BYLAWS OF THE MEDICAL STAFF

RUMFORD HOSPITAL

RUMFORD, MAINE

With updates adopted by the Medical Staff on March 23, 2017

Approved by the Rumford Hospital Board of Directors on April 11, 2017

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PREAMBLE

WHEREAS, Rumford Hospital ("Rumford Hospital") is a non-profit corporation organized under the laws of the State of Maine; and,

WHEREAS, Rumford Hospital's purpose is to serve as a critical access hospital providing a uniform standard of patient care, education and research consistent with the mission, vision and value statement as set forth in the Rumford Hospital bylaws; and,

WHEREAS, it is recognized that the Medical Staff (as defined in ARTICLE 1), by delegation of the Governing Body (as defined in ARTICLE 1), is responsible for actively participating in providing professional leadership for measuring, assessing and improving its performance in providing quality care in the Hospital (as defined in ARTICLE 1), and must accept and discharge this responsibility, subject to the ultimate authority of the Governing Body of the Hospital, and that the cooperative efforts of the Medical Staff, the President of Rumford Hospital, and the Governing Body are necessary to fulfill the Hospital's obligations to its patients; and,

WHEREAS, in recognition of its responsibility to improve the quality of care provided in the Hospital, each member of the Medical Staff has agreed to fully participate in the quality improvement activities of the Hospital, including participation in Performance Working Groups at the request of the Medical Executive Committee, except as otherwise set forth in these Bylaws;

THEREFORE, the Physicians (as defined in ARTICLE 1) practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

ARTICLE 1 DEFINITIONS

1.1 Active Medical Staff has the meaning set forth in Section 4.1.A.

1.2 Admitting Privileges means the rights of certain members of the Staff to admit their patients to the Hospital.

1.3 Associate Professional Staff means those individuals who have been granted Clinical Privileges to provide services at Rumford Hospital as a dentist, podiatrist, optometrist, physician assistant, psychologist, nurse practitioner, certified registered nurse anesthetist, certified nurse midwife, licensed clinical social worker, or psychiatric clinical nurse specialist pursuant to ARTICLE 4. For purposes of clarity, Members of the Associate Professional Staff are not considered members of the Medical Staff.

1.4 Associate Professional Staff Liaison has the meaning set forth in Section 4.3.

1.5 Chief Quality and Safety Officer means the physician who reports to the Medical Staff President and is responsible for overseeing quality improvement at the Hospital, including credentialing, peer review, and clinical performance. The Chief Quality and Safety Officer assumes a leadership role on the Clinical Excellence/Quality and Safety Committee, the Credentials Committee, and the Peer Review Committee to coordinate the work of each committee with the Hospital departments responsible for quality and credentialing. If no chief quality and safety officer has been appointed the duties and responsibilities of as described in these bylaws shall be the responsibility of the medical staff president or their designee.

1.6 Clinical Privileges means the permission granted to a Staff member to admit their patients to the Hospital and/or to render specific diagnostic, therapeutic, medical, dental, surgical, podiatric, or psychological services to Hospital patients.

1.7 CME means continuing medical education.

1.8 CMHC means Central Maine Healthcare Corporation.

1.9 Courtesy Medical Staff has the meaning set forth in Section 4.2

1.10 Governing Body means the Board of Directors of Rumford Hospital.

1.11 Hospital means the hospital of Rumford Hospital, including all associated treatment areas, clinical areas, and services included in the hospital license.

1.12 Investigation Committee has the meaning set forth in Section 7.1.C. For purposes of clarity, references to the Investigation Committee shall include any Joint Investigation Committees created at the Medical Executive Committee's discretion.

1.13 Joint Investigation Committee has the meaning set forth in Section 7.1.C.

1.14 Locum Tenens Allied Health Professional has the meaning set forth in Section 4.4.

1.15 Locum Tenens Physician has the meaning set forth in Section 4.4.

1.16 Locum Tenens Staff has the meaning set forth in Section 4.4.

1.17 Medical Staff has the meaning set forth in Section 2.1. For purposes of clarity, Medical Staff includes Active Medical Staff, Courtesy Medical Staff, Honorary Medical Staff, and Locum Tenens Physicians. Medical Staff does not include Associate Professional Staff or Locum Tenens Allied Health Professionals.

1.18 Medical Staff Chief means the Physician elected by the Medical Staff to the office of Medical Staff Chief pursuant to Section 9.3.

1.19 Medical Staff President means the *ex officio* Officer of the Medical Staff further described in Section 9.1.

1.20 Medical Staff Rules and Regulations has the meaning set forth in ARTICLE 16.

1.21 Medical Staff Vice Chief means the Physician elected by the Medical Staff to the office of Medical Staff Vice Chief pursuant to Section 9.3.

1.22 MMA means the Maine Medical Association.

1.23 Nominating Committee has the meaning set forth in Section 9.3.B.

1.24 Officers of the Medical Staff means the Medical Staff President, the Medical Staff Chief, and the Medical Staff Vice Chief.

1.25 Performance Working Group has the meaning set forth in Section 11.2.

1.26 Physician means an appropriately licensed allopathic or osteopathic physician or an appropriately licensed oral surgeon.

1.27 Practitioners means members of the Medical Staff, Associate Professional Staff, and Locum Tenens Allied Health Professionals.

1.28 President of Rumford Hospital means the chief executive officer who acts on behalf of the Governing Body with respect to the overall management of the Hospital.

1.29 RHPG means the unincorporated division of Rumford Hospital referred to as the "Rumford Hospital Physician Group."

1.30 Rumford Hospital has the meaning set forth in the Preamble.

1.31 Special Committee means a committee formed on an "as needed" basis by the Medical Executive Committee. Special Committees are sometimes referred to as "*ad hoc*" committees.

1.32 Staff means Medical Staff, Associate Professional Staff, and Locum Tenens Allied Health Professionals.

1.33 Telemedicine means the use of medical information exchanged from one site to another via electronic communications, such as video conferencing, for diagnosis, treatment and education of the patient or healthcare provider, and for the purpose of improving patient care, treatment and services. For the purposes of this definition, the originating site shall mean the site where the patient is located at the time and the service is provided and the distant site shall mean the site where the person providing the professional service is located.

1.34 Voting Medical Staff Members has the meaning set forth in Section 13.7.

ARTICLE 2 NAME AND PURPOSES

2.1 Name

The name of this organization shall be the Medical Staff of Rumford Hospital ("Medical Staff"). It is the intent of the Medical Staff and of these Bylaws that the Medical Staff is, and for all purposes should be considered, a constituent part of Rumford Hospital and is not intended to be a separate legal entity.

2.2 Purposes

The purposes of the Medical Staff are as follows:

(a) To ensure that all patients admitted to or treated in any of the facilities or services of the Hospital shall receive the most appropriate level of care within the resources of available staff, equipment, and physical plant and care that is consistent with applicable professional standards of quality and appropriateness;

(b) To ensure a high level of professional performance by all Practitioners authorized to practice in the Hospital through the appropriate delineation of the Clinical Privileges that each Practitioner may exercise in the Hospital and through an on-going review and evaluation of each Practitioner's performance in the Hospital;

(c) To ensure that personal or professional conflicts of interest are disclosed and where appropriate, prohibited, in fulfilling any of the functions of the Staff and in the provision of patient care;

(d) To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement of professional knowledge and skill, which may include maintaining an appropriate graduate medical education program;

(e) To initiate and maintain Medical Staff Rules and Regulations for self-governance of the Medical Staff consistent with the ultimate authority of the Governing Body and such rules and policies as are necessary to clearly define acceptable Medical Staff practices regarding provision of medical and surgical care, maintenance of medical records, conduct, and any other elements of Medical Staff functions within the Hospital;

(f) To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Governing Body and the President of Rumford Hospital and to ensure that there will be Medical Staff representation and participation in any Hospital deliberation affecting the discharge of Medical Staff responsibilities;

(g) To provide input to the allocation of financial resources as it relates to the provision of patient care;

(h) To provide for obligations of the Staff concerning peer review, ethical standards, and quality improvement activities; and

(i) To provide methods for assuring accountability of its members to the Staff, these Bylaws, and the Medical Staff Rules and Regulations by stipulating disciplinary processes, including processes for enforcement and appeals.

ARTICLE 3 MEDICAL STAFF MEMBERSHIP

3.1 Nature of Medical Staff Membership

Membership on the Medical Staff is a privilege which shall be extended only to professionally competent Physicians (as described in ARTICLE 4) who continuously meet the qualifications, standards, and requirements set forth in these Bylaws, the Medical Staff Rules and Regulations and in any applicable Staff policies. All determinations about Medical Staff membership and Clinical Privileges will be made without regard to race, religion, gender, or national origin and in compliance with applicable federal and state non-discrimination laws.

3.2 Qualifications for Medical Staff Membership

3.2.A **General Qualifications**. To be qualified for membership on the Medical Staff, Physicians must: (i) be licensed to practice in the State of Maine, (ii) be "geographically and otherwise available" to meet the needs of patients and of the Hospital, and (iii) be able to document, with sufficient adequacy to assure the Medical Staff and the Governing Body that any patient treated by them in the Hospital will be given a uniform standard of quality medical care, the following: their background, experience, training (including the adequacy of training programs), demonstrated and continued competence, adherence to the ethics of their profession, good character and compliance with federal and state laws and regulations (including those governing the Medicare and Medicaid programs), and ability to work with others.

3.2.A.1 **Changes to License and Certification**. Medical Staff members shall notify the Medical Staff office immediately upon restriction, suspension, non-renewal, or revocation of state license or certification.

3.2.A.2 **Geographically Available**. Whether a Physician is "geographically and otherwise available" shall be determined, in each case, by the Governing Body, after consultation with or recommendation by the Medical Executive Committee and/or the Credentials Subcommittee, considering such factors as the distance from the Physician's home and office to the Hospital, coverage arrangements, and the nature of the Clinical Privileges being sought.

3.2.A.3 **Inadequate Grounds for Membership**. No Physician 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, that he/she is a member of any professional organization, or that he/she had in the past, or presently has, such Clinical Privileges at another hospital.

3.2.B **Board Certification**. In addition to the general qualifications set forth above, to be qualified for membership on the Medical Staff, Physicians must meet the

board certification requirements below and must continually maintain such qualifications during their term of appointment, subject to the exceptions below.

A member certified in more than one board shall maintain board certification in the board most proximate to their practice.

3.2.B.1 **Completion of Residency Program**. Physicians must have successfully completed the required number of years in a specialty residency program approved by the Accreditation Council for Graduate Medical Education, American Osteopathic Association, the Canadian Medical Association or the Royal College of Physicians and Surgeons of Canada, the Royal College of Physicians of London or the Royal College of Surgeons of England, or other postdoctoral medical training program. Physicians must also demonstrate other qualifications sufficient to satisfy the requirement in effect on the date of application for examination and subsequent certification in his/her approved medical specialty. For purposes of this Section 3.2.B.1, "approved medical specialty" shall mean approved by a specialty board recognized by the American Board of Medical Specialties and the Council on Medical Education of the American Medical Association, American Osteopathic Association, the Canadian Medical Association or the Royal College of Physicians and Surgeons of Canada, or the Royal College of Physicians of London or the Royal College of Surgeons of England.

3.2.B.1.a **Exceptions**. On the recommendations of the Medical Executive Committee and the Credentials Subcommittee, the Governing Body may make an exception to the requirements of this Section 3.2.B.1 for a Physician trained outside of the United States and Canada or for a Physician who is within his/her final year of his/her residency and is supervised by a Physician who is a member of the Active Medical Staff if the Governing Body finds that granting such Physician Clinical Privileges would promote enhanced quality of and access to patient care in the Hospital, and further finds that the education and training of the Physician is substantially equivalent to the education and training otherwise required by this Section 3.2.B.1.

3.2.B.2 **Changes in Board Certification Requirements**. A Physician already certified in his/her approved medical specialty at the time of application shall not be affected by subsequent changes and requirements for the number of years in a residency program or other certification requirements.

3.2.B.3 **Failure to Obtain Board Certification**. Any Physician or oral surgeon (who was not a member of the Active Medical Staff as of April 14, 1989) who has failed to obtain board certification within five

(5) years of becoming eligible to sit for a specialty board examination for each area in which he/she has Clinical Privileges shall not be appointed or reappointed with respect to such Clinical Privileges.

3.2.B.3.a **Exceptions.** The Governing Body may make an exception to the requirements of this Section 3.2.B.3 on the recommendations of the Medical Executive Committee and the Credentials Subcommittee if the Governing Body finds that it would promote enhanced quality of and access to patient care in the Hospital if the Physician was granted or retained such Clinical Privileges despite lack of certification. The Credentials Subcommittee shall solicit the input of members of the Medical Staff in the appropriate clinical area in considering such a request.

3.2.C **Ethics**. Acceptance of membership on the Medical Staff shall constitute the Medical Staff member's agreement that he/she will strictly abide by the Principles of Medical Ethics of the American Medical Association, of the American Osteopathic Association, or by the Principles of Ethics of the American Dental Association, whichever is applicable.

3.2.D **Coverage Responsibilities**. All Medical Staff members will be expected to respond or to arrange an appropriate response in a timely manner when a member of the Medical Staff requests assistance.

