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# **RULES AND REGULATIONS OF THE MEDICAL STAFF**

**Central Maine Medical Center**

**Lewiston, Maine**

**WITH UPDATES ADOPTED BY THE MEDICAL STAFF ON SEPTEMBER 18, 2017**

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September 25, 2017

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It is the goal of the Central Maine Medical Center (“Hospital”) to serve the community by providing high quality medical care. These Rules and Regulations have been developed to implement more specifically the general principles found within the Bylaws of the Medical Staff of the Hospital (“Medical Staff Bylaws”). The Medical Staff has also developed policies and procedures to further implement the principles found within the Medical Staff Bylaws and these Rules and Regulations. A list of such policies and procedures is provided in Appendix A. A list of Hospital and other policies and procedures further implementing the requirements in these Rules and Regulations is provided in Appendix B.

## **I. DEFINITIONS**

As used in these Rules and Regulations, the terms set forth below have the following definitions. Capitalized terms used in these Rules and Regulations and not defined herein have the definitions set forth in the Medical Staff Bylaws.

- A. “Code of Conduct” has the meaning set forth in Section II.
- B. “Core Physician Reviewers” has the meaning set forth in Section III.B(a).
- C. “Emergency Medical Condition” has the meaning set forth in Section VI.B.2.
- D. “EMTALA” has the meaning set forth in Section VI.B.
- E. “Event Reporting Policy” means Central Maine Healthcare Administrative Policy No. HC-PA-2036(R1) (Patient Adverse Events/Reporting).
- F. “Expedited Review Event” has the meaning set forth in Section III.B(b).
- G. “Governing Body” means the Board of Trustees of the Hospital.
- H. “Hospital” has the meaning set forth in the introductory paragraph.
- I. “Inappropriate or Disruptive Conduct” has the meaning set forth in Section II.C.
- J. “Medical Staff” has the meaning set forth in the Medical Staff Bylaws.
- K. “Medical Staff Bylaws” has the meaning set forth in the introductory paragraph.
- L. “Permitted Disciplinary Action” means any disciplinary action that does not require approval of the Governing Body (as defined in the Medical Staff Bylaws), including, without limitation, (i) a warning, admonishment, or reprimand; or (ii) the imposition of probation or a requirement for consultation or counseling.
- M. “Physician” means an appropriately licensed allopathic or osteopathic physician or an appropriately licensed oral surgeon. The term also includes a Certified

Nurse Midwife in those instances where they are privileged to admit patients to the Hospital.

- N. “Sentinel Event” has the meaning set forth in the Event Reporting Policy.
- O. “Stabilize” has the meaning set forth in Section VI.B.2.
- P. “Staff” means Medical Staff, Associate Professional Staff (as defined in the Medical Staff Bylaws), and Locum Tenens Allied Health Professionals (as defined in the Medical Staff Bylaws).

## II. CODE OF CONDUCT

- A. **Statement of Purpose.** The Hospital desires to provide an environment where interpersonal conduct recognizes the importance of respectful, honorable, and dignified interaction between and among members of the Staff and others in the Hospital, and this Section II sets forth the standards of interpersonal conduct (“Code of Conduct”) that help to produce such an environment. While there should always be an opportunity for criticism and free speech, such actions should be constructive and take place through appropriate channels, such as one on one conversations and providing input through committees, Division/Section Chiefs, Officers of the Medical Staff, managers of the Nursing Department or other departments of the Hospital. In dealing with inappropriate or disruptive conduct, the protection of patients, employees, Staff members and other persons at the Hospital is the primary concern. The well-being of the Staff member whose conduct is in question is also of concern, as is the orderly operation of the Hospital.
- B. **Overview of Role and Responsibilities.** It is the Hospital’s goal to foster excellence in the Staff, to listen and communicate with the Staff, to educate the Staff and facilitate graduate medical education and continuing medical education opportunities for the Staff, to reward teamwork and individual excellence, and to manage and lead the Hospital and the Staff with integrity and accountability. It is the responsibility of each member of the Staff to focus on patient care and involve patients in care and treatment decisions, to collaborate with each other on delivery of care, to act with the highest level of ethical and professional standards, to listen and communicate, to take ownership of the clinical processes, to embrace innovation and continuous improvement in care delivery, and to participate in necessary organizational change. Staff members should carry out these responsibilities in a manner that is consistent with economic responsibilities and considerations.
- C. **Inappropriate or Disruptive Conduct.** Conduct may be considered inappropriate or disruptive and in violation of the Code of Conduct (“Inappropriate or Disruptive Conduct”) when it potentially adversely affects

patient care or the legitimate operations of the Hospital. Conduct may be unusual, unorthodox or different without being inappropriate or disruptive.

