 **CRP Policy and Procedure.** The CRP policy and procedure should minimally require that:

8.1.1.1 allegations and concerns be documented;

8.1.1.2 the practitioner be made aware of the allegations/concerns in a timely fashion;

8.1.1.3 the practitioner have the right to waive the complaint resolution process in favor of the formal review[8] process;

8.1.1.4 the documentation of the allegations/concerns and the actions, findings and recommendations of the CRP be reported to the Executive Committee at its next meeting following resolution of the allegation/concern;

8.1.1.5 the practitioner involved be informed of the findings and recommendations of the CRP and have the opportunity to rebut or comment in written form to the Executive Committee; and

8.1.1.6 upon Executive Committee approval, the actions, findings, recommendations, and documentation of the CRP be retained in the practitioner's credential file.

8.1.2 **CRP Does Not Limit Executive Committee Action.** The CRP findings and recommendations do not bar the Executive Committee from recommending or taking further action regarding allegations/concerns.

8.2 Formal Review. Formal review may be requested whenever the activities or professional conduct of any practitioner with a staff appointment or clinical privileges are considered to:

8.2.1 Have been grounds for denial of staff appointment;

8.2.2 Be detrimental to patient safety or likely to affect adversely the delivery of quality patient care in the Medical Center;

8.2.3 Violate bylaws, policies, rules or standards adopted by the Medical Staff or by the Board;

8.2.4 Be disruptive to the operations of the medical center or materially impede the orderly and efficient administration of the Medical Center's affairs; or

8.2.5 Whenever a practitioner fails to meet and satisfy the qualifications for staff status or to fulfill the responsibilities of staff status provided in these bylaws.

Other than with respect to (i) a Practitioner who is not employed by St. Mary's Health System or one of its affiliates; or (ii) a Practitioner matter or concern that relates to clinical quality of care, treatment or services issues, which is a professional review action as defined in 42 USC 11151(9), as it may be amended, that could lead to adverse decisions regarding reappointment, denial, reduction, suspension or revocation of privileges, Practitioner discipline, sanction or remediation shall be within the sole jurisdiction of the St. Mary's Health System Human Resources Department progressive discipline policies and procedures.

8.3 Request for Formal Review. A request for formal review[8] against the practitioner may be initiated by any of the following persons:

8.3.1 Chief Medical Officer;

8.3.2 Chief Quality Officer;

8.3.3 The Chair of any Medical Staff Department;

8.3.4 The Chair of any standing committee of the Medical Staff;

8.3.5 The CEO; or

8.3.6 The Board.

8.4 Discretionary Interview.

8.4.1 **Interview.** Before initiating or proceeding with formal review[8] against a practitioner, the person(s) requesting the formal review[8] may, but is (are) not required to, confer with the practitioner regarding the circumstances that prompted the request for formal review[8].

8.4.2 **Written Report.** If a conference is held, a written report reflecting the substance and conclusion of the interview may be made and, if made, must be transmitted to the practitioner, the Chief Medical Officer of the Medical Staff, the CEO and the practitioner's credentials file.

8.5 Procedures for Initiating and Processing Requests. Other than for summary or automatic suspension, the specific procedures for initiating and processing a request for formal review are contained in these bylaws. In addition, the practitioner's rights to due process are delineated in the Fair Hearing Plan and Appellate Procedure.

8.5.1 All requests for formal review must:

8.5.1.1 Be in writing;

8.5.1.2 Be made to the Executive Committee; and

8.5.1.3 Be supported by specific reference to particular activities or conduct that constitute(s) the grounds for the request.

8.5.2 Action by the Chief Medical Officer of the Medical Staff:

8.5.2.1 The Chief Medical Officer shall notify the CEO of all requests for formal review.

8.5.2.2 The Chief Medical Officer shall keep the CEO informed of all actions taken concerning a request for formal review.

8.6 Executive Committee Review of Request.

8.6.1 A request for formal review and any supporting documentation will be considered by the Executive Committee no later than the next scheduled Executive Committee meeting.

8.6.2 The Chief Medical Officer shall make a reasonable effort to notify the affected practitioner within two (2) business days by Special Notice of the request for formal review after the Executive Committee has considered the request.

8.7 Investigation by Executive Committee and/or by Ad Hoc Committee. After initial deliberation, the Executive Committee shall either act on the request or direct that investigation concerning the grounds for the request for formal review[8] be undertaken, or may do some combination of the two. Such investigative process is not a hearing and does not invoke the provisions of the Fair Hearing Plan and Appellate Procedure.

8.7.1 **Executive Committee Investigation.** This may include a conference with the practitioner involved and with the person or group making the request and with other persons who may have knowledge bearing on the matter.

8.7.2 **Ad Hoc Committee Investigation.**

8.7.2.1 **Formation of the Ad Hoc Committee.** The Chief Medical Officer of the Medical Staff or his designee shall ask the Chair of the affected practitioner's Department to form an Ad Hoc Committee of three practitioners from the same department. If assigning three practitioners from the same department is not possible, the Chair shall ask the Chief Medical Officer to assign additional members from other departments of the medical staff.

8.7.2.2 **Activities of the Ad Hoc Committee.** The Ad Hoc Committee may undertake such investigation of the request for formal review[8] as it deems appropriate

to evaluate and report on the request for formal review[8].

8.7.2.3 **Meeting of the Ad Hoc Committee and the Practitioner.** The Ad Hoc committee shall, at some point during the investigation, meet with the affected practitioner. The practitioner will be given Special Notice of the meeting with the Ad Hoc committee at least five (5) business days before such meeting, unless the Practitioner approves shorter notice. Notice shall include the date, time, and place, a statement of the issue(s) involved, and a statement that the Practitioner's appearance is requested.

8.7.2.4 **Report of the Ad Hoc Committee.** The Ad Hoc Committee shall forward a written report of the investigation to the Executive Committee as soon as practical after the investigation has been completed, but in any event within sixty (60) days of referral by the Executive Committee.

8.7.3 **Executive Committee Discretion.** The Executive Committee may, in its discretion, terminate the investigative process any time and proceed with action as provided below.

8.7.4 **Resources Available.** The Executive Committee or the Ad Hoc Committee shall have available the full resources of the Medical Staff and the Medical Center, and the authority to use outside consultants as deemed necessary and approved by the Executive Committee, the Chief Medical Officer of the Medical Staff or the Chair of the relevant Department.

8.7.5 **Impartial Physical and/or Mental Evaluation.** If there is reasonable cause indicating the necessity for an impartial physical and/or mental evaluation, the Executive Committee may require the practitioner to submit to such evaluation within thirty (30) days of their request and pursuant to the guidelines set forth below.

8.7.5.1 Failure of the practitioner to submit to an impartial physical or mental evaluation without good cause shall result in immediate suspension of the practitioner's staff status and all clinical privileges until the evaluation is obtained and the results are reported to the Executive Committee indicating no physical or mental condition that could impair the practitioner's clinical competency and/or judgment.

8.7.5.2 The evaluator who will conduct the examination shall be selected by the Executive Committee.

8.7.5.3 Fees for an evaluation under this Section shall be paid by the Medical Staff.

8.7.5.4 The evaluator's report shall be submitted to the Chief Medical Officer of the Medical Staff, who shall share the results with the Executive Committee at their next meeting following receipt of the report.

8.8 Executive Committee Action. The Executive Committee shall act as soon as practical after the conclusion of the investigative process if any, but in any event within six (6) months after receipt of the request for formal review[8]. These actions may include, but are not necessarily limited to, the following:

8.8.1 Reconvene the Ad Hoc Committee to address specific issues;

8.8.2 Reject the request for formal review[8];

8.8.3 Modify the request for formal review[8];

8.8.4 Issue a verbal warning, a letter of admonition or a letter of reprimand;

8.8.5 Recommend additional education and/or training;

8.8.6 Recommend individual medical/psychiatric treatment;

8.8.7 Recommend a retrospective review of cases and/or other review of professional behavior, but without special requirements of prior or concurrent or direct supervision;

8.8.8 Impose terms of probation or a requirement for consultation, supervision, counseling or community service, or a fine;

8.8.9 Recommend suspension of appointment prerogatives that do not affect clinical privileges;

8.8.10 Recommend limitation of the right to admit patients where such limitation is not related to the adoption or implementation of an administrative or Medical Staff policy within the Medical Center as a whole or within one or more specific Departments or Services.

8.8.11 Recommend reduction, suspension, or revocation of any part or all of the clinical privileges granted;

8.8.12 Recommend reduction, suspension, or revocation of staff membership.

8.9 Summary Suspension

8.9.1 **Applicable Circumstances.** Summary suspension is appropriate if immediate action is required to protect the life or safety of any patient(s) or to reduce the substantial likelihood of injury or damage to the health or safety of any patient or of any person present in the Medical Center, in circumstances in which a practitioner:

8.9.1.1 willfully disregards these Bylaws or other Medical Center policies or if the practitioner acts in violation of these Bylaws or Policies of the Medical Center or of the Medical Staff, or

8.9.1.2 has engaged in conduct that jeopardizes the health or safety of any patient or of any person at the Medical Center, or

8.9.1.3 has engaged in conduct that exposes any patient or any person at the Medical Center to an extraordinary or immediate risk of injury or damage.

8.9.2 **Authority to Summarily Suspend.** The CEO, COO, Chief Medical Officer of the Medical Staff, Department Chair or the Executive Committee shall have the authority to summarily suspend the staff appointment or all or any portion of the clinical privileges of a practitioner.

8.9.3 **Effective Date of Summary Suspension.** A summary suspension is effective immediately upon verbal communication or Special Notice to the affected Practitioner. Verbal communication shall be subsequently documented and delivered to the practitioner by Special Notice.

8.9.4 **Notice to the Executive Committee.** The party imposing the summary suspension shall immediately notify the Executive Committee and the CEO of the fact of the summary suspension and of the specific reason(s) for the summary suspension. Notification of a practitioner's suspension involving restriction of privileges will be the responsibility of the CEO's office to the appropriate Medical Center areas.

8.10 Review and Action by the Executive Committee

8.10.1 **Meeting of the Executive Committee.** As soon as practical, but in no event later than five (5) business days after a summary suspension becomes effective, the Executive Committee shall convene to review and consider the decision to summarily suspend the Practitioner, unless the Practitioner has agreed to a longer period.

8.10.2 **Range of Action by the Executive Committee.** The Executive Committee may recommend modification, continuation or termination of all or any terms of the suspension.

8.10.3 **Entitlement to Fair Hearing.** Any action by the Executive Committee that in any manner continues any aspect of the practitioner's suspension entitles the Practitioner, upon timely and proper request, to the procedural rights contained in the Fair Hearing Plan and Appellate Procedure (as appended to these bylaws).

8.10.4 **Suspension Remains in Effect.** The terms of the summary suspension, as originally imposed remain in effect pending a final decision by the Board.

8.10.5 **Assignment of Alternative Medical Coverage for the Practitioner's Patients.** If a summary suspension will adversely affect a practitioner's ability to care for patients, then the suspended practitioner's patients then in the Medical Center shall immediately be assigned to another practitioner by the Chief Medical Officer of the Medical Staff, the applicable Department Chair, or their designees, considering the wishes of the patients in selecting a substitute Practitioner.

8.10.6 **Recommendation to Terminate Suspension.** Action by the Executive Committee to terminate the suspension shall be transmitted immediately, with supporting documentation, to the Board. The Practitioner's privileges will be reinstated pending a final decision by the Board.

8.10.7 **Recommendation to Modify Suspension to Lesser Sanction.** Action by the Executive Committee to modify the suspension to a lesser sanction not giving rise to procedural rights is to be handled the same as a Recommendation to Terminate Suspension.

8.11 Review and Action by the Board

8.11.1 **Meeting of the Board.** All decisions to continue any aspect of a summary suspension shall be reviewed by the Board as soon as

practical, but in no event later than five (5) business day after referral from the Executive Committee.

8.11.2 **Range of Action by the Board.** The Board may adopt or reject, in whole or in part, the recommendation of the Executive Committee or refer the matter back to the Executive Committee for further consideration stating the reasons for such referral and setting a time limit within which a subsequent recommendation must be made to the Board.

8.12 Automatic Suspension

8.12.1 **Licensure Discipline.** If a practitioner's license, certificate or other legal credential authorizing him/her to practice his/her profession in this State is modified, suspended or revoked, whether voluntarily or pursuant to proceedings before the applicable State licensing Board, the practitioner shall immediately and automatically be suspended from practicing in the Medical Center, and shall have his/her staff status and privileges suspended. If the practitioner's license is partially limited, modified, or restricted, clinical privileges within the scope of such limitation, modification, or restriction shall be immediately and automatically suspended.

8.12.2 **Drug Enforcement Agency Registration Action.** A practitioner whose Drug Enforcement Agency (DEA) registration or other right to prescribe and/or dispense controlled substances is surrendered, suspended or revoked, whether voluntarily or pursuant to proceedings, shall have his/her medical staff status and privileges reviewed consistent with the following:

8.12.2.1 **Restriction.** Whenever a practitioner's DEA registration is restricted or limited in any manner, the practitioner's right to prescribe medications covered by this registration is similarly restricted or limited effective upon, for at least the term of, and consistent with any other conditions of the restriction or limitation.

8.12.2.2 **Suspension.** Whenever a practitioner's DEA registration is suspended, the practitioner is suspended at least to the extent of limitation of the DEA suspension.

8.12.2.3 **Revocation or Surrender.** Whenever a practitioner's DEA registration is revoked or surrendered, the practitioner immediately and automatically loses the right to prescribe scheduled drugs.

8.12.3 **Failure to Maintain Adequate Professional Liability Insurance.** A practitioner who fails to satisfy the requirements of maintaining professional liability insurance consistent with Section 15.3 of these Bylaws shall immediately and automatically be suspended from practicing in the medical center, from his/her staff status and from the exercise of privileges.

8.12.3.1 **Requesting Reinstatement.** A practitioner whose Staff appointment and clinical privileges are suspended for failure to maintain the minimum level of insurance required may request reinstatement of appointment and clinical privileges by sending a written notice to the CEO, along with a certified copy of the insurance certificate from the insurance company and any limitations on the new policy. The CEO may grant reinstatement after review of an appropriate request.

8.12.3.2 **Activities during Period of Suspension.** The practitioner must submit a written summary of relevant activities during the period of suspension if the Department Chair, Chief Medical Officer of the Medical Staff, Executive Committee, or the Board so requests.

8.12.4 **Failure to Complete Medical Records**

8.12.4.1 **Timely Completion.** An automatic suspension shall, after not less than three (3) business days advance

written warning of delinquency, be imposed for failure of a practitioner to complete medical records in a timely manner as required by medical center policies. Such suspension shall take the form of withdrawal of the practitioner's admitting and clinical privileges.

8.12.4.2 **Repeated Suspensions.** A third suspension and all subsequent suspensions in any twelve (12) month period will result in a suspension of all admitting and clinical privileges. The practitioner will not be permitted to admit any patient or schedule any inpatient or outpatient procedure until all medical records are completed. This suspension will also entail canceling any scheduled admissions or procedures and arranging and communicating alternate call coverage through the respective service until the medical records are complete. Notification of a practitioner's suspension involving restriction of privileges will be the responsibility of the CEO's office to the appropriate Medical Center areas.

8.12.5 **Federal Government Payor Action.** A Practitioner who is listed on the List of Excluded Individuals and Entities by the Office of Inspector General of the United States Department of Health and Human Services or listed in the Excluded Parties List issued by the United States General Services Administration shall immediately and automatically be suspended from practicing in the Medical Center, from his/her staff status and from the exercise of privileges.

8.13 Review and Action by the Executive Committee.

8.13.1 **Review by the Executive Committee. Review by the Executive Committee.** Any automatic suspension or other adverse action arising from licensure discipline, DEA registration action, federal government payor action, or failure to maintain adequate professional liability insurance, shall be reviewed by the Executive

Committee at their next meeting following the automatic suspension taking effect.

8.13.2 **Practitioner Not Entitled to Hearing.** A practitioner under automatic suspension by operation of automatic suspension provisions of these Bylaws is not entitled to the procedural rights afforded by the Fair Hearing Plan and Appellate Procedure. Such suspension is not the result of action of the Board or the Medical Staff.

8.13.3 **Further Action by the Executive Committee.** The Executive Committee may then recommend further action as is appropriate to the facts disclosed in the investigation, including limitation of prerogatives or privileges. Adverse action[8] entitles the practitioner, upon timely and proper request, to the procedural rights contained in the Fair Hearing Plan and Appellate Procedure.

8.14 Reinstatement

8.14.1 **No Automatic Reinstatement With Licensure Discipline, Federal Government Payor Action or DEA Registration Automatic Suspension.** Any practitioner automatically suspended for licensure discipline, federal government payor action, or DEA registration, shall not, by the passage of time or the curing of the event that caused automatic suspension, be automatically reinstated to his/her staff status and clinical privileges.

8.14.1.1 **Required to File Initial Application.** For such practitioners to regain staff status and clinical privileges, such persons shall be required to file an initial application for staff status and clinical privileges, which application shall be processed as provided in Article 6.

8.14.2 **Reinstatement of Practitioners Automatically Suspended for Failure to Maintain Appropriate Levels of Professional Liability Insurance or Failure to Complete Medical Records.** Any practitioner automatically suspended for failure to maintain appropriate levels of professional liability insurance or failure to

complete medical records shall be reinstated after curing the relevant breach of these Bylaws.

8.14.2.1 **Failure to Reinstate.** If a practitioner cures the failure that caused the automatic suspension and the practitioner is not immediately reinstated, the practitioner, subject to the provisions of Section 5.4, shall be entitled to the procedural rights in the Fair Hearing Plan and Appellate Procedure.

ARTICLE 9: FAIR HEARING & APPELLATE REVIEW

9.1 Necessity for Adverse Action. When a practitioner receives Special Notice of an adverse recommended action made by the Executive Committee or an adverse action made by the Board, as such action is defined in the Fair Hearing Plan and Appellate Procedure (as appended to these bylaws) he/she is entitled, upon timely and proper request, to a hearing according to the procedures set forth in the Fair Hearing Plan and Appellate Procedure.

9.2 Process for Hearings and Reviews. When a practitioner receives Special Notice of summary suspension made in keeping with these Bylaws, he/she is entitled, upon timely and proper request to a hearing according to procedures set forth in the Fair Hearing Plan and Appellate Procedure (as appended to these bylaws).

ARTICLE 10: OFFICERS

10.1 Officers of the Medical Staff. The officers of the Medical Staff shall be:

10.1.1 Chief Medical Officer
10.1.2 Chief Quality Officer

10.2 Qualifications of Officers. Officers must be members of the active Medical Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. Nominees must not have any material conflict of interest that prevents the nominee from acting in good faith and in the best interest of the Medical

Center. Once appointed, officers shall not enter into transactions or relationships that would compromise his or her ability to provide good faith direction to the Medical Center. Officers will complete a disclosure statement as required by the Medical Center's policy on conflict of interest.[10]

10.3 Appointment of Officers. The Officers of the Medical Staff shall be appointed by the Chief Executive Officer after the Chief Executive Officer has received advice and counsel with respect to such choice from Members of the Medical Staff using processes or procedures with respect to the receipt of such information as may be developed by the Chief Executive Officer and Medical Executive Committee and after taking into account evaluative information that may be made available in accordance with Section 10.6, below.

10.4 Removal from Office. Any officer may be removed by action of the Chief Executive Officer, at any time.

10.5 Vacancies in Office. Any vacancies in office, shall be filled by the Chief Executive Officer.

10.6 Evaluation of Officers. Biannually, or more frequently, as may be determined by the Chief Executive Officer, the service of the Chief Medical Officer and Chief Quality Officer shall be evaluated by the Chief Executive Officer or his or her designee, based upon an evaluative tool and process as outlined in the Rules and Regulations. The Chief Executive Officer shall refer to such evaluations in connection with the decision to appoint, retain or remove an Officer.

10.7 Conference Regarding Officer Appointments. If Five (5) of the Members of the Active Medical Staff evidence their dissatisfaction with the quality of service of the Chief Medical Officer or Chief Quality Officer by providing a signed written statement to the Chief Executive Officer, the Chief Executive Officer shall, within Thirty (30) days of receipt thereof convene a meeting with the Medical Executive Committee (with or without the Officer in question, as determined by the Medical Executive Committee), to review matters of concern with respect to the Chief Executive Officer's choice of Chief Medical Officer or Chief Quality Officer.

The Chief Executive Officer may take any action (or no action) with respect to his or her appointment of Chief Medical Officer or Chief Quality Officer at the conclusion of the meeting or meetings with the Medical Executive Committee regarding the choice of Chief Medical Officer or Chief Quality Officer.

10.8 Duties of Officers

10.8.1 **Chief Medical Officer:** The Chief Medical Officer shall serve as the chief administrative officer of the Medical Staff to:

10.8.1.1 act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the Medical Center;

10.8.1.2 call, preside at and be responsible for the agenda of all general meetings of the Medical Staff;

10.8.1.3 serve as Chair of the Executive Committee and as a member of the joint conference committee;

10.8.1.4 serve as an ex officio member of all other Medical Staff committees;

10.8.1.5 be responsible for the enforcement of Medical Staff bylaws, rules and regulations, for implementation of sanctions where these are indicated and for the Medical Staff's compliance with procedural safeguards in all instances where formal review[8] has been requested against a Practitioner;

10.8.1.6 appoint committee members to all standing, special and multi-disciplinary committees, except the Executive Committee, subject to the approval of the Executive Committee;

10.8.1.7 represent the view, policies, needs and grievances of the Medical Staff to the Board and to the Chief Executive Officer;

10.8.1.8 receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;

10.8.1.9 be responsible for the educational activities of the Medical Staff; and

10.8.1.10 be the spokesperson for the Medical Staff in its external professional and public relations.

10.8.1.11 keep or cause to be kept accurate and complete minutes of all Medical Staff and Executive Committee Meetings, attend to all correspondence, monitor and report on Medical Staff finances.

10.8.2 **Chief Quality Officer:** In the absence of the Chief Medical Officer, he/she shall assume all of the duties and have the authority of the Chief Medical Officer.

ARTICLE 11: CLINICAL DEPARTMENTS

11.1 Organization of Clinical Departments. Each department shall be organized as a separate part of the Medical Staff and shall have a Chair who shall be responsible for the overall supervision of the clinical work within the department.

11.2 Departments. The Medical Staff shall be divided into the following departments:

11.2.1 **Department of Emergency Services**

11.2.2 **Department of Diagnostic Services**

11.2.3 **Department of Psychiatry**

11.2.4 **Department of Surgical Services**

11.2.5 **Department of Subspecialty Medicine**

11.2.6 **Department of Primary Care**

These departments may be modified and eliminated, and other departments may be established by the Executive Committee upon the recommendation of the Medical Staff as best fits the needs of the Medical Center.

11.3 Department Chair, Vice Chair, Additional Executive Committee Members

11.3.1 **Qualifications.** Each Chair, Vice Chair, and additional department members that serve on the Executive Committee, shall be a member of the active Medical Staff qualified by training, experience and demonstrated ability for the position. Each shall be certified by an appropriate specialty board, or affirmatively establish, through the privilege delineation process, that he/she is possessed of comparable competence. Appointees for these positions must not have any material conflict of interest that prevents the nominee from acting in good faith and in the best interest of the Medical Center. Once appointed, the Chair, Vice Chair, or additional department members that serve on the Executive Committee shall not enter into transactions or relationships that would compromise his or her ability to provide good faith direction to the Medical Center. Each Chair, Vice Chair and additional member that serves on the Executive Committee will complete a disclosure statement as required by the Medical Center's policy on conflict of interest.

11.3.2 **Appointment**. Each Department Chair or Vice Chair shall be appointed by the Chief Executive Officer. Appointment of Department Chairs or Vice Chairs by the Chief Executive Officer shall be with the advice and counsel of Medical Staff Members within each Department. Within Thirty (30) days of the appointment of a Department Chair or Vice-Chair by the Chief Executive Officer, a majority of the Members of the Active Medical Staff within that Department must approve such appointment. The Chief Executive Officer may appoint up to Two (2) additional

Executive Committee members who are not employed by St. Mary's Health System or one of its affiliates, who shall serve on the Executive Committee.

11.3.3 **Term of Office**. Each Chair, Vice Chair and additional department member that serves on the Executive Committee shall serve in such capacity according to any applicable contract with the Medical Center or at the pleasure of the Chief Executive Officer for a term of Two (2) years. A Chair, Vice-Chair and additional department member that serves on the Executive Committee may be reappointed for additional terms of Two (2) years each by the Chief Executive Officer.

11.3.4 **Removal From Office.** Removal of a Chair, Vice Chair, or additional Executive Committee members during his/her term of office shall be per action of the Chief Executive Officer, and replacement of a removed Department Chair, Vice-Chair or additional Department Executive Committee Member shall be by the Chief Executive Officer.

If at any time Two-Thirds (2/3) of the Members of the Active Medical Staff within a Department request termination of the service of a Chair or Vice-Chair of the Department, the Chief Executive Officer shall act upon such request, and shall appoint a replacement Chair or Vice-Chair to fill the position of the removed Chair or Vice-Chair.

11.4 Functions of Department Chair. The Department Chair is administratively responsible for activities of the Department. Each Chair shall:

11.4.1 Facilitate the integration of the department into the functions of the Medical Center.

11.4.2 Be a member of the Executive Committee of the Medical Staff, giving guidance on the overall medical policies of the Medical Center and making specific recommendations and suggestions

regarding the development of policies and procedures in his/her own department to facilitate quality patient care.

11.4.3 Assess and seek to improve the quality of care and services provided in the department by:

11.4.3.1 participating in and encouraging department staff involvement in the organization's quality assessment and performance improvement process;

11.4.3.2 making recommendations for a sufficient number of qualified and competent Practitioners; and

11.4.3.3 maintaining continuing review of the professional performance of all Practitioners with clinical privileges in his/her department including Allied Health Professionals not licensed as independent practitioners[5] by reporting regularly thereon to the Executive Committee of the Medical Staff.

11.4.4 Recommend to the Medical Staff the department's criteria for clinical privileges per 11.6.1.

11.4.5 Be responsible for the enforcement of the Medical Center bylaws and of the Medical Staff bylaws, rules and regulations within his/her department.

11.4.6 Be responsible for implementation within his/her department of actions taken by the Executive Committee of the Medical Staff.

11.4.7 Review initial applicants for appointment and reappointment and transmit to the Executive Committee of the Medical Staff his/her recommendations concerning their staff classification, their appointment/reappointment and their delineation of privileges.

11.4.8 Assist in the coordination and integration of interdepartmental and intra-departmental services.

11.4.9 Establish with the Medical Staff and Medical Center administration the type and scope of services required to meet

patient needs and assist in the preparation of such annual reports, including budgetary planning, concerning his/her department as may be required.

11.4.10 Establish subspecialty services and service chiefs where necessary and appropriate.

11.4.11 Assure orientation and continuing education of all persons in the department.[5]

11.4.12 Assess and recommend to hospital administration off-site sources for needed patient care services not provided by the department or the organization.[5]

11.4.13 Provide a process which includes, at a minimum on a yearly basis, relevant documented provider-specific clinical performance improvement feedback to each member of the Medical Staff department who participates in patient care.

11.5 Functions of Department Vice Chair. Each Vice Chair shall, in the absence of the Chair, assume all the duties and have the authority of the Chair. They shall automatically succeed the Chair when the latter fails to serve for any reason.

11.6 Functions of Departments

11.6.1 **Department Criteria for Privileges and Office.** Each department shall establish its own criteria for the granting of clinical privileges and for the holding of office in the department consistent with pertinent external review organization requirements, the bylaws and policies of the Medical Staff and Board.

11.6.2 **Quality Assessment, Peer Review and Performance Improvement.** Each department shall establish mechanisms designed to document and involve department staff in quality assessment, peer review and performance improvement activities as specified in Section 12.2.11.

11.6.3 **Meetings.** Each department shall meet at least four (4) times a year[8] to review quality assessment and performance improvement initiatives.

11.6.4 **Minutes and Reports.** Each department shall maintain a permanent record of its proceedings and actions. Copies of minutes shall be submitted to the Executive Committee.

ARTICLE 12: COMMITTEES AND FUNCTIONS

12.1 Executive Committee-Designation and Substitution. The Executive Committee shall perform all of the functions described in Section 12.2. The preceding sentence aside, the Executive Committee shall have the authority to establish one or more committees of the Medical Staff to perform one or more of the required staff functions listed in Section 12.2 (See Medical Staff Committee Structure - Appendix C). Absent the formation of such additional committees, all functions described below shall be performed by the Executive Committee. The Executive Committee is responsible for organizing the Medical Staff's performance improvement activities, as detailed in Appendix C.

12.1.1 The Executive Committee shall be a standing committee and shall consist of:

12.1.1.1 the immediate past Chief Medical Officer;

12.1.1.2 the Chairs of the Medical Staff departments;

12.1.1.3 the Chief Medical Officer of the Medical Center;

12.1.1.4 the Chief Quality Officer of the Medical Center;

12.1.1.5 Up to Two (2) additional members who are not employed by St. Mary's Health System or one of its affiliates appointed by the Chief Executive Officer.

12.1.1.6 the Chief Executive Officer and the Chief Operating Officer, Chief Nursing Officer, and other members of Administration at the discretion of the Chief Executive Officer or Chief Medical Officer, shall be invited, non-voting attendees.

12.2 Staff Functions.

12.2.1 **In General.** The staff functions listed in this Section 12.2 shall be performed by the Executive Committee or by other committees as the Executive Committee shall from time to time authorize and establish. The Executive Committee, in establishing other committees shall determine membership, voting rights, and committee mission. The role of such committees shall be advisory and the Executive Committee retains final authority to act on all matters.

12.2.2 **Executive Function.** The duties involved in carrying out the executive function shall be to take appropriate actions in the following areas and, if appropriate or required by these bylaws, make recommendations to the Board regarding the same:

12.2.2.1 To coordinate the activities and general policies of the various departments.

12.2.2.2 To receive and act upon committee reports.

12.2.2.3 To execute policies of the Medical Staff not otherwise the responsibility of the departments, and the functions of the Medical Staff listed in Subsections 12.2.3 through 12.2.13.

12.2.2.4 To provide liaison between the Medical Staff and the Chief Executive Officer and the Board.

12.2.2.5 To recommend action to the Chief Executive Officer on matters of a medico-administrative nature.

12.2.2.6 To make recommendations on hospital management matters to the Board through the Chief Executive Officer.

12.2.2.7 To fulfill the Medical Staff's accountability to the Board for the medical care rendered to patients of the Medical Center.

12.2.2.8 To ensure that the Medical Staff is actively involved in the accreditation process and kept abreast of the accreditation status of the Medical Center.

12.2.2.9 To provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent.

12.2.2.10 To establish guidelines regarding the mechanism used to review credentials and requests for clinical privileges and to review the credentials of all applicants and to establish guidelines for staff membership, assignments to departments and delineation of clinical privileges.

12.2.2.11 To review periodically all information available regarding the performance and clinical competence of staff members and as a result of such reviews to make recommendations for appointments and reappointments and renewal or change in clinical privileges.

12.2.2.12 To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance by all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted.

12.2.2.13 To make recommendations regarding the structure of the Medical Staff.

12.2.2.14 To be empowered to act for the Medical Staff at intervals between Medical Staff meetings.

12.2.3 **Medical Staff Credentials Function.** The duties involved in coordinating and reviewing credentials investigations and recommendations are:

12.2.3.1 To review and evaluate the qualifications of each applicant for initial appointment to staff status, reappointment or modification of appointment and/or clinical privileges.

12.2.3.2 To submit a report, according to Articles 6 and 7, to the Chief Executive Officer and the Board on each applicant for Medical Staff membership, and each applicant for reappointment. This report shall include recommendations

with respect to appointment, staff status, clinical privileges and special conditions attached thereto.