3.2.D.1 **Primary Coverage Responsibilities**. All members of the Active Medical Staff, Courtesy Medical Staff, Locum Tenens Physicians, and members of the Associate Professional Staff in independent practice shall provide continuous coverage for both their inpatients and their private practices, if applicable. This coverage must be by an appropriately privileged member of the Staff, and must be consistent with the requirements of the Medical Staff Rules and Regulations, unless otherwise determined by the Medical Executive Committee upon request of an individual. A statement confirming such an arrangement, including the plan for ensuring such continuous coverage and the names of the Staff members who will assist in providing such continuous coverage, shall be submitted at the time of both initial appointment to the Staff and upon application for reappointment.

3.2.D.2 **Service Coverage Responsibilities**.

3.2.D.2.a **General Responsibilities**. All members of the Active Medical Staff and other Practitioners with Admitting Privileges shall participate in providing coverage for patients who are without an available local Physician and who present to the Hospital needing services. This coverage obligation includes both

inpatient hospital care and outpatient follow-up care of acute illness and/or injuries, but does not require the provision of long term or ongoing comprehensive care.

3.2.E. Basic Life Support: All members of the Active Medical Staff and Associate Professional Staff, who provide direct patient care, shall obtain certification in Basic Life Support prior to the completion of their provisional staff appointment and shall maintain such certification during the term of their appointment. Current ACLS and PALS certification, and maintenance of both, will meet this requirement.

3.3 Qualifications for Medical Staff Clinical Privileges

3.3.A **Documentation of Qualifications**. To document qualifications for Clinical Privileges, Physicians shall submit the items set forth below in this Section 3.3.A.

3.3.A.1 **Application for Membership and Clinical Privileges.** Physicians shall submit a completed Medical Staff application and Clinical Privilege delineation application appropriate to the clinical area in which the Physician is seeking Clinical Privileges (for Associate Professional Staff, see Section 4.3).

3.3.A.2 **Education**. Physicians shall submit proof of graduation from a medical or dental school, which is approved by the Liaison Committee on Medical Education of the Association of American Medical Colleges and the American Medical Association or the American Osteopathic Association.

3.3.A.3 **Training**. Physicians shall submit proof of completion of an approved residency program (as described in Section 3.2.B.1) in the specialty for which the Physician is seeking Clinical Privileges or other past residency academic or experiential training that is required or that qualifies for the exception set forth in Section 3.2.B.1.a.

3.3.A.4 **Procedure Lists**. Physicians shall submit appropriate procedure lists as defined by the Medical Executive Committee in consultation with members of the Medical Staff.

3.3.A.5 **Letters of Reference and Peer Attestations.** Physicians shall submit letters of reference and peer attestations regarding clinical skills and competence. Three (3) letters of reference shall be submitted. Two (2) of the three (3) letters shall be from persons who have been immediately involved in the supervision or training of the individual or in practice with the individual. Each reference shall be asked to comment specifically on the applicant's clinical skills and competence, judgment, character, knowledge base, health, and interpersonal relationships. These letters of reference will be used

as evidence of the applicant's personal performance and conduct at other institutions. References may be confirmed by telephone by the Chair of the Credentials Subcommittee (or his/her designee).

3.3.A.6 **Liability Insurance**. Physicians shall submit proof of liability insurance in the amount required by Rumford Hospital.

3.3.A.7 **Licensure**. Physicians shall submit proof of current State of Maine medical licensure (or dental licensure in the case of an oral surgeon) and a federal Drug Enforcement Administration license (if applicable). Physicians shall also provide consideration of past licensure in the State of Maine and other states or countries, and consideration of the history of sanctions by any licensing authority or disciplinary action by any professional association or specialty board in the immediate past ten (10) years.

3.3.B **Primary Source Verification**. The applicant's licensure, board certification status, professional liability claims history (from the carrier), and professional sanctions (*e.g.*, National Practitioner Data Bank) shall be primary source verified at the time of initial appointment and reappointment for all Medical Staff categories.

3.4 Conditions and Duration of Medical Staff Appointment

3.4.A **Governing Body Action**. The Governing Body shall make initial appointments and reappointments to the Medical Staff. The Governing Body shall act on appointments, reappointments, or revocation or restrictions of appointments only after there has been a recommendation from the Medical Executive Committee as provided by these Bylaws.

3.4.B **Term**. Initial appointment to the Medical Staff, except for Locum Tenens Physicians, shall be for a period of at least one (1) year. Reappointments to any category of the Medical Staff shall be for a period of not more than two (2) years. All initial appointments may provide for a period of supervision and any other conditions which shall be determined by the Governing Body upon the recommendation of the Medical Executive Committee.

3.4.C **Provisional**. All initial appointments to any category of the Medical Staff or applications for enhancement of Clinical Privileges shall be provisional (*i.e.*, "under supervision" of the Medical Staff Chief) for a period of at least six (6) months. Successive reappointments to provisional membership may not total more than three (3) full years, at which time the failure to advance the appointee from provisional to regular Medical Staff status shall be deemed a termination of his/her Medical Staff appointment. Provisional Medical Staff members shall have all the above stated Clinical Privileges, rights, and responsibilities of the category of Medical Staff to which they were provisionally appointed. Members provisionally appointed to the Active Medical Staff may not hold office until their supervisory restrictions are lifted.

3.4.C.1 **Medical Staff Chief**. Before completion of the provisional period, or if review is not practicable before completion, then soon after completion of the provisional period, the Medical Staff Chief (or designee) shall review all pertinent information available on each provisional appointee. Criteria for review of provisional status include assessment of quality of patient care, documentation skills, and interpersonal relationships affected by the appointee during the probationary period established in Section 3.4.C. As set forth in Section 5.3, the Medical Staff Chief (or designee) will recommend to the Credentials Subcommittee either regular Medical Staff membership (in the appropriate category) or continuation of provisional status, subject to the three (3) year limitation. The Credentials Subcommittee shall forward the recommendation of the Medical Staff Chief to the Medical Executive Committee for review and recommendation to the Governing Body, which shall take final action.

3.4.C.2 **Notification of Adverse Recommendation**. Any provisional appointee shall be notified in writing in a timely manner of any adverse recommendation from the Credentials Subcommittee or the Medical Executive Committee. Upon serving the maximum number of provisional terms, the provisional appointee shall be given an opportunity to appear before the Credentials Subcommittee prior to the Credentials Subcommittee's recommendation to the Medical Executive Committee. Nothing in this Section 3.4.C.2 shall be construed as entitling a provisional appointee to a hearing in accordance with these Bylaws.

3.4.D **Scope of Clinical Privileges**. Appointments to the Medical Staff shall confer on the appointee only such Clinical Privileges as have been granted by the Governing Body after review by the Medical Staff Chief, the Credentials Subcommittee, and the Medical Executive Committee.

3.4.E **Signature and Agreement**. Every application for Medical Staff appointment shall be signed by the applicant and shall contain appropriate references to the Medical Staff Rules and Regulations, the bylaws of Rumford Hospital, and Medical Staff policies to ensure acceptance of Performance Working Group and committee assignments and an agreement to accept consultation and service call assignments as specified in these Bylaws.

3.5 Medical Staff Dues and Assessments

3.5.A **General Requirements**. All members of the Medical Staff shall pay dues and assessments as determined to be appropriate by the Medical Executive Committee unless waived for hardship circumstances by the Medical Staff President upon consent of the Medical Executive Committee. Notwithstanding the foregoing, members of the Locum Tenens Staff will not be required to pay dues and assessments, except that members of the Locum Tenens Staff will be required to pay application fees. The dues

paid shall not be commingled with Hospital funds and may be used only for Medical Staff purposes authorized by the Medical Executive Committee or the Medical Staff.

3.5.B **Failure to Pay**. If a Medical Staff member fails to pay dues or assessments within ninety (90) days after notification by the Medical Staff President, then such Medical Staff member shall be provided a second notice by certified mail. If dues remain unpaid thirty (30) days after receipt of the second notice, such Medical Staff member shall be subject to corrective action.

3.6 Leaves of Absence from Medical Staff and Associate Professional Staff

3.6.A **Procedure**. An application for a leave of absence is required for any absence from the Staff which is greater than forty (40) days. The request shall include the reason for absence and the time period involved. The application shall be submitted to the senior Hospital administrator responsible for medical affairs who shall consult with the Medical Staff President and provide notice to Active Medical Staff members with Clinical Privileges in the same ~~Section~~ clinical area as the applicant. Such senior Hospital administrator may then grant or deny the application, or impose conditions on approval. The applicant may appeal a denial, or conditions imposed, to the Medical Executive Committee, whose decision on the application shall be final. A leave of absence shall not operate to stay or preclude corrective action.

3.6.B **Categories of Leaves of Absence**.

3.6.B.1 **Medical Leave**. A medical leave of absence may be granted for as long as is medically necessary. In the case of a medical leave of absence, before resuming regular Clinical Privileges, the Practitioner shall (i) provide documentation of health status sufficient to justify resumption of those Clinical Privileges, and (ii) meet with the Medical Staff chief as appropriate Committee, to develop a plan for transitioning back to practice.

3.6.B.2 **Educational Leave**. An educational leave of absence may be granted for the duration of the educational program. Practitioners on an educational leave of absence must submit verification of attendance as requested and determined by the Credentials Subcommittee.

3.6.B.3 **Personal Leave**. A personal leave of absence may be taken for up to one (1) year, provided that the Practitioner is not actively engaged in medical practice in the Hospital service area.

3.6.C **Unapproved Absence**. An absence of greater than forty (40) days without a submitted written request shall be cause for termination of Staff membership, Clinical privileges, and prerogatives without right of hearing or appellate review. A subsequent request for staff privileges for a practitioner so terminated shall be submitted and processed in the manner specified for application for initial appointment.

3.6.D **Return from Leave**. Upon return from any leave of absence and upon request of the Medical Staff Chief, the Practitioner shall provide the Medical Staff Chief with a written description of professional/medical activities in which he/she may have been involved during the period of leave in order to assist in assessing maintenance of competency for the Clinical Privileges the Practitioner holds.

ARTICLE 4 CATEGORIES OF THE MEDICAL STAFF AND THE ASSOCIATE PROFESSIONAL STAFF

4.1 Active Medical Staff

4.1.A **Qualifications and Requirements**. The active medical staff ("Active Medical Staff") shall consist of Physicians who have been granted Clinical Privileges by the Governing Body, who regularly admit or care for Hospital patients or regularly use Hospital services or facilities for their patients, and who assume all the functions and responsibilities of membership on the Active Medical Staff, including, where appropriate, emergency and service call as well as consultation assignments.

4.1.B **Duties and Responsibilities**. Active Medical Staff members shall be eligible to vote, hold office, and serve on Medical Staff committees and shall be required to attend Medical Staff meetings (as set forth in Section 13.4). Active Medical Staff members who are on the call schedule shall provide call coverage services consistent with the requirements of the Medical Staff Rules and Regulations. Active Medical Staff members shall fully participate in Performance Working Groups and fully participate in other quality improvement activities at the request of the Medical Executive Committee.

4.1.C **Transfers.** Any applicant for transfer to the Active Medical Staff who is a member of a lesser category of the Medical Staff shall be subject to the same standard of review as applicants who are not members of the Medical Staff.

4.1.D **Exceptions.** With the recommendation of the Medical Staff Executive Committee and approval of the Board, other members of the Medical Staff or Associate Professional Staff holding positions that are exclusively administrative may retain their membership without holding Clinical Privileges or meeting other staff requirements appropriate to members with Clinical Privileges, including specifically the requirements of Article 5 and 6.

4.2 Courtesy Medical Staff

4.2.A **Qualifications and Requirements**. The consulting and courtesy medical staff (collectively, "Courtesy Medical Staff") shall consist of Physicians qualified for Medical Staff membership as set forth in Section 3.2. A Physician's appointment to and continued eligibility to serve on the Courtesy Medical Staff may, at the discretion of the Governing Body, be conditioned upon such Physician having and maintaining an active medical staff appointment at another licensed hospital, except for a physician in his/her last year of residency training as described in section 3.2.B.1.A. or a physician completing a fellowship. If not on active staff at another facility, the member will be responsible for unassigned emergency department call for his/her specialty, if required.

4.2.B **Duties and Responsibilities**. Members of the Courtesy Medical Staff shall not be eligible to vote or hold office. Admitting Privileges of any Courtesy Medical

Staff Member shall be granted or denied during the credentialing process. Members of the Courtesy Medical Staff shall fully participate in Performance Improvement Working Groups and fully participate in other quality improvement activities at the request of the Medical Executive Committee.

4.2.C **Transfers**. All applications for transfer from the Courtesy Medical Staff to Active Medical Staff status shall be handled in the same manner as an initial appointment to the Active Medical Staff.

4.2.D **Use of Hospital Facilities**. The use of Hospital facilities by members of the Courtesy Medical Staff shall be minimal. Specific guidelines for inpatient admissions, consultations, day Hospital procedures, and outpatient procedures shall be recommended by the Medical Staff Chief when necessary. Issues that arise and that cannot be settled in a timely manner shall be resolved by the Medical Executive Committee. A member of the Courtesy Medical Staff who performs call coverage for an inpatient in the Hospital shall be available within the timeframe set forth in the Medical Staff Rules and Regulations.

4.3 Associate Professional Staff

The Medical Staff shall maintain an Associate Professional Staff . Members of the Associate Professional Staff are not considered members of the Medical Staff. Unless otherwise required by the Medical Executive Committee or the Hospital, allied health professionals who are employed by the Hospital may, but shall not be required to, apply for membership on the Associate Professional Staff.

4.3.A **Duties and Responsibilities**. Members of the Associate Professional Staff will have the duties and responsibilities set forth below. Notwithstanding the foregoing, the Medical Executive Committee may from time to time waive any of the duties and responsibilities set forth in this Section 4.3.A for members of the Associate Professional Staff who practice exclusively in an ambulatory care setting.

