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PREAMBLE

WHEREAS, St. Joseph Healthcare is a non-profit denominational corporation organized and existing under the laws of the State of Maine, and,

WHEREAS, its purpose is to serve as a general hospital providing patient care, and education; and,

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in St. Joseph Hospital, and associated outpatient medical practices, and must accept and discharge this responsibility subject to the ultimate authority of the hospital's Board of Trustees, and,

WHEREAS, it is recognized that the interests of patients attended in the hospital and the associated outpatient medical practices are best served by the concerted effort of the Medical Staff.

NOW THEREFORE, the Medical Staff formulates Bylaws, Rules and Regulations for its governance in conformity with the Bylaws of the Hospital Corporation.

These Bylaws, Rules and Regulations shall be at all times in conformity with the laws and statutes of the State of Maine, CMS Medicare Conditions of Participation and in conformity with the Charter and Bylaws of the St. Joseph Hospital Corporation. In the event of a conflict between these Bylaws, Rules and Regulations and the Charter and/or the Bylaws of the Hospital Corporation, the latter shall prevail.

Every member of the medical staff by virtue of accepting such membership shall demonstrate his/her voluntary intention to practice his/her profession in this hospital in accordance with the Roman Catholic moral and ethical principles and values enunciated in the Ethical and Religious Directives for Catholic Health Care Services, 5th edition (see Exhibit 5) attached hereto and incorporated herein.
DEFINITIONS

For the purpose of these Bylaws, Rules and Regulations the following terms shall have the following meanings:

**Allied Health Staff:** Includes non-physician practitioners, advanced practice registered nurses, physician assistant, first assistants (RNFA, SA, CST) psychologists, podiatrist, dental assistants, licensed clinical social workers, licensed, certified or registered by a State Licensing Board who are granted specific privileges according to their area of education, training, expertise, experience, current clinical competence and State of Maine licensure.

**Corrective Action:** The termination of medical staff membership or a restriction, reduction, modification, or termination of medical staff privileges for reasons of clinical incompetence or unprofessional conduct.

**Investigation:** The act or process of investigating; the condition of being investigated; a searching inquiry for ascertaining facts; detailed or careful examination all of which are meant to address concerns about professional competence or conduct.

**Medical Care:** Encompasses the field of total medical, dental, and other professional care, the evaluation and management of health as well as disease management, utilizing supporting personnel, services and facilities at the level of the practitioner and his/her patients.

**Medical Education:** Education in all disciplines, specialties, and at all levels, in all of the professional and technical fields that can contribute to the effectiveness of health and medical care. It is not limited to the education of physicians and dentists.

**Medical Executive Committee:** The Executive Committee of the Medical Staff, unless specific reference is made to the Executive Committee of the Board of Trustees.

**Medical Staff:** Includes doctors of medicine or osteopathy, and doctors of dental surgery or dental medicine, licensed, certified or registered by a State Licensing Board, who are granted specific privileges according to their areas of education, training, expertise, experience, current clinical competence and State of Maine licensure. The term “medical staff” includes member of both the medical and allied health staff.

**Member, Practitioner, Provider or Staff:** Unless specifically stated otherwise, these terms refer to any individual appointed to the medical staff of St. Joseph Hospital by authority of the Board of Trustees in accordance with these Bylaws, Rules and Regulations, and associated policies, and the Bylaws of the Hospital.

**Peer Reference:** As defined by SJH’s CMS deemed status surveyor, are “practitioners in the same professional discipline as the applicant” (i.e., MD/DO to MD/DO; NP/PA to NP/PA). The peer reference should have personal knowledge (through direct observation/knowledge) of the applicant’s current clinical abilities, ethical character, and ability to work with others. Peer references shall not include relatives, partners, or those who have a financial relationship to the applicant.
ARTICLE I

NAME

The name of this organization shall be the “Medical Staff of St. Joseph Hospital, Bangor, Maine”, hereinafter sometimes referred to as the “medical staff” or as the “staff”.

ARTICLE II

PURPOSES

The purpose of this organization shall be as follows:

a. To pursue quality care and patient safety for all patients evaluated and/or treated in the hospital, inpatient and outpatient, irrespective of age, gender, sexual orientation, race, creed, disability, national origin, religion, health status, ability to pay or source of payment.

b. To establish and maintain high professional and ethical standards in general conformity with the requirements established by each physician's medical specialty board, the Ethical and Religious Directives for Catholic Health Care Services, 5th edition, SJH's CMS deemed status surveyor, CMS Medicare Conditions of Participation and any other standards as approved by the Board of Trustees to the end that the hospital shall maintain its status as a respected community hospital.

c. To ensure the clinical work of the staff is guided by the principles of continuous quality improvement, patient safety, regular peer review of the clinical work of its members, and ethical professional practice.

d. To assist the Board of Trustees, at the request of the Board, in all matters pertaining to the wellbeing of the hospital.

e. To serve as the primary means for accountability to the Board of Trustees for the appropriateness of the Medical Staff’s professional performance and ethical conduct of its members by maintaining the Medical Staff Bylaws, Rules and Regulations for the governing of the Medical Staff.

f. To serve as the primary means for accountability to the Board of Trustees for the appropriateness of the Medical Staff’s professional performance and ethical conduct of its members. To maintain a high level of performance by medical staff members and medical staff affiliates through appropriate delineation of staff privileges, and the continuous review and evaluation of the hospital activities of all individuals granted clinical privileges throughout appointment and reappointment.

g. To provide a means whereby issues of a medical administrative nature may be discussed by the Medical Staff with the Board of Trustees and Administration.

h. To provide and maintain such medical education and educational standards as are approved by the Board of Trustees.

i. To support such programs associated with community public health needs as are deemed appropriate by the Board of Trustees.

j. To render such other services as are reasonably necessary to carry out the foregoing purposes, as well as any other related purposes.
To uphold and support the mission of St. Joseph Healthcare, which is committed to wellness promotion and holistic healing, providing healthcare services which embody Compassion, Competence and Community. St. Joseph Healthcare, under the sponsorship of Covenant Health Systems, is an extended ministry of Christ's healing and mercy. This healthcare ministry is rooted in the tradition of our Foundress Blessed Mary Angela's vision of spirituality --- renewing society through compassionate caring of the whole person in all circumstances.

Therefore, St. Joseph Healthcare believes in:

* Pursuing excellence in the care and wellness of the whole person, body, mind and soul, throughout the continuum of life from conception through death.

* Fostering a spiritual environment in which all people feel welcome.

* Supporting the Ethical and Religious Directives for Catholic Health Care Services.

* Creating an atmosphere of respect and dignity.

* Encouraging personal and professional growth for all employees.

* Promoting social justice and access to healthcare for the poor and disadvantaged.

* Collaborating with others to enhance community healthcare services.
ARTICLE III

MEDICAL STAFF MEMBERSHIP

SECTION 1. Nature of Medical Staff Membership

Membership on the Medical Staff of St. Joseph Hospital is a privilege extended by the Board of Trustees only to those individuals judged by their peers to be of good character, qualified and competent in their respective fields who continuously meet the qualification standards and requirements set forth in these Bylaws, Rules and Regulations, and the Bylaws of St. Joseph Hospital.

SECTION 2. Qualifications for Membership

a. Only physicians and dentists currently licensed or authorized to practice in the State of Maine, who can document their background, experience, training and demonstrated competence, adherence to their professional ethics, their good reputation, and their ability to work with others with sufficient adequacy to ensure the Medical Staff and the Board of Trustees that any patient treated by them will be given high quality medical care, shall be qualified for membership on the Medical Staff.

No physician or dentist shall be entitled to membership on the medical staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that he/she is duly licensed to practice in this or any other State, or that he/she is a member of any professional organization, is certified by any specialty board or has attained fellowship or member in a specialty body or society or that he/she had in the past, or presently has, such privileges at another hospital.

b. All applicants for privileges to treat patients in the hospital must practice within a reasonable distance of St. Joseph Hospital. Any exception to this rule must be made by the Medical Executive Committee and approved by the Board of Trustees. Reasonable distance shall be defined by the Medical Executive Committee whenever necessary.

c. No applicant shall be denied appointment to the Medical Staff on the basis of age, gender, sexual orientation, race, creed, disability, national origin, religion, and health status. See Article V, Section 2 a.

d. Initial applicants must also meet the requirements of Article V, Section 2 a.

SECTION 3. Practitioner Ethics, Principles and Responsibilities

Acceptance of membership on the Medical Staff shall constitute the staff member's agreement that he/she will strictly abide by and be accountable for the following ethics, principles and responsibilities. Failure to comply with these ethics, principles and responsibilities may result in referral to the corrective action process or dismissal from the Medical Staff of the Hospital (See Article VII).

a. To abide by the most recent edition of the Ethical and Religious Directives for Catholic
b. To abide by the Medical Staff Bylaws and Rules and Regulations and all other lawful standards, policies and rules of the Medical Staff and the Hospital.

c. To comply with all applicable State and Federal laws and to render care to patients that is consistent with applicable professional standards of quality and appropriateness.

d. To not engage in the practice of division of fees under any guise whatsoever; not to receive from, or pay to, another physician or dentist, or any other person, either directly or indirectly, any part of a fee received for professional services except as otherwise authorized by Federal, State, or local statutory or administrative law.

e. To disclose any personal or professional conflicts of interest in fulfilling any of the functions of the Medical Staff or in the provision of patient care.

f. To participate in peer review, ethical standards and quality management activities and to refrain from harassing those who are participating in such activities.

g. To discharge such Medical Staff, Department, Service and committee functions for which he or she is responsible by appointment, election or otherwise.

h. To prepare and complete, in a timely manner, the medical records and any other required documentation for all patients to whom the Medical Staff in any way provides services in the Hospital or associated outpatient practices and maintaining confidentiality of patient-identifiable information (written or verbal) consistent with all State and Federal confidentiality laws and regulations.

i. To refrain from any unlawful harassment or discrimination against any person (including any patient, Hospital employee, Hospital independent contractor, Medical Staff member, volunteer or visitor) based upon the person’s age, gender, sexual orientation, race, creed, disability, national origin, religion, health status, ability to pay or source of payment.

j. To delegate responsibility for diagnosis or care of hospitalized patients only to a practitioner, practitioner in training, or Allied Health staff who is qualified to undertake this responsibility and who is adequately supervised.

k. To actively participate in and regularly cooperate with the Medical Staff in assisting the Hospital to fulfill its obligations relating to patient care and education including, but not limited to, patient safety, continuous quality improvement, peer review, utilization management, quality evaluation and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time.
l. To ensure no member of the Medical Staff may delegate to a commercial or other referral service, or a professional corporation or any other legal entity, the staff privileges assigned to him/her, including but not limited to the admission of patients to the hospital.

m. To not engage in disruptive behavior as it is inappropriate and unprofessional under any circumstances, whether or not it directly involves patient care and safety. All medical staff members are expected to demonstrate the ability to work cooperatively with the healthcare organization and its staff, its professional and medical staff, and refrain from disruptive behavior which could interfere with patient care, quality and safety, or the operation of the healthcare organization. Reference Exhibit 2, Subcommittee for Practitioner Health Guidelines.

n. To complete continuing medical education (CME) that is appropriate to the Practitioner’s specialty or licensure and related to the privileges requested and State licensure requirements.

o. To participate in emergency service coverage and serve on the service roster for unassigned patients as required by the Bylaws.

p. To cooperate with the Medical Staff in assisting the Hospital to meet its uncompensated or partially compensated patient care obligations.

q. To continuously inform the Medical Staff of any significant changes in the information required on appointment and reappointment.

r. To continuously meet the qualifications for membership as set forth in the Medical Staff Bylaws. A member may be required to demonstrate ongoing satisfaction of any of the requirements of the Bylaws upon reasonable request of the Medical Executive Committee or Credentials Committee.

SECTION 4. Medical Staff Rights

a. In the event a Practitioner and/or Medical Staff Member disagrees with a decision of the Department Chief, Service Leader, Medical Director, and/or Lead Physician, or a medical staff committee, and after all attempts to resolve the matter have been pursued with the Department Chief, Service Leader, Medical Director, and/or Lead Physician, or the medical staff committee, the Practitioner and/or Medical Staff Member is entitled to request an independent review of the matter. See Article VII.

SECTION 5. Conditions and Duration of Appointment and Reappointment

a. Initial appointments and reappointments to the Medical Staff shall be made by the Board of Trustees. The Board shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Executive Committee as provided in these Bylaws; provided that in the event of unwarranted delay on the part of the Medical Executive Committee, the Board of Trustees may act without such recommendations on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from
reliable sources other than the medical staff. For the purposes of this section, unwarranted delay with respect to appointments shall mean in excess of one hundred (100) calendar days from the date that the fully completed application has been submitted to the Medical Executive Committee.

b. Initial appointment shall be provisional for a period of approximately one year from the date temporary privileges or final Board approval is granted. Reappointments shall be for a period not to exceed 24 months.

c. Appointment to the Medical Staff shall confer upon the practitioner only such privileges as shall be herein provided, and, in any event, a clear distinction shall be made between an appointment to the Medical Staff and specific privileges to attend patients in particular Departments and on particular Services.

d. 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 Ethical and Religious Directives for Catholic Health Facilities and the Mission and Values Statement of the hospital, to abide by the Medical Staff Bylaws, Rules & Regulations, to accept committee assignments, consultation assignments, and participate in staffing the Emergency Service.

e. Appointment to or termination from employment and/or administrative responsibilities by the Hospital Administration has no effect on a practitioner's Medical Staff privileges.

f. Reporting Requirements
A member of staff must report the following events to the Medical Staff Office as soon as practicable and in no case greater than five (5) business days after receiving knowledge or notice of:

1. Any filed and served malpractice suit or arbitration action.
2. The receipt of a Notice of Claim relating to or alleging professional liability.
3. Any denials, cancellations, non-renewal or material reduction or restrictions imposed in medical liability insurance policy coverage, any surcharge or imposition of deductibles in medical liability insurance policy coverage.
4. Any limitation on clinical privileges placed by another healthcare entity.
5. Resignation or privileges at another healthcare entity while under investigation, or as a result of a proceedings in which clinical competence or professional conduct of the staff member was in question.
6. Any final adverse action taken, or report made to the National Practitioner Data Bank as defined under the Healthcare Quality Improvement Act of 1986.
7. Any report made to the Healthcare Integrity and Protection Data Bank.
8. Any notice that the practitioner has been placed on the Office of Inspector General (OIG) excluded provider's list.
9. Any temporary restraining order or interim suspension order sought or obtained in connection with the practitioner's professional services.
10. Any public letter of reprimand or any form of denial, restriction, probation, suspension or revocation of licensure, certification, membership, or clinical privileges by any healthcare entity including any voluntary withdrawal of
privileges.
11. Any revocation of DEA registration.
12. Being charged with a Class A, B, C crime or being charged with a Class D or E crime involving professional practice.
13. Being charged with operating a motor vehicle while under the influence of drugs or alcohol or being charged with any drug related crimes.
14. Any action against the Staff members’ certification under Medicare or Medicaid programs.
15. Any denial of medical staff membership or denials of requested advancement of such status.
16. Receipt of letter of complaint or notice of final action taken by a professional licensing board.
17. Any discipline by a professional society or resignation from such a society while allegations were pending.

The Manager of the Medical Staff Office in concert with the Director of Quality/PI, the President, the Vice President of Medical Affairs, the Chair of the Credentials Committee and the Chief of the respective service will review all reports and triage based on significance and impact on patient safety or quality. Reports deemed significant will be referred to the Professional Practice Evaluation Committee for further review, with the PPEC submitting its findings to the Credentials Committee.

A practitioner is required to immediately advise the President in writing of any revocation, suspension or change in status of the practitioner’s Medicare or Medicaid provider number. Failure to notify the President in a timely manner will be grounds for corrective action.

SECTION 6. Leave of Absence

a. Absence from medical staff and patient care responsibilities for longer than 60 days shall require a Medical Staff member to request a leave of absence. Medical Staff Members appointed to the medical staff may request a leave of absence by submitting a written request to the Medical Staff Office. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave, such as military duty, additional training, family matters, or personal health condition. During the period of an approved leave of absence, the medical staff member will not exercise clinical privileges at the hospital or outpatient practices. Absences without an approved leave of absence may constitute grounds for termination from medical staff membership which includes the exercise of clinical privileges.

b. The Board of Trustees delegates the authority to make determinations in connection with requests for leaves of absence, provided that the Board reserves the right to make final determinations, at its discretion. Requests will be submitted to the Credentials and Medical Executive Committees.

c. Medical Staff Office personnel will contact the medical staff member no later than thirty (30) days prior to the conclusion of the leave of absence, to request documentation in support of reinstatement. If applicable, a written summary of professional activities
performed during the leave of absence will be requested. The Department Chief/Service Leader shall review the documentation to be submitted to the Credentials and Medical Executive Committees for a recommendation. The practitioner bears the burden of providing information and documentation sufficient to demonstrate current competence and all other applicable qualifications. The practitioner shall provide any other information requested by the Department Chief/Service Leader, the Credentials Committee or the Medical Executive Committee, including executing any releases that may be necessary to require third parties, including the practitioner’s physician, to respond to any request for information or clarification.

d. If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the practitioner’s physician indicating that the practitioner is physically and/or mentally capable of resuming clinical practice and safely exercising the clinical privileges requested.

e. The Board shall consider the recommendations of the Credentials and Medical Executive Committees and may approve reinstatement to either the same or a different staff category. The practitioner’s clinical privileges may be limited or modified upon reinstatement or conditions imposed for the practitioner’s practice if deemed reasonably necessary for patient quality and safety or the effective operation of the hospital. In the event that the Board determines that denial of reinstatement or modifications or conditions would require a report to the appropriate Maine licensing body and/or National Practitioner Data Bank, the practitioner shall be given written notice and the opportunity to request a hearing within thirty (30) days. Corrective action hearing and appellate review is outlined in Article VII of these Bylaws. Voluntary withdrawal of staff privileges while under investigation by the hospital for possible professional conduct or in return for not conducting such an investigation or taking a professional review action is reportable to the National Practitioner Data Bank and may be reportable to the applicable Maine licensing body.

f. Absence for longer that one (1) year shall result in automatic relinquishment of medical staff appointment and clinical privileges unless an extension is requested in writing at least thirty (30) days prior to the end of the leave, endorsed by the Medical Executive Committee, and granted by the Board. Extensions will be considered only in extraordinary cases of hardship and when extension of a leave is found to be in the best interest of the hospital. If privileges exhaust the appointment/reappointment period, upon return, documentation of competency/capability to perform privileges must be provided.

g. Leaves of absence and reinstatement are matters of courtesy, not of right. In the event that it is determined that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal (except for those limited circumstances outlined in paragraph (e).
ARTICLE IV

MEDICAL STAFF CATEGORIES

SECTION 1. Categories

There shall be seven categories of membership on the Medical Staff: Active, Adjunct, Affiliate, Allied Health, Locum Tenens, Honorary and Telemedicine. It should be noted that the Active category with the exception of the Allied Health Staff, has four sub-categories – High, Occasional, Call Only, and Ambulatory Care.

SECTION 2. Active Medical Staff

The medical staff is comprised of Medical Staff and Allied Health Staff who are licensed independent practitioners and other dependent practitioner, non-physician providers privileged through established medical staff processes, who are subject to the Medical Staff Bylaws, Rules and Regulations and associated policies, who reside in the area, who have authority to participate in the governance of the Medical Staff (per assigned obligations and citizenship requirements), and provide medical and/or dental patient care services at St. Joseph Healthcare.

The “Medical Staff” shall consist of doctors of medicine or osteopathy and doctors of dental surgery or dental medicine.

The “Allied Health Staff” shall consist of non-physician providers, advanced practice registered nurses, physician assistants, first assistants (RNFA, SA, CST), psychologists, podiatrists, dental assistants, licensed clinical social worker and psychiatry, and nurse practitioner (Allied Health).

Depending on the obligations, citizenship requirements and privileges granted by the Board of Trustees, medical staff members may vote, serve on committees, hold office, and admit patients.

A. Obligations of the Medical Staff, Physicians and Dentists

1. Contribute to the organization and administrative affairs of the medical staff including service on medical staff, department/service and/or hospital committees, as assigned, and faithfully performing the duties of any office or position to which elected or appointed, as applicable;

2. Serve on the service roster for unassigned patients, and participate in emergency department coverage (per assigned citizenship requirements) as determined by the Department Chief, Service Leader, Medical Director, or Lead Physician (as applicable), and Credentials Committee, MEC, and Board of Trustees;

3. Attend medical staff meetings, department/service meetings, hospital or any assigned committee meetings at a level determined by the Department Chief, Service Leader, Medical Director, or Lead Physician (as applicable),
4. Participate in quality assurance/performance improvement and patient safety activities required by the medical staff at a level determined by the Department Chief, Service Leader, Medical Director or Lead Physician (as applicable), and Credentials Committee, MEC, and Board of Trustees;

5. Discharge the recognized functions of staff membership by providing specialty coverage in the emergency department (per citizenship requirements), attending patients as required, giving consultation to other staff members consistent with delineated privileges, and fulfilling such other staff functions as may reasonably be required of staff members;

6. Vote on all matters presented at medical staff meetings, department/service meetings, or hospital committee meetings of which you hold membership;

7. Admit, in accordance with assigned staff category;

8. Pay medical staff dues and application fees (appointment and reappointment) in a timely manner; and

9. At the age of 60, members of the Medical Staff may choose to reduce their obligations. Emergency department call and committee assignments shall not be required. Attendance at medical staff, department/service, or hospital committee meetings may be required (depending on citizenship requirements).

In order to exercise voting privileges, all obligations and citizenship requirements must be met, including meeting attendance, committee assignment, payment of annual dues, etc.

Definitions of Sub-Categories and Citizenship Requirements for Active Medical Staff:

High: includes providers who regularly utilize the services of the hospital with a medium to high volume of patient care activity.

1. Officers/Committees – may serve on any committee and/or hold office.
2. Call – shall participate in call obligations (see Section 2. a., Obligations).
3. Meeting Attendance - must attend 50% of medical staff, department/service, hospital committee meetings, or any other assigned committee meetings. General Medical Staff meeting attendance is optional.
4. Members in this category shall have admitting privileges.

Occasional: includes providers who utilize the services of the hospital with a low volume of patient care activity.

1. Officers/Committees - may serve on any committee and/or hold office.
2. Call - may participate in call for unassigned patients.
3. Meeting Attendance – attendance at department/service meetings is optional except during discussions involving their patient(s) and/or quality of care. Attendance during medical staff, hospital committee meetings, or any other assigned committee meetings must be 50%. General Medical Staff meeting attendance is optional.
4. Members in this category may have admitting privileges.

Call Only: includes providers who are on staff in order to provide emergency on-call coverage only.
1. Officers/Committees - shall not serve on committees or hold office.
2. Call – shall participate in call obligations (see Section 2. a., Obligations).
3. Meeting Attendance – department/service meetings are optional, except during quality of care discussions involving their patient(s). General Medical Staff meeting attendance is optional.
4. Members in this category may have admitting privileges.

Ambulatory Care: includes providers in outpatient settings.

1. Officers/Committees – may serve on any committee and/or hold office.
2. Call – not obligated to participate in call for unassigned patients.
3. Meeting Attendance – must attend 50% of medical staff, department/service, hospital committee meetings, or any other assigned committee meetings. General Medical Staff meeting attendance is optional.
4. Members in this category do not have admitting privileges.

Individual exceptions to the citizenship requirements outlined above can be made upon the recommendation of the Department Chief and Service Leader, Medical Director or Lead Physician and approval of the Credentials Committee, Medical Executive Committee and the Board of Trustees.

SECTION 3.  Allied Health Staff

The Allied Health Staff shall consist of non-physician providers (advanced practice registered nurses, physician assistants, first assistants (RNFA, SA, CST), psychologists, podiatrists, and dental assistants) who are educationally and clinically prepared, and who have maintained competency in a discipline which the Board of Trustees has determined by policy to allow to practice within the hospital or in an outpatient setting.

Providers in this category have a recognized but limited scope of practice within medicine and are licensed and permitted to provide patient care as delineated in the privileges granted, either independently (i.e. without supervision), or in a medical support role (requiring supervision) to another provider (Dependent Allied Health practitioners).

A. Obligations of the Allied Health Staff:

1. Contribute to the organization and administrative affairs of the medical staff including service on medical staff, department/service and/or hospital committees, as assigned;
2. Attend medical staff, department/service, hospital committee, or any assigned committee meetings, at a level determined by the Department Chief and Service Leader or Medical Director (when applicable), and Credentials Committee, MEC and Board;
3. Participate in quality assurance/performance improvement and patient safety activities required by the medical staff;
4. Discharge the recognized functions of staff membership by attending patients as required, giving consultation to other staff members consistent with delineated privileges, and fulfilling such other staff functions as may reasonably be required of
staff members;
5. Vote on all matters presented at medical staff committee meetings, department/service meetings, hospital committee meetings, or other assigned committees of which you hold membership; and
6. Pay medical staff dues and application fees (appointment and reappointment) in a timely manner.

In order to exercise voting privileges, all obligations and citizenship requirements must be met, including meeting attendance, committee assignment, payment of annual dues, etc.

B. Citizenship Requirements of the Allied Health Staff:

1. Meeting Attendance - must attend 50% of medical staff, department/service, hospital or any other assigned committee meetings.
2. May attend General Medical Staff meetings and vote;
3. May not hold medical staff office; and
4. Shall not have admitting privileges.

Pursuant to policy adopted by the Board of Trustees, following are the only categories of independent and dependent Allied Health Staff currently authorized to provide services, and the criteria necessary for application at St. Joseph Hospital:

C. Independent Allied Health Staff:

The following practitioners are permitted under hospital policy to practice independently at St. Joseph Hospital with membership on the Allied Health Staff. They are permitted to independently perform the professional services for which they are licensed and according to the privileges granted. They will be assigned to a specific department/service, must have a scope of practice established by the Department Chief, Service Leader, Medical Director or Lead Physician and participate in the quality assurance activities of the hospital.

1. Clinical Psychologist - An earned doctorate in clinical psychology from an American Psychological Association (APA) accredited college or university, an APA accredited internship, and an active and valid Maine license. Psychology shall be a specialty of the Department of Medicine/ Family Practice.

2. Podiatrist - A Doctor of Podiatric Medicine degree (D.P.M.) from an American Board of Podiatric Surgery accredited school of podiatric medicine and an active and valid Maine license. Podiatry shall be a Service of the Department of Orthopaedics.

3. Nurse Practitioners – An advanced practice registered nurse degree (MSN) from an accredited school and an active and valid Maine license indicating approval to practice independently from the Maine Board of Nursing.

D. Nurse Practitioners:

Nurse practitioners may practice:
Independently (without direction or immediate supervision) in the ambulatory care setting; Independently utilizing a Plan of Collaboration in the inpatient hospital setting; or Dependent under the direction and supervision of a physician or another nurse practitioner (granted supervising status by the Maine Board of Nursing) utilizing a Plan of Supervision in either the ambulatory care or hospital setting.

Dependent nurse practitioners are not permitted by law or license to provide certain health care services without specific supervision by a physician or supervising nurse practitioner authorized to do so by the Maine Board of Nursing, and/or are not approved to practice or choose not to practice independently at St. Joseph Hospital.

Independent Nurse Practitioners must:

1. Be a graduate of a master’s degree accredited program for advanced practice registered nurses (APRN);
2. Maintain active and valid Maine APRN licensure;
3. Maintain active and valid certification by the American Nurses Credentialing Center (ANCC), the American Academy of Nurse Practitioners (AANP), or equivalent nurse practitioner certifying body;
4. Submit a current Plan of Collaboration (POC) signed by a member of the hospital’s Medical Staff who holds privileges covering the clinical activity the nurse practitioner performs within the hospital. The POC must contain a list of physicians who collaborate with the nurse practitioner (primary and/or secondary) as well as confirm that they will be available upon the request of the nurse practitioner to discuss patient care, and education, diagnostic and therapeutic decisions and agree to assume patient care which is beyond the nurse practitioner’s privileges;
5. Obtain independent practice status through the Maine Board of Nursing;

E. Dependent Allied Health Staff Categories:

The following providers are required under hospital policy to practice dependently at St. Joseph Hospital. These providers are required to perform the professional services for which they are licensed under the direction or immediate supervision of a provider authorized to do so by the applicable licensing body. They will be assigned to a specific department/service, must have a scope of practice established by their supervisor and must be recommended by the appropriate Department Chief and Service Leader, Medical Director or Lead Physician, and participate in the quality assurance activities of the hospital.

1. **Physician Assistants must:**
   a. Be a graduate of an accredited physician assistant program;
   b. Maintain active and valid certification from the National Commission on Certification of Physician Assistants (NCCPA);
   c. Maintain active and valid Maine licensure;
d. Maintain a current Plan of Supervision (POS) signed by a member of the hospital's Medical Staff qualified to be a supervising physician by the appropriate licensing board. The POS must be submitted with the initial appointment application and updated with each application for reappointment.

The physician assistant wishing to function as surgical first assistant must provide documentation of training specific for the role, which includes both didactic and supervised clinical components.

2. **Dependent Nurse Practitioner must:**

   a. Be a graduate of an accredited program for advanced practice registered nurses (APRN);
   b. Maintain active and valid Maine APRN licensure;
   c. Maintain active and valid certification by the American Nurses Credentialing Center (ANCC), the American Academy of Nurse Practitioners (AANP), or equivalent nurse practitioner certification body;
   d. Function under direction and/or immediate supervision of a member of the Medical Staff, or by a member of the Allied Health Staff who has been granted supervisory status by the Maine Board of Nursing.
   e. Provide a current Plan of Supervision (POS) signed by a member of the hospital's Medical Staff, or Allied Health Staff (described in d. above) who holds privileges in the same specialty area. The POS must be submitted with each application for appointment and updated with each application for reappointment, must include Supervisor(s) information, must conform to regulations as applicable, and be recommended by the appropriate Department Chief and Service Leader, Medical Director or Lead Physician.

A nurse practitioner wishing to function as a surgical first assistant must provide documentation of formal educational and training specific for the role, which includes both didactic and supervised clinical components.