12.2.3.3 Investigate, review and report on matters, including the clinical or ethical conduct of any professional assigned or referred to it by: 1) the Chief Medical Officer of the Medical Staff; 2) any member of the active Medical Staff; 3) the Chief Executive Officer; or 4) those responsible, respectively, for functions described in Section 12.2.4 through 12.2.13.

12.2.4 **Medical Records Review Function.** The duties involved in this review function include assuring the completeness, accuracy, legibility[8] and timely completion of information in the medical records on at least a quarterly basis.

12.2.4.1 This function is done in cooperation with nursing, medical records, administration, and other departments as appropriate.

12.2.4.2 This function evaluates all or a representative sample of records to determine that they:

12.2.4.2.1 reflect the diagnosis, results of diagnostic tests, therapy rendered, condition and progress of the patient, and condition of the patient at discharge;

12.2.4.2.2 are always sufficiently complete to facilitate continuity of care and communications between all those providing patient care services in the Medical Center; and

12.2.4.2.3 are adequate in form and content to permit quality assessment and performance improvement activities to be performed.

12.2.5 **Medication Use Evaluation and Improvement Function:** There is an ongoing and interdisciplinary mechanism for improving the processes involved in medication prescribing, preparation and dispensing, administration, and monitoring. The medication monitoring and

improvement function:

12.2.5.1 Focuses on the most important medications used in the Medical Center.

12.2.5.2 Provides a basis for selecting medications that are to be evaluated and for identifying the key sets of processes that are to be the specific subject of evaluation.

12.2.5.3 Seeks to maximize the benefits of evaluation by using the results of review to improve the processes involved in prescribing, preparing and dispensing, administering, and monitoring the use of medications.

12.2.5.4 Develops and maintains a process for defining, identifying, and reviewing significant medication errors and adverse drug reactions to improve patient safety.

12.2.5.5 Evaluates clinical data concerning new drugs or preparations requested for use in the Medical Center.

12.2.5.6 Develops and reviews periodically a formulary or drug list for use in the Medical Center.

12.2.5.7 Director of Pharmacy is responsible for the procurement, stocking, distribution and accountability of medications at the Medical Center.

12.2.6 **Infection Control Function.** There is an ongoing and interdisciplinary mechanism for improving the processes involved in preventing, investigating and controlling infection. The duties involved in preventing, investigating and controlling infections include:

12.2.6.1 Approving the type and scope of surveillance activities.

12.2.6.2 Reviewing designated microbiological reports.

12.2.6.3 Reviewing patient infections, as appropriate, to determine whether an infection is nosocomial, using approved definitions and criteria, aggregating data to determine opportunities to improve patient safety.

12.2.6.4 Approving actions to prevent or control infection.

12.2.6.5 Reviewing and approving all policies and procedures related to infection surveillance, prevention and control at least every two years.

12.2.7 **Intensive and Critical Care Function.** The duties involved in the effective management of the intensive and critical care unit are to:

12.2.7.1 Establish and implement policies for the effective operation of the intensive and critical care unit.

12.2.7.2 Provide guidance to the director of the intensive and critical care unit.

12.2.7.3 Conduct quality assessment and performance improvement activities that improve the quality of care provided to patients in the unit.

12.2.7.4 Foster a climate of collaboration among the Practitioners who care for the unit's patients.

12.2.8 **Continuing Medical Education Function.** The duties involved in arranging and carrying out the educational programs of the Medical Staff are to:

12.2.8.1 Develop and plan programs of continuing medical education that are designed to keep the Medical Staff and Allied Health Professionals informed of significant new developments and new skills that are responsive to evaluation findings and relevant to the type of patient care delivered in the Medical Center, and responsive to the expressed educational needs of Practitioners.

12.2.8.2 Evaluate the effectiveness of the educational programs developed and implemented, and document each Practitioner's participation in continuing education.

12.2.8.3 Analyze the Medical Center's and staff's needs for library services.

12.2.8.4 Act upon continuing education recommendations from the Executive Committee or other committees responsible for quality assessment and performance improvement functions.

12.2.9 **Bylaws Review and Revision Function.** The duties involved in maintaining appropriate bylaws, rules, regulations and other organizational documents concerning the Medical Staff are to:

12.2.9.1 Conduct an annual review of the bylaws and the rules, regulations, procedures and forms promulgated in connection therewith.

12.2.9.2 Submit recommendations to the Executive Committee and to the Board for changes in these documents.

12.2.9.3 Act upon all matters as may be referred by the Board, the Executive Committee, the Chief Medical Officer of the Medical Staff, the Chief Executive Officer and committees of the Medical Staff.

12.2.10 **Safety and Risk Management Function.** The duties involved in planning to provide an appropriate therapeutic environment and adequate safety are to develop and periodically review, in cooperation with administration, procedures and facilities for maintaining:

12.2.10.1 Functional safety and security for patients, employees and visitors.

12.2.10.2 An effective emergency preparedness program.

12.2.10.3 Effective policies and procedures regarding the use of special treatment procedures (e.g., restraint and seclusion, electroconvulsive therapy).

12.2.10.4 An environment that enhances the self-image of patients and preserves their human dignity.

12.2.11 **Quality Assessment, Peer Review and Performance Improvement Function.** The Medical Staff assists in the development and participates in the implementation of the Medical Center's planned, systematic, organization-wide approach to designing, measuring, assessing, and improving performance. The Medical Staff requires that the organization have a written quality improvement plan.[9]

12.2.11.1 Quality assessment, peer review, and performance improvement activities monitor, evaluate and seek to improve:

12.2.11.1.1 the use of surgical and other invasive procedures;

12.2.11.1.2 the use of medications;

12.2.11.1.3 the use of blood and blood components;

12.2.11.1.4 the appropriateness of admissions and continued hospitalization;

12.2.11.1.5 the completeness, accuracy, and timely completion of information in the medical records;

12.2.11.1.6 the clinical performance of individuals with delineated clinical privileges; and

12.2.11.1.7 other high risk and/or problem prone procedures or processes.

12.2.11.2 Quality assessment, peer review and performance improvement activities are documented and reported to the Executive Committee on a periodic basis. In addition, at least annual provider-specific clinical performance improvement feedback will be provided to each member of the Medical Staff who participates in care.[8]
The department chair is responsible for ensuring that feedback is provided annually.

12.2.11.3 The quality assessment, peer review and performance improvement system is evaluated annually to determine its effectiveness in improving the quality of patient care.

12.2.12 **Blood Use Evaluation and Improvement Function.** There is an ongoing and interdisciplinary mechanism for improving the processes involved in blood and blood component ordering; distribution, handling, and dispensing; administration; and monitoring. The blood use evaluation and improvement function:

12.2.12.1 Focuses on the most important blood and blood components used in the Medical Center.

12.2.12.2 Provides a basis for selecting blood and blood components that are to be evaluated and for identifying key sets of processes that are to be the specific subject of evaluation.

12.2.12.3 Seeks to maximize the benefits of evaluation by using the results of review to improve the processes involved in ordering; distributing, handling, and dispensing; administration; and monitoring the use of blood and blood components.

12.2.12.4 Assures that the Medical Center has effective policies and procedures related to blood and blood component ordering; distribution, handling, and dispensing; administering; and monitoring.

12.2.12.5 Evaluates all confirmed transfusion reactions.

12.2.13 **Surgical and Other Invasive Procedures Evaluation and Improvement Function.** There is an ongoing and interdisciplinary mechanism for improving the processes involved in surgical and other invasive procedures (e.g., selecting the appropriate procedures, preparing patients for these procedures, performing procedures, monitoring patients, and providing post-procedure care). The surgical and other invasive procedures evaluation and improvement function:

12.2.13.1 Focuses on the most important surgical and other invasive procedures used in the Medical Center.

12.2.13.2 Provides a basis for selecting surgical and other invasive procedures that are to be evaluated and for identifying the key sets of processes that are to be the specific subject of evaluation.

12.2.13.3 Seeks to maximize the benefits of evaluation by using the results of review to improve the processes involved in selecting the procedure, preparing the patient for the procedure, performing the procedure, monitoring the patient during the procedure, and providing post-procedure care for surgical and other invasive procedures.

12.2.13.4 Responds to all major discrepancies, or patterns of discrepancies, between preoperative and postoperative (including pathologic) diagnoses, including those identified during the pathologic review of specimens removed during surgical or invasive procedures.

12.3 Joint Conference Committee. The Joint Conference Committee shall be composed of Three (3) Members of the Board of Directors and Three (3) Members of the Executive Committee of the Medical Staff. The Three (3) Members of this Committee from the Board shall be appointed by the Chairperson of the Board, and the Three (3) Members from the Medical Staff Executive Committee shall be appointed by the Chief Medical Officer of the

Medical Staff. The President of the Medical Center shall be an ex-officio member of the Committee without vote.

This Committee shall conduct itself as a forum for the discussion of matters of hospital policy and practice, especially those pertaining to efficient and effective patient care, and shall act as a liaison committee between the Board of Directors, the Medical Staff and the administration of the hospital. Meetings of this Committee may be called by the Chief Medical Officer, Three (3) members of the Medical Staff Executive Committee, the Chairperson of the Committee, a majority of the Board of Directors, or the President of the Medical Center.

This Committee shall meet as necessary and shall transmit written minutes of its activities to the Medical Staff Executive Committee and the Board of Directors. The Three (3) members of the Joint Conference Committee who are members of the Board of Directors shall be appointed by the Board Chair at such time that the Joint Conference Committee is convened. The first Chairperson of the Committee shall be one of the three Medical Staff Executive Committee Members, appointed by the Chief Medical Officer, and retain such office until the matter subject to review by the Joint Conference Committee is concluded. The next time the Joint Conference Committee is convened, the Chairperson of the Committee shall be one of the three Board Members appointed to the Committee, as designated by the Board Chair, and shall retain such office until the matter subject to review by the Joint Conference Committee is concluded. Appointment of the Chairperson of the Joint Conference Committee shall thereafter alternate with respect to each subject matter thereafter reviewed by the Joint Conference Committee.

12.4 Executive Committee. The Executive Committee shall meet as often as is necessary to discharge its functions but not less frequently than ten times a year. The Executive Committee shall maintain minutes of its proceedings. In performing the functions listed in Section 12.2, the Executive Committee may include and use, in the discretion of the Chief Medical Officer of the Medical Staff and the Chief Executive Officer, Allied Health Professionals and representatives from administration, nursing, medical records, pharmacy, patient and family services and other areas as are appropriate to the function to be discharged.

12.4.1 **Subcommittee on Physician Health.** The Chief Medical Officer of the Medical Staff, with the consent of the Executive Committee, will appoint a Subcommittee on Physician Health. The goal of this committee is to

establish a system that is secure and confidential aimed at the prevention and early intervention of behaviors that are or may become detrimental to patient care. The purpose of this intervention process is assistance and rehabilitation, rather than discipline, and it is designed to aid a physician in retaining or regaining optimal professional functioning, consistent with the protection of patients. This process is not intended to preclude or limit the use of the corrective action process provided for in the Medical Staff Bylaws whenever such action is deemed necessary and appropriate.

12.4.1.1.1 The subcommittee will be composed of three physicians, one of whom will be designated as the Chair of the subcommittee. No member of the subcommittee will be a current member of the Executive Committee. One member of the subcommittee will be from the Department of Psychiatry. Members of the medical staff with experience and judgment will be given preference for appointment to the subcommittee, in particular former Executive or Clinical Practice Committee members. In order to assure continuity on the subcommittee, members shall be appointed to serve staggered terms.

12.4.1.2 The objectives of the subcommittee will be:

12.4.1.2.1 Education of the medical staff and hospital coworkers about recognition of physician illness.

12.4.1.2.2 Establishment of a system of early identification and Intervention for physicians at risk of health impairment,
behavioral deficiencies or chemical dependency.

12.4.1.2.3 Identification and assistance to members of the Medical
Staff whose ability to practice medicine may be compromised because of medical or psychological reasons.

12.4.1.3 The subcommittee will receive referrals or concerns from any source, including self-referrals. Upon receipt of the referral or concern, the subcommittee will log the referral or concern and the

chair will appoint two members of the subcommittee, who do not have a conflict of interest, to investigate the matter. In the event that subcommittee members have a conflict of interest, the Chief Medical Officer of the Medical Staff shall appoint a member or members of the Medical Staff to conduct the investigation as ad hoc subcommittee members.

12.4.1.4 The subcommittee shall review the findings of this investigation and if remedial action is recommended, shall report these recommendationsto the Chief Medical Officer of the Medical Staff. The subcommittee may recommend referral to an external source, such as the Physician Health Committee of the Maine Medical Association.

12.4.1.5 The subcommittee shall maintain the confidentiality of the physician seeking referral or referred for assistance, except as limited by law, ethical obligation or when the safety of a patient is threatened.

12.4.1.6 The Medical Affairs Office will keep records of the subcommittee review. Records will be retained for a period of five years in a secure storage place separate from physician credential files. Access to such files shall be limited to members of the subcommittee and the Chief Medical Officer of the Medical Staff, provided, however, if the written agreement provided for herein is violated, such records may be reviewed as part of any consequent corrective action process.

12.4.1.7 The Physician Health Committee of the Maine Medical Association will
serve as a resource to the subcommittee.

12.4.1.8 The subcommittee will be considered a professional competence committee pursuant to the Maine Health Security Act. Its members, including ad hoc appointees, shall be familiar with and abide by applicable State and Federal laws relating to physician health, applicable laws and rules of the Maine Board of Registration in Medicine, and the State Physicians Health Program.

12.5 **Cancer Committee.** The Cancer Committee shall be a multi-disciplinary, standing committee and shall consist of at least six members of the active medical staff. Membership shall fulfill the standards for a Cancer Committee as required by the American College of Surgeons (ACS) for a community hospital cancer program.

12.5.1 **Membership.** Membership shall include physician representation from pathology, medical oncology, diagnostic radiology, surgery and the ACS Cancer Liaison physician. Representation from internal medicine and family practice is also encouraged. Non-physician members shall include representatives from the tumor/cancer registry, quality assurance, nursing, social services and administration.

12.5.2 **Duties.** The Cancer Committee shall be responsible for cancer program activities as required for an ACS Community Hospital Cancer Program. These shall include, but are not limited to:

12.5.2.1 supervision of the Tumor Registry;
12.5.2.2 presentation of Tumor Conferences;
12.5.2.3 availability of consultative services;
12.5.2.4 evaluation of quality of care; ~~and~~
12.5.2.5 establish, as necessary, subcommittees to assure accreditation of clinical programs; and to provide oversight of those subcommittees. These subcommittees may include, but are not limited to, the Breast Health Program and the Chest Oncology Program; and
12.5.2.6 annual reporting.

12.5.3 **Meetings.** The Cancer Committee shall meet not less than quarterly. The

committee may meet jointly with the Cancer Committee from other health facilities. A permanent record of the proceedings of the committee shall be maintained.

12.6 Other Committees. Any committee (other than the Executive Committee) established to perform one or more of the staff functions required by Section 12.2 shall be composed of members of the active staff and may include, at the discretion of the Chief Medical Officer of the Medical Staff and the Chief Executive Officer, courtesy and consulting staff, Allied Health Professionals and other representatives as are appropriate to the function to be discharged. The Chair, Secretary and members of any such committee shall be appointed by the Chief Medical Officer of the Medical Staff. Appointments to such committees shall be for one year. Only active staff members will have a vote or may occupy the position of Chair of a Committee.

12.6.1 The Chief Medical Officer of the Medical Staff and Chief Executive Officer, or their respective designees, shall serve as ex-officio members without vote on all such committees.

12.6.1.1 A committee member shall continue as such until the end of his/her normal period of appointment and until his/her successor is elected or appointed.

12.6.1.2 A committee member (other than a member of the Executive Committee) may be removed by a majority vote of the Executive Committee.

12.6.1.3 Vacancies on any such committee shall be filled in the same manner in which original appointment to such committee is made.

12.6.2 Any committees appointed or established pursuant to this Section 12. *6* to perform one or more of the staff functions required by these bylaws shall meet as often as necessary, but not less than ~~4~~ times per year, to discharge its assigned duty. Such committees shall maintain minutes and records of their proceedings and submit these on a timely basis to the Committee responsible for the Medical Staff's quality assessment function (see Appendix C). If the Committee is not the Executive Committee, the

minutes of the Committee shall be forwarded to and reviewed by the Executive Committee.

12.7 **Medical Staff Communication in Governance.** In addition to the Joint Conference Committee (see Section 12.3), there are several mechanisms to assure communication between the medical staff and those levels of governance involved in policy decisions affecting patient care services at the Medical Center. These include, but are not necessarily limited to, the following: 1) medical staff representation on the Board and key Board committees; 2) administrative representation on the Executive Committee of the Medical Staff; 3) administrative representation at Medical Staff department and committee meetings; 4) formal and informal meetings between leadership members of the Board, Administration and Medical Staff; and 5) written communication between the Board, Administration, and the Medical Staff (e.g., newsletters, memos, reports).

ARTICLE 13: MEETINGS

13.1 **Staff Meetings.**

13.1.1 **Regular Meeting.** A regular quarterly staff meeting shall be held the second Monday of March, June, September and December. The December meeting shall be considered the annual meeting.

13.1.2 **Order of Business and Agenda.** The order of business at the annual meeting shall include:

13.1.2.1 Reading and acceptance of the minutes of the last annual meeting and of all special meetings held since the last annual meeting.

13.1.2.2 Reading of communications to and from the staff since the last annual meeting.

13.1.2.3 Administrative reports from the Chief Executive Officer, the Chief Medical Officer, department and committee Chairs.

13.1.2.4 Reserved.

13.1.2.5 Reports by responsible officers, committees and departments on the overall results of quality assessment and performance improvement activities and the fulfillment of the other required staff functions.

13.1.2.6 Recommendations for improving patient care within the Medical Center.

13.1.2.7 Old business.

13.1.2.8 New Business.

13.1.2.9 Adjournment.

13.1.3 **Special Meetings.** Special meetings of the Medical Staff may be called any time by the Board, the Chief Medical Officer of the Medical Staff or the Executive Committee, and shall be held at the time and place designated in the meeting notice.

13.1.3.1 No business shall be transacted at any special meeting except that stated in the meeting notice.

13.1.3.2 Written notice stating the place, day and hour of any special meeting shall be delivered by regular notice. Attendance at a meeting shall constitute a waiver of notice of such meeting, except for attendance for the purpose of objecting to sufficiency of notice.

13.2 Committee and Department Meetings.

13.2.1 **Regular Meetings.** Committees and departments shall provide the time for holding regular meetings and no notice shall then be required.

13.2.2 **Special Meetings.** A special meeting of any committee or department may be called by or at the request of the Chair thereof, the Board, the Chief Medical Officer of the Medical Staff, or by written petition of one-third of the group's current members. No business shall be transacted at any special meeting except that stated in the meeting notice, unless all members waive this restriction in writing.

13.3 **Quorum.**

13.3.1 **Staff Meetings.** The presence of one-third of the total membership of the active Medical Staff at any regular or special meeting shall constitute a quorum for all actions.

13.3.2 **Committee and Department Meetings.** One third of the active Medical Staff members of a committee or department, but not less than two members, shall constitute a quorum at any meeting.

13.4 **Manner of Action.** The action of a majority of the members present at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken) signed by each member entitled to vote thereat.

13.5 **Minutes.** Minutes of each regular and special meeting shall be prepared and shall include a record of the attendance of members and the actions taken on each matter. The minutes shall be signed by the presiding officer and a copy forwarded to the Executive Committee. A permanent file of the minutes of each meeting shall be maintained.

13.6 **Attendance Requirements.** Each active member of the Medical Staff is expected to attend all Medical Staff, Department and Committee meetings. Compliance with this requirement will be considered in the reappointment/re-privileging process.

13.7 **Absence from Meetings.** Absence from required meetings will be excused for written documentation of emergencies, medical leaves, vacations, or conflict with educational or administrative meetings.

Participation in medical staff organization activities including meeting attendance is reviewed at time of reappointment as part of the process described in Appendix B. A pattern of unexcused absences from meetings will categorize the application as Category 2 with the accompanying processing noted in Appendix B and may lead to the initiation of the Complaint Resolution Process noted in Appendix J.

ARTICLE 14: CONFIDENTIALITY, IMMUNITY AND RELEASES

14.1 Special Definitions. For the purposes of this Article, the following definitions shall apply:

14.1.1 **Information** means record of proceedings, minutes, records, reports, memoranda, statements, recommendations, letters, data and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 14.5.2.

14.1.2 **Malice** means the purposeful dissemination of a known falsehood or of untrue information with a reckless disregard for whether or not it is true or false.

14.1.3 **Representative** means a Board, any member or committee thereof; a Chief Executive Officer, a Medical Staff organization and any member, officer, or committee thereof; any member of the medical staff; and any individual authorized by any of the foregoing or these bylaws to perform information gathering, disseminating, communicating or evaluating functions.

14.1.4 **Third Parties** means both individuals and organizations providing information to any Representative.

14.2 Authorizations and Conditions. By applying or reapplying for, or requesting or exercising staff status or clinical privileges within this Medical Center, a Practitioner:

14.2.1 Authorizes Representatives and the Medical Center to solicit, provide, receive, review, evaluate, verify and act upon information bearing on his/her professional ability, qualifications, training, background, ethics, physical and mental health, emotional stability, and any other matter relevant to his/her application, reapplication or exercise.

14.2.2 Agrees to be bound by the provisions of this Article and to waive all legal and equitable claims and actions (whether known or unknown to the Practitioner) against the Medical Center, any Representative or third party who acts according to the provisions of this Article; and

14.2.3 Acknowledges that the provisions of this Article are express conditions to his/her application or reapplication for or acceptance of staff status and/or clinical privileges, or his/her exercise of clinical privileges at the Medical Center.

14.3 Confidentiality of Information. Information with respect to any Practitioner submitted, collected or prepared by any Representative for the purpose of performing functions under these bylaws, achieving and maintaining quality patient care, reducing morbidity and mortality, reviewing or evaluating Practitioner performance, or contributing to medical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a Representative nor used in any way except as provided herein. Such confidentiality shall also extend to information of like kind that may be provided by third parties. Practitioner will have access to this information at reasonable times and upon reasonable advance notice. This information shall not become part of any particular patient's files or of the general Medical Center records. Breach of confidentiality by response to legal process apparently valid on its face or exercise of legal rights by or on behalf of or in respect of a patient shall not nullify or void any other provision of this Article.

14.4 Immunity from Liability.

14.4.1 **For Action Taken.** Neither the Medical Center nor any Representative shall be liable for damages or other relief for any action taken or statement or recommendation made within the express or implied or reasonably inferable scope of its or his/her duties, if such acts are taken or made without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement, or recommendation is warranted by such facts as the same are believed to exist by the Medical Center or such Representative or by reasonable inferences made from such facts as the same are believed to exist by the Medical Center or such Representative. Assuming appropriate procedures were followed, as described in these bylaws, truth shall be an absolute defense in all circumstances. Nothing in this paragraph shall restrict or modify immunities otherwise accorded under state or federal law.

14.4.2 **For Providing Information.** Neither the Medical Center, any Representative nor any third party shall be liable for damages or other

relief because of providing information, including otherwise privileged or confidential information, to the Medical Center or a Representative or to any other hospital, state or other licensing or similar agency or board, organization of health professionals or other health-related organization concerning a Practitioner who is or has been an applicant or reappointment applicant or member or holder of other staff status or who did or does exercise clinical privileges at this Medical Center; provided that the Medical Center, such Representative or third party acts without malice.

14.5 Activities and Information Covered.

14.5.1 **Activities.** The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, letters, or disclosures performed or made concerning this or any other health-related institution's or organization's activities related, but not limited to:

14.5.1.1 Applications for appointment, staff status or clinical privileges.

14.5.1.2 Periodic reappraisals for reappointment, renewal of staff status or clinical privileges.

14.5.1.3 Formal review and complaint resolution, including summary suspension.

14.5.1.4 Hearings and appellate reviews.

14.5.1.5 Utilization review.

14.5.1.6 Other Medical Center, department, service or committee activities related to monitoring, evaluating and improving the quality of patient care and appropriate professional conduct.

14.5.1.7 Other staff functions provided by these bylaws.

14.5.2 **Information.** The information referred to in this Article may relate to a Practitioner's professional qualifications, current competence, judgment, training, background, experience, character, physical and mental health,

emotional stability, professional ethics or any other matter that might directly or indirectly affect patient care.

14.6 Releases and Authorizations. Each Practitioner shall, at any time and from time to time upon request of the Medical Center, execute general and specific releases according to the tenor and import of this Article, subject to the requirements and conditions of this Article. Execution of such releases is not a prerequisite to the effectiveness of this Article. Upon request by the Medical Center, each Practitioner shall also execute specific authorizations authorizing other hospitals, agencies, institutions, schools and professional associations to release, without liability, to the Medical Center information concerning the Practitioner.

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

ARTICLE 15: GENERAL PROVISIONS

15.1 Staff Rules and Regulations. The Executive Committee shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws, subject to the approval of the Board. These shall relate to the proper conduct of Medical Staff organizational activities and embody the level of practice required of each Practitioner in the Medical Center. Such rules and regulations shall be a part of these bylaws and the Executive Committee may amend at any time, and such changes shall become effective when approved by the Board. In case of conflict between rules and regulations and bylaws, the bylaw language will prevail. If Medical Staff Members eligible to vote propose to adopt a rule, regulation or policy or an amendment thereto, such proposal shall be communicated in writing to the Executive Committee. If the Executive Committee proposes to adopt a rule or regulation, or an amendment thereto, it shall first communicate the proposal to the Medical Staff, and shall not take action thereon for Fifteen (15) days after notice thereof is provided to the Medical Staff.

15.1.1 **Temporary Rules and Regulations**. In the event of a documented and urgent need to amend the Medical Staff rules and regulations in order to comply with any governmental law or regulation, the Executive Committee may provisionally adopt, and the Board may provisionally

approve, an amendment to the Medical Staff rules and regulations without prior notification to the Medical Staff. Such amended rules or regulations shall initially be referred to as "Temporary Rules or Regulations". The Executive Committee shall provide notice to the Medical Staff at the time any Temporary Rule or Regulation is approved. In the event of a conflict between the Active Staff and the Executive Committee regarding the adoption of a Temporary Rule or Regulation, the Active Staff may, in accordance with the process set forth in Medical Staff Bylaws, Appendix K, submit the matter to conflict management within thirty (30) days of notice of adoption of the Temporary Rule or Regulation. The Temporary Rule or Regulation shall remain in effect unless or until modified by the conflict management process. If no timely request for conflict management is filed, the Temporary Rule or Regulation shall stand.

15.2 Department Rules and Regulations. Subject to the approval of the Executive Committee, each department shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these bylaws, and the general rules and regulations of the Medical Staff or other policies of the Medical Center.

15.3 Professional Liability Insurance. Each Physician and Allied Health Professional granted clinical privileges in the Medical Center shall maintain in force professional liability insurance in not less than the minimum amounts as from time to time may be determined by resolutions of the Executive Committee and of the Board. Subject to the approval of the Board, the Executive Committee may, for good cause shown by a Practitioner, waive this requirement, if any such waiver is not granted or withheld on an arbitrary, discriminatory or capricious basis. In considering any request for a waiver, the Executive Committee may consider the following: (a) whether the professional has applied for professional liability insurance; (b) whether such application was rejected and, if so, why; (c) whether such insurance is available to such professional and, if not, why; (d) whether the professional is financially responsible in the absence of insurance coverage; and (e) whether the professional is eligible to purchase such insurance at a coverage level less than that established from time to time hereunder. The minimum amount of required coverage established pursuant to this provision shall not exceed the amount of professional liability insurance carried by the Medical Center.

15.4 Notification of Disciplinary Action. Each Practitioner granted clinical privileges in the Medical Center, shall notify the Chief Executive Officer in writing within ten days following the receipt by such Practitioner, of notice from another hospital or health care facility where such Practitioner holds Medical Staff membership, or has the right to exercise clinical privileges, or from a government agency, initiating or in any way relating to the initiation of a process, which could result in corrective or disciplinary action being taken by such other hospital or health care facility or government agency with respect to such Practitioner. The term "corrective or disciplinary action" shall include action seeking to institute probation or require consultation or supervision; reduce, suspend or revoke privileges; reduce staff status or limit any prerogatives directly related to patient care; suspend or revoke staff membership; or suspend or revoke such Practitioner's license or right to prescribe any medication. The affected Practitioner shall provide the Medical Center with complete information as to the reasons for the initiation of corrective or disciplinary action and the progress of the proceedings.

15.5 Forms. Application forms and any other forms required by these bylaws for use in connection with staff appointments, reappointments, delineation of clinical or specified department privileges, formal review[8], notices, recommendations, reports and other matters shall be reviewed and approved by the Executive Committee.

15.6 Transmittal of Reports. Reports and other information that these bylaws require the Medical Staff to transmit to the Board shall be deemed so transmitted when delivered to the Chief Executive Officer.

15.7 Exclusive Means. These bylaws provide the sole and exclusive means for the delivery of patient services by Practitioners at the Medical Center. No Practitioner shall deliver any such services at the Medical Center unless such Practitioner has been granted privileges hereunder to deliver such services at the Medical Center.

ARTICLE 16: ADOPTION AND AMENDMENT OF BYLAWS

16.1 Medical Staff Responsibility and Authority. The Medical Staff shall have the initial responsibility and authority to formulate, adopt and recommend to the Board Medical Staff bylaws and amendments thereto which shall be effective when approved by the Board.

16.2 Methodology. Medical staff bylaws shall be adopted, amended or repealed only by the following combined action:

16.2.1 **Medical Staff.** The affirmative vote of a two-thirds majority of the staff members eligible to vote on this matter who are present at a meeting at which a quorum is present, provided at least thirty days' Regular Notice, accompanied by the proposed bylaws and/or alterations, has been given of the intention to take such action.

16.2.1.1 In the event that a quorum is not reached for two (2) consecutive meetings to act on a bylaw change, the change will be referred to the Executive Committee for final action of the Medical Staff. Such change can be effected only by a two-third majority vote of the Executive Committee.

16.2.2 **Board.** The affirmative vote of a majority of the Board.

16.3 Amendments to Rules. Notwithstanding any of the foregoing, the Executive Committee may amend Rules and Regulations applicable to the Medical Staff, subject to approval by the Board.

APPENDIX A
Fair Hearing Plan and Appellate Procedure

1 Purpose. The hearings provided for in this Fair Hearing Plan and Appellate procedure are for resolving, on an intra-professional basis, matters bearing on professional competency and conduct. All hearings and appellate reviews shall be according to the procedural safeguards set forth in this Fair Hearing and Appellate Procedure.

2 Adverse Recommendations or Actions. A Practitioner shall be entitled to a hearing pursuant to the provisions of the bylaws and this Fair Hearing Plan and Appellate Procedure only after an adverse recommendation or adverse action. The following actions, when not voluntarily imposed or accepted by the practitioner, are "adverse recommendations" or "adverse actions":

2.1 Denial of initial appointment to staff status.

2.2 Denial of reappointment.

2.3 Summary suspension of staff status.

2.4 Revocation of staff status.

2.5 Denial of requested modification in staff status.

2.6 Reduction in staff status.

2.7 Denial of requested clinical privileges.

2.8 Reduction in or limitation of clinical privileges.

2.9 Summary suspension of clinical privileges.

2.10 Revocation of clinical privileges.

2.11 Probation and its terms.

2.12 Requirement of consultation, supervision or monitoring.

2.13 Non-reinstatement of staff status or clinical privileges after a leave of absence.

2.14 Non-reinstatement within thirty days after curing an event of default that caused an automatic suspension under the bylaws.