4.3.A.1 **Meetings and Committees**. Members of the Associate Professional Staff may attend Medical Staff meetings. Members of the Associate Professional Staff shall fully participate in Performance Working Groups and fully participate in other quality improvement activities at the request of the Medical Executive Committee.

4.3.A.2 **Admitting**. Members of the Associate Professional Staff will not have Admitting Privileges or be admitting providers of record, except that certified nurse midwives may be granted Admitting Privileges to admit patients for obstetric care not covered by Medicare.

4.3.A.3 **Changes to License and Certification**. Members of the Associate Professional Staff shall notify the Medical Staff office immediately

upon restriction, suspension, non-renewal, or revocation of state license or certification.

4.3.A.4 **Professional Organization Ethics**. Members of the Associate Professional Staff shall strictly adhere to the standards of ethics of the appropriate professional organization for their profession.

4.3.A.5 **Performance Review**. The clinical competence and performance of each member of the Associate Professional Staff shall be reviewed at least annually by the Associate Professional Staff member's administrative supervisor or supervising Physician, as applicable, or by an *ad hoc* committee of the Medical Staff appointed by the Medical Executive Committee.

4.3.A.6 **Corrective Action**. Members of the Associate Professional Staff will be subject to the same corrective action process as members of the Medical Staff but will not be entitled to the procedural rights described in Article 7 of these bylaws. However, Associate Professional Staff shall be entitled to the following before the board makes the final decision:

A. Receive written notice of any adverse recommendation by the MEC or adverse action by the Board with respect to the Associate Professional Staff's authority to furnish patient care at the hospital, including a statement of the reason(s) for said recommendation or action.

B. Appear before the MEC to respond to an adverse recommendation by the MEC, before the deadline set forth in the notice described in "A" above.

C. Submit to the Board a written response to an adverse action by the Board, before the deadline set forth in the notice described in "A' above.

4.3.B **Applicant Requirements**. Applicants to the Associate Professional Staff shall meet the qualifications for Clinical Privileges set forth in Section 4.3 and Section 5.1.1 as appropriate to their discipline. When required by law, applicants to the Associate Professional Staff shall be fully licensed, registered, or certified. Applicants must have the competence, training, and experience appropriate for the Clinical Privileges for which they are applying. Applicants must submit letters of reference, must be in good standing in their professional fields, and must abide by the ethical principles established by their respective professional associations. Applicants shall provide proof of professional liability insurance coverage to cover the scope of Clinical Privileges requested in the same amount and subject to the same conditions as required by Rumford Hospital for members of the Medical Staff. Applications for appointment and delineation of Clinical Privileges shall be reviewed and voted upon in the manner designated for

Medical Staff applications. Associate Professional Staff appointment is limited to persons with acceptable credentials in the following categories:

(a) Certified registered nurse anesthetist;

(b) Psychologist;

(c) Dentist;

(d) Certified nurse midwife;

(e) Nurse practitioner;

(f) Optometrist

(g) Physician assistant; and

(h) Podiatrist.

4.3.C **Limitations on Clinical Privileges**. Certain members of the Associate Professional Staff are considered dependent upon the supervision of an Active Medical Staff Physician, such as certified registered nurse anesthetists and physician assistants. In addition, certified nurse midwives and nurse practitioners during the first two (2) years of post-training practice shall be under the supervision of a member of the Active Medical Staff. The supervising Physician must accept full responsibility and accountability for the conduct of the supervised Practitioner when the supervised Practitioner is performing services for Rumford Hospital directly or through RHPG. In the event that a supervising Physician withdraws from the supervisory relationship, or the supervising Physician's Clinical Privileges are surrendered, suspended, or terminated, the supervised Practitioner's Clinical Privileges are automatically suspended until the supervising Physician's Clinical Privileges are fully restored or another qualified Physician has agreed to assume supervisory responsibility. Each supervising Physician shall provide the Medical Staff office with a letter attesting to the supervisory relationship. A supervising Physician may resign from such a relationship at his/her discretion and must notify the Medical Staff office of his/her resignation. The supervised Practitioner shall be responsible for advising the Medical Staff office in writing of any change in supervising Physician status.

4.3.D **Members Not Subject to Supervisory Requirement**. Members of the Associate Professional Staff who are not subject to the supervisory requirement set forth in Section 4.3.C shall be responsible to the Medical Staff Chief or his/her designee. Dentists and podiatrists may provide care to patients admitted by a member of the Active Medical Staff or Courtesy Medical Staff who shall be responsible for the medical aspects of the patient's care throughout the Hospital stay and shall complete the relevant components of the "history and physical."

4.3.E **Podiatrists.**

4.3.E.1 **Privileging Standards**. In order to be granted podiatric Clinical Privileges, podiatrists must meet the standards set forth below.

4.3.E.1.a **Non-Surgical.** Non-surgical podiatrists must meet the following two (2) requirements: (i) hold a Doctor of Podiatric Medicine (DPM); and (ii) demonstrate successful completion of a one (1) year surgical residency, a one (1) year postgraduate training program in primary podiatric orthopedics, or a one (1) year postgraduate training program in primary podiatric medicine, which residency or program is approved by the Council on Podiatric Medical Education (CPME).

4.3.E.1.b **Surgical**. Surgical podiatrists must meet the requirements set forth above that apply to non-surgical podiatrists and must meet the following additional requirements: (i) demonstrate prior competent performance of each requested procedure and (ii) hold board certification by the American Board of Podiatric Surgery (ABPS) within five (5) years of eligibility for that board examination.

4.3.E.2 **Patient Care**. As set forth in the Medical Staff Rules and Regulations, podiatrists are responsible for that part of the patient's history and physical which relates to podiatry and podiatrists may admit patients in collaboration with a member of the Active Medical Staff or Courtesy Medical Staff who shall be responsible for the medical aspects of the patient's care throughout the Hospital stay.

4.3.E.3 **Responsibility and Reappointment**. Podiatrists shall be responsible to the Medical Staff Chief and will be reappointed in accordance with standard reappointment practices for the Associate Professional Staff.

4.3.F **Clinical Privileges**. Clinical Privileges shall be granted to members of the Associate Professional Staff based on defined standards reflecting their documented training, experience, demonstrated competence, judgment, and license, registration, or certification and on the criteria set forth in Section 4.3. Periodic expansion or reduction of Clinical Privileges based upon ongoing experience or changes in training, experience, proficiency, current clinical competence and quality of care may occur at any time through appropriate requests to, and action of, the Credentials Subcommittee, the Medical Executive Committee, and the Governing Body. The procedures that apply for initial application of Clinical Privileges (set forth in Section 5.2) shall apply when expanding Clinical Privileges of members of the Associate Professional Staff. In addition to the foregoing criteria, the Governing Body may apply the same factors in making a determination of appointment, reappointment, or scope of Clinical Privileges for a member of the Associate Professional Staff that it applies to a member of the Medical Staff.

4.3.G **General Considerations**. Appointment to the Associate Professional Staff will not be determined solely based on professional criteria such as certification or membership in a professional society or health care network, but the use of any such criteria as specific requirements for appointment is not precluded.

4.4 Locum Tenens Staff

4.4.A **Qualifications and Requirements**. The locum tenens staff ("Locum Tenens Staff") shall consist of Physicians ("Locum Tenens Physicians") or allied health professionals ("Locum Tenens Allied Health Professionals") who (i) meet the qualifications for membership under Section 5.1 and for Locum Tenens Physicians only, under Sections 3.2 and 3.3; and (ii) are appointed for the specific purpose of providing temporary coverage in various disciplines where the number of appointed Staff members is insufficient to meet patient care needs.

4.4.B **Term**. Locum Tenens Staff shall be appointed for a specified term that is no longer than necessary to meet the identified patient care needs, provided that Locum Tenens Staff shall not be appointed for a term that is longer than two (2) years. If the term of the contract is cancelled or expires, privileges shall be considered to be voluntarily relinquished. Except for limits established by the applicable State of Maine licensing board, there are no limits on the number of times that an individual may be appointed to the Locum Tenens Staff. Appointment and reappointment to the Locum Tenens Staff shall follow the appointment and reappointment provisions set forth in ARTICLE 5.

4.4.C **Duties and Responsibilities.** Locum Tenens Physicians will not be required to meet Medical Staff meeting attendance requirements and will not be required to pay dues and assessments (except for any applicable application fees). Locum Tenens Physicians will not be eligible to vote, to hold office or to serve on standing committees but may be appointed to Special Committees or assigned other responsibilities by Officers of the Medical Staff or the Medical Staff Chief. Members of the Locum Tenens Staff shall fully participate in Performance Working Groups and fully participate in other quality improvement activities at the request of the Medical Executive Committee. Members of the Locum Tenens Staff are encouraged to attend educational conferences and appropriate Medical Staff meetings.

4.4.D **Transfers**. Locum Tenens Physicians may be transferred to the Active Medical Staff or Courtesy Medical Staff, provided that they meet the requirements of the applicable category of the Medical Staff. In the event that a Locum Tenens Physician transfers to another category of the Medical Staff, such Locum Tenens Physician would be subject to the provisions of Section 5.3 regarding provisional appointment.

4.5 Telemedicine Medical Staff

Telemedicine Medical Staff shall consist of those Physicians and/or Associate Professional Staff who provide Telemedicine services to patients from a distant site. Such individuals must be licensed in Maine and provide all the information required of any applicant for membership in any other staff category. Such information may be provided by a service provider acting on behalf of the employed healthcare Practitioners.

Members of the Telemedicine Medical Staff shall not be required to comply with those provisions of these Bylaws, Rules and Regulations or Policies which require or imply a physical presence at the hospital, including but not limited to the provisions of Article 3.2,

Members of the Telemedicine Medical Staff shall not be privileged to admit patients. They shall not be required to attend Medical Staff meetings, nor be eligible to vote or hold office.
The Medical Executive Committee shall recommend to the Governing Body the clinical services to be provided through a telemedicine link. In making such a recommendation, Medical Executive Committee shall evaluate the ability of the RH to safely provide the services on an on-going basis, including specifically the appropriate use of telemedicine equipment and its maintenance. If at any time the contract is cancelled, a telemedicine practitioner leaves the employ of the distant site organization, if membership or privileges lapse at the distant site, or if the State of Maine medical license expires, is suspended or revoked, the telemedicine practitioner shall be considered to have voluntarily relinquished all clinical privileges related to telemedicine.

If approved by the MEC, credentialing by proxy is allowable for telemedicine providers. These practitioners may be privileged relying on the credentialing and privileging decisions of the distant site through a contact and if the distant site is a Medicare participating organization. If at any time the contract is cancelled, a telemedicine practitioner leaves the employ of the distant site organization, if membership or privileges lapse at the distant site, or if the State of Maine medical license expires, is suspended or revoked, the telemedicine practitioner shall be considered to have voluntarily relinquished all clinical privileges related to telemedicine. If credentialing is performed by the distant site organization, the Credentials SubCommittee will be provided an updated list of Practitioners providing services under the contract and credentialing arrangement will be evaluated at least annually. The Credentials Committee may request an audit of the distant site credentials files at any time. If the contract with the distant site organization includes such credentialing services, then all of the provisions of these Bylaws concerning quality data from such service providers are applicable.

> **Credentialing by Proxy.** If approved by the Medical Executive Committee, credentialing by proxy is allowable for telemedicine providers. These practitioners may be privileged relying on the credentialing and privileging decisions of the distant site through a contract and if the distant site is a Medicare participating organization. If the contract with the service provider includes such credentialing services, then all provisions of these Bylaws concerning quality data from such service providers are applicable. The Credentials Committee may request an audit of the distant site credentials files at any time. Additional processes shall be established in the Medical Staff policies and approved by the Medical Executive Committee and the Governing Body as necessary.

4.6 Other Clinical Staff

Individuals who are not Physicians, who are not members of the Medical Staff, Associate Professional Staff or Locum Tenens Allied Health Professionals, and who provide or assist in providing clinical services at the Hospital shall not be governed by these Bylaws, shall not be considered to hold Clinical Privileges, and shall be subject to the administrative policies of the Hospital.

4.6.B. With the approval of the Medical Executive Committee, Clinical Privileges may be granted to health professionals employed by the hospital or by entities contracted to provide services to the hospital as Medicare or other regulatory agencies or payors require such privileging. Such health professionals may include individuals performing procedures defined as surgery by CMS conditions of participation surgery chapter 482.51.

ARTICLE 5 PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

5.1 Application for Appointment

5.1.A **Form of Application**. All applications for appointment to the Staff shall be in writing, signed by the applicant, and submitted on a form prescribed by the Governing Body after consultation with the Medical Executive Committee. The application shall require detailed information concerning the applicant's professional qualifications, and shall include the following items:

(a) The names of at least three (3) persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence, training and experience, and ethical character;

(b) Information as to whether the applicant's membership status and/or clinical privileges have ever voluntarily or involuntarily been revoked, suspended, reduced or not renewed at any other hospital or institution, and as to whether his/her membership in local, state or national medical societies, or his/her license to practice any profession in any jurisdiction, has ever been voluntarily or involuntarily suspended, restricted, or terminated;

(c) Information as to whether the applicant's narcotic license has ever been voluntarily or involuntarily suspended, restricted, or revoked;

(d) Information concerning the applicant's malpractice experience, including all pending claims, settlements, and judgments, a consent to the release of information from his/her present and past professional liability insurance carrier(s), and proof of current liability insurance in the amounts required by the bylaws of Rumford Hospital;

(e) Information concerning the applicant's history of sanctions or disciplinary action taken by his/her specialty board or professional society for the immediate past ten (10) years; and

(f) Results of the National Practitioner Data Bank query.

