RULES AND REGULATIONS
OF THE
MEDICAL STAFF
RUMFORD HOSPITAL

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It is the goal of Rumford Hospital ("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 implementing policies and procedures is provided in Appendix A. A list of other policies and procedures (including Hospital 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.1.

C. "Emergency Medical Condition" has the meaning set forth in Section V.E.2(a).

D. "EMTALA" means the Emergency Medical Treatment and Labor Act.

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.2.

G. "Governing Body" means the Board of Directors 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, 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 V.E.2(b).

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, officers of the Medical Staff, performance working groups, and 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 Roles 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.

1. **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.

2. **Noncommunication.** 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.

3. **Refusal to Return Calls.** Refusing to return telephone calls or pages from Hospital staff is Inappropriate or Disruptive Conduct.

4. **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.

5. **Physical Abuse.** Offensive or nonconsensual physical contact is generally deemed to be disruptive, as is intentional damage to facility premises or equipment.

6. **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.

7. **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.

8. **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 VI, 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 Medical Staff President (or his/her designee).

2. **Determination Process.** If, in the opinion of the Medical Staff President (or his/her designee), a reported incident warrants further inquiry, the Medical Staff President (or his/her designee) shall, after appropriate verification of the nature and particulars of the incident, determine whether Permitted Disciplinary Action will be taken.

   (a) **Referral to Human Resources Department**. The Medical Staff President (or his/her designee) may consult with the Hospital's Human Resources Department as appropriate. If the Staff member involved is a Hospital employee and upon consultation with, or upon the request of, the Human Resources Department it is determined that the incident is more prudently addressed by the Human Resources Department, the determination process in this Section II.E.2 may be automatically suspended. Upon completion of the Human Resources Department's investigation and determination as to what, if any, action is to be taken by the Hospital administration in consultation with the Human Resources Department, the Human Resources Department will inform the Medical Staff President of the Hospital's final determination.

3. **Action.** If it is determined that Permitted Disciplinary Action is to be taken, the Medical Staff President (or his/her designee) shall promptly hold a meeting with the Staff member. At the onset of this meeting, the Staff member shall be informed of his/her rights under Section II.H to submit to the corrective action process set forth in Section 7 of the Medical Staff Bylaws and avail himself/herself of the procedural rights thereunder. In the event it is determined that disciplinary action is not required, but that the Staff member would nevertheless benefit from a meeting to discuss the incident, such meeting may be held. Refusal of the Staff member to meet will be cause for initiation of the corrective action process under the Medical Staff Bylaws.

   (a) **Conduct of Meeting**. The meeting should (i) be collegial and designed to educate and help the Staff member, (ii) clearly indicate how and why the conduct was inappropriate, and (iii) emphasize that if the Inappropriate or Disruptive Conduct continues, further Permitted Disciplinary Action will be taken.

   (b) **Documentation**. In the event Permitted Disciplinary Action is taken, this meeting and the Permitted Disciplinary Action taken shall be documented in the Staff member's credentials file. The Staff member may read this documentation and attach a response.

Said documentation shall be considered credentialing materials protected as part of the peer review process and treated as confidential.

4. **Providing Notification to Reporting Individual.** The Medical Staff President (or his/her designee) will communicate to the reporting individual that either (i) the reported incident did not warrant disciplinary action, or (ii) Permitted Disciplinary Action was taken and the issue has been addressed with the Staff member.

F. **Documentation of Inappropriate or Disruptive Conduct.** Whether an individual incident or pattern of conduct is under review, adequate documentation of Inappropriate or Disruptive Conduct is critical. Adequate documentation of individual incidents of Inappropriate or Disruptive Conduct is especially important because although an individual incident of Inappropriate or Disruptive Conduct may not justify disciplinary action, multiple documented individual incidents may demonstrate a pattern of Inappropriate or Disruptive Conduct which does justify disciplinary action.

1. **Providing Report or Complaint to Staff Member.** If a determination has been made pursuant to Section II.E.3 that Permitted Disciplinary Action will be taken, the Staff member will receive a copy of any written report made (either a photocopy of the original or a reproduction which, where consistent with the Staff member's due process rights, protects confidentiality of the reporting individual, or any other individual implicated in the incident, when retaliation is considered to be a legitimate possibility).