2.15 Termination of staff status or privileges pursuant to the third sentence of Section 3.7.3 in the bylaws.

3 **Right to Hearing and to Appellate Review.** A Practitioner has the right to a hearing and/or appellate review in the following cases:

3.1 **Adverse Recommendation by the Executive Committee.** When any Practitioner receives notice of a recommendation of the Executive Committee that, if ratified by decision of the Board, will adversely affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges, he/she shall be entitled to a hearing before an ad hoc committee of the Medical Staff.

3.1.1 If the recommendation of the Executive Committee following such hearing is still adverse to the affected Practitioner, he/she shall then be entitled to an appellate review by the Board before the Board makes a final decision on the matter.

3.2 **Adverse Board Action Without Adverse Recommendation from Executive Committee.** When any Practitioner receives notice of a decision by the Board that will affect his/her appointment to or status as a member of the Medical Staff or his/her exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the Executive Committee of the Medical Staff with respect to which he/she was entitled to a hearing and appellate review, he/she shall be entitled to a hearing by a committee appointed by the Board, and if such hearing does not result in a favorable recommendation, to an appellate review by the Board, before the Board makes a final decision on the matter.

4 **Notice of Adverse Recommendation or Action.** Within ten (10) days, the Chief Executive Officer or Chief Medical Officer shall give the affected Practitioner Special Notice of an adverse recommendation or decision. The notice shall include:

4.1 The nature of the proposed action and a statement of the practitioner's alleged acts or omissions, a list by number of the specific or representative patient records or subject matter forming the basis for the adverse recommendations or actions.

4.2 Notice that the practitioner has thirty (30) days after receiving notice to submit a request for a hearing and that such request must satisfy the conditions for such a request.

4.3 Notice that failure to request a hearing within the prescribed time and/or in the proper manner constitutes a waiver of rights to a hearing and to appellate review.

5 **Request for Hearing.** The Practitioner shall have thirty (30) days following the receipt of the notice to request in writing to the Chief Executive Officer or Chief Medical Officer a hearing or an appellate review.

6 **Waiver by Failure to Request Hearing or Appellate Review.**

6.1 The failure of a Practitioner to request a hearing within the time and in the manner herein provided shall be deemed a waiver of his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled on the matter.

6.2 The failure of a Practitioner to request an appellate review within the time and in the manner herein provided shall be deemed a waiver of his/her right to such appellate review on the matter.

6.2.1 When the waived hearing or appellate review relates to an adverse recommendation of the Executive Committee or of a hearing committee appointed by the Board, the same shall then become and remain effective against the Practitioner pending the Board's decision on the matter.

6.2.2 When the waived hearing or appellate review relates to an adverse decision by the Board, the same shall then become and remain effective against the Practitioner in the same manner as a final

decision of the Board provided for in Section 29 of this Fair Hearing Plan and Appellate Procedure.

6.3 In either of such events, the Chief Executive Officer or Chief Medical Officer shall promptly notify the affected Practitioner of his/her status by Special Notice.

7 Practitioner Access to Information. The practitioner shall have the right, as soon as practical after the hearing has been requested, to inspect and copy, at his/her expense, any documents, charts, correspondence, or other evidence upon which the adverse recommendations or actions are based and which are reasonably necessary to enable the practitioner to prepare a defense.

8 **Notice of Hearing.** Within ten (10) days after receipt of a request for hearing from a Practitioner entitled to the same, the Executive Committee or the Board, whichever is appropriate, shall schedule and arrange for such a hearing and shall through the Chief Executive Officer or Chief Medical Officer, notify the Practitioner of the time, place and date so scheduled, by Special Notice. The notice of hearing shall state in concise language the acts or omissions with which the Practitioner is charged, a list of specific or representative medical records being questioned, a list of witnesses expected to testify, and/or the other reasons or subject matter considered in making the adverse recommendation or decision.

9 **Hearing Date.** The hearing date shall be not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request for hearing, unless the affected practitioner and the Chair of the Ad Hoc Committee agree to a hearing within a shorter time.

10 **Composition of Hearing Committee.**

10.1 **Appointment by Chief Medical Officer.** When a hearing relates to an adverse recommendation of the Executive Committee, such hearing shall be conducted by an ad hoc hearing committee of not less than five members of the Medical Staff appointed by the Chief Medical Officer in consultation with the Executive Committee, with one member designated as Chair.

10.1.1 The Hearing Committee shall be composed of unbiased individuals who shall gain no direct financial benefit from the outcome and have not acted as accuser, investigator, fact-finder, or initial decision-maker in the same matter.

10.1.2 There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy.

10.2 **Appointment by Board.** When a hearing relates to an adverse decision of the Board that is contrary to the recommendation of the Executive Committee, the Board shall appoint a hearing committee to conduct such hearing and shall designate one member of this committee as Chair. At

least one representative from the Medical Staff shall be included on this committee.

11 **Moderator.** Either a hearing officer, if one is appointed, or the Chair of the hearing committee or his/her designee, shall preside over the hearing. Service as moderator shall not in any way prevent the moderator from full participation in the deliberations and actions of the hearing committee. The role of the moderator shall be to:

11.1 determine the order of procedure during the hearing;

11.2 assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence;

11.3 maintain decorum;

11.4 promulgate rules of procedure;

11.5 limit the role, exclude or remove any person who is disruptive to an orderly and professional hearing; and

11.6 refuse to admit evidence that is not relevant to the subject matter of the hearing.

12 **Representation.**

12.1 The affected Practitioner shall be entitled to be accompanied by and/or represented at the hearing by any or all of the following: 1) a member of the Medical Staff in good standing, 2) a member of his/her local professional society, 3) an attorney, or 4) such other person as the practitioner may select.

12.2 The Executive Committee, when its action has prompted the hearing, shall appoint a Medical Staff member or an attorney to represent its position at the hearing, to present the facts in support of its adverse recommendation or action, and to examine witnesses.

12.3 The Board, when its action has prompted the hearing, shall appoint one of its members or an attorney to represent its position at the hearing, to

present the facts in support of its adverse recommendation or action, and to examine witnesses.

12.4 When legal counsel attends and participates in the hearing, it is with the understanding that the proceedings are not a judicial forum, but a forum for evaluating the practitioner's qualifications to provide health services.

13 **Personal Presence of Practitioner at Hearing.** The personal presence of the Practitioner for whom the hearing has been scheduled shall be required.

13.1 A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided in Section 6 above and to have accepted the adverse recommendation or decision involved, and the same shall then become and remain in effect as provided in said Section 6.

14 **Rights of Participants.** During a hearing, the representatives of each of the participants shall have the right:

14.1 To call and examine witnesses who voluntarily agree to appear on behalf of the participant calling such witnesses. Notice is hereby given to the participants that neither the Medical Staff nor the Medical Center has the legal power of subpoena.

14.2 To introduce exhibits and documents relevant to the issues.

14.3 To cross-examine any witness on any matter relevant to the issue of the hearing.

14.4 To challenge any witness and to rebut any evidence.

14.5 Subject to the provisions of Section 17, to request that the record of the hearing be made by use of a court reporter or, if the material recorded is to be reduced to writing promptly after the hearing, an electronic recording device.

14.6 If the Practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

15 **Procedure and Evidence.**

15.1 The hearing shall be de novo.

15.2 The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence.

15.3 Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, despite the existence of any common law or statutory rule that might make evidence inadmissible over objection in civil or criminal actions.

15.4 The Practitioner for whom the hearing is being held shall, before or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

15.5 The Practitioner for whom the hearing is being held shall be given opportunity, on request, to refute the officially noticed matters by evidence or by written or oral presentation of authority.

15.6 The committee shall also be entitled to consider any pertinent material contained on file in the Medical Center.

16 Obligations to Present Evidence.

16.1 In hearings on adverse recommendations or actions of the type identified in 2.2, 2.3, 2.4, 2.6, 2.8, 2.9, 2.10, 2.11, 2.12, or 2.14 above, the body whose adverse recommendation or action occasioned the hearing shall have the obligation of showing by the evidence that the adverse recommendation or action was not arbitrary, irrational or capricious.

16.2 In hearings on adverse recommendations or actions of the type identified in 2.1, 2.5, 2.7, 2.13, or 2.15, the body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of its recommendation or action; and the affected Practitioner shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or that

such basis or any action based thereon is either arbitrary, unreasonable or capricious.

17 **Record of Hearing.** An accurate record of the hearing must be kept. The mechanism shall be established by the ad hoc hearing committee, and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by the taking of adequate minutes.

17.1 A Practitioner electing the method under Section 14.5 shall bear the cost thereof unless such method has also been selected by the hearing committee.

18 **Postponement.** Postponement of hearings beyond the time set forth in these bylaws shall be made only with the approval of the presiding officer. Granting of such postponements shall only be for good cause shown and in the sole discretion of the presiding officer.

19 **Recesses and Deliberations.** The hearing committee may, without Special Notice, recess the hearing and reconvene the same for the convenience of the participants or to obtain new or additional evidence or consultation.

19.1 Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may then, at a time convenient to itself, conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened.

20 **Hearing Committee Report.** Within thirty (30) days after final adjournment of the hearing, the hearing committee shall make a written report and recommendation and shall forward the same with the hearing record and all other documentation to the Executive Committee or to the Board, whichever appointed it.

20.1 The report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Executive Committee or decision of the Board.

20.2 The hearing committee has the option to extend the period for issuance of its report for not more than thirty (30) days with Executive Committee or Board approval, whichever appointed it.

20.3 The practitioner shall also be given a copy of the report by Special Notice.

21 **Request for Appellate Review.** A Practitioner shall have ten (10) days after receipt of a notice of an adverse recommendation or decision made or adhered to after a hearing as above provided, to request by written notice to the Board delivered through the Chief Executive Officer by Special Notice, an appellate review by the Board.

21.1 Such notice may request that the appellate review be held only on the record on which the adverse recommendation or decision is based, as supported by the Practitioner's written statement provided for below, or may also request that oral argument be permitted as part of the appellate review.

22 **Waiver by Failure to Request Appellate Review.** If such appellate review is not requested within ten days, the affected Practitioner shall be deemed to have waived his/her right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately as provided in Section 6 above.

23 **Notice of Time and Place for Appellate Review.** As soon as practicable, the Board Chair shall schedule an Appellate Review to commence no less than ten (10) days nor more that twenty (20) days after receipt of such notice of request for appellate review. The Board shall schedule a date for such review, including a

time and place for oral argument if such has been requested, and shall, through the Chief Executive Officer, by Special Notice, notify the affected Practitioner of the same.

24 **Appellate Review Body.** The appellate review shall be conducted by the Board or by a duly appointed appellate review committee of the Board of not less than five members.

25 **Written Statements.** The affected Practitioner may submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees and the reasons for his/her disagreement.

25.1 He/She shall submit this written statement to the Board, by Special Notice through the Chief Executive Officer, no more than fifteen (15) days after the hearing record is made available to the practitioner, unless the time limit is altered by the Board Chair.

25.2 This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation.

25.3 A similar statement may be submitted by the Executive Committee of the Medical Staff or by the Chair of the hearing committee appointed by the Board.

25.3.1 If such a statement is submitted, the Chief Executive Officer shall provide a copy thereof to the Practitioner by Special Notice.

25.4 The appellate review body shall review the record created in the proceedings, and shall consider the written statements submitted to determine whether the adverse recommendation or decision against the affected Practitioner was justified and was not arbitrary or capricious.

26 **Oral Argument.**

26.1 If oral argument is requested as part of the review procedure, the affected Practitioner shall be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him/her by any member of the appellate review body.

26.2 The Executive Committee or the Board, whichever is appropriate, shall also be represented by an individual who shall be permitted to speak in favor of the adverse recommendation or decision and shall answer questions put to him/her by any member of the appellate review body.

27 **Consideration of New or Additional Matters.** New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Board or the committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.

28 **Action Taken.**

28.1 If the appellate review is conducted by the Board, it may affirm, modify or reverse its prior decision, or, in its discretion refer the matter back to the Executive Committee of the Medical Staff for further review and recommendation with thirty (30) days.

28.2 If the appellate review is conducted by a committee of the Board, such committee shall, within fourteen (14) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Board affirm, modify or reverse its prior decision, or refer the matter back to the Executive Committee for further review and recommendation within thirty (30) days.

29 **Final Decision by Board.** Within sixty (60) days after the appellate review, the Board shall make its final decision in the matter and shall send notice thereof to the Executive Committee and, through the Chief Executive Officer, to the affected Practitioner, by Special Notice.

29.1 If this decision is in accordance with the Executive Committee's last recommendation in the matter, it shall be immediately effective and final, and shall not be subject to further hearing or appellate review.

29.2 If this decision is contrary to the Executive Committee's last such recommendation, the Board shall refer the matter to the joint conference committee for further review and recommendation within fourteen (14)

days. Following the joint conference committee's recommendation, the Board shall make its final decision with like effect and notice as provided above.

30 **Limit of One Hearing and One Appellate Review.** Despite any other provision of these bylaws, no Practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of action by the Executive Committee of the Medical Staff, or by the Board, or by a duly authorized committee of the Board, or by both.

31 **Waiver or Modification of Time Limits.** The time limits set forth herein may be waived or modified upon the mutual agreement of the Practitioner and Executive Committee or Board.

32 **Amendment of the Fair Hearing Plan and Appellate Procedure.** The Fair Hearing Plan and Appellate Procedure may be amended or repealed, in whole or in part, by a resolution of the Executive Committee recommended to and adopted by the Board.

APPENDIX B
Appointment and Reappointment Plan

1. Appointment Process: It is this medical center's policy to process all applications by applying equal standards only after the medical affairs office has obtained a completed, verified application. It is the intent of this policy to expedite applications that meet the predefined, board-approved criteria set forth in Section 1.3.1. [13]

    1.1. **Applicant's Burden.** The applicant shall have the burden of producing adequate information for a proper evaluation of his/her experience, background, training, physical health status, mental health status and emotional stability, professional competence, character, ethics and other qualifications and for resolving any doubts about these or any of the other basic qualifications specified in these bylaws.

    1.2. **Verification of Information.** The completed application form[8] shall be submitted to the Chief Executive Officer or his/her designee, who shall, quickly collect or verify the references, licensure and other qualification information deemed pertinent, including any verifications or requests for information required by state or federal law. The Chief Executive Officer or his/her designee shall promptly notify the applicant of any failure of others to respond within fourteen (14) days to such collection or verification efforts. After such notice, the applicant shall have the obligation of obtaining responses to requests for information.

    1.3. **Categorizing Applications.** The Chief Medical Officer will review each application and its associated additional information, and will categorize the application according to the following criteria:

        1.3.1. Category One
            1.3.1.1. All requested information has been provided promptly
            1.3.1.2. There are no recommendations requiring further review or investigation
            1.3.1.3. There are no discrepancies in information received from the applicant or references
            1.3.1.4. The applicant completed an education/training sequence as normally expected for the applicant's specialty

1.3.1.5. There have been no disciplinary actions or legal sanctions by a licensing board or another healthcare organization where the applicant has had medical staff membership. For reappointment applications, none since the time of the last appointment.

1.3.1.6. There are no current challenges or previously successful challenges to licensure or registration.

1.3.1.7. There have been no malpractice cases within the past two years

1.3.1.8. The applicant has an unremarkable medical staff/employment history

1.3.1.9. There has been no final judgment adverse to the applicant in a professional liability action. For reappointment applications, none since time of last appointment.

1.3.1.10. The applicant has submitted a request for clinical privileges consistent with experience, training, and competence and is in compliance with applicable criteria

1.3.1.11. The applicant has never been sanctioned by a third-party payer (e.g., Medicare, Medicaid, etc.)

1.3.1.12. The applicant has never been convicted of a felony

1.3.1.13. The applicant is requesting privileges consistent with his or her specialty

1.3.1.14. The applicant's history shows an ability to relate to others in a harmonious, collegial manner.

1.3.1.15. There are no gaps in time for which the applicant has not accounted.

1.3.1.16. The applicant has not experienced removal from a provider panel or a managed care entity for reasons of unprofessional conduct or quality of care issues.

1.3.2. Category Two: All those applications that do not meet the Category One criteria for expedited review shall be processed in a routine, nonexpedited manner as per Section1.4.2 below.

1.4. **Processing Category One and Two Applications**

1.4.1. Category One:

1.4.1.1. The appropriate department chair, or his/her designee reviews the completed and verified application.

1.4.1.2. The department chair, or his/her designee forwards a report with findings and a recommendation to the Chief Medical Officer, who is hereby authorized to review and make recommendations on the Category One applications on behalf of the medical executive committee (MEC).

1.4.1.3. The Chief Medical Officer then forwards the MEC's recommendation to the System Quality Committee, who reviews and may grant the applicant appointment to the staff and the requested clinical privileges. The System Quality Committee may also ask for Board consideration and ratification of its' action, if deemed appropriate by the System Quality Committee,. If the committee's decision is adverse to an applicant, the matter is referred back to the Medical Executive Committee for further evaluation as a Category 2 application.

1.4.1.4. The Chair of the System Quality Committee, makes a report of the committee's positive decisions to the board at its next regular meeting.

1.4.1.5. If, at any time, the department chair, or his/her designee, the Chief Medical Officer, or the System Quality Committee, determines that the application requires more time for appropriate decision making, the application shall be classified as Category Two and processed accordingly.

1.4.2. Category Two:

1.4.2.1. The application is forwarded to the appropriate department chair, or his/her designee for review and recommendation. The department chair, or his/her designee reviews the application to make sure it meets the established standards for membership and clinical privileges.

1.4.2.2. The department chair, or his/her designee forwards the application to the medical executive committee for review and recommendation. The medical executive committee reviews the application for membership and clinical privileges.

1.4.2.3. The MEC forwards the application, with its recommendation, to the System Quality Committee,. The System Quality Committee, reviews the application for membership and clinical privileges.

1.4.2.4. The System Quality Committee forwards the application, with its recommendations, to the board for final action.

1.4.2.5. In the event the MEC's or the Board's recommendation is negative, Section 1.5 of this plan shall apply.[13]

1.5. Adverse Recommendations.

1.5.1. **Adverse Recommendation of the Executive Committee.** When the recommendation of the Executive Committee is adverse to the applicant, either in respect to appointment or clinical privileges, the Chief Executive Officer shall promptly so notify the applicant by Special Notice. No such adverse recommendation need be forwarded to the Board until after the applicant has exercised or has been deemed to have waived the right to a hearing as provided in Article 9 of these bylaws. For the purposes of this section, an "adverse recommendation" by the Executive Committee is as defined in the Fair Hearing Plan and Appellate Procedure (appended to these bylaws).

1.5.2. **On Favorable Executive Committee Recommendation.** The Board, may in whole or in part, adopt or reject a favorable recommendation of the Executive Committee, or refer the recommendation back to the Executive Committee for further consideration stating the reasons for such referral and setting a reasonable time limit within which a subsequent recommendation shall be made. If the Board's action is adverse, as defined in the Fair Hearing Plan and Appellate Procedure, to the applicant, the Chief Executive Officer shall promptly so inform the applicant by Special

Notice. If the applicant is a Physician or a member of an Allied Health Professional staff to which the Board has granted rights under Article 9, he/she shall be entitled to the procedural rights as provided in Article 9.

1.5.3. **Without Benefit of Executive Committee Recommendation.** If the Board does not receive an Executive Committee recommendation within the time specified in Section 1.8 it may, after five days notice to the Executive Committee, take action on its own initiative. If such action is favorable, it shall become effective as of the decision of the Board. If such action is adverse, as defined in the Fair Hearing Plan and Appellate Procedures, the Chief Executive Officer shall promptly so inform the applicant by Special Notice. If the applicant is a Physician or a member of an Allied Health Professional staff to which the Board has granted rights under Article 9, he/she shall be entitled to the procedural rights as provided in Article 9.

1.5.4. **After Procedural Rights.** In the case of an adverse Executive Committee recommendation pursuant to Section 1.5.1 or an adverse Board decision pursuant to Section 1.5.2 or 1.5.3, the Board shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights as provided in Article 9. Action thus taken shall be the conclusive decision of the Board, except that the Board may defer final determination by referring the matter to the Executive Committee for further consideration. Any such referral back shall state the reasons therefor and shall set a reasonable time limit within which a subsequent recommendation to the Board shall be made. After receipt of such subsequent recommendation, the Board shall make a final decision.

1.5.5. **Denial for Accommodation Reasons.** A recommendation by the Executive Committee, or a decision by the Board, to deny staff status or particular clinical privileges either:

1.5.5.1. Because the Medical Center does not then provide adequate facilities or supportive services for the applicant and his/her patients, for whatever reason, including, but not limited to, utilization levels then existing or services not then offered, or

1.5.5.2. Because of inconsistency with the Medical Center's plans in respect to its development, including the organization of the Medical Center and the mix of patient care services to be provided, as currently being implemented, shall be considered adverse and shall entitle the applicant if he/she is a Physician or a member of an Allied Health Professional staff to which the Board has granted rights under Article 9, to the procedural rights as provided in Article 9. However, in a proceeding under Article 9, a determination made without malice by the Board not to offer a service or not to expand a service, or a determination made without malice under 1.5.5.1 or 1.5.5.2 above shall not be subject to challenge regarding the validity or appropriateness of such determination.

1.6. **Notice of Final Decision.**

1.6.1. Notice of the Board's final decision shall be given to the Chief Executive Officer, the Chief Medical Officer, and by Special Notice, to the applicant.

1.6.2. A decision and notice to appoint shall include: (1) the staff status to which the applicant is appointed; (2) the clinical privileges he/she may exercise; and (3) any special conditions attached to the appointment.

1.7. **Reapplication after Adverse Appointment Decision.** An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply for two years from the date of the final adverse decision. Any such reapplication shall be processed as an initial application.

1.8. **Time Limits for Processing.** Applications for staff appointments shall be:

1.8.1. considered in a timely manner without malice by all individuals and groups required by these bylaws to act thereon; and

1.8.2. shall be processed within the time limits specified in any applicable state law, and, except for good cause, shall be processed within the time specified in this section.

1.8.3. The Chief Executive Officer or his/her designee shall transmit an application to the Chief Medical Officer (for Category 1) or to the Executive Committee (for Category 2)[13] upon completing the information collection and verification tasks, but in any event within ninety days after receiving the application.

1.8.3.1. No such transmittal shall be made unless responses have been received from references. If all responses are not received within eighty (80) days after request, the application shall be deemed rejected, and such action shall not be deemed to be adverse to the applicant.

1.8.3.2. Upon request of the applicant for good cause shown, the Chief Medical Officer or[13] Executive Committee shall allow ten additional days for receipt of responses from references.

1.8.3.3. The Chief Medical Officer or[13] Executive Committee shall act on an application within sixty (60) days after receiving it from the Chief Executive Officer or his/her designee. The System Quality Committee (for Category 1) or the Board (for Category 2)[13] shall then take action on the application not later than its next regular meeting.

2. Reappointment

2.1. **Verification of Information.** The completed reappointment form shall be submitted to the Chief Executive Officer or his/her designee, who shall, quickly seek to collect or verify:

2.1.1. additional information made available on each reappointment form;

2.1.2. information relating to current competence, judgment and technical/clinical skills, as indicated by the results of quality assessment, peer review and performance improvement activities and other indicators of continuing qualifications;

2.1.3. recommendations from peers of the reappointment applicant;

2.1.4. any requests for information required by state or federal law; and

2.1.5. any other materials or information deemed pertinent, including information regarding the applicant's professional activities, performance and conduct in this or any other hospital.

2.1.6. When collection and verification are accomplished by receipt of responses from all persons or entities so contacted, the Chief Executive Officer or his/her designee shall transmit the information form and related materials in which the reappointment applicant requests privileges to the Executive Committee.

2.2. **Review Process.** The reappointment process will be as outlined in 1 through 1.6.2 above except that Section 2.4 shall control processing times.[13] For purposes of reappointment, the terms "applicant" and "appointment" as used in those sections shall be read respectively, as "reappointment applicant" and "reappointment."

2.3. **Bases for Recommendations and Determinations.** Each recommendation concerning the reappointment of a reappointment applicant and the clinical privileges to be granted upon reappointment, and the determinations made with respect thereto, shall be based upon such reappointment applicant's:

2.3.1. current professional competence and clinical judgment in the treatment of his/her patients;

2.3.2. professional ethics;

2.3.3. meeting of the qualifications for staff status and fulfilling of the responsibilities of staff status;

2.3.4. discharge of obligations;

2.3.5. compliance with the Medical Staff bylaws, rules and regulations and Medical Center and Board policies;

2.3.6. cooperation with other professionals and with patients;

2.3.7. disruptions, if any, of Medical Center operations;

2.3.8. physical or mental health, emotional stability and substance abuse problems that may adversely affect patient care;

2.3.9. participation in continuing education,

2.3.10. maintenance of board certification or eligibility unless specifically exempted per section 3.2.4.4, *and*

2.3.11. recommendations from peers of the reappointment applicant.[8]

2.4. **Time Limits for Processing.** Transmittal of the reappointment form to a reappointment applicant and his/her return of it shall be carried out according to Section 6.4.1. Thereafter and, except for good cause, each person and committee required by these bylaws to act thereon shall complete such action in timely fashion such that all reports and recommendations concerning reappointment shall have been transmitted to permit System Quality Committee (for Category One) or Board (for Category Two) action[13] before the expiration date of the appointment of the reappointment applicant. The Chief Executive Officer or his/her designee shall not transmit a reappointment application pursuant to Section 2.1 until the information referred to in Section 2.1 has been collected and verified; and, if responses from references have not been received within thirty[13] days, the reappointment application shall be

deemed rejected and such action shall not be deemed to be adverse to the reappointment applicant.

3. **Individuals in Administrative Positions.** Individuals in administrative positions who desire medical staff membership or clinical privileges are subject to the same procedures as all other applicants for membership or privileges.[11]

4. **Services Pursuant to a Contract.** When physicians or other individuals eligible for delineated clinical privileges are engaged by the medical center to provide patient care services pursuant to a contract, their clinical privileges to admit or treat patients are defined through medical staff mechanisms.[11]

5. **Amendment to the Appointment and Reappointment Plan.** The Appointment and Reappointment Plan may be amended or repealed, in whole or in part, by a resolution of the Executive Committee recommended to and adopted by the Board.

APPENDIX C
Medical Staff Committee Structure

Chapter 12 of the Medical Staff bylaws lists 12 functions that are the responsibility of the Medical Staff. Per section 12.1, the Executive Committee authorizes the following committees to perform the following functions:

Committee	Responsible for the following Function(s)
Executive Committee	Executive function (12.2.2), credentials function (12.2.3), and bylaws function (12.2.9)
Clinical Practice Committee	Medical Records Review (12.2.4) and Quality Assessment (12.2.11)
Pharmacy Committee	Medication Use Evaluation (12.2.5)
Infection Control Committee	Infection Control (12.2.6)
ICU-CCU Committee	Intensive Care (12.2.7)
Medical Education Committee	Continuing Medical Education (12.2.8)
Safety Committee	Safety and Risk Management (12.2.10)
Surgical Review Committee	Surgical Review (12.2.13)
Transfusion Committee	Blood Use Evaluation (12.3)

APPENDIX D
Rules and Regulations

1. General Admission Procedures

1.1 For purposes of complying with EMTALA and the Medical Center's EMTALA policies, all Physician members of the Active, Senior-Active, Courtesy and Consulting Medical Staff are authorized to conduct a medical screening examination ("MSE") to determine if an emergency medical condition exists or to determine, after a reasonable period of observation, whether a woman experiencing contractions is in false labor. Physician Assistant and Advance Practice Nurse members of the Allied Health Professional Staff, acting within the scope of their license and/or certification, may also be credentialed to perform MSEs and/or to determine, after a reasonable period of observation, whether a woman experiencing contractions is in false labor. All such Practitioners shall be considered Qualified Medical Personnel ("QMP") under

EMTALA. With respect to an individual with psychiatric symptoms, a medical screening examination consists of both a medical and psychiatric screening.

1.2 **Care of All Disease Categories.** The medical center shall accept patients for care and treatment of all disease categories.

1.10 **Physician Rounding Responsibility:** It is the expectation that the attending physician or the physician covering for the attending will see all inpatients daily. Alternative plans for rounding/coverage must be submitted by the respective department or service for approval by the Medical Executive Committee.

For any patient in the ICU, the attending physician, or the physician covering for the attending, is expected to round on the patient daily and document in the medical record.

1.2 **Admission Only by Privileged Medical Staff Members.** A patient may be admitted to the medical center only by a member of the medical staff who has admitting privileges and follows the admitting policy of the medical center.

1.3 **Timely and Professional Care.** Each member of the staff must assure timely, adequate professional care for his/her patients in the medical center by complying with all provisions of the Medical Center and Medical Staff bylaws, rules, regulations, policies, and procedures.

1.4 **Development of Admission Priority Criteria.** The medical staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. Each clinical department shall develop such categories and criteria, which shall be approved by the Executive Committee and made a part of these rules and regulations.

1.5 **Admission Priority Criteria.** The admitting office will admit patients on the basis of the following order of priorities when a bed shortage exists:

1.5.1 **Emergency Admissions.** Within twenty-four (24) hours following an emergency admission, the attending practitioner shall document the need for this admission. Failure to furnish this documentation,

or evidence of willful or continued misuse of this category of admission, will be brought to the attention of the Executive Committee for appropriate action.

1.5.2 **Urgent Admissions.** When all such admissions for a specific day are not possible, priority shall be given to patients of members of the active medical staff in the order of the date of scheduling for admission. Patients of members of the courtesy medical staff shall be admitted in the same manner after such priorities have been filled.

1.5.3 **Pre-operative Admissions.** This category includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the chairman of the department of surgery may decide the urgency of any specific admission. The priority of patients of members of the active medical staff for urgent admissions shall apply.

1.5.4 **Routine Admissions.** This category includes elective admissions involving all services. When all such admissions for a specific day are not possible, priority shall be given to patients of members of the active medical staff as in urgent admissions.

1.6 **Transfer Priority Criteria.** No patient shall be transferred without such transfer being approved by the responsible practitioner. Transfer priorities shall be as follows:

1.6.1 Emergency Room to appropriate patient bed.

1.6.2 From Intensive Care Unit to general care area.

1.6.3 From Coronary Care Unit to general care area.

1.6.4 From Obstetric care area to general care area, when medically indicated.

1.6.5 From temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient.

1.7 **Restricted Bed Utilization Areas.** Areas of restricted bed utilization and assignment of patients are listed below. Patients must meet specific admission criteria to be admitted to these areas.

1.7.1 Coronary Care Unit

1.7.2 Intensive Care Unit

1.7.3 Obstetrics

1.7.4 Pediatrics

1.7.5 Psychiatry

1.8 **Communicating Risk of Harm.** The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his/her patients might be a source of danger from any cause whatever.

2. Admissions

2.1 **Contacting the Admitting Office.** When admission is necessary, the practitioner shall, when possible, first contact the admitting office to ascertain whether there is an available bed.

2.2 **Documenting Justification for Admission.** Except in an emergency, no patient shall be admitted to the medical center until a provisional diagnosis or valid reason for admission has been documented . In the case of an emergency, such statement shall be recorded as soon as possible. The history and physical examination must clearly justify the patients admission and these findings must be recorded on the patient's chart as soon as possible after admission.

2.3 **Patients Without a Private Practitioner.** A patient to be admitted on an emergency basis who does not have a private practitioner will be provided with a practitioner in the applicable department or service to attend to him/her. The member of the active staff on duty in the department or service will be assigned to the patient.

2.3.1 The Chairman of each department shall provide a schedule of such rotation assignments.

2.4 **Patients Who Do Not Require Admission.** Patients presenting themselves to the emergency department, but who do not require admission, should be accepted for any urgently needed emergency care by the appropriate active staff practitioner on call that day unless other suitable disposition is readily available. The active staff practitioner will be responsible for any urgent needs of that current health problem of that patient regardless of the patient's ability to pay or method of payment.