3. **Physician-employed Surgical Assistant**

   **Level I:** A certified surgical technologist, a registered nurse or a licensed practical nurse

   a. **Surgical Technologist** – A graduate of an accredited school for surgical technologists or possess competence comparable to that of an individual who has graduated from an accredited school, at least two years practical experience in activity area requested, and a current Plan of Supervision with a member of the hospital's Active Medical Staff. Candidates are expected to pursue certification by the Liaison Council of Certification for the Surgical Technologist, the National Assistant at Surgery Council, or similar organization, and to maintain such certification while a staff member.

   b. **Registered Nurse/Licensed Practical Nurse** – Active and valid Maine nursing
license, proficiency in perioperative nursing practice as scrub for at least two years, and a current Plan of Supervision with a member of the hospital's Active Medical Staff.

Level II – a surgical technologist first assistant, a registered nurse first assistant or physician assistant.

a. Registered Nurse First Assistant (RNFA) – Active and valid Maine license, current certification in perioperative nursing (CNOR), proficiency in perioperative nursing practice as both scrub and circulator for at least five years, additional formal educational preparation specific for the role of RNFA per the Association of Operating Room Nurses' (AORN) position statement, and a current Plan of Supervision with a member of the hospital’s Active Medical Staff. Candidates are expected to pursue certification as an RNFA by the National Certification Board for Preoperative Nursing and to maintain such certification while a staff member.

b. Physician Assistant - See Section 5.E.1 for requirements for the physician assistant wishing to function as Surgical First Assistant.

Members of the Allied Health Staff may provide specifically designated services under established conditions of supervision and may write orders as determined by the medical staff but within legal constraints.

If the supervisor of an Allied Health Staff member should have his or her privileges suspended, then the privileges of the Allied Health Staff member shall also be suspended until the supervisor’s privileges are reinstated or an alternate supervisor is identified.

**SECTION 4. Locum Tenens Medical Staff**

The Locum Tenens medical staff shall consist of practitioners who provide recurring, short-term care and are appointed for the specific purpose of providing temporary coverage due to urgent patient care needs. Locum Tenens applicants are appointed in the same manner as other applicants. Locum Tenens medical staff are not required to attend meetings and are not eligible to vote, hold office, or serve on committees. Providing medical staff services through the use of locum tenens may be used for a period not to exceed six months.

**SECTION 5. Honorary Medical Staff**

The Honorary medical staff shall consist of physicians or dentists who are not active in the hospital and who may be (1) retired from the Active Medical Staff, or (2) of outstanding reputation not necessarily resident in the community. The Honorary medical staff shall not vote, hold office, pay dues, or have assigned duties. Honorary Medical Staff members have no privileges to provide patient care in any manner. Honorary Medical Staff members are not required to attend meetings, maintain a license, DEA, or malpractice insurance. Reappointment is not required.

**SECTION 6. Telemedicine Medical Staff**

Members of the Telemedicine Medical Staff, providers who use electronic communication or other communication technologies to provide or support clinical care from a distance, shall
consist of licensed independent practitioners. Providers shall be licensed in Maine and must provide the same information as required of other applicants for membership in any other staff category.

When Telemedicine Services are furnished to hospital patients through an agreement with a distance site hospital, it is the responsibility of the governing body of the distant site hospital to meet the following requirements:

1. Must be a Medicare participating hospital, and
2. Ensure providers at the distant site are privileged to provide these services.
3. Must hold an active license issued by the State of Maine.

The distant site will provide evidence of its internal review of the performance of its providers which will be used as a periodic appraisal. At a minimum, this information will include all adverse events that resulted from Telemedicine services provided by the distant site provider to the hospital’s patients and all the complaints the hospital received about the distant site provider.

Such information may be obtained through an Agreement by and between SJH and Telemedicine Service Provider. Refer to the Telemedicine Credentialing and Privileging by Proxy policy, MSO015.

The Agreement shall include the methods of obtaining credentialing, privileging, and quality data information, etc.

Members of the Telemedicine Medical Staff do not have admitting privileges, shall not be required to attend meetings, vote, hold office, or pay annual medical staff dues. See Article VI, Section 8.

**SECTION 7. Staff Dues**

a. The staff dues fund shall consist dues paid by members of the Medical Staff. All members of the Active, Adjunct, Affiliate and Allied Health Staff shall be assessed dues annually.

b. The staff dues structure shall be governed by the needs and requirements of the medical staff based upon a review by the Secretary/Treasurer of the Medical Staff and approval by the Medical Executive Committee.

c. The Secretary/Treasurer of the Medical Staff shall conduct an annual review of Medical Staff funds and present a detailed report to the Medical Executive Committee. Upon MEC approval, the report shall be presented at the April General Medical Staff meeting. If an audit of the Medical Staff funds is requested, an Audit Committee shall be appointed by the President of the Medical Staff to include three (3) staff members, one of whom shall be appointed as Chairman of the Audit Committee. Any member of the Medical Staff can request an audit.

d. The Secretary/Treasurer of the Medical Staff shall notify members who are six (6) months delinquent in payment of their dues. Upon recommendation of the MEC and Board of Trustees approval, the medical staff member who continues to be delinquent after sixty (60) days may be dropped from the medical staff for nonpayment of dues.
e. Following written notification, special dues assessments may be made by a majority vote of the dues paying members present and voting at any general or special medical staff meeting.
ARTICLE V

PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

SECTION 1. Application for Appointment

a. All applications for appointment to the Medical Staff shall be submitted in writing to the Medical Staff Office, or designee, signed by the applicant, and indicating the Department/Service to which the candidate shall be assigned, the privileges requested, and the staff category desired. Applications shall be submitted on a form recommended by the Credentials and Medical Executive Committee and approved by the Board of Trustees. Such application shall require detailed information concerning the applicant's education and training, and shall include the name of at least two (2) peers who have trained, observed and/or worked with the applicant and can provide adequate references pertaining to the applicant's current clinical competence and ethical character. Such application shall contain information regarding membership status and/or clinical privileges, whether they have ever been limited, suspended, revoked, not renewed or made subject to probationary conditions and otherwise adversely affected, to include withdrawn involuntarily or voluntarily surrendered or modified while under or to avoid investigation or disciplinary action in any other hospital or institution, and as to whether his/her membership in medical societies or his/her license to practice any profession has ever been involuntarily or voluntarily restricted, suspended, revoked, denied, made subject to probationary conditions or otherwise disciplined. It shall further contain information as to whether the DEA license has ever been denied, modified, suspended, revoked, or voluntarily surrendered.

b. Applicants for clinical privileges must provide proof of medical liability insurance coverage for the past five years, stating the amount of liability coverage and the company providing the insurance, as well as a personal attestation of professional liability claims history. Claims history will be verified with the carrier, to the extent possible. The insured's current company must be licensed or approved by the State insurance department. The minimum limit of malpractice insurance coverage is $1,000,000 per occurrence. Insurance information submitted in the appointment/reappointment process will be kept confidential and will not be released without a signed Consent for Release by the applicant.

c. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competency, character, health status, ethics, and other qualifications, and for resolving any doubts about such qualifications. The application is not considered complete until all supporting information is received by the Medical Staff Office, or their designee.

d. The completed application shall be reviewed by the appropriate Department Chief/Service Leader, recommended by the Credentials Committee, the Medical Executive Committee and final approval rests with the Board of Trustees.

e. Once final Board approval is obtained, applicants will be announced in writing to the
Medical Staff and appropriate internal hospital parties and will be distributed by the Medical Staff Office. Any member of the Medical Staff may review his/her own application upon written request to the President, VPMA, Chair of Credentials Committee, Chair of Medical Executive Committee, or Director of Quality/PI. This review will be conducted with supervision to ensure and maintain the integrity of the record.

f. By applying for Medical Staff appointment, the applicant thereby signifies his/her willingness to appear for interviews in regard to the application process, authorizes the hospital to consult with members of the medical staffs and administrations at other institutions with which the applicant has been associated, and releases the hospital, all representatives of the hospital, and all members of its medical staff from any liability, as more particularly described by Article XII of these Bylaws.

g. The application form shall contain a statement that fully informs the applicant of the scope and extent of the above release and consent provisions and of the immunity provisions contained in Article XII of these Bylaws.

h. The Consent for Release shall include a statement that the applicant has received, read, and agrees to be bound by the terms of the Medical Staff Bylaws, Rules and Regulations.

SECTION 2. Standards for Initial Appointment to the Medical Staff for Physicians

The following subsections: a, b, c, e, and o apply only to physicians and dentists, the remaining elements apply to all.

a. In addition to Article III, Section 2, all applicants shall meet the following standards:

1. Graduation from an approved and accredited medical or dental school in the United States or Canada; or,

2. Graduation from an approved and accredited foreign medical school and successful completion of an examination: (1) by the Educational Commission for Foreign Medical Graduates (ECFMG) or successor agency, OR (2) by the National Board of Medical Examiners.

b. Successful completion of an accredited residency training program which qualifies the applicant to sit for examination by their medical specialty board.

c. Board Certification (pursuing and on track to achieve) by a Board included in the American Board of Medical Specialties (ABMS); American Osteopathic Board (AOB); American Dental Association (ADA); the American Board of Podiatric Surgery (ABPS); or the Royal College of Physicians and Surgeons in Canada maintained continuously while appointment is in effect (and needs to be maintained throughout reappointment period) unless not required by specialty (e.g. Pathology). All members of the medical staff, prior to January 1, 2014, shall be grandfathered from the certification and recertification requirements and shall maintain their staff membership under the present credentialing criteria and guidelines.
The Board of Trustees may, upon request of the Department Chief and recommendations of the Credentials and Medical Executive Committees, waive the requirement for board certification, or in the case of Allied Health Staff, certification. Examples would include but are not limited to a locum tenens provider. See MS0022 Board Certification Waiver Criteria for additional information.

d. If the applicant is not a US citizen, (a) successful completion of a visa-qualifying examination, OR (b) possession of a permanent visa.

e. Active Maine medical or dental licensure maintained continuously while appointment is in effect. At the time of appointment, documentation of the current five (5) year licensure history, in Maine and/or other states or countries including any professional discipline or sanctions by any Board, will be obtained and considered.

f. Active DEA registration, if applicable, issued by the United States Department of Justice, Drug Enforcement Administration, and maintained continuously while appointment is in effect, unless not required by specialty (e.g. Pathology).

g. Ability to communicate effectively by verbal and written means with or without reasonable accommodation as may be required by applicable federal and state laws and regulations.

h. Agreement to abide by the Medical Staff Bylaws, Rules and Regulations, and associated hospital and/or medical staff policies and procedures.

i. Evidence of current clinical competence, to include procedure logs, final summative evaluations, and peer attestations regarding clinical skills and competence. Evidence of CME activity relating at least in part to the privileges requested.

j. Absence of mental or physical disabilities that would jeopardize safe exercise of the privileges requested. Attestation by the applicant regarding acceptability of current health status to perform activities required to fulfill the requested privileges will be acceptable.

k. Favorable recommendations from director(s) of the applicant's professional training program(s) and/or from others deemed by the hospital to be competent and knowledgeable regarding the applicant's ability, training, competence and character.

l. Other character references acceptable to the hospital.

m. Verifiable documentation of the applicant's qualifications for appointment to an appropriate service, and to receive specific clinical privileges delineated in accordance with the standards listed in Section 4, Standards for Initial Granting of Clinical Privileges. Documentation of a current five (5) year history of the applicant’s professional performance and conduct at other institutions where privileges to practice are or were held, will be obtained.
n. Full disclosure by the applicant of any history of Class A, B, C crimes, or their equivalent, convictions, current/past substance abuse, or sanctions by federal or state payers. An NPDB report will be run within four (4) months prior to the presentation to the Credentials Committee.

o. Current report from the National Practitioner Data Bank (NPDB), Office of the Inspector General, Maine Fraud Prevention and Detection, etc. A NPDB report will be run within (4) months prior to presentation to the Credentials Committee.

p. Expected professional practice structure and coverage arrangements that are acceptable to the hospital, will be provided prior to medical staff appointment.

SECTION 3. Primary Source Verification Requirements

Primary source verification of the following, directly from the granting or certifying authority (when feasible); will be documented during the appointment and/or reappointment process:

a. Education/training (appointment only)
b. Active and past licensure (appointment only); active licensure (reappointment)
c. Board certification, if applicable
d. Professional liability claims history for the current five (5) year period
e. Professional sanctions (i.e., NPDB, OIG, Medicare/Medicaid Exclusion Program, etc.)
f. Identity (appointment only)

SECTION 4. Standards for Initial Granting of Clinical Privileges

For the initial granting of clinical privileges, the following department-specific standards are required:

a. For privileges in the Department of Surgery and Orthopaedics, and associated Services (see Article IX, Clinical Departments), (a) certification by a specialty board of the American Board of Medical Specialties (ABMS) or by the American Board of Oral and Maxillofacial Surgery; OR (b) successful completion of accredited residency-training qualifying the applicant to sit for examination appropriate to the specific specialty board.

b. For privileges in the Department of Medicine/Family Practice, and associated Services (see Article IX, Clinical Departments), (a) certification by a member specialty board of the American Board of Medical Specialties, or (b) successful completion of accredited residency training qualifying the applicant to sit for examination appropriate to the specific specialty board, or successful completion of three years of accredited post-graduate training qualifying the applicant to sit for examination by a member specialty board of the American Board of Medical Specialties,

c. For privileges in the Department of Radiology, Anesthesiology, and Pathology, and associated Services (see Article IX, Clinical Departments), (a) certification by the respective specialty board of the American Board of Medical Specialties; or (b) successful completion of accredited post-graduate training qualifying the applicant to sit for examination appropriate to the specific specialty board.
For privileges in the Department of Emergency Medicine (a) certification by the American Board of Emergency Medicine (an ABMS member board); or (b) successful completion of an accredited Emergency Medicine Residency program and completion of board certification within three years of graduation; or (c) at least three years post-graduate residency training in a clinical specialty which qualifies the applicant for board certification in their specialty and prior experience in an active emergency department.

Certification by the American Osteopathic Association member boards, the Royal College of Physicians and Surgeons of Canada or by the American Board of Oral and Maxillofacial Surgery is considered equivalent to certification by the American Board of Medical Specialties in all areas.

NOTES:

1. "Accredited" medical school means a medical school that is accredited by the Liaison Committee on Medical Education (LCME), Committee on Accreditation of Canadian Medical Schools (CACME), the Commission on Dental Accreditation of the American Dental Association or by the American Osteopathic Association.

2. "Approved" implies approval by the government of a foreign country in which the school is located or by the World Health Organization (WHO).

3. "Accredited residency training" and "accredited post-graduate training" mean graduate training in programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), Royal College of Physicians and Surgeons of Canada (RCPSC), by the Commission on Dental Accreditation of the American Dental Association or by the American Osteopathic Association.

4. "Qualifying the applicant" implies a determination by a specialty-board that is a member of the American Board of Medical Specialties, the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada or by the American Board of Oral and Maxillofacial Surgery. The phrase does not imply a determination by the applicant or the Hospital. An otherwise satisfactory applicant who (a) has successfully completed accredited satisfactory post-graduate training qualifying the applicant to sit for examination, but (b) has not completed post-training practice requirements of a specialty-board may be considered for appointment and clinical privileges.

5. The word, "privileges" appearing here and elsewhere in these standards does not imply "full", "unlimited", or "unrestricted" privileges. The scope and number of privileges are to be determined on an individual basis.

6. "Clinical privileges" include emergency, primary, secondary and tertiary levels of patient care, as well as clinical, supervisory, educational and research privileges.
SECTION 5. Appointment Process

a. Within thirty (30) days of the Department Chief’s final review, which includes an interview of the applicant or statement regarding why the interview was unnecessary, and approval of a completed application for membership and privileges, applicants shall be scheduled to attend Orientation, as appropriate. The Credentials Committee may request additional information in support of privileges requested. The Credentials Committee recommendations are transmitted to the Medical Executive Committee in the form of meeting minutes with all actions clearly specified.

b. The Medical Executive Committee shall, based on review of the Credentials Committee minutes and report by the Credentials Committee Chairman during the meeting, decide whether to forward the recommendations of the Credentials Committee to the Board of Trustees, reject the recommendations, or defer the recommendations for further consideration.

c. When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within thirty (30) days with a subsequent recommendation for appointment or for rejection.

d. When the Medical Executive Committee rejects an application, either in respect to appointment or clinical privileges, the President of the Hospital, or designee, shall promptly so notify the applicant. No such adverse recommendation shall be forwarded to the Board of Trustees until after the applicant has exercised or has been deemed to have waived his/her right to a hearing as provided in Article VII of these Bylaws.

e. If, after the Medical Executive Committee has considered the report and recommendation of the Hearing Committee, and recommends appointment to the medical staff, the President of the Hospital shall promptly forward it, and all supporting documentation, to the Board of Trustees. If such recommendation continues to be adverse, the President of the Hospital shall promptly so notify the applicant, and shall also forward such recommendation and documentation to the Board of Trustees. The Board of Trustees will take action after the applicant has exercised or has been deemed to have waived his/her right to an appellate review as provided in Article VII of these Bylaws.

f. Whenever the recommendations of the Credentials and/or Medical Executive Committee, or final decisions of the Board of Trustees are in disagreement with respect to appointments or reappointments, such disagreements shall be reviewed by the Joint Conference Committee.

g. When the Board of Trustees' decision is final, it shall send notice of such decision through the President to the Medical Staff Office who, in turn, notifies the applicant.
SECTION 6. Provisional Appointment/Reappointment

a. All initial appointments to the medical or allied health staff shall be provisional for a period of approximately one year from the time temporary privileges or final Board approval is granted. Refer to Article III, Section 5.b.

b. During the provisional period, applicants shall be assigned to a department/service, and participate in a focused professional practice evaluation (FPPE) where his/her clinical competence and ethical and moral conduct may be observed by the Department Chief and Service Leader, Medical Director or Lead Physician, as applicable, and other members of the staff. Each member shall practice in accordance with the Roman Catholic moral and ethical principles and values enunciated in the Ethical and Religious Directives for Catholic Health Facilities (refer to Exhibit 5). The purpose of such observation shall be to determine his/her current clinical competence in regards to the clinical privileges provisionally requested/granted.

c. By the end of the provisional period, the Department Chief, Service Leader, Medical Director and/or Lead Physician will review the applicant based on the FPPE results and recommend one of the following:

   1) A change in status (advancement) from provisional to the appropriate staff category (Refer to Article IV).

   2) Continue the FPPE, not to exceed two years from the time initial privileges were granted, in order to obtain sufficient data for decision-making.

   3) Terminate appointment/deny privileges.

d. After this time, failure to advance to regular medical staff status shall be deemed a termination of appointment. A provisional appointee whose membership is so terminated shall have rights to appellate review as outlined in Article VII, Corrective Action, Hearing, and Appellate Review.

e. A recommendation for provisional reappointment for up to a year may be made by the Department Chief, Service Leader, Medical Director, and/or Lead Physician. It may be used to assist an applicant in meeting medical staff requirements (i.e., meeting attendance, CME, etc.), or to assist the Department Chief, Service Leader, Medical Director, or Lead Physician in obtaining information not readily available at the time of reappointment review. Provisional reappointments must be approved by the Credentials Committee, the Medical Executive Committee, and the Board of Trustees.

SECTION 7. Reappointment Process

a. Each staff member will be evaluated for reappointment on a two-year cycle, not to exceed 365 + 365 days based on the year/month they were born, with those born in odd years evaluated in odd years and those born in even years evaluated in even years.
b. Approximately six (6) months prior to the expiration date of the current reappointment cycle, the CVO will send an application packet to each provider in the specific cycle.

c. Approximately four (4) months prior to the expiration date of the current reappointment cycle, the Medical Staff Office, or their designee, assembles the reappointment file and arranges a time for the Department Chief/Service Leader to perform their review.

d. Each recommendation concerning the reappointment of a medical staff member and the clinical privileges to be granted shall be based on the continuous evaluation of a practitioner’s performance through the ongoing professional practice evaluation (OPPE) process. The individual’s current clinical competence regarding patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, CME activity relating at least in part to the privileges requested and systems-based practice will be considered. In addition, the individual’s health status, ethics and conduct, attendance at meetings, compliance with the Medical Staff Bylaws, rules and regulations, cooperation with hospital personnel, the overall use of the hospital facilities for patients, relations with other practitioners and general attitude toward patients and the hospital, and a current report from the National Practitioner Data Bank will also be considered.

e. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competency, character, health status, ethics, and other qualifications, and for resolving any doubts about such qualifications. The application is not considered complete until all supporting information is received.

f. The Department Chief/Service Leader shall review and make his/her recommendation regarding the applicant within sixty working days (60) of receipt of reappointment completed application.

g. Within thirty working days (30) of the Department Chief/Service Leader’s review and recommendation, the Credentials Committee shall make a written recommendation, via meeting minutes, to the Medical Executive Committee concerning the reappointment and clinical privileges of each staff member.

h. Within thirty working days (30) of the Credentials Committee’s recommendation, the Medical Executive Committee shall make a written recommendation, via meeting minutes, to the Board of Trustees, through the President of the Hospital, concerning the reappointment and clinical privileges of the staff member. Where non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendation shall be stated and documented. Reappointments, if granted, shall be for a period of not more than two years.

i. If a member of the Medical Staff is not reappointed within two (2) years of the last appointment or reappointment, regardless of fault or reason, the practitioner may no longer admit patients or attend patients in the hospital. The Department Chief or designee who is responsible for supervising the practitioner will assign all the practitioner’s patients who are in this hospital to another practitioner. When feasible,
the Department Chief will consider the patient’s wishes in choosing a substitute practitioner.

j. If a member of the Medical Staff is not reappointed within two (2) years of the last appointment or reappointment and elects to reapply for Medical Staff membership, that application shall be treated as an initial application.

k. Primary Source Verification Requirements. See Article V, Section 3.

SECTION 8. Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE)

FPPE is a time limited evaluation of practitioner competence in performing a specific privilege and is implemented for all initially requested privileges and whenever a question arises regarding a practitioner’s ability to provide safe, high-quality patient care and education.

A request for a FPPE may be made by the President of the Medical Staff, the Department Chief, Service Leader, Medical Director, and/or Lead Physician, as appropriate, a chairperson or a majority of any Medical Staff committee, the Chairperson of the Board of Trustees, the President, or VPMA whenever he/she has cause, or information and belief, to question any of the following:

1. the clinical competence of any practitioner;

2. the care or treatment of a patient or patients or management of a case by any practitioner;

3. the known or suspected violation by any practitioner of any applicable ethical standards or the Medical Staff Bylaws, Policies, Rules or Regulations of St. Joseph Healthcare or its Board of Trustees, including, but not limited to the Hospital’s performance improvement, risk management, and utilization review programs;

4. Intensive evaluation may be deemed necessary to determine whether or not a practitioner’s performance may require more specific evaluation than routine professional practice evaluation in order to evaluate his/her performance.

5. the behavior or conduct on the part of any practitioner that is considered lower than the standards of St. Joseph Healthcare or disruptive of the orderly operation of the Hospital or Medical Staff, including the inability of the practitioner to work collegially with others.

a. **Request for Focused Professional Practice Evaluation.** All requests for Focused Professional Practice Evaluation shall be in writing, directed to the Professional Practice Evaluation Committee, copied to the President, VPMA, and shall be supported by written documentation setting forth the specific activities or conduct supporting the request.
b. **Notification of Request for Focused Professional Practice Evaluation.** The President shall make a reasonable effort to notify the affected practitioner in writing within ten (10) business days of the request for Focused Professional Practice Evaluation.

c. **Circumstances requiring external PPE:**

The Professional Practice Evaluation Committee will determine the need for external peer review and communicate this to the Credentials Committee and Medical Executive Committee.

External peer review will take place under the following circumstances: if deemed appropriate by the PPEC, Credentials Committee, Medical Executive Committee, or the Board of Trustees. Providers may request an external peer review process be undertaken if deemed appropriate by the PPEC, Credentials Committee, Medical Executive Committee, or Board of Trustees.

Circumstances that may require external peer review might include the following:

- Potential litigation cases
- Ambiguity when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from review that will directly affect a provider’s membership or privileges.
- Lack of internal expertise when no one on the medical staff has adequate technical expertise in the specialty under review or when the only providers on the medical staff with that expertise are determined to have a conflict of interest regarding the provider under review.
- External Peer Review will take place if the potential for conflict of interest cannot be resolved appropriately by the Professional Practice Evaluation Committee, or Credentials Committee or Medical Executive Committee or Board of Trustees.
- New technology when a medical staff member requests permission to use new technology or perform a procedure new to the hospital and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.
- Miscellaneous issues when the Medical Staff needs an expert witness for a fair hearing, for evaluation of a credential file or for assistance in developing a benchmark for quality monitoring.
- Sentinel events of unclear etiology.

d. **Professional Practice Evaluation Committee Review of Request for Focused Professional Practice Evaluation.** No later than its next regularly scheduled meeting the Professional Practice Evaluation Committee shall review the request and determine whether:

1. the request for Focused Professional Practice Evaluation contains sufficient information to warrant a recommendation for corrective action and, if so, at its
discretion may make such a recommendation to the Credentials Committee, with or without a personal interview with the practitioner; or

2. the request for Focused Professional Practice Evaluation does not, at that point, contain sufficient information to warrant a recommendation, in which case, the Professional Practice Evaluation Committee shall immediately commence an investigation to determine the necessity of a Focused Peer Evaluation.

e. **Ongoing Professional Practice Evaluation (OPPE):** OPPE allows an organization to identify professional practice trends that impact on quality of care and patient safety. Such identification may require intervention by the organized medical staff. Criteria used in the OPPE process are outlined in the Quality Assessment Performance Improvement Plan (QAPI). Please refer to the Scope section of the Plan. OPPE information is factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal.

f. **Notification of Professional Practice Evaluation Committee Determination.** The President shall make a reasonable effort to notify the affected practitioner in writing within ten (10) business days of the Professional Practice Evaluation Committee’s determination. If an investigation is commenced, the notice shall advise the affected practitioner of his/her right to meet with the Professional Practice Evaluation Committee as prescribed in these Bylaws.

g. **Events Involving a Provider.** Part of the OPPE/FPPE process is monitoring provider quality data including the data in the Quality Department Database. The following outlines the process for reviewing and monitoring provider events:

Any event or incident involving a provider will be reviewed by the Quality Department who will collect all pertinent data, information, documentation, medical records, and interviews. The Quality Department will document its assessment in Quality Management Database.

The event with accompanying documentation will then be referred for review by the Chief of Service to a Physician Reviewer who may be the practice lead, Practice Medical Director or a designee of the Chief of Service. The Reviewer will use the "St. Joseph Healthcare Professional Practice Clinical Review" form in the review. The Medical Director for Quality and Vice President of Medical Affairs (VPMA) will also be notified. The provider will be notified that a review is in progress.

The Physician Reviewer performs an independent review. After the Physician Reviewer completes and documents his/her review, there are one of two results:

1. The Physician Reviewer finds no Deviation of Care (DOC) and no further review is needed. The Chief of Service, Medical Director of Quality, and VMPA are notified.
2. The Physician Reviewer finds a possible Deviation of Care (DOC). The Quality Department will notify the Chief of Service, Medical Director of Quality and VPMA. The VPMA or a designee will review the documentation then document his/her own assessment. The VPMA or designee will find one of two results:
   a. The VPMA or designee finds no significant DOC. The Physician Reviewer, Chief of Service, and Medical Director of Quality are notified by the Quality Department and no further action is needed.
   b. The VPMA or designee agrees there may be a DOC. The VPMA then confers with the Chief of Service for appropriate action. This discussion is documented.

All of the documentation will be maintained in the confidential portion of the Provider's file in the Quality Department.

The provider will be notified of the above process and findings and have the right to review the documentation and reports collected with the exception of information that is deemed confidential.

The event involving a provider will be tracked by Quality for trending and presented quarterly to the Professional Practice Evaluation Committee.

h. Investigatory Procedure.

1. **Medical Staff Professional Practice Evaluation Committee.** The Professional Practice Evaluation Committee shall conduct all focused peer evaluation investigations.

2. **Resources.** The Professional Practice Evaluation Committee shall have available to it the resources of the Medical Staff and the Hospital to aid in its work, as well as the authority to use outside consultants as required.

3. **Physical/Behavior Health Examination.** The committee may recommend a physical and/or behavior health examination of the practitioner by a physician or physicians satisfactory to the committee and may require that the results of such examination be made available for the committee’s consideration. The practitioner may be suspended pending verification that there is no physical or behavior health condition that could impair the practitioner's clinical competency and/or judgment.

4. **Meeting with Practitioner.** The affected practitioner shall have an opportunity to meet with the Professional Practice Evaluation Committee before it makes its report. At this meeting, the practitioner shall be informed of the general nature of the evidence supporting the investigation requested and shall be invited to discuss, explain, or refute it. This meeting shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. This meeting will be recorded and made a part of the investigation.
5. **Report of Investigation.** The Professional Practice Evaluation Committee shall report its findings and make a recommendation to the Credentials Committee. A summary of any meetings with the practitioner shall be made by the Professional Practice Evaluation Committee and be included with its report to the Credentials Committee. The Credentials Committee may accept, modify, or reject the recommendation.

6. **Suspension During Investigation.** At any time during the investigation, the President upon the recommendation of the Credentials Committee may suspend all or part of the clinical privileges of the affected practitioner. This suspension shall be deemed to be administrative in nature for the protection of Hospital’s patients. It shall remain in effect during the investigation only, and shall not indicate the validity of the allegation. If such a suspension is in effect, the investigation shall be completed within 14 business days of the suspension. If the investigation cannot be completed in 14 business days, the President will notify the practitioner. The results will also be transmitted to the Board of Trustees.

7. **Credentials Committee’s Action.** The Credentials Committee shall act as soon as practicable after the conclusion of the investigation, and, under no circumstance, should exceed six (6) months after receipt of the request for Focused Peer Evaluation. Its actions may include, but are not limited to, the following:

   - Reconvene the Professional Practice Evaluation Committee to address specific issues;
   - Reject the request for Focused Professional Practice Evaluation;
   - Modify the request for Focused Professional Practice Evaluation;
   - Issue a verbal warning or letter of reprimand;
   - Require retrospective review of cases or other review of professional behavior and/or performance,
   - Impose terms of probation that may include, but are not limited to, requirements for additional education and/or training, consultation, supervision, counseling, community service or a fine;
   - Recommend reduction, suspension for a term, or revocation of any part or all of the practitioner’s clinical privileges; and/or
   - Recommend reduction, suspension for a term or revocation of the practitioner’s Medical Staff membership.