- D. **Examples of Inappropriate or Disruptive Conduct.** Inappropriate or Disruptive Conduct may include, but is not limited to, the following.
- (a) **Verbal Abuse.** Verbal abuse generally involves vulgar, profane or demeaning language, screaming, sarcasm or non-constructive criticism. Verbal abuse is often intimidating to the recipient, and may impact the ability of the recipient or others around him/her to effectively perform his/her responsibilities.
  - (b) **Non-communication.** Refusal to communicate may (i) be the intentional refusal to share with responsible persons, directly in a patient care setting, important information that should be communicated or (ii) consist of incomplete or ambiguous communications that divert patient care resources by requiring substantial amounts of time to follow-up or obtain clarification.
  - (c) **Refusal to Return Calls.** Refusing to return telephone calls or pages from Hospital staff is Inappropriate or Disruptive Conduct.
  - (d) **Inappropriate Communication.** Similar to verbal abuse, inappropriate communication may include criticism of the Hospital, its staff or peers outside of the appropriate channels. Inappropriate communication, however, also includes written or verbal derogatory statements to an inappropriate audience, such as patients and families, or statements placed in patient medical records.
  - (e) **Physical Abuse.** Offensive or nonconsensual physical contact is generally deemed to be disruptive, as is intentional damage to facility premises or equipment.
  - (f) **Threatening Behavior.** Threats to another's employment or position or threats that are otherwise designed to intimidate a person from performing his/her designated responsibilities or interfere with his/her well-being are generally considered to be Inappropriate or Disruptive Conduct. Examples include threats of litigation against peer review participants or against persons who report concerns in accordance with established reporting channels, and threats to another's physical or emotional safety or property. Notwithstanding the foregoing, supervisor feedback on performance and potential termination in no way shall be construed as threatening behavior.
  - (g) **Combative Behavior.** Combative behavior refers to behavior that constantly challenges, verbally or physically, legitimate and

generally recognized authority or generally recognized lines of professional interaction and communication. Behavior becomes combative at the point that it results in an inability to acknowledge or to deliver constructive comments and criticism.

- (h) **Failure to Comply.** Willful violation of any of the Medical Staff Bylaws, these Rules and Regulations, or Medical Staff policies and procedures, including those policies and procedures referenced in Section VII, is considered Inappropriate or Disruptive Conduct.

**E. Procedure for Addressing Inappropriate or Disruptive Conduct.**

1. **Reporting Process.** Any Staff member who observes Inappropriate or Disruptive Conduct should report it. While anonymous reports are discouraged, every effort will be made to protect the identity of the reporting individual in circumstances where there is a possibility of retaliation. Reports of Inappropriate or Disruptive Conduct should be directed to the Section Chief or Division Chief.
2. **Determination Process.** If, in the opinion of the Section Chief or Division Chief, a reported incident warrants further inquiry, the Section Chief or Division Chief should follow the steps outlined in Article 7 for Collegial, Educational and Informal Proceedings as well as Investigation and action as warranted .

**III. EXPEDITED REVIEW PROCESS**

- A. **Rationale for Rule.** An expedited review process allows for timely review of medical care rendered by Staff members when the medical care raises issues of patient safety but does not constitute a Sentinel Event.
- B. **Definitions.** For purposes of this Section III, the following terms have the following meanings.
  - (a) “Core Physician Reviewers” means Physicians on the Medical Staff who agree to be available to review cases subject to the expedited review process. These Physicians will represent all medical Sections and will be trained in all aspects of the review process.
  - (b) “Expedited Review Event” means an event that raises issues of patient safety but does not constitute a Sentinel Event.
- C. **Confidentiality.** The expedited review process set forth in this Section III will be part of the peer review process and therefore will be confidential and privileged from disclosure to the maximum extent permitted by law.
- D. **Procedure.**