3. General Medical Record Policies

3.1 **Authenticating Entries.** All clinical entries in the patient's medical record shall be accurately dated, and authenticated. Authentication means to verify that an entry is complete, accurate, and final[11] by legible written signature, identifiable initials or computer key. The use of rubber stamp signature is acceptable under the following conditions:

3.1.1 The practitioner whose signature the rubber stamp represents is the only one who has possession of the stamp and is the only one who uses it; and

3.1.2 The practitioner places in the administrative offices of the medical center a signed statement to the effect that he/she is the only one who will use it.

3.2 **Use of Symbols and Abbreviations.** The symbols and abbreviations which may be used have been approved by the medical staff. A copy is on file in the record room (see Appendix G).

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

3.4 **Removal of Records.** Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute.

3.4.1 All records are the property of the medical center and shall not otherwise be taken away without permission of the Chief Executive Officer or designated Medical Records staff.

3.4.2 Unauthorized removal of charts from the medical center is grounds for suspension of the practitioner for a period to be determined by the Executive Committee of the medical staff.

3.5 **Records of Readmitted Patients.** In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or another.

3.6 **Use of Records for Research.** Free access to all medical records of all patients shall be afforded to members of the medical staff for bonafide study and research consistent with preserving the confidentiality of personal information concerning the individual patients.

3.6.1 All such projects shall be approved by the Executive Committee of the medical staff before records can be studied.

3.6.1.1 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 medical center.

3.7 **Filing the Medical Record.** A medical record shall not be permanently filed until it is completed by the responsible practitioner. **The record must be filed as permanent within 30 days of discharge.** In the event that the responsible practitioner cannot complete the record within 30 days following discharge, the record shall be filed incomplete. Health Information Management will report information on incomplete records filed in periodic reports to the Executive Committee (or the designated committee overseeing medical records review).[8]

3.8 **Process for Determining Incomplete Records.** The patient's medical record shall be complete at the time of discharge, including progress notes, final diagnosis, and written or dictated clinical summary.

3.8.1 Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart will be available in a stated place in the medical record room for fourteen (14) days after discharge.

3.8.2 Each week, incomplete records fourteen (14) or more days following discharge are reviewed and each practitioner with such incomplete records is notified in writing that the records must be completed within 3 days of notice .

3.8.2.1 Failing this, the Medical Records Coordinator or his/her designee shall, per bylaw provision 8.12.4, notify the practitioner that his/her privileges shall be suspended until the records have been completed.

3.9 **Notifying Medical Records of Practitioner Absences.** Practitioners should notify Medical Records prior to any planned absence of 14 days or more.

4. Medical Record Policies Specific to the Medical Staff

4.1 **Responsibility for a Complete, Legible, Pertinent and Current Record.** The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its content shall be pertinent and current. This record shall include:

4.1.1 identification data;

4.1.2 complaint;

4.1.3 personal history;

4.1.4 family history;

4.1.5 history of present illness;

4.1.6 physical examination;

4.1.7 special reports such as consultations;

4.1.8 clinical laboratory and radiology services and others;

4.1.9 provisional diagnosis;

4.1.10 medical and surgical treatment;

4.1.11 operative report;

4.1.12 pathological findings;

4.1.13 progress notes;

4.1.14 final diagnosis;

4.1.15 condition on discharge;

4.1.16 summary or discharge note;

4.1.17 clinical summary; and

4.1.18 in the event of death,

4.1.18.1 a summation statement as a final progress note or as a separate resume; and

4.1.18.2 autopsy report when performed.

4.2 **Admission History and Physical.**

A complete admission history and physical examination shall be completed within thirty (30) days prior to or within twenty-four (24) hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. To conform with specific requirements for day hospital programs, a history and physical examination will be required within 72 hours. "Day Hospital" is defined as a psychiatric

treatment program characterized by: 1) attendance during some portion of the day by patients residing at home or in the community; and 2) a daily schedule of therapeutic groups and activities overseen by a multi-disciplinary team. Day Hospitalization is an appropriate level of care for psychiatric patients who require more intensive and structured treatment than can be offered by traditional office visits; but who are not ill enough to require inpatient treatment.[1]

4.2.1 The history and physical shall include, at a minimum:

- Chief complaint
- History of the current illness, including, when appropriate, assessment of emotional, behavioral and social status (HPI)
- Relevant past medical, family and/or social history appropriate to the patient's age
- Review of body systems
- A list of current medications and dosages
- Any known allergies including past medication reactions and biological allergies
- Physical examination: current physical assessment
- Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
- Initial plan: Statement of the course of action planned for the patient while in the Medical Center

4.2.2 For other outpatient (ambulatory) surgical patients, as necessary for treatment:

- A list of current medications and dosages
- Any known allergies including past medication reactions
- Existing co-morbid conditions
- Assessment of mental status
- Exam specific to the procedure performed

4.2.3 **IV moderate sedation:** For patients receiving **IV** moderate sedation, all of the above elements in 4.2.2, plus the following:

- Examination of the heart and lungs by auscultation
- American Society of Anesthesia (ASA) status
- Documentation that patient is appropriate candidate for IV moderate sedation

4.2.4 A medical history and physician examination must be completed for each patient by a physician or other qualified individual in accordance with State requirements. The medical history and physical examination must be placed in the patient's medical record within twenty-four (24) hours after registration or inpatient admission, but prior to surgery or any procedure requiring anesthesia services. When the medical history and physical are completed within thirty (30) days prior to registration or inpatient admission, the physician or other qualified individual shall ensure that an updated

medical record entry documenting any changes in the patient's condition is completed. The update must be completed and documented in the patient's medical record within twenty-four (24) hours after registration or inpatient admission, but prior to surgery or any procedure requiring anesthesia services.

4.2.4.1 In such instances an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded.

4.2.4.2 Only physicians, physician assistants and advanced practice registered nurses may perform and record physicals and transmit verbal orders from the sponsoring physician.

4.2.4.3 Except where otherwise required by law or regulation, medical record entries or orders by Dependent Practitioners, acting within the scope of their license, need not be authenticated by the sponsoring physician. Except where otherwise required by law or regulation, medical record entries or orders by Independent Practitioners, acting within the scope of their license, need not be authenticated by a physician. (Examples of laws or regulations requiring a physician's authentication include, but are not limited to, the Medicare Conditions of Participation that require discharge summaries to be countersigned when a physician delegates the task of preparing discharge summaries to a physician assistant, and the Emergency Medical Treatment and Active Labor Act (EMTALA) that permits qualified medical personnel to certify the transfer of a patient, but requires a physician to countersign the certification. Questions regarding the applicability of other laws or regulations should be directed, in a timely manner, to the Chief Medical Officer.).

4.2.4.4 The attending physician shall authenticate the history, physical examination and pre-operative note when they have been recorded by a resident or enter their own notes[11].

4.3 **Admission Pre-Operative Note.** An admission or pre-operative note shall be recorded in the progress notes immediately following admission and prior to surgery stating:

4.3.1 the reason for admission,

4.3.2 the provisional or pre-operative diagnosis,

4.3.3 the planned treatment or operation and the fact that the history and physical examination have been dictated, when applicable.

4.3.3.1 When such a note, or the history and physical examination, is not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending practitioner states in writing in the patient's chart that such delay would be detrimental to the patient.

4.4 **Progress Notes.** Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability.

4.4.1 Wherever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

4.4.2 Progress notes shall be written at least daily on all acute medical-surgical patients and at least every 48 hours on all behavioral medicine inpatients. For Skilled Nursing and Intermediate Care Facility patients whose discharge is delayed because an appropriate facility bed is not available, the following progress note guidelines shall apply:

4.4.2.1 for Skilled Nursing Facility level patients, progress notes shall be written at least every seven (7) days;

4.4.2.2 for Intermediate Care Facility level patients at least every seven (7) days.

4.5 **Operative Reports.** Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Reports minimally must contain the following elements: name of the primary surgeon and assistants; findings; technical procedure used; specimens removed; and postoperative diagnosis.[11]

4.5.1 Operative reports shall be written or dictated immediately following surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made a part of the patient's current medical record.

4.5.1.1 Any practitioner with undictated operative reports twenty-four (24) hours following the day of the operation shall be automatically suspended from operative privileges,

except for any inpatients who have already been scheduled for surgery, until the reports have been completed.

4.6 **Consultations.** Consultation notes or reports shall include:

4.6.1 evidence of a review of the patient's record by the consultant,

4.6.2 pertinent findings on examination of the patient, and

4.6.3 the consultant's opinion and recommendations.

4.6.4 When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

4.7 **Obstetrical Records.** The current obstetrical record shall include a complete prenatal record.

4.7.1 The prenatal record may be a legible copy of the attending practitioner's office record transferred to the medical center before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

4.8 **Recording the Final Diagnosis.** The final diagnosis shall be recorded in full without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

4.9 **Discharge Summaries.** A discharge clinical summary shall be written or dictated on all medical records of hospitalized patients. **Discharge summaries are to be completed within 14 days of discharge.**

4.9.1 pertinent history and physical findings;

4.9.2 pertinent laboratory data;

4.9.3 diagnoses;

4.9.4 allergies;

4.9.5 consultations;

4.9.6 pertinent medical and/or surgical treatment given;

4.9.7 complications;

4.9.8 condition on discharge; and

4.9.9 instructions given on discharge such as diet, activities when applicable, follow-up visit, medications (name, dosage, and duration), etc.

4.10 **Orders.** A practitioner's 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.

4.10.1 A practitioner who will be unavailable for over twenty-four (24) hours should, on the order sheet of the chart of each of his/her patients, indicate in writing the name of the practitioner who will be assuming responsibility for the care of the patient during his/her absence.

4.11 **Outpatient Reports.** The results of all outpatient tests and procedures shall be documented no later than 24 hours after the test/procedure. **The clinical interpretation will be on the chart within a reasonable period of time not to exceed 30 days from the date of service.** Exceptions to this standard may only be granted by the Executive Committee upon specific written request..[3]

5. General Conduct of Care

5.1 **General Consent for Treatment.** A general consent form, signed by or on behalf of every patient admitted to the medical center, must be obtained at the time of admission.

5.1.1 The admitting office should notify the attending practitioner whenever such consent has not been obtained.

5.1.1.1 When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the medical center.

5.2 **Orders.** All orders for treatment shall be in writing and signed, dated and timed.

5.2.1 A verbal order shall be considered to be in writing if dictated to a duly authorized person functioning within his/her sphere of competence and signed by the responsible practitioner or appropriate member of the house staff.

5.2.2 All orders dictated over the telephone shall be signed by the appropriately authorized person to whom dictated with the name of the practitioner per his/her own name.

5.2.2.1 All verbal orders and telephone orders must be authenticated by signing, dating and timing a physician or other practitioner operating within the scope of his/her license, within seventy-two (72) hours.

5.2.2.2 Authorized personnel shall be registered nurses, licensed practical nurses, pharmacists, *dieticians*[11] and members of the house staff.

5.2.3 The practitioner's orders must be written clearly, legibly and completely.

5.2.3.1 Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

5.2.3.1.1 The use of the terms "Renew orders", "Repeat orders", and "Continue orders" are not acceptable.

5.2.3.1.2 "Daily" laboratory orders shall not be processed for more than three (3) consecutive days, except for anticoagulation monitoring.

5.2.4 All previous orders are canceled when patients go to surgery or are transferred to the Coronary Care, Intensive Care Units, or the Psychiatric Unit.

5.2.5 The medical staff supports nurse-driven protocols that have been approved by the medical staff.

5.3 **Justifying Continued Stay.** The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as identified by medical center's utilization standards, and approved by the particular department and the Executive Committee of the medical staff. This documentation must contain:

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

5.3.2 The estimated period of time the patient will need to remain in the medical center.

5.3.3 Plans for post-hospital care.

5.4 **Discharging Patients.** Patients shall be discharged only on a written order of the attending practitioner.

5.4.1 Should a patient leave the medical center against the advice of the attending practitioner, the patient shall be requested to sign a release against advice form. Should the patient refuse to do so or leave without proper discharge, a notation of the incident shall be made by the physician in the patient's medical record.

5.4.2 It shall be the responsibility of the attending practitioner to discharge his/her patients in a timely fashion.

5.5 **Prescribing Medications.** All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospitals Formulary Service, or A.M.A. Drug Evaluations. Drugs for bonafide 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 prepared by the American Society of Medical center Pharmacists and all regulations of the Federal Drug Administration.

5.5.1 **Automatic Stop Orders.** Schedule II controlled drugs shall be automatically discontinued after seven (7) days. All other drugs shall be automatically discontinued after thirty (30) days.[10] These stop orders do not apply when:

5.5.1.1 The order indicates an exact number of doses to be administered;

5.5.1.2 An exact period of time that the medication is to be administered is specified; or

5.5.1.3 The attending practitioner reorders the medication.

5.5.2 "Hold" medication orders shall be interpreted as discontinued orders unless a time for resumption is specified.

5.5.3 Drugs should not be discontinued without notifying the attending practitioner.

5.6 **Consultations.** Any qualified practitioner with clinical privileges in this medical center can be called for consultation within the area of his/her expertise.

5.6.1 The attending practitioner is primarily responsible for requesting consultation when indicated and for calling a qualified consultant.

5.6.2 The attending practitioner will provide written authorization to permit the consultant to attend or examine the patient, except in an emergency.

5.6.3 Except in emergencies, consultation is required in the following situations:

5.6.3.1 When the patient is not a good risk for operation or treatment;

5.6.3.2 Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;

5.6.3.3 Where there is doubt as to the choice of therapeutic measures to be utilized;

5.6.3.4 In unusually complicated situations where specific skills of other practitioners may be needed; and

5.6.3.5 When requested by the patient or his/her family.

5.6.3.6 In any complication of pregnancy in a patient under the care of a practitioner not holding unlimited privileges in obstetrics.

5.6.3.7 On all critically ill newborn and pediatric patients under the care of practitioners not holding unlimited privileges in pediatrics.

5.7 **Deaths.** In the event of a medical center death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable time.

5.7.1 The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the medical staff.

5.7.1.1 Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death.

5.7.1.2 Policies with respect to release of dead bodies shall conform to local law.

5.8 **Autopsies.** It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. The criteria for identifying deaths in which an autopsy should be performed, the mechanisms for documenting permission to perform an autopsy, the system for notifying the medical staff and the attending practitioner when an autopsy is being performed, and the use of autopsies in quality assessment and improvement activities can be found in Appendix I.
es can be found in Appendix I.

6. General Rules Regarding Surgical Care

6.1 The policies, rules and regulations applicable to the operating room shall be contained in the medical center policy book and posted in the operating room.

6.2 A patient admitted for dental care is a dual responsibility involving the dentist and a physician member of the medical staff. Patients admitted by Oral and Maxillofacial surgeon members of the medical staff are exempt from dual responsibility as defined by section 6.2.[1]

6.2.1 Dentist's Responsibilities:

6.2.1.1 A detailed dental history justifying medical center admission;

6.2.1.2 A detailed description of the examination of the oral cavity and a preoperative diagnosis;

6.2.1.3 A complete operative report, describing the findings and technique; (In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments

removed. All hard and soft tissue excepting decayed, impacted, and periodontally involved teeth[1] shall be sent to the medical center pathologist for examination.)

6.2.1.4 Progress notes as are pertinent to the oral condition; and

6.2.1.5 Clinical resume (or summary statement).

6.2.2 Physician's Responsibilities:

6.2.2.1 Medical history pertinent to the patient's general health;

6.2.2.2 A physical examination to determine the patient's condition prior to anesthesia and surgery; and

6.2.2.3 Supervision of the patient's general medical status while hospitalized.

6.2.3 The discharge of the patient shall be on the written order of the dentist member of the medical staff.

6.2a A patient admitted for podiatric care is a dual responsibility involving the podiatrist and a physician member of the medical staff.

6.2a.1 Podiatrist's Responsibilities:

6.2a.1.1 A detailed podiatric history justifying medical center admission;

6.2a.1.2 A detailed description of the examination of the foot, ankle and governing and related structures and a preoperative diagnosis;

6.2a.1.3 A complete operative report, describing the findings and technique;

6.2a.1.4 Progress notes as are pertinent to the podiatric condition; and

6.2a.1.5 Clinical resume (or summary statement).

6.2a.2 Physician's Responsibilities:

6.2a.2.1 Medical history pertinent to the patient's general health;

6.2a.2.2 A physical examination to determine the patient's condition prior to anesthesia and surgery; and

6.2a.2.3 Supervision of the patient's general medical status while hospitalized.

6.2a.3 The discharge of the patient shall be on the written order of the podiatrist member of the medical staff.[11]

6.3 The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow up of the patient's condition. Anesthesia policies, rules and regulations shall be contained in the medical center policy book and posted in the operating room.

6.4 The surgical procedures in which a surgical assistant must be present and scrubbed shall be listed in the Operating Room Policies, Rules and Regulations.

6.5 All tissue removed at the operation shall be sent to the medical center pathologist who shall make such examination as he/she may consider necessary to arrive at a tissue diagnosis. His/her authenticated report shall be made a part of the patient's medical record.

6.6 No member of the Medical Staff shall be permitted to use the operating room for surgical procedures without applying to and receiving approval for surgical privileges through the Department of Surgery.

7. General Rules Regarding Obstetrical Care

7.1 The policies, rules and regulations applicable to the obstetrical suite shall be contained in the medical center policy book and posted in the delivery room.

7.2 Appropriate surgical, laboratory and anesthetic equipment to meet any possible emergency complications of normal labor and delivery must be kept readily available in the obstetrical suite.

7.3 Pregnant patients, regardless of the length of gestation, shall be admitted to the obstetrical unit.

8. Emergency Services

8.1 Medical coverage in the emergency services area shall be provided 24 hours a day, seven (7) days a week by full time emergency care physicians who shall be members of the medical staff with clinical privileges in emergency care. Physicians in the various specialties shall be on call for consultation or definitive treatment.

8.2 An appropriate medical record shall be kept for every patient receiving emergency service and incorporated in the patient's medical center record, if it exists. The record shall include:

8.2.1 Adequate patient identification;

8.2.2 Information concerning the time of the patient's arrival, means of arrival and by whom transported;

8.2.3 Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his/her arrival at the medical center;

8.2.4 Description of significant clinical, laboratory and roentgenologic findings;

8.2.5 Diagnosis;

8.2.6 Treatment rendered;

8.2.7 Condition of the patient on discharge or transfer; and

8.2.8 Final disposition, including instruction given to the patient and/or his/her family, relative to necessary follow-up care.

8.3 Each patient's medical record shall be signed by the practitioner who is responsible for its clinical accuracy.

8.4 The emergency services department shall review the emergency room medical records at its monthly meeting and submit a report to the Executive Committee.

9. Intensive and Critical Care Unit

9.1 An Intensive and Critical Care Committee as prescribed in Article 12.2.7, of these bylaws shall establish, implement and review at least annually policies and

procedures for the Intensive and Critical Care Unit. A copy is contained in the medical center policy book.

9.2 Patients admitted to the unit shall be those whose condition is acute or critical, who require constant nursing observation and/or specialized care and equipment.

9.3 All patients with acute myocardial infarction or suspected of having had a recent myocardial infarction may be admitted or transferred immediately to the cardiac section of the unit for monitoring and treatment.

9.4 When requests for admission and/or transfer exceed the number of available beds, the Chairman of the intensive and critical care committee or his/her designate shall establish the priority of beds. His/her decision shall be final.

9.5 In any question as to the validity of admission to or discharge from the intensive or coronary care units should arise, that decision shall be made through consultation with the Chair of the Intensive and Critical Care Committee, or his/her designate.

10. Medical Staff Dues

10.1 The medical staff dues shall be $150 per year for Active and Courtesy staff. Dues for members on staff as of January 1st of each year will be due by January 31st of each year. Dues not received by January 31st will be considered delinquent and reported to the Executive Committee for further action.

10.2 Those monies assigned to medical education may be dispersed by the Medical Education Committee, up to an amount of $500 per event, without prior staff approval, provided a full accounting is given at the next regular medical staff meeting.

11. Medical Staff Application Fee

11.1 An application fee of $150 will be due upon submission of all initial applications for all categories of medical staff and allied health professional staff membership (Active, Courtesy, Consulting, Locum Tenens and Allied Health Professional). For active and courtesy staff applicants approved for membership by the Medical Staff and Board, this fee will be applied to the dues payable in the year of their approval.

12. Management of Medical Staff Funds

12.1 **Monthly Reports.** The Secretary-Treasurer of the Medical Staff, in collaboration with the Medical Affairs Office, shall provide the Executive Committee with regular reports showing itemized expenditures, income, existing balance as of the date of the statement, and reconciliation of the statement.

12.2 **Signatories.** For any amount equal to or less than $500, one signature from the list of approved signatories is required. For any amount greater than $500, two signatures are required. The approved signatories are as follows:

12.2.1 the Chief Medical Officer
12.2.2 the vice-president of the medical staff

12.2.3 the secretary-treasurer of the medical staff

12.3 **Authorization to Spend Funds.** No checks should be drafted by Medical Affairs until there is written authorization by an approved signatory requesting a check. The written authorization should be filed as a matter of record.

12.3.1 The Executive Committee can approve expenditures of $500 or less.

12.3.1.1 In case of an emergency, the Executive Committee may approve an expenditure of over $500, provided a three-fourth approval of the Executive Committee members and full disclosure to the Medical Staff at their next regularly scheduled meeting.

12.3.2 The Medical Staff must approve expenditures of greater than $500.

12.3.3 No other individual or group shall be empowered to authorize the expenditure of funds.

12.4 **Annual Budget Approval.** The Secretary-Treasurer shall prepare an annual budget and present it to the Executive Committee and Medical Staff for approval. Medical Staff resolutions should be renewed annually for payment of legal representation allowance, education committee allotment, and any other yearly budgetary items.

12.5 **Annual Audit.** The Secretary-Treasurer, in collaboration with Medical Affairs, shall present an annual financial report which shall permit the Executive Committee to perform an audit of income and expense for the past year.

12.6 **Medical Staff Account.** The medical staff checking account should be administered in the most economical manner.

13. Credential File Management

13.1 **Purpose.** The purpose of this policy is to articulate how Medical Staff credential files are managed (including their content, organization, storage, and archiving), as well as procedures regarding access to and distribution of credential file information.

13.2 **Content of Credential Files.** Credential files will contain all information pertinent to a practitioner's membership and privileges. This includes, but is not necessarily limited to, the following:

13.2.1 the Medical Staff Application and all supporting documents related to it.

13.2.2 Medical Staff Reappointment form and all supporting documents related to it.

13.2.3 Peer review and quality assessment data and reports related to the practitioner.

13.2.4 Copies of licenses, diplomas, certifications, insurance, and data bank queries.

13.2.5 Correspondence to and from the practitioner related to membership and privileges.

13.3 **Organization of Credential Files.** The credential files are color-coded to identify the membership status of the practitioner (Blue = Active/Senior Active; Red = Courtesy; Yellow = Consulting; and Green = Allied Health Practitioner). Honorary practitioners and those practitioners that have resigned from staff are maintained in manila folders. The credential files are divided into six sections:

13.3.1 Appointment tracking form and correspondence related to appointment

13.3.2 Medical Staff application and supporting information

13.3.3 Copies of licenses, certifications, insurance and primary source verifications

13.3.4 Reappointment applications and supporting information

13.3.5 Peer review and quality assessment data and reports

13.3.6 The practitioner's current privileges

As the credential file becomes filled, a second credential file (a manila folder) is created for the purpose of maintaining expired licenses, certifications, insurance, dated peer review and quality assessment data, and for storing old reappointment packets. These second files are stored with the original file and should not be kept separate for any purpose.

13.4 **Purging Credential File Information.** Credential file information will not be purged, kept in files separate from credential files, or destroyed, except in the following instances:

13.4.1 Documents that are not attributable or related to any formal mechanisms of review (e.g., appointment, reappointment, formal review[8], incident investigation, peer review, quality assessment, etc.); or

13.4.2 Documents that are misfiled.

13.4.3 Archived files (see Archiving below).

13.5 **Storage.** Credential files of current members will be kept in file cabinets in the Medical Affairs office. These file cabinets will be locked when the office is unattended. Credential files may only be taken out of the Medical Affairs office by the Chief Medical Officer or the Director of Medical Staff Relations or their designee for the following purposes:

13.5.1 When the credential file is needed by an individual or committee performing their review duties related to appointment, reappointment or peer review, and the review must be done at another location; or

13.5.2 When the credential file is subpoenaed by court order. Release of the credential file will occur only after notification and approval by the organization's Chief Executive Officer, the Chief Medical Officer, hospital legal counsel, and medical staff counsel.

13.6 **Archiving.** Upon the resignation or termination of a practitioner or their transfer to Honorary status, a "Medical Staff Archive Form" will be completed

(see attached). All information in credential files will be kept for five years following the resignation or transfer to Honorary status. Thereafter, the credential file will be purged of all information except the following:

13.6.1 the original application and supporting information

13.6.2 the last complete reappointment and supporting information

13.6.3 the last copies of licenses, privileges, insurance, data bank queries, etc.

13.6.4. all peer review and quality assessment data and reports

13.6.5 the Medical Staff Archive form Archived credential files will be maintained in a locked file cabinet within Medical Affairs. If archived to electronic media (e.g., microfiche, CD-ROM), media will be stored in locked file cabinets in Medical Affairs. Archived credential files will be kept for 25 years, after which they can be destroyed.

13.7 **Access to Credential Files and Information.** With the exceptions as noted in Sections 13.8 below, access to credential files and the information contained in them is limited to the following:

13.7.1 the practitioner;

13.7.2 the Medical Affairs staff;

13.7.3 members of the Medical Staff, Administration and Board who are responsible for reviews related to appointment, reappointment or peer review or their designees;

13.7.4.surveyors from the State's Hospital Licensing Division or Board of Registration;

13.7.5 surveyors from the Joint Commission on Accreditation of Healthcare Organizations or other accrediting bodies that may review the hospital's credentialing practices; and

13.7.6 other individuals or entities for whom the practitioner has signed a specific written release of information

Access and review of credential files by anyone other than Medical Affairs staff or surveyors on unannounced visits, must be scheduled with the Chief Medical

Officer or his/her designee. A member of the Medical Affairs staff must be present to supervise the review of the credential files at all times.

13.8 **Release of Credential File Information (Practitioner Consent Not Required).** Upon request and without specific practitioner consent, Medical Affairs personnel may provide the following information:

13.8.1 the practitioner's name;

13.8.2 the practitioner's office address and phone;

13.8.3 the practitioner's specialty;

13.8.4 the educational institutions the practitioner attended and graduation dates;

13.8.5 the practitioner's UPIN number;

13.8.6 the practitioner's membership category and date appointed to the medical staff;

13.8.7 the practitioner's current list of privileges (only to St. Mary's patient care or treatment units requiring them for compliance with accrediting or licensing standards)

All other information related to the practitioner may only be supplied after written consent from the practitioner has been obtained or pursuant to law.

13.9 **Method for Requesting Purging or Destruction of Credential File Information.** A practitioner may request that specific information in his or her credential file be purged or destroyed. This request must be made in writing to the Chief Medical Officer and address the specific document(s) to be purged or destroyed, as well as the reason for requesting purging or destruction of the document(s). Once the practitioner has filed his or her written request, the following procedure will be followed:

13.9.1 The Chief Medical Officer will review the request.

13.9.2 If the Chief Medical Officer determinesthat the document is clearly not attributable or related to any formal mechanism of review described in 13.4.1 above, or if it is clearly misfiled, the document will be immediately purged from the file.

The Chief Medical Officer will address requests for purging or destructions of documents in as timely a manner as possible. The decision of the Chief Medical Officer is final and is not subject to any formal Medical Staff hearing or appeal process. The Chief Medical Officer's decision shall be communicated to the Executive Committee at the next Executive Committee meeting.[2]

14. The Peer Review Process

14.1 **Purpose.** Peer Review is an important element of the Medical Staff's quality assessment and improvement process. This section describes the guidelines for assuring timely and effective peer review.

14.2 **Responsibility for Peer Review.** According to the Medical Staff bylaws, maintaining a peer review process is one of the responsibilities of the Executive Committee (or a committee it so designates). The Executive Committee shall establish a Clinical Practice Committee (CPC) .[8] The CPC shall have as one of its responsibilities, the coordination and oversight of the Medical Staff's peer review process.

14.3 **Priority Review/Generic Review Protocols.** The peer review process shall have two protocols--a priority review protocol and a generic review protocol.

14.3.1 **Priority Review.** The priority review protocol should be designed to rapidly identify cases of significant concern[1] and complete initial physician peer review of these cases within 3 business days of case identification.

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[1] A "significant concern" is defined here as activities or professional conduct that may meet criteria for *formal review*[8] (e.g., detrimental to patient safety or likely to affect adversely the delivery of quality patient care).

14.3.2 **Generic Review.** The generic review protocol should be designed to review other cases of concern that do not meet priority review criteria, but whose outcomes may signal an opportunity to improve. The initial physician peer review of generic review cases should be completed within 30 days of case identification.

14.4 **Case Selection, Case Review and Case Documentation Criteria.** The CPC shall establish clear criteria for priority and generic review case selection. As necessary, the CPC shall also develop guidelines for assuring case review effectiveness, documentation and tracking. These criteria shall be appended to these rules and regulations. Medical Staff Departments and Services may elect, but are not required, to conduct additional peer review activities.

14.5 **Priority Review Protocol.**

14.5.1 The hospital staff member, who is designated to assist the CPC in its peer review coordination role, immediately refers the case to the Department Chair and notifies the CPC Chair, Chief Medical Officer, and Risk Manager. He/She shall provide support to the physicians in this process and assure that all steps in the process are well-documented.

14.5.2 The Department Chair immediately notifies the physician (whose case has been identified for priority review) and immediately selects and notifies an appropriate physician reviewer as defined below.

14.5.2.1 The physician reviewer may not be the physician whose case is under review. The physician reviewer should be unbiased. That means they cannot have been involved in the case or have previously reviewed the case, be embroiled in other controversies with the physician, or have any particular reason they cannot be objective.

14.5.3 The physician reviewer reviews and dictates the case within 3 business days of case identification. Medical Records transcribes the dictation within 24 hours of dictation and immediately submits

copies to the Department Chair, Chief Medical Officer, and CPC Chair.

14.5.4 As soon as possible after the review, the physician reviewer communicates (via phone or in-person) his/her findings to the Department Chair.

14.5.5 If the review identifies a significant concern requiring further action, the Department Chair:

14.5.5.1 Contacts the CPC Chair and the physician[8] immediately by phone or in-person and notifies them[8] of the concern.

14.5.5.2 The CPC and Department Chair then arrange a meeting with the physician to discuss the case and to allow the physician an opportunity to address any concerns that have been raised.[8]

14.5.5.3 Following this meeting, the CPC and Department Chair determine whether significant concerns remain. If so, the CPC and Department Chair refer the case for formal review (see Bylaws Section 8.2) or the Department Chair may summarily suspend the physician if warranted (see Bylaws Section 8.9). If no significant concerns remain following the meeting, the case is summarized at the next Department meeting (per 14.5.6 below). This procedure shall not be interpreted to prohibit a summary suspension as otherwise provided in Section 8.9 of the Medical Staff Bylaws.[8]

14.5.6 If the review identifies no significant concerns and the case requires no further review, the Department Chair notifies the physician of the outcome and the reviewer summarizes the case at the next Department meeting.

14.5.7 If there are no significant concerns but the reviewer feels the case should be reviewed by another Department or Service, the case shall follow the generic review protocol below.