2. **Contents of Documentation.** Documentation of incidents serious enough to trigger the collegial process in Section II.E.3 above may, when practicable, include:

(a) The date, time and location of the incident;

(b) If the Inappropriate or Disruptive Conduct affected or involved a patient in any way, the name of the patient (and the medical record number if possible);

(c) The circumstances which precipitated or surrounded the incident;

(d) An objective description of the Inappropriate or Disruptive Conduct in question, limited to factual material and objective language as much as possible;

(e) The consequences, if any, of the Inappropriate or Disruptive Conduct as it related to patient care or Hospital operations;

(f) A record of any Permitted Disciplinary Actions taken to remedy the situation, including the date, time, place, action, or names of those intervening and the nature of the interventions; and

(g) Documentation of the Staff member's response to the written report and the intervention process.

3. **Follow-Up Letter to Staff Member.** A follow-up letter to the Staff member should state the problem and the expectation that the Staff member is required to behave professionally and cooperatively. This letter shall also be placed in the Staff member's credentials file.

G. **Recurrent Episodes of Inappropriate or Disruptive Conduct.** If a Staff member has been notified of a problem but the Staff member continues to engage in Inappropriate or Disruptive Conduct, the Medical Staff President (or his/her designee) shall make a recommendation to the Medical Executive Committee regarding what disciplinary action is appropriate, including but not limited to referral to a behavioral consultant or a recommendation to institute the corrective action process as described in the Medical Staff Bylaws. If referral to a behavioral consultant is recommended, the recommendation may include a requirement that an evaluation be shared with the Medical Staff President and the Medical Staff Office. Whatever action is taken, it shall be documented and placed in the Staff member's credentials file. Further incidents of Inappropriate or Disruptive Conduct may result in initiation of corrective action pursuant to the Medical Staff Bylaws.

H. **Rights of the Staff Member.** A Staff member may review and respond to all documentation placed in his/her credentials file. A Staff member may also request that an investigation be initiated pursuant to the Medical Staff Bylaws to determine whether corrective action should be initiated, thereby allowing the Staff member to avail himself/herself of the procedural rights accorded thereunder, to the extent available, and subject to the Medical Executive Committee's decision to act upon the request and initiate the investigation. For any Staff member who is a Hospital employee, the terms of such member's employment agreement or any review or disciplinary action under the employment agreement, including termination, shall supersede the rights of the Staff member under the Medical Staff Bylaws and these Rules and Regulations.

I. **Conflict with Medical Staff Bylaws.** This Section II is not intended to be the sole and exclusive procedure to deal with Inappropriate or Disruptive Conduct by Staff members and may not be interpreted to suspend or replace any provision of the Medical Staff Bylaws or to limit in any way the corrective action process or the rights of the Medical Executive Committee or the Governing Body under the Medical Staff Bylaws. If the Staff member or the Medical Executive Committee initiates the corrective action process set forth in Section 7 of the Medical Staff Bylaws with respect to Inappropriate or Disruptive Conduct being addressed under this Section II, such corrective action process shall take precedence and shall stay further action under this Section II.

J. **Annual Review of Rule.** This Section II and its implementation shall be reviewed annually by the Medical Staff President in collaboration with the Medical Executive Committee to assess its effectiveness. This review shall include but not be limited to:

1. The total number of reported incidents;

2. The total number of incidents acted upon; and

3. General description of the types of Inappropriate or Disruptive Conduct reported.

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.

1. "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 be trained in all aspects of the review process.

2. "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) 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 (or his/her designee) under this Section III.D create a conflict of interest, the Medical Staff Chief will carry out the duties of the Medical Staff President under this Section III.D. If the Medical Staff Chief also has a conflict of interest, the Medical Staff Vice Chief will then be appointed to review the case pursuant to this Section III.D.

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 Medical Executive Committee with its duties under the Medical Staff Bylaws.

I. **Annual Review of Rule.** This Section III and its implementation shall be reviewed annually to assess its effectiveness. This review shall include but not be limited to:

1. The total number of reported events;

2. The total number of events acted upon as expedited reviews; and

3. A general description of the findings of the expedited reviews.

IV. MEDICAL RECORDS

A. **Discipline for Noncompliance.** Noncompliance with the requirements set forth in the Medical Staff Bylaws, Rules and Regulations or policies and procedures regarding history and physicals, operative reports, or completion of medical records may result in disciplinary action, including, without limitation, temporary automatic suspension of a Staff member's admitting privileges under Section 7.3.B of the Medical Staff Bylaws.

B. **Procedure.**

1. **Report by Director of Health Information Management.** The medical records office will report a Staff member's failure to complete medical records or otherwise comply with the requirements regarding history and physicals, operative reports, or medical records to the Medical Staff President and the Medical Executive Committee, or such other committee as may be designated by the Medical Executive Committee from time to time.

2. **Medical Informatics and Records Committee Recommendations.** The Medical Informatics and Records Committee, or such other committee as may be designated by the Medical Executive Committee from time to time, shall submit recommendations regarding any matters reported by the director of the medical records office to the Medical Executive Committee as appropriate.

3. **Medical Executive Committee Recommendations.** The Medical Executive Committee shall then recommend to the Governing Body any action that should be taken with respect to a Staff member's privileges due to such Staff member's failure to comply with requirements regarding history and physicals, operative reports, or medical records.

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"), in the electronic health record order entry mechanism and/or the medical record.

C. **Time Frame for Consultations.** Requests for consultations should be honored within 24 hours when feasible.

D. **Obtaining a Consultation.**

1. **Required Consultations.** Except in an emergency, consultations with another qualified Physician are required in all cases in which according to the judgment of the Physician:

   (a) The patient is not a good medical or surgical candidate;

   (b) The diagnosis is unclear or obscure; and

   (c) There is doubt as to the best therapeutic measures to be utilized.

2. **Upon Patient Request.** A patient has the right to request a second opinion or consultation about his/her medical care. The choice of a consultant should be mutually agreeable to the attending Physician and the patient or responsible party.

3. **Process.** The request for consultation should be made directly between Physicians and documented in the Physician's order sheet and/or the medical record. A nurse should not be asked to make the initial contact with the consulting Physician(s).

E. **On-Call Physician Rule.** The Hospital intends to comply with 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 V.E 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 V.E, 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 effect 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 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. **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.

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

   (a) The on-call Physician must satisfy the requirements of Section 3.2.D of the Medical Staff Bylaws and 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.

8. **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.

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

VI. 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 Appendix A and Hospital policies and procedures, and all provisions set forth in applicable federal and state laws.

VII. AMENDMENTS

A. **Proposal and Approval.** Any amendment to these Rules and Regulations shall be proposed and approved in accordance with Article 15 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 in accordance with Article 13 of the Medical Staff Bylaws and do not require approval by the Governing Body in order to become effective.

Approved: Jolan Ippolito Chair, Governing Board, Rumford Hospital	May 08, 2012
Approved: R. David Frum CEO/President, Rumford Hospital	May 08, 2012
Approved: John Kroger, M.D. President, Medical Staff, Rumford Hospital	March 08, 2012
Approved: Sean Callender, M.D. Chief of Staff, Rumford Hospital	March 08, 2012

Reviewed: 02/26/2015

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 and Procedure
- Autopsy Policy and Procedure
- Consultants Recommended by Consultants Policy and Procedure
- Coverage Requirement Response Times Policy and Procedure
- Determining Need for Surgery Policy and Procedure
- Drug Order Policy and Procedure
- Emergency Medicine Department Policy and Procedure
- ICU Admissions Policy and Procedure
- Informed Consent Policy and Procedure
- Medical Records Policy and Procedure
- Non-Invasive Mechanical Ventilation for Adults (NPPV) Policy and Procedure
- Notification and Role of Primary Care Physician when Patient is Admitted by Consultant or Physician Other than the Primary Physician Policy and Procedure
- Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) Policy for Current Practitioners Policy