1. **Event Reporting.** Staff members should report events related to patient care in accordance with the Event Reporting Policy.
  2. **Medical Staff President Review.** The Medical Staff President or his/her designee, in consultation with the chair of Peer Review committee as appropriate, shall review the event in an expedited manner and in accordance with the Event Reporting Policy to determine which of the following categories the case falls into:
    - (a) Sentinel Event;
    - (b) Expedited Review Event;
    - (c) Routine peer review process; or
    - (d) No review necessary from Medical Staff perspective.
  3. **Conflict of Interest.** If any duties of the Medical Staff President under this Section create a conflict of interest, the Medical Staff Chief will carry out the duties of the Medical Staff President under this Section. If the Medical Staff Chief also has a conflict of interest, either the Medical Staff Vice-Chief or the applicable Division Chief will then be appointed to review the case pursuant to this Section.
- E. **Action Taken.** After the initial review, one of the following actions will be taken if it is determined that further review is required:
1. **Sentinel Event.** Cases meeting the definition of a Sentinel Event will be reviewed and reported as set forth in the Event Reporting Policy. Staff members involved will be notified that this process has been started and that the event has been characterized as a Sentinel Event.
  2. **Expedited Review Event.** Cases meeting the definition of Expedited Review Event will follow the procedure set forth in the Event Reporting Policy. Staff members involved will be notified that this process has been started and that the event has been characterized as an Expedited Review Event.
  3. **Regular Peer Review.** In all other circumstances, the procedures set forth in the Medical Staff Bylaws or the Peer Review Clinical Case Review Policy and Procedure will be followed.
- F. **No Limitation of Corrective Action.** While intended to be an educational process, nothing in this Section III shall be construed as limiting the ability of any of the individuals or committees listed in Section 7.1.A of the Medical Staff Bylaws from initiating corrective action based upon the same events which are the subject of review pursuant to this Section III.
- G. **Refusal to Cooperate.** If Staff members involved with the case refuse to meet with the panel conducting the review of an Expedited Review Event or otherwise refuse to cooperate, a written notice will be sent indicating that failure to

participate will be referred to the Medical Executive Committee for corrective action.

H. **Professional Competence Committee.** The panel reviewing an Expedited Review Event shall be considered a professional competence committee under the laws of the State of Maine and shall be construed as assisting the Peer Review Committee with its duties under the Medical Staff Bylaws.

**IV. MEDICAL RECORDS**

A. **Monitoring and managing delinquent medical records.**

B. **Procedure.**

1. Patient is discharged or outpatient encounter is completed.
2. HIM-Chart is analyzed and made available to the practitioner for completion.
3. The HIM department will generate a list and send to each practitioner of any incomplete records.
4. The HIM department will send a monthly report to Section chiefs, Division Chiefs and associated CMH practice managers. Section chief will review this list with the involved provider and investigate causes and barriers to timely completion within 2 weeks of receipt
5. If 2 consecutive months of delinquent records or 3 or more months of delinquent records in a 6 month period occur, then the section chief will make a referral to the Division Chief for involvement. The Division Chief will investigate barriers to timely completion and determine any actions warranted within 2 weeks of referral.
6. For continued recurrent delinquencies in a subsequent 2 month period the Section and or Division chief will make a referral to MEC. MEC will investigate interventions to date, consider resources/practice patterns, and recommend disciplinary actions or corrective actions such as suspension of privileges or working with human resources for employment action.

The delinquent medical record monitor will include the following record types and documents:

a) Inpatient: Admission

b) Outpatient: Same day surgery, Observation status, Invasive procedures with anesthesia services or moderate/deep sedation in Cardiology, Endoscopy and Interventional Radiology. Emergency department visits, Ambulatory office visits

Document	Documentation requirement	Authentication requirement
H+P	24 hours from admission or	30 days

	prior to surgery/procedure	
Discharge summary	15 days	30 days
Operative/Invasive Procedure report	1 day post op/procedure	30 days
Emergency Report	15 days	30 days
Ambulatory office note	15 days	15 days
Results to review-Office	15 days	15 days

## V. CONSULTATION AND TRANSFERS

### A. General Principles.

1. **One Physician in Charge.** One Physician will be in charge of the care of each patient, and the identity of this Physician should be documented in the medical record. This is true even for patients with multiple consultants, such as a cardiac patient with musculoskeletal trauma. Patient care will be better served when one Physician has the primary responsibility.