14.6 **Generic Case Review Protocol.**

14.6.1 A physician reviewer rotation,, shall be established for each medical staff Department, Service or standing Committee (Appendix C) meeting. [8]

14.6.2 The hospital staff member, who is designated to assist the CPC in its peer review coordination role, refers cases to the assigned reviewer and also inform the physician (whose case is to be reviewed) the reason for the review.[8] If 14.6.2.1 applies to the assigned reviewer, the hospital staff member shall refer the case to the next assigned reviewer. He/She shall provide support to the physicians in this process and assure that all steps in the process are well-documented.

14.6.2.1 The physician reviewer may not be the physician whose case is under review. The physician reviewer should be unbiased. That means they cannot have been involved in the case or have previously reviewed the case, be embroiled in other controversies with the physician, or have any particular reason they cannot be objective.

14.6.3 The reviewer reviews the case and dictates his/her report within 30 days of case identification.

14.6.4 If the review identifies a priority review concern, the reviewer immediately notifies the Department Chair and 14.5.5 is followed.

14.6.5 If the review identifies no significant concerns and the case requires no further review, the reviewer summarizes the case at the next Department, Service or Committee[8] meeting.

14.6.6 If there are no significant concerns but the reviewer feels the case should be reviewed by another Department or Service or

Committee[8], the case shall be referred per 14.6.2 and reviewed according to the generic review protocol outlined in 14.6.3 through 14.6.5 above.

14.7 **Priority Review Case Selection Criteria.** The following criteria constitute grounds for priority review:

14.7.1 all unexpected deaths;

14.7.2 any case identified by a Medical Staff Officer, Department or Committee Chair, Chief Executive Officer, Chief Operating Officer, or Chief Medical Officer, that potentially identifies care or conduct that may jeopardize the health or safety of patients or of any person at the Medical Center, or expose any patient or any person at the Medical Center to an extraordinary or immediate risk of injury or damage.

14.8 **Generic Review Case Selection Criteria.** The following criteria constitute grounds for generic review:

14.8.1 those cases selected using predefined criteria identified by the Department, Service or Committee Chair in collaboration with the Quality Improvement Coordinator .[8]

14.8.2 A minimum of one case per physician per year is required.[2]

15. Disruptive Behavior by Medical Staff Members

In order to promote high standards of patient care and a professional environment, it is expected that members of the Medical Staff treat all individuals with respect, courtesy and dignity, consistent with the mission and values of St. Mary's Regional Medical Center, and conduct themselves in a professional and cooperative manner consistent with the Medical Staff Bylaws so as to promote patient safety and quality patient care. Appropriate conduct is an important factor in appointment and reappointment decisions.

Definition of Disruptive Behavior

Disruptive conduct is defined as conduct which has the potential to adversely affects the hospital's ability to accomplish the goals set out in its mission

statement and conduct which is inconsistent with the basic responsibilities of medical staff membership delineated in Article 3.5 of the Medical Staff Bylaws and the standards of conduct set out in the Principles of Medical Ethics in Appendix F of the Medical Staff Bylaws. Disruptive behavior includes, but is not necessarily limited to, the following actions toward colleagues, hospital personnel, patients, families, or visitors:

- Use of abusive, threatening or profane language;
- Degrading or demeaning comments;
- Threatening or intimidating physical contact;
- Destruction of property or throwing items;
- Intimidation of staff, patients, or families, whether verbal or physical, in person or over the telephone;
- Conduct which is inconsistent with the Medical Center's policy on sexual harassment;
- Conduct that intimidates staff from raising concerns about safe patient care;
- Conduct that creates a hostile work environment;
- Conduct that interferes with an individual's ability to practice competently;
- Conduct that adversely affects the hospital's ability to provide safe, quality patient care;
- Inappropriate medical record entries; and
- Retaliatory action against anyone reporting disruptive behavior.

15.2 Documenting Alleged Disruptive Behavior. Adequate documentation of disruptive conduct is critical, since it is ordinarily not an individual incident that justifies an adverse action, but rather a pattern of conduct. Documentation of alleged disruptive behavior shall include:

15.2.1 The date, time and location of the incident;

15.2.2 if the behavior affected or involved a patient in any way, the name of the patient (and the medical record number if possible);

15.2.3 the circumstances which precipitated or surrounded the incident;

15.2.4 an objective description of the behavior in question, limited to factual material and objective language as much as possible;

15.2.5 the consequence(s), if any, of the behavior as it related to patient

care or hospital operations;

15.2.6 a record of any action(s) taken to remedy the situation, including the date, time, place, action, or names(s) of those intervening and the nature of the intervention(s);

15.2.7 documentation of the staff member's response to the complaint and the intervention process.

15.2.8 name and signature of the person making the complaint.

15.3 Reporting and Acting on Alleged Disruptive Behavior. Anyone who observes what they deem to be disruptive behavior should report it in writing to the Chief Medical Officer. If the Chief Medical Officer receives a report, he/she will provide a copy of the report to the Chair of the practitioner's department immediately. The Chief Medical Officer, in consultation with the Chair and others as necessary, will make a determination whether action is warranted. If further action is not warranted, no record of the incident will be made in the staff member's credential file. If action is to be taken, a meeting will be held with the Chief Medical Officer or his/her designee with the involved medical staff member:

15.3.1 The initial approach should be collegial and designed to be educational and helpful to the medical staff member while making clear how and why the behavior was inappropriate and emphasizing that if the behavior continues, more action will be taken.

15.3.2 This meeting shall be documented in the member's credential file. The member shall have the opportunity to read this documentation and to attach a response. Said documentation shall be considered credentialing materials protected as confidential.

15.3.3 The Chief Medical Officer or designee, at his/her discretion, will communicate to the person reporting the behavior that the issue has been addressed with the member.

15.3.4 A follow-up letter to the staff member shall state the problem and the expectation that the member is required to behave professionally and cooperatively. A copy of this letter shall be

placed in the member's credential file.

15.4 Recurrent Episodes of Disruptive Behavior. If a medical staff member has been notified of a disruptive behavior problem and such behavior continues or recurs, the Chief Medical Officer and Chair in consultation with the Executive Committee of the Medical Staff shall determine what action is appropriate, including but not limited to referral to a behavioral consultant, in accordance with Bylaws Section 8.7.5, or a recommendation to institute the Complaint Resolution (Appendix J), Formal Review (Bylaws Section 8.2 through 8.8.12), or Summary Suspension (Bylaws Section 8.9 through 8.11.2).[12]

15.5 Reappointment. A medical staff member's pattern of conduct will be considered in reappointment decisions.

15.6 Egregious Episode of Disruptive Behavior. A single episode of disruptive behavior that is judged to have a serious impact on patient safety will result in the actions noted in 15.4 above.

APPENDIX E
Ethical and Religious Directives for Catholic Health Facilities[2]

Issued by NCCB/USCC, June 15, 2001

Ethical and Religious Directives for Catholic Health Care Services, Fourth Edition

United States Conference of Catholic Bishops

This fourth edition of the *Ethical and Religious Directives for Catholic Health Care Services* was developed by the Committee on Doctrine of the National Conference of Catholic Bishops and approved as the national code by the full body of bishops at its June 2001 General Meeting. This edition of the Directives, which replaces all previous editions, is recommended for implementation by the diocesan bishop and is authorized for publication by the undersigned.

Monsignor William P. Fay
General Secretary
USCCB

[2] The Ethical and Religious Directives for Catholic Health Care Services (current edition) are appended to these Bylaws.

To order *Ethical and Religious Directives, Fourth Edition*, in its official published format, contact USCCB Publishing Services, 800-235-8722 (in the Washington metropolitan area or from outside the United States, 202-722-8716). Pocket-size format: No. 5-452; Three-hole punch format: No. 5-454. $2.95 per copy plus shipping and handling; quantity discounts are available.

Contents

Preamble

Health care in the United States is marked by extraordinary change. Not only is there continuing change in clinical practice due to technological advances, but the health care system in the United States is being challenged by both institutional and social factors as well. At the same time, there are a number of developments within the Catholic Church affecting the ecclesial mission of health care. Among these are significant changes in religious orders and congregations, the increased involvement of lay men and women, a heightened awareness of the Church's social role in the world, and developments in moral theology since the Second Vatican Council. A contemporary understanding of the Catholic health care ministry must take into account the new challenges presented by transitions both in the Church and in American society.

Throughout the centuries, with the aid of other sciences, a body of moral principles has emerged that expresses the Church's teaching on medical and moral matters and has proven to be pertinent and applicable to the ever-changing circumstances of health care and its delivery. In response to today's challenges, these same moral principles of Catholic teaching provide the rationale and direction for this revision of the *Ethical and Religious Directives for Catholic Health Care Services*.

These Directives presuppose our statement *Health and Health Care* published in 1981.[1] There we presented the theological principles that guide the Church's vision of health care, called for all Catholics to share in the healing mission of the Church, expressed our full commitment to the health care ministry, and offered encouragement to all those who are involved in it. Now, with American health care facing even more dramatic changes, we reaffirm the Church's commitment to health care ministry and the distinctive Catholic identity of the Church's institutional health care services.[2] The purpose of these *Ethical and Religious Directives* then is twofold: first, to reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person; second, to provide authoritative guidance on certain moral issues that face Catholic health care today.

The *Ethical and Religious Directives* are concerned primarily with institutionally based Catholic health care services. They address the sponsors, trustees, administrators, chaplains, physicians, health care personnel, and patients or residents of these institutions and services. Since they express the Church's moral teaching, these Directives also will be helpful to Catholic professionals engaged in health care services in other settings. The moral teachings that we profess here flow principally from the natural law, understood in the light of the revelation Christ has entrusted to his Church. From this source the Church

has derived its understanding of the nature of the human person, of human acts, and of the goals that shape human activity.

The Directives have been refined through an extensive process of consultation with bishops, theologians, sponsors, administrators, physicians, and other health care providers. While providing standards and guidance, the Directives do not cover in detail all of the complex issues that confront Catholic health care today. Moreover, the Directives will be reviewed periodically by the United States Conference of Catholic Bishops (formerly the National Conference of Catholic Bishops), in the light of authoritative church teaching, in order to address new insights from theological and medical research or new requirements of public policy.

The Directives begin with a general introduction that presents a theological basis for the Catholic health care ministry. Each of the six parts that follow is divided into two sections. The first section is in expository form; it serves as an introduction and provides the context in which concrete issues can be discussed from the perspective of the Catholic faith. The second section is in prescriptive form; the directives promote and protect the truths of the Catholic faith as those truths are brought to bear on concrete issues in health care.

General Introduction

The Church has always sought to embody our Savior's concern for the sick. The gospel accounts of Jesus' ministry draw special attention to his acts of healing: he cleansed a man with leprosy (Mt 8:1-4; Mk 1:40-42); he gave sight to two people who were blind (Mt 20:29-34; Mk 10:46-52); he enabled one who was mute to speak (Lk 11:14); he cured a woman who was hemorrhaging (Mt 9:20-22; Mk 5:25-34); and he brought a young girl back to life (Mt 9:18, 23-25; Mk 5:35-42). Indeed, the Gospels are replete with examples of how the Lord cured every kind of ailment and disease (Mt 9:35). In the account of Matthew, Jesus' mission fulfilled the prophecy of Isaiah: "He took away our infirmities and bore our diseases" (Mt 8:17; cf. Is 53:4).

Jesus' healing mission went further than caring only for physical affliction. He touched people at the deepest level of their existence; he sought their physical, mental, and spiritual healing (Jn 6:35, 11:25-27). He "came so that they might have life and have it more abundantly" (Jn 10:10).

The mystery of Christ casts light on every facet of Catholic health care: to see Christian love as the animating principle of health care; to see healing and compassion as a continuation of Christ's mission; to see suffering as a participation in the redemptive power of Christ's passion, death, and resurrection; and to see death, transformed by the resurrection, as an opportunity for a final act of communion with Christ.

For the Christian, our encounter with suffering and death can take on a positive and distinctive meaning through the redemptive power of Jesus' suffering and death. As St.

Paul says, we are "always carrying about in the body the dying of Jesus, so that the life of Jesus may also be manifested in our body" (2 Cor 4:10). This truth does not lessen the pain and fear, but gives confidence and grace for bearing suffering rather than being overwhelmed by it. Catholic health care ministry bears witness to the truth that, for those who are in Christ, suffering and death are the birth pangs of the new creation. "God himself will always be with them [as their God]. He will wipe every tear from their eyes, and there shall be no more death or mourning, wailing or pain, [for] the old order has passed away" (Rev 21:3-4).

In faithful imitation of Jesus Christ, the Church has served the sick, suffering, and dying in various ways throughout history. The zealous service of individuals and communities has provided shelter for the traveler; infirmaries for the sick; and homes for children, adults, and the elderly.[3] In the United States, the many religious communities as well as dioceses that sponsor and staff this country's Catholic health care institutions and services have established an effective Catholic presence in health care. Modeling their efforts on the gospel parable of the Good Samaritan, these communities of women and men have exemplified authentic neighborliness to those in need (Lk 10:25-37). The Church seeks to ensure that the service offered in the past will be continued into the future.

While many religious communities continue their commitment to the health care ministry, lay Catholics increasingly have stepped forward to collaborate in this ministry. Inspired by the example of Christ and mandated by the Second Vatican Council, lay faithful are invited to a broader and more intense field of ministries than in the past.[4] By virtue of their Baptism, lay faithful are called to participate actively in the Church's life and mission.[5] Their participation and leadership in the health care ministry, through new forms of sponsorship and governance of institutional Catholic health care, are essential for the Church to continue her ministry of healing and compassion. They are joined in the Church's health care mission by many men and women who are not Catholic.

Catholic health care expresses the healing ministry of Christ in a specific way within the local church. Here the diocesan bishop exercises responsibilities that are rooted in his office as pastor, teacher, and priest. As the center of unity in the diocese and coordinator of ministries in the local church, the diocesan bishop fosters the mission of Catholic health care in a way that promotes collaboration among health care leaders, providers, medical professionals, theologians, and other specialists. As pastor, the diocesan bishop is in a unique position to encourage the faithful to greater responsibility in the healing ministry of the Church. As teacher, the diocesan bishop ensures the moral and religious identity of the health care ministry in whatever setting it is carried out in the diocese. As priest, the diocesan bishop oversees the sacramental care of the sick. These responsibilities will require that Catholic health care providers and the diocesan bishop engage in ongoing communication on ethical and pastoral matters that require his attention.

In a time of new medical discoveries, rapid technological developments, and social change, what is new can either be an opportunity for genuine advancement in human culture, or it can lead to policies and actions that are contrary to the true dignity and

vocation of the human person. In consultation with medical professionals, church leaders review these developments, judge them according to the principles of right reason and the ultimate standard of revealed truth, and offer authoritative teaching and guidance about the moral and pastoral responsibilities entailed by the Christian faith.[6] While the Church cannot furnish a ready answer to every moral dilemma, there are many questions about which she provides normative guidance and direction. In the absence of a determination by the magisterium, but never contrary to church teaching, the guidance of approved authors can offer appropriate guidance for ethical decision making.

Created in God's image and likeness, the human family shares in the dominion that Christ manifested in his healing ministry. This sharing involves a stewardship over all material creation (Gn 1:26) that should neither abuse nor squander nature's resources. Through science the human race comes to understand God's wonderful work; and through technology it must conserve, protect, and perfect nature in harmony with God's purposes. Health care professionals pursue a special vocation to share in carrying forth God's life-giving and healing work.

The dialogue between medical science and Christian faith has for its primary purpose the common good of all human persons. It presupposes that science and faith do not contradict each other. Both are grounded in respect for truth and freedom. As new knowledge and new technologies expand, each person must form a correct conscience based on the moral norms for proper health care.

PART ONE

The Social Responsibility of Catholic Health Care Services

Introduction

Their embrace of Christ's healing mission has led institutionally based Catholic health care services in the United States to become an integral part of the nation's health care system. Today, this complex health care system confronts a range of economic, technological, social, and moral challenges. The response of Catholic health care institutions and services to these challenges is guided by normative principles that inform the Church's healing ministry.

First, Catholic health care ministry is rooted in a commitment to promote and defend human dignity; this is the foundation of its concern to respect the sacredness of every human life from the moment of conception until death. The first right of the human person, the right to life, entails a right to the means for the proper development of life, such as adequate health care.[7]

Second, the biblical mandate to care for the poor requires us to express this in concrete action at all levels of Catholic health care. This mandate prompts us to work to ensure that our country's health care delivery system provides adequate health care for the poor. In Catholic institutions, particular attention should be given to the health care needs of

the poor, the uninsured, and the underinsured.[8]

Third, Catholic health care ministry seeks to contribute to the common good. The common good is realized when economic, political, and social conditions ensure protection for the fundamental rights of all individuals and enable all to fulfill their common purpose and reach their common goals.[9]

Fourth, Catholic health care ministry exercises responsible stewardship of available health care resources. A just health care system will be concerned both with promoting equity of care—to assure that the right of each person to basic health care is respected—and with promoting the good health of all in the community. The responsible stewardship of health care resources can be accomplished best in dialogue with people from all levels of society, in accordance with the principle of subsidiarity and with respect for the moral principles that guide institutions and persons.

Fifth, within a pluralistic society, Catholic health care services will encounter requests for medical procedures contrary to the moral teachings of the Church. Catholic health care does not offend the rights of individual conscience by refusing to provide or permit medical procedures that are judged morally wrong by the teaching authority of the Church.

Directives

1. A Catholic institutional health care service is a community that provides health care to those in need of it. This service must be animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church.

2. Catholic health care should be marked by a spirit of mutual respect among care-givers that disposes them to deal with those it serves and their families with the compassion of Christ, sensitive to their vulnerability at a time of special need.

3. In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.

4. A Catholic health care institution, especially a teaching hospital, will promote medical research consistent with its mission of providing health care and with concern for the responsible stewardship of health care resources. Such medical research must adhere to Catholic moral principles.

5. Catholic health care services must adopt these Directives as policy, require

adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel.

6. A Catholic health care organization should be a responsible steward of the health care resources available to it. Collaboration with other health care providers, in ways that do not compromise Catholic social and moral teaching, can be an effective means of such stewardship.[10]

7. A Catholic health care institution must treat its employees respectfully and justly. This responsibility includes: equal employment opportunities for anyone qualified for the task, irrespective of a person's race, sex, age, national origin, or disability; a workplace that promotes employee participation; a work environment that ensures employee safety and well-being; just compensation and benefits; and recognition of the rights of employees to organize and bargain collectively without prejudice to the common good.

8. Catholic health care institutions have a unique relationship to both the Church and the wider community they serve. Because of the ecclesial nature of this relationship, the relevant requirements of canon law will be observed with regard to the foundation of a new Catholic health care institution; the substantial revision of the mission of an institution; and the sale, sponsorship transfer, or closure of an existing institution.

9. Employees of a Catholic health care institution must respect and uphold the religious mission of the institution and adhere to these Directives. They should maintain professional standards and promote the institution's commitment to human dignity and the common good.

PART TWO

The Pastoral and Spiritual Responsibility of Catholic Health Care

Introduction

The dignity of human life flows from creation in the image of God (Gn 1:26), from redemption by Jesus Christ (Eph 1:10; 1 Tm 2:4-6), and from our common destiny to share a life with God beyond all corruption (1 Cor 15:42-57). Catholic health care has the responsibility to treat those in need in a way that respects the human dignity and eternal destiny of all. The words of Christ have provided inspiration for Catholic health care: "I was ill and you cared for me" (Mt 25:36). The care provided assists those in need to experience their own dignity and value, especially when these are obscured by the burdens of illness or the anxiety of imminent death.

Since a Catholic health care institution is a community of healing and compassion, the care offered is not limited to the treatment of a disease or bodily ailment but embraces

the physical, psychological, social, and spiritual dimensions of the human person. The medical expertise offered through Catholic health care is combined with other forms of care to promote health and relieve human suffering. For this reason, Catholic health care extends to the spiritual nature of the person. "Without health of the spirit, high technology focused strictly on the body offers limited hope for healing the whole person."[11] Directed to spiritual needs that are often appreciated more deeply during times of illness, pastoral care is an integral part of Catholic health care. Pastoral care encompasses the full range of spiritual services, including a listening presence; help in dealing with powerlessness, pain, and alienation; and assistance in recognizing and responding to God's will with greater joy and peace. It should be acknowledged, of course, that technological advances in medicine have reduced the length of hospital stays dramatically. It follows, therefore, that the pastoral care of patients, especially administration of the sacraments, will be provided more often than not at the parish level, both before and after one's hospitalization. For this reason, it is essential that there be very cordial and cooperative relationships between the personnel of pastoral care departments and the local clergy and ministers of care.

Priests, deacons, religious, and laity exercise diverse but complementary roles in this pastoral care. Since many areas of pastoral care call upon the creative response of these pastoral care-givers to the particular needs of patients or residents, the following directives address only a limited number of specific pastoral activities.

Directives

10. A Catholic health care organization should provide pastoral care to minister to the religious and spiritual needs of all those it serves. Pastoral care personnel—clergy, religious, and lay alike—should have appropriate professional preparation, including an understanding of these Directives.

11. Pastoral care personnel should work in close collaboration with local parishes and community clergy. Appropriate pastoral services and/or referrals should be available to all in keeping with their religious beliefs or affiliation.

12. For Catholic patients or residents, provision for the sacraments is an especially important part of Catholic health care ministry. Every effort should be made to have priests assigned to hospitals and health care institutions to celebrate the Eucharist and provide the sacraments to patients and staff.

13. Particular care should be taken to provide and to publicize opportunities for patients or residents to receive the sacrament of Penance.

14. Properly prepared lay Catholics can be appointed to serve as extraordinary ministers of Holy Communion, in accordance with canon law and the policies of the local diocese. They should assist pastoral care personnel—clergy, religious, and laity—by providing supportive visits, advising patients regarding the availability of priests for the sacrament of Penance, and distributing Holy Communion to the faithful who request it.

15. Responsive to a patient's desires and condition, all involved in pastoral care should facilitate the availability of priests to provide the sacrament of Anointing of the Sick, recognizing that through this sacrament Christ provides grace and support to those who are seriously ill or weakened by advanced age. Normally, the sacrament is celebrated when the sick person is fully conscious. It may be conferred upon the sick who have lost consciousness or the use of reason, if there is reason to believe that they would have asked for the sacrament while in control of their faculties.

16. All Catholics who are capable of receiving Communion should receive Viaticum when they are in danger of death, while still in full possession of their faculties.[12]

17. Except in cases of emergency (i.e., danger of death), any request for Baptism made by adults or for infants should be referred to the chaplain of the institution. Newly born infants in danger of death, including those miscarried, should be baptized if this is possible.[13] In case of emergency, if a priest or a deacon is not available, anyone can validly baptize.[14] In the case of emergency Baptism, the chaplain or the director of pastoral care is to be notified.

18. When a Catholic who has been baptized but not yet confirmed is in danger of death, any priest may confirm the person.[15]

19. A record of the conferral of Baptism or Confirmation should be sent to the parish in which the institution is located and posted in its Baptism/Confirmation registers.

20. Catholic discipline generally reserves the reception of the sacraments to Catholics. In accord with canon 844, §3, Catholic ministers may administer the sacraments of Eucharist, Penance, and Anointing of the Sick to members of the oriental churches that do not have full communion with the Catholic Church, or of other churches that in the judgment of the Holy See are in the same condition as the oriental churches, if such persons ask for the sacraments on their own and are properly disposed.

    With regard to other Christians not in full communion with the Catholic Church, when the danger of death or other grave necessity is present, the four conditions of canon 844, §4, also must be present, namely, they cannot approach a minister of their own community; they ask for the sacraments on their own; they manifest Catholic faith in these sacraments; and they are properly disposed. The diocesan bishop has the responsibility to oversee this pastoral practice.

21. The appointment of priests and deacons to the pastoral care staff of a Catholic institution must have the explicit approval or confirmation of the local bishop in collaboration with the administration of the institution. The appointment of the director of the pastoral care staff should be made in consultation with the diocesan bishop.

22. For the sake of appropriate ecumenical and interfaith relations, a diocesan policy should be developed with regard to the appointment of non-Catholic members to the pastoral care staff of a Catholic health care institution. The director of pastoral care at a Catholic institution should be a Catholic; any exception to this norm should be approved by the diocesan bishop.

PART THREE

The Professional-Patient Relationship

Introduction

A person in need of health care and the professional health care provider who accepts that person as a patient enter into a relationship that requires, among other things, mutual respect, trust, honesty, and appropriate confidentiality. The resulting free exchange of information must avoid manipulation, intimidation, or condescension. Such a relationship enables the patient to disclose personal information needed for effective care and permits the health care provider to use his or her professional competence most effectively to maintain or restore the patient's health. Neither the health care professional nor the patient acts independently of the other; both participate in the healing process.

Today, a patient often receives health care from a team of providers, especially in the setting of the modern acute-care hospital. But the resulting multiplication of relationships does not alter the personal character of the interaction between health care providers and the patient. The relationship of the person seeking health care and the professionals providing that care is an important part of the foundation on which diagnosis and care are provided. Diagnosis and care, therefore, entail a series of decisions with ethical as well as medical dimensions. The health care professional has the knowledge and experience to pursue the goals of healing, the maintenance of health, and the compassionate care of the dying, taking into account the patient's convictions and spiritual needs, and the moral responsibilities of all concerned. The person in need of health care depends on the skill of the health care provider to assist in preserving life and promoting health of body, mind, and spirit. The patient, in turn, has a responsibility to use these physical and mental resources in the service of moral and spiritual goals to the best of his or her ability.

When the health care professional and the patient use institutional Catholic health care, they also accept its public commitment to the Church's understanding of and witness to the dignity of the human person. The Church's moral teaching on health care nurtures a truly interpersonal professional-patient relationship. This professional-patient relationship is never separated, then, from the Catholic identity of the health care institution. The faith that inspires Catholic health care guides medical decisions in ways that fully respect the dignity of the person and the relationship with the health care professional.

Directives

23. The inherent dignity of the human person must be respected and protected

regardless of the nature of the person's health problem or social status. The respect for human dignity extends to all persons who are served by Catholic health care.

24. In compliance with federal law, a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to make an advance directive for their medical treatment. The institution, however, will not honor an advance directive that is contrary to Catholic teaching. If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored.

25. Each person may identify in advance a representative to make health care decisions as his or her surrogate in the event that the person loses the capacity to make health care decisions. Decisions by the designated surrogate should be faithful to Catholic moral principles and to the person's intentions and values, or if the person's intentions are unknown, to the person's best interests. In the event that an advance directive is not executed, those who are in a position to know best the patient's wishes—usually family members and loved ones—should participate in the treatment decisions for the person who has lost the capacity to make health care decisions.

26. The free and informed consent of the person or the person's surrogate is required for medical treatments and procedures, except in an emergency situation when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment.

27. Free and informed consent requires that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.

28. Each person or the person's surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person's surrogate is to be followed so long as it does not contradict Catholic principles.

29. All persons served by Catholic health care have the right and duty to protect and preserve their bodily and functional integrity.[16] The functional integrity of the person may be sacrificed to maintain the health or life of the person when no other morally permissible means is available.[17]

30. The transplantation of organs from living donors is morally permissible when such a donation will not sacrifice or seriously impair any essential bodily function and the anticipated benefit to the recipient is proportionate to the harm done to the donor. Furthermore, the freedom of the prospective donor must be respected, and economic advantages should not accrue to the donor.

31. No one should be the subject of medical or genetic experimentation, even if it is therapeutic, unless the person or surrogate first has given free and informed consent. In instances of nontherapeutic experimentation, the surrogate can give this consent only if the experiment entails no significant risk to the person's well-being. Moreover, the greater the person's incompetency and vulnerability, the greater the reasons must be to perform any medical experimentation, especially nontherapeutic.

32. While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.[18]

33. The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the patient.

34. Health care providers are to respect each person's privacy and confidentiality regarding information related to the person's diagnosis, treatment, and care.

35. Health care professionals should be educated to recognize the symptoms of abuse and violence and are obliged to report cases of abuse to the proper authorities in accordance with local statutes.

36. Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.[19]

37. An ethics committee or some alternate form of ethical consultation should be available to assist by advising on particular ethical situations, by offering educational opportunities, and by reviewing and recommending policies. To these ends, there should be appropriate standards for medical ethical consultation within a particular diocese that will respect the diocesan bishop's pastoral responsibility as well as assist members of ethics committees to be familiar with Catholic medical ethics and, in particular, these Directives.

PART FOUR

Issues in Care for the Beginning of Life

Introduction

The Church's commitment to human dignity inspires an abiding concern for the sanctity of human life from its very beginning, and with the dignity of marriage and of the marriage act by which human life is transmitted. The Church cannot approve medical practices that undermine the biological, psychological, and moral bonds on which the strength of marriage and the family depends.

Catholic health care ministry witnesses to the sanctity of life "from the moment of conception until death."[20] The Church's defense of life encompasses the unborn and the care of women and their children during and after pregnancy. The Church's commitment to life is seen in its willingness to collaborate with others to alleviate the causes of the high infant mortality rate and to provide adequate health care to mothers and their children before and after birth.

The Church has the deepest respect for the family, for the marriage covenant, and for the love that binds a married couple together. This includes respect for the marriage act by which husband and wife express their love and cooperate with God in the creation of a new human being. The Second Vatican Council affirms:

> This love is an eminently human one. . . . It involves the good of the whole person. . . . The actions within marriage by which the couple are united intimately and chastely are noble and worthy ones. Expressed in a manner which is truly human, these actions signify and promote that mutual self-giving by which spouses enrich each other with a joyful and a thankful will.[21]
>
> Marriage and conjugal love are by their nature ordained toward the begetting and educating of children. Children are really the supreme gift of marriage and contribute very substantially to the welfare of their parents. . . . Parents should regard as their proper mission the task of transmitting human life and educating those to whom it has been transmitted. . . . They are thereby cooperators with the love of God the Creator, and are, so to speak, the interpreters of that love.[22]

For legitimate reasons of responsible parenthood, married couples may limit the number of their children by natural means. The Church cannot approve contraceptive interventions that "either in anticipation of the marital act, or in its accomplishment or in the development of its natural consequences, have the purpose, whether as an end or a means, to render procreation impossible."[23] Such interventions violate "the inseparable connection, willed by God . . . between the two meanings of the conjugal act: the unitive and procreative meaning."[24]

With the advance of the biological and medical sciences, society has at its disposal new

technologies for responding to the problem of infertility. While we rejoice in the potential for good inherent in many of these technologies, we cannot assume that what is technically possible is always morally right. Reproductive technologies that substitute for the marriage act are not consistent with human dignity. Just as the marriage act is joined naturally to procreation, so procreation is joined naturally to the marriage act. As Pope John XXIII observed:

> The transmission of human life is entrusted by nature to a personal and conscious act and as such is subject to all the holy laws of God: the immutable and inviolable laws which must be recognized and observed. For this reason, one cannot use means and follow methods which could be licit in the transmission of the life of plants and animals.[25]

Because the moral law is rooted in the whole of human nature, human persons, through intelligent reflection on their own spiritual destiny, can discover and cooperate in the plan of the Creator.[26]

Directives

38. When the marital act of sexual intercourse is not able to attain its procreative purpose, assistance that does not separate the unitive and procreative ends of the act, and does not substitute for the marital act itself, may be used to help married couples conceive.[27]

39. Those techniques of assisted conception that respect the unitive and procreative meanings of sexual intercourse and do not involve the destruction of human embryos, or their deliberate generation in such numbers that it is clearly envisaged that all cannot implant and some are simply being used to maximize the chances of others implanting, may be used as therapies for infertility.