(g) Application fee in accordance with the medical staff policy, all active, courtesy and locum tenens staff shall be required to pay application fees.

5.1.B **Applicant's Burden**. The applicant shall have the burden of producing adequate information for processing the application to allow a proper evaluation of his/her competence, experience, character, ethics, mental and physical well-being, and other qualifications, and for resolving any doubts about such qualifications. Any material misrepresentation in, or omission from, the application and related documents shall be grounds for denial of Clinical Privileges or corrective action regardless of when the misrepresentation or

omission is discovered. Notwithstanding anything to the contrary herein, the applicant will not be entitled to a hearing in the event of denial of Clinical Privileges or corrective action due to material misrepresentation in, or omission from, the application and related documents.

5.1.C **Submission and Distribution**. The completed application shall be submitted to the Medical Staff office. The Medical Staff office will distribute the application for review by the appropriate committees and/or individuals.

5.1.D **Applicant's Authorization, Consent, and Certification**. By applying for appointment to the Staff, each applicant thereby signifies the following:

(a) The applicant is willing to appear for interviews in regard to his/her application;

(b) The applicant authorizes the Hospital to consult with members of medical staffs of other hospitals/institutions with which the applicant has been associated and with others who may have information bearing on his/her competence and character, including mental and emotional stability, and ethical qualifications;

(c) The applicant consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the Clinical Privileges he/she requests as well as of his/her moral and ethical qualifications for Staff membership;

(d) The applicant releases from any liability all representatives of the Hospital and its Staff for their acts performed in good faith;

(e) The applicant certifies that he/she does not have any physical or mental disability that might interfere with his/her ability to provide quality patient care consistent with the Clinical Privileges he/she has requested with or without reasonable accommodation.

(f) The applicant certifies that during the term of his/her appointment and subsequent reappointments, if any, the applicant agrees to fully participate in Performance Working Groups as described in Section 11.2 and to fully participate in other quality improvement activities at the request of the Medical Executive Committee.

5.2 Appointment Process

5.2.A **Medical Staff Chief Review and Recommendation**. The Medical Staff Chief shall provide the Credentials Subcommittee with specific, written recommendations for delineating the practitioner's Clinical Privileges, and these recommendations will be included in the Credentials Subcommittee's report.

5.2.B **Credentials Subcommittee Review and Recommendation**. The Credentials Subcommittee's review shall include, without limitation, an examination of the applicant's character (including emotional stability), professional competence, qualifications, training, health, and ethical standing and the criteria set forth in Section 5.3.B. The Credentials Subcommittee shall determine, through its review and through information contained in references given by the applicant and other sources, including an appraisal by the Medical Staff Chief, whether the applicant meets all of the necessary qualifications for the category of Staff membership and the Clinical Privileges requested. Upon completion of the review of the application, the Credentials Subcommittee shall submit to the Medical Executive Committee the completed application and a recommendation that the practitioner be either provisionally appointed, rejected, or that the application be deferred for further consideration.

5.2.C **Medical Executive Committee Review and Recommendation**. After receipt of the application and the report and recommendation of the Credentials Subcommittee, the Medical Executive Committee shall promptly recommend to the Governing Body, through the President of Rumford Hospital or the designee, either provisional appointment, rejection, or deferral for further consideration. Except for those applicants qualifying for active medical staff membership by virtue of the provisions of Article 4.1.D., all recommendations for provisional appointment must also specifically recommend the Clinical Privileges to be granted, which may be qualified by probationary conditions relating to such Clinical Privileges. When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within a reasonable time with a subsequent recommendation for provisional appointment with specific Clinical Privileges or for rejection for Staff membership.

5.2.D **Governing Body Review and Action**. Upon receiving the recommendation of the Medical Executive Committee, the Governing Body shall take one (1) of the following actions: (i) grant the applicant provisional appointment, with or without conditions; (ii) reject the application; or (iii) defer the application for further consideration. If the Governing Body concludes that its action substantially conflicts with the recommendation of the Medical Executive Committee, the Governing Body and Medical Executive Committee will work together to attempt to resolve this conflict. The action of the Governing Body shall remain in effect, and shall not be stayed during the process. It is not the intent of this provision that the addition of conditions to an appointment, modification of recommended conditions or scope of privileges, or deferral of the application for further consideration constitutes substantial conflict.

5.3 Evaluation of Provisional Appointees

5.3.A **Medical Staff Review and Recommendation**. Before the expiration of any provisional appointment or reappointment, the Medical Staff Chief shall begin to review all pertinent information. Criteria for review of provisional status may include an assessment of patient care, documentation skills and interpersonal relationships demonstrated by the appointee during the probationary period. If

the level of activity in the facility is low or non-existent, the burden is on the appointee to provide sufficient information from the institutions in which he/she has practiced or from his/her office practice to satisfy the above criteria. Following the review of Medical Staff Chief, the Medical Staff Chief will make a written recommendation to the Credentials Subcommittee.

5.3.B **Credentials Subcommittee Review and Recommendation**. The Credentials Subcommittee shall conduct appropriate inquiry and review, including an assessment of the provisional appointee based on the criteria set forth in Sections 5.3.B.1 and 5.3.B.2. After completing its review, the Credentials Subcommittee shall recommend to the Medical Executive Committee that the provisional appointee be advanced to the applicable category of Staff, appointed to provisional status, or not appointed.

5.3.B.1 **First Criterion**. The first criterion will be a thorough review of patient charts for the purpose of assessing (i) effective documentation of "history and physical," (ii) proper use of consultants, (iii) appropriate discharge summaries, (iv) quality of patient care delivered, and (v) other applicable data.

5.3.B.2 **Second Criterion**. The second criterion will be an evaluation of the interpersonal relationships affected by the Practitioner during the provisional period, including the Practitioner's working rapport with other Practitioners and members of the health care delivery team. The Credentials Subcommittee shall give specific attention to any aspect of the Practitioner's behavior that appears to compromise the goals and objectives of quality clinical care.

5.3.C **Medical Executive Committee Review and Recommendation**. The Medical Executive Committee shall consider the recommendation of the Credentials Subcommittee and then forward its recommendation to the Governing Body for action.

5.3.D **Governing Body Review and Action**. Upon receiving the recommendation of the Medical Executive Committee, the Governing Body shall take one (1) of the following actions: (i) advance the provisional appointee to the applicable category of Staff, (ii) appoint the provisional appointee to another term of provisional appointment, with or without conditions, or (iii) terminate the provisional appointment and reject the application for Staff membership. If the Governing Body has not acted by the expiration date of a provisional appointment, the provisional appointment shall be deemed extended until the effective date of formal action by the Governing Body. If the Governing Body concludes that its action substantially conflicts with the recommendation of the Medical Executive Committee, the Governing Body and Medical Executive Committee will work together to attempt to resolve this conflict. The action of the Governing Body shall remain in effect, and shall not be stayed during the process. It is not the intent of this provision that the addition of conditions to an appointment,

modification of recommended conditions or scope of privileges, or deferral of the application for further consideration constitutes substantial conflict.

5.3.E **Rights of Provisional Appointees**. A provisional appointee whose appointment is terminated shall not have the rights accorded by these Bylaws to a member of the Medical Staff who has failed to be reappointed, except as provided in Section 3.4.C for provisional appointees to the Medical Staff.

5.4 Reappointment Process

5.4.A Term of Appointment

The term of a regular appointment to any category of the Staff shall be for up to two (2) years, except in the following instances:
A. The term of a regular appointment for Locum Tenens Staff will be set forth in Section 4.4.B.
B. The term for any physician in a non-ACGME accredited fellowship program shall be limited to duration of their participation in the program.

5.4.B **Medical Staff Chief Review and Recommendation**. The Medical Staff Chief shall review the reappointments of all Practitioners and transmit his/her comments to the Credentials Subcommittee.

5.4.C **Credentials Subcommittee Review and Recommendation**. The Credentials Subcommittee shall review all relevant available information regarding the Practitioner being considered for reappointment to determine its recommendations for reappointment and granting of Clinical Privileges for the ensuing term of appointment. The Credentials Subcommittee shall transmit such recommendations, in writing, to the Medical Executive Committee. In the event that the Credentials Subcommittee recommends non-reappointment or a change in Clinical Privileges, the Credentials Subcommittee shall document its reasons for such recommendation.

5.4.C.1 **Basis for Recommendations**. The Credentials Subcommittee's recommendation on the reappointment of a Practitioner and the Clinical Privileges to be granted upon reappointment shall be based on the following factors:

(a) Professional qualifications, based on a peer evaluation of documented clinical competence, including review of any patient, staff, or professional complaint concerning the applicant;

(b) Maintenance of active board certification in at least one (1) of the specialties in which the Practitioner actively provides services;

(c) Clinical judgment in the treatment of patients as demonstrated by peer review;

(d) Ethics and conduct;

(e) Participation in Performance Working Groups and other quality improvement activities;

(f) Attendance at Staff and committee meetings;

(g) Compliance with the bylaws of Rumford Hospital, these Bylaws, the Medical Staff Rules and Regulations, and Medical Staff policies;

(h) Cooperation with Hospital personnel;

(i) Proper medical use of the Hospital's facilities for his/her patients;

(j) Relations with other Practitioners;

(k) General attitude toward patients, the Hospital, and the public;

(l) Evidence of professional liability coverage consonant with the requirements of Rumford Hospital;

(m) Report of liability experience, which must be reviewed each time a Practitioner is evaluated for reappointment;

(n) Certification that the applicant does not have any physical or mental disability which might interfere with his/her ability to provide quality patient care consistent with the Clinical Privileges he/she has requested;

(o) Certification that the applicant is not impaired by any form of substance abuse;

(p) Information as to whether (i) the applicant's membership status and/or clinical privileges have ever voluntarily or involuntarily been revoked, suspended, reduced, or not renewed at any other hospital or institution, and (ii) the applicant's membership in any local, state or national medical societies, license to practice any profession in any jurisdiction, or narcotic license has ever been voluntarily or involuntarily suspended, restricted, or revoked;

(q) Information from the U.S. Department of Health and Human Services Office of Inspector General's list of excluded individuals;

(r) Certification that the applicant has never been convicted of any Class A, B, or C criminal offense;

(s) Certification that the applicant has never voluntarily surrendered or modified his/her privileges or resigned from medical staff membership while under, or to avoid, investigation or disciplinary action;

(t) Record of the applicant's professional performance and conduct at other institutions where he/she holds or has held privileges to practice;

(u) Results of the National Practitioner Data Bank query; and

(v) Certification of coverage arrangements consistent with these Bylaws.

Regarding clause (a), above, outside peer review will be used when, in the judgment of the Medical Staff President or President of Rumford Hospital, acting on behalf of the Medical Staff, there is not adequate expertise within the Hospital, there may be a conflict of interest, or in any other situation where the Medical Staff President or President of Rumford Hospital decides that outside peer review would be in the best interests of the safe and effective operations of the Hospital. The information required in clauses (a) through (v), above, may be limited to experience since the date of the most recent reappointment.

5.4.D **Medical Executive Committee Review and Recommendation**. After receipt of the application and the report and recommendation of the Credentials Subcommittee, the Medical Executive Committee shall determine whether to recommend to the Governing Body that (i) the applicant be reappointed to the Staff, (ii) the applicant not be reappointed to the Staff, or (iii) the applicant's application be deferred for further consideration. In the event that the Medical Executive Committee makes a recommendation for reappointment, the Medical Executive Committee shall specifically recommend the Clinical Privileges to be granted, which may be qualified by certain conditions. The Medical Executive Committee shall transmit its recommendations to the Governing Body promptly.

5.4.E **Governing Body Review**. After receipt of the application and the report and recommendation of the Medical Executive Committee, the Governing Body shall determine whether (i) the applicant will be reappointed to the Staff, (ii) the applicant will not be reappointed to the Staff, or (iii) the applicant's application will be deferred for further consideration. In the event that the Governing Body reappoints the applicant to the Staff, the Governing Body shall specify the

Clinical Privileges being granted, which may be qualified by certain conditions relating to such Clinical Privileges.

5.4.F **Deferred Action**. A recommendation by the Medical Executive Committee, or action of the Governing Body, to defer an application for further consideration shall be followed within a reasonable time with a subsequent recommendation for reappointment with specific Clinical Privileges or for rejection for Staff membership.

5.4.G **Conflict Management Process**. If the Governing Body concludes that its action substantially conflicts with the recommendation of the Medical Executive Committee, the Governing Body and Medical Executive Committee will work together to attempt to resolve this conflict. The action of the Governing Body shall remain in effect, and shall not be stayed during the process. It is not the intent of this provision that the addition of conditions to an appointment, modification of recommended conditions or scope of privileges, or deferral of the application for further consideration constitutes substantial conflict.

5.5 Continuing Medical Education

Reappointment to the Staff pursuant to Section 5.4 and continued active association with the Hospital will be dependent on meeting the following educational requirements:

5.5.A All members of the Staff will participate in CME; and

5.5.B All members of the Medical Staff shall meet the CME requirements of the Maine Board of Licensure in Medicine or the agency responsible for such Medical Staff members' particular educational certification, and all members of the Associate Professional Staff and Locum Tenens Allied Health Professionals shall meet the applicable board or organization's requirements for continuing education. At least fifty percent (50%) of the required educational hours shall be in the Practitioner's special area of practice.