2. **Physician Acceptance of Patient.** A patient will not be admitted to the service of a Physician unless that Physician or his/her designee has first agreed to accept the patient.

B. **Transfer of Service.** Transfer of a patient from one Physician to another should be mutually agreed upon by both Physicians and the patient or responsible party. A Physician will be responsible for the care of a patient until he/she writes an order to transfer the patient's care to another Physician. The transfer of responsibility will be appropriately documented in the Physician's order sheet or, if using a computerized Physician order entry system (CPOE), then in the electronic health record order entry mechanism and/or the medical record.

## VI. ON CALL RESPONSIBILITIES

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

1. **Primary Coverage Responsibilities.** All members of the Active Medical Staff, Senior Active Medical Staff, and 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 if not provided by the member, and must be consistent with the requirements, unless otherwise determined by the Medical Executive Committee upon request of an individual or Section. 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, if any, shall be submitted at the time of initial appointment to the Staff and upon application for reappointment.

(a) Service Coverage Responsibilities.

- (i) **General Responsibilities.** All members of the Active Medical Staff and other Practitioners with Admitting Privileges, if required by their section or employment, 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.
- (ii) **Section Policies.** Individual Sections will determine service coverage policies, subject to approval of the applicable Division Chief and the Medical Executive Committee and adoption by the Governing Body. Physicians will not be expected to provide services for problems outside their area of specialty or expertise. Two (2) or more Physicians may establish a system of coverage for their subspecialty, subject to approval by both their Section and by the Medical Executive Committee.
- (iii) **Other Hospitals.** Recognizing the role of the Hospital as a regional referral center, all members of the Active Medical Staff will also respond, when on call, to calls from staff members at other area hospitals. However, nothing in this shall be construed as requiring the on-call member of the Active Medical Staff to examine a patient unless said patient presents to the Hospital.

B. **On-Call Physician Rule.** The Hospital intends to comply with the Emergency Medical Treatment and Labor Act, as amended (“EMTALA”) at all times. EMTALA requires that any patient who presents at the Hospital must receive an appropriate medical screening examination to determine if that patient has an Emergency Medical Condition (defined below). If any Emergency Medical Condition exists, the patient’s condition must be stabilized prior to discharge or transfer from the Hospital. The provisions of EMTALA apply not only to the Hospital but also to the Physician who provides on-call coverage.

1. **Purpose of Rule.** The purpose of the rule set forth in this Section IVI.B is to ensure compliance with EMTALA by explaining the obligations of on-call Physicians under the law and under Medical Staff requirements.

2. **Definitions.** For purposes of this Section VI.B, the following terms have the following meanings.

- (a) **“Emergency Medical Condition”** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
  - (i) Serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child);
  - (ii) Serious impairment to bodily functions;
  - (iii) Serious dysfunction of any bodily organ or part; or
  - (iv) With respect to a pregnant woman who is having contractions, that there is inadequate time to affect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.
- (b) **“Stabilized”** means, with respect to an Emergency Medical Condition, to have provided such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or with respect to an Emergency Medical Condition involving a pregnant woman, that the woman has delivered (including the placenta).

3. **Obligation to Examine Patient.** With respect to a patient covered by EMTALA, the on-call Physician must come to the Hospital when requested by the consulting Physician or any Hospital worker making the request on behalf of a consulting Physician or nurse who is not available to call the on-call Physician directly. The on-call Physician must not see the patient in the on-call Physician’s office or clinic unless and until the patient has been Stabilized or is determined not to have an Emergency Medical Condition.

4. **Disputes Over Need to Respond.** If the on-call Physician disagrees about the need to come to the Hospital, the on-call Physician must come to the Hospital and render care irrespective of the disagreement. The on-call Physician may address the disagreement with the appropriate individual at the Hospital at a later time.

5. **Assistance in Screening and/or Stabilization.** If requested, the on-call Physician must be physically present in the Hospital to assist in providing an appropriate medical screening examination, as well as in the ongoing stabilization and treatment of a patient prior to transfer or treatment. The on-call Physician must

remain in the Hospital until the consulting Physician no longer requires his/her services.