8. **Recommendations of the Credentials Committee** will be forwarded to the MEC for further action.

9. **Appearance Before the Medical Executive Committee.** If, after reviewing the recommendations of the Credentials Committee, and if the MEC agrees with the recommendation of revocation, reduction, or suspension of clinical privileges or a
reduction, suspension or revocation of Medical Staff membership, the MEC may request the affected practitioner appear before the MEC prior to taking action on such a recommendation. The affected practitioner shall be sent the request by certified mail, return receipt requested. Should the practitioner accept the offer to appear before the MEC, this appearance shall not constitute a hearing and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. The MEC shall make a record of the appearance. No member of the MEC who has a conflict of interest with the practitioner shall participate in this proceeding.

10. **Notice of Medical Executive Committee Action.** The President shall make a reasonable effort to notify the affected practitioner, in writing, within fourteen (14) business days of the MEC’s action. With respect to the MEC’s recommendations that would entitle the affected practitioner to the hearing rights provided in these Bylaws, the notice to the affected practitioner shall be sent by certified mail, return receipt requested. The following MEC’s recommendations entitle the affected practitioner to a hearing in accordance with these Bylaws:

- denial of initial Medical Staff appointment;
- denial of requested advancement in Medical Staff category;
- denial of Medical Staff reappointment;
- revocation of Medical Staff appointment;
- denial of requested initial clinical privileges;
- denial of requested increased clinical privileges;
- decrease of clinical privileges;
- suspension of clinical privileges;
- revocation of clinical privileges; or
- imposition of a mandatory concurring consultation requirement.

The President shall not act upon the MEC recommendation until after the affected practitioner has exercised or has been deemed to have waived his/her right to a hearing as provided in these Bylaws. At such time, the President shall forward the recommendation of the MEC, together with all supporting documentation, to the Board of Trustees. If the action of the MEC does not entitle the affected practitioner to a hearing, the action shall take effect immediately without action of the Board of Trustees and without the right of appeal to the Board of Trustees. A report of the action taken and reasons therefore shall be made to the Board of Trustees through the President and the action shall stand unless modified by the Board of Trustees.

11. **Board of Trustee Action.** At its next regular meeting the Board of Trustees shall review the recommendation of the MEC. If the Board of Trustees determines to consider modification of the action of the MEC and the proposed modification would entitle the affected practitioner to a hearing in accordance with these Bylaws, it shall notify the affected practitioner through the President, and shall take no final action thereon until the individual has exercised or has been deemed to have waived his/her right to a hearing in accordance with these Bylaws.
For additional information, please refer to PI 010, Medical Staff Ongoing Professional Practice Evaluation (Peer Review).

**SECTION 9. Credential File**

A separate Credential file is maintained for each medical staff member or applicant.

**SECTION 10. Peer Review File**

A separate Peer Review file is maintained in the Quality Department for each medical staff member containing the OPPE and FPPE information as well as other quality information. This file is maintained per Medical Staff Policy PI.010 and is maintained as a peer review file per Maine Peer Review Statute.
ARTICLE VI

CLINICAL PRIVILEGES

SECTION 1. Granting of Privileges

All medical staff members will have delineated clinical privileges that define the scope of patient care services comply with State scopes of practice laws) they may provide independently in the hospital. Privileges granted shall be consistent with State laws limiting scopes of practice.

SECTION 2. Determination of Privileges

a. Initial clinical privileges shall be determined by the applicant’s training, current competence, experience, character, judgment, professional education, professional recommendations and written credentials. Recommendations regarding privileges shall be made by the Department Chief, Service Leader, Medical Director or Lead Physician in which privileges are requested, by the Credentials Committee, and by the Medical Executive Committee, to the Board of Trustees.

b. Continuing clinical privileges will be based on recommendations by the Credentials Committee and the Medical Executive Committee based on demonstrated ability of the staff member and on the recommendation of the Department Chief, Service Leader, Medical Director, or Lead Physician. This application will be handled in the same manner as the reappointment process. (See Article V, Section 7)

c. At any time in the reappointment cycle, a physician may request expansion or reduction of privileges based upon ongoing experience or changes in training, experience, proficiency, current clinical competence or quality of care through the Department Chief, Service Leader, Medical Director, or Lead Physician. This application will be handled in the same manner as the reappointment process. (See Article V, Section 7)

SECTION 3. Classification of Privileges

a. Each Department Chief, Service Leader, Medical Director, or Lead Physician shall evaluate and define the clinical privileges of each staff member requesting privileges in his/her Department/Service. Each Department Chief, Service Leader, Medical Director, or Lead Physician will develop the delineation of privileges relevant to the department/service and keep it updated. Applicants applying for privileges on more than one department/service need the review of the Department Chief, Service Leader, Medical Director, or Lead Physician in each area. Current copies of delineation of privilege forms are on file in the Medical Staff Office.

b. Applicants will initially request the category in which he/she desires clinical privileges; however, determination of each practitioner’s privileges will be made by the
c. If there is a conflict in the decision between the Department Chief, Service Leader, Medical Director or Lead Physician, and the Credentials Committee, the Credentials Committee can supersede the recommendation of the Department Chief/Service Leader. If such conflicts do arise, a resolution should be attempted by inviting the Department Chief, Service Leader, Medical Director or Lead Physician to the Credentials Committee. If this does not result in resolution of the conflict, then the Medical Executive Committee will make a recommendation to the Board of Trustees for final approval.

d. The privileges of Service Leaders, Medical Directors and Lead Physicians shall be reviewed by Department Chiefs and forwarded to the Credentials Committee. The privileges of the Department Chiefs shall be reviewed by the President of the Medical Staff, or designee, and forwarded to the Credentials Committee. If there is a dispute between the Department Chief and the recommendation of the Credentials Committee, this dispute will be resolved by the Medical Executive Committee who will make a recommendation to the Board of Trustees for final approval.

SECTION 4. Temporary Privileges

a. The President of the Hospital, or their authorized designee, may grant temporary privileges to a licensed practitioner who is not a member of the medical staff, subject to prior approval of the Department Chief, Service Leader, Medical Director or Lead Physician, or designee.

b. The applicant for temporary privileges must provide the same information as applicants for initial appointment to the Medical Staff (See Article V).

c. The applicant for temporary privileges must have the same verifications as required of applicants for initial appointment to the Medical Staff and Allied Health Staff, and a query must be made to the National Practitioner Data Bank (NPDB). Verifications and the results of the NPDB query must be in the possession of the hospital's authorized agent before temporary privileges are granted.

d. Temporary privileges may be granted for two specific reasons:

1. For new staff appointment and privileges, or those requesting additional privileges (including during the reappointment process), with a complete, clean application that raises no concerns and is awaiting review and approval of the Medical Executive Committee and the Board of Trustees.

2. To fulfill an important patient care, treatment and service need.
e. Temporary privileges shall not exceed sixty (60) days with one renewal of sixty (60) days, if necessary.

f. Temporary clinical privileges can be granted for the care of a specific patient to a practitioner who is not an applicant for membership to the staff by the President of the Hospital, or designee, upon recommendation of either the applicable clinical Department Chief or the President of the Medical Staff provided there is a verification of active licensure and current competence. Such temporary privileges shall not be given to any one practitioner for the treatment of more than four patients in any one calendar year.

g. Applicants granted temporary privileges are subject to all provisions of the Bylaws, Rules and Regulations, and policies while exercising those privileges.

h. The temporary appointment process shall not be utilized as a regular means to provide ongoing physician staffing.

i. The President of the Medical Staff, or designee, or the President of the Hospital, or designee, after consultation with the appropriate Department Chief/Service Leader, or designee, may terminate a practitioner’s temporary privileges at any time and must terminate a practitioner’s temporary privileges upon the discovery of information or the occurrence of an event that raises questions about the practitioner’s professional qualifications or ability to exercise any or all of his or her temporary privileges. If it is determined that the practitioner is endangering the life or well being of a patient, any person who has the authority to impose summary suspension may terminate the practitioner’s temporary privileges (See Article VII, Section 3).

j. If the hospital terminates a practitioner’s temporary privileges, the Department Chief/Service Leader who is responsible for supervising the practitioner will assign all the practitioner’s patients who are in this hospital to another practitioner. When feasible, the Department Chief/Service Leader will consider the patients’ wishes in choosing a substitute practitioner.

k. Rights of the practitioner with temporary privileges: A practitioner whose request for temporary privileges is refused or whose temporary privileges are terminated or suspended is not entitled to the procedural rights afforded by the fair hearing plan. (See Article VII).

SECTION 5. Locum Tenens Medical Staff

a. Practitioners seeking appointment to the locum tenens medical staff and associated privileges must provide the same information as applicants for initial appointment to the Medical Staff. (See Article V).

b. The applicant must have the same verifications as required of applicants for initial appointment to the Medical Staff and a query must be made to the National Practitioner
Data Bank (NPDB). Verifications and the results of the NPDB query must be in the possession of the hospital’s authorized agent before temporary privileges are granted.

c. Any practitioner licensed in Maine may be granted Locum Tenens Medical Staff privileges upon the recommendation of the Department Chief and/or President of the Medical Staff and the approval of the Hospital President. These privileges will be effective for not more than one year for the purpose of permitting the physician to serve as locum tenens provider for reasons deemed sufficient by the Department Chief/Service Leader. After one year, and at the discretion of the Department Chief/Service Leader, the applicant may be moved to the Adjunct Medical Staff category.

SECTION 6. **Emergency/Disaster Privileges**

a. Should the hospital’s emergency or disaster management plan be activated and the hospital be unable to handle immediate patient needs without additional support, any practitioner to the degree permitted by his/her license and regardless of service or staff status, shall be permitted and assisted to do everything practicable to save the life of a patient, using every means necessary and available at the hospital.

b. Individuals holding a valid license to practice medicine may volunteer to provide services during an emergency/disaster. The President, VPMA, Medical Staff President, or their designee(s), as identified in the Emergency Operations Plan, may grant temporary emergency/disaster privileges dependent upon the needs of the patient population and the facility and upon presentation of valid government-issued photo identification (for example, a driver’s license or passport) and at least one of the following:

1. A current photo hospital ID that clearly identifies professional designation.
2. An active license to practice.
3. Primary source verification of the license.*
4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), or the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups.
5. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity.
6. Identification by a current hospital or medical staff member(s) who possesses personal knowledge regarding the volunteer’s ability to act as a licensed independent practitioner during a disaster.

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

c. The medical staff will oversee the professional practice of volunteer licensed independent practitioners by direct observation, mentoring or medical record review.

d. The Disaster Team Captain, with input from Administration, will decide (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether the disaster privileges initially granted shall be continued.

e. Additional requirements for granting temporary emergency/disaster privileges:

1. Approvals shall be documented in writing.
2. The practitioner shall be issued appropriate hospital security identification noting this individual as a volunteer LIP.
3. The practitioner shall be assigned to a medical staff member, in the same specialty if possible, with whom to collaborate in the care of disaster victims.
4. As soon as reasonably possible, the appropriate Department Chief shall be given all information available regarding those practitioners who have been granted temporary disaster privileges in his/her department.
5. Care provided under disaster privileges by the practitioners, to the extent possible, shall be under the supervision of the appropriate Department Chief.
6. Federally deployed practitioners shall be limited to their privileges to the scope of their federal employment.

f. The following additional information shall be obtained, photocopied as possible and appropriate, and verified as soon as is reasonably possible:

1. DEA registration (if available).
2. Certificate of malpractice insurances, except for practitioners deployed by the Federal Government, who are covered by the Federal Tort Claims Act.
3. List of hospitals where the practitioner holds active staff privileges, or evidence of government agency employment (e.g. CDC identification badge).
4. National Practitioner Date Bank query.

g. Termination of temporary disaster privileges shall occur:

1. In the event that verification of information results in negative or adverse information about the qualifications of the practitioner.
2. When the patients are out of imminent danger of death or serious deterioration of
condition.
3. When the emergency situation no longer exists, or when SJH medical staff members can adequately provide care.
4. When temporary disaster privileges are otherwise withdrawn by the individual(s) authorized to grant temporary emergency/disaster privileges.
5. Termination of these privileges will not give rise to a hearing or review.

h. In the event that the hospital is completely overwhelmed by the emergency/disaster situation, and the above information cannot be collected, help from non-privileged practitioners shall be accepted when it is needed to save the life of patients or to prevent serious deterioration in a patient’s emergency medical condition.

i. In such a situation, emergency help shall be accepted in the following order:

1. Expert practitioners from government agencies and medical staff members from other local hospitals.
2. Volunteer practitioners sent from known agencies (e.g. Disaster Medical Assistance Teams, Red Cross, etc.).
3. Volunteers from the community.

j. For the purposes of this section, an "emergency" can also be defined as a condition in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, and any delay in administering treatment could add to the danger. In such a situation, any member of the Medical Staff is authorized to do everything possible to save the patient’s life or to save the patient from serious harm to the degree permitted by the member’s license, but regardless of departmental affiliation, staff category, or privileges. Emergency privileges exercised under this provision shall be for a maximum of seventy-two (72) hours and are not renewable.

SECTION 7. NON-DISASTER EMERGENCY PRIVILEGES

a. An attending physician may request the assistance of another physician or surgeon, not presently on the Medical Staff, in any situation where a patient under their care may suffer loss of life or permanent harm from a lack of immediate specialty care. Privileges are granted by the President or authorized designee upon the recommendation of the President of the Medical Staff or authorized designee. Primary source verification of the active state licensure and current competence will occur.

b. The attending physician has sole discretion in selecting assistance whenever the need is immediate.

c. The attending physician will simultaneously ask supporting nursing services to notify the Medical Staff Office and Administration (President, VPMA, AOD) that they have requested assistance. Such notification shall not interfere in patient care and education.

d. The Medical Staff Office will verify (through primary sources where feasible) licensure, sanctions, current hospital affiliation, malpractice insurance coverage, and NPDB
report on the same day, or the next available business day when the request is made
during evenings, weekends, holidays, etc.

e. The President, or designee, shall grant temporary privileges not to exceed 48 hours
based upon an urgent patient care need. Such privileges are not renewable.

f. The attending physician assumes the responsibility for the actions of the requested
assisting physician in the care of their patient. The attending physician is accountable
to the Medical Staff in any subsequent examination of the circumstances leading up to
the emergency situation, the undertaken treatment and subsequent events.

g. The MEC will discuss and analyze the events within 60 calendar days and take action,
if necessary, to commend or discipline those involved.

SECTION 8. Telemedicine Privileges

a. The delivery of quality care may necessitate medical information exchange by licensed
independent practitioners for the health of a patient and for the purpose of improving
patient care, education, treatment and services from this hospital (originating healthcare
facility where patients are receiving telemedicine services) through the use of electronic
communication to a distant site (location where a practitioner providing telemedicine
services is credentialed and privileged).

b. Telemedicine providers shall consist of licensed independent practitioners.

c. All practitioners providing care to hospital patients through telemedicine must be
appointed to the Medical Staff and must hold appropriate clinical privileges. No member
of a group contracting with the hospital for telemedicine services may provide services
until such time as they have been granted temporary privileges or received final
approval by the Board of Trustees.

d. Practitioners providing telemedicine services must be licensed in Maine.

e. Practitioners providing telemedicine services will be credentialed and granted privileges
by one of the following means and in accordance with the Medical Staff Bylaws:

1. Based on the current Medical Staff process, policies and procedures as outlined in
these Medical Staff Bylaws or in the Medical Staff Office, which is preferable (see
Article V); or

2. based on the credentialing and privileging decisions of the distant site; or

3. based on information from the physician’s credentials’ file provided by the distant
site (i.e., peer references, claims history, verification of education and training).

f. Telemedicine providers are not eligible to vote or to hold office.

g. Telemedicine providers shall not pay medical staff dues.
h. Comply with the credentialing and privileging requirements in the Medicare Conditions of Participation for Medicare (CoPs) participating entity (42 CFR 481.12 (a)(1) through (a)(9) and 482.22(a)(1) through (a)(4)); or represent and warrant compliance as previously stated for non-entities;

i. If at any time the contract and/or agreement between the hospital or distant site is canceled, by either party, or if the provider leaves the employ of the contracted organization, or the telemedicine provider’s membership and/or privileges lapse at the distant site, the provider shall be considered to have voluntarily relinquished all clinical privileges related to telemedicine. The practitioner will not be entitled to the procedural rights provided in the Hearing and Appellate Review section of the Medical Staff Bylaws (see Article VII). (Reference Article IV, Section 8.)

SECTION 9. New Technology Privileges

On occasion new technology/equipment becomes available which may warrant requests for additional privileges. Requests to perform either a significant procedure not currently being performed at SJH or a new technique for an existing procedure and/or new procedure will not be processed until it is determined that the procedure should be offered and criteria to be eligible to request such clinical privileges have been established.

If it is recommended that the new procedure be offered, the Credentials Committee will conduct an assessment and consult with internal and/or external experts to develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure; (2) the extent of monitoring and supervision that should occur if the privilege is granted and (3) the necessary hospital resources needed to appropriately support the new technology and privileges. The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate.

a. The burden of establishing qualifications and competency in the clinical privilege requested rests with the applicant. Requests may or may not coincide with the reappointment process.

b. Factors that may be considered include, but are not limited to (1) whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients; (2) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and (3) whether SJH has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

c. The Credentials Committee will review applications for new technology privileges upon approval of the Department Chief/Service Leader and then forward its recommendation to the Medical Executive Committee.

d. The Medical Executive Committee will forward its recommendations for final action to the Board of Trustees.
e. Temporary privileges may be granted for new technology by the President of the Hospital, or designee, subject to prior approval of the Department Chief/Service Leader. The applicant must have met the required expertise level as designated by the Medical Executive Committee. Such approval shall be in writing.
ARTICLE VII
CORRECTIVE ACTION HEARING
AND APPELLATE REVIEW

SECTION 1. Complaint Resolution

a. Complaint Resolution. The Medical Executive Committee (MEC) shall develop and implement a Complaint Resolution Process to address documented allegations or concerns regarding a practitioner for the purpose of determining whether peer review is necessary. The Complaint Resolution Process in no way limits the MEC’s prerogative to proceed, in its sole discretion, directly to the Focused Professional Practice Evaluation process prescribed in these Bylaws.

b. Complaint Resolution Procedures. The MEC shall abide by the hospital’s Patient Complaints/Grievances Policy. If a complaint/grievance involves a medical provider, to include physician assistants and nurse practitioners, the patient advocate will review the case. This review will include notification to the provider that there has been a complaint made against him/her. The Patient Advocate will contact the Department Chief, Service Leader, Medical Director or Lead Physician of the particular department/service and/or the Medical Staff Quality Improvement Director and/or the President of the Medical Staff to request that he/she review the case to determine the merit of the complaint. Based on the findings of this initial investigation, the case may be referred to the Medical Staff Professional Practice Evaluation Committee. The chief of the department/service, the Patient Advocate or their designee may make this referral.

c. In addition to the hospital complaint/grievance process, any person may provide information to the appropriate medical staff officer about the conduct, performance or competency of practitioners. When reliable information indicates a practitioner may have exhibited acts, demeanor, or conduct reasonably likely to be: detrimental to patient safety or to the delivery of patient care and education within the Hospital; in violation of the Medical Staff Bylaws or Rules and Regulations; or below applicable professional standard, the concern will be forwarded to the Department Chief, Service Leader, Medical Director or Lead Physician for further review.

See Article 4, Section 8, FPPE/OPPE.

d. Events Involving a Provider

The following procedures will be followed:

1. All allegations or concerns shall be recorded;

2. The practitioner shall be advised of the allegations or concerns in a timely manner;

3. The matter will be forwarded to the Department Chief, Service Leader, Medical
Director, Lead Physician, the President of the Medical Staff, to the Medical Staff Quality Improvement Director and Chair, Professional Practice Evaluation Committee (PPEC).

4. The practitioner shall be informed of the findings and recommendations of the Complaint Resolution Process and shall have an opportunity to file a written response with the Department Chief, Service Leader, Medical Director or Lead Physician before he/she takes action on the recommendations and findings; and

5. Upon completion of the Complaint Resolution Process, any findings or recommendations shall be reported to the Professional Practice Evaluation Committee. A summary report of the findings, prepared by the Professional Practice Evaluation Committee, will be provided to the practitioner, the Department Chief, Service Leader, Medical Director, or Lead Physician, as appropriate, and the Credentials Committee and will be retained in the practitioner’s quality file. Any peer review information provided to the Credentials Committee remains protected from discovery by the peer review process.

6. The Credentials Committee may approve the findings and recommendations of the Complaint Resolution Process; may reject the findings and recommendations of the Complaint Resolution Process and recommend Focused Peer Evaluation; and/or determine that some or all of the allegations or concerns are without merit and dismiss those allegations and concerns. The action of the Credentials Committee must be documented and retained in the practitioner’s quality file.

7. If the complainant resolution has not been completed by the time of reappointment, the Credentials Committee or MEC may recommend extension or provisional privileges period for not longer than six months after the date of reappointment while the resolution of complaint is achieved. Such provisional privileges shall be recorded as continuation of current privilege status. Notifications of the provisional extension of privileges shall be made available to the provider within fifteen (15) days after approval by the Board of Trustees.

8. The practitioner may waive the Complaint Resolution Process and request that the matter be resolved through the Professional Practice Evaluation Committee.

**SECTION 2. Summary Suspension**

a. **Grounds for Summary Suspension.** The President of the Medical Staff, the President, the VPMA, or the chairperson of the Board of Trustees shall each have the authority to summarily suspend all or any portion of the clinical privileges of a practitioner whenever failure to take such action may result in an imminent danger to the health of an individual or the orderly operations of the Hospital, in the event of a serious violation of accepted medical care or a serious breach of medical ethics, or if evidence of significant medical or psychological impairment exists with respect to the practitioner or there has been termination or revocation of the practitioner’s Medicare or Medicaid status. Such summary suspension shall be deemed an interim precautionary step related to the ultimate professional review action to be taken with respect to the suspended individual. It is not a complete professional review action in and of itself. It shall not imply any final
finding with respect to the situation that caused the suspension.

b. **Effective Date.** A summary suspension shall become effective immediately upon imposition; shall immediately be reported in writing to the affected practitioner, the President, the VPMA, the President of the Medical Staff, and the practitioner’s Department Chief. It shall remain in effect unless or until modified by the President with a consensus agreement of the President of the Medical Staff, the MEC, VPMA and the Chairperson of the Board of Trustees.

c. **Preliminary Review of Suspension.** Within three business days of a summary suspension, the President, VPMA, the President of the Medical Staff, and the appropriate Department Chief, will meet to review the suspension.

d. **Duration and Extension of Summary Suspension.** Any person exercising authority under paragraph (a) of this section of the Bylaws to summarily suspend clinical privileges on a precautionary basis shall immediately report his/her action to the President of the Medical Staff for investigation of the matter (Reference Article V, Section 8, responsibility of Credentials and PPE Committee). The investigation shall be completed within 14 business days of the suspension, or reasons for the delay shall be communicated to the President, for consideration as to whether the suspension should be extended. At that point, the MEC shall take such further action as required in paragraph (b) of this section of the Bylaws. The summary suspension shall remain in force unless and until modified as described in paragraph (b) above or until the matter that required the suspension is resolved. Any suspension greater than 30 calendar days is reportable to the state licensing board and National Practitioner Data Bank (NPDB).

e. **Care of Suspended Practitioner’s Patients.** Immediately upon the imposition of a summary suspension, the Department Chief, or in his or her absence, the President of the Medical Staff shall assign care of the suspended practitioner’s hospitalized patients to another individual with appropriate clinical privileges until such time as they are discharged. The patient’s wishes shall be considered in the selection of an alternative practitioner. The President of the Medical Staff and the Department Chief shall cooperate with the President in enforcing all suspensions.

**SECTION 3. Automatic Suspension**

The President of the Medical Staff, the President, the VPMA or the chairperson of the Board of Trustees shall each have the authority to impose automatic suspension of all or any portion of the clinical privileges of a practitioner when any one of the following situations occurs.”

a. **Failure to Complete Medical Records.** The elective and emergency admitting clinical privileges of any practitioner shall be voluntarily relinquished for failure to complete medical records in accordance with the Hospital and Medical Staff’s rules and policies after notification by the Health Information Department of the delinquency. The relinquishment shall continue until all records of the practitioner’s patients are no longer delinquent. Failure to complete the medical records that caused relinquishment of clinical privileges within ten (10) days (unless there are extenuating circumstances
given in writing to, and accepted by, the President) shall constitute a voluntary relinquishment of all clinical privileges and resignation from the Medical Staff. Any failure to complete delinquent records within 30 days maybe reportable to the applicable licensing board.

b. Licensing Matters

1. Adverse Licensing Matters - Action by the appropriate state licensing board or agency revoking or suspending a practitioner’s professional license, or loss or lapse of the practitioner’s state license to practice for any reason, shall result in voluntary relinquishment of all hospital clinical privileges as of that date, until the matter is resolved and the license restored. In the event the practitioner’s license is only partially restricted, the clinical privileges that would be affected by the license restriction shall be similarly restricted.

2. Other Licensing Matters – The Credentials Committee monitors Title 5 and Consent Decree matters and communicates via its minutes to the Medical Staff Executive Committee as appropriate. Medical Staff Executive will report to the Board of Trustees as appropriate.

d. Failure to be Adequately Insured. If at any time, a practitioner’s professional liability insurance coverage lapses, falls below the required minimum (as determined from time to time by the Board of Trustees), is terminated, or otherwise ceases to be in effect (in whole or in part), the practitioner’s clinical privileges that would be affected shall be voluntarily relinquished or restricted as applicable as of that date until the matter is resolved and adequate professional liability insurance coverage is restored.

e. DEA Certification. The practitioner’s DEA certification has been revoked, suspended or placed on probation for any reason.

f. Medicare or Medicaid Action. Automatic suspension of clinical privileges will occur when the practitioner has been subject to termination or revocation of the practitioner’s status within the Medicare or Medicaid Program.

g. Effective Date. An automatic suspension shall become effective immediately upon imposition; shall immediately be reported in writing to the affected practitioner, the President, the VPMA, the President of the Medical Staff, and the practitioner’s Department Chief. It shall remain in effect unless or until modified by the President with a consensus agreement of the MEC, the President of the Medical Staff, VPMA and the Chairperson of the Board of Trustees.

h. Preliminary Review of Suspension. Within three business days of an automatic suspension, the President, VPMA, the President of the Medical Staff, and the appropriate Department Chief, will meet to review the suspension.

i. Duration and Extension of Automatic Suspension. Any person exercising authority under paragraph (a) of this section of the Bylaws to automatically suspend clinical privileges on a precautionary basis shall immediately report his/her action to the President of the Medical Staff for investigation of the matter (Reference Article V, Section
8, responsibility of Credentials and PPE Committee). The investigation shall be completed within 14 business days of the suspension, or reasons for the delay shall be communicated to the President, for consideration as to whether the suspension should be extended. At that point, the MEC shall take such further action as required in paragraph (b) of this section of the Bylaws. The summary suspension shall remain in force unless and until modified as described in paragraph (b) above or until the matter that required the suspension is resolved. Any suspension greater than 30 calendar days is reportable to the state licensing board and National Practitioner Data Bank (NPDB).

j. Care of Suspended Practitioner’s Patients. Immediately upon the imposition of an automatic suspension, the Department Chief, or in his or her absence, the President of the Medical Staff shall assign care of the suspended practitioner’s hospitalized patients to another individual with appropriate clinical privileges until such time as they are discharged. The patient’s wishes shall be considered in the selection of an alternative practitioner. The President of the Medical Staff and the Department Chief shall cooperate with the President in enforcing all suspensions.

Reference Section 2. Summary Suspension, b, c, d, and e, apply here.

SECTION 4. Confidentiality and Peer Review Protection

a. Complaint resolution and peer review. Focused Professional Practice Evaluation and any corrective action contemplated or conducted pursuant to these Bylaws shall be treated as confidential in accordance with such policies regarding confidentiality as may be adopted by the Board of Trustees. In addition, reports of actions taken pursuant to these Bylaws shall be made by the President to such governmental agencies as may be required by law. All minutes, reports, recommendations, communications and actions made or taken pursuant to these Bylaws are deemed to be covered by the provisions of 32 M.R.S.A. §§ 2599, 3293 and 3296; 24 M.R.S.A. §§ 2501-2511; and 42 U.S.C. §§ 11101-11152; or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.

SECTION 5. Hearing and Appellate Review Procedure

a. Right to Hearing and to Appellate Review. An applicant for Medical Staff appointment or practitioner shall be entitled to a hearing whenever he or she is the subject of an unfavorable recommendation by the MEC, including the following:

- denial of initial Medical Staff appointment;
- denial of requested advancement in Medical Staff category;
- denial of Medical Staff reappointment;
- revocation of Medical Staff appointment;
- denial of requested initial clinical privileges;
- denial of requested increased clinical privileges;
- decrease of clinical privileges;
- suspension of total clinical privileges;
- revocation of clinical privileges; or
- imposition of mandatory concurring consultation requirement.
The affected applicant or practitioner shall also be entitled to a hearing before the Board of Trustees enters a final decision, in the event the Board of Trustees should determine, without a similar recommendation from the MEC, to take any of the following actions:

- denial of initial Medical Staff appointment;
- denial of requested advancement in Medical Staff category;
- denial of Medical Staff reappointment;
- revocation of Medical Staff appointment;
- denial of requested initial clinical privileges;
- denial of requested increased clinical privileges;
- decrease of clinical privileges;
- suspension of total clinical privileges;
- revocation of clinical privileges; or
- imposition of mandatory concurring consultation requirement.