ARTICLE 6 CLINICAL PRIVILEGES

6.1 Delineation of Clinical Privileges

Only members of the Staff shall be entitled to exercise Clinical Privileges in the Hospital. A Staff member shall be entitled to exercise only those Clinical Privileges specifically granted to him/her by the Governing Body, except as provided in Section 6.2 and Section 6.3.

6.1.A **Appointment**. Every application for appointment to the Staff must contain a request for the specific Clinical Privileges desired. The evaluation of such request shall be based upon the applicant's education, training, qualifications, experience, demonstrated competence, references, and other relevant information, including an appraisal by the Medical Staff Chief. The applicant shall have the burden of producing documentation to establish his/her qualifications, training, education, experience and demonstrated competency in the Clinical Privileges he/she requests.

6.1.B **Reappointment**. All members of the Staff will be reappointed, and their Clinical Privileges reviewed, as outlined in Section 5.4.

6.1.C **Requesting Additional Clinical Privileges**. The requirements set forth in this ARTICLE 6 shall also apply to a member of the Staff who requests additional Clinical Privileges other than during the reappointment process. The procedures to follow in such a case shall be the same as for an initial application for Clinical Privileges as set forth in Section 5.2.

6.1.D **New, Investigational, or Unproven Techniques**. Any request for Clinical Privileges that are new to the Practitioner, to the Practitioner's professional or medical discipline, or to the Hospital and might include investigational or unproven techniques shall be individually granted based on relevant criteria for competence, training, and experience.

6.1.E **Providing Care Via Telemedicine.** The Medical Staff shall determine which clinical services are appropriately delivered through Telemedicine according to commonly accepted quality standards. If a Practitioner prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at the Hospital via Telemedicine, the Practitioner shall be credentialed and privileged through the Staff mechanisms set forth in these Bylaws. The Staff may use credentialing information from another licensed hospital only if the decision to delineate Clinical Privileges is made at the Hospital.

6.2 Temporary Admitting and Clinical Privileges

6.2.A **General Temporary Clinical Privileges**. Upon receipt of an application for Medical Staff membership from an appropriately licensed practitioner who meets the qualifications for Clinical Privileges set forth in Section 3.3 and Section 5.1, as appropriate to their discipline, the President of Rumford Hospital, or in his/her absence the Medical Staff President, may grant temporary Clinical Privileges to

the practitioner upon receipt of the following: (i) verification of active State of Maine licensure, (ii) verification of current professional liability insurance and past claims history, (iii) verification of acceptable competence and training to perform the functions for which Clinical Privileges would be granted, (iv) results of a National Practitioner Data Bank query, (v) the written concurrence of the Medical Staff Chief and the Medical Staff President, and (vi) confirmation that the approved number of reference phone calls have been completed and the Credentials Subcommittee has reviewed the application.

6.2.A.1 **Urgent Need**. Notwithstanding anything to the contrary in this Section 6.2.A, the President of Rumford Hospital or the Medical Staff President, as applicable, may grant temporary Clinical Privileges absent completion of reference phone calls and Credentials Subcommittee review in the event of an urgent need for a practitioner to provide a service not otherwise available by Staff members.

6.2.B **Temporary Clinical Privileges for Care of a Specific Patient**. Temporary Clinical Privileges for the care of a specific patient may be granted by the President of Rumford Hospital, or in his/her absence the Medical Staff President, to a practitioner who is not an applicant for membership in the same manner and upon the same conditions as set forth in Section 6.2.A only if such practitioner provides a signed acknowledgment that (i) he/she has received and read copies of these Bylaws and the Medical Staff Rules and Regulations and (ii) he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary Clinical Privileges.

6.2.C **Duration of Clinical Privileges**. Temporary Clinical Privileges granted pursuant to Sections 6.2.A and 6.2.B shall be restricted to not more than sixty (60) days (with only one (1) sixty (60) day renewal, if necessary). Upon the expiration of a practitioner's temporary Clinical Privileges, such practitioner may attend patients in, or admit patients to, the Hospital only if (i) in the case of a practitioner granted Clinical Privileges under Section 6.2.A, such practitioner has been granted provisional membership on the Medical Staff pursuant to Section 3.4.C; or (ii) in the case of a practitioner granted Clinical Privileges under Section 6.2.B, such practitioner has applied for membership on the Medical Staff.

6.2.D **Clinical Privileges and Rights**. Practitioners who have been granted temporary Clinical Privileges under this Section 6.2 shall exercise only those Clinical Privileges delineated with respect to patient care. Such Practitioners shall not exercise any of the other Clinical Privileges and rights associated with permanent Staff membership (*e.g.*, voting, holding office, or due process rights).

6.2.E **Supervision**. In exercising temporary Clinical Privileges, a practitioner shall act under the supervision of the Medical Staff Chief. The Medical Staff Chief shall perform concurrent review of such practitioner's care for appropriateness and quality and will report his/her findings to the Medical Executive Committee.

6.2.F **Termination**. Notwithstanding any provision of these Bylaws to the contrary, the President of Rumford Hospital may immediately terminate temporary Clinical Privileges granted under this Section 6.2, at any time if he/she believes that the practitioner granted temporary Clinical Privileges has failed to comply with these Bylaws or the Medical Staff Rules and Regulations or has not provided or documented care of appropriate quality.

6.2.F.1 **Notification**. In the event that the President of Rumford Hospital terminates a practitioner's temporary Clinical Privileges, such practitioner shall be notified in writing of the action.

6.2.F.2 **Patients**. The Medical Staff Chief or, in his/her absence, the Medical Staff President, shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the Hospital.

6.2.G **Temporary Disaster Response Plan Clinical Privileges**. In addition to the foregoing provisions in this Section 6.2 for temporary Clinical Privileges, temporary Clinical Privileges may also be granted in connection with implementation of any disaster response plan approved by Rumford Hospital.

6.2.G.1 **General**. Clinical Privileges may be granted under this Section 6.2.G to an appropriately licensed practitioner by the President of Rumford Hospital, the Medical Staff President or the Medical Staff Chief upon the basis of information then available which may reasonably be relied upon. The individual granting such temporary Clinical Privileges shall make reasonable attempts to verify active State of Maine licensure, current professional liability insurance, past claims history, and acceptable competence and training to perform the functions for which the Clinical Privileges are requested. The lack of such verification shall not preclude the individual granting the temporary Clinical Privileges from acting on his/her present knowledge and belief and the granting or denial of such Clinical Privileges in these specific circumstances shall be within the sole discretion of such individual.

6.2.G.2 **Duration of Clinical Privileges**. Clinical Privileges granted under this Section 6.2.G shall terminate upon revocation of such Clinical Privileges by any individual having the authority to grant the Clinical Privileges or after seventy-two (72) hours, whichever occurs first. Temporary Clinical Privileges granted under this Section 6.2.G shall not be renewed.

6.3 Emergency Clinical Privileges

For the purpose of this Section 6.3, an "Emergency" means a situation in which serious permanent harm would result to a patient or in which (i) the life of a patient is in immediate danger and any delay in administering treatment would add to the danger and (ii) there is no

reasonable or safe alternative to making an emergency appointment in order to assure appropriate patient care.

6.3.A **General**. In the case of Emergency, any Practitioner on the Medical Staff, and any resident in the Hospital's residency program, to the degree permitted by his/her license and regardless of Staff status or level of Clinical Privileges, shall be permitted and assisted to do everything possible to save the life of a patient, or to save the patient from serious harm, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable.

6.3.B **Duration of Clinical Privileges**. When an Emergency no longer exists, and in no case more than seventy-two (72) hours after the Emergency appointment, the Practitioner must request the Clinical Privileges necessary to continue to treat the patient. An Emergency appointment is not renewable. In the event such necessary Clinical Privileges are denied or he/she does not desire to request such necessary Clinical Privileges, the patient shall be assigned to an appropriate member of the Staff. For purposes of clarity, this Section 6.3.B shall be construed to be consistent with the Hospital's policies on patient consent to treatment.

6.4 Reduction or Surrender of Clinical Privileges and Resignation

6.4.A **Submission of Written Request**. At any time, a Practitioner may voluntarily reduce his/her Clinical Privileges or resign from the Medical Staff by submitting a written and signed request to the senior Hospital administrator responsible for medical affairs or to the Medical Staff President, and such reduction or resignation shall take effect immediately upon receipt, provided that no corrective action is pending.

6.4.B **Absence from Medical Staff**. Absence from the Medical Staff for greater than forty (40) days, as provided in Section 3.6.C for leaves of absence, shall constitute a voluntary surrender of Clinical Privileges. If no corrective action is pending, such voluntary reduction or resignation shall not be considered disciplinary action for any purpose.

6.4.C **Pending Corrective Action**. If corrective action is pending at the time of a voluntary surrender of Clinical Privileges under Sections 6.4.A or 6.4.B, the Governing Body shall decide whether to accept or reject such voluntary surrender of Clinical Privileges.

ARTICLE 7 CORRECTIVE ACTION

7.1 Investigation

7.1.A **Requesting or Initiating a Corrective Action Investigation**. Whenever the conduct or competence of a Practitioner may be inconsistent with good patient care or the effective operation of the Hospital, whether such acts or omissions constitute a single serious incident or a pattern of behavior, an investigation to determine whether corrective action should be recommended may be initiated by the Medical Executive Committee in its discretion or may be requested by the Medical Staff President, the Medical Staff Chief, the President of Rumford Hospital or the Executive Committee of the Governing Body. Such requests for an investigation shall be submitted to the Medical Executive Committee. If the Medical Executive Committee, in its discretion, proceeds to take action upon a request for an investigation, the Medical Executive Committee shall promptly notify the affected Practitioner, whenever practicable, of the investigation. In addition to notifying the affected Practitioner, the Medical Executive Committee shall promptly provide written notice to the President of Rumford Hospital and the Medical Staff President of all requests for corrective action received by the Medical Executive Committee or investigations initiated in its discretion and shall continue to keep the President of Rumford Hospital and the Medical Staff President fully informed of all actions taken in connection therewith.

7.1.B **Grounds for Corrective Action**. Grounds for initiating corrective action shall include, but not be limited to, the following:

(a) Material violation of (i) these Bylaws; (ii) the Medical Staff Rules and Regulations, including the “Code of Conduct;” (iii) Hospital policies, including the Hospital’s disruptive behavior policy, as in effect from time to time; or (iv) Staff policies;

(b) Any incidences of disruptive behavior or inappropriate communication to Practitioners, Hospital staff, patients, family members, or visitors;

(c) Provision of substandard patient care;

(d) Violation of the ethical standards of the Practitioner’s profession as set forth by a recognized national association or board of such profession;

(e) Imposition of sanctions for violations of Medicare or Medicaid statutes or regulations;

(f) Unprofessional conduct toward patients, other Practitioners, or Hospital staff; and

(g) Disciplinary action by the Maine Board of Licensure in Medicine, the Maine Board of Osteopathic Licensure, the Maine Board of Dental Examiners, other state licensing boards, or insurers.

7.1.C **Investigation Committee**. At the request of the Practitioner or on its own motion, prior to making its report, the Medical Executive Committee may refer the matter to an investigation committee ("Investigation Committee"), which will be a Special Committee with the composition set forth in Section 7.1.C.1 or 7.1.C.2. The Investigation Committee shall exercise the authority and assume the responsibilities of the Medical Executive Committee with respect to investigating the Practitioner's competence or conduct. After the Investigation Committee completes its investigation, it shall report its findings, conclusions, and recommendations to the Medical Executive Committee.

7.1.C.1 **General Composition of the Investigation Committee**. The Medical Staff President in consultation with the Medical Staff Chief shall appoint to the Investigation Committee not less than three (3) nor more than five (5) Voting Medical Staff Members and may also appoint one (1) or more individuals who are not members of the Medical Staff to serve as non-voting advisors or consultants, or as a presiding officer. The Chair of the Investigation Committee will be appointed by the Medical Staff President in consultation with the Medical Staff Chief. The Investigation Committee shall serve as a professional competence committee pursuant to the Maine Health Security Act (Me. Rev. Stat. tit. 24, §§ 2501–2511).

7.1.C.2 **Appointment of a Joint Investigation Committee**. In lieu of referring the matter to an Investigation Committee with the composition set forth in Section 7.1.C.1, the Medical Executive Committee may refer the matter to a joint investigation committee ("Joint Investigation Committee") which shall function as the Investigation Committee and shall include (i) certain members of the Peer Review Committee of the Medical Staff of CMMC who shall be selected by CMMC in consultation with the Medical Staff President, and (ii) at least one (1) member of the Active Medical Staff of Rumford Hospital who is appointed by the Medical Staff President. At the discretion of the Medical Staff President, the Joint Investigation Committee may include other members, including, without limitation, other Voting Medical Staff Members or individuals who are not members of the Medical Staff to serve as non-voting advisors or consultants. The Joint Investigation Committee shall serve as a professional competence committee pursuant to the Maine Health Security Act (Me. Rev. Stat. tit. 24, §§ 2501–2511).

7.1.D **Opportunity to Appear**. The Practitioner shall be offered an opportunity to appear before the body that conducts the investigation pursuant to this Section 7.1, either the Medical Executive Committee or the Investigation Committee, before a recommendation is made by such body.