40. Heterologous fertilization (that is, any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouses) is prohibited because it is contrary to the covenant of marriage, the unity of the spouses, and the dignity proper to parents and the child.[28]

41. Homologous artificial fertilization (that is, any technique used to achieve conception using the gametes of the two spouses joined in marriage) is prohibited when it separates procreation from the marital act in its unitive significance (e.g., any technique used to achieve extra-corporeal conception).[29]

42. Because of the dignity of the child and of marriage, and because of the uniqueness of the mother-child relationship, participation in contracts or arrangements for surrogate motherhood is not permitted. Moreover, the commercialization of such surrogacy denigrates the dignity of women, especially the poor.[30]

43. A Catholic health care institution that provides treatment for infertility should

offer not only technical assistance to infertile couples but also should help couples pursue other solutions (e.g., counseling, adoption).

44. A Catholic health care institution should provide prenatal, obstetric, and postnatal services for mothers and their children in a manner consonant with its mission.

45. Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.

46. Catholic health care providers should be ready to offer compassionate physical, psychological, moral, and spiritual care to those persons who have suffered from the trauma of abortion.

47. Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.

48. In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.[31]

49. For a proportionate reason, labor may be induced after the fetus is viable.

50. Prenatal diagnosis is permitted when the procedure does not threaten the life or physical integrity of the unborn child or the mother and does not subject them to disproportionate risks; when the diagnosis can provide information to guide preventative care for the mother or pre- or postnatal care for the child; and when the parents, or at least the mother, give free and informed consent. Prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect.[32]

51. Nontherapeutic experiments on a living embryo or fetus are not permitted, even with the consent of the parents. Therapeutic experiments are permitted for a proportionate reason with the free and informed consent of the parents or, if the father cannot be contacted, at least of the mother. Medical research that will not harm the life or physical integrity of an unborn child is permitted with parental consent.[33]

52. Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them,

instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning.

53. Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.[34]

54. Genetic counseling may be provided in order to promote responsible parenthood and to prepare for the proper treatment and care of children with genetic defects, in accordance with Catholic moral teaching and the intrinsic rights and obligations of married couples regarding the transmission of life.

PART FIVE

Issues in Care for the Dying

Introduction

Christ's redemption and saving grace embrace the whole person, especially in his or her illness, suffering, and death.[35] The Catholic health care ministry faces the reality of death with the confidence of faith. In the face of death—for many, a time when hope seems lost—the Church witnesses to her belief that God has created each person for eternal life.[36]

Above all, as a witness to its faith, a Catholic health care institution will be a community of respect, love, and support to patients or residents and their families as they face the reality of death. What is hardest to face is the process of dying itself, especially the dependency, the helplessness, and the pain that so often accompany terminal illness. One of the primary purposes of medicine in caring for the dying is the relief of pain and the suffering caused by it. Effective management of pain in all its forms is critical in the appropriate care of the dying.

The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life. We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options.

The task of medicine is to care even when it cannot cure. Physicians and their patients must evaluate the use of the technology at their disposal. Reflection on the innate dignity of human life in all its dimensions and on the purpose of medical care is indispensable for formulating a true moral judgment about the use of technology to maintain life. The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering, and death. Only in this way are two extremes avoided: on the one hand, an insistence on

useless or burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death.[37]

Some state Catholic conferences, individual bishops, and the USCCB Committee on Pro-Life Activities (formerly an NCCB committee) have addressed the moral issues concerning medically assisted hydration and nutrition. The bishops are guided by the Church's teaching forbidding euthanasia, which is "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."[38] These statements agree that hydration and nutrition are not morally obligatory either when they bring no comfort to a person who is imminently dying or when they cannot be assimilated by a person's body. The USCCB Committee on Pro-Life Activities' report, in addition, points out the necessary distinctions between questions already resolved by the magisterium and those requiring further reflection, as, for example, the morality of withdrawing medically assisted hydration and nutrition from a person who is in the condition that is recognized by physicians as the "persistent vegetative state" (PVS).[39]

Directives

55. Catholic health care institutions offering care to persons in danger of death from illness, accident, advanced age, or similar condition should provide them with appropriate opportunities to prepare for death. Persons in danger of death should be provided with whatever information is necessary to help them understand their condition and have the opportunity to discuss their condition with their family members and care providers. They should also be offered the appropriate medical information that would make it possible to address the morally legitimate choices available to them. They should be provided the spiritual support as well as the opportunity to receive the sacraments in order to prepare well for death.

56. A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.[40]

57. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.[41]

58. There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient.

59. The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected

and normally complied with, unless it is contrary to Catholic moral teaching.

60. Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.[42]

61. Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.

62. The determination of death should be made by the physician or competent medical authority in accordance with responsible and commonly accepted scientific criteria.

63. Catholic health care institutions should encourage and provide the means whereby those who wish to do so may arrange for the donation of their organs and bodily tissue, for ethically legitimate purposes, so that they may be used for donation and research after death.

64. Such organs should not be removed until it has been medically determined that the patient has died. In order to prevent any conflict of interest, the physician who determines death should not be a member of the transplant team.

65. use of tissue or organs from an infant may be permitted after death has been determined and with the informed consent of the parents or guardians.

66. Catholic health care institutions should not make use of human tissue obtained by direct abortions even for research and therapeutic purposes.[43]

PART SIX

Forming New Partnerships with Health Care Organizations and Providers

Introduction

Until recently, most health care providers enjoyed a degree of independence from one another. In ever-increasing ways, Catholic health care providers have become involved with other health care organizations and providers. For instance, many Catholic health

care systems and institutions share in the joint purchase of technology and services with other local facilities or physicians' groups. Another phenomenon is the growing number of Catholic health care systems and institutions joining or co-sponsoring integrated delivery networks or managed care organizations in order to contract with insurers and other health care payers. In some instances, Catholic health care systems sponsor a health care plan or health maintenance organization. In many dioceses, new partnerships will result in a decrease in the number of health care providers, at times leaving the Catholic institution as the sole provider of health care services. At whatever level, new partnerships forge a variety of interwoven relationships: between the various institutional partners, between health care providers and the community, between physicians and health care services, and between health care services and payers.

On the one hand, new partnerships can be viewed as opportunities for Catholic health care institutions and services to witness to their religious and ethical commitments and so influence the healing profession. For example, new partnerships can help to implement the Church's social teaching. New partnerships can be opportunities to realign the local delivery system in order to provide a continuum of health care to the community; they can witness to a responsible stewardship of limited health care resources; and they can be opportunities to provide to poor and vulnerable persons a more equitable access to basic care.

On the other hand, new partnerships can pose serious challenges to the viability of the identity of Catholic health care institutions and services, and their ability to implement these Directives in a consistent way, especially when partnerships are formed with those who do not share Catholic moral principles. The risk of scandal cannot be underestimated when partnerships are not built upon common values and moral principles. Partnership opportunities for some Catholic health care providers may even threaten the continued existence of other Catholic institutions and services, particularly when partnerships are driven by financial considerations alone. Because of the potential dangers involved in the new partnerships that are emerging, an increased collaboration among Catholic-sponsored health care institutions is essential and should be sought before other forms of partnerships.

The significant challenges that new partnerships may pose, however, do not necessarily preclude their possibility on moral grounds. The potential dangers require that new partnerships undergo systematic and objective moral analysis, which takes into account the various factors that often pressure institutions and services into new partnerships that can diminish the autonomy and ministry of the Catholic partner. The following directives are offered to assist institutionally based Catholic health care services in this process of analysis. To this end, the United States Conference of Catholic Bishops has established the Ad Hoc Committee on Health Care Issues and the Church as a resource for bishops and health care leaders.

This new edition of the *Ethical and Religious Directives* omits the appendix concerning cooperation, which was contained in the 1995 edition. Experience has shown that the brief articulation of the principles of cooperation that was presented there did not

sufficiently forestall certain possible misinterpretations and in practice gave rise to problems in concrete applications of the principles. Reliable theological experts should be consulted in interpreting and applying the principles governing cooperation, with the proviso that, as a rule, Catholic partners should avoid entering into partnerships that would involve them in cooperation with the wrongdoing of other providers.

Directives

67. Decisions that may lead to serious consequences for the identity or reputation of Catholic health care services, or entail the high risk of scandal, should be made in consultation with the diocesan bishop or his health care liaison.

68. Any partnership that will affect the mission or religious and ethical identity of Catholic health care institutional services must respect church teaching and discipline. Diocesan bishops and other church authorities should be involved as such partnerships are developed, and the diocesan bishop should give the appropriate authorization before they are completed. The diocesan bishop's approval is required for partnerships sponsored by institutions subject to his governing authority; for partnerships sponsored by religious institutes of pontifical right, his *nihil obstat* should be obtained.

69. If a Catholic health care organization is considering entering into an arrangement with another organization that may be involved in activities judged morally wrong by the Church, participation in such activities, must be limited to what is in accord with the moral principles governing cooperation.

70. Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide, and direct sterilization.[44]

71. The possibility of scandal must be considered when applying the principles governing cooperation.[45] Cooperation, which in all other respects is morally licit, may need to be refused because of the scandal that might be caused. Scandal can sometimes be avoided by an appropriate explanation of what is in fact being done at the health care facility under Catholic auspices. The diocesan bishop has final responsibility for assessing and addressing issues of scandal, considering not only the circumstances in his local diocese but also the regional and national implications of his decision.[46]

72. The Catholic partner in an arrangement has the responsibility periodically to assess whether the binding agreement is being observed and implemented in a way that is consistent with Catholic teaching.

Conclusion

Sickness speaks to us of our limitations and human frailty. It can take the form of infirmity resulting from the simple passing of years or injury from the exuberance of youthful energy. It can be temporary or chronic, debilitating, and even terminal. Yet the follower of Jesus faces illness and the consequences of the human condition aware that our Lord always shows compassion toward the infirm.

Jesus not only taught his disciples to be compassionate, but he also told them who should be the special object of their compassion. The parable of the feast with its humble guests was preceded by the instruction: "When you hold a banquet, invite the poor, the crippled, the lame, the blind" (Lk 14:13). These were people whom Jesus healed and loved.

Catholic health care is a response to the challenge of Jesus to go and do likewise. Catholic health care services rejoice in the challenge to be Christ's healing compassion in the world and see their ministry not only as an effort to restore and preserve health but also as a spiritual service and a sign of that final healing that will one day bring about the new creation that is the ultimate fruit of Jesus' ministry and God's love for us.

Notes

1. National Conference of Catholic Bishops, *Health and Health Care: A Pastoral Letter of the American Catholic Bishops* (Washington, D.C.: United States Catholic Conference, 1981).

2. Health care services under Catholic auspices are carried out in a variety of institutional settings (e.g., hospitals, clinics, out-patient facilities, urgent care centers, hospices, nursing homes, and parishes). Depending on the context, these Directives will employ the terms "institution" and/or "services" in order to encompass the variety of settings in which Catholic health care is provided.

3. *Health and Health Care*, p. 5.

4. Second Vatican Ecumenical Council, *Decree on the Apostolate of the Laity (Apostolicam Actuositatem)* (1965), no. 1.

5. Pope John Paul II, Post-Synodal Apostolic Exhortation, *On the Vocation and the Mission of the Lay Faithful in the Church and in the World (Christifideles Laici)* (Washington, D.C.: United States Catholic Conference, 1988), no. 29.

6. As examples, see Congregation for the Doctrine of the Faith, *Declaration on Procured Abortion* (1974); Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980); Congregation for the Doctrine of the Faith, *Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation: Replies to Certain Questions of the Day (Donum Vitae)* (Washington, D.C.: United States

Catholic Conference, 1987).

7. Pope John XXIII, Encyclical Letter, *Peace on Earth (Pacem in Terris)* (Washington, D.C.: United States Catholic Conference, 1963), no. 11; *Health and Health Care*, pp. 5, 17-18; *Catechism of the Catholic Church*, 2nd ed. (Washington, D.C.: United States Catholic Conference, 2000), no. 2211.

8. Pope John Paul II, *On Social Concern, Encyclical Letter on the Occasion of the Twentieth Anniversary of "Populorum Progressio" (Sollicitudo Rei Socialis)* (Washington, D.C.: United States Catholic Conference, 1988), no. 43.

9. National Conference of Catholic Bishops, *Economic Justice for All: Pastoral Letter on Catholic Social Teaching and the U.S. Economy* (Washington, D.C.: United States Catholic Conference, 1986), no. 80.

10. The duty of responsible stewardship demands responsible collaboration. But in collaborative efforts, Catholic institutionally based health care services must be attentive to occasions when the policies and practices of other institutions are not compatible with the Church's authoritative moral teaching. At such times, Catholic health care institutions should determine whether or to what degree collaboration would be morally permissible. To make that judgment, the governing boards of Catholic institutions should adhere to the moral principles on cooperation. See Part Six.

11. *Health and Health Care*, p. 12.

12. Cf. *Code of Canon Law*, cc. 921-923.

13. Cf. ibid., c. 867, § 2, and c. 871.

14. To confer Baptism in an emergency, one must have the proper intention (to do what the Church intends by Baptism) and pour water on the head of the person to be baptized, meanwhile pronouncing the words: "I baptize you in the name of the Father, and of the Son, and of the Holy Spirit."

15. Cf. c. 883, 3 .

16. For example, while the donation of a kidney represents loss of biological integrity, such a donation does not compromise functional integrity since human beings are capable of functioning with only one kidney.

17. Cf. directive 53.

18. *Declaration on Euthanasia*, Part IV; cf. also directives 56-57.

19. It is recommended that a sexually assaulted woman be advised of the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures; cf. Pennsylvania Catholic Conference, "Guidelines for Catholic Hospitals Treating

Victims of Sexual Assault," *Origins* 22 (1993): 810.

20. Pope John Paul II, "Address of October 29, 1983, to the 35th General Assembly of the World Medical Association," *Acta Apostolicae Sedis* 76 (1984): 390.

21. Second Vatican Ecumenical Council, "Pastoral Constitution on the Church in the Modern World" (*Gaudium et Spes*) (1965), no. 49.

22. Ibid., no. 50.

23. Pope Paul VI, Encyclical Letter, *On the Regulation of Birth (Humanae Vitae)* (Washington, D.C.: United States Catholic Conference, 1968), no. 14.

24. Ibid., no. 12.

25. Pope John XXIII, Encyclical Letter, *Mater et Magistra* (1961), no. 193, quoted in Congregation for the Doctrine of the Faith, *Donum Vitae*, no. 4.

26. Pope John Paul II, Encyclical Letter, *The Splendor of Truth (Veritatis Splendor)* (Washington, D.C.: United States Catholic Conference, 1993), no. 50.

27. "Homologous artificial insemination within marriage cannot be admitted except for those cases in which the technical means is not a substitute for the conjugal act but serves to facilitate and to help so that the act attains its natural purpose" (*Donum Vitae*, Part II, B, no. 6; cf. also Part I, nos. 1, 6).

28. Ibid., Part II, A, no. 2.

29. "Artificial insemination as a substitute for the conjugal act is prohibited by reason of the voluntarily achieved dissociation of the two meanings of the conjugal act. Masturbation, through which the sperm is normally obtained, is another sign of this dissociation: even when it is done for the purpose of procreation, the act remains deprived of its unitive meaning: 'It lacks the sexual relationship called for by the moral order, namely, the relationship which realizes "the full sense of mutual self-giving and human procreation in the context of true love"'" (*Donum Vitae*, Part II, B, no. 6).

30. Ibid., Part II, A, no. 3.

31. Cf. directive 45.

32. *Donum Vitae*, Part I, no. 2.

33. Cf. ibid., no. 4.

34. Cf. Congregation for the Doctrine of the Faith, "Responses on Uterine Isolation and Related Matters," July 31, 1993, *Origins* 24 (1994): 211-212.

35. Pope John Paul II, Apostolic Letter, *On the Christian Meaning of Human Suffering (Salvifici Doloris)* (Washington, D.C.: United States Catholic Conference, 1984), nos. 25-27.

36. National Conference of Catholic Bishops, *Order of Christian Funerals* (Collegeville, Minn.: The Liturgical Press, 1989), no. 1.

37. *Declaration on Euthanasia*.

38. Ibid., Part II, p. 4.

39. Committee for Pro-Life Activities, National Conference of Catholic Bishops, *Nutrition and Hydration: Moral and Pastoral Reflections* (Washington, D.C.: United States Catholic Conference, 1992). On the importance of consulting authoritative teaching in the formation of conscience and in taking moral decisions, see *Veritatis Splendor*, nos. 63-64.

40. *Declaration on Euthanasia*, Part IV.

41. Ibid.

42. Cf. ibid.

43. *Donum Vitae*, Part I, no. 4.

44. While there are many acts of varying moral gravity that can be identified as intrinsically evil, in the context of contemporary health care the most pressing concerns are currently abortion, euthanasia, assisted suicide, and direct sterilization. See Pope John Paul II's *Ad Limina* Address to the bishops of Texas, Oklahoma, and Arkansas (Region X), in *Origins* 28 (1998): 283. See also "Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals" (*Quaecumque Sterilizatio*), March 13, 1975, *Origins* 10 (1976): 33-35: "Any cooperation institutionally approved or tolerated in actions which are in themselves, that is, by their nature and condition, directed to a contraceptive end . . . is absolutely forbidden. For the official approbation of direct sterilization and, a *fortiori*, its management and execution in accord with hospital regulations, is a matter which, in the objective order, is by its very nature (or intrinsically) evil." This directive supersedes the "Commentary on the Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals" published by the National Conference of Catholic Bishops on September 15, 1977 in *Origins* 11 (1977): 399-400.

45. See *Catechism of the Catholic Church*: "Scandal is an attitude or behavior which leads another to do evil" (no. 2284); "Anyone who uses the power at his disposal in such a way that it leads others to do wrong becomes guilty of scandal and responsible for the evil that he has directly or indirectly encouraged" (no. 2287).

46. See "The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry,"

Origins 26 (1997): 703.

APPENDIX F
Principles of Medical Ethics

The American Medical Association

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following standards of conduct which define the essentials of honorable behavior for the physician.

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity;

2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception;

3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient;

4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law;

5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated;

6. A physician shall, in the provision of appropriate care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services;

7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

The American Dental Association

The practice of dentistry first achieved the stature of a profession in the United States where, through the heritage bestowed by the efforts of many generations of dentists, it acquired the three unfailing characteristics of a profession: education beyond the usual level, the primary duty of service to the public and the right of self-government.

The maintenance and enrichment of this heritage of professional status place on everyone who practices dentistry an obligation which should be willingly accepted and willingly fulfilled. This obligation cannot be reduced to a changeless series of urgings and prohibitions for, while the basic obligation is constant, its fulfillment may vary with the changing needs of a society composed of the human beings that a profession is dedicated to serve. The spirit and not the letter of the obligation, therefore, must be the guide of conduct for the professional man. In its essence, this obligation has been summarized for all time and for all men in the golden rule which asks only that "whatsoever ye would that men should do to you, do ye even so to them."

The following statements constitute the Principles of Ethics of the American Dental Association. The constituent and component societies are urged to adopt additional provisions or interpretations not in conflict with these Principles of Ethics which would enable them to serve more faithfully the traditions, customs and desires of the members of these societies.

Section 1: Education Beyond the Usual Level

The right of a dentist to professional status rests in the knowledge, skill and experience with which he serves his patients and society. Every dentist has the obligation of keeping his knowledge and skill freshened by continuing education through all of his professional life.

Section 2: Service to the Public

The dentist's primary duty of serving the public is discharged by giving the highest type of service of which he is capable and by avoiding any conduct which leads to a lowering of esteem of the profession of which he is a member. In serving the public, a dentist may exercise reasonable discretion in selecting patients for his practice. However, a dentist may not refuse to accept a patient into his practice or deny dental service to a patient solely because of the patient's race, creed, color or national origin.

Section 3: Government of a Profession

Every profession receives from society the right to regulate itself, to determine and judge its own members. Such regulation is achieved largely through the influence of the professional societies, and every dentist has the dual obligation of making himself a part of a professional society and of observing its rules and ethics.

Section 4: Leadership

The dentist has the obligation of providing freely of his skills, knowledge and experience to society in those fields in which his qualifications entitle him to speak with professional competence. The dentist should be a leader in his community, including all efforts leading to the improvement of the dental health of the public.

Section 5: Emergency Services

The dentist has an obligation when consulted in an emergency by the patient of another dentist to attend to the conditions leading to the emergency and to refer the patient to his regular dentist who should be informed of the conditions found and treated.

Section 6: Use of Auxiliary Personnel

The dentist has an obligation to protect the health of his patient by not delegating to a person less qualified any service or operation which requires the professional competence of a dentist. The dentist has a further obligation of prescribing and supervising the work of all auxiliary personnel in the interests of rendering the best service to the patient.

Section 7: Consultation

The dentist has the obligation of seeking consultation whenever the welfare of the patient will be safeguarded or advanced by having recourse to those who have special skills, knowledge and experience. A consultant will hold the details of a consultation in confidence and will not undertake treatment without the consent of the attending practitioner.

Section 8: Unjust Criticism and Expert Testimony

The dentist has the obligation of not referring disparagingly, orally or in writing, to the services of another dentist to a member of the public. A lack of knowledge of conditions under which the services were afforded may lead to unjust criticism and to a lessening of the public's confidence in the dental profession. If there is indisputable evidence of faulty treatment, the welfare of the patient demands that corrective treatment be instituted at once and in such a way as to avoid reflection on the previous dentist or on the dental profession. The dentist also has the obligation of cooperating with appropriate public officials on request by providing expert testimony.

Section 9: Rebates and Split Fees

The dentist may not accept or tender "rebates" or "split fees".

Section 10: Secret Agents and Exclusive Methods

The dentist has an obligation not to prescribe, dispense or promote the use of drugs or other agents whose complete formulae are not available to the dental profession. He also has the obligation not to prescribe or dispense, except for limited investigative purposes, any therapeutic agent the value of which is not supported by scientific evidence. The dentist has the further obligation of not holding out as exclusive, any agent, method or technique.

Section 11: Patents and Copyrights

The dentist has the obligation of making the fruits of his discoveries and labors available to all when they are useful in safeguarding or promoting the health of the public. Patents and copyrights may be secured by a dentist provided that they and the remuneration derived from them are not used to restrict research, practice or the benefits of the patented or copyrighted material.

Section 12: Advertising

Advertising reflects adversely on the dentist who employs it and lowers the public esteem of the dental profession. The dentist has the obligation of advancing his reputation for fidelity, judgment and skill solely through his professional services to his patients and to society. The use of advertising in any form to solicit patients is inconsistent with this obligation.

Section 13: Cards, Letterheads and Announcements

A dentist may properly utilize professional cards, announcement cards, recall notices to patients of record and letterheads when the style and text are consistent with the dignity of the profession and with the custom of other dentists in the community. Announcement cards may be sent when there is a change in location or an alteration in the character of practice, but only to other dentists, to members of other health professions and to patients of record.

Section 14: Office Door Lettering and Signs

A dentist may properly utilize office door lettering and signs provided that their style and text are consistent with the dignity of the profession and with the custom of other dentists in the community.

Section 15: Use of Professional Titles and Degrees

A dentist may use the titles or degrees, Doctor, Dentist, D.D.S., or D.M.D., in connection with his name on cards, letterheads, office door signs and announcements. A dentist who also possesses a medical degree may use this degree in connection with his name on cards, letterheads, office door signs and announcements. A dentist who has been certified by a national certifying board for one of the specialties approve by the American Dental Association may use the title "diplomate" in connection with his specialty on his cards, letterheads and announcements if such usage is consistent with the custom of dentists in the community. A dentist may not use his title or degree in connection with the promotion of any commercial endeavor. The use of eponyms in connection with drugs, agents, instruments or appliances is generally to be discouraged.

Section 16: Health Education of the Public

A dentist may properly participate in a program of health education of the public involving such media as the press, radio, television and lecture, provided that such programs are in keeping with the dignity of the profession and the custom of the dental profession of the community.

Section 17: Contract Practice

A dentist may enter into an agreement with individuals and organizations to provide dental health care provided that the agreement does not permit or compel practices which are in violation of these Principles of Ethics.

Section 18: Announcement or Limitation of Practice

Only a dentist who limits his practice exclusively to one of the special areas approved by the American Dental Association for limited practice may include a statement of his limitation in announcements, cards, letterheads and directory listings (consistent with the custom of dentists of the community), provided at the time of the announcement, he has met the existing educational requirements and standards set by the American Dental Association for members wishing to announce limitation of practice. In accord with the established ethical ruling that dentists should not claim or imply superiority, use of the phrases "Specialist in..." or "Specialist on..." in announcements, cards, letterheads or directory listings should be discouraged. The use of the phrase "Practice limited to..." is preferable. A dentist who use his eligibility to announce himself as a specialist to make the public believe that specialty services rendered in his dental office are being rendered by ethically qualified specialists when such is not the case, is engaged in unethical conduct. The burden is on the specialist to avoid any inference that general practitioners who are associated with him are ethically qualified to announce themselves as specialists.

Section 19: Directories

A dentist may permit the listing of his name in a directory provided that all dentists in similar circumstances have access to a similar listing and provided that such listing is consistent in style and text with the custom of the dentists in the community.

Section 20: Name of Practice

A dentist may practice in a partnership, or as a solo practitioner, professional corporation or professional association. The use of practice names other than the names of participating dentists is unethical, except that corporate designations may be used if required by state law. Designations such as "Professional Corporation", "Inc.", "Group", "Clinic", or similar designations, may not be used as a part of the name of a practice on cards, letterheads, signs, directories and announcements, unless required by state law. **Note:** The following policy was approved by the 1970 House of Delegates:

Resolved, that dentists using assumed names for their dental practices prior to June 1, 1970 be allowed to continue to use ethically such assumed names until not later than January 1, 1972.

Section 21: Judicial Procedure

Problems involving questions of ethics should be solved at the local level within the broad boundaries established in these Principles of Ethics and within the interpretation of the code of ethics of the component society. If a satisfactory decision cannot be reached, the question should be referred, on appeal, to the constituent society and the Judicial Council of the American Dental Association, as provided in Chapter XI of the Bylaws of the American Dental Association.

APPENDIX G
Approved Medical Abbreviations and Symbols

The St. Mary's Medical Staff have approved for use the abbreviations and symbols contained in the text: Common Medical Abbreviations, L.R. DeSousa, Delmar Publishers, 1995. This text and any additional approved abbreviations and/or symbols which may be appended will be available on all patient care units and in Medical Records.

APPENDIX H
Policy on Etiquette for the Attending and Consulting Physician

1. A single physician should be in overall charge of the medical care of each patient. This is true even for patients with multiple consultants, such as the cardiac patient with musculoskeletal trauma; overall responsibility for total patient management is more safely lodged with one individual than with a committee.

2. A patient should not be admitted to the service of any physician unless that physician, or his/her designate, has first agreed to accept the patient.

3. Transfer of a patient from one physician to another should be mutually agreed upon by both physicians and the patient, and this transfer should be appropriately documented on the written orders. This should be made especially clear when the patient goes to the operating room.

4. The attending physician should indicate to the consultant if he wishes the consultant to render his/her opinion only, or to assume management of a specific problem, or if he/she wishes the consultant to accept the patient in transfer. Unless the order sheet indicates transfer of the patient, nursing service should continue to refer management questions to the attending physician, unless that physician deems otherwise. As much as is possible, the request for consultation should be directly between physicians. After completing the consultation the consultant should directly contact the attending physician with the proper information. If this is not possible, he/she should leave a short note on the chart aside from any dictation.

5. Consultants Recommended by Consultants. A consultant who wishes to have additional consultation on a patient should discuss the choice of the additional consultant with the attending physician.

6. The patient who wishes to change physicians should notify the original physician that his/her services are no longer desired. The patient bears the responsibility for terminating his/her relationship with the first physician. In a case where the patient is unable to express himself/herself to the primary physician, there is nothing wrong with the second physician speaking in behalf of the patient to the first physician.

7. If the patient wishes a second opinion or consultation during a hospitalization, the patient has that right. The choice of the consultant should be mutually agreed upon by the attending physician and the patient.

8. Notification of a patient's primary care physician in case of admission of that patient by another physician should be made. This is not necessarily to be equated with a request for consultation. The primary care physician should receive a copy of the discharge summary. This should apply regardless of the primary care physician's staff status.

9 When a patient visiting the Emergency Services identifies a physician as his/her primary care physician, that physician should be sent a copy of the record regardless of the primary care physician's staff status.

10 When a consulting physician is needed for a patient, it is usually in the patient's best interest to request the patient's previous consultant unless there is a specific reason not to call that consultant.

11 When a primary care physician wishes that his/her patient be seen in the Emergency Department by another physician and that he/she be admitted to the hospital by that physician, the primary care physician should personally contact that designated physician.

12 The Emergency Department physician should not be responsible for the transfer of a patient's care from one physician to another. That arrangement should be made directly between the two other physicians.

APPENDIX I
Indications and Instructions for Autopsies

1. Indications

1.1 Autopsies may be performed on properly admitted patients and those patients actively being followed by a St. Mary's Staff Physician. Indications for autopsies include the following:

1.1.1 to investigate the cause of death;

1.1.2 to verify a clinical diagnosis;

1.1.3 to follow-up on a biopsy;

1.1.4 to isolate etiologic agents in nosocomial and opportunistic infections;

1.1.5 to evaluate treatment, surgical complications and possible iatrogenic pathology; and

1.1.6 a medical examiner case where death is suspected of resulting from:

1.1.6.1 violence of any kind;

1.1.6.2 any cause where death occurs suddenly while the person is in apparent good health;

1.1.6.3 any cause when there is no attending physician capable of certifying the death as due to natural causes;

1.1.6.4 poisoning, either chronic or acute;

1.1.6.5 disease, injury or a toxic agent related to employment;

1.1.6.6 diagnostic or therapeutic procedures under circumstances indicating gross negligence or unforeseen clearly traumatic causes;

1.1.6.7 any cause while the person is in custody or confinement, unless clearly certifiable by an attending physician as due to natural causes;

1.1.6.8 disease or pathological process constituting a threat to public health;

1.1.6.9 any cause when the death is not known to have been properly certified, including, but not limited to, any body brought into the State without proper certification, and any buried remains uncovered other than under an exhumation order;

1.1.6.10 in the case of a child under the age of 3 years, any cause including sudden infant death syndrome, unless the death is clearly due to a specific natural cause; or

1.1.6.11 any cause when a body already certified, but not yet buried or cremated, is suspected of having been improperly certified as to the cause or manner of death.

2. Instructions for Physicians

2.1 Informing Relatives Regarding an Autopsy. When interviewing relatives regarding autopsies, the physician should assure that the responsible relative understands its meaning and gives consent. The physician should adhere to the following guidelines:

2.1.1 Before requesting an authorization for an autopsy from the next of kin the physician should know or find out if the case is a medical examiner's case (see 1.1.6 through 1.1.6.11 above). If so, no permit from the next of kin is necessary.

2.1.2 If the case is not a medical examiner's case, the physician should explain clearly to the relatives that an autopsy includes opening the head and examining the brain.

2.1.2.1 If only a limited autopsy is desired, be sure to specify the organs to be examined.

2.2 Documenting Consent to Perform an Autopsy. Except in medical examiner cases, where consent is not necessary, the physician should obtain a witnessed consent from the next of kin. Authority of the next of kin include in the following order:

2.2.1 Spouse;

2.2.2 Adult Children (Age 18 or over);

2.2.3 Father or Mother;

2.2.4 Adult Grandchildren;

2.2.5 Adult brothers and sisters;

2.2.6 Adult nephew or niece; or

2.2.7 Person claiming the body.

2.3 Phone Permission. A phone permission witnessed by the operator is acceptable if next of kin is out of town. The permit should state clearly if the autopsy is to be complete or limited.

2.4 Ordering an Autopsy. The physician should write an order for an autopsy. The chart of the deceased and the permit should accompany the body to the morgue.

2.4.1 For all autopsies on patients who have not been admitted, the attending physician should contact the Pathologist "on call". This also includes patients who expire in the Emergency Department.

3. Instructions for Nursing Personnel

3.1 Notify Pathology. Upon receipt of the physician's order for an autopsy, notify pathology that an autopsy has been requested.