6. Who May Conduct a Medical Screening:

Any physician, physician assistant, or nurse practitioner appropriately credentialed to provide services in the Emergency Medicine Department, or any other appropriately credentialed physician may conduct a medical screening to determine whether or not an emergency medical condition exists. In the case of an obstetrical patient, the medical screening exam may be performed by a registered nurse with appropriate qualifications, credentialed physician, certified nurse midwife, physician assistant or nurse practitioner

7. **Ability to Pay Not to Be Considered.** With respect to an Emergency Medical Condition, the on-call Physician must not consider the patient's financial circumstances or the patient's insurance or means of payment in the decision to respond to, treat, or transfer the patient.

8. **Timely Response.** The on-call Physician must satisfy the following requirements when providing coverage.

- (a) The on-call Physician must satisfy the requirements of the Coverage Requirement Response Times Policy and Procedure.
- (b) The on-call Physician is not required to interrupt critical care – that is, care that requires his/her personal management that he/she is providing to a specific patient. Immediately after the Physician finishes caring for the specific patient, he/she will contact the requesting unit, respond if requested, and give an estimated time of arrival.
- (c) It is not acceptable for on-call Physicians to delay seeing an Emergency Medicine Department patient until the end of office hours or finishing the daily surgical caseload, nor is it acceptable to hold the patient in the Emergency Medicine Department until morning.
- (d) The on call physician, if engaged in other patient care, can ask a team NP or PA to initiate the process of seeing a patient in the ED to start the workup and admission process. Communication between the physician and NP/PA would occur to establish an initial plan for the patient. If the on-call physician is still engaged and not able to see the patient in the ED, which is generally preferred, they must see and examine the patient in their inpatient location and confirm the plan within 8 hours of the NP/PA examination.

9. **Follow-Up Care.** Unless other arrangements are made, with respect to an Emergency Medical Condition, the on-call Physician must provide follow-up patient care throughout the episode of illness. The on-call Physician must not condition the first follow-up office visit on advance payment or otherwise consider the patient's ability to pay.

10. **Disciplinary Actions.** Any violation of the rules set forth in this Section by an on-call Physician will be reported to the Medical Staff President and the Medical Executive Committee.

## **VII. PATIENT CARE AND TREATMENT**

A. **General Rule.** Staff members must comply with all policies and procedures related to patient care and treatment, including the Medical Staff policies set forth on Exhibit A and Hospital policies and procedures, and all provisions set forth in applicable federal and state laws.

## **VIII. AMENDMENTS**

A. **Proposal and Approval.** Any amendment to these Rules and Regulations shall be proposed and approved in accordance with Article 17 of the Medical Staff Bylaws. The adoption of any policies and procedures implementing the requirements set forth in these Rules and Regulations, and any amendments thereto, may be approved and adopted by the Medical Executive Committee directly, and do not require approval by the Governing Body in order to become effective.

## **APPENDIX A.**

### **Medical Staff Policies and Procedures**

The following Medical Staff policies further implement the provisions in these Rules and Regulations and the Medical Staff Bylaws:

- Admission Diagnosis Policy Autopsy Policy
- CMMC Medical/Surgical ICU Care: Co-Management Requirements, Admission & Discharge Criteria & Triage Responsibilities Policy
- Coverage Requirement Response Times Policy Determining Need for Surgery Policy
- Emergency Medicine Department Policy
- Medical Records Policy
- Medical Staff ID Badges policy
- Medical Staff Impaired Provider policy
- Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) Policy for Current Practitioner Policy
- Patient Termination of Physician's Services Policy
- Peer Review Clinical Case Review Policy
- POLST; Physicians orders for life sustaining treatment policy
- Supervision of Fellows, Residents, Medical and Associate Professional Staff Students, Policy
- Tissue Submissions Policy
- Use of Consultants

#### Medical Staff Guidelines

- Guideline for self-prescribing

In addition there are specific Clinical or Administrative policies reviewed and endorsed by the medical staff

- Informed Consent; HC PA 2003
- Non Invasive Mechanical Ventilation for Adults; Clinical Policy
- Credentialing of non-staff Volunteer Clinical Practitioners in a Disaster, MC-SC 6019
- Reporting of Critical Values and Findings; HC PA 2024
- Sedation and Analgesia for Diagnostic Therapeutic and Invasive Procedures; Clinical Policy



## **APPENDIX B.**

### **Other Policies Referenced**

The following Hospital and other policies are referenced in these Rules and Regulations:

- Central Maine Healthcare Administrative Policy No. HC-PA-2036(R1) (Patient Adverse Events/Reporting)