7.1.E **Medical Executive Committee Action**. After completing its investigation or receiving a report from the Investigation Committee of its findings, conclusions,

and recommendations, the Medical Executive Committee shall take one (1) of the following actions:

(a) Notify the Practitioner that no further action will be taken;

(b) The practitioner should (i) be warned, admonished or reprimanded, or (ii) be subject to probation or a requirement for consultation upon such terms and conditions as the Medical Executive Committee deems appropriate.

(c) All or any portion of the practitioner's privileges should be summarily suspended pursuant to section 7.2.A. Impose a probation or requirement for consultation upon such terms and conditions as it deems appropriate;

(d) The Medical Executive Committee should recommend to the Governing Body that the Practitioner's Clinical Privileges be restricted, reduced, suspended, or revoked; or

(e) The Medical Executive Committee should recommend to the Governing Body that the Practitioner's membership on the Staff be suspended or terminated; or

(f) Refer the matter back to the Investigation Committee for further investigation.

Upon taking any action set forth in clauses (i) through (iv), above, the Medical Executive Committee shall notify the Practitioner, and the person or body who requested the investigation, of the Medical Executive Committee's final actions or recommendations. Upon referring the matter back to the Investigation Committee as set forth in clause (e), above, the Medical Executive Committee shall await the Investigation Committee's further findings, conclusions, and recommendations before taking action pursuant to this Section 7.1.E. In addition to taking one of the forgoing actions, the Medical Executive Committee may summarily suspend all or any portion of the Practitioner's privileges pursuant to Section 7.2.A.

7.1.F **Governing Body Notification**. In the event that the Medical Executive Committee has not already done so pursuant to Section 7.1.E, the Medical Executive Committee shall report its actions and the findings, conclusions, and recommendations to the Governing Body. Notwithstanding anything to the contrary in this Section 7.1 and except as set forth in Sections 3.4.C, 7.2, and 7.3, only the Governing Body shall have the authority to take action that constitutes a restriction, reduction, suspension, or revocation of Clinical Privileges or a suspension or termination of membership on the Staff.

7.1.G **Adjudication**. Any final order, judgment of conviction, or plea of guilty, no contest, or *nolo contendere* in any criminal, civil, or administrative proceeding shall constitute conclusive evidence of the matters alleged therein for purposes of any proceeding under this ARTICLE 7.

7.1.H **Sharing Information with Other Professional Review Bodies**. As part of the peer review process, any person acting on behalf of the Medical Staff may share peer review records and related information regarding a particular Physician with other professional review bodies of CMMC or CMMC affiliated hospital who may engage in similar peer review activities with respect to such Physician. Such sharing of information will not result in a waiver of any privilege against disclosure under state or federal law, including, without limitation, under the Maine Health Security Act (Me. Rev. Stat. tit. 24, §§ 2501–2511).

7.2 Summary Suspension

7.2.A **Authority**. The Medical Staff President, the Medical Staff Chief, the President of Rumford Hospital, the Medical Executive Committee, or the Executive Committee of the Governing Body shall have the authority to summarily suspend all, or any portion, of the Clinical Privileges of a Practitioner whenever such person or body concludes that there is a substantial risk that continuing such Clinical Privileges until a hearing could be held would be likely to jeopardize the health or safety of any patient, Rumford Hospital employee, or another Practitioner. Such summary suspension may be made effective immediately upon notice to the Practitioner. The party imposing the suspension shall notify the Medical Executive Committee promptly of the summary suspension.

7.2.B **Medical Executive Committee Review**. The Medical Executive Committee shall convene promptly to review the basis for the summary suspension.

7.2.B.1 **Investigation Committee**. At the request of the Practitioner or on its own motion the Medical Executive Committee may refer the matter to an Investigation Committee, which functions as a Special Committee and has the composition set forth in Section 7.1.C.1. The Investigation Committee shall exercise the authority and assume the responsibilities of the Medical Executive Committee with respect to reviewing the summary suspension. After the Investigation Committee completes its review, it shall report its findings, conclusions, and recommendations to the Medical Executive Committee . The Investigation Committee shall serve as a professional competence committee pursuant to the Maine Health Security Act (Me. Rev. Stat. tit. 24, §§ 2501–2511).

7.2.C **Opportunity to Appear**. A Practitioner whose Clinical Privileges have been summarily suspended shall be offered an opportunity to appear personally and respond before the Medical Executive Committee or Investigation Committee no later than ten (10) days after the imposition of the suspension, unless the Practitioner requests additional time.

7.2.D **Medical Executive Committee Action and Notification**. After receiving the findings, conclusions, and recommendations of the Investigation Committee, the Medical Executive Committee may uphold, revoke, or revise the terms of the

Practitioner's summary suspension. The Medical Executive Committee shall report its actions to the Practitioner and to the Governing Body.

7.2.E **Alternative Medical Coverage**. Immediately upon the imposition of summary suspension, the Medical Staff President or the Medical Staff Chief shall have authority to provide for alternative medical coverage for the patients of the suspended Practitioner still in the Hospital at the time of such suspension. When practical, patients' wishes shall be considered in the selection of such alternative Practitioner.

7.3 Automatic Suspension

7.3.A **Suspension or Revocation of License**. Action by the relevant state licensing body revoking or suspending the license of a Practitioner shall automatically suspend all of his/her Clinical Privileges, and unless the license is restored within ninety (90) days, the Practitioner's Clinical Privileges and Staff membership shall be automatically terminated.

7.3.B **Delinquent Medical Records**. Medical record completion policies are delineated in the Rumford Hospital Medical Staff Medical Records Policy and Procedures. Failure to comply with those policies will result in consequences, up to and including suspension of all privileges, until the medical records are completed. Repeated noncompliance with medical record completion policies may result in permanent loss of privileges.

7.3.C **Loss of Active Membership at a Licensed Hospital**. The Clinical Privileges of a member of the Courtesy Medical Staff whose appointment to the Medical Staff is conditioned upon membership on the active staff at a licensed hospital and is no longer a member of the active staff of any other licensed hospital shall be suspended automatically, and unless written evidence of active staff membership at another licensed hospital is provided to the Medical Staff office within ninety (90) days, the Practitioner's Clinical Privileges and Staff membership shall be automatically terminated.

7.3.D **Lapse In Liability Insurance**. The Clinical Privileges of a Practitioner shall be automatically suspended in the event of a lapse in professional liability insurance coverage as specified in Section 3.3.A.6 and shall not be reinstated until the Practitioner produces satisfactory evidence of coverage.

7.3.E **No Appeal Rights**. Automatic suspensions under this Section 7.3 shall not confer on the affected Practitioner any right to appellate review set forth in ARTICLE 8.

7.3.F **Enforcement**. It shall be the duty of the Medical Staff President to cooperate with the President of Rumford Hospital in enforcing all automatic suspensions.

ARTICLE 8 ACTION ON ADVERSE RECOMMENDATION

8.1 Hearing Rights

In the event that the Medical Executive Committee sends a member of the Active Medical Staff or Courtesy Medical Staff notice of an adverse recommendation relating to restriction, reduction, suspension, denial, or revocation of Clinical Privileges, denial of reappointment, or suspension or termination of Medical Staff membership, such practitioner may deliver a written response to the President of Rumford Hospital on behalf of the Governing Body not more than ten (10) days after such practitioner of the Medical Staff receives notice of the adverse recommendation.

8.1.A **No Response**. If the President of Rumford Hospital does not receive such practitioner's written response within the ten (10) day period, the Governing Body may take final action on the recommendation without further notice to such member.

8.1.B **Timely Response**. If the President of Rumford Hospital receives such practitioner's written response within the ten (10) day period, the Governing Body shall proceed to consider action on the recommendation in accordance with its procedures and the bylaws of Rumford Hospital. If (i) such *practitioner* did not have an opportunity to be heard before the Medical Executive Committee made the adverse recommendation and (ii) the Governing Body is considering adverse action, then such practitioner will be given an opportunity for a hearing before the Governing Body takes final adverse action.

8.2 Employment Agreement Controls

Not withstanding any provisions of these Bylaws to the contrary herein, if (i) there is a written employment agreement between a member of the Medical Staff who is employed by the Hospital, CMMC, or a partnership or professional association with a contract to provide services at the Hospital or CMMC and (ii) such employment agreement contains an express provision relating to restriction, reduction, suspension, denial or revocation of Clinical Privileges, denial of reappointment, or suspension or termination of Medical Staff membership, then action under any such provision of the employment agreement shall not entitle such member to the hearing rights set forth in this Section 8.2.

8.3 Summary Suspension

In the case of a summary suspension of Clinical Privileges, the affected practitioner may deliver a written request for restoration of Clinical Privileges to the President of Rumford Hospital on behalf of the Governing Body not more than ten (10) days after such practitioner receives notice that the Medical Executive Committee has declined to fully restore suspended Clinical Privileges.

8.3.A **No Response**. If a written request from such practitioner is not delivered to the President of Rumford Hospital within the ten (10) day period, the Governing Body may take final action without further notice to the practitioner.

8.3.B **Timely Response**. If the President of Rumford Hospital receives such practitioner's written request within the ten (10) day period, the Governing Body shall proceed to consider action on the suspension in accordance with its procedures and the bylaws of Rumford Hospital. The practitioner's timely written request shall not suspend the action of the Medical Executive Committee, and the summary suspension of the practitioner's Clinical Privileges shall remain in effect unless and until the Governing Body takes contrary action.

ARTICLE 9 OFFICERS

9.1 Officers of the Medical Staff

The Officers of the Medical Staff shall be a Medical Staff President, a Medical Staff Chief, and a Medical Staff Vice Chief. The Medical Staff President shall ordinarily be the person serving from time to time as Division Chief of RHPG, as designated by the President of Central Maine Medical Group, an unincorporated division of CMMC. The Medical Staff Chief and Medical Staff Vice Chief shall be elected by the Medical Staff as set forth in Section 9.3.

9.2 Qualifications of Officers

Officers of the Medical Staff must be members of the Active Medical Staff at the time of appointment or nomination and election and must remain members of the Active Medical Staff in good standing during their term of office. The failure of an Officer of the Medical Staff to maintain status as a member of the Active Medical Staff in good standing during their term of office shall immediately create a vacancy in the office involved.

9.3 Election of the Medical Staff Chief and Medical Staff Vice Chief

9.3.A **General**. The Medical Staff Chief and Medical Staff Vice Chief will be elected at the annual meeting of the Medical Staff from nominees selected by the Nominating Committee. Only Voting Medical Staff Members shall be eligible to vote in the election of the Medical Staff Chief and Medical Staff Vice Chief. It is the general intent of the Medical Staff that the Medical Staff Vice Chief will be elected to the office of Medical Staff Chief at the expiration of the Medical Staff Chief's term.

9.3.B **Nominating Committee**. The Medical Executive Committee may appoint an *ad hoc* nominating committee ("Nominating Committee"), which will be a Special Committee, with responsibility for nominating qualified members at large from the Active Medical Staff for election to the offices of Medical Staff Chief and Medical Staff Vice Chief. The Nominating Committee shall solicit input from the Medical Staff before making such nominations. In the event that the Medical Executive Committee does not appoint the Nominating Committee, the Medical Executive Committee shall fulfill the responsibilities of the Nominating Committee.

9.3.C **Procedure**. The Nominating Committee or the Medical Executive Committee, as applicable, shall ordinarily present its slate of nominees at the November meeting of the Medical Staff. Medical Staff members may make additional nominations from the floor only at the Medical Staff meeting during which the Nominating Committee or the Medical Executive Committee, as applicable, presents its slate of nominees. If there are three (3) or more nominees for an office, the candidate receiving the majority of votes shall be elected to that office. If a majority is not obtained on the first ballot, the candidate receiving the lowest number of votes shall be eliminated successively until a majority is reached.

9.4 Term of Office

The Medical Staff Chief and Medical Staff Vice Chief shall serve for two (2) successive years from his/her election date or until a successor is appointed or elected. The Medical Staff Chief and Medical Staff Vice Chief shall take office at the annual January meeting of the Medical Staff.

9.5 Vacancies in Office

9.5.A **Vacancy in the Office of Medical Staff Chief**. In the event that the Medical Staff Chief is temporarily unable to fulfill the responsibilities of his/her office, the Medical Staff Vice Chief shall assume such responsibilities until the Medical Staff Chief is able to resume his/her duties. In the event that, for any reason, the Medical Staff Chief is unable to complete his/her term of office, the Medical Staff Vice Chief shall assume the office of Medical Staff Chief, and the office of Medical Staff Vice Chief will be filled pursuant to Section 9.5.B.

9.5.B **Vacancy in the Office of Medical Staff Vice Chief**. If, for any reason, the Medical Staff Vice Chief is unable to complete his/her term of office, an election to fill the office of Medical Staff Vice Chief will be held pursuant to Section 9.3. The Medical Executive Committee may appoint a member of the Active Medical Staff to assume the office of Medical Staff Vice Chief until a new Medical Staff Vice Chief is elected.

9.5.C **Vacancy in the Office of the President of the Medical Staff**. In the event of a vacancy in the office of the RH Medical Staff President, the President of CMMG shall appoint a replacement. If such appointment is not made within 30 days, the Medical Executive Committee shall appoint an acting medical staff President until such time as the President of CMMG makes an appointment.

9.6 Removal of Medical Staff Chief and Medical Staff Vice Chief

The Medical Staff Chief or Medical Staff Vice Chief may be removed from his/her office for cause upon a two-thirds (2/3) vote of the Voting Medical Staff Members. The office of the removed Medical Staff Chief or Medical Staff Vice Chief will be filled pursuant to Section 9.5.