3.2 Chart and Permit Required. The patient's chart and signed permit should be brought to the morgue with the body.

3.3 Contact Lab Personnel. Obtain laboratory personnel to sign body into morgue.

3.4 Transport Body. Transport the body from the stretcher to the autopsy table.

3.5 Notify Pathology. Notify pathology after the above tasks have been completed.

4. Instructions for Laboratory Personnel

4.1 Notify Pathology. Laboratory personnel will notify pathologist "on call" when notified of pending autopsy and also at the time the body has been transported to the morgue.

4.2 Removal from Morgue. The pathologist will notify lab personnel when body may be removed from the morgue.

4.3 Notifying Admitting. Laboratory personnel will notify the Admitting Office when the body may be removed from the morgue.

5. Medical Examiner Cases

5.1 Definition. All deaths ultimately ascribable to trauma or poisoning are medical examiner cases regardless of how long the patient has been under medical care and regardless of whether terminal conditions, immediately causing death, are natural disease processes so long as they may have followed from the initial injury or poisoning. Conversely, a natural death, that an attending physician can reasonably certify, does not become a medical examiner case simply because the physician has cared for the patient for only a short time or because the physician has not seen the patient shortly before death. See also indicators for Medical Examiner cases above (1.1.6 through 1.1.6.11).

5.2 Attendance By Physician. A medical examiner case exists whether or not the deceased had been attended by a physician or was a patient in a

hospital for any time immediately preceding death and regardless of the time between the cause and the death.

5.3 Transplant Operations. No operation for the transplant of an organ or a portion thereof shall take place, when the donor's death occurs under circumstances indicating a medical examiner case, with the approval of a medical examiner. Any doctor performing a transplant operation where the donor has died under these circumstances shall note the condition of the vital organs in the region of surgery and shall include this notation in a written report of the operation and manner in which death was pronounced, the report to be given to the medical examiner upon his request. The Medical Examiner may choose to be present during the removal of the donated organ.

5.4 Immediate Reporting. A medical examiner case must be reported at once. Cases are reported by calling the Office of the Chief Medical Examiner, 1-800-452-8744, any day, any time.

APPENDIX J
Complaint Resolution Process

Definitions:

Complaint Resolution Process means a process for addressing documented allegations or concerns regarding a practitioner's clinical performance, conduct or health which upon initial identification fails to meet the criteria for *formal review*[8]. Complaint resolution may avoid *formal review*[8] or serve as a preliminary review activity of the Executive Committee to determine if further review or action is warranted.

Practitioner means any member of the medical staff.

Policy:

The medical staff shall have a fair and timely complaint resolution process for responding to documented allegations or concerns regarding a practitioner's competency, conduct, or health. The circumstances of these allegations or concerns will initially be addressed by the Chief Medical Officer. The Chief Medical Officer shall document his/her findings and recommendations for the Executive Committee. The Executive Committee shall review and dispose of the allegations or concerns, and approve any documentation that may be entered into the practitioner's credential file in regard to the allegations/concerns.

Procedure:

1. Individuals who have a concern regarding a practitioner's competency, conduct, or health, should immediately report their concerns in writing to the Chief Medical Officer. Only written and signed concerns will be acted upon. The person who files the concern should understand that their identity will be revealed to the practitioner during the complaint resolution process. The practitioner should understand that retaliation against the person filing the concern will be grounds for additional complaint resolution or *formal review*[8].

2. The Chief Medical Officer will determine whether the allegations or concerns should be managed through the complaint resolution process.

3. If the Chief Medical Officer determines that the complaint resolution process should be initiated, he/she will determine the course of action and who should be

involved in the process. The practitioner will be informed of the reported concern by the Chief Medical Officer (or his/her designee) in as timely a manner as the situation requires. The Chief Medical Officer (or his/her designee) will forward a copy of the written concern to the practitioner prior to the Complaint Resolution meeting.[2]

4. The Chief Medical Officer, the practitioner and any other participants as determined by the Chief Medical Officer, will meet to initiate the complaint resolution process. The practitioner will be given five (5) working days notice, or less notice if mutually agreed upon by the Practitioner and Chief Medical Officer, to prepare for the Complaint Resolution Process with the option of waiving the Complaint Resolution Process in favor of the *Formal Review*[8] process. This meeting, and any subsequent meetings that may be required in the discretion of the Chief Medical Officer and/or practitioner to reach a resolution, will be documented and forwarded to the Executive Committee (see attached form).

5. The practitioner involved will be informed of the findings and recommendations of the Chief Medical Officer and may rebut or comment in writing to the Executive Committee.

6. The Chief Medical Officer's documentation of the circumstances and recommendations will be reviewed by the Executive Committee during the Executive Session of its next meeting following the conclusion of the complaint resolution process.

7. The Executive Committee shall approve or reject the Chief Medical Officer's recommendations regarding each allegation or concern addressed through the complaint resolution process. If approved, the disposition and documentation of the allegation or concern will be considered satisfactory and final. If rejected, the Executive Committee shall notify the practitioner of its rationale for rejecting the Chief Medical Officer's recommendations and its alternative recommendations or actions.

8. In all cases, the Executive Committee shall approve the documentation to be included in the practitioner's credential file pertaining to the concern. All documentation of cases found to be unsubstantiated shall not be included in the practitioner's credential file and shall be destroyed.

ST. MARY'S REGIONAL MEDICAL CENTER
Complaint Resolution Process Form

Practitioner ID #:_____ Date Allegation/Concern was identified:

Date Chief Medical Officer was notified:

Date CRP Meeting was held:

Participants:

Summary of Meeting:

Finding:
- Concern/Allegation Substantiated
- Lack of Evidence to either Support or Reject the Concern/Allegation
- Concern/Allegation Unsubstantiated

Recommendation:

_____

Chief Medical Officer Date

Executive Committee Review

The Executive Committee reviewed this CRP issue on _____ and:

- Approved the resolution of this concern/allegation
- Rejected the resolution of this concern/allegation (Document reason below)

Comments:

Appendix K
Conflict Management

1. In the event of a conflict between members of the Active Staff and the Medical Executive Committee regarding the adoption of any bylaw, rule, regulation or policy, or any amendment thereto, or with regard to any other matter, upon a petition signed by Twenty Five Percent (25%) of the members of the Active Staff entitled to vote, the matter shall be submitted to the following conflict resolution process.
2. A Conflict Resolution Committee shall be formed consisting of up to Five (5) representatives of the Active Staff designated by the Active Staff members submitting the petition and an equal number of representatives of the Medical Executive Committee appointed by the Chief Medical Officer.
3. The members of the Conflict Resolution Committee shall gather information regarding the conflict, meet to discuss the disputed matter, and work in good faith to resolve the differences between the parties in a manner consistent with protecting safety and quality.
4. Any recommendation which is approved by a majority of the Active Staff representatives and a majority of the Medical Executive Committee representatives shall be submitted to the Board of Directors for consideration and subject to final approval by the Board. If agreement cannot be reached by a majority of the Active Staff representatives and a majority of the Medical Executive Committee representatives, the members of the Conflict Resolution Committee shall individually or collectively report to the Board of Directors regarding the unresolved differences for consideration by the Board of Directors in making its final decisions regarding the matter in dispute.
5. In the event of a dispute between leaders or segments of the Medical Staff, the matter in dispute shall be submitted to a Conflict Resolution Committee composed of an equal number of members representing opposing viewpoints who are appointed by the Chief Medical Officer. The members of the Conflict Resolution Committee shall proceed in accordance with Sections 3 and 4 above.
6. In the event of a dispute between the Board of Directors and the Medical Staff or the Medical Executive Committee, the matter in dispute shall be submitted to a Joint Conference Committee pursuant to Section 12.3 of the Medical Staff Bylaws.

7. If deemed appropriate by the Chief Medical Officer and the Medical Center Chief Executive Officer, an outside mediator or facilitator may be engaged to assist with the resolution of any disputed issue.

APPENDIX L
Focused Professional Practice Evaluation

DEPARTMENT:		**Medical Staff**	**POLICY #:**
POLICY:	**Medical Staff FPPE Policy**	**EFFECTIVE:**	**REVISED**
DEVELOPED BY:_____			
AUTHORIZATION:_____			

I. **POLICY:** MEDICAL STAFF FOCUSED PROFESSIONAL PRACTICE EVALUATION FOR INITIAL APPOINTEES TO THE MEDICAL STAFF AND FOR MEMBERS OBTAINING ADDITIONAL CLINICAL PRIVILEGES

The Medical Staff, in carrying out its responsibility to determine the competency of its members to provide high quality safe patient care establishes the following Focused Professional Practice Evaluation ("FPPE") policy. FPPE shall apply to all initial appointees to the Medical Staff and to all Medical Staff members obtaining additional clinical privileges. FPPE shall be conducted as soon as adequate information is available to support the process, but no later than six months after granting initial membership or new privileges.

II. **PURPOSE:** To provide a mechanism to confirm the privilege-specific clinical competence of initial appointees and members obtaining additional clinical privileges by monitoring, evaluating, documenting, and reporting their performance. FPPE shall also apply whenever questions arise regarding a practitioner's professional practice during the course of Ongoing Professional Practice Evaluation. FPPE is not considered formal review under the Bylaws, Rules and Regulations of the Medical Staff (the "Bylaws"). If, however, FPPE results in a recommendation to restrict or revoke a specific clinical privilege, the formal review process as set forth in the Bylaws shall apply.

III. **PROCEDURE:**

1. FPPE will be managed by the most appropriate person (i.e., clinical director, department and/or service chief, etc).

2. The maximum length of time for completion of FPPE is six months.

3. Data and information used to support FPPE may include data available from Ongoing Professional Practice Evaluation, variation reports, concurrent and retrospective care management review, resource utilization, 360 coworker review, and all other generally accepted data and information.

4. FPPE information may be obtained through, but not limited to: concurrent or targeted medical record review; direct observation; monitoring/ proctoring/mentoring; discussion

with other providers involved in the care of specific patients; data collected and assessed for the organization's quality improvement indicators; sentinel event data; and any other applicable peer review data.

5. During FPPE, the practitioner may be assigned a mentor (physician, allied health provider, clinical director, etc.) by the Department and/or Service Chief.

6. The mentor will monitor the practitioner regarding the six areas of competence established by the Joint Commission: medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.

7. During FPPE practitioners may be observed with regard to technique, skill, patient interaction, interaction with staff, adherence to hospital policy and directives. In situations where procedures are not performed during the six month FPPE timeframe, Ongoing Professional Practice Evaluation of procedural skills will be monitored, as appropriate, and may result in referral for further FPPE.

8. As procedural skills are observed, the mentor will complete the FPPE evaluation and send it to the Medical Staff Office. If after one year the procedure not performed requires unique non overlapping skills with other procedures, the Department Chair will make a recommendation on continuing that privilege.

9. Practitioners requesting initial or additional privileges for reading images will have selective over reading of images for a period of 6 months or of a specified number of readings as determined by the Department and/or Service Chief.

10. Practitioners requesting initial or additional privileges that are unique, such that no other Medical Staff member can monitor competence, will have a mentoring plan created by the Department and/or Service Chief that is satisfactory to the Medical Executive Committee.

11. The Medical Staff Office will provide the mentor with a copy of the FPPE evaluation requesting written feedback regarding the affected practitioner.

12. At the end of the FPPE period, the Medical Staff Office will provide the department/service chief with the draft FPPE assessment, which will include the FPPE evaluations and any other information and feedback, as requested. The Chief's assessment will be forwarded to the Medical Staff Office for submission to the Medical Executive Committee and the applicant's Credentials file.

13. If affected practitioner fails to satisfactorily complete the formal FPPE review process, the Chief will submit a plan for completion to the Medical Staff Office for presentation to the Medical Executive Committee.

14. Applicants will be provided with a copy of the FPPE summary. Documentation from outside sources may be considered in lieu of the St. Mary's Regional Medical Center forms.

IV. **RESPONSIBILITIES:** All members of the Medical Staff are subject to this policy.

REFERENCES: The Joint Commission, MS 08.01.01, Focused Professional Practice Evaluation; The

FPPE Toolbox, Field-Tested Documents for Credentialing, Competency and Compliance.

ATTACHMENT(S): EXAMPLES of FPPE Evaluation form; FPPE Assessment form.

THE ATTACHED *FPPE ASSESSMENT* IS TO BE COMPLETED BY THE DEPARTMENT/SERVICE CHIEF AT THE END OF THE FIRST YEAR OF ALL NEW REQUESTS FOR PRIVILEGES. THIS INCLUDES NEW APPLICANTS TO THE HOSPITAL AS WELL AS CURRENT PROVIDERS REQUESTING NEW PRIVILEGES.

THE CHIEF SHALL CONSIDER THE *FPPE EVALUATIONS* PREVIOUSLY COMPLETED AS WELL AS ANY ADDITIONAL INFORMATION THEY DEEM APPROPRIATE (CHART REVIEW, QUALITY DATA FROM PRIMARY FACILITY, ETC.) WHEN COMPLETING THE *FPPE ASSESSMENT*.

THE MEDICAL STAFF OFFICE WILL COMPILE THE INFORMATION, AS APPLICABLE, ON PAGE 2 PRIOR TO THE CHIEF'S REVIEW.

COMPLETED *FPPE ASSESSMENTS* WILL BE PROCESSED THROUGH MEDICAL EXECUTIVE COMMITTEE, AND THE BOARD OF TRUSTEES.

Example Form

ST. MARY'S HEALTH SYSTEM

Focused Professional Practice Evaluation for assessment of medical st

19. Demonstrates sensitivity/responsiveness to patient/coworker's culture, age, gender, and disabilities		
20. Physical/mental ability to safely render care		
21. **Patient satisfaction**	☐ No comments on file ☐ Comments on file: Positive #_____ Negative #_____* ☐ Co ☐ Trends*	
22.	**Utilization management Assessment:**	Number of unanticipated transfers to acute care: ☐ Appropriate ☐ Trends* ☐ Referred for CME* ☐ Peer review* ☐ Imp
23.	**Blood usage Assessment:**	Transfusion of packed cells ordered: ☐ Appropriate ☐ Trends* ☐ Referred for CME* ☐ Peer review* ☐ Imp
24.	**Medication management**	☐ Appropriate ☐ Trends* ☐ Referred for CME* ☐ Peer review* ☐ Imp
25.	**Morbidity and mortality Assessment:**	☐ None requiring review Mortalities reviewed: Resuscitations reviewed: ☐ No adverse outcomes ☐ Medical management appropriate. No quality issues. Minor adverse outcomes: Major adverse outcomes: Care appropriate: Medical management controversial: Medical management inappropriat ☐ No action warranted ☐ System problems* ☐ Referred for CME* ☐ Improve ☐ Peer review*
26.	**Medical records Assessment:**	Delinquent: Deficient history and physical: Summary: Ord ☐ Appropriate ☐ Trends* ☐ Peer review* ☐ Improvement plans*
27.	**Physician orders for lifesaving treatment (i.e., do not resuscitate orders)** (goal – within first 48 hours)	Completed and on file within the first 48 hours of admission:

Example Form

ST. MARY'S HEALTH SYSTEM **Focused Professional Practice Evaluation for assessment of medical st**

_____

_____

_____

Measurements pre-populated by the medical staff office.

RECOMMENDATIONS

_____Recommend continued appointment as a member of the Medical Staff in the Department of:

_____

_____Recommend continued FPPE from_____ through_____

Reasons:_____

_____

_____Deny continued appointment and privileges based on:_____

_____

_____

SERVICE CHIEF:_____ Date:_____

DEPARTMENT CHIEF:_____ Date:_____

Example Form

ST. MARY'S HEALTH SYSTEM

Focused Professional Practice Evaluation for Mid-Level Provi

APPLICANT: DATE:

Indicator	Evaluation C = Comments on last page		
Patient care	**Yes**	**No**	**C**
1. Patient assessments are comprehensive, accurate, and current			
2. Timely development, implementation, and revision of patient management plans			
3. Demonstrated clinical competence and judgment			
4. Appropriate and timely utilization of consultants			
5. Appropriate, compassionate, and effective communication with patients/families			
6. Compassionate and audience-specific patient/family counseling and education			
Clinical knowledge, learning, and improvement	**Yes**	**No**	**C**
7. Demonstrates knowledge of basic and discipline-specific medicine			
8. Timely ordering, appraisal, and follow-up of diagnostic tests			
9. Proactive and appropriate when facilitating learning in other healthcare professionals			
Interpersonal and communication skills	**Yes**	**No**	**C**
10. Fosters a therapeutic and ethical relationship with patients/families			
11. Fosters a collegial and ethical relationship with members of the healthcare team			
12. Effective nonverbal, listening, explanatory, and questioning skills			
13. Timely, appropriate, and concise communication that facilitates continuity of care and consistency of treatment plan when assuming care of patients and when handing off to next practitioner			
14. Effective as a member of the interdisciplinary healthcare team			
15. Attends/actively participates in interdisciplinary meetings/discussions as required/requested			
Professionalism	**Yes**	**No**	**C**
16. Responsive, accountable, and committed to patients, the hospital, and the healthcare team			

Example Form

ST. MARY'S HEALTH SYSTEM **Focused Professional Practice Evaluation for Mid-Level Provid**

21. Physically and mentally able to safely render care					
22. **Patient Satisfaction**	☐ No comments on file ☐ Complaints ☐ Trends	☐ Comments on file: Positive Number_____		Negative Number ___	
23.	**Medical records Assessment:**	Delinquent: _____ History and physical: _____ Discharge summary: _____ T/V Orders: _____ Timely authentication:_____Yes _____No Legibility:____Satisfactory _____Needs Improvement Overall Assessment of medical record keeping:_____Satisfactory _____N			

Comments (include factor number, as appropriate): _____

_____

_____

Example Form

ST. MARY'S HEALTH SYSTEM

Focused Professional Practice Evaluation for Mid-Level Pr

RECOMMENDATIONS

_____Recommend continued appointment as a member of the ALLIED HEALTH STAFF in the Department of:

_____

_____Recommend continued FPPE from_____ through_____

Reasons:_____

_____

_____Deny continued appointment and privileges based on:_____

_____

_____

SERVICE CHIEF:_____ Date:_____

DEPARTMENT CHIEF:_____ Date:_____

MEDICAL EXECUTIVE COMMITTEE: _____YES _____NO Date:_____

BOARD OF TRUSTEES APPROVAL: _____YES _____NO Date:_____

THE ATTACHED *FPPE EVALUATION* IS TO BE COMPLETED BY THE "*MOST APPROPRIATE PERSON*" AS DESIGNATED BY THE DEPARTMENT/SERVICE CHIEF, PRACTICE PHYSICIAN, ETC.

MOST APPROPRIATE PERSON CAN BE DEFINED AS A CLINICAL DIRECTOR, DEPARTMENT/SERVICE CHIEF, PRACTICE COLLEAGUE, ETC.

THE *FPPE EVALUATION* WILL BE SENT TO THE PERSON DESIGNATED ON A QUARTERLY BASIS FOR THE FIRST YEAR OF ALL NEW REQUESTS FOR PRIVILEGES. THIS INCLUDES NEW APPLICANTS TO THE HOSPITAL AS WELL AS CURRENT PROVIDERS REQUESTING NEW PRIVILEGES.

THE *FPPE EVALUATION* WILL BE ONE COMPONENT UTILIZED BY THE DEPARTMENT/SERVICE CHIEF WHEN COMPLETING THE ANNUAL *FPPE ASSESSMENT*.

Example Form

FOCUSED PROFESSIONAL PRACTICE EVALUATION

Provider's Name: _____

Dates: **From**_____**through**_____

TYPE OF PROCEDURE/ACTIVITY:_____

EVALUATION BY: ☐ Interdisciplinary team ☐ Chart review ☐ Observation ☐ Staf
☐ Peer review/reports* ☐ Comments/survey*

Please evaluate this provider using the following scale.

	Poor	Fair	Good
Procedural technique			
Skill Level			
Patient Interaction			
Interaction with staff			
Adherence to Hospital Policy & Directives			

IMAGE READING (if applicable)

Type and/or number of images read: _____

Please comment on this physician's performance using the following scale.

	Poor	Fair	Good
Accuracy in interpretation			
Interaction with staff and other providers			
Timely and accurate reporting			
Adherence to Hospital Policy & Directives			

SIGNATURES:

_____ _____
MENTOR/PEER/COLLEAGUE Date

_____ _____

Example Form

FOCUSED PROFESSIONAL PRACTICE EVALUATION

Provider's Name: _____

Dates: **From**_____**through**_____

TYPE OF PROCEDURE/ACTIVITY:_____

EVALUATION BY: ☐ Interdisciplinary team ☐ Chart review ☐ Observation ☐ St
☐ Peer review/reports* ☐ Comments/survey*

Please evaluate this provider using the following scale.

	Poor	Fair	Good
Procedural technique			
Skill Level			
Patient interaction			
Interaction with staff			
Adherence to Hospital Policy & Directives			

IMAGE READING (if applicable)

Type and/or number of images read: _____

Please comment on this physician's performance using the following scale.

	Poor	Fair	Good
Accuracy in interpretation			
Interaction with staff and other providers			
Timely and accurate reporting			
Adherence to Hospital Policy & Directives			

SIGNATURES:

_____ _____
PEER/MENTOR/SUPERVISING PHYSICIAN Date

APPENDIX M
Ongoing Professional Practice Evaluation

The Medical Staff shall conduct and participate in ongoing professional practice evaluation ("OPPE") for the purpose of identifying trends that may impact the quality of care rendered and patient safety. Data to support OPPE shall address, among other criteria, each practitioner's operative or other clinical procedures including outcomes, patterns of blood and pharmaceutical usage, length of stay patterns, morbidity and mortality data, and use of consults.

Clinical Competence – update at least once every 6 months.

Clinical indicator data for use in OPPE shall be derived from appropriate clinical indicators such as, but not limited to, CMS/Core measures, SCIP measures, HBIPS measures, MHQC, and nursing home data. Clinical indicator data for use in OPPE may also be acquired from periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, and discussion with other individuals involved in the care of each patient.

Data to support OPPE shall be collected, to the extent possible, using the Medical Center's MIDAS or other appropriate information systems. Such data shall be collected and forwarded to the Medical Affairs Office at least once every six months.

Medical Staff Responsibilities – update annually.

Department or Service Directors shall report to the Medical Affairs Office at east once each year the following information regarding each member of their Department/Service:

1. Meeting attendance
2. Achievement of departmental or service goals
3. Participation in department or service quality initiatives
4. Evidence of particular competencies, such as CLIA testing

Malpractice Experience, Licensure, CME, Certifications, Privileges and Peer References – update biannually.

Each practitioner shall provide the following information to the Medical Staff Office at least once every two years and the Medical Staff Office shall verify such information where appropriate:

1. Malpractice experience including notices of claims, settlements, judgments and status of any pending litigation or malpractice screening panel proceeding.
2. Licensure status; provided however, that any license suspension, termination or sanction shall be reported immediately to the Medical Affairs Office.
3. CME compliance.
4. Maintenance of certifications.
5. Maintenance/status of privileges at the Medical Center or other health care providers where the practitioner maintains privileges; provided, however, that any suspension, limitation or termination of privileges shall be reported immediately to the Medical Affairs Office.

Additional information from "360" type surveys shall also be provided to the Medical Affairs Office.

Complaints – ongoing reporting required.

Any complaints/compliments reported in the Medical Center's MIDAS system, sentinel events involving the practitioner, and any other information deemed relevant by practitioner's department or service chair shall be reported on an ongoing basis.

OPPE TEMPLATE

The Medical Affairs Office shall maintain an OPPE file for each practitioner. Such file shall follow the OPPE Template form attached hereto and made a part of this OPPE policy.

ONGOING REVIEW

At least once each six months, and more frequently if deemed necessary by practitioner's department or service chair, the department or service chair will review the OPPE file for each member of his/her department/service. The department or service chair may, if necessary, meet with the practitioner to discuss any concerns; and, if there is any uncertainty regarding the practitioner's professional performance, shall refer the matter to FPPE or any other course of action defined in the Medical Staff Bylaws to further evaluate the practitioner.

DOCUMENTATION

The department/service chair will document the fact that the OPPE review has been completed and shall complete and place such documentation in each practitioner's Peer Review File using one of the templates attached and made a part of this OPPE policy. Such information shall be utilized and integrated into the Medical Center's performance improvement activities. All documentation regarding OPPE shall be maintained in each practitioner's credentials file and/or in the peer review section of the R drive.

****

[st mary's letterhead]

Date:

To: Peer Review File

Re:[practitioner name]

I have reviewed the ongoing professional practice evaluation (OPPE) measures, as defined in the St. Mary's Regional Medical Center Rules and Regulations of the Medical Staff, for [practitioner name.] [Practioner name]'s performance on the OPPE measures were within acceptable limits for the time period [6 month period ending with date of assessment].

_____

[name of service director or department chief]

This communication contains confidential and privileged information regarding professional competence review activity within the meaning of the Maine Health Security Act, 24 M.R.S.A. §§ 2401 et seq., medical staff review within the meaning of 32 M.R.S.A. §§ 3293 and 3296, patient safety work product within the meaning of the Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. §§ 299-21 et seq., and/or professional review action within the meaning of the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101 et seq., and the corresponding provisions of any subsequent federal or state statute providing confidentiality and protection for peer review or related activities.

[st mary's letterhead]

Date:

To: Peer Review File

Re:[practitioner name]

I have reviewed the ongoing professional practice evaluation (OPPE) measures, as defined in the St. Mary's Regional Medical Center Rules and Regulations of the Medical Staff, for [practitioner name.] I identified concerns in the following area(s)

1.

2.

3.

I have met with [practitioner name] about these concerns. After reviewing the materials with [practitioner name], I find [practitioner name]'s performance to be within acceptable limits for the time period [6 month period ending with date of assessment].

_____

[name of service director or department chief]

This communication contains confidential and privileged information regarding professional competence review activity within the meaning of the Maine Health Security Act, 24 M.R.S.A. §§ 2401 et seq., medical staff review within the meaning of 32 M.R.S.A. §§ 3293 and 3296, patient safety work product within the meaning of the Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. §§ 299-21 et seq., and/or professional review action within the meaning of the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101 et seq., and the corresponding provisions of any subsequent federal or state statute providing confidentiality and protection for peer review or related activities.

[st mary's letterhead]

Date:

To: Peer Review File

Re:[practitioner name]

I have reviewed the ongoing professional practice evaluation (OPPE) measures, as defined in the St. Mary's Regional Medical Center Rules and Regulations of the Medical Staff, for [practitioner name.] I identified concerns in the following area(s)

1.

2.

3.

I have met with [practitioner name] about these concerns. After reviewing the materials with [practitioner name], I have continued concerns about [practitioner name]'s performance in these areas. I am therefore going to initiate a focused professional practice evaluation (FPPE), per the St. Mary's Regional Medical Center Rules and Regulations of the Medical Staff.

_____

[name of service director or department chief]

This communication contains confidential and privileged information regarding professional competence review activity within the meaning of the Maine Health Security Act, 24 M.R.S.A. §§ 2401 et seq., medical staff review within the meaning of 32 M.R.S.A. §§ 3293 and 3296, patient safety work product within the meaning of the Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. §§ 299-21 et seq., and/or professional review action within the meaning of the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101 et seq., and the corresponding provisions of any subsequent federal or state statute providing confidentiality and protection for peer review or related activities.

Ongoing Professional Performance Evaluation year

Physician Name Licensure Dates: to

Area	Measure	Source	Outcome	Inadequate for Full Privileges	Interval
Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease and care at the end of life.	**Malpractice Cases-Cases** that meet the requirement of reporting to NPDB	**Medical Affairs Office - part of application process for reprivileging**	**# of Cases Identified**	evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant	Every Two years with License renewal
	Mandated Sentinel Events (Joint Commission and State of Maine)	**Hospital, Provider Based Practices, CCS, Nursing Home**	**Results of Case Reviews by Department Chair or Designee**	Reviewed in peer review process and > 1 and judged to exhibit consistent pattern of inappropriate practice	on going
	Department or Service Specific Clinical Care Measures (SCIPS, etc.)	**Midas, Provider Based Practices, CCS, Nursing Home**	**Meets Established Department or Service Standards**	Practitioner consistently falls below norms established for the Department/Service	Every 6 months
	Priority Reviews and Generic Reviews involving the practitioner.	**Risk Management Office, Department Chair, Service Director**	**Results of Case Reviews by Department Chair or Designee**	Reviewed in peer review process and judged to exhibit consistent pattern of inappropriate practice	Ongoing
Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward thier patients, their profession and society	**Comment Tracking** - any comments from patients, their relatives, referring physicians or hospital coworkers regarding a practitioner's behavior, professionalism or communication are captured. Complaints and compliments are reviewed by the Department Chair or Service Director, with the individual practitioner. All complaints will be processed through the established Health System protocols, including the Medical Staff, HR, and Risk Management Office, as indicated.	**Survey Data, Complaint/Compli ment Database, Medical Staff actions, HR actions, Provider Based Practices, CCS, Nursing Home**		numerous complaints and judged to exhibit consistent patterns of inappropriate behavior	Ongoing
	Meeting Attendance	**Medical Affairs Office**	**Attends at least 50% of Medical Staff, Department, and assigned Committee meetings**		Yearly
Interpersonal and communication skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families and other members of health care teams.	**Practitioner Feedback Program** - the practitioner is graded by peers, coworkers, direct reports, supervisors, physician directors and/or office staff on a scale of 1 (low) to 5 (high). A review summary and individual practitioner data (in an anonymous format) will be shared and discussed with the practitioner. At the end of each year, an annualized peer comparison summary (anonymously) will be reviewed and distributed.	**Survey Tool**	**Date of last survey was date. Next Participation will be date. Department Chair or Designee reviewed survey results with practitioner on date.**	Did not participate in the review process q 2 years.	Every Two years with reappointment cycle
Medical/Clinical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences and the application of their knowledge to patient care and the education of others	**Continuing Medical Education and Subspecialty Specific Credits** - Each physician who is actively practicing medicine shall complete a minimum of 40 Category I credit hours of continuing medical education as defined by State of Maine Board of Licensure in Medicine, every 2 years. Other practitioners will meet their minimum continuing education credit hours as required by their particular licensing board. Specialty and Subspecialty board certification maintenance will be monitored as required by the Medical Staff Bylaws; and by employment agreements as indicated.	**Medical Affairs Office - part of application process for reprivileging**	**Met the State of Maine requirement for last license renewal on date. Next renewal is date. Board Certification is through date. Subspecialty Certification is through date.**	Does not meet the required 40 hours Category I in 2 years. Does not meet Continuing Eductation requirements for practitioner specific licensure. Does not obtain specialty boards, once on staff, within 5 years of completion of residency; or lets time-limited certificate lapse. Does not maintain Certification as required by the practitioner specific board (i.e PA, or NP.)	Every Two years with reappointment cycle
	BLS, ACLS, PALS Certification and Maintenance	**Medical Staff Office**	**List Certifications and Dates of Expiration.**	Allows required certifications for practice in the health system to lapse	Every two years with reappointment cycle

	New Privilege Requests	Medical Affairs Office	Demonstrates sufficient knowledge base to obtain new privilege as defined in privilege criteria	Does not meet criteria to obtain new privilege as specified in privileging criteria	Ongoing
	Maintenance of Privileges	Medical Affairs Office	Demonstrates sufficient knowledge base to maintain current privileges as defined in privilege criteria	Does not meet criteria to maintain privilege as specified in privileging criteria	Every two years with reappointment cycle
	Peer References	Medical Affairs Office on Reappointment Cycle	All reference categories are greater than 'fair.'	Any pattern of "fair" or "poor" references that would raise concerns re. appropriate practice patterns.	Every two years with reappointment cycle
Practice-based learning and improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate and improve patient care.	Participation in Quality Programs implemented in the Department or Service. Performing Generic or Priority Reviews when requested by Department Chair or Designee. Performing Focused Practice Review for other practitioners when requested by Department Chair or Designee.	Department Chair or Designee; Risk Management, Medical Affairs	# of generic or priority reviews performed/ #of requests to do so; #of FPPE performed/#of requests to do so	Lack of participation with quality programs	yearly
	Use of Information Technology	IS	% of hospital orders by CPOE. # of unsigned documents in Centricity	Pattern of refusing to utilize the electronic medical record	Every 6 months
Systems-Based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided and the ability to apply this knowledge to improve and optimize healthcare	Length of Stay Data (if applicable.)	Utilization Review	LOS falls within department norms	Pattern of LOS raises concerns about appropriate practice; Department Chair or Designee review of cases supports these concerns	Every 6 months
	Department or Service Specific Goal Achievement	Medical Affairs, Department Chair, Service Director	Department Chair or Service Director Documents that Practitioner has actively participated in helping to achieve designated goals.	Department Chair or Designee reports that practitioner has not participated in helping to achieve the Department/Service specific goals.	Yearly
	Medication Reconciliation	Hospital, Provider Based Practices, CCS, Nursing Home	Practitioner participates in established practices to assure proper medication reconciliation	Practitioner does not participate in established practices to assure proper medication reconciliation	Yearly
	Applicant's statement that no health problems exist that could affect his or hers practice				

ENDNOTES

1. On October 11, 1995 the Board approved the following amendments previously recommended by the Medical Staff:

    - On May 1, 1995, the Executive Committee recommended a bylaw revision to clarify the sections pertinent to requests for clinical privileges. The Medical Staff approved this revision on September 11, 1995.