The purpose of the hearing shall be to recommend a course of action to those acting for the Hospital, whether Medical Staff or Board of Trustees, and the duties of the Hearing Panel shall be so defined and so carried out. Accordingly, the hearing shall be conducted according to the rules and procedures set forth in these Bylaws.

b. **Notice of Recommendation.** Within ten (10) business days of the time that a recommendation is made which, according to these Bylaws, entitles an applicant or practitioner to a hearing prior to a final decision of the Board of Trustees on that recommendation, the affected applicant or practitioner shall be given notice by the President, in writing, return receipt requested. This notice shall contain:

1.) a statement of the recommendation made and the general reasons for it;

2.) notice that the practitioner has the right to request a hearing on the recommendation within thirty (30) days of the receipt of the notice; and

3.) a summary of the rights in the hearing as provided for in these Bylaws.

c. The affected applicant or practitioner shall have thirty (30) business days following the date of the receipt of the notice to request a hearing by the Hearing Panel. This request shall be made by written notice to the President. In the event the affected applicant or practitioner does not request a hearing within the time and in the manner as set forth above, he or she shall be deemed to have waived the right to the hearing and to have accepted the action involved. The action shall thereupon become effective immediately upon final Board of Trustees action.

d. **Grounds for Hearing.** No recommendation or action other than those listed below shall constitute grounds for a hearing:

- denial of initial Medical Staff appointment;
- denial of requested advancement in Medical Staff category;
- denial of Medical Staff reappointment;
revocation of Medical Staff appointment;
- denial of requested initial clinical privileges;
- denial of requested increased clinical privileges;
- decrease of clinical privileges;
- suspension of total clinical privileges;
- revocation of clinical privileges; or
- imposition of mandatory concurring consultation requirement.

e. **Notice of Hearing and Statement of Reasons.** The President shall schedule the hearing and shall give notice of its time, place, and date, in writing, return receipt requested, to the person who requested the hearing. The notice shall also include a proposed list of witnesses who will give testimony or evidence in support of the MEC or the Board of Trustees at the hearing. The hearing shall begin as soon as practicable, but no sooner than thirty (30) business days nor more than sixty (60) business days after the notice of the hearing unless a different hearing date has been specifically agreed to in writing by the parties. This notice shall contain a statement of the specific reasons for the recommendation as well as a list of those patient records and other documentation that the MEC or the Board of Trustees reviewed in making the recommendation. This list may be amended at any time, even during the hearing, so long as any additional material is relevant to the continued appointment or clinical privileges of the practitioner requesting the hearing, and the practitioner and his or her counsel have sufficient time to review and respond to this additional information.

f. **List of Witnesses.** A written list of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony or evidence in support of the MEC or the Board of Trustees at the hearing, shall be given with the notice of hearing. The practitioner requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on his or her behalf within ten (10) business days after receiving the notice of the hearing. The witness list of either party may, at the discretion of the Presiding Officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

g. **Hearing Panel.** When a hearing is requested, the President, acting for the Board of Trustees and after considering the recommendations of the President of the Medical Staff (and that of the Chair of the Board of Trustees, if the hearing is occasioned by a Board of Trustees determination), shall appoint a Hearing Panel which shall be composed of not less than three members. The majority of the Hearing Panel shall be composed of Medical Staff members who shall not have actively participated in the consideration of the matter involved at any previous level, or of physicians or a combination of such persons. The panel shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is professionally associated with or related to the affected practitioner, unless waived by mutual agreement. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel. All panel participants will sign a confidentiality statement.

h. **Failure to Appear.** Failure, without good cause, of the applicant or practitioner requesting the hearing to appear and proceed at the hearing shall be deemed to constitute a voluntary acceptance of the recommendations or actions pending, which shall then
become final and effective immediately upon final action of the Board of Trustees.

i. **Postponements and Extensions.** Postponements and extensions of time beyond any time limit set forth in these Bylaws may be requested by any party, but shall be permitted only by the Hearing Panel, its chairperson, or the President on a showing of good cause.

j. **Representation.** The applicant or practitioner requesting the hearing shall be entitled to be represented at the hearing by an attorney to examine and cross-examine witnesses and present his or her case. The applicant or affected practitioner shall inform the President in writing of the name of that attorney at least ten (10) days prior to the date of the hearing. The President shall request corporate counsel or their designee to participate in the Hearing.

k. **Presiding Officer.** The President shall appoint a Chair of the Hearing Panel to act as Presiding Officer, who may not be legal counsel to the hospital but is an attorney approved by the President and the President of the Medical Staff. The Presiding Officer must not act as a prosecuting officer or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel and is a legal advisor to it, but shall not be entitled to vote on its recommendations. He or she may thereafter continue to advise the Board of Trustees on the matter.

The Presiding Officer shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, that decorum is maintained throughout the hearing, and that no intimidation is permitted. The Presiding Officer shall determine the order of procedure throughout the hearing, and shall have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions which pertain to the matters of the procedure and to the admissibility of evidence, upon which the Presiding Officer may be advised by legal counsel to the Hospital. In all instances the Presiding Officer shall act in such a way that all information relevant to the continued appointment or clinical privileges of the person requesting the hearing is made available and considered by the Hearing Panel in formulating its recommendations to the Board of Trustees.

l. **Record of Hearings.** The Presiding Officer shall arrange for the creation of a verbatim transcript of the hearing. The cost of the transcript shall be borne by the Hospital, but copies of the transcript shall be provided to the applicant or practitioner requesting the hearing at his or her expense. The Hearing Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

m. **Rights of Both Parties.** Each party (the affected applicant or practitioner, MEC or Board of Trustees, as the case may be) shall have the following rights at the hearing: to call and examine witnesses to the extent available; to introduce exhibits; to cross-examine any witness on any matter relevant to the issues; and to rebut any evidence. If the applicant or practitioner requesting the hearing does not testify on his or her own behalf, he or she may be called and examined as if under cross-examination.
n. **Admissibility of Evidence.** The hearing shall not be conducted according to the rules of law, evidence or procedure relating to the examination of witnesses or presentation of evidence in a court of law. The Presiding Officer shall admit any relevant evidence if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, and the Hearing Panel may request that such a memorandum be filed following the close of the hearing. The Hearing Panel may question the witnesses; call additional witnesses, or request documentary evidence if it deems it relevant.

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

p. **Basis of Decision.** The decision of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

1. oral testimony of witnesses;
2. any documentary evidence admitted at the hearing;
3. memoranda of points and authorities presented in connection with the hearing;
4. any information regarding the applicant or practitioner who requested the hearing so long as that information has been admitted into evidence at the hearing and the applicant or practitioner who requested the hearing had the opportunity to comment on it and to offer, if desired, other evidence to refute it;
5. any and all applications, references, and accompanying documents contained in the applicant’s or practitioner’s credentials file;
6. all officially noticed matters; and
7. any other evidence that has been admitted.

q. **Burden of Proof.** The following rules governing the burden of proof at the hearing shall apply:

1. The Board of Trustees or MEC, depending on whose recommendation prompted the hearing, has the initial burden of presenting evidence in support of its recommendation. Thereafter, the burden shall shift to the applicant or practitioner who requested the hearing to come forward with evidence in his or her support.
2. After all the evidence has been submitted by both parties, the Hearing Panel shall recommend in favor of the MEC or the Board of Trustees unless it finds that the applicant or practitioner who requested the hearing has established by evidence of record that the recommendation that prompted the hearing was unreasonable, not sustained by the evidence, or otherwise unfounded.

r. **Attendance by Panel Members.** Recognizing that it may not be possible for all members of the Hearing Panel to be present continually at all sessions of the Panel, and because it is necessary to conduct a hearing as soon as reasonable after the event or events that gave rise to its necessity, the hearing shall continue even though certain members of the Hearing Panel are not present at all times. The fact that certain panel members were not physically present at all times during the hearing will not disqualify them or invalidate the hearing, so long as those panel members review the evidentiary material presented at the hearing and at least a majority of the panel (not less than 3) is present at all times while the hearing is being conducted. No member may vote by proxy. The action of a majority of those appointed to the Hearing Panel shall constitute an action of the Panel itself.

s. **Adjournment and Conclusion.** The Presiding Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

t. **Deliberations and Recommendations of the Hearing Panel.** Within fifteen (15) days after final adjournment of the hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person (except the Presiding Officer), and shall render a recommendation, accompanied by a written report, which shall contain a concise statement of the reasons justifying the recommendation made, and shall deliver such report to the President.

u. **Disposition of Hearing Panel Report.** Upon its receipt, the President shall forward the Hearing Panel’s report and recommendation, return receipt requested, to the applicant or practitioner who requested the hearing. The President shall also send a copy of the report and recommendation, along with all supporting documentation, to the Board of Trustees and the MEC.

If the hearing has been conducted by reason of an adverse recommendation by the MEC, the MEC shall review the report and recommendation at its next meeting. The MEC may ratify the recommendation of the Hearing Panel or renew its original recommendation. The action of the MEC shall be forwarded to the Board of Trustees for action at its next meeting.

If the hearing has been conducted by reason of an adverse recommendation by the Board of Trustees, the Board of Trustees shall take further action at its next meeting.
SECTION 6. Appeal to the Board of Trustees

a. Request for Appeal to Board of Trustees. An affected applicant or practitioner may request an appellate review within fifteen (15) business days after the affected applicant or practitioner is notified of an adverse recommendation to the Board of Trustees, listed below, from the Hearing Panel, the MEC (after review pursuant to Section 6.u. of these Bylaws), or from a Board Committee modifying one or more of the following recommendations from the Hearing Panel that was not previously appealed.

- denial of initial Medical Staff appointment;
- denial of requested advancement in Medical Staff category;
- denial of Medical Staff reappointment;
- revocation of Medical Staff appointment;
- denial of requested initial clinical privileges;
- denial of requested increased clinical privileges;
- decrease of clinical privileges;
- suspension of total clinical privileges;
- revocation of clinical privileges; or
- imposition of mandatory concurring consultation requirement.

The request shall be in writing, and shall be delivered to the President, either in person or by certified mail, and shall include a brief statement of the reasons for appeal. The affected applicant or practitioner may also request that oral argument be permitted as part of the appellate review. If such appellate review is not requested within fifteen (15) business days as provided herein, the affected applicant or practitioner shall be deemed to have accepted the recommendation of the Hearing Panel, MEC or the Board Committee, as the case may be, involved and it shall thereupon become final and immediately effective.

d. Grounds for Appeal from Adverse Recommendations. The grounds for appeal to the Board of Trustees from an adverse recommendation shall be limited to instances in which:

1. the affected practitioner believes that there was substantial failure on the part of the MEC, Hearing Panel, or the Board Committee, whichever recommendation is the subject of the appellate review, to comply with these Bylaws and/or the Hospital’s Bylaws in the matter which was the subject of the hearing so as to deny due process or a fair hearing; or

2. the affected practitioner believes that the recommendation of the MEC, Hearing Panel, or the Board Committee were made arbitrarily or capriciously; or

3. the affected practitioner believes that the recommendations on the MEC, Hearing Panel, or the Board Committee were not supported by the evidence.

c. Time, Place, and Notice. When an appeal to the Board of Trustees is requested, the Chair of the Board of Trustees will, within ten (10) business days after receipt of such request, schedule and arrange for an appellate review. The Board of Trustees, through
the President, by certified mail, return receipt requested, shall cause the affected applicant or practitioner to be given notice of the time, place and date of the appellate review.

The date of appellate review shall be not less than twenty (20) business days, nor more than forty (40) business days, from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from a practitioner who is under a suspension then in effect the appellate review shall be held as soon as the arrangements may reasonably be made and not more than fourteen (14) business days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chair of the Board of Trustees for good cause.

d. **Nature of Appellate Review.**

1. The Chair of the Board of Trustees shall appoint a Review Panel composed of not less than three reputable persons, either members of the Board of Trustees or others, including but not limited to persons not affiliated with the Hospital, or any combination of the same, to consider the record upon which the recommendation before it was made. All panel participants will sign a confidentiality statement.

2. The Review Panel may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that he or she was deprived of the opportunity to admit it at the hearing and then only at the discretion of the Review Panel. All oral arguments will be followed by submission of written statements to support a comprehensive record.

3. Each party shall have the right to present a written statement in support of its position on appeal, and in its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral arguments. If the affected applicant or practitioner requests oral argument, then it shall be allowed. The Review Panel shall recommend final action to the Board of Trustees.

4. The Board of Trustees may affirm, modify, or reverse the recommendation of the Review Panel or, at its discretion, refer the matter to the Review Panel for further review and recommendation.

e. **Final Decision of the Board of Trustees.** Within thirty (30) business days after receipt of the Review Panel’s recommendation, the Board of Trustees shall render a final decision in writing and, through the President, shall deliver copies thereof to the affected applicant or practitioner and to the MEC, in person or by certified mail.

f. **Further Review.** Except where the matter is referred for further action and recommendation in accordance with Section 7.d.4. of these Bylaws, the final decision of the Board of Trustees following the appeal shall be effective immediately and shall not be subject to further review; provided, however, that if the matter is referred for further action and recommendation, such recommendations shall be promptly made to the Board of
Trustees in accordance with the instructions given by the Board of Trustees.

This further review process and the report back to the Board of Trustees shall in no event exceed thirty (30) business days in duration except as the parties may otherwise stipulate.

g. **Right to One Appeal Only.** No applicant or practitioner shall be entitled as a matter of right to more than one appellate review on any single matter that may be the subject of an appeal, without regard to whether such subject is the result of action by the MEC, the Board of Trustees, or Hearing Panel, or a combination of acts of such bodies. In the event that the Board of Trustees ultimately determines to deny initial appointment and clinical privileges of an applicant, that individual may not reapply for Medical Staff appointment or clinical privileges at the Hospital until the expiration of three years from the date of such Board of Trustees action, or otherwise waives this restriction during the three year period.
ARTICLE VIII

OFFICERS

SECTION 1. Officers of the Medical Staff

The Officers of the Medical Staff shall be:

1. President
2. Vice-President
3. Secretary/Treasurer

SECTION 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 the term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. Automatic suspension by reason of incomplete medical records will not be deemed to create a vacancy in an office of the Medical Staff.

SECTION 3. Election of Officers

a. Officers shall be elected through a ballot process. Ballots may be mailed or sent via an electronic system using e-mail addresses provided by each member of the Active Medical Staff. Results will be announced at the annual meeting of the Medical Staff. Members of the Active Medical Staff and Allied Health Staff shall be eligible to vote.

b. The President of the Medical Staff shall appoint a Nominating Committee. This Committee shall consist of five members of the Active Medical Staff, including three past-presidents of the medical staff, whenever possible.

c. Approximately two months before the annual meeting of the Medical Staff, a representative of the Nominating Committee (the Medical Staff Office) will send an e-mail ballot to each member of the Active Medical Staff requesting their vote. Each ballot shall contain the slate of candidates selected by the Nominating Committee for each office of the Medical Staff. A space on the ballot for write-in candidate(s) for each office shall also be included.

d. Ballots shall be returned to the Medical Staff Office prior to the annual meeting and tabulated by Medical Staff Office personnel. Results will be confirmed by the Secretary/Treasurer and reported to the Medical Executive Committee prior to the annual meeting.

e. The candidate for each office receiving the plurality of votes for that office shall be thereby elected to that office.
The Secretary/Treasurer of the Medical Staff will be moderator of the tabulation of the votes.

At-large members of the Medical Executive Committee shall be elected in the same manner as herein provided for election of officers of the Medical Staff; however, the Nominating Committee shall be the Medical Executive Committee.

SECTION 4. Term of Office

All officers shall serve for a period of two years, or until a successor is elected. Officers shall take office on the first day of the calendar year.

SECTION 5. Resignation and Removal from Office

a. Resignation

Any officer may resign at any time by giving written notice to the Medical Executive Committee. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any later time specified in the written notice.

b. Removal

The Medical Executive Committee may affect removal of a Medical Staff officer after such recommendation by a two thirds vote by secret ballot of the Active Medical Staff members present at a mandatory special meeting called for that purpose by the Medical Executive Committee. Permissible bases of removal of a Medical Staff officer include, without limitation:

1. Failure to perform the duties of position held in timely and appropriate manner;
2. Having a conflict of interest with the Hospital;
3. Conduct or statements harmful or damaging to the best interests of the Hospital or Medical Staff or to their goals, programs or public image;
4. Failure to continuously satisfy the qualifications for the position;
5. Physical or mental infirmity that renders the individual incapable of fulfilling duties;
6. Failure to abide by the Medical Staff Standards of Conduct (policy PI.008).
SECTION 6.  Vacancies in Office

The Medical Executive Committee shall fill vacancies in office during the term, except for the president. If there is a vacancy in the office of the President, the Vice-President shall serve out the remaining term.

SECTION 7.  Duties of the Officers

a. Medical Staff President shall serve as the chief administrative officer of the medical staff to:

1. Act in coordination with the President of the Hospital and the VPMA in all matters of mutual concern within the hospital;

2. Preside at General Medical Staff meetings;

3. Preside at Medical Executive Committee meetings;

4. Serve as ex-officio member of all other staff committees, without vote;

5. Be responsible for enforcement of Medical Staff Bylaws, Rules and Regulations, and associated policies and procedures for implementation of sanctions where indicated, and for the medical staff's compliance with the procedural safeguards where corrective action has been requested;

6. Appoint chairman and members to all staff committees, except for the Medical Executive Committee;

7. Present the views, policies, needs and grievances of the medical staff to the President, VPMA, and to the Board of Trustees;

8. Receive and interpret the policies of the Board of Trustees to the medical staff;

9. Be spokesman for the medical staff in its external professional and public relations; and

10. Act as Chief of Staff, overseeing the clinical work and being responsible for the clinical organization of the Hospital.

b. Medical Staff Vice-President shall:

1. In the absence or disability of the president, discharge the functions of the president. In the absence or disability of both the president and the vice-president, the Medical Executive Committee shall appoint a president pro tempore;
2. Preside at meetings of the Credentials Committee; and
3. Carry out such duties as assigned by the president.

c. Medical Staff Secretary/Treasurer shall:
   1. Preside at meetings of the Bylaws Committee;
   2. Perform such other duties as ordinarily pertain to his/her office;
   3. Keep accurate account of the financial status and financial transactions of the Medical Staff organization with assistance from the Medical Staff Office;
   4. Render financial reports at the annual meeting of the Medical Staff; and
   5. Oversee collection of Medical Staff dues.
ARTICLE IX
CLINICAL DEPARTMENTS

SECTION 1. Departments

The medical staff shall be divided into departments. The following is a list of the approved departments and those services assigned to each department:

a. Department of Anesthesiology:
   1. Anesthesiology
   2. Pain Management

b. Department of Emergency Medicine

c. Department of Medicine/Family Practice:
   1. Allergy & Immunology
   2. Cardiovascular Diseases
   3. Dermatology
   4. Endocrinology
   5. Gastroenterology
   6. Hematology/Oncology (Medical and Radiation)
   7. Hospitalists (includes Internal Medicine)
   8. Infectious Diseases
   9. Hospice and Palliative Care Medicine
   10. Nephrology
   11. Neurology
   12. Outpatient Medicine (includes Internal Medicine, Family Medicine/Practice, and Pediatrics)
   13. Physical and Rehabilitative Medicine
   14. Psychiatry
   15. Pulmonary/Critical Care/Sleep Medicine
   16. Radiation Oncology
   17. Rheumatology

d. Department of Orthopaedics:
   1. Orthopaedic Surgery
   2. Podiatry

e. Department of Pathology

f. Department of Radiology
g. Department of Surgery:
   1. Cardiothoracic Surgery
   2. General Surgery
   3. Gynecology
   4. Hyperbaric Oxygen/Wound Care Medicine
   5. Neurosurgery
   6. Ophthalmology
   7. Oral Maxillofacial/Dental Surgery
   8. Otolaryngology
   9. Urology
   10. Vascular Surgery

SECTION 2. Organization of Clinical Departments

Each department shall be organized as a separate part of the Medical Staff and shall have a Department Chief who shall be responsible for the overall supervision of the clinical work within the department. Each member of the Medical Staff shall be assigned to the appropriate department and/or service that most closely reflects his/her professional training and experience, and the clinical area in which his/her practice is concentrated. A practitioner may be granted clinical privileges in one or more departments or services, and his/her exercise of clinical privileges is always subject to the rules and regulations of that department or service and the authority of the Department Chief, and Service Leader, Medical Director, or Lead Physician, as appropriate.

SECTION 3. Department Chiefs

a. A Department Chief is a physician qualified for the position through certification by an appropriate specialty board or comparable clinical competence (affirmatively established through the credentialing process), training and experience within his/her specialty area and appropriate clinical privileges delineated in the department so as to qualify for a leadership position. Each Department Chief shall be a member of the Active Medical Staff, shall be nominated by the Medical Executive Committee, and appointed by the Board of Trustees. Each Department Chief must adhere to the Medical Staff Bylaws and Rules and Regulations, and fulfill the responsibilities of his/her Department/Service and the Medical Staff.

b. When a Department Chief’s position is vacant or to be vacated, a search committee shall be appointed by the President of the Medical Staff. It shall consist of at least 4 members of the Medical Staff, to include the President of the Medical Staff and the Chairman of the Credentials Committee. The committee shall first seek out and consider candidates for the position. In its deliberation, the Search Committee shall consider the recommendations of the department involved. When the committee has concluded its search, it shall make specific recommendations to the Medical Executive Committee. The Medical Executive Committee shall then forward its recommendation for approval by the Board of Trustees.
c. The Medical Executive Committee, through appointment of an acting officer, shall fill an unexpected vacancy of the Department Chief. This appointee shall act as the Department Chief until the search for a chief has concluded and is approved by the Board of Trustees.

d. Each Department Chief shall serve for a term of two years commencing on January 1, unless he/she resigns or is removed from office. Continued appointment may be based on the results of 360 evaluations performed in conjunction with the reappointment process.

e. The Credentials Committee shall review the performance of each Department Chief as part of the reappointment process. The 360 evaluation includes a survey of various individuals, including members of individual departments/services. If the 360 tool is used, the results are included as part of the reappointment evaluation. Recommendations for continued appointment will be made by the Credentials Committee, who in turn will make a recommendation to the Medical Executive Committee, who will in turn make a recommendation to the Board of Trustees.

f. A Department Chief may resign at any time by giving written notice to the Medical Executive Committee. Such resignation shall take effect on the date of receipt or at any later time specified in it.

g. Removal of the Department Chief during his/her term may be initiated by a two-thirds majority vote of all the voting staff members of the department, or by a two-thirds majority vote of the Medical Executive Committee. No removal shall be effective unless and until it has been ratified by the Medical Executive Committee and the Board of Trustees. Such removal of the Department Chief during his/her term of office shall not otherwise affect his/her status on the Medical Staff. Permissible grounds for removal include, but are not limited to, failure to perform the functions of the position in a timely and appropriate manner, and failure to continuously satisfy the qualifications for the position, and adherence to the Medical Staff Bylaws, Rules and Regulations.

h. When the Department Chief is planning to be absent for 72 hours or more, he/she must designate a member of the Department to assume this responsibility and notify the Medical Staff Office. If a designee is not appointed, then the President of the Medical Staff shall assume these duties.

SECTION 4. Functions of a Department Chief

The Department Chief shall:

a. Be accountable to the Medical Executive Committee and through it to the Board of Trustees for all professional and administrative activities within his/her department unless otherwise provided for by the hospital. This will include ensuring that minutes are taken at all department and service meetings and that these minutes are referred to the Medical Executive Committee for review.
b. Each Department Chief, Service Leader, Medical Director or Lead Physician, as applicable, is responsible for the quality of care within the respective department in accordance with regulatory agencies’ requirements, QAPI initiatives focus on the patient care, education and services specific to that department. The Department Chief, Service Leader, Medical Director or Lead Physician, as applicable, is responsible for ensuring that provider-specific QAPI information is communicated to individual members of his or her respective departments annually. The Department Chief, Service Leader, Medical Director or Lead Physician, as applicable, is also responsible for ensuring that data is provided to the Credentials Committee for the purposes of Ongoing Professional Practice Evaluation (OPPE) and/or Focused Professional Practice Evaluation (FPPE).

c. Collaborate with the Administration to ensure that rules and regulations, policies and procedures adopted by the Medical Staff and Hospital are followed by their Department members.

d. Be accountable for enforcement of Hospital and Medical Staff Bylaws, Rules and Regulations within his/her department in concert with the Medical Executive Committee and Medical Staff President.

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

f. Document, for Credentials Committee review at the time of initial appointment and reappointment, his/her recommendations for membership and clinical privileges for each department member based on qualifications and current clinical competence relevant to the care provided in the department.


g. Develop and maintain criteria for clinical privileges for his/her department.

h. Work with the Administration including the President and VPMA to ensure that each member of his/her department fulfills his/her responsibilities to the hospital. This shall include timely completion of medical records and attendance at department, general medical staff and committee meetings.

i. Assess and recommend to the relevant hospital authority off-site sources for needed patient care and education services not provided by the department or the organization.

j. Participate in the coordination and integration of interdepartmental and intradepartmental services.

k. Determine the qualifications and current competence of department or service personnel who are not licensed independent practitioners and who provide patient care and education services.
l. Shall assist in the appropriate orientation to the hospital and medical staff for each of their
Department members and provide for the continuing education of all persons in the
department, as appropriate.

m. Assist administration in determining the space and other resources needed by the
department members.

n. Shall access the services of the VPMA to support their duties as listed above.

SECTION 5. Functions of Departments

a. Each department shall establish a mechanism to ensure the continuous assessment and
improvement of the quality of care and services within the department.

b. At least quarterly, each department will review performance improvement/peer review
activities. The minutes of the meeting will include the findings, conclusions and
recommendations, as well as, analysis of any trends/problems.

c. Each department shall conduct regular meetings and shall meet at least four times per
year. Minutes shall be submitted to the Medical Executive Committee detailing the
proceedings. The department meetings must be conducted through a means that allows
interactive participation and may include e-mail, teleconference, real-time video and/or
face-to-face meetings.

SECTION 6. Services within Departments

a. Each Service shall have a Service Leader, Medical Director, or Lead Physician, as
appropriate, who shall be responsible to the Department Chief.

b. The qualifications, appointment, tenure, and functions of the Service Leader, Medical
Director, or Lead Physician shall be the same as those of the Department Chief, except
that he/she shall be accountable to his/her Department Chief (see Section 3 above).

c. Service Leaders shall be nominated by members of the service or the Department Chief
and confirmed by the Medical Executive Committee. Medical Directors and Lead
Physicians are physicians employed by St. Joseph Healthcare and, as such, are identified
through the terms of their contract.

d. The functions of a service shall be the same as a department, except that it shall submit
meeting minutes in a timely manner to the Department Chief and the Medical Executive
Committee.

e. Each Service within the Department shall conduct its own meetings or attend the
respective department meetings. The Service Leader, Medical Director or Lead
Physician shall determine the time and location of these meetings.
f. Each practitioner shall attend department/service meetings as stipulated in the medical staff obligations assigned by their respective Department Chief, Service Leader, Medical Director or Lead Physician.

g. A Department Chief may also serve as Service Leader.

h. Evaluation of a Service Leader will be conducted in the same manner as that of a Department Chief (see Section 3 above). Evaluations of Medical Directors and Lead Physicians will be performed during contract renewal.

SECTION 7. Future Departments and Services

From time to time it may be desirable to add departments or services to the structure of the Staff. The Medical Executive Committee in this regard shall make recommendations to the Board of Trustees. Action of the Board of Trustees shall be required to add new departments or services. The same provisions apply to removing departments or services in the structure of the staff.

SECTION 8. Regular Meetings

a. Departments/Services shall hold regular meetings at least four times per year to review and evaluate the clinical work of practitioners with privileges in the department. Emphasis must be placed on morbidity and mortality analysis with detailed consideration of particular patients selected by the department head, unimproved hospitalized patients, infections, complications, errors in diagnosis, and results of treatment with analytical reports relative to patient care within the hospital.

b. Meetings must be conducted through a means that allows interactive participation and may include e-mail, teleconference, real-time video and/or face-to-face meetings.

c. If a member fails to meet attendance requirements as outlined in his/her medical staff obligations, the Department Chief, Service Leader, Medical Director or Lead Physician shall notify the member in writing. If the attendance is not corrected in the subsequent reappointment cycle, the Department Chief, Service Leader, Medical Director or Lead Physician may take corrective action. Any such action will not entitle a staff member to a hearing or appellate review.

d. A member of the staff who has attended a patient whose case is to be presented for clinical discussion shall be notified seven (7) days in advance of such meeting by the Department Chief, Service Leader, Medical Director or Lead Physician and shall be requested to be present.
SECTION 9. Special Meetings

A special meeting of the department may be called by or at the request of the Chief thereof, by the President of the staff, or by one third of the department's members, but not by less than two (2) members.

SECTION 10. Quorum

Fifty percent (50%) of the voting members of a department, but not less than two (2) members, shall constitute a quorum at any department or service meeting.

SECTION 11. Manner of Action

a. The action of a majority of the members present at a meeting at which a quorum is present shall be the action of the department.

b. Action may be taken without a meeting by unanimous consent.

SECTION 12. Minutes

a. Minutes of each regular and special department and/or service meeting shall be prepared and shall include a record of the attendance of members and the vote taken on each matter.

b. The minutes shall be forwarded to the appropriate body (e.g., Medical Executive Committee, Department Chief, etc.).

c. Each department and service shall maintain a permanent file of the minutes of each meeting.
ARTICLE X
COMMITTEES

SECTION 1. Purpose

The purpose of Medical Staff Committees and meetings is:

a. To perform such functions and carry out such business of the Medical Staff as is outlined in these Medical Staff Bylaws, Rules and Regulations;

b. To document meaningful compliance with the functions and goals defined in the Medical Staff Quality Improvement Plan;

c. To provide a forum for ongoing review of clinical care rendered by the members;

d. To provide professional education of members;

e. To improve the clinical care of patients.

SECTION 2. Meetings

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

A special meeting of any committee may be called by, or at the request of, the Chairman, the President of the Medical Staff, or one-third of the Committee's members, but not by less than two (2) members.

Meetings must be conducted through a means that allows interactive participation and may include e-mail, teleconference, real-time video and/or face-to-face meetings.

SECTION 3. Quorum

Fifty percent (50%) of the members of a committee, but not less than two (2) members, shall constitute a quorum at any meeting. At least one physician must be present to conduct business.

SECTION 4. Manner of Action

The action of a majority of the voting members present at a meeting at which a quorum is present shall be the action of the committee. Action may be taken without a meeting by unanimous consent.
SECTION 5. Rights of Ex-Officio Members

Persons serving as ex-officio members of a committee shall have rights and privileges of regular members, except that they shall not be entitled to vote and shall not be counted in determining the existence of a quorum.