9.7 Duties of Officers

9.7.A **Medical Staff President**. The Medical Staff President shall serve as the chief administrative officer of the Medical Staff and shall perform the following duties:

(a) Act in coordination and cooperation with the President of Rumford Hospital in all matters of mutual concern within the Hospital;

(b) Act in coordination and cooperation with the Medical Staff Chief in all matters of mutual concern within the Hospital and the Medical Staff;

(c) Serve as Chair of the Medical Executive Committee; or with his/her concurrence the Chief of Staff may chair the committee.

(d) Appoint members to Special Committees formed by the Medical Executive Committee;

(e) Have the right to attend all Performance Working Group meetings in his/her discretion;

(f) Be responsible for the enforcement of these Bylaws and the Medical Staff Rules and Regulations, for implementation of sanctions where sanctions are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner;

(g) Receive and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide quality clinical care;

(h) In coordination with the Medical Staff Chief, serve as an official spokesperson for the Medical Staff;

(i) Attend meetings of the Governing Body to provide effective communication among the Medical Staff, Hospital administration, and the Governing Body; and

(j) Meet at least monthly with representatives of the Hospital administration to discuss matters of mutual concern and interest. These meetings may be informal and no agenda or minutes shall be required.

9.7.B **Medical Staff Chief**. The Medical Staff Chief shall perform the following duties:

(a) Act in coordination and cooperation with the Medical Staff President in all matters of mutual concern within the Hospital and the Medical Staff;

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

(c) Serve as Chair of the Credentials Subcommittee;

(d) Recommend to the Medical Executive Committee individuals to serve as members and Chairs of Performance Working Groups;

(e) Represent the views, policies, needs, and grievances of the Medical Staff to the Governing Body and the Hospital administration, including the President of Rumford Hospital;

(f) In coordination with the Medical Staff President, serve as an official spokesperson for the Medical Staff;

(g) Attend meetings of the Governing Body to provide effective communications among the Medical Staff, Hospital administration, and Governing Body; and

(h) At the invitation of the Medical Staff President, attend the Medical Staff President's monthly meetings with the Hospital administration to discuss matters of mutual concern and interest.

(i) To serve as chair, if requested, by the President of the Medical Staff.

9.7.C **Medical Staff Vice Chief**. The Medical Staff Vice Chief shall perform the following duties:

(a) Assume the duties and authority of the Medical Staff Chief in the event of a vacancy in the office of Medical Staff Chief; and

(b) Perform such other duties as the Medical Staff Chief may assign or as may be delegated by these Bylaws or the Medical Executive Committee.

ARTICLE 10 ORGANIZATION OF THE MEDICAL STAFF

10.1 Organization of the Medical Staff

10.1.A The medical staff shall be organized using a medical staff committee of the whole structure.

10.1.B The Medical Executive Committee may organize the Medical staff into clinical areas for purposes of designating categories of Clinical Privileges or as necessary to further the Medical Staff's quality and peer review activities. The Medical Executive Committee may create such organization through the adoption or revision of staff policies without amending these Bylaws.

ARTICLE 11 COMMITTEES AND MEETINGS

11.1 Medical Executive Committee

11.1.A **Chair**. The Medical Staff President will be the Chair of the Medical Executive Committee.

11.1.B **Composition**.

11.1.B.1 **Voting Members**. The voting membership of the Medical Executive Committee shall consist of (i) the Medical Staff President, (ii) the Medical Staff Chief and (iii) the Medical Staff Vice Chief.

11.1.B.2 **Non-Voting Members**. The non-voting membership of the Medical Executive Committee shall consist of (i) the President of Rumford Hospital, (ii) the senior Hospital administrator responsible for quality, (iii) the Chief Nursing Officer, and (iv) a member of the Governing Body designated by the Governing Body.

11.1.B.3 **Qualifications**. No member of the Medical Staff shall be ineligible for membership on the Medical Executive Committee solely based on medical discipline or specialty. A majority of the voting members of the Medical Executive Committee shall be fully licensed and actively practicing in the Hospital.

11.1.C **General Duties**. The Medical Executive Committee shall have the duties set forth in these Bylaws, including, without limitation, the following duties delegated by the Medical Staff:

(a) To act for the Medical Staff in the intervals between Medical Staff meetings within the scope of its responsibilities as defined by the Voting Medical Staff Members, subject to (i) such limitations as may be imposed by these Bylaws and (ii) the authority of the Voting Medical Staff

Members to remove duties or authority granted to the Medical Executive Committee by amending these Bylaws pursuant to Section 17.1;

(b) To request, receive, review, and act upon reports, recommendations and guidance from Performance Working Groups, committees, Officers of the Medical Staff, and CMMC, including, but not limited to, (i) reports and recommendations concerning performance improvement activities and other quality initiatives, and (ii) quality and utilization management monitoring reports;

(c) To implement and amend policies of the Medical Staff;

(d) To amend on behalf of the voting Medical Staff members, Medical Staff Rules and Regulations pursuant to section 17.

(e) To develop and maintain methods for the protection and care of patients and others in the event of internal or external disaster;

(f) To set objectives for establishing, maintaining and enforcing professional standards within the Hospital and for the continuing improvement of the quality of care rendered in the Hospital (including, but not limited to, infection control and pharmacy and therapeutics practices) and to assist in developing programs to achieve these objectives through (i) direct Medical Executive Committee action, (ii) creation of Medical Staff committees, Performance Working Groups and Special Committees as appropriate, all of which shall report to the Medical Executive Committee, and (iii) coordination and collaboration with the Clinical Excellence / Quality and Safety Committee and other committees of CMMC;

(g) To provide for the preparation of all programs, either directly or through delegation to a program committee or other suitable agent;

(h) To create the appropriate Medical Staff committee structure and Performance Working Group structure to carry out necessary duties, including by designating Special Committees as appropriate;

(i) To appoint members to, and the Chairs of, all Performance Working Groups upon the recommendation of the Medical Staff Chief;

(j) To oversee the activities of all Performance Working Groups and Special Committees;

(k) To designate an *ad hoc* Bylaws Committee, which will function as a Special Committee, to conduct a review from time to time of the Medical Staff Bylaws and present recommended revisions to the Medical Executive Committee;

(l) To establish the amount of annual Medical Staff dues and assessments for each category of Medical Staff membership and to establish the amount of fees paid by applicants to the Staff;

(m) To designate a member of the Medical Executive Committee to account for and be custodian of all funds, collect dues, and disburse such monies to settle legitimate bills incurred by the Medical Staff and pay other sums as may be directed by authorized members of the Medical Staff;

(n) To establish an annual budget for Medical Staff activities that reflects the anticipated expenses and income for the coming year;

(o) To fulfill the Medical Staff's accountability to the Governing Body for the quality of clinical care rendered to all Hospital patients;

(p) To provide liaison among the Medical Staff, the President of Rumford Hospital and the Governing Body;

(q) To recommend action to the President of Rumford Hospital on matters of a medico-administrative nature;

(r) To make recommendations on Hospital management to the Governing Body through the President of Rumford Hospital;

(s) To recommend to the Peer Review Subcommittee the mechanism for a fair hearing process;

(t) To ensure the Medical Staff is apprised of the requirements of regulatory agencies and accreditation bodies and the status of compliance with these requirements;

(u) To assist in obtaining and maintaining accreditation;

(v) To take all reasonable actions to ensure the existence of professional and ethical conduct and competent clinical performance on the part of all members of the Medical Staff and to report all such actions to the Governing Body;

(w) To implement a process to identify and manage matters of individual health for Practitioners, in accordance with Section 11.1.G which is separate from actions taken for disciplinary purposes and which includes making referrals to the MMA Medical Professionals Health Program, as appropriate;

(x) To establish a mechanism for dispute resolution between and among members of the Staff involving the care of a patient;

(y) To report at general Medical Staff meetings;

(z) To designate a member of the Medical Executive Committee to maintain minutes and a permanent record of Medical Executive Committee proceedings and actions and to transmit such minutes and record to the Medical Staff and Governing Body; and

(aa) To make recommendations directly to the Governing Body for its approval, including recommendations on the following: (i) the Medical Staff's structure; (ii) the mechanism used to review credentials and to delineate individual Clinical Privileges; (iii) the mechanism by which Medical Staff membership may be terminated; (iv) the mechanism for fair-hearing procedures; (v) individuals for Medical Staff membership; (vi) the delineation of Clinical Privileges for Practitioners privileged through the Medical Staff process; (vii) participation of the Medical Staff in organization performance-improvement activities; (viii) the Medical Executive Committee's review of, and actions on, reports of Performance Working Groups, Special Committees, and other activity groups; and (ix) sources of clinical services to be provided by consultation, contractual arrangements, or other agreements.

11.1.D **Peer Review Duties**. In addition to the general duties set forth in Section 11.1.C, the Medical Executive Committee shall have the following duties with respect to peer review:

(a) To conduct corrective action investigations when requested as set forth in Section 7.1 and to report its findings, conclusions, and recommendations from such investigations to the Governing Body;

(b) To review periodically all information available regarding the performance and competence of Practitioners and to conduct, as appropriate, so-called "Focused Professional Practice Evaluations" to evaluate the privilege-specific competence of a Practitioner who does not have documented evidence of competently performing certain Clinical Privileges;

(c) To review clinical and safety outcomes for major illnesses and procedures against national benchmarks;

(d) To make recommendations to Hospital administration and Staff regarding priorities for care redesign, performance improvement, and the use of technology;

(e) To make recommendations to the Hospital's continuing medical education and risk management departments regarding priorities for educational activities and risk management activities;

(f) To make available to the Credentials Subcommittee its files relating to performance and competence reviews, including, but not limited to, documentation of its findings, recommendations, and conclusions;

(g) To appoint and refer matters to an *ad hoc* Investigation Committee on its own motion or at the request of the Practitioner being investigated pursuant to Section 7.1;

(h) To maintain written reports and minutes of its peer review-related activities; and

(i) To perform such other functions as specified in these Bylaws.

11.1.E **Meeting Frequency**. The Medical Executive Committee shall hold meetings no less than ten (10) times annually. The Medical Executive Committee shall meet in consultation with the Governing Body as requested.

11.1.F **Credentials Subcommittee**. The Credentials Subcommittee shall be a subcommittee of the Medical Executive Committee.

11.1.F.1 **Chair**. The Medical Staff Chief will be the Chair of the Credentials Subcommittee.

11.1.F.2 **Composition.** The members of the Credentials Subcommittee shall be selected by the Medical Executive Committee. The Credentials Subcommittee may include members of the Medical Executive Committee and other individuals.

11.1.F.3 **Duties.** The Credentials Subcommittee shall have the duties set forth below.

11.1.F.4

General Review Criteria. The Credentials Subcommittee shall conduct its reviews and evaluations in accordance with the then-current credentialing and privileging standards of regulatory agencies and accreditation bodies. The Credentials Subcommittee's review and evaluation may include, without limitation, the following: (i) an assessment of general competencies, including patient care, medical and clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice; (ii) a so-called "Focused Professional Practice Evaluation" whereby the Credentials Subcommittee evaluates the privilege-specific competence of a practitioner who does not have documented evidence of competently performing the requested privilege at the Hospital; and (iii) a so-called "Ongoing Professional Practice Evaluation" that is focused on the practitioner's ongoing performance reviews. The Credentials Subcommittee shall work in collaboration with members of the Associate Professional Staff as necessary to

facilitate the credentialing of members of the Associate Professional Staff.

11.1.F.4.a **Recommendations for Appointment and Reappointment**. The Credentials Subcommittee shall review the credentials of all applicants, including specific consideration of the recommendations from the Medical Staff, and make recommendations for appointment and reappointment to membership on the Staff and the delineation of Clinical Privileges in compliance with ARTICLE 5 and ARTICLE 6. The Credentials Subcommittee shall ensure that Clinical Privileges granted are supported by evidence of appropriate current clinical experience and competence.

11.1.F.4.b **Reviewing Reappointments**. The Credentials Subcommittee shall be responsible for reviewing individual reappointments. The Credentials Subcommittee's review shall include a review of peer review information from the Medical Executive Committee, Practitioner-specific quality assurance and quality improvement activities, complaints, remedial actions, recommendations from the Medical Staff and any other pertinent information. The Credentials Subcommittee shall forward its recommendations to the Medical Executive Committee and shall include delineation of any changes in a member's Clinical Privileges or status.

11.1.F.4.c **Evaluating Provisional Appointees**. The Credentials Subcommittee shall evaluate the provisional status of each new Active Medical Staff member and Courtesy Medical Staff member no later than twelve (12) months after provisional appointment in accordance with Section 5.3.B.

11.1.F.4.d **Forms, Processes, and Procedures**. The Credentials Subcommittee shall develop, review and revise credentialing and privileging forms and processes and review and approve credentialing procedures.

11.1.F.4.e **Coordination with Credentials Committee of the Medical Staff of CMMC**. The Credentials Subcommittee shall perform the functions set forth in this Section 11.1.F in coordination and collaboration with the Credentials Committee of the Medical Staff of CMMC.

11.1.F.5 **Meetings**. The Credentials Subcommittee shall meet monthly and when called, at least within thirty (30) days after receiving an application for appointment or change in status.

11.1.F.6 **Reporting and Documentation**. The Credentials Subcommittee shall maintain written reports and minutes of its activities and shall submit such reports to the Medical Executive Committee.

11.1.G **Physician Health**.