    - On May 1, 1995, the Executive Committee recommended this bylaw revision to be consistent with the hospital bylaws related to approval and installation of Chairs, Vice Chairs and additional Executive Committee members. The Medical Staff approved this revision on September 11, 1995.

    - On May 1, 1995, the Executive Committee recommended this revision to add a requirement for history and physicals for day hospital patients. This additional requirement is in compliance with the State's regulations for day hospitals. On June 5, 1995, the "day hospital" definition was added for clarification. The Medical Staff approved this revision on June 12, 1995.

    - On June 5, 1995, the Executive Committee recommended this revision to differentiate between the responsibilities of dentists and oral-maxillofacial surgeons and what types of tissue must be sent to the pathologist for examination. The Medical Staff approved this revision on June 12, 1995.

2. On April 3, 1996 the Board approved the following revisions previously recommended by the Medical Staff:

    - On January 8, 1996, the Executive Committee recommended this revision to govern the management of credential files. The Medical Staff approved this revision on March 11, 1996.

    - On February 5, 1996, the Executive Committee recommended this revision to govern the Medical Staff's peer review process. The Medical Staff approved this revision on March 11, 1996.

    - On March 4, 1996, the Executive Committee recommended this revision to the Complaint Resolution Policy to assure that practitioners are made

aware of concerns prior to the Complaint Resolution meeting. The Medical Staff approved this revision on March 11, 1996.

3. On July 24, 1996 the Board approved the following revision previously recommended by the Medical Staff:

   - On May 6, 1996, the Executive Committee recommended revision to include a standard for timely outpatient reports. The Medical Staff approved this addition on June 10, 1996.

4. On December 18, 1996, the Board approved these revision previously recommended by the Medical Staff:

   - On November 4, 1996, the Executive Committee recommended elimination of dues for Senior Active members. The Medical Staff approved this amendment on December 9, 1996.

   - On September 9, 1996, the Medical Staff proposed this bylaw revision which was subsequently voted on and approved at the December 9, 1996 meeting. This amendment reduced the fine for absence from meetings and articulates the method for being excused from required meetings.

5. On April 16, 1997, the Board approved this revision previously recommended by the Medical Staff:

   - On December 2, 1996, the Executive Committee recommended this bylaw revision to assure full compliance with the 1997 JCAHO standards for Department Leadership (MS.4 through MS.4.2.1.15). The Medical Staff approved this revision on March 10, 1997.

6. On March 12, 1998 the Executive Committee of the Board (and subsequently the full Board on March 25, 1998) approved this revision previously recommended by the Medical Staff:

   - On August 18, 1997, the Executive Committee recommended this bylaw revision to formally recognize medical specialties and residencies approved by the American Osteopathic Association in our "Qualifications for Membership." The Medical Staff approved this revision on March 9, 1998.

7. On June 17, 1998, the Board approved this revision previously recommended by the Medical Staff on June 8, 1998:

    - On March 4, 1998, Dr. Treworgy at an Executive Committee meeting raised a concern regarding this section of the bylaws. The concern was that this language could be interpreted to mean that a physician applicant who became board certified after 5 years from their residency graduation date, would not be eligible to join our medical staff. The Executive Committee felt that the important qualification for applicants is board certification regardless of when such certification is achieved.

8. On January 20, 1999, the Board approved these revisions previously recommended by the Medical Staff on December 14, 1998:

    - On November 2, 1998 the Executive Committee considered a series of revisions to the bylaws, rules and regulations to keep pace with the changing standards of the Joint Commission and State of Maine Regulations for Hospitals. This revision also: replaced the phrase "corrective action" with the phrase "formal review" throughout the document when referring to the investigative process; eliminated fines for absence at meetings in favor of complaint resolution for three consecutive unexcused absences; simplified the process for filing incomplete records; and modified the peer review protocols for priority and generic reviews to include timely notification of the physician whose case is to be reviewed, as well as an opportunity for the physician to have a meeting with their Department Chair and the Clinical Practice Committee Chair if a review identifies a significant concern.

9. On March 17, 1999, the Board approved these revisions previously recommended by the Medical Staff on March 8, 1999:

    - On February 8, 1999 the Executive Committee considered a series of revisions to the bylaws, rules and regulations in response to State Survey recommendations including revisions to the temporary and emergency privileges sections and the quality assessment function section.

10. On June 16, 1999, the Board approved these revisions previously recommended by the Medical Staff on June 14, 1999:

- On May 3, 1999 the Executive Committee considered a series of revisions to the bylaws, rules and regulations that added conflict of interest statements to the qualifications of medical staff officers and modification of the automatic stop orders.

15. On March 22, 2000, the Board approved these revisions previously recommended by the Medical Staff on March 13, 2000:

    - On January 3, 2000 the Executive Committee considered a series of revisions to the bylaws, rules and regulations that added disclosure of conflict of interest as one of the basic responsibilities of staff members. A series of minor revisions were made to assure compliance with JCAHO standards. Other clauses were modified to reflect or improve current processes.

12. On December 20, 2000, the Board approved these revisions previously recommended by the Medical Staff on December 11, 2000:

    - On December 4, 2000 the Executive Committee considered a revision to the rules and regulations that added a process for dealing with disruptive physician behavior.

13. On June 13, 2001, the Board approved these revisions previously recommended by the Medical Staff on June 11, 2001:

    - On May 7, 2001 the Executive Committee considered a revision to the bylaws that moved a substantive portion of Article 6: Procedure for Appointment and Reappointment to Appendix B: Appointment and Reappointment Plan and created a procedure for expedited credentialing for applicants who met certain criteria.

14. On January 16, 2002, the Board approved this revision previously recommended by the Medical Staff on December 10, 2001:

- On October 1, 2001 the Executive Committee considered a revision to the bylaws that added *sexual orientation* to Section 3.4 of the Bylaws.

15. On September 12, 2002, the Board approved this revision previously approved by the Medical Staff on June 10, 2002:

- 12.4.1 was added to the bylaws to create and charge a Subcommittee on Physician Health.

16. On March 19, 2003, the Board approved these revisions approved by the Medical Staff on March 10, 2002:

- 4.7 was added to create a new category of medical staff membership for locum tenens.

- Other changes made to the bylaws included minor changes to 6.2.2.5, 6.4.1, 6.4.2, 12.2.2.11, 12.2.5.4, and 12.2.6.3.1 for compliance with JCAHO standards, and 13.6.

- Changes to the rules and regulations included the deletion of 1.9 as well as changes to 4.4.2, 4.11, 5.2.2.1 for compliance with changes in state law, and 12.1.1.

- The change to bylaw 13.6 and rule and regulation 12.1.1 reflect expectation of meeting attendance and reporting of medical staff finances, respectively.

17. On September 17, 2003, the Board approved these revisions approved by the Medical Staff on September 8, 2003:

- Amendments to 3.5.4, 3.6.3, 6.2.2.2 and 7.5.2 to have bylaws reflect current practice of credentialing verification.
- Amendments to 11.4.13, 12.1 and 12.2.11.2 to reflect role of Chair in performance improvement process.
- Amendments to 12.2.5 to reflect the role of the medical staff in medication use.

18. On March 17, 2004, the Board approved these revisions approved by the Medical Staff on March 8, 2004:

- Amendments to 11.6.3, 12.6.2 and 13.7 regarding meeting attendance requirements.

19. On April 27, 2005, the Board approved this revision supporting nurse-driven protocols approved by the medical staff that was approved by the Medical Staff on March 14, 2005:
    - 5.2.5 The medical staff supports nurse-driven protocols that have been approved by the Clinical Practice Committee.

20. On June 15, 2005, the Board approved these revisions approved by the Medical Staff on June 13, 2005:

    - Amendment to 8.12.4.2 addressing repeated suspensions for incomplete medical records.

21. On September 21, 2005, the Board approved these revisions approved by the Medical Staff on June 13, 2005 and September 19, 2005 respectively:

    - Amendment to 4.2.2 related to CMS requirement for History & Physicals.
    - Amendment to Article 15 addressing disruptive behavior.

22. On March 29, 2006, the Board approved the revisions approved by the Medical Staff on March 13, 2006.

- 7.7 addressing Disaster Privileging.

23. On September 27, 2006, the Board approved the revisions approved by the Medical Staff on June 12, 2006.

    Under the Executive Function of the Medical Executive Committee add:
    - 12.2.2.14 To be empowered to act for the Medical Staff at intervals between Medical Staff meetings.

24. On January 24, 2007, the Board approved the amendments approved by the Medical Staff on December 11, 2006.

    Under **Medical Record Policies Specific to the Medical Staff**

    - 4.9 **Discharge Summaries.** A discharge clinical summary shall be written or dictated on all medical records of hospitalized patients. **Discharge summaries are to be completed within 14 days of discharge.**

    Under **General Medical Record Policies**

    - 3.7 **Filing the Medical Record.** A medical record shall not be permanently filed until it is completed by the responsible practitioner. **The record must be filed as permanent within 30 days of discharge.** In the event that the responsible practitioner cannot complete the record within 30 days following discharge, the record shall be filed incomplete. Health Information Management will report information on incomplete records filed in periodic reports to the Executive Committee (or the designated committee overseeing medical records review).

    Under **General Medical Record Policies**

    - 4.11 **Outpatient Reports.** The results of all outpatient tests and procedures shall be documented no later than 24 hours after the test/procedure. **The clinical interpretation will be on the chart within a reasonable period of time not to exceed 30 days from the date of service.** Exceptions to this standard may only be granted by the Executive Committee upon specific written request.[3]

25. On June 27, 2007, the Board approved the amendments approved by the Medical Staff on June 11, 2007.

    Under **Medical Staff Membership**, specialty board recognition would be broadened under 3.2.4.1.3 to include the Royal College of Physicians and General Medical Council of the United Kingdom.

    Royal College of Physicians and Surgeons of Canada **or the Royal College of Physicians and General Medical Council of the United Kingdom.**

    Similarly, under **approved residency programs**, 3.2.5.3 would be broadened similarly:

    Royal College of Physicians and Surgeons of Canada **or the Royal College of Physicians and General Medical Council of the United Kingdom.**

26. On January 23, 2008, the Board approved the amendments approved by the Medical Staff on December 17, 2007.

    Under History & Physical

    4.2 A medical history and physician examination must be done for each patient by a physician, or ~~no more than 7 days before or 48 hours after admission~~ **other qualified individual in accordance with State requirements. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission .** When the medical history and physical examination are completed within 30 days before admission ~~to the medical center~~, the physician or other qualified individual shall ensure that an updated medical record entry documenting an examination for any changes in the patient's condition is completed. The updated examination must be completed and documented in the patient's medical record within 24 hours after admission. ~~a reasonably durable, legible copy of these reports may be used in the patient's medical center medical record if a) an appropriate assessment including physical examination to update any components of the patient's current medical status that may have changed is completed, b) the physician documents this assessment & attaches to the existing H & P, even if there are no changes in the patient's status, and c) this updated documentation is completed within 7 days prior to, or~~

~~within 48 hours after admission.~~

~~4.2.3 Only physicians and psychologists, social workers, physician assistants, and registered nurses who are granted the privilege are allowed to take and record histories.~~

4.2.4 Only physicians, physician assistants and ~~nurse practitioners~~ **advanced practice registered nurses** may perform and record physicals and transmit verbal orders from the sponsoring physician.

4.2.5 The sponsoring physician(s) of the physician assistant, ~~nurse practitioners~~ **advanced practice registered nurses**, or other Allied Health Professional must authenticate the entries on the medical record within 24 hours or enter their own notes[11].

Under Signing/Dating/Timing of Orders

5.2 **Orders.** All orders for treatment shall be in writing **and signed, dated and timed.**

5.2.2.1 All verbal orders and telephone orders must be **authenticated by signing, dating and timing** by a physician within seventy-two (72) hours.

27. On July 28, 2008, the Board approved the amendments approved by the Medical Staff on June 16, 2008.

1.10 **Physician Rounding Responsibility:** It is the expectation that the attending physician or the physician covering for the attending will see all inpatients daily. Alternative plans for rounding/coverage must be submitted by the respective department or service for approval by the Medical Executive Committee.

For any patient in the ICU, the attending physician, or the physician covering for the attending, is expected to round on the patient daily and document in the medical record.

28. On September 30, 2009 the Board approved the amendments approved by the Medical Staff on June 15, 2009 regarding the Cancer Committee.

29. On April 21, 2010 the Board approved the revised Bylaws approved by the Medical Staff on March 8, 2010.

30. On June, 14, 2010 the Medical Staff approved changes to the Rules & Regulations in regard to the removal of the VPMA & Medical Staff President titles & replacement with the Chief Medical Officer title.

31. On August 11, 2010 the Board approved the revised Bylaws and Rules & Regulations approved by the Medical Staff on June 14, 2010.

32. On March 7, 2011 the Medical Staff Executive Committee voted to add Appendix K (Conflict Management) to the Rules & Regulations.

33. On June 27, 2011 the Medical Staff voted to approve the addition of a new section 3.5.10.

    On June 27, 2011 the Medical Staff voted to approve the addition sentence be added to Section 15.1 as follows: If Medical Staff Members eligible to vote propose to adopt a rule, regulation or policy or an amendment thereto, such proposal shall be communicated in writing to the Executive Committee. If the Executive Committee proposes to adopt a rule or regulation, or an amendment thereto, it shall first communicate the proposal to the Medical Staff, and shall not take action thereon for Fifteen (15) days after notice thereof is provided to the Medical Staff.

34. On September 19, 2011 the Medical Staff voted to amend the Bylaws as follows:

Proposed New Section 8.12.5

8.12.5 **Federal Government Payor Action.** A Practitioner who is listed on the List of Excluded Individuals and Entities by the Office of Inspector General of the United States Department of Health and Human Services or listed in the Excluded Parties List issued by the United States General Services Administration shall immediately and automatically be suspended from practicing in the Medical Center, from his/her staff status and from the exercise of privileges.

Proposed Revised New Section 8.13.1

8.13.1 **Review by the Executive Committee.** Any automatic suspension or other adverse action arising from licensure discipline, DEA registration action, federal government payor action, or failure to maintain adequate professional liability insurance, shall be reviewed by the Executive Committee at their next meeting following the automatic suspension taking effect.

Proposed Revised New 8.14.1

8.14.1 **No Automatic Reinstatement With Licensure Discipline, Federal Government Payor Action or DEA Registration Automatic Suspension.** Any practitioner automatically suspended for licensure discipline, federal government payor action, or DEA registration, shall not, by the passage of time or the curing of the event that caused automatic suspension, be automatically reinstated to his/her staff status and clinical privileges.

35. On December 12, 2011 the Medical Staff voted to amend the Bylaws as follows:

3.2.4.1.3 Royal College of Physicians and Surgeons of Canada; or the Royal College of Physicians and General Medical Council of the United Kingdom; or the Intercollegiate Specialty Board of the United Kingdom, which includes the Royal College of Surgeons of England, the Royal College of Physicians and Surgeons of Glasgow, the Royal College of Surgeons of Edinburgh, and the Royal College of Surgeons in Ireland; or

3.2.5.3 Royal College of Physicians and Surgeons of Canada, or the Royal College of Physicians and General Medical Council of the United Kingdom; or the Intercollegiate Specialty Board of the United Kingdom, which includes the Royal College of Surgeons of England, the Royal College of Physicians and Surgeons of Glasgow, the Royal College of Surgeons of Edinburgh, and the Royal College of Surgeons in Ireland; or

36. On February 28, 2012, the Board approved the inclusion of the FPPE policy & forms Appendix L) approved by the Medical Executive Committee on January 9, 2012
37. On March 19, 2012 the Medical Staff voted to approve amendments to Article 7 Clinical Privileges as follows:

7.1 Clinical Privileges Restricted. Every Practitioner practicing at the Medical Center, by virtue of Medical Staff membership or otherwise, shall in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him/her by the Board, except as provided in Sections 7.2 and 7.3 of this Article 7. Despite the clinical privileges granted to a Practitioner, each Practitioner shall obtain consultation when necessary or appropriate for patient care or when required by medical staff or department rules or regulations.

7.2 Delineation of Privileges.

7.2.1 **Requests.** Every application for appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. All initial or additional clinical privileges granted shall be subject to the Medical Staff Focused Professional Practice Evaluation policy, as it may be amended from time-to-time. A request pursuant to Section 6.5 for a modification of privileges must be supported by documentation of training and/or experience supportive of the request. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests.

7.2.2 **Bases for Privileges Determinations.** Requests for clinical privileges shall be evaluated based on the Practitioner's licensure, education, training, experience, demonstrated professional competence, judgment, physical and mental health status, references and other relevant information. The bases for privileges determinations to be made in connection with periodic reappointment or otherwise shall include, but not necessarily be limited to, the following:

38. On March 28, 2012 the Board approved the amendment to 12.5 Cancer Committee as follows:

12.5 **Cancer Committee.** The Cancer Committee shall be a multi-disciplinary, standing committee and shall consist of at least six members of the active medical staff. Membership shall fulfill the standards for a Cancer Committee as required by the American College of Surgeons (ACS) for a community hospital cancer program.

12.5.1 **Membership.** Membership shall include physician representation from pathology, medical oncology, diagnostic radiology, surgery and the ACS Cancer Liaison physician. Representation from internal medicine and family practice is also encouraged. Non-physician members shall include representatives from the tumor/cancer registry, quality assurance, nursing, social services and administration.

12.5.2 **Duties.** The Cancer Committee shall be responsible for cancer program activities as required for an ACS Community Hospital Cancer Program. These shall include, but are not limited to:

12.5.2.1 supervision of the Tumor Registry;
12.5.2.2 presentation of Tumor Conferences;
12.5.2.3 availability of consultative services;
12.5.2.5 evaluation of quality of care; ~~and~~
12.5.2.5 establish, as necessary, subcommittees to assure accreditation of clinical programs; and to provide oversight of those subcommittees. These subcommittees may

include, but are not limited to, the Breast Health Program and the Chest Oncology Program; and

12.5.2.~~5~~ 6 annual reporting.

12.5.3 **Meetings.** The Cancer Committee shall meet not less than quarterly. The committee may meet jointly with the Cancer Committee from other health facilities. A permanent record of the proceedings of the committee shall be maintained.

39. On June 27, 2012 the Board approved the amendment to 12.3 Join Conference Committee as follows:

~~**12.3 Joint Conference Committee.** The Joint Conference Committee shall be composed of three (3) Board members and the three (3) officers of the Executive Committee of the Medical Staff. The Chief Executive Officer and the Chief Operating Officer shall be ex-officio members of the committee without vote. The Chairperson of this Committee shall alternate on an annual basis between a Board member and a physician. The Committee shall conduct itself as a forum for the discussion of matters of Medical Center policy and practice, especially those concerning efficient and effective patient care, and shall act as a liaison committee between the Board, the Medical Staff and the administration of the Medical Center. Meetings of this Committee may be called by the Chief Medical Officer of the Medical Staff, or a majority of the Executive Committee members, the Chair of the Joint Conference Committee, the Chair or a majority of the Board members, or the Chief Executive Officer. This committee shall meet as necessary and shall transmit written reports of its activities to the Executive Committee and the Board.~~

12.3 Joint Conference Committee. The Joint Conference Committee shall be composed of Three (3) Members of the Board of Directors and Three (3) Members of the Executive Committee of the Medical Staff. The Three (3) Members of this Committee from the Board shall be appointed by the Chairperson of the Board, and the Three (3) Members from the Medical Staff Executive Committee shall be appointed by the Chief Medical Officer of the Medical Staff. The President of the Medical Center shall be an ex-officio member of the Committee without vote.

This Committee shall conduct itself as a forum for the discussion of matters of hospital policy and practice, especially those pertaining to efficient and effective patient care, and shall act as a liaison committee between the Board of Directors, the Medical Staff and the administration of the hospital. Meetings of this Committee may be called by the Chief Medical Officer, Three (3) members of the Medical Staff Executive Committee, the Chairperson of the Committee, a majority of the Board of Directors, or the President of the Medical Center.

This Committee shall meet as necessary and shall transmit written minutes of its activities to the Medical Staff Executive Committee and the Board of Directors. The Three (3) members of the Joint Conference Committee who are members of the Board of Directors shall be appointed by the Board Chair at such time that the Joint Conference Committee is convened. The first

Chairperson of the Committee shall be one of the three Medical Staff Executive Committee Members, appointed by the Chief Medical Officer, and retain such office until the matter subject to review by the Joint Conference Committee is concluded. The next time the Joint Conference Committee is convened, the Chairperson of the Committee shall be one of the three Board Members appointed to the Committee, as designated by the Board Chair, and shall retain such office until the matter subject to review by the Joint Conference Committee is concluded. Appointment of the Chairperson of the Joint Conference Committee shall thereafter alternate with respect to each subject matter thereafter reviewed by the Joint Conference Committee.

40. On June 27, 2012 the Board approved to **Amend Article 15, Section 15.1 by adding a new subsection 15.1.1 to read:**

Temporary Rules and Regulations. In the event of a documented and urgent need to amend the Medical Staff rules and regulations in order to comply with any governmental law or regulation, the Executive Committee may provisionally adopt, and the Board may provisionally approve, an amendment to the Medical Staff rules and regulations without prior notification to the Medical Staff. Such amended rules or regulations shall initially be referred to as "Temporary Rules or Regulations". The Executive Committee shall provide notice to the Medical Staff at the time any Temporary Rule or Regulation is approved. In the event of a conflict between the Active Staff and the Executive Committee regarding the adoption of a Temporary Rule or Regulation, the Active Staff may, in accordance with the process set forth in Medical Staff Bylaws, Appendix K, submit the matter to conflict management within thirty (30) days of notice of adoption of the Temporary Rule or Regulation. The Temporary Rule or Regulation shall remain in effect unless or until modified by the conflict management process. If no timely request for conflict management is filed, the Temporary Rule or Regulation shall stand.

41. On June 27, 2012 the Board approved the inclusion of the OPPE policy & forms Appendix M) approved by the Medical Executive Committee on May 7, 2012

42. On September 14, 2012 the Board approved the revision of 4.2 Admission History & Physical approved by the Medical Executive Committee on August 6, 2012 as follows:

4.2 **Admission History and Physical.** A complete admission history and physical examination shall be completed ~~recorded & in the chart~~ within thirty (30) days prior to or within twenty-four (24) hours ~~of~~ after registration or inpatient admission ~~for inpatients~~**,** but prior to surgery or a procedure requiring anesthesia services. To

conform with specific requirements for day hospital programs, a history and physical examination will be required within 72 hours. "Day Hospital" is defined as a psychiatric treatment program characterized by: 1) attendance during some portion of the day by patients residing at home or in the community; and 2) a daily schedule of therapeutic groups and activities overseen by a multi-disciplinary team. Day Hospitalization is an appropriate level of care for psychiatric patients who require more intensive and structured treatment than can be offered by traditional office visits; but who are not ill enough to require inpatient treatment.[1]

4.2.1 ~~This report should include all pertinent findings resulting from an assessment of all systems of the body.~~ The history and physical shall include, at a minimum:

- Chief complaint
- History of the current illness, including, when appropriate, assessment of emotional, behavioral and social status (HPI)
- Relevant past medical, family and/or social history appropriate to the patient's age
- Review of body systems
- A list of current medications and dosages
- Any known allergies including past medication reactions and biological allergies
- Physical examination: current physical assessment
- Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
- Initial plan: Statement of the course of action planned for the patient while in the Medical Center

For other outpatient (ambulatory) surgical patients, as necessary for treatment:
- A list of current medications and dosages
- Any known allergies including past medication reactions
- Existing co-morbid conditions
- Assessment of mental status
- Exam specific to the procedure performed

IV moderate sedation: For patients receiving **IV** moderate sedation, all of the above elements in the above section, plus the following:
- Examination of the heart and lungs by auscultation
- American Society of Anesthesia (ASA) status
- Documentation that patient is appropriate candidate for IV moderate sedation

4.2.2 A medical history and physician examination must be ~~done~~ completed for each patient by a physician or other qualified individual in accordance with State requirements. The medical history and physical examination must be placed in the patient's medical record within twenty-four (24) hours ~~of~~ after registration or inpatient

admission, but prior to surgery or any procedure requiring anesthesia services. When the medical history and physical are completed within thirty (30) days ~~before~~ prior to registration or inpatient admission, the physician or other qualified individual shall ensure that an updated medical record entry documenting ~~an examination for~~ any changes in the patient's condition is completed. The update~~d examination~~ must be completed and documented in the patient's medical record within twenty-four (24) hours after registration or inpatient admission, but prior to surgery or any procedure requiring anesthesia services.

4.2.2.1 In such instances an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded.

43. On March 26, 2014 the Board approved the addition to Article 7 (Clinical Privileges) 7.8 Telemedicine Privileges approved by the Medical Executive Committee on March 3, 2014.

44. On June 18, 2014 the Board approved the revisions to the Bylaws related to Podiatry approved by the Medical Executive Committee on May 5, 2014 and the Medical Staff on June 9, 2014 as follows:

1. Paragraph 10 of the Definition Section of the Bylaws amended to read as follows:

10. PHYSICIAN means a doctor of medicine, ~~of~~ osteopathy, ~~or of~~ dentistry, or podiatric medicine.

2. Section 3.2.4 of the Bylaws amended by adding the additional redlined terms:

3.2.4.1.5 Committee on Post-Doctoral Training of the American Osteopathic Association; or

3.2.4.1.6 American Podiatric Medical Association.

3. Section 3.2.5 of the Bylaws amended by adding the following redlined terms:

3.2.5.6 American Podiatric Medicine Association, or

3.2.5.7 Other equal postdoctoral medical training programs. The burden of proof of equal training will be upon the applicant.

4. Section 5.2 of the Bylaws amended by deleting the category "podiatrist" from the list of Allied Health Professionals.

5. Section 7.a of the Bylaws amended by adding a new subsection to cover podiatrists as follows:

7.3 Special Conditions for Privileges

7.3.2 **Podiatrists.** The scope and extent of surgical procedures that a podiatrist may perform in the Medical Center shall be delineated and

recommended to the Board in the same manner as all other clinical privileges. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chief of the Surgical Service. The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination as well as all appropriate elements of the patient's record. The podiatrist may write orders within the scope of his or her license consistent with the Medical Staff Bylaws, Rules and Regulations.

45. The Medical Executive Committee proposed the following addition to our Rules of the Hospital Bylaws on November 15, 2018; the Board of Directors approved the suggested addition on December 12, 2018. This proposed language is recommended to be added to the Rules in Bylaws, Appendix D:

"For purposes of complying with EMTALA and the Medical Center's EMTALA policies, all Physician members of the Active, Senior-Active, Courtesy and Consulting Medical Staff are authorized to conduct a medical screening examination ("MSE") to determine if an emergency medical condition exists or to determine, after a reasonable period of observation, whether a woman experiencing contractions is in false labor. Physician Assistant and Advance Practice Nurse members of the Allied Health Professional Staff, acting within the scope of their license and/or certification, may also be credentialed to perform MSEs and/or to determine, after a reasonable period of observation, whether a woman experiencing contractions is in false labor. All such Practitioners shall be considered Qualified Medical Personnel ("QMP") under EMTALA. With respect to an individual with psychiatric symptoms, a medical screening examination consists of both a medical and psychiatric screening."

46. On October 11, 2021 the Medical Staff Executive Committee considered proposed revisions to the Medical Staff Bylaws in accordance with the change in Maine law removing the supervision requirement for PAs with more than 4,000 hours of documented clinical practice. The revisions remove these PAs from the Dependent category and leaves those with less than 4,000 hours in the Dependent category and subject to written Collaborative Practice Agreements as required by the licensing rules. These changes were approved by vote at the December 13, 2021 Medical Staff Meeting.

47. On December 12, 2022 the Medical Staff approved the proposed changes to the Medical Staff Bylaws as follows:

Article 4, Section 4.5.1 of the Bylaws is amended to read as follows:

4.5.1 **Qualifications.** Prior to January 1, 2023 members of the Active Medical Staff had the option of becoming members of the Senior-Active Medical Staff at the age of sixty-two (62) years, or after having completed twenty-five (25) years of duty on the Active Medical Staff. Active Medical Staff members who exercised that option prior to January 1, 2023 may continue to retain Senior-Active Status. Effective January 1, 2023 Active Medical Staff members shall no longer have the option of becoming members of the Senior-Active Medical Staff.

Article 11, Section 11.2 of the Bylaws is amended to read as follows:

11.2 Departments. The Medical Staff shall be divided into the following departments:

11.2.1 **Department of Emergency Services**

11.2.2 **Department of Diagnostic Services**

11.2.3 **Department of Psychiatry**

11.2.4 **Department of Surgical Services** [OB/GYN]

11.2.5 **Department of Subspecialty Medicine** [Hospitalists and Eldercare]

11.2.6 **Department of Primary Care** [FP, IM and Pediatrics]

These departments may be modified and eliminated, and other departments may be established by the Executive Committee upon the recommendation of the Medical Staff as best fits the needs of the Medical Center.

48. On June 26, 2023 the Medical Staff approved the proposed changes to the Medical Staff Bylaws as follows:

7.9 Residents. Residents at the Medical Center shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. They may, however, provide patient care under the supervision of an Attending Doctor of Medicine or Osteopathy and subject to training protocols developed by their ACGME approved (or equivalent accreditation) residency program as accepted by the Medical Center. Medical

Center acceptance of such training protocols shall include review by the Chief Medical Officer, and prior approval by the Medical Executive Committee and the Board. All Residents shall, as part of their orientation, review the Bylaws, Rules and Regulations of the Medical Staff.

On June 17, 2024 the Medical Staff voted approval of the proposed changes to the Medical Staff Bylaws as follows:

4.2.2 For other outpatient (ambulatory) surgical patients, as necessary for treatment:

- A list of current medications and dosages
- Any known allergies including past medication reactions
- Existing co-morbid conditions
- Assessment of mental status
- Exam specific to the procedure performed

4.2.3 IV moderate sedation: For patients receiving **IV** moderate sedation, all of the above elements in 4.2.2, plus the following:

- Examination of the heart and lungs by auscultation
- American Society of Anesthesia (ASA) status
- Documentation that patient is appropriate candidate for IV moderate sedation