SECTION 6. Minutes

Minutes of each regular and special meeting of a committee shall be prepared and include a record of attendance and the vote taken on each matter. The minutes shall document discussion, decisions, votes, remedial actions, follow up to all issues and report all activities and findings. The minutes shall be forwarded to the Medical Executive Committee. A permanent file of the minutes shall be maintained for each committee.

The chairperson of a committee may, upon the request of the Medical Executive Committee, be invited to attend the Medical Executive Committee for the purpose of giving a report in person.

SECTION 7. Attendance Requirements

Each committee member shall be assigned attendance obligations appropriate to their level of activity at the hospital (See Article IV). If a member fails to meet these requirements, he/she shall be notified in writing by the chairperson. If the attendance is not corrected in the subsequent six (6) months, corrective action may be taken by the Department Chief/Service Leader. Such action will not entitle a staff member to a hearing or appellate review.

SECTION 8. Appointment

Except as otherwise provided in these Bylaws, the Medical Executive Committee shall make appointments to all committees and designate the chairperson. Initial committee appointments shall be for a period of two (2) years. The chairperson of each committee shall be a physician. No member shall be required to serve simultaneously on more than two (2) committees. The President of the Medical Staff and the President of the Hospital, or their designees, shall be ex-officio, non-voting members of all committees of the staff, whether standing or special.

SECTION 9. Standing Committees of the Medical Staff

There shall be the following standing committees:

1. Bylaws Committee
2. Credentials Committee
3. Infection Prevention and Control Committee
4. Medical Executive Committee
5. Covenant Health Pharmacy and Therapeutics Committee
6. Professional Practice Evaluation Committee
7. Quality Senate – See Exhibit 4, Covenant Board Quality algorithm.
The executive authority of the medical staff shall be vested in the Medical Executive Committee which shall have the duty of coordinating the professional activities and general policies of the various departments of the hospital and have such other functions and responsibilities as are provided in these Bylaws and the Bylaws of St. Joseph Hospital. The majority of Medical Executive Committee membership will be physician members of the Medical Staff actively practicing within the hospital.

2. The Medical Executive Committee shall consist of the following members:

   President of the Medical Staff
   Vice President of the Medical Staff
   Secretary/Treasurer of the Medical Staff
   Immediate Past President of Medical Staff
   Department Chief, Anesthesia
   Department Chief, Emergency Medicine
   Department Chief, Medicine/Family Practice
   Department Chief, Orthopedics
   Department Chief, Pathology
   Department Chief, Radiology
   Department Chief, Surgery
   Service Leader, Hospitalist Program
   Members-at-Large (4)

3. Four members-at-large shall be elected by the Medical Staff as provided in Article VIII, Section 3 of these Bylaws.

4. In the event that the President of the Medical Staff is the Department Chief, and thus serving on the Medical Executive Committee by virtue of both positions, the department may elect an additional member to the Medical Executive Committee for the term of office of the President.
5. There shall also be the following non-voting, ex-officio members:
   a) The President of the Hospital or his/her designee
   b) The Vice-President of Medical Affairs
   c) CNO or designee

6. Officers of the Medical Staff shall be the officers of the Medical Executive Committee. The Medical Staff President shall be the presiding officer.

7. Any member of the Medical Executive Committee may resign at any time by giving written notice to the President of the Medical Staff. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any later time specified in the written notice.

8. The Medical Executive Committee acting upon a two-thirds vote may affect removal of a committee member by secret ballot of the medical staff members of his/her department at a mandatory special meeting called for that purpose by the President of the Medical Staff. Permissible bases for removal of a Department Chief/Service Leader include, without limitation:
   a.) Failure to perform the duties of position held in timely and appropriate manner.
   b.) Having a conflict of interest with the St. Joseph Healthcare.
   c.) Conduct or statements harmful or damaging to the best interest of the Hospital or Medical Staff or to their goals, programs or public image.
   d.) Failure to continuously satisfy the qualifications for the position.
   e.) Physical or mental infirmity that renders the member incapable of fulfilling duties.

b. Duties

The duties of the Medical Executive Committee shall be as follows:

1. To represent and to act on behalf of the medical staff in the intervals between staff meetings, subject to such limitations as provided in these Bylaws. NOTE: Authority delegated to the Medical Executive Committee to act on behalf of the St. Joseph Hospital medical staff may be removed by a two-thirds majority vote of the medical staff during any General Medical Staff meeting and by secret ballot.

2. To coordinate the activities and general policies of the various departments/services.
3. To review and act on reports of all Medical Staff committees, departments, services and other assigned activity groups.

4. To implement policies of the medical staff not otherwise the responsibility of the department/service.

5. To provide liaison between the medical staff, the Hospital President, and the Board of Trustees.

6. To recommend action to the Hospital President on matters of a medical administrative nature.

7. To fulfill the medical staff's accountability to the Board of Trustees for the medical care rendered (quality and patient safety) to patients in the hospital.

8. To make recommendations regarding the mechanism designed to review credentials applications and delineate individual clinical privileges.

9. To review credentialing applications and requests for delineation of clinical privileges of applicants for appointment and reappointment to membership of the medical staff and to make recommendations to the Governing Board for membership, assignments to departments/services, and delineation of clinical privileges.

10. To organize the medical staff’s performance improvement activities and establish a mechanism designed to conduct, evaluate and revise such activities.

11. To annually approve the written Quality Assessment/Performance Improvement Plan and ensure it is an integral part of the hospital’s Performance Improvement Plan.

12. To annually approve the following key guiding Plans, Assessments & Goals for the upcoming year: Quality Plan (which includes the Medical Staff Quality Plan), Infection Prevention Plan, Utilization Management Plan and the Patient Safety Plan. Once the Medical Executive Committee approves the above, they will submit their recommendations to the Board of Trustees for final approval.

13. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the medical staff, including the initiation of and/or participation in medical staff corrective or review measures when warranted.

14. To be responsible for investigation of any reports of breach of Bylaws, Rules and Regulations, associated policies and procedures, ethics, standards of professional behavior, clinical competence or other deviations from standards of practice.

15. To assist in the process of identifying and managing matters of individual practitioner health that is separate from the medical staff disciplinary function (see Exhibit 2, Subcommittee for Practitioner Health Guidelines). To that end, the
Medical Executive Committee has established a Subcommittee for Practitioner Health.

a. The Subcommittee for Practitioner Health, shall be an ad hoc committee consisting of three physicians appointed by the Medical Staff President with the consent of the Medical Executive committee and the Hospital President. The Medical Staff President will designate one member as the Chairperson. The members may, but need not be, appointed from the Medical Executive Committee.

b. The Subcommittee on Practitioner Health will serve three objectives:
   - Educate medical staff members and other employees on issues related to practitioner health and impairment.
   - Encourage, initiate or assist any endeavor to improve the health and well being of all members of the medical staff.
   - Identify and assist any provider whose ability to practice medicine safely is compromised because of medical or psychological illness, including alcohol and drug abuse/dependency, or any other potentially impairing condition. The Hospital President will be informed of any instance in which a practitioner is providing unsafe treatment because of impairment. *In such an instance, appropriate corrective action may be employed.

16. Report activities during each meeting of the General Medical Staff.

c. Meetings

The Medical Executive Committee shall meet at least ten times a year and submit minutes in a timely manner to the Board of Trustees for review.

SECTION 11. Credentials Committee

The Credentials Committee has the primary responsibility of reviewing and making recommendations on each application for medical staff membership and clinical privileges. It also oversees the development of eligibility criteria for clinical privileges. In addition, it is commonly responsible for reviewing questions of clinical competence and the behavior of all medical staff appointees, making recommendations to the Medical Executive Committee.

a. Membership

The Credentials Committee shall consist of at least six (6) members of the Medical Staff representing various specialty areas, and one member of the Allied Health staff. Department Chiefs/Service Leaders shall not be members of the Credentials Committee.

The chairperson of the Credentials Committee shall be the Vice President of the Medical Staff.

Whenever the Credentials Committee reviews applications for appointment or reappointment that require additional input from specific specialty areas, additional individuals may be invited to meetings or provide consultation, as needed, by the
chairman of the committee.

b. Duties

The Credentials Committee shall be an investigational and advisory body only. It shall investigate the credentials and qualifications of each applicant for membership on the staff. The committee may interview the applicant and shall recommend to the Medical Executive Committee whether the application should be accepted, modified, deferred, or rejected as elsewhere provided in these Bylaws. It shall recommend the category, classification, departmental assignment and delineation of privileges in conformity with these Bylaws.

It shall investigate the qualifications of members of the staff in consideration of reappointment, non-reappointment, and each request for privileges, and shall make appropriate and specific recommendations to the Medical Executive Committee in these matters. It may invite to its proceedings, as non-voting participants, as it shall deem necessary or proper in such investigation. It shall investigate any breach of ethics reported to it.

c. Meetings

The Credentials Committee shall meet upon the call of the chairperson and submit minutes of each meeting in a timely manner to the Medical Executive Committee for review.

SECTION 12. Tissue and Transfusion Committee

a. Membership

The Tissue and Transfusion Committee shall consist of at least five (5) members of the Medical Staff from various areas such as general surgery, orthopedics, gynecology, pathology, anesthesiology the inpatient care/hospitalist service, as well as for emergency medicine, and one member of the Allied Health Staff. It shall also include the blood bank supervisor, Director of Quality/PI or his/her designee, and representatives from nursing services and administration.

b. Duties

1. Operative and other invasive and non-invasive procedure review shall be performed for cases in which a specimen was removed, for all cases in which there is a major discrepancy between the preoperative, postoperative and histological diagnoses and for a sampling of those cases in which no specimen was removed. The review criteria shall be consistent with current regulatory requirements.

2. It shall review blood and blood component transfusions for proper utilization. The review criteria shall be consistent with current regulatory requirements.
3. It shall review all significant transfusion reactions.

c. Meetings

The Tissue and Transfusion Committee shall meet at least quarterly and on call of the chairperson and submit minutes of each meeting in a timely manner to the Medical Executive Committee for review.

SECTION 13. Bylaws Committee

a. Membership

The Bylaws Committee shall consist of at least five (5) members of the Medical Staff, one member of the Allied Health Staff, and a representative from Administration.

b. Duties

1. The committee shall review the Bylaws, Rules and Regulations of the Medical Staff every two years and may recommend amendments and changes whenever the need may arise. These recommendations shall be submitted to the Medical Executive Committee and General Medical Staff for their review and recommendations to the Board of Trustees.

2. It shall keep the medical staff informed of the provisions of federal, state and local statutory and administrative law affecting hospitals.

3. It shall concern itself with the acquisition and/or maintenance of the Hospital's accreditation and certification status by The SJH's CMS deemed status surveyor, CMS, or any other CMS deemed agency and all other applicable accrediting and certifying bodies, insofar as such status relates to patient care and education responsibilities, and shall assist and advise the Medical Executive Committee in regard to the factors influencing such status.

c. Meetings

The Bylaws Committee shall meet at least quarterly and upon the call of the chairperson and submit minutes of each meeting in a timely manner to the Medical Executive Committee.

SECTION 14. Covenant Health Pharmacy and Therapeutics Committee

The Covenant Health Pharmacy and Therapeutics Committee follows a process that ensures that its recommendations are scientifically based and recognize different perspectives of best practices of medical care.

The Covenant Health Pharmacy and Therapeutics Committee, during the process of formulating recommendations, will consider scientific evidence of effectiveness and safety,
comparative value, best practice of medical care as defined by national and local sources, best practice of nursing care, impact on information management systems and the ethical and Religious Directives when making recommendations for formulary changes.

a. Membership

The Covenant Health Pharmacy and Therapeutics Committee shall consist of at least two (2) members of the Medical Staff from each member hospital, the Pharmacy Director, and the Lead Pharmacist, or his/her designee. Therefore, each member hospital will have three voting members.

b. Duties  (Note: this is to provide a descriptive overview ONLY)

1. This committee shall serve as an advisory group to the Medical Executive Committee in all matters relating to the use of pharmaceuticals.

2. Its duties shall include managing the Covenant Health Formulary and related Therapeutic Interchange policies, clinical protocols requiring pharmacy participation, and Pharmacy Substitution policies.

3. It shall assist in the formulation of written policies and procedures relating to the intra-hospital drug distribution system, including their evaluation, selection, procurement, labeling, storage and safe administration, so as to ensure optimum drug use with a minimum of potential hazard to the patient.

4. It shall recommend such policies and procedures as will ensure that the distribution and administration of controlled drugs is adequately documented and that there is a drug recall procedure within the hospital which can be readily implemented.

5. It shall review all reports of drugs and other tissue reactions occurring within the hospital, investigate the possible cause of these reactions and make recommendations to the Medical Executive Committee whenever necessary for improvement in the use of drugs and other therapeutic measures.

6. It shall have joint responsibility with other designated groups for antibiotic stewardship and medication safety including medication administration.

c. Meetings

The Covenant Health Pharmacy and Therapeutics Committee shall meet at least quarterly and upon the call of the chairperson and submit minutes of each meeting in a timely manner to the Medical Executive Committee for review. These meetings are open to medical staff members and employees of Covenant Health.
SECTION 15. **Professional Practice Evaluation Committee**

a. **Membership**

1. The Professional Practice Evaluation Committee members, appointed by the Medical Executive Committee (MEC), shall consist of the Department Chief of Surgery, Department Chief of Medicine/Family Practice, Medical Director of St. Joseph Internal Medicine (or designee), a non-employed member of the Medical Staff, one member of the Allied Health Staff, and the Medical Director of Quality Improvement who shall serve as the chairperson. The Director of Quality/PI will serve as a non-voting member. The MEC may appoint an appropriate designee for any committee member should the need arise.

2. Additional medical staff members may be requested to provide consultation to the committee during a review should their expertise be required to ensure a thorough and objective evaluation. External peer review services will also be sought by the committee if deemed appropriate.

3. Partners, associates or relatives of a practitioner under review will not participate in the final disposition.

b. **Duties**

1. It shall have the responsibility to develop and implement a Peer Review Plan to ensure open and honest communication and full review of available information and to ensure the proceedings of the Professional Practice Evaluation Committee be protected from disclosure, as allowed by state and federal regulations.

2. It shall have the responsibility to ensure that the hospital, through the activities of its medical staff, assesses the performance of individuals who are granted clinical privileges and uses the results of such assessments to improve patient safety, quality and efficiency of health care services provided by the hospital as outlined in the Peer Review Policy.

3. When it has been determined that circumstances have occurred indicating the standard of care within the medical community has not been met by a specific practitioner, a focused peer evaluation may be conducted by the Professional Practice Evaluation Committee as specified by the Peer Review Policy.

c. **Meetings**

1. The Professional Practice Evaluation Committee shall meet at least quarterly and on call of the chairperson and submit minutes of each meeting in a timely manner to the Credentials Committee for review.
Whenever a suspected deviation from standard clinical or professional practice is identified, the committee chair may require the practitioner to confer with the committee regarding the alleged deviation. A practitioner’s failure to appear at such a meeting after two notices would result in an automatic suspension of membership and privileges. Automatic suspension does not give rise to the fair hearing/due process, but would be rescinded upon the practitioner’s participation in the previously referenced meeting.

SECTION 16. Quality Senate

The Medical and Allied Health Staff of St. Joseph Hospital is organized for the purpose of providing quality medical care to the patients of this hospital. The clinical work of the staff is guided by the principles of continuous quality improvement, quality assurance, and adherence to the American Medical Association or the American Osteopathic Association Code of Ethics.

The Quality Senate provides a structure to align people, processes and technology to effectively implement evidence-based practices that will improve the value of patient care, education and patient safety. This framework supports clinical transformation by engaging clinicians and staff in the redesign of care to improve the patient experience and provide value. Process improvement tools such as Lean and Root Cause Analysis are used to strengthen the outcomes developed.

a. Membership:

Individual departments are combined into larger Service Groups for maximum collaboration and goal alignment. Each Service Group has a matrix that appropriately funnels and supports process improvement opportunities. Lean process improvement is overseen by the Lean Steering Committee who report progress to the Quality Senate. The Lean Steering Committee Chair serves on the Quality Senate. Each Service Group has an appointed Lean Partner who, when in that capacity, reports to the Lean Steering Committee (See Exhibit 4).

Services Groups are as follows:

- Ambulatory Care Services – PBB primary care and specialty practices
- Medical Services – CPCU, Med-Neuro, cardiology, critical care
- Surgical Services – PAT, ASU, PACU, Endo, OR, Sterile Processing, surgery, orthopedics, anesthesia
- Emergency Services – emergency medicine
- Integrated Services (ancillary departments)

Membership includes physician leadership, nursing leadership, administration representation, and other relevant leadership. A director co-chair and a physician co-chair as well as an appointed facilitator (the Lean Partner). Co-chairs serve a one-year term or longer as may be appropriate.

Members of the medical staff have a responsibility to participate in quality assessment/performance improvement, patient safety and risk reduction efforts. These
responsibilities are fulfilled by participation on committees, task forces, teams, or as individuals offering their expertise to special projects and efforts.

b. Duties:

In order to create and implement a comprehensive organizational structure to establish the following:

1. A framework for all process improvement/quality assessment
2. Multi-disciplinary, cross-organizational workgroups
3. Mechanisms for appropriate routing of process improvement opportunities
4. Integration of Lean philosophy and practice at every level

c. Meetings

The Quality Senate shall meet at least quarterly and on call of the chairperson and submit a written report of each meeting to the Medical Executive Committee.

Medical Staff and Allied Health Staff hold active membership on the committees that encompass activities comprised within the performance improvement and patient safety plans, along with appropriate hospital staff.

Members of the medical staff have a responsibility to participate in quality assessment/performance improvement, patient safety and risk reduction efforts. These responsibilities are fulfilled by participation on committees, task forces, teams, or as individuals offering their expertise to special projects and efforts.

Performance Improvement Plan

a. The details of the quality assessment/performance improvement and patient safety initiatives can be found in the Scope section of the Plan.

1. The Plan will be an integral part of the organization’s performance;
2. The MEC ensures that the medical staff meets its own QAPI responsibilities as part of the overall hospital plan. This includes a review of practitioners-specific performance improvement, peer review data and review of systems and processes that impact care and outcomes. Therefore, the Plan will be reviewed and approved at least annually by the Medical Executive Committee and the Governing Board;
3. Accountabilities for reporting of the Plan elements will be clearly stated in the Plan;
4. Medical and Allied Health Staffs will be appropriately represented on the hospital-wide Committees and Teams.
b. The Plan encompasses all hospital departments, Medical and Allied Health Staff departments and committees, and other services (including those services furnished under contract or arrangement).

c. The Plan focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors, aligning with our “Do No Harm” philosophy.

d. The organization will identify, measure, analyze, improve, track and report key quality indicators associated with safety, patient outcomes, and the quality of patient care and education. These key indicators will include but are not limited to:

1. Clinical operational aspects;
2. Adverse patient events (e.g., deaths, complications, etc.);
3. Processes for screening of all tissue removed surgically, and selected tissues for appropriateness of care, where indicated. Specimens in Exhibit 1 are expressly excluded;
4. All transfusions of blood products for appropriateness;
5. All hospital acquired infections, antibiotic usage, adverse drug reactions, and other measures of drug usage, safety and efficacy;
6. Patient safety; and
7. Risk management, etc.;

e. Practitioner specific quality management data shall be utilized, where appropriate;

1. This data shall be utilized in the periodic appraisal and reappointment processes of the medical staff;
2. Privacy protections shall be in place to ensure thorough, candid, and fair appraisal of individual practitioners;
3. Opportunities for feedback to and from practitioners regarding peer review observations shall be available and documented.

f. Quality management activities relating to the outcomes and processes of care which are not necessarily on an individual practitioner basis shall also be included in this review.

g. Review shall include systematic process and outcome-based analyses with indicator based, screening, quantitative review, trending, conclusions, and improvement interventions with assessment of ultimate efficacy of these interventions.

h. The Plan will identify methods of reporting and assessing activities including:

1. Committee, department or service meetings which shall be held for the purpose of reviewing PI processes, data, and findings at least six (6) times per year;
2. Minutes reflecting committee assessment, action, and reporting and follow-up of information to appropriate accountability channels;

3. A workable and functioning system for management of deferred, pending, and unresolved quality issues;

4. The Medical Executive Committee and Governing Board regularly receiving, reviewing and approving quality management activities;

5. Quality management information generating interventions designed to improve deficiencies and which are audited for effectiveness;

6. Department and/or Service level accountability which is present, consistent with medical and professional staff structure and function, and clinical work;

7. Practitioners with limited or no hospital clinical activity shall provide quality data sufficient to judge competency at the time of reappointment. This information may come from another CMS deemed status surveyor accredited healthcare entity, from the practitioner’s practice setting or from information obtained from another source approved by the Department Chief, Service Leader, Medical Director or Lead Physician (as applicable) and the Medical Executive Committee.

SECTION 17. Infection Prevention and Control Committee

a. Membership

The Infection Prevention and Control Committee shall consist of at least three(3) members of the Medical Staff, one member of the Allied Health Staff, the Infection Prevention and Control Coordinator, the Microbiology Supervisor, the Director of Perioperative Services, the Pharmacy Director, the Director of Quality/PI and a representative from Administration.

b. Duties

1. It shall have the responsibility of investigating infections occurring among patients and personnel, and of making recommendations for the control of such infections and any other situations which might contribute to hospital hazards for patients and personnel. It shall develop a practical system for reporting, evaluating, and keeping records to ensure that endemic levels, and well as epidemic levels of infection will be brought to the attention of the Medical Executive Committee for corrective action.

2. It shall provide assistance in the development of the Hospital's personnel health programs.
3. It shall recommend standards of sanitation and medical asepsis, as well as the procedures used for isolation.

c. Meetings

The Infection Prevention and Control Committee shall meet at least quarterly and on call of the chairperson and submit minutes of each meeting in a timely manner to the Medical Executive Committee.

The Chairperson and the Infection Preventionist meet routinely to ensure the Infection Prevention & Control meetings are addressing relevant issues.

SECTION 18. Radiation Safety Committee

a. Membership

1. The Radiation Safety Committee shall consist of an authorized user for each type of use permitted by license (i.e. Pathology, Radiology, Nuclear Medicine), a representative of Administration, the Radiation Safety Officer, and the Physicist Consultant. The Radiation Safety Officer will be the Committee chairperson and, as such, preside over all meetings.

b. Duties

1. Discussing any radiation safety problems requiring a general solution.
2. Determining whether current procedures are maintaining exposures ALARA.
3. Considering new proposals for the use of radionuclides and evaluating the safety of those uses and the qualifications of the users.
4. Auditing the Radiation Safety Program to ensure that it meets all goals and all pertinent regulations.
5. The duties and functions of this Committee will be consistent with the guidelines specified by the Nuclear Regulatory Commission.

c. Meetings

The Radiation Safety Committee shall meet at least quarterly and upon call of the chairperson and will submit minutes in a timely manner for Medical Executive Committee review. A quorum must include the Radiation Safety Officer and the Administration representative.
SECTION 19. Utilization Management Committee

a. Membership

The Utilization Management Committee shall consist the UM Physician Advisor, the Medical Director for Quality Review who serves as the Chair, a Medical Staff representation from Emergency Department and the Hospitalist Service, one member of the Allied Health Staff, as well as representatives from Administration, Case Management, Information Systems, Medical Records, Nursing, Director of Quality/PI, and Radiology. Representatives from the Surgical Services Disciplines will be invited to the committee on an as needed basis to discuss quality issues.

Each member is responsible for reviewing all data collected and making recommendations for continued and/or improved processes related to clinical/patient care as well as utilization of resources. All recommendations will be reviewed at the following meeting to ensure proper follow-up.

The purpose of the Utilization Management Plan is to provide the basis for a comprehensive program that will improve both the quality of patient care and the effective utilization of health care resources, both on an inpatient and outpatient basis.

b. Duties

1. Establish and monitor an effective review of the appropriateness and clinical necessity of admission, continued stays, and support services for all patients regardless of payment.
2. Provide leadership to the utilization review activities of non-physician Case Managers serving as UR Coordinators, and hospital Discharge Planners.
3. Initiate continual monitors, more intensive evaluation, or other reviews of activities as directed by the Utilization Management Committee of St. Joseph Hospital.
4. To review patterns and profiles generated by the most currently designated QIO/QIN for SJH, thirds party payers, and the hospital, (i.e.: cost and day outliers, delay days, denial trending, appropriateness of discharge planning, etc); to identify opportunities to improve the provision of care and to recommend appropriate actions to the hospital’s Utilization Management Committee.
5. To recommend to the Utilization Management Committee modification or adoption of criteria and standards, as deemed necessary, and to recommend changes in hospital procedures or Medical Staff practices that are identified by the analysis of review findings.
6. Oversee the medical record review function regarding timeliness, pertinence review, CMI processes, etc.

c. Meetings

The Utilization Management Committee shall meet at least four (4) times per year and on call of the chairperson and submit minutes in a timely manner to the Medical Executive Committee for review.
SECTION 20. Joint Conference Committee

a. Membership

The Joint Conference Committee shall consist of the President of the Medical Staff, the Chairman of the Board of Trustees, and the Hospital’s President. Other committee members will have equal representation of medical staff members appointed by the Medical Staff President, and non-physicians members of the Board appointed by the Chairman of the Board. The Vice President of Medical Affairs may be a member, without vote, at the discretion of the Medical Staff President and Chairman of the Board.

b. Duties

1. Provides advice in the development of hospital policy;
2. Mediates/resolves conflicts between the Credentials Committee and/or the Medical Executive Committee and the Board of Trustees; and
3. Mediates/resolves conflicts between the Medical Executive Committee and the medical staff.

c. Minutes

Minutes will be maintained.

SECTION 21. Future Committees

a. From time to time it may be desirable to add, remove, or consolidate standing committees in the structure of the Medical Staff. The Medical Executive Committee in this regard shall make recommendations to the Board of Trustees. Action by the Board of Trustees in such matters shall constitute an amendment to these Bylaws and shall not require compliance with the provisions of Article XIV.

b. Special Committees

1. The Medical Executive Committee and the President of the Medical Staff may appoint special committees from time to time for such purposes, as it may deem appropriate. Tenure and authority of such committees shall be defined at the time of appointment, but their tenure shall not exceed one year.

2. Such committees shall confine their work to the fulfillment of their purpose for which they were created and shall report to the Medical Executive Committee. They shall have no power of action unless authority of the Executive Committee specifically grants such. Minutes shall be kept of all meetings of such committees and submitted in a timely manner to the Medical Executive Committee for review.
ARTICLE XI
MEDICAL STAFF MEETINGS

SECTION 1. The Annual Meeting

a. The annual meeting shall be the General Medical Staff meeting held in October or in any other month designated by the President of the Medical Staff with approval of the Medical Executive Committee.

b. Meetings must be conducted through a means that allows interactive participation and may include e-mail, teleconference, real-time video and/or face-to-face meetings.

c. Election of Medical Staff Officers shall be ratified during this meeting. Elections shall be conducted in accordance with these Bylaws (Article VIII, Section 3).

SECTION 2. Regular Meetings

The medical staff shall hold meetings twice each year. Such meetings will ordinarily be held during the months of April and October.

a. Meetings must be conducted through a means that allows interactive participation and may include e-mail, teleconference, real-time video and/or face-to-face meetings.

SECTION 3. Special Meetings

a. Special meetings of the medical staff may be called at any time by the President of the Medical Staff, at the request of the Board of Trustees, or upon the written request of any ten members of the Active Medical Staff.

b. Written notice shall be given to each Active Medical Staff member and such written notice shall indicate the purpose of such special meeting.

c. A special meeting shall be limited to discussion and action of the specific purpose indicated in the notice of the meeting.

SECTION 4. Notice of Meetings

a. Notice of the annual, regular and special meetings of the Medical Staff shall be e-mailed by Medical Staff Office personnel on behalf of the Secretary of the Medical Staff one week prior to such meeting.

b. Any change in the date of a regular meeting shall be made by direction of the President of the Medical Staff.

SECTION 5. Quorum

Members in attendance shall constitute a quorum.
SECTION 6. Action of Medical Staff Meetings

Upon the adoption of motions at regular and special meetings of the medical staff, all such decisions shall be forwarded in the form of recommendations to the Board of Trustees through the Medical Executive Committee for action.

SECTION 7. Attendance at Meetings

a. Attendance at General Medical Staff meetings is strongly encouraged.

SECTION 8. Agenda

a. The agenda at any regular Medical Staff meeting shall be:

1. Review and approval of the minutes
2. Old business
3. New business
4. Adjournment

b. The agenda at special meetings shall be:

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

IMMUNITY FROM LIABILITY

The following authorizations, immunities, and definitions shall be express conditions to any practitioner’s application for, or exercise of, clinical privileges or medical staff membership at this Hospital. These provisions shall be included on the Applicant’s Consent and Release, which each practitioner shall be required to sign as a part of the application form.

By applying for appointment and clinical privileges, the practitioner authorizes the Hospital to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on his or her professional qualifications, credentials, clinical competence, character, ethics, behavior, or any other matter bearing on satisfaction of the criteria for initial or continued appointment to the medical staff and granting of privileges. The practitioner also authorizes the Hospital to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties relating to such questions. The practitioner specifically authorizes said third parties to release such information to the Hospital and its authorized representatives upon request.

To the fullest extent permitted by law, the practitioner extends absolute immunity to, and releases from any and all liability, the Hospital, its authorized representatives, and any third parties, as defined below for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving him or her, performed, made, requested sent or received by this Hospital and its authorized representatives to, from or by any third party, including otherwise privileged or confidential information relating but not limited to the following:

1. applications for appointment or clinical privileges, including temporary privileges, as well as periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;

2. proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other corrective action or disciplinary sanction, as well as any hearings and appellate reviews;

3. formal or informal inquiries, reviews, or investigations, including utilization reviews, quality assurance reviews, or medical care evaluations concerning his or her professional qualifications, credentials, clinical competence, character, ethics, or behavior;

4. any other Hospital, medical staff, department, service, or committee activities related to his or her quality of care or professional conduct.

The foregoing shall be privileged to the fullest extent permitted by law. The immunity and release created by the above paragraph shall apply regardless of whether the practitioner is granted appointment or privileges, and shall survive any separation from the Hospital medical
staff or any denial, reduction, suspension, limitation, surrender, or termination of clinical privileges.

The phrase “Hospital” or “Hospital and its authorized representatives” means the Hospital and its parent corporation, and any individuals who have or have had any responsibility for conducting the activities described above, including without limitation current or former Trustees, Directors, hospital employees, and their appointed representatives; members of the medical staff; consultants to the Hospital or its medical staff; the Hospital’s attorney and his or her partners, associates or designees.

The phase “third parties” means all persons, including without limitation, members of the medical staff; members of the medical staff of other hospitals; other physicians or health care practitioners and nurses; or other organizations, associations, partnerships, corporations or government agencies, whether hospitals, health care facilities, managed care organizations, provider networks, or professional liability carriers, from whom information has been requested by the Hospital.
ARTICLE XIII

AMENDMENTS TO RULES AND REGULATIONS, EXHIBITS, AND APPENDICES

SECTION 1. Rules and Regulations of the Medical Staff

a. The Medical Staff shall adopt such rules and regulations, exhibits, and appendices as may be necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of medical staff organizational activities, as well as embody the level of practice that is to be required of each practitioner in the hospital. Such rules and regulations shall be part of these Bylaws.

b. They shall become effective when approved by the Board of Trustees.

SECTION 2. Amendments to Rules and Regulations, Exhibits, and Appendices

a. These rules and regulations, exhibits, and appendices may be amended at any meeting of the Medical Staff (i.e., face-to-face, or virtual), by a two-thirds majority vote.

b. The method of information communication may be via mail, e-mail notification, a formal meeting, and/or electronic voting.

c. A quorum requires 25% response of voting members of the Medical Staff. Failure to respond, by the date indicated on the notification, shall be considered a vote with the majority. The action of a majority of the Medical Staff responding shall be the action of the whole.

d. Such amendments shall become effective upon final approval by the Board of Trustees.

e. In response to requirements imposed by regulatory agencies necessitating an urgent amendment to the rules and regulations, the MEC is delegated to act on behalf of the medical staff.

f. Any amendments shall be provisionally adopted by the MEC and provisionally approved by the Board of Trustees.

h. The medical staff shall have the opportunity for retrospective review of and comment on the provisional amendment(s) during the next General Medical Staff meeting and/or via email discussion.

i. If there is a conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the MEC is implemented by the Joint Conference Committee.

j. If there is no conflict between the organized medical staff and the MEC, the provisional amendment(s) stands.
ARTICLE XIV

AMENDMENTS TO MEDICAL STAFF BYLAWS

SECTION 1.

These Bylaws may be amended by a two thirds vote of all members of the Active Medical Staff during any meeting (i.e., face-to-face or virtual) of the Medical Staff, provided a quorum is established and provided written notice of the proposed amendments has been provided to each voting member at least two (2) weeks in advance of such meeting.

The method of information communication may be via mail, e-mail notification, a formal meeting, and/or electronic voting.

A quorum requires 25% response of the voting members of the Active Medical Staff. Failure to respond, by the date indicated on the notification, shall be considered a vote with the majority. The action of a majority of the Active Medical Staff responding shall be the action of the whole.

SECTION 2.

An amendment shall be effective when approved by the Board of Trustees.
ARTICLE XV ADOPTION OF
MEDICAL STAFF BYLAWS

SECTION 1. Initial Adoption

a. These Bylaws will be adopted following a two thirds vote of all members of the Active Medical Staff during any meeting (i.e., face-to-face or virtual), provided a quorum has been established and written notice of the proposed adoption has been provided to each voting member at least two (2) weeks in advance of such meeting.

b. The method of information communication may be via mail, e-mail notification, a formal meeting, and/or electronic voting. Notice of the meeting shall contain an express reference to the review of the proposed Bylaws' changes;

c. A quorum requires 25% response of the voting members of the Active Medical Staff. Failure to respond by the date indicated on the notification, shall be considered a vote with the majority. The action of a majority of the Active Medical Staff responding shall be the action of the whole.

d. Approval by the Board of Trustees of the hospital as indicated in the minutes of a any meeting of the Board and communicated to the Medical Staff by the Hospital President.


a. The Medical Executive Committee shall act as an Ad Hoc Bylaws Transition Committee so as to effect an orderly transition from operation under the existing Bylaws, Rules and Regulations, to operation under these new Bylaws, Rules and Regulations.

b. Anything contained in these Bylaws to the contrary notwithstanding, the members of the Medical Staff, Officers, Committees, Chairmen, Chiefs, etc., serving immediately preceding the effective date of these Bylaws shall continue to serve with the same powers and duties, rights and responsibilities possessed by authority of the former Bylaws until such time as the Ad Hoc Bylaws Transition Committee directs.
ARTICLE XVI

PRECEDENCE OF HOSPITAL BYLAWS

The Bylaws of the Medical Staff shall conform to the Bylaws of St. Joseph Hospital and be accepted by the Board of Trustees. No change in the Medical Staff Bylaws can be made without the approval of the Medical Staff.
ARTICLE XVII
RULES AND REGULATIONS

SECTION 1. Admission and Discharge of Patients

a. The hospital shall accept all patients for care and treatment for which the appropriate facilities and staff exist. All patients will be seen and evaluated for appropriateness of hospitalization at St. Joseph Hospital, stabilized if necessary and suitable disposition made.

b. Members of the High Medical Staff shall admit patients to the hospital. All other members of the medical staff may admit patients according to citizenship requirements and privileges granted.

c. A member of the Medical Staff admitting a patient to the hospital shall be responsible for the medical care of that patient in the hospital and for the timely completion and accuracy of the medical record. Whenever there is a change of attending physician, transfer of these responsibilities shall be appropriately documented in the medical record.

d. Except in an emergency situation, no patient shall be admitted to the hospital without a provisional diagnosis.

e. When admitted on an emergency basis, a patient who does not have a private practitioner will be assigned to the staff physician on emergency duty in the appropriate department or service. The Department Chief, Service Leader, Medical Director or Lead Physician, as applicable, shall provide a schedule of physicians on emergency service.

f. Any member of the Medical Staff who is not available within thirty (30) minutes of the hospital shall name a member of the Medical Staff who is available within thirty (30) minutes who may be called to attend patients in an emergency. In case of failure to name such a physician, the President of the Hospital shall have the authority to call any member of the Medical Staff should it be necessary.

g. The admitting practitioner shall be held responsible for providing such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever the patient might be a source of danger from any cause whatever.

h. The attending practitioner is required to document the medical need for hospitalization of each patient. The daily progress notes must reflect the need for continued hospitalization. Failure of compliance with this policy will be brought to the attention of the appropriate Department Chief, Service Leader, Medical Director or Lead Physician for suitable action.
Patients shall be discharged only on an order of a physician or his/her Allied Health practitioner, as appropriate. Should a patient choose to leave the hospital against the advice of the attending physician or without proper discharge, he/she will be asked to sign a Release from Responsibility Discharge and Procedure form stating such, and a notation shall be made in the patient's medical record. If the patient refuses to sign the form, that fact shall be noted in the medical record as well. (See Nursing Administration policy #1-003.)

In the event of a hospital death the deceased shall be pronounced dead by the attending practitioner or his/her designee. 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. 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. Policies with respect to release of dead bodies shall conform to local law.

Each member of the medical staff should attempt to secure autopsies in all cases of unusual deaths and of medical-legal or educational interest. No autopsy shall be performed without a written consent of the next of kin and in accordance with State law. The hospital pathologist or the State Medical Examiner shall perform all autopsies. Provisional anatomical diagnosis shall be recorded on the medical record within 3 days and the complete report shall be made a part of the record within 60 days. Cases which are to be considered for autopsy include, but are not limited to:

1. Answering clinical questions or explaining unknown or unanticipated medical complications;
2. Confirming clinical diagnosis and monitoring results of therapy;
3. Determining the cause of death where a diagnosis is unknown with certainty on clinical grounds or in cases with unexpected or unexplained deaths during or following any dental, medical, or surgical diagnostic procedure;
4. Providing reassurance to the family/public;
5. Disclosing known or suspected conditions that have direct bearing on organ recipients or survivors;
6. Providing confirmation of known or suspected death resulting from environmental or occupational hazards; or
7. Determining the cause of death of participants of clinical trials approved by IRBs.

For Medical Examiner cases, please refer to the organizational policy.

SECTION 2. Medical Records

The medical staff shall be actively involved in assuring that the maintenance of patient medical records is complete, timely and clinically pertinent. The medical record must contain information such as notes, documentation, records, reports, recordings, test results assessments, etc. to justify admission, justify continued hospitalization, support the diagnosis, describe the patient's progress, describe the patient's response to
medications, interventions, care, treatments, etc. The medical record must contain complete information/documentation regarding evaluations, interventions, care provided, services, care plans, discharge plans and the patient’s response to those activities. Patient medical record information, such as laboratory reports, test results, consults, assessments, radiology reports, dictated notes, etc. must be promptly filed in the patient’s medical record in order to be available to the physician and other care providers to use in making assessments of the patient’s condition, to justify continued hospitalization, to support the diagnosis, to describe the patient’s progress, and to describe the patient’s response to medication, interventions, and services, in planning the patient’s care, and in making decision on the provision of care to the patient.

b. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The medical record must be completed within 30 days of the patient’s discharge. The medical record shall include identification data, complaint, personal history, all practitioner’s orders, family and social history, history of present illness, physical examination, review of systems, all nursing notes, including nursing care plans, special reports such as consultations, clinical laboratory and radiology services, and others; provisional/admitting diagnosis, consents, advance directives, medical or surgical treatment, operative report, anesthesia report, pathological finding, initial plan of care, progress notes, complications, hospital-acquired infections, unfavorable reactions to drugs, blood products, and/or anesthesia, final diagnosis, condition on discharge, summary or discharge note, discharge instructions, clinical resume, vital signs, all medication records, autopsy report when performed, and all other information necessary to monitor the patient’s condition.

c. Except as specified for emergency situations in the hospital’s informed consent policies, all inpatient and outpatient medical records must contain a properly executed and completed written informed consent form prior to conducting any procedure or other type of treatment that requires informed consent by the hospital’s medical staff, or State or Federal laws or regulations. The informed consent must contain at least the following:

1. Name of patient, and when appropriate, patient’s legal representative;
2. Name of the hospital;
3. Name of specific procedure(s) or other type of medical treatment;
4. Name of practitioner(s) performing the procedure(s), important aspects of the procedure(s), or administering the medical treatment as well as the name(s) and specific significant surgical tasks that will be conducted by practitioners other than the primary surgeon/practitioner. (Significant surgical tasks include (but are not exclusive to): harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues.);
5. Indication or listing of the material risks* of the procedure or treatment that were discussed with the patient or the patient’s representative;
6. Alternative procedures, treatments or therapies;
7. Signature of the patient or patient’s legal representative;
8. Date and time the consent is signed by the patient or the patient’s legal
9. Statement that procedure or treatment, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient’s legal representative;

10. Date, time and signature of professional person witnessing the consent;

11. Name/signature of person who explained the procedure to the patient or the patient’s legal representative.

*Material risks could include risks with a high degree of likelihood but a low degree of severity, as well as those with a very low degree of likelihood but a high degree of severity.

d. A complete medical history and physical examination must be performed by an MD/DO, Podiatrist or a Dentist (per 2017 State of Maine Law), no more than 30 days prior to, or within twenty-four (24) hours of, registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services. Please refer to policy #4007, Medical Record Content. The history and physical shall include:

1. vital signs,
2. chief complaint,
3. history of present illness,
4. relevant past medical history,
5. allergies to medications and/or food,
6. medications,
7. family history,
8. social history,
9. physical examination to include vital signs and review of pertinent body systems to include, at a minimum, a cardiac and lung examination,
10. all pertinent findings resulting from an assessment of all systems of the body including a provisional diagnosis, impression, and a treatment plan,
11. and any other information necessary to monitor the patient’s condition.

Independent members of the Allied Health Staff may perform that part of the history and physical examination related to their specialty.

If a complete history has been recorded and a physical examination performed no more than 30 days prior to registration or inpatient admission to the hospital, a copy of these reports may be used in the patient’s hospital medical record in lieu of the admission history and report of physical examination. In such instance, an appropriate assessment performed by the MD/DO, must include a physical assessment of the patient to update any components of the patient’s current medical status that may have changed since the original assessment. If there has been no change, this must be noted. This update must be completed within twenty-four (24) hours of admission or registration, but prior to surgery or a procedure requiring anesthesia services. The update and the original assessment must be in the record in the aforementioned time frames. Until such time as dictated admission history and physical examinations are
recorded, a brief admission note shall be made at the time of admission.

e. The medical record of any inpatient requiring any invasive procedure must meet the requirements of the pre-procedure evaluation as outlined in MS0021, Pre-Procedure Patient Evaluation, Section IV, Procedure.

f. In the event a patient is readmitted within thirty (30) days for the same condition, reference to the previous history with an interval note suffices.

g. The ultimate responsibility of a current history and physical documented and in the medical record at the time of admission as defined by federal regulations, is that of the attending physician.

h. Whenever the pre-procedure evaluation or a written note is not recorded on the patient’s chart prior to an operation or diagnostic procedure, the procedure shall be canceled unless the attending practitioner states in writing that such delay would be detrimental to the patient.

i. Pertinent progress notes shall be made daily, including the day of admission and the day of discharge and shall be recorded at the time of observation. The progress note shall be sufficient to permit continuity of care and transferability. Entries made on any day other than the day of service must be identified as late entries.

j. All operative reports will be dictated immediately following surgery and signed by the surgeon for all patients. Operative reports are required for procedures that are operative, invasive and noninvasive in nature, if those procedures place the patient at risk. A brief operative note will be immediately written in the patient’s record following surgery and before the patient is transferred to the next level of care.

Brief operative notes include:

1. name(s) of the primary surgeon(s) and his/her assistant(s),
2. procedure performed,
3. description of each procedure finding,
4. establish blood loss,
5. specimens removed, and
6. post-operative diagnosis.

Dictated operative reports will include:

1. name and hospital identification number of the patient;
2. date and time of the surgery;
3. pre-operative diagnosis;
4. name of surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
5. name and description of the specific surgical procedure(s) performed;
6. description of techniques, findings, and tissues removed or altered;
7. estimate blood loss as indicated;
8. specimens removed; disposition of each specimen;
9. surgeon(s) or practitioners' name(s) and a description of the specific significant surgical tasks that were conducted by a practitioner other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues);
10. complications, if any;
11. type of anesthesia administered and unfavorable reactions, if any;
12. a detailed report of the surgical technique and findings;
13. Prosthetic devices, grafts, tissues, transplants or devices implanted, if any;
14. post-operative diagnosis; and
15. disposition of the patient.

The completed operative report will be authenticated by the surgeon and made available in the medical record as soon as possible after the procedure.

k. Consultations shall show evidence of review of the patient’s record by the consultant (physician), pertinent findings on examination of the patient, the consultant’s (physician’s) opinion and recommendations. This report shall be made part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation. The attending/ordering physician shall note in the progress notes receipt and acceptance/disagreement with the consultant’s report.

l. All entries in the medical record must be legible, timed, dated and authenticated by the person who is responsible for ordering, providing, or evaluating the service provided.

m. With patient safety in mind, the use of symbols and abbreviations in the medical record is strongly discouraged. Prohibited abbreviations can be found in policy IM-011, Attachment A the official “Do Not Use” abbreviations list recommended by the SJH’s CMS deemed status surveyor. This policy is available on the hospital’s intranet through the PolicyStat software.

n. The attending physician will dictate a discharge summary on all patients hospitalized over twenty-four (24) hours. The discharge summary must be dictated within 15 days of a patient’s discharge. Dictated discharge summaries will include reason for hospitalization, significant clinical findings, procedures/operations performed, treatments rendered, condition on admission and condition at discharge, instructions issued, follow up plans, provisional and final diagnoses, and discharge disposition. Complications, including but not limited to any hospital-acquired infections, unfavorable reactions to drugs, and unfavorable reactions to anesthesia, diet, activity, DNR status, prognosis at discharge, results of any pathology report, and a brief summary of the hospital stay must also be documented. Follow up care provisions including any post hospital appointments, how post hospital patient care needs are to be met, and any plans for
post-hospital care by providers such as home health, hospice, nursing homes or assisted living shall also be included. The dictated discharge summary shall be concise and reflect the care given to the patient and the final diagnosis shall be supported by the documentation in the patient chart.

o. Written authorization by the patient/legal guardian is required for release of medical information to persons not otherwise authorized to receive this information, unless access is otherwise permitted or required by state or federal law.

p. All records are the property of the hospital and shall not otherwise be removed from hospital property. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order and in the custody of the custodian of records/Director of Health information Management. In the case of readmission of a patient, all previous records shall be available for use of the attending practitioner. This shall apply whether the patient is attended by the same physician or by another. Unauthorized removal of charts from the hospital is grounds for suspension of a physician for a period to be determined by the Medical Executive Committee.

q. Access to all medical records of all patients shall be afforded to members of the medical staff for authorized hospital-related performance improvement/peer review consistent with preserving the confidentiality of personal information concerning the individual patients. Subject to the discretion of the Hospital President, former members of the medical staff shall be permitted authorized access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

r. A medical record shall not be permanently filed until it is completed by the attending physician or is ordered filed by the President of the Medical Staff, or designee. The attending physician, at his/her discretion, may sign off on all orders and progress notes dictated by other physicians. The attending may also sign orders and dictations written by a member of the Allied Health Staff. The entire medical record must be completed and filed within 30 days of the patient’s discharge.

s. All practitioners are encouraged to access the Electronic Document Manager (EDM) on a regular basis.

t. Practitioners shall notify the Health Information Department of vacation or other planned absence prior to the beginning of such absence, and of illness or other unplanned absence as soon as practicable under the circumstances.

u. The Health Information Department will advise the appropriate Department Chief, Service Leader, Medical Director, or Lead Physician, along with the non-compliant practitioner of any failure to complete records for two consecutive weeks after which they were due and will also note any excuse claimed. Approval of excuses is at the discretion of the Department Chief, Service Leader, Medical Director, or Lead Physician.
v. If the Department Chief, Service Leader, Medical Director, or Lead Physician determines that any practitioner has significantly deviated from the requirements noted above, or has failed to complete any available discharge summary for more than fifteen (15) days or any available record for more than thirty (30) days, then he/she shall seek such corrective action as may be reasonable under the circumstances as provided elsewhere in these Bylaws.

The President of the Medical Staff, or designee, shall carry out the function of the Department Chief, Service Leader, Medical Director, or Lead Physician with respect to their own patient records.

w. A short stay record may be used for patients whose period of hospitalization does not exceed twenty-four (24) hours. For surgical patients only, the short stay record may be used if the hospitalization does not exceed forty-eight (48) hours. The Medical Executive Committee shall approve the format of such stay records.

x. Orders shall be written upon admission to or discharge from the Critical Care Unit. All previous orders are canceled when patients go to surgery or upon discharge. It is unacceptable after a surgical or non-surgical procedure, with local and/or conscious sedation, for the physician to write an order to resume all previous orders (see CoP 482.25).

y. A physician shall sign progress notes made by dependent Allied Health Staff. The attending physician must sign history and physical examinations, pre-procedure evaluations, and discharge summaries made by Allied Health Staff, and consultations made by dependent Allied Health Staff.

z. The author of each entry in the medical record must be identified and must legibly authenticate his/her entry. Authentication may include legible signature or, when appropriate, written initials.

aa. The following timelines are required by regulations and are restated here:

1. A complete admission history and physical examination shall be dictated within 24 hours. A brief admission note shall be made at the time of admission.
2. Progress notes shall be made daily, including the day of admission and the day of discharge.
3. Operative reports shall be dictated immediately following surgery. A brief operative note will be immediately written in the patient’s record following surgery.
4. A physician must authenticate telephone/verbal orders within 48 hours.
5. Discharge summaries shall be dictated within 15 days of patient’s discharge.
6. The entire medical record must be completed and filed within 30 days of the patient’s discharge.
SECTION 3.  General Conduct of Care

a. A general consent form signed by or on behalf of every patient admitted to the hospital must be obtained at the time of admission. The admitting staff should notify the attending practitioner whenever such consent has not been obtained. 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 hospital. In addition to obtaining the patient's general consent, a specific consent that informs the patient of the nature of the risk inherent in any special treatment or surgical procedure shall be obtained. It is the physician's responsibility to provide the patient with the necessary information (i.e., explanation of surgery, possible complications, risk factors, alternative treatment) to allow for the completion of the Hospital's Informed Consent. The physician may request nursing to secure the patient's signature and witness the consent; however, any questions concerning the details of the procedure, risks, complications or alternative treatments, will be referred to the physician. Specific procedures for obtaining informed consent are detailed in Hospital policies.

b. Prior to any invasive procedure, a pre-procedure evaluation, as outlined in MS0021, Pre-Procedure Patient Evaluation, Section IV, Procedure, will be performed and recorded on the chart and there will be documentation of the conversation leading to informed consent. Invasive procedures are defined as the surgical entry into tissues, cavities, or organs and in addition, will include but need not be limited to the following:

1. Any procedures performed in the operating room;
2. Any procedure in which moderate or deep sedation or anesthesia is used;
3. Any of the following, even if sedation is not used:
   - Endoscopy
   - Transesophageal Echocardiogram (TEE)
   - Therapeutic Nerve Blocks
   - Central Line Insertions (involving primary entry into a major vessel)
   - Cardioversion
   - Pacemakers
   - Defibrillation
   - Interventional Radiology Procedures
   - Abdominal and/or Intrathoracic Biopsy/Aspiration
   - Insertion of Chest Tube

c. All orders for treatment shall be in writing. A telephone order shall be considered to be in writing if conveyed to a duly authorized person. All RNs and LPNs may receive telephone orders. Respiratory therapists, physical, occupational and speech therapists, x-ray technologists, pharmacists, certified hyperbaric technologists, certified wound specialists and registered dieticians may receive telephone orders in the field of their expertise and the specialty in which they are licensed or certified. Telephone or verbal orders will be accepted from physicians, dentists, and Allied Health Staff functioning within the scope of their licensure. The appropriately authorized person receiving that
order must read-back for verification and date, time and sign all orders conveyed over the telephone, including the name of the ordering practitioner.

All verbal orders must be promptly documented in the patient’s medical record by the individual receiving the order and shall be authenticated within forty-eight (48) hours of the order being given. (See Patient Care Policy #3-073).

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

e. The Covenant Health Pharmacy and Therapeutics Committee and the Medical Executive Committee shall approve all medications administered to patients. The use of non-formulary medications is discouraged.

f. The patient's physician and/or dentist are responsible for requesting consultations when indicated. It is the duty of the medical staff through its chiefs and Medical Executive Committee to make certain that members of the Medical Staff do not fail in the matter of calling consultations as needed. Consultation is required in the following situations:

1. When the patient is not a good risk for an operative procedure.
2. Where the diagnosis remains obscure after ordinary diagnostic procedures have been completed.
3. Where there are significant differences of opinion as to the best choice of therapy.
4. In unusually complicated situations where specific skills of other practitioners may be helpful.
5. When specifically requested by the patient or family and with the approval of the attending physician.

g. Essentials of a consultation shall include examination of the patient and the record. A written opinion signed by the consulting physician and/or dentist shall be entered on the record. When operative procedures are involved, the consultation note, except in emergencies, shall be recorded prior to operation.

h. The medical record shall document justification for the use of restraint or seclusion in accordance with hospital policy. Orders for the use of restraint or seclusion must include specific time limits for each use of restraint or seclusion episode and directions for use and otherwise be consistent with state law and regulations.

i. Medications and intravenous fluid orders will automatically be canceled when the patient is sent to surgery requiring general or spinal/epidural anesthesia, or the patient leaves ICU for another floor.

Administration of the following drugs will be stopped automatically as indicated unless a definite number of doses or a definite period of time has been specified in the orders:
1. Class II - Narcotics - 48 hours
2. Intravenous Anticoagulants - 48 hours
3. Class III, IV and V drugs - 7 days
4. Antibiotics - 7 days
5. Steroids - 7 days (given intravenously)

Medications and intravenous fluids should not be discontinued without notification of the physician and/or dentist. If the order expires in the night (5 p.m. to 8 a.m.), it will be called to the attention of the physician the following morning.

The above rule does not prevent the physician from specifying the number of doses or days the medications and intravenous fluids are to be administered.

j. In light of the fact smoking is prohibited in the hospital, alternative forms of nicotine delivery should be offered the patient if medically indicated.

k. Physicians are expected to participate in emergency service coverage and serve on the service roster for unassigned patients as defined in their medical staff obligations assigned by the Department Chief, Service Leader, Medical Director or Lead Physician. On-call physicians are expected to respond, within a reasonable period of time, to requests by attending physicians to examine and treat patients presenting with emergency medical conditions. Emergency medical conditions are described as acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in serious impairment to any bodily functions or serious dysfunction of any bodily organ or part.

In an under-represented specialty, a physician may have reduced on-call responsibilities as determined by the Medical Executive Committee. The definition of an under-represented specialty is any specialty or sub-specialty with a total number of two or fewer physicians. While it is understood that a physician in an under-represented specialty may have increased on-call responsibilities, no physician shall be required to have more than ten (10) call days per month. When there are uncovered time segments in the on-call schedule, all patients presenting during the uncovered segments and requiring the services of that specialty will be transferred or diverted as needed to another appropriate facility consistent with the hospital’s patient transfer policy. It is the responsibility of each under-represented specialty to have a call schedule in place and any physician who is not scheduled may voluntarily respond to an emergency if he/she is available. Physicians in an under-represented specialty will help arrange, by verbal response, an alternative plan of care, diversion or transfer of the patient, if the need arises.

l. All patients presenting to the hospital for care will have a medical screening exam and be stabilized within the capability of the hospital prior to transfer to another facility. A physician, physician assistant, or nurse practitioner, as appropriate, shall perform this medical screening. Prior to transfer, the screening practitioner will complete and sign
the appropriate certificate of transfer. The attending physician will countersign the mid-
level provider’s documentation within twenty-four hours.

**SECTION 4. General Rules Regarding Surgical Care**

a. Except in severe emergencies, the preoperative diagnosis and required laboratory tests
must be recorded on the patient’s medical record prior to any surgical procedure. The
practitioner shall complete a pre-procedure evaluation, as outlined in MS0021, Pre-
Procedure Patient Evaluation, prior to induction of anesthesia and start of surgery.

b. Written, signed, informed, surgical consent shall be obtained prior to the operative
procedure except in those situations wherein the patient’s life is in jeopardy and suitable
signatures cannot be obtained due to the condition of the patient. In emergencies
involving a minor or unconscious patient when consent for surgery cannot be immediately
obtained from parent, guardian, or next of kin, these circumstances shall be fully
explained on the patient’s medical record. If time permits, a confirmatory consultation with
another physician in such instances is desirable before the emergency operative
procedure is undertaken. Such consultation shall be appropriately documented.

c. Compliance with Universal Protocol for preventing wrong-site, wrong-patient, wrong-
procedure surgery is mandatory.

d. The Anesthesiologist shall maintain a complete anesthesia record to include evidence of
pre-anesthetic evaluation and documentation of admission and discharge status of the
postoperative patient when in the post anesthesia area.

e. The operating physician will decide on the necessity of a first assistant. First assistants
will receive their privileges through the usual credentialing process.

f. All tissues removed at operation, with the exception of those listed in Exhibit 1, shall be
sent to the Pathology Department. The pathologist shall make such examination, as he/she may consider necessary to arrive at a tissue diagnosis. His/her authenticated report shall be made part of the patient’s medical record.

g. Surgical scheduling shall be in accordance with the rules of the hospital. Scheduling shall
be a joint responsibility of the Chief of the Department of Surgery and the Director of
Perioperative Services. A list of those physicians who have surgical privileges and the
delineation of such privileges shall be made available to the Director of Perioperative
Services and shall be maintained by him/her. Any violation of privileges outlined on this
list shall be reported immediately to the Hospital President and the Chief of the
Department of Surgery.

h. Surgeons must be in the operating room and ready to begin operations at the time
scheduled.
i. All practitioners utilizing the services of the surgical suite shall conform to the policies, rules and regulations that are formulated by the Governance Council and approved by the Medical Executive Committee and Board of Trustees.

SECTION 5. General Rules Regarding the Oral Maxillofacial/Dental Service

a. Oral maxillofacial surgeons and dentists shall be organized as a service under the Department of Surgery.

b. Oral maxillofacial surgeons and dentists must be qualified legally and professionally as provided by these Bylaws for members of the Medical Staff.

c. Delineation of privileges of dentists shall be provided for in the same manner as for other departments and services.

d. The dentist shall admit patients for dental service to the Surgical Department, Oral Maxillofacial/Dental Service.

e. There must be a staff physician in attendance that is responsible for the medical care of the patient throughout the hospital stay. A pre-procedure evaluation, as outlined in MS0021, Pre-Procedure Patient Evaluation, shall be done and recorded by a member of the Medical Staff before surgery is performed. If a history and a physical examination has been performed within 30 days before admission, a durable, legible copy of this report may be used in the patient’s medical record, provided any changes that may have occurred are updated and recorded in the medical record at the time of admission.

f. Patients admitted by a dentist other than an oral surgeon shall receive the same careful medical assessment as those admitted by other physicians. In this regard, the care of the patient shall be the dual responsibility of the attending dentist and a staff physician or oral surgeon; each limited to his/her respective professional specialty and privileges.

g. The requirements in paragraphs e. and f. are waived in the case of individual oral surgeons whose training specifically qualifies them to perform admission history and physical examinations, and whose credentials meet the requirements of the Oral Maxillofacial Service as approved by the Chief of Surgery.

SECTION 6. General Rules Regarding Emergency Services

a. The hospital shall staff the emergency area with physicians at all times. One physician shall be designated Chief of the Emergency Department. Qualifications for appointment to the Emergency Department shall be in conformity with other provisions of these Bylaws. It will be duty of such physicians to render initial care to patients seeking emergency care.

b. In addition, the chief of each department/service shall supply a roster of on-call physicians who will be available to cover the emergency care in his/her field of specialty. Such on-call physicians shall be available for consultation with the emergency physician and shall be in attendance to render emergency care if circumstances warrant. Specialty consultation must be available within thirty (30) minutes. Initial consultation by telephone is acceptable. When a physician is on-call, it is not appropriate to refer unstable emergency cases to his/her office for examination and treatment.
c. The physicians in the Emergency Department will not be responsible to be the attending physician after a patient has been admitted to the hospital.

d. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record. The record shall include:

1. adequate patient identification,
2. identification of primary care physician,
3. information concerning the time of the patient's arrival, means of arrival, and by whom transported,
4. whether the patient left against medical advice,
5. pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to arrival at the hospital,
6. description of significant clinical laboratory and x-ray findings,
7. diagnosis,
8. treatment given,
9. condition of the patient on discharge or transfer,
10. final disposition including instructions given to the patient and/or family relative for necessary follow-up care,
11. a notation that a copy of the record is available to the primary care physician or medical organization providing follow-up care, treatment and/or services.

e. Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

f. Treatment rendered in the Emergency Department shall conform to the policies, rules and regulations concerning the emergency care as formulated by the Emergency Department and approved by the Medical Executive Committee and the Board of Trustees. Such policies, rules and regulations shall be posted in the Emergency Department at all times.

g. Privileges of practitioners using the emergency facilities shall be delineated as provided elsewhere in these Bylaws.

**SECTION 7. General Rules Regarding Critical Care Unit**

All physicians utilizing the services of the Critical Care Unit shall conform to the policies, rules and regulations formulated by the Governance Council and approved by the Medical Executive Committee and the Board of Trustees.

**SECTION 8. Mass Casualties**

Rules and regulations regarding the care of mass casualties at the time of a major disaster shall be based upon the hospital's current disaster plan.
SECTION 9. Responsibilities for Residents and Medical Students

Note: For the purpose of this section, a sponsoring physician is a physician willing to assist in the training of a resident or student. On occasion, the sponsoring physician could also include those physicians who cross-cover in the same practice.

a. Resident Responsibilities:

1. Any active member of the medical staff agreeing to sponsor a resident must notify Administration at least two-weeks prior to the resident’s arrival. The resident must be currently enrolled in an accredited U.S. residency program and provide the institution with proof of medical liability insurance.

2. Residents are expected to interact with patients at St. Joseph Hospital with their permission, and under the direction of active members of the medical staff who delegate to residents some defined portion of that medical care responsibility. Medical care begins with admission of the patient, continues through the daily progress of the hospitalization, and concludes with discharge of that patient from the hospital with completion of the permanent medical record on that patient.

3. Key, specific responsibilities of the supervising physician and of the resident are listed below:

   a.) The resident may evaluate the supervising physician’s patients in the Emergency Department provided the sponsoring physician also evaluates the patient and cosigns the Emergency Department record prior to admission to the hospital or discharge from the Emergency Department.

   b.) For those patients admitted to the hospital, the sponsoring physician shall evaluate the patient in person and be in a position to confirm the findings of the resident and discuss the care plan in the following time table: as soon as possible for an unstable and deteriorating patient; within one hour for a patient in the Intensive Care Unit; or within four hours for a stable medical patient admitted to a general hospital bed.

   c.) The sponsoring physician confirms the subjective and objective findings of the resident, reviews the differential diagnosis, and discusses patient care management with the resident.

   d.) At least on a daily basis (more often as the needs of the individual patient may dictate), the resident and the sponsoring physician will review progress of the patient, make the necessary modification in the care plan, plan family conferences as needed, and agree on the type and scope of documentation for the medical record.

   e.) The sponsoring physician must cosign all orders written by the resident.
f.) When a medical patient develops a condition that the resident feels is potentially critical for that patient, the resident will contact the sponsoring physician and report these developments. The resident may identify the need for the physician to see the patient at an agreed upon time to assist in the evaluation and treatment of such a patient.

g.) As the level of skill and knowledge increases for individual residents, sponsoring physicians may delegate increasing levels of responsibilities and allow increasing levels of participation in patient care, excluding the performance of invasive procedures.

h.) At the time of discharge, the sponsoring physician may delegate some of the discharge planning to the resident, and should review any discharge documents generated by the resident and must sign any attestation statements required.

i.) The sponsoring physician should insure the completeness of the medical record by offering suggestions to the resident or by making additional comments in the progress notes.

j.) The principal documents of each hospital stay that are prepared by the residents, (the history and physical and the discharge summary, for example), must be reviewed for completeness by the sponsoring physician and pertinent suggestions should be offered to the resident about form, content or both.

k.) These documents are to be countersigned by the sponsoring physician or his or her coverage. The sponsoring physician remains responsible for the completeness and accuracy of the medical record generated by the resident.

b. Medical Student/Physician Assistant Student Responsibilities

1. Any active member of the medical staff agreeing to sponsoring a student, either a medical student or a physician assistant student, must notify Administration at least two-weeks prior to the student’s arrival. The student must be currently enrolled in an accredited U.S. medical school and have completed one year of basic clinical rotations. The student must also provide the institution with proof of medical liability insurance.

2. Students are expected to interact with patients at St. Joseph Hospital with their permission, and under the direct supervision of active members of the medical staff at all times.

3. Key specific responsibilities of the sponsoring physician and of the student are listed below:
a.) For those patients admitted to the hospital, the student may enter a history and physical examination or consultation into the written record for educational purposes only. The sponsoring physician must still dictate an authenticated history and physical examination or consultation.

b.) The student may write orders in the presence of the sponsoring physician and that physician must immediately cosign those orders before the orders can be acted upon. The student may not dictate telephone orders.

c.) The student may assist the sponsoring physician in the emergency room or in the operating room to include wound closure in suturing of skin. The sponsoring physician must be physically present in the emergency room or in the operating room at all times. The student may first assist only on cases previously approved by the Chief of Surgery. It is the sponsoring physician’s responsibility to obtain the necessary approval. Approval from the President or his/her designee, with input from the Department Chief, must be obtained for student involvement in any invasive procedure. It is the sponsoring physician’s responsibility to obtain the necessary approval from the President or his/her designee.

d.) The student may round, with the patients’ consent, with the sponsoring physician on hospitalized patients.

SECTION 10. Responsibility for Non-Covered Patients in Event Physician Loses Privileges

In the event a practitioner loses privileges, the Department Chief or the President of the Medical Staff shall promptly assign the member’s patients to another service member. Whenever feasible, the wishes of the patient in the choice of a substitute member will be considered, unless otherwise indicated by the terms of the summary restriction or suspension.
**Document Title:** Specimens Not Required for Submission to Pathology Laboratory  
**Document Number:** SP.371  
**Written By:** Robert Clukey  
**Manual(s):** Surgical Pathology Manual  
**Linked Documents:**  
**Effective Date:** December 2003  
**Authorized:** David Renedo M.D.  
**Authorized Date:** December 2003  
**Last Approval or Periodic Review Completed:** 5/9/18  
**Next Periodic Review Needed On or Before:** 5/20/20

**PRINCIPLE:**
There are specimens that may be removed during surgery or a procedure that are not required to be submitted to surgical pathology. If there are clinical or radiological features that are unusual or the surgeon has a specific question they would like answered, with regard to possibility of infection, tumor, or other pathologic process, the specimen should be submitted to pathology. Any specimen listed may be submitted to pathology at the surgeon's discretion.

**PROCEDURE:**
The categories of specimens that may be exempt from laboratory examination include:

a. Teeth, removal must be recorded in the medical record.
b. Orthopedic hardware.
c. Toenails and fingernails that are grossly unremarkable.
d. Cataract lenses, iris, and muscle fragments.
e. Ear ossicles (staples, incus, malleus).
f. Intrauterine devices.
g. Grossly unremarkable foreskin from circumcision of a newborn.
h. Bullets, missiles and weapons; removal must be recorded in the medical record.
i. Foreign objects/foreign body.
j. Donor organs for transplantation.
k. Placentas without medical indications.
l. Products of conception/fetus when family or clinician does not request an exam and there is no suspicion of ectopic pregnancy or anomalies
m. Pacemakers and other medical devices.
n. Normal skin from plastic surgery procedures.
o. Fat removed by liposuction.
p. Aspirated and/or impacted food or foreign material.
q. Oral hardware
r. Medical devices not contributing to patient illness, injury or death (e.g. gastrostomy tubes, stents, sutures).
s. Intravascular catheters
t. Normal rib removed for surgical access (provided no history of malignancy).
u. Eyelid tissue removed for cosmetic surgery only.
v. Extra digits.
w. Nasal septal cartilage and/or bone.
x. Meniscus.
y. Tissue from acromio-clavicular joint surgery.
z. Tissue from rotator cuff repair. aa.
   Vaginal mucosa for repair.
b. Bunion/claw toes/hammertoes.
c. Surgical specimens obtained from an arthroscopic knee procedure where documentation exists of the pathologic changes confirming the indications for the procedure and the presence of disease, (ex. permanent photographic or video record).
dd. Mucosa, bone, and cartilage removed during plastic surgical procedures for non neoplastic disease (ex. septoplasty and uvulectomy).
ew. Tissue removed from joint replacement surgery, for osteoarthritis, rheumatoid arthritis, and reconstructive purposes.
f. Traumatically amputated digits.¹
g. Tissue such as ligamentum flavum, intervertebral disc fragments, and bone removed during routine spinal surgery²
hh. Blood Clot
ii. Amputated limbs due to trauma, non-union, and/or dysfunction jj.
   Varicose veins³

If a physician desires further documentation or evaluation on any of the above specimens, the laboratory will accept them and provide gross documentation, and will do microscopic examination if requested and if feasible for the type of specimen submitted.

REFERENCES: Specimens which need not be sent to pathology Anthony Whittemore M.D. Brigham and Women's Hospital, August 2003

REVISIONS:

¹ Traumatic amputation digits was added to the list (Michael Tan 12/9/2011)
² Added spinal surgery specimens (Michael Tan 4/18/2012)
³ Added blood clot, amputated limbs ganglion cyst, and varicose veins (Michael Tan 2/3/2016)
PRINCIPLE:
This a list of specimens that out lab considers "Gross Only". The gross only examination will consist of macroscopic examination, description and gross diagnosis of the material received (no sections are submitted for histology).

PROCEDURE:
1. The following is a list of specimens that are examined only grossly unless clinical information or gross examination dictates otherwise.
   1.1 Accessory bones and digits.
   1.2 Acromio-clavicular joint.
   1.3 Arthroscopic shavings.
   1.4 Breast implant.
   1.5 Bullets.
   1.6 Bunions/claw toes/hammer toes.
   1.7 Calculi, usually submitted for chemical analysis unless stated otherwise.
   1.8 Common bile duct stone.
   1.9 Foreign objects/foreign body.
   1.10 Gallstones
   1.11 Bones for degenerative arthritis/OA
   1.12 Lenses.
   1.13 Meniscus.
   1.14 Nasal septum.
   1.15 Orthopedic hardware.
   1.16 Ossicles of the ear.
   1.17 Panniculectomy tissue.
   1.18 Parasites.
   1.19 Prosthetic material (metallic or synthetic).
   1.20 Rib- incidental removal.
   1.21 Scar tissue from plastic surgery.
   1.22 Skin- cosmetic tissue.
   1.23 Teeth.
1.24 Tissue from rotator cuff repair.
1.25 Toenail and fingernails.
1.26 Tonsils and adenoids 17 and under.
1.27 Traumatic amputation specimens (extremity, fingers, toes) and debridement tissue from trauma.
1.28 Uvula from sleep apnea.
1.29 Vaginal mucosa for repair.
1.30 Varicose veins.
1.31 Any structure, tissue or material not specifically mentioned above, that in the opinion of a pathologist, does not require microscopic examination.

2. A gross exam only will be performed at the discretion of the clinician. Gross-only exam must be explicitly documented on the requisition by the clinician for pre-approved specimen types.

To Request a Gross Only Exam:

a) The specimen type must be on the approved list (above), so that may undergo a gross exam only.

b) The gross only exam choice must be selected on the requisition.

3. A routine microscopic exam may be requested on any tissue specimen type.

The hospital and its medical staff are committed to providing patients with quality care. The delivery of quality care can be compromised if a member of the medical staff is suffering from impairment. Impairment may result from a physical or mental condition.

Issues of impairment relating to members of the medical staff will be referred to the Maine Medical Association’s (MMA) Medical Professionals Health Program (MPHP) (hereafter Subcommittee). To the extent possible, and consistent with quality of care concerns, the Subcommittee will handle impairment matters in a confidential fashion. The Chief Executive Officer, the Vice President of Medical Affairs, the President of the Medical Staff and the Chairperson of the Credentials Committee shall be kept apprised of matters under review by the Subcommittee.

PURPOSE

The hospital has an obligation to protect patients from harm. In this regard, the medical staff and hospital and leaders have designed a process that provides education about practitioner health addresses prevention of physical, psychiatric, or emotional illness and facilitates confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition.

The purpose of this process is assistance and rehabilitation, rather than discipline, to aid a practitioner in retaining or regaining optimal professional functioning, consistent with protection of patients. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a practitioner is unable to safely perform the privileges he or she had been granted, the matter is forwarded to the medical staff leadership for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

PROCEDURE:

The Subcommittee will receive referrals from any source, including self-referral. Upon receipt of the information, two members, who do not have any conflict of interest; will be delegated to perform an investigation. At this time consultation may be sought from the Maine Medical Association’s (MMA) Medical Professionals Health Program (MPHP). This investigation will include contact with the complainant with an inquiry about the specific details of the precipitating event or events and names of any other witnesses of the event(s) who will also be contacted.
If it is determined the complaint has merit, the identified practitioner will be notified of the general nature of the complaint and the subsequent investigation. The practitioner will be provided the opportunity to present a written report of his/her view of the event(s), which will be included in the final report to the Chairperson.

As part of its review, the Subcommittee shall also have the authority to request the practitioner be evaluated by an outside organization and have the results of the evaluation provided to it. Consent for the release of information to the Subcommittee is attached as Appendix A.

A detailed written report will be prepared and submitted to the Chairperson. If information is discovered that indicates impairment, a referral can be made to the Maine Medical Association’s (MMA) Medical Professionals Health Program (MPHP) and further remedial action decided. If a referral is made, the President of the Medical Staff shall be notified.

Depending upon the severity of the problem and the nature of the impairment, the Subcommittee has the following options available to it:

a. recommend the practitioner voluntarily take a leave of absence, during which time he or she would participate in a rehabilitation or treatment program to address and resolve the impairment;

b. recommend appropriate conditions or limitations be placed on the practitioner’s practice;

c. recommend the practitioner voluntarily agree to refrain from exercising some or all privileges in the hospital until rehabilitation or treatment has been completed or an accommodation has been made to ensure the practitioner is able to practice safely and competently;

d. recommend some or all of the practitioner’s privileges be suspended if the practitioner does not voluntarily agree to refrain from practicing in the hospital.

If intervention, treatment and monitoring are indicated, the Subcommittee may consult with and assist the Maine Medical Association’s (MMA) Medical Professionals Health Program (MPHP). In carrying out its mission, Subcommittee members will become familiar with and abide by State and Federal law (as it pertains to practitioner health) and State Licensing Board Rules and Regulations. Medical Executive Committee members should also be familiar with the State Physician Health program, its functions and method of contacting them.

The Subcommittee will be considered a professional competence committee pursuant to the Health Security Act.

Every effort will be made to maintain the confidentiality of the practitioner seeking referral or referred for assistance, except as limited by law, ethical obligation or when the safety of a patient is threatened.

The purpose of this process is assistance and rehabilitation, rather than discipline, in order to aid a practitioner in retaining or regaining optimal professional functions, consistent with protection of patients. Nothing in this policy is intended to preclude or limit the use of the
regular corrective action process, under Article VII of the Medical Staff Bylaws, when this is deemed necessary.

Reinstatement:

Upon sufficient proof a practitioner who has been suffering from impairment has successfully completed rehabilitation or treatment program, the Subcommittee may recommend the practitioner’s clinical privileges be reinstated. In making a recommendation that an impaired practitioner be reinstated, the Subcommittee must consider patient care interests as paramount.

Prior to recommending reinstatement, the Subcommittee must obtain a letter from the physician overseeing the rehabilitation or treatment program. (A copy of a release from the practitioner authorizing this letter is attached as Appendix B.) The letter must address the following:

a. the nature of the practitioner’s condition:

b. whether the practitioner is participating in a rehabilitation or treatment program and a description of the program;

c. whether the practitioner is in compliance with all of the terms of the program;

d. to what extent the practitioner’s behavior and conduct need to be monitored;

e. whether the practitioner is rehabilitated;

f. whether an after-care program has been recommended to the practitioner and, if so, a description of the after-care program; and

g. whether the practitioner is capable of resuming medical practice and providing continuous, competent care to patients.

Before recommending reinstatement, the Subcommittee may request a second opinion on the above issues from a physician of its choice.

Assuming all of the information received indicates the practitioner is capable of resuming care of patients; the following additional precautions should be taken before the practitioner’s clinical privileges are reinstated:

a. the practitioner must identify at least one practitioner who is willing to assume responsibility for the care of his or her patients in the event of the practitioner’s inability or unavailability; and

b. the practitioner shall be required to provide periodic reports to the Subcommittee from his or her attending physician, for a period of time specified by the Subcommittee, stating the practitioner is continuing rehabilitation or treatment, as appropriate, and his or her ability to treat and care for patients in the hospital is not impaired. Additional conditions may also be recommended for the practitioner’s reinstatement.

The final decision to reinstate a practitioner’s clinical privileges must be approved by the Chief Executive Officer in consultation with the President of the Medical Staff and/or the Chairperson of the Credentials Committee.
The practitioner’s exercise of clinical privileges in the hospital shall be monitored by the Department Chief/Service Leader, or by a physician appointed by the Department Chief/Service Leader. If the practitioner is suffering from an impairment relating to substance abuse, the practitioner must, as a condition of reinstatement, agree to submit to random alcohol or drug screening tests at the request of the Chief Executive Office, the President of the Medical Staff, and the Chairperson of the Credentials Committee or any member of the Subcommittee.

Commencement of an Investigation:

The hospital and the medical staff believe the Subcommittee to the extent possible can best deal with issues of impairment. If, however, the Subcommittee makes a recommendation, including a recommendation for an evaluation or a restriction or limitation on privileges, and the practitioner refuses to abide by the recommendation, the matter shall be referred to the Credentials Committee for an investigation to be conducted pursuant to Article VII, Corrective Action Hearing and Appellate Review of the medical staff bylaws.

Documentation and Confidentiality

The original report and a description of any recommendations made by the Subcommittee shall be included in the practitioner’s Performance Improvement file. If, however, the review reveals there was no merit to the report, the report will be destroyed. If the review reveals there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in the practitioner’s Performance Improvement file and the practitioner’s activities and practice shall be monitored until it can be established whether there is an impairment that might affect the practitioner’s practice. The practitioner shall have an opportunity to provide a written response to the concern about the potential impairment and this shall also be included in his or her Performance Improvement file. Any records of the review will be kept by the Medical Staff Office in a secure storage place for five (5) years, separate from the practitioner’s credentials file. After five years, if no further problems are reported, the record shall be destroyed.

The Chief Executive Officer or the President of the Medical Staff shall inform the individual who filed the report that follow-up action was taken.

Throughout this process, all parties should avoid speculation, conclusions, gossip, and any discussions of this matter with anyone other than those described in this policy.

Every effort will be made to maintain the confidentiality of the practitioner seeking referral or referred for assistance, except as limited by law, ethical obligation or when the safety of a patient is threatened.

If at any time it becomes apparent the matter cannot be handled internally, or jeopardizes the safety of the practitioner or others, the Chief Executive Officer, the President of the Medical
Staff and/or the chairperson of the Credentials Committee may contact law enforcement authorities or other governmental agencies. All requests for information concerning the impaired practitioner shall be forwarded to the Chief Executive Officer for response.

A practitioner may self-refer to the Subcommittee and will be treated with utmost dignity and respect.

REFERENCES:

The Comprehensive Accreditation Manual for Hospital: The Official Handbook, published by SJH’s CMS deemed status surveyor, Medical Staff Standards MS.11.01.01, most recent edition.

Bylaws, Rules and Regulations of the Medical Staff, published by St. Joseph Hospital, Article X, Committees, Section 9, most recent edition.

ATTACHMENTS:

Appendix A: Consent for Release of Information Pertaining to Evaluation
Appendix B: Consent for Release of Information

RESCISSION: None
Subcommittee for Practitioner Health Guidelines

Consent for Release of Information Pertaining to Evaluation

I hereby request that ____________________________
Joseph Hospital with all information relevant to my evaluation.

I also request the Hospital provide ____________________________ (the organization) with a copy of any information which it believes supports the need for the evaluation and any other information (the organization) and the Hospital (and any practitioner on the Hospital’s medical staff who is involved in reviewing my practice) for providing the information set forth above.

Date: ____________________ Signature of Practitioner: ___________________________
Consent for Release of Information

I hereby request that Dr. ____________________________ (Physician overseeing treatment) provide St. Joseph Hospital with information pertaining to my rehabilitation or treatment program. Specifically, this information should include:

a. the nature of my condition;
b. whether I am participating in a rehabilitation or treatment program;
c. whether I am in compliance with all of the terms of the program;
d. to what extent my behavior and/or conduct needs to be monitored;
e. whether I am rehabilitated;
f. whether an after-care program has been recommended for me and, if so, a description of the after-care program; and
g. whether I am capable of resuming medical practice and providing continuous, competent care to patients.

I also request Dr. ____________________________ provide the Hospital with periodic reports relating to my ongoing rehabilitation or treatment and my ability to treat and care for patients in the Hospital.

I release from liability and grant absolute immunity to Dr. ____________________________ for providing the information set forth above.

Date ___________________ Signature of Practitioner ________________________
Medical Staff Clinical Peer Review PI.010

PURPOSE:

To ensure that the hospital, through the activities of its medical staff, assesses the performance of individuals who are granted clinical privileges and uses the results of such assessments to improve patient safety, quality, effectiveness and efficiency of health care services provided by the hospital. This policy guides the medical staff as it oversees quality processes that measure, assess, and improve the quality of care provided at St. Joseph Hospital.

- All peer review information is privileged and confidential and is considered a quality and patient safety work product in accordance with Medical Staff and Hospital Corporate Bylaws, Maine State and Federal laws and regulations pertaining to confidentiality and non-discoverability.
- Practitioners will receive provider-specific feedback at least annually via the Ongoing Professional Practice Evaluation (OPPE) and/or through identified time frames via the Focused Professional Practice Evaluation (FPPE).
- The Medical Staff Clinical Peer Review process will be transparent with the practitioner along with those involved in the process understanding each phase of as it proceeds.
- Peer review files and data will be maintained in a confidential manner and access will be granted based on a need to know to fulfill assigned responsibilities.

GOALS:

A. Improve the quality of care provided by individual physicians.
B. Monitor and evaluate in an ongoing manner the professional practice and performance of practitioners who have clinical privileges.
C. Create a culture with an educational approach to peer review to recognize physician excellence and identify opportunities for performance improvement.
D. Perform focused professional practice evaluation when opportunities for physician improvement are identified and to ensure competence before granting new or expanded privileges.
E. Monitor significant trends by analyzing aggregate data for compliance to accepted clinical standards of care/practice.

F. Ensure that the process for peer review is clearly defined, fair, defensible, timely, useful and transparent.

G. Promote efficient use of physician resources.

DEFINITIONS:

A. Practitioner

Unless specifically stated otherwise, these terms refer to any individual appointed to the medical staff of St. Joseph Hospital by authority of the Board of Trustees in accordance with these Bylaws, Rules and Regulations, and associated policies, and the Bylaws of the Hospital.

B. Peer Review

Peer review is the evaluation of an individual practitioner's professional performance and includes the identification of opportunities to improve care. Peer review is:

- the evaluation of aggregate data
- the evaluation of the individual practitioner's performance.

Peer review is conducted using multiple sources of information, including the review of individual cases, the review of aggregate data for compliance with clinical standards. The individual's evaluation is based on generally recognized standards of care. This process provides practitioners with feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical and interpersonal skills in providing patient care.

A. Peer

There are two generally accepted classifications of peer review.

- The first peer review grouping encompasses general medical and or surgical knowledge that has been attained by virtue of licensure as a MD or DO. For quality issues related to general medical care, any physician may review the care of another physician. For specialty specific clinical issues, such as evaluating the techniques of a specialized surgical procedure, a peer is an individual who is similarly trained and competent in that specialty
- A "Peer" is an individual who is practicing in the same profession and who has expertise in the appropriate subject matter. The level of the subject matter expertise required to provide meaningful evaluation of a practitioner's performance will determine what "practicing in the same profession" means on a case basis. It should be appreciated that the assessment of technical skill requires the review of a peer with similar training.

For example: evaluating the performance of an open-heart procedure would be performed by a Cardiac Surgeon with specialized technical skill to perform the procedure.

The initial peer review body will be the Chief of Service, supported by the respective medical staff departments, unless otherwise designated by the specific circumstances by the Medical Executive Committee. If the Chief designates a peer to perform the initial review, he or she will determine the degree of subject matter expertise required for a provider to be considered a peer.

A. Conflict of Interest

A member of the medical staff asked to perform peer review may have a conflict of interest if he or she might not be able to render an unbiased opinion due to either involvement in the patient's care or a relationship with the physician involved as a direct competitor or partner. It is the individual reviewer's
obligation to disclose the potential conflict to the peer review committee. The peer review body's responsibility is to determine whether the conflict would prevent the individual from participating and the extent of that participation. Individuals determined to have a conflict may not be present during discussions of or decisions of the peer review of the case. The individual who has the conflict of interest may believe it is appropriate to be excused from the meeting. The Medical Executive Committee is the ultimate decision maker concerning the presence of a substantive conflict. The Covenant Health Systems, Inc, policy entitled "Conflicts of Interest" will be followed and annually the disclosure statement – conflict of interest will be signed by those performing peer review.

B. Sentinel Events
Please refer to the sentinel event plan. Sentinel events involving providers will be submitted to appropriate Medical Staff committees as well as the Professional Practice Evaluation Committee for peer review to ensure an objective assessment is secured. All other Sentinel events will be submitted for review and discussion. Note: Near misses – See Sentinel Event Plan/Policy.

C. Focused Professional Practice Evaluation (FPPE)
FPPE is a time limited, privilege specific process of evaluating a practitioner's present ability to competently exercise clinical privileges the practitioner has been granted or is seeking. The duration of the FPPE for newly credentialed providers should be at least quarterly until the department chief or designee indicates satisfactory performance has been achieved. A FPPE may be initiated when:

- New appointed.
- New privileges are requested and approved
- Patterns that arise the merit further review and analysis.

A. Ongoing Professional Practice Evaluation (OPPE)
OPPE is an ongoing process of identifying a practitioner's professional practice trends that affect the quality of care and the safety of patients in the hospital and for improving the quality of the care the practitioner provides. OPPE includes the routine monitoring and evaluation of a practitioner's current competency to exercise granted clinical privileges. This feedback should occur at least annually.

B. Practitioner Competency Framework
The following six components comprise the competency framework supporting OPPE and FPPE processes:

1. **Patient Care**: Ability to provide patient care that is compassionate, appropriate, safe and effective for the promotion of health, prevention of illness, treatment of disease.

2. **Medical Knowledge**: Ability 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.

3. **Practice Based Learning and Improvement**: Ability to be able to use scientific evidence and methods to investigate, evaluate and improve patient care.

4. **Interpersonal and Communication Skills**: Ability to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families and other members of the healthcare team.

5. **Professionalism**: Ability to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession and society.
6. **Systems Based Practice:** Ability to demonstrate both an understanding of the contexts and systems in which healthcare is provided and the ability to apply this knowledge to improve and optimize healthcare.

**A. Professional Practice Evaluation Committee (PPEC)**

The PPEC reports to the Credentials Committee and shall have the responsibility to develop and implement the Peer Review Plan outlined in this Policy. The PPEC shall also review quality data and other sources in a routine and regular basis. The PPEC is chaired by the Medical Director of Quality Management. The membership is appointed by the Medical Staff Executive Committee. Members will include the Chief of Surgery, Medical Director of Hospitalist Service (or designee), Department Chief of Medicine/Family Practice, Medical Director of the Integrated Medical Group (or designee), one non-employed member of the Medical Staff, one member of the Allied Health Staff, Vice President of Medical Affairs and other physicians as appointed. The Director of Quality or designee will serve as a non-voting member. The Medical Executive Committee may appoint an appropriate designee should the need arise such as a review that requires certain expertise to ensure a thorough and objective evaluation. The PPEC will meet at least quarterly and on call of the Chair and will submit a summary/minutes of its findings as appropriate to the Credentials Committee and/or MEC.

**PEER REVIEW PROCESS:**

**A. The Peer Review Process (See Attachment A)**

The Peer Review Process is managed and supported by the Quality Department. All issues are tracked and triaged by the Quality Department throughout the Peer Review Process until resolution.

**B. General Medical Staff Peer Review** - Medical staff departments will engage in peer review under the direction of the Chief of these medical staff departments.

**C. Peer Review Worksheet** - Attachment B - will be completed for each case and tracked by the Quality Department.

**D. Service Meetings**

Medical Staff service meetings will be conducted as per Medical Staff Bylaws and will include a separate peer review section. Separate Peer Review minutes will be maintained for all peer review meetings, recording date, time, location, member's present, case summary, assessment, committee conclusions, follow up or action items, and assigning a level for each case (Level 0, 1, 2, or 3).

**E. Thresholds for Focus Review- Focused Professional Practice Evaluation (FPPE)**

When it has been determined that circumstances may have occurred indicating the standard of care within the medical community has not been met by a specific practitioner, a focused peer review or FPPE may be conducted.

Events which would trigger a Focused Professional Practice Evaluation may include but are not limited to:

- Any single egregious case which would require data review/analysis to determine incidence of similar occurrences -and/or rates of occurrence within the last 12 months.

- Any occurrence of 3 cases or more case leveling summaries of 2 and/or 3 within a 12-month period of time.

- Patient grievances representing concern regarding standard of care as determined by Department Chief or PPEC.

- Written complaints of non-professional/inappropriate behavior, as defined by the Medical Staff Bylaws Abandonment of patient care responsibilities.
Delay in response to change in patient status, which negatively impacted or could have negatively impacted patient outcome.

F. Circumstances for Peer Review
The following categories, not an all-inclusive list, are included in the peer review process:

- Mortality Review
- Complications
- Unplanned removal, injury or repair of organ or structure
- Unplanned return to the operating room
- Medical record and/or documentation issues
- Infection Prevention issues
- Blood & blood component issues/problems
- Department specific occurrence screens/metrics
- Moderate sedation issues
- Sentinel Events
- Near Miss
- Risk Management - selected cases
- Potential selected litigation cases
- Any cases representing quality of care concerns

G. Case Processing for Peer Review

- All cases submitted for peer review will flow through the Quality Management department (see attachment A).
- Issues include but are not limited to: quality issues, metric fallouts, trended and tracked data/variances, risk, HIM concerns, complaints/grievances, serious events and others. All these issues are triaged and tracked by the Quality Management Department through the peer review process until resolution is achieved. Once the Quality Management Department has initiated the triage and tracking process, Quality may pursue options as outlined in attachment A.
- After Quality has reviewed a case: Quality will recommend: no action, a level zero for the case and send the case to the Chief of Service for confirmation, or Quality will send the case to the Chief of Service for review. The case should be finalized from a medical record perspective or may undergo concurrent inpatient/outpatient case review given the issues at hand.
- Cases will be submitted to Peer Review as soon as practicable (the case should be finalized from a medical record perspective or may undergo concurrent inpatient case review given the issues at hand).
- The "Peer Review Worksheet - Attachment B will be completed by those assigned peer review to support a consistent case assessment process with assignment of a level which is voted upon at any peer review meeting, as appropriate.
- The Medical Staff Departments and the Professional Practice Evaluation Committee's (PPEC), "Annual Case Leveling Summaries" (completed for the calendar year) which facilitates trending and patterning, will be
maintained by Quality Management and submitted semi-annually to the Chiefs of Departments, the VPMA, and to the PPEC.

- To support transparency of, and participation in and encourage the education focus of peer review, the providers whose case is being submitted for peer review will receive a notification letter or email prior to the date of the peer review meeting noting:
  - Why the case is being discussed.
  - Invite the provider to attend
  - Invite the provider to submit a written summary outlining the provider's insight on the case. This will be submitted to the appropriate Medical Staff Department or PPEC. (See Attachment A)
  - When the appropriate Medical Staff Department or PPEC has concluded its review and leveling of the case, the provider will receive a letter of notification outlining:
    - Salient discussion points from the peer review
    - Any necessary recommended follow up action needed by the provider
    - The case level assigned
    - A notation that the provider has ten days after the date of the letter to submit any further comments
    - Unless the provider submits a response to this letter, agreement with its contents will be presumed to exist.

- The annual trended peer review data will be considered part of the OPPE and FPPE as may be relevant. For any case that is submitted for peer review (Department or PPEC), the provider will be notified.
- The Peer Review process as outlined in Attachment A will be followed. Occasionally it is appreciated that a PPEC member may be assigned to review a case; the process outlined in Attachment A will be followed. For cases scored a level 2 or 3, the completed worksheet as well as an excerpt from the Peer Review minutes (Department and/or PPEC) will be copied and included in the provider's Peer Review file. Information from the completed peer review worksheets will be aggregated annually for trend assessment utilizing the Professional Practice Evaluation Annual Case Leveling Summary form (Attachment E). Annually, the PPEC will share the trended assessment with the Credentials Committee who in turn will report to the Medical Executive Committee.
- Once the peer review has been completed on a case, the PPEC and/or Department Committee findings, including the leveling, will be communicated to the physician whose case was reviewed and this information will be maintained in the provider's Peer Review file.

H. Concurrent Phase of Peer Review Process (Case is referred for Peer Review while a patient is receiving services either as an inpatient or outpatient)

All aspects of the Peer Review Policy are applicable to the concurrent phase of this process unless noted herein. The concurrent phase of the Peer Review process is intended to enhance patient care, minimize or reduce the risk to a patient and attempt to avoid a patient care situation from rising to the level of a Sentinel Event or Near Miss. All cases referred for the concurrent phase of peer review will be requested to be reviewed within 24 hours of the referral which facilitates implementation of any necessary supportive interventions.

I. Oversight and Reporting

Direct oversight of the peer review process is delegated by the Board of Trustees to the Medical Executive Committee and to the Professional Practice Evaluation Committee which receives Medical Staff Department Peer Review minutes. Annually, the Professional Practice Evaluation Committee will submit a
summary of peer review leveling to the Credentialing Committee who in turn will submit this summary to the Medical Executive Committee.

J. External Peer Review Process
After receiving PPEC's recommendations, the Credentialing Committee, will send its finding to MEC who will then determine the need for external peer review. The external peer review will take place under the following circumstances: if deemed appropriate by Medical Executive Committee and/or the Board of Trustees. No provider may request the external peer review process unless deemed appropriate by the Credentials Committee, the Professional Practice Evaluation Committee, MEC or the Board of Trustees.

Circumstances that may require external peer review might include the following:

◦ Potential litigation cases

◦ Ambiguity when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from review that will directly affect a provider's membership or privileges.

◦ Lack of internal expertise when no one on the medical staff has adequate technical expertise in the specialty under review or when the only providers on the medical staff with that expertise is determined to have a conflict of interest regarding the provider under review.

◦ External Peer Review will take place if the potential for conflict of interest cannot be resolved appropriately upon recommendation by the Professional Practice Evaluation Committee to the Credentials Committee and/or Medical Executive Committee and/or Board of Trustees.

◦ New technology - when a medical staff member requests permission to use new technology or perform a procedure new to the hospital and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.

◦ Miscellaneous issues - when the Medical Staff needs an expert witness for a fair hearing, for evaluation of a credential file or for assistance in developing a benchmark for quality monitoring. ◦ Sentinel events of unclear etiology

COMPONENTS OF PEER REVIEW INFORMATION:

A. Practitioner specific peer review and other quality information will be maintained in a secure place separate from the Credentials files. Provider specific peer review information may include, but is not limited to:

◦ Performance data for dimensions of performance measured for that individual physician as established by each medical staff department.

◦ The practitioner's role in sentinel events, near misses, significant incidences, complaints, grievances, management of comorbidities/complications/mortalities, trended not present on admission (NPOA) data, readmissions, infection, utilization management, core measures etc.

◦ Correspondence to the physician regarding commendations, comments regarding practice performance and/or corrective action.

CONFIDENTIALITY AND ACCESS TO PEER REVIEW INFORMATION:
A. Annual Signing of Confidentiality Statements
Medical staff members serving on Peer Review committees will annually sign confidentiality statements.
(Attachment D)

B. Access to Peer Review Information
Peer review information is available only to authorized individuals who have demonstrated legitimate need to know this information based upon their responsibilities as medical staff leadership or hospital staff in leadership roles. Access to this information will be granted only to the extent necessary to carry out their assigned responsibilities and will be done under the supervision of the Quality Management staff. A Peer Review Access Log (Attachment C) memorializing access will be maintained, noting date, person requesting access and what was accessed; this peer review access log will be maintained in the Quality Management office.
Only the following individuals will have access to provider specific peer review information:

- Medical Staff Officers with demonstrated need as noted above
- Medical Staff department chiefs (for members of their respective departments only)
- Members of the Medical Executive Committee, Credentials Committee and PPEC as it relates to their area of responsibility with the respective department chiefs' knowledge and approval.
- Practitioner will have access to his/her own peer review information upon request and under supervision.
- The Quality Director will serve as the peer review contact whose responsibilities include: receive, request, gather, assimilate, format, prepare, maintain, submit and as appropriate report peer review data on behalf of the Professional Performance Evaluation (PPEC).
- The Vice President of Medical Affairs
- Medical Staff office personnel to the extent that access to this information is necessary for the credentialing/re-credentialing processes.
- Individuals surveying for Maine Division of Licensing and Regulatory Services, and/or CMS deemed accrediting bodies with appropriate jurisdiction.
- The hospital President for purposes of summary, when information is needed to take immediate formal corrective action as defined in the Medical Staff Bylaws.

C. Copies of Peer Review Information

REFERENCES:
1. CMS Conditions of Participation – SOM A – Hospitals - most current
2. Deemed survey agency for accreditation
3. Sentinel Event Plan
4. Medical Staff Bylaws/Rules and Regulations

Attachments:

Case Review form updated CURRENT attachment B.docx
Confidentiality Form Attachment D.pdf
Peer Review Access log Attachment C.docx
Peer Review Process v06 Updated attachment A 2.27.19.pdf

Approval Signatures

Approver                                      Date
Sandra Levesque: MANAGER MEDICAL STAFF OFFICE 03/2019

C Beth Young: Manager of Regulatory Services & QI Coordinator 03/2019

### Applicability

Bangor St. Joseph Hospital
The Peer Review Process is managed by the Quality Department.

All ISSUES are tracked and triaged by the Quality Department throughout the Peer Review Process until resolution.

The Provider is notified of all Level 1 and above reviews in real time and at resolution. Level 0 are reviewed at OPPE.
Provider #: 
Patient MR #: 
Account #: 
Reviewer: Quality/Risk Department

Reason for Review:

☐ Sentinel Event Screening or Case RCA’d
☐ Quality Occurrence Screening
☐ Incident Report
☐ Mortality
☐ Other: Specify:

☐ Patient/Family Complaint or Grievance
☐ Provider/Staff Request
☐ Infection Prevention
☐ Morbidity

Brief Summary of issues/questions leading to review:

Key Questions for Reviewer:

1.
2.
3.
4.
5.

St. Joseph Healthcare Clinical Review Form - To be completed by reviewing physician

Step 1- Assessment (select one):

☐ 0 Most experienced, competent practitioners would have managed the case similarly in all of the aspects listed below.
☐ 1 Most experienced, competent practitioners might have managed the case differently and care was not detrimental to patient safety or the delivery of patient care.

If you select 2-3, Please complete steps 2-5 below.

☐ 2 Most experienced, competent practitioners might have managed the case differently and care was minimally detrimental to patient safety or the delivery of patient care.
☐ 3 Most experienced, competent practitioners would have managed the case differently in one or more of the aspects listed with the care being detrimental to patient safety or the delivery of patient care and was below the acceptable professional standards.

Step 2- Completed on ALL cases:

Overall Clinical Care: Check ONE:

This is a SECURE Document: THIS IS A PEER REVIEW FILE AS REFERRED TO IN MAINE REVISED STATUTES ANNOTATED CH.32 3296 (1988)

All proceedings concerning medical staff reviews, hospital reviews and other reviews of medical care conducted by committees of physicians and other health care personnel on behalf of hospitals located within the State or on behalf of individual physicians, when the reviews are required by state or federal law, rule or regulations or as a condition of accreditation by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association Committee on Hospital Accreditation or are conducted under the auspices of the state or county professional society to which the physician belongs, are confidential and shall be exempt from discovery.
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<th>1</th>
<th>Excellent/Acceptable (Meets standard of care)</th>
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<tr>
<td>2</td>
<td>Opportunity for Improvement</td>
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<tr>
<td>3</td>
<td>Needs Improvement</td>
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<tr>
<td>0</td>
<td>Reviewer Uncertain, needs more information</td>
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**Note:**

If Overall Care = 1, then the issue must = A

If Overall Care = 2, 3, or 0 then the issue must = B through O

**Key definitions for Clinical Care Issues: (right column)**

**Pt Care:** Provide care that is compassionate, appropriate, and effective to promote health, prevent illness, treat disease and provide end of life care.

**Medical Knowledge:** Demonstrates knowledge of established and evolving biomedical, clinical and social sciences and apply this to patient care and education of others.

**Communication/Inter-Personal Skills:** Demonstrates interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families and other members of the healthcare team.

**Professionalism:** Demonstrates behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity and an responsible attitude toward their patient, their profession and society

**System Based Practice:** Demonstrates understanding of the contexts and systems in which health care is provided and the ability to apply this knowledge and improve and optimize health care.

## Clinician Care Issues: Check all that apply

- **A** No Issues with clinician care
- **B** Diagnosis (Pt Care)  
- **C** Clinical Judgment/Decision-making (e.g. medical decision making questionable) (Pt Care)  
- **D** Technique/Skills (Pt Care)  
- **E** Planning (Pt Care)  
- **F** Supervision: House Clinician or Non-Clinician Clinician (Pt Care)  
- **G** Knowledge (e.g. medical knowledge deficiency) (Medical Knowledge)  
- **H** Timely/Clear Communication (e.g. communication impeded) (Communication/Interpersonal Skills)  
- **I** Responsiveness (Professionalism)  
- **J** Follow-up/Follow-through (Professionalism)  
- **K** Policy Compliance (System Based Practice)  
- **L** Inattention to detail (Medical Knowledge)  
- **M** Deficient documentation (e.g. not timely to communicate with other caregivers, unreadable, documentation does not substantiate clinical course treatment) (Medical Knowledge)  
- **N** Failure in supervision of physician extenders (Professionalism)  
- **O** Other:

## Step 3- Interventions recommended (select all that apply and note specifics):

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<th>Intervention</th>
<th>Describe specific recommendation</th>
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<td>☐ Supervision</td>
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<td>☐ Focused review</td>
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<td>☐ Other</td>
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## Step 4- Conclusion (select one):

☐ A

☐ B

☐ C

☐ D

☐ E

☐ F

☐ G

☐ H

☐ I

☐ J

☐ K

☐ L

☐ M

☐ N

☐ O
No Opportunity for Practitioner Improvement  (Definition: NO deviation of clinical care from medical standards (continue trending as usual))

Opportunity for Practitioner Improvement  (Definition: Deviation of clinical care from medical standards)

Please comment on what can be improved:

____________________________________________________________________________________________________
____________________________________________________________________________________________________

Additional comments:

Electronic Signature: _______________________________  Date: __________
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As a participation in SJH's Peer Review process, I understand and agree that in the performance of all duties related to this activity, the information which is either in verbal or written format will be held in strict confidence and will not be disclosed.

This Peer Review activity and its associated records of proceedings will be maintained in accordance with 32 M.R.S.A. Sub-section 3296 (Medical Practice Act).

Name Printed: ________________________________ Date: ______________

Signature: ________________________________

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Goal
Create and implement a comprehensive organizational structure to establish the following:
1. A framework for all process improvement/quality assessment
2. Multi-disciplinary, cross-organizational workgroups
3. Mechanisms for appropriate routing of process improvement opportunities
4. Integration of Lean philosophy and practice at every level
5. Maximal engagement
6. Alignment and coordination of process improvement work and prioritization

Underlying Philosophy
Changing a culture requires engaging individuals in problem solving, creating an environment of leadership and ownership, and engendering a commitment to improvement as an organization. Only this will have lasting results and lead to true transformation.

Brief Overview of Organizational Structure
Individual departments are combined into larger Service Groups for maximum collaboration and goal alignment. Each Service Group (represented below as triangles) has a matrix that appropriately funnels and supports process improvement opportunities. Lean process improvement is facilitated by Lean Partners who report to the Senate (Quality Council). Integrated Departments are departments that coordinate with multiple Service Groups. Examples of Integrated Departments are: Facilities, Dietary, Radiology and Lab. To maximize coordination between Service Groups, Lean Partners meet monthly to better facilitate cross-departmental work.

Matrix Structure
The matrix in each Service Group has mechanisms in place to funnel process improvement opportunities to one of three levels based on scope, complexity and level of resources needed. These levels are: Governance Council, Efficiency Teams and Departmental Teams. The matrix structure supports and integrates with the Lean Huddles and Gemba Walks which, along with Departmental Teams, are supported by the Director of Lean.

Governance Councils:

Purpose:
A multi-disciplinary collaborative governance group that drives high-level process improvement and establishes overall strategies and priorities for the Service Group. The Council also assures that these strategies and priorities align with those of the organization. In the case of the Ambulatory Council (Local Operating Council), it reports to and integrates with the System Operating Council for IMG.

Membership:
Physician leadership, nursing leadership, administration representation, other relevant leadership. Each Council has a director co-chair and a physician co-chair as well as an appointed facilitator (usually the Lean Partner).

Scope:
1. Addressing politically charged changes
2. Addressing physician needs that would be best considered in a collaborative multi-disciplinary forum
3. Strategizing complex operational improvements that have to do with throughput, volume growth, value streams or clinical outcomes
4. Setting priorities for the Service Group
5. Assessing ideas elevated from director level huddles

Rules of engagement:
1. The goal of every decision is consensus.
2. In the event of consensus, administration will support the decision made by the Council.
3. In the absence of consensus, administration will make the final determination.
4. Administration will make all final financial decisions and, in some cases, will set broad parameters for issues addressed by the Council.
5. The members from administration on the Council will function as working members of the Council as well as representatives of overall administration.
6. A facilitator is appointed who acts in support of the group.
7. The Council resembles a board of directors rather than a stakeholder model; members make decisions based on the good of the organization overall.
8. Every member is an equal participant.

Efficiency Teams:

Purpose:
Mixed membership, director-led workgroups that examine mid-level efficiency and improvement initiatives generated, in part, by director/manager huddles. Efficiency Teams are project workgroups that can be reassembled with new members when projects are completed within one area of opportunity. More than one Efficiency Team can be working in a Service Group at one time through director coordination.

Membership:
Mix of staff at multiple levels, led by a director within the Service Group. Other directors in the Service Group can serve on the efficiency team or the director-leader can coordinate with the other directors individually.

Scope:
- Operational projects that originate outside the department, such as through committees, Quality Department, Human Resources, System Standard Work, etc.
- Projects generated from director/manager huddles
- Operational projects identified by Council

Departmental Teams:

Purpose:
Frontline teams working on ground-level initiatives (Everyday Lean Ideas) which are generated by staff through the daily huddle. Initiatives are reflected on the Everyday Lean Ideas section of the huddle board. Departmental Teams work on local projects that affect only the department where initiated, are led by a staff member identified at huddle, and are supported by the department leader.

Membership:
All staff members

Scope:
- Every Day Lean Ideas that impact only the department where the idea was identified.
- Project estimated to take less than 30 days
- Every Day Lean Ideas that do not fit the scope of Departmental Teams are escalated to the manager/director huddle and continue to get elevated until the appropriate level is reached.

Role of Lean Partners:

Lean Partners support process improvement and facilitate engagement throughout the organization. A Lean Partner is assigned to each Service Group and provides support to Efficiency Teams as needed, especially in facilitating cross-
departmental projects and acting as a liaison between Service Groups and departments, creating a collaborative and cohesive team. Efficiency projects in Integrated Departments are supported by all Lean Partners, depending on which Service Group is impacted by a project. The Lean Partner reports to the Senate on behalf of the Service Group. In most cases the Lean Partner also is the Council facilitator. The Lean Partner works in coordinated effort with the Director of Lean to support the integration of the Covenant Management Method and lean tools.

*Created: August 2014*

*Revised: April 2015*

*Revised: January 2016*

*Revised: August 2017*
This sixth edition of the Ethical and Religious Directives for Catholic Health Care Services was developed by the Committee on Doctrine of the United States Conference of Catholic Bishops (USCCB) and approved by the USCCB at its June 2018 Plenary Assembly. This edition of the Directives replaces all previous editions, is recommended for implementation by the diocesan bishop, and is authorized for publication by the undersigned.

Msgr. J. Brian Bransfield,
STD General Secretary,
USCCB

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Digital Edition, June 2018

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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. 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. By virtue of their Baptism, lay faithful are called to participate actively in the Church’s life and mission. 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. 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 caregivers 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.” 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 lay exercise diverse but complementary roles in this pastoral care. Since many areas of pastoral care call upon the creative response of these pastoral caregivers 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.
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.

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.

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.

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.

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.

All persons served by Catholic health care have the right and duty to protect and preserve their bodily and functional integrity. 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.

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.

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.” 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.\textsuperscript{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 extracorporeal 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 Seriously Ill and Dying

Introduction

Christ’s redemption and saving grace embrace the whole person, especially in his or her illness, suffering, and death. 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.

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. In this way two extremes are 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.

The Church’s teaching authority has addressed the moral issues concerning medically assisted nutrition and hydration. We are guided on this issue by Catholic teaching against 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.” While medically assisted nutrition and hydration are not morally obligatory in certain cases, these forms of basic care should in principle be provided to all patients who need them, including patients diagnosed as being in a “persistent vegetative state” (PVS), because even the most severely debilitated and helpless patient retains the full dignity of a human person and must receive ordinary and proportionate care.

Directives

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 care.

55.
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.  

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.

58. In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the “persistent vegetative state”) who can reasonably be expected to live indefinitely if given such care.  

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.

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. The 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
Collaborative Arrangements with Other Health Care Organizations and Providers

Introduction

In and through her compassionate care for the sick and suffering members of the human family, the Church extends Jesus’ healing mission and serves the fundamental human dignity of every person made in God’s image and likeness. Catholic health care, in serving the common good, has historically worked in collaboration with a variety of non-Catholic partners. Various factors in the current health care environment in the United States, however, have led to a multiplication of collaborative arrangements among health care institutions, between Catholic institutions as well as between Catholic and non-Catholic institutions.

Collaborative arrangements can be unique and vitally important opportunities for Catholic health care to further its mission of caring for the suffering and sick, in faithful imitation of Christ. For example, collaborative arrangements can provide opportunities for Catholic health care institutions to influence the healing profession through their witness to the Gospel of Jesus Christ. Moreover, they can be opportunities to realign the local delivery system to provide a continuum of health care to the community, to provide a model of a responsible stewardship of limited health care resources, to provide poor and vulnerable persons with more equitable access to basic care, and to provide access to medical technologies and expertise that greatly enhance the quality of care. Collaboration can even, in some instances, ensure the continued presence of a Catholic institution, or the presence of any health care facility at all, in a given area.

When considering a collaboration, Catholic health care administrators should seek first to establish arrangements with Catholic institutions or other institutions that operate in conformity with the Church’s moral teaching. It is not uncommon, however, that arrangements with Catholic institutions are not practicable and that, in pursuit of the common good, the only available candidates for collaboration are institutions that do not operate in conformity with the Church’s moral teaching.

Such collaborative arrangements can pose particular challenges if they would involve institutional connections with activities that conflict with the natural moral law, church teaching, or canon law. Immoral actions are always contrary to “the singular dignity of the human person, ‘the only creature that God has wanted for its own sake.’” It is precisely because Catholic health care services are called to respect the inherent dignity of every human being and to contribute to the common good that they should avoid, whenever possible, engaging in collaborative arrangements that would involve them in contributing to the wrongdoing of other providers.

The Catholic moral tradition provides principles for assessing cooperation with the wrongdoing of others to determine the conditions under which cooperation may or may
not be morally justified, distinguishing between “formal” and “material” cooperation. Formal cooperation “occurs when an action, either by its very nature or by the form it takes in a concrete situation, can be defined as a direct participation in an [immoral] act . . . or a sharing in the immoral intention of the person committing it.” Therefore, cooperation is formal not only when the cooperator shares the intention of the wrongdoer, but also when the cooperator directly participates in the immoral act, even if the cooperator does not share the intention of the wrongdoer, but participates as a means to some other end. Formal cooperation may take various forms, such as authorizing wrongdoing, approving it, prescribing it, actively defending it, or giving specific direction about carrying it out. Formal cooperation, in whatever form, is always morally wrong.

The cooperation is material if the one cooperating neither shares the wrongdoer’s intention in performing the immoral act nor cooperates by directly participating in the act as a means to some other end, but rather contributes to the immoral activity in a way that is causally related but not essential to the immoral act itself. While some instances of material cooperation are morally wrong, others are morally justified. There are many factors to consider when assessing whether or not material cooperation is justified, including: whether the cooperator’s act is morally good or neutral in itself, how significant is its causal contribution to the wrongdoer’s act, how serious is the immoral act of the wrongdoer, and how important are the goods to be preserved or the harms to be avoided by cooperating. Assessing material cooperation can be complex, and legitimate disagreements may arise over which factors are most relevant in a given case. Reliable theological experts should be consulted in interpreting and applying the principles governing cooperation.

Any moral analysis of a collaborative arrangement must also take into account the danger of scandal, which is “an attitude or behavior which leads another to do evil.” The cooperation of a Catholic institution with other health care entities engaged in immoral activities, even when such cooperation is morally justified in all other respects, might, in certain cases, lead people to conclude that those activities are morally acceptable. This could lead people to sin. The danger of scandal, therefore, needs to be carefully evaluated in each case. In some cases, the danger of scandal can be mitigated by certain measures, such as providing an explanation as to why the Catholic institution is cooperating in this way at this time. In any event, prudential judgments that take into account the particular circumstances need to be made about the risk and degree of scandal and about whether they can be effectively addressed.

Even when there are good reasons for establishing collaborative arrangements that involve material cooperation with wrongdoing, leaders of Catholic healthcare institutions must assess whether becoming associated with the wrongdoing of a collaborator will risk undermining their institution’s ability to fulfill its mission of providing health care as a witness to the Catholic faith and an embodiment of Jesus’ concern for the sick. They must do everything they can to ensure that the integrity of the Church’s witness to Christ and his Gospel is not adversely affected by a collaborative arrangement.
In sum, collaborative arrangements with entities that do not share our Catholic moral tradition present both opportunities and challenges. The opportunities to further the mission of Catholic health care can be significant. The challenges do not necessarily preclude all such arrangements on moral grounds, but they do make it imperative for Catholic leaders to undertake careful analyses to ensure that new collaborative arrangements—as well as those that already exist—abide by the principles governing cooperation, effectively address the risk of scandal, abide by canon law, and sustain the Church’s witness to Christ and his saving message.

While the following Directives are offered to assist Catholic health care institutions in analyzing the moral considerations of collaborative arrangements, the ultimate responsibility for interpreting and applying of the Directives rests with the diocesan bishop.

**Directives**

67. Each diocesan bishop has the ultimate responsibility to assess whether collaborative arrangements involving Catholic health care providers operating in his local church involve wrongful cooperation, give scandal, or undermine the Church’s witness. In fulfilling this responsibility, the bishop should consider not only the circumstances in his local diocese but also the regional and national implications of his decision.

68. When there is a possibility that a prospective collaborative arrangement may lead to serious adverse consequences for the identity or reputation of Catholic health care services or entail a risk of scandal, the diocesan bishop is to be consulted in a timely manner. In addition, the diocesan bishop’s approval is required for collaborative arrangements involving institutions subject to his governing authority; when they involve institutions not subject to his governing authority but operating in his diocese, such as those involving a juridic person erected by the Holy See, the diocesan bishop’s *nihil obstat* is to be obtained.

69. In cases involving health care systems that extend across multiple diocesan jurisdictions, it remains the responsibility of the diocesan bishop of each diocese in which the system’s affiliated institutions are located to approve locally the prospective collaborative arrangement or to grant the requisite *nihil obstat*, as the situation may require. At the same time, with such a proposed arrangement, it is the duty of the diocesan bishop of the diocese in which the system’s headquarters is located to initiate a collaboration with the diocesan bishops of the dioceses affected by the collaborative arrangement. The bishops involved in this collaboration should make every effort to reach a consensus.

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.48

71. When considering opportunities for collaborative arrangements that entail material cooperation in wrongdoing, Catholic institutional leaders must assess whether scandal might be given and whether the Church’s witness might be undermined. In some cases, the risk of scandal can be appropriately mitigated or removed by an
explanation of what is in fact being done by the health care organization under Catholic auspices. Nevertheless, a collaborative arrangement that in all other respects is morally licit may need to be refused because of the scandal that might be caused or because the Church’s witness might be undermined.

72. The Catholic party in a collaborative arrangement has the responsibility to assess periodically whether the binding agreement is being observed and implemented in a way that is consistent with the natural moral law, Catholic teaching, and canon law.

73. Before affiliating with a health care entity that permits immoral procedures, a Catholic institution must ensure that neither its administrators nor its employees will manage, carry out, assist in carrying out, make its facilities available for, make referrals for, or benefit from the revenue generated by immoral procedures.

74. In any kind of collaboration, whatever comes under the control of the Catholic institution—whether by acquisition, governance, or management—must be operated in full accord with the moral teaching of the Catholic Church, including these Directives.

75. It is not permitted to establish another entity that would oversee, manage, or perform immoral procedures. Establishing such an entity includes actions such as drawing up the civil bylaws, policies, or procedures of the entity, establishing the finances of the entity, or legally incorporating the entity.

76. Representatives of Catholic health care institutions who serve as members of governing boards of non-Catholic health care organizations that do not adhere to the ethical principles regarding health care articulated by the Church should make their opposition to immoral procedures known and not give their consent to any decisions proximately connected with such procedures. Great care must be exercised to avoid giving scandal or adversely affecting the witness of the Church.

77. If it is discovered that a Catholic health care institution might be wrongly cooperating with immoral procedures, the local diocesan bishop should be informed immediately and the leaders of the institution should resolve the situation as soon as reasonably possible.
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


2. Health care services under Catholic auspices are carried out in a variety of institutional settings (e.g., hospitals, clinics, outpatient 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.


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.


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, 3º.

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.


22. Ibid., no. 50.


24. Ibid., no. 12.


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.


37. See *Declaration on Euthanasia*.

38. Ibid., Part II.


40. See Pope John Paul II, Address to the Participants in the International Congress on “Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas” (March 20, 2004), no. 4, where he emphasized that “the administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*.” See also Congregation for the Doctrine of the Faith, “Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration” (August 1, 2007).


42. See *Declaration on Euthanasia*, Part IV.


47. *Catechism of the Catholic Church*, no. 2284.

48. 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 6 (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* 7 (1977): 399-400.

49. See *Catechism of the Catholic Church*: “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).
The foregoing Medical Staff Bylaws, Rules and Regulations were approved and adopted by resolution of the Board of Trustees of St. Joseph Hospital after considering the Medical Staff's recommendation and in accordance with and subject to the St. Joseph Hospital's charter, bylaws and rules and regulations.

The overall responsibility for the management and control of St. Joseph Hospital rests with the Board of Trustees. Therefore, to the extent that these bylaws differ from or are inconsistent with the charter, bylaws or any rule or regulation of the Board of Trustees, the Board of Trustees' charter, bylaws or rules or regulations shall take precedence and prevail.

APPROVED THIS 31ST DAY OF JANUARY, 2019 AD

FOR THE MEDICAL STAFF MEMBERSHIP

Ganesha Santhyadka, MD
Medical Staff President

ASHA SHRESTHA, MD
Medical Staff Secretary/Treasurer

FOR THE HOSPITAL CORPORATION

MARY PRYBYLO, RN, MSN, FACHE
President

Signature on file - Presidents Office