11.1.G.1 **Special Committee**. The Medical Executive Committee may form an *ad hoc* Special Committee to assist the Medical Executive Committee in performing its duties under Section 11.1.C. Any such Special Committee will be considered a professional competence committee pursuant to the Maine Health Security Act (Me. Rev. Stat. tit. 24, §§ 2501–2511).

11.1.G.2 **Confidentiality**. In performing its duties under Section 11.1.C, the Medical Executive Committee, including any Special Committee formed pursuant to Section 11.1.C. shall make every effort to maintain the confidentiality of any person providing information and 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.

11.1.G.3 **Assistance and Rehabilitation**. The purpose of the process followed by the Medical Executive Committee in performing its duties under Section 11.1.C 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 Section is intended to preclude or limit the use of the regular corrective action process set forth in ARTICLE 7 when such corrective action process is deemed necessary.

11.1.G.4 **Professional Competence Committee**. The Medical Executive Committee shall serve as a professional competence committee pursuant to the Maine Health Security Act (Me. Rev. Stat. tit. 24, §§ 2501–2511).

11.2 Performance Working Groups

The Medical Executive Committee shall establish clinical performance working groups ("Performance Working Groups") as duly-authorized working groups or so-called "microsystems" of the Medical Staff reporting to the Medical Executive Committee. A Performance Working Group may be established by the Medical Executive Committee to perform functions within a specific clinical area or to perform functions that affect multiple clinical areas. For each Performance Working Group, the Medical Executive Committee shall develop a charter that sets forth the Performance Working Group's purpose, duration, composition and selection of its members, and reporting obligations. The Medical Executive Committee shall develop Performance Working Group policies and procedures as necessary. The Medical Executive Committee shall have the right to amend any Performance Working Group's charter or policies and procedures or dismantle any Performance Working Group at any time.

11.3 Special Committees

The Medical Executive Committee shall have the authority to form Special Committees from time to time. Members of Special Committees formed by the Medical Executive Committee shall be appointed by the Medical Staff President. Members of Special Committees shall retain their appointments until discharged by the Medical Executive Committee.

ARTICLE 12 MEETING REQUIREMENTS FOR STANDING COMMITTEES AND SECTIONS

SEE ARTICLE 13, MEDICAL STAFF MEETINGS (RUMFORD HOSPITAL DOES NOT HAVE STANDING COMMITTEES OR SECTIONS DUE TO MEDICAL STAFF COMMITTEE OF THE WHOLE STRUCTURE.

ARTICLE 13 MEDICAL STAFF MEETINGS

13.1 Regular Meetings

The Medical Staff shall hold at least six (6) meetings per year with meetings scheduled for January, March, May, July, September and November. To the extent possible, meetings should be spaced evenly throughout the year. The annual meeting shall occur on the date of the regular September meeting of the Medical Staff. The agenda of regular meetings shall include a report from the Medical Executive Committee on general and performance improvement activities.

13.2 Special Meetings

The Medical Staff Chief may call a special meeting of the Medical Staff at any time in his/her discretion. The Medical Staff Chief shall call a special meeting of the Medical Staff upon written request of at least one-fourth (1/4) of the Voting Medical Staff Members. Written notice stating the purpose and place and time of any special meeting of the Medical Staff shall be delivered to each Voting Medical Staff Member not less than five (5) days before the date of such special meeting. Business transacted at any special meeting shall be limited to that stated in the notice calling the meeting.

13.3 Quorum

For purposes of amendment of these Bylaws, the Medical Staff Rules and Regulations, and for all other actions, a quorum shall be presumed to exist as long as adequate notice of the meeting has been provided. If a quorum count is requested, presence of thirty-five percent (35%) or more of the Voting Medical Staff Members shall constitute a quorum.

13.4 Attendance Requirements

Each member of the Active Medical Staff shall be expected to attend at least fifty percent (50%) of all regular Medical Staff meetings.

13.5 Agenda

The agenda at any regular Medical Staff Committee of the Whole meeting shall be as follows:

(a) Call to order;

(b) Acceptance of the minutes of the last regular and all special meetings of the Medical Executive Committee and Medical Staff and reports of meetings of the Governing Body as indicated;

(c) Presentation of the administrative report, which is designed in part to provide effective communication among the Medical Staff, Hospital administration and the Governing Body;

(d) Presentation of the Medical Executive Committee report, including a summary of general activities and performance improvement activities;

(e) Presentation of old business;

(f) Presentation of new business;

(g) Presentation of communications; and

(h) Adjournment.

13.6 Attendance Limited

Only members of the Active Medical Staff, Courtesy Medical Staff, and Associate Professional Staff will be entitled to attend Medical Staff meetings unless otherwise determined by the Medical Executive Committee.

13.7 Voting

Only members of the Active Medical Staff, Senior Active Medical Staff and Associate Professional Staff (APS) known as “Voting Medical Staff Members” will be authorized to vote on matters at Medical Staff meetings. Action may be taken without a meeting by the affirmative action of two-thirds of voting Medical and Associate Professional members. Members may respond in writing or electronically.

The intent is that amendments to Bylaws, Rules and Regulations, and policy, as well as other business that comes before the committee can be voted upon by Active Medical Staff, Senior Active Medical Staff as well as Associate Professional Staff. Exception to this would be the

election of Medical Staff Officers will be voted on by Medical Staff voting members and the election of APS liaison will be voted upon by the APS members. Associate Professional Staff shall be granted this voting privilege after being licensed and serving two full years on the Medical Staff.

ARTICLE 14 CONFIDENTIALITY, IMMUNITY, AND REMEDIES

Each practitioner who applies for, or is granted, Clinical Privileges, thereby expressly agrees to the provisions of this ARTICLE 14.

14.1 Confidentiality

All reports by any other practitioner, or by any other health care provider or facility, or by any employee, officer, agent or trustee of Rumford Hospital, in connection with or relating to a practitioner's application for Clinical Privileges or any peer review process, whether formal or informal, shall be confidential and shall be privileged from disclosure to the maximum extent permitted by law, and shall not be disclosed to persons outside of the Hospital administration and Medical Staff except as otherwise necessary to an application for Clinical Privileges or peer review process or as expressly required by law.

14.2 Immunity

14.2.A **General Privilege**. Any act, communication, report, recommendation, or disclosure, with respect to any practitioner, performed or made by or to an authorized representative of this or any other health care facility, relating to the clinical competence, professional performance, professional conduct, or compliance with hospital policies, bylaws, rules and regulations, or ethical standards, in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

14.2.B **Extension of Privilege**. Such privileges shall extend to members of the Medical Staff and the Governing Body, the Hospital's other Practitioners, employees, agents, and contractors, the President of Rumford Hospital and his/her representatives, and to third parties who supply information to any of the foregoing authorized to receive, release or act upon the same. For the purpose of this ARTICLE 14, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Governing Body of the Medical Staff.

14.2.C **Immunity**. There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged. Such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to, the following:

(a) Application for appointment or Clinical Privileges;

(b) Periodic reappraisals for reappointment or Clinical Privileges;

(c) Corrective action, including summary suspension;

(d) Medical Executive Committee, Credentials Subcommittee, Special Committee, and Performance Working Group proceedings;

(e) Medical care evaluations;

(f) Utilization reviews;

(g) Other Hospital, clinical area, service, committee, and Performance Working Group activities related to quality patient care and inter-professional conduct;

(h) The acts, communications, reports, recommendations, and disclosures referred to in this ARTICLE 14 that may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any matter that might directly or indirectly have an effect on patient care or on the effective operation of the Hospital; and

(i) The consents, authorizations, releases, rights, privileges, and immunities provided by Sections 5.1 and 5.2 for the protection of the Hospital's Practitioners, other appropriate Hospital officials and personnel, and third parties, in connection with applications for initial appointment.

14.3 Remedies

Any actual or threatened violation of the confidentiality and non-disclosure provisions of this ARTICLE 14 shall entitle the Hospital or practitioner to injunctive relief. Any practitioner who initiates legal action against any person based on actions or omissions which are subject to immunity under this ARTICLE 14 shall be liable for the reasonable attorney fees and costs incurred by such person in defending such claims.

ARTICLE 15 POLICIES AND PROCEDURES

15.1 Adoption and Amendment

15.1.A **Medical Executive Committee Action**. The Medical Executive Committee shall adopt and amend Staff policies as may be necessary or desirable for the proper conduct of the work of the Staff. The Medical Executive Committee may, but shall not be required to, propose the adoption or amendment of a policy to the Medical Staff before such adoption or amendment takes effect. Policies adopted or amended by the Medical Executive Committee shall be consistent with the

bylaws of Rumford Hospital, these Bylaws, and the Medical Staff Rules and Regulations.

15.1.B **Medical Staff Action**. Without limiting the rights of the Medical Executive Committee set forth in Section 15.1.A, the Medical Staff shall have the right to recommend, by a vote of a majority of the Voting Medical Staff Members, to the Medical Executive Committee the adoption of new Staff policies or amendment to existing Staff policies.

15.1.C **Conflict**. If the Medical Executive Committee concludes that it is in the best interests of the Medical Staff to disapprove a policy adoption or amendment recommended by the Medical Staff, the Medical Executive Committee and the Voting Medical Staff Members will work together to attempt to resolve this conflict.

15.1.D **Notification**. All individuals with Clinical Privileges shall be provided with notification of the adoption of any significant policies or any significant amendments to existing policies.

15.2 Policy for Medical History and Physical Examination

15.2.A **History and Physical**. A medical history and physical examination shall be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, or prior to surgery or a procedure requiring anesthesia, whichever comes first. The medical history and physical examination must be completed and documented by a Physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with state law, the Medical Staff Rules and Regulations, and Staff policies.

15.2.B **Updated Examination**. In the event that the medical history and physical examination are completed within thirty (30) days before admission or registration, an updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty-four (24) hours after admission or registration, or prior to surgery or a procedure requiring anesthesia, whichever comes first. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a Physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with state law, the Medical Staff Rules and Regulations, and Staff policies.

ARTICLE 16 RULES AND REGULATIONS

16.1 Adoption and Amendment

16.1.A **Medical Staff Action**. The Medical Staff shall adopt or amend rules and regulations ("Medical Staff Rules and Regulations") as may be necessary to implement more specifically the general principles contained within these Bylaws, subject to the approval of the Governing Body. The Medical Staff Rules and Regulations may relate to the proper conduct of the Medical Staff organizational activities as well as to the level of practice that is to be required of each practitioner in the hospital. Proposed amendments to the Medical Staff Rules and Regulations will be referred to the Medical Executive Committee. The Medical Executive Committee will review the proposed amendments and make its recommendation to the Medical Staff. To be endorsed by the Medical Staff, a proposed amendment to the Medical Staff Rules and Regulations shall require the affirmative vote of a majority of the Voting Medical Staff Members. The Medical Staff vote may be taken at any regular meeting of the Medical Staff at which a quorum is present without prior notice or at any special meeting of the Medical Staff following notice. Such proposed amendment shall be effective when approved by the Governing Body. Neither the Governing Body nor the Medical Staff may unilaterally amend the Medical Staff Rules and Regulations.

16.1.B **Notification**. All individuals with Clinical Privileges shall be provided with notification of any significant amendments to the Medical Staff Rules and Regulations.

ARTICLE 17 AMENDMENTS TO BYLAWS, RULES AND REGULATIONS AND POLICIES

17.1 Amendment to Bylaws

17.1.A **Initiated by the Medical Staff**. These Bylaws shall be reviewed not less than triennially for consideration of changes which may be necessary or advisable. Proposed amendments to these Bylaws will be referred to the Medical Executive Committee. The Medical Executive Committee may appoint an *ad hoc* Bylaws Committee to review the proposed amendments and make a recommendation to the Medical Executive Committee. The Medical Executive Committee shall make its recommendation to the Medical Staff. To be endorsed by the Medical Staff, a proposed amendment to these Bylaws shall require the affirmative vote of a majority of the Voting Medical Staff Members. The Medical Staff vote may be taken at any regular meeting of the Medical Staff at which a quorum is present without prior notice or at any special meeting of the Medical Staff following notice. Such proposed amendment shall be effective when approved by the Governing Body. Except to the limited extent permitted in Section 17.1.B, neither the Governing Body nor the Medical Staff may unilaterally amend these Bylaws.

17.1.B **Initiated by the Governing Body**. Notwithstanding anything to the contrary in these Bylaws, the Governing Body may on its own motion, after consultation with

the Medical Staff, amend these Bylaws in whole or in part, at any meeting, if (i) such amendment is necessary to comply with applicable law or regulation or necessary to maintain accreditation, and (ii) the Medical Staff has not proposed an appropriate amendment and will be unable to propose an appropriate amendment within the time required.

17.1.C **Notification**. All individuals with Clinical Privileges shall be provided with notification of any significant amendments to the Medical Staff Bylaws.

17.1.D. **Conflict with Rumford Hospital Bylaws**

To the extent practicable, the provisions of these Bylaws, the Medical Staff Rules and Regulations, and Staff policies shall be construed so as to be consistent with the bylaws of Rumford Hospital as amended from time to time, but in the event of any conflict or inconsistency, the bylaws of Rumford Hospital shall govern.

ARTICLE 18 APPLICABILITY

When these Bylaws contain what appear to be mandatory provisions with respect to action by the Governing Body and the President of Rumford Hospital, it is recognized that ultimate authority with respect to such matters is vested by law in the Governing Body. These Bylaws shall not, therefore, be deemed to limit the power of the Governing Body to change any provisions made herein with respect to its actions, the actions of the President of Rumford Hospital, or the actions of any other Hospital officers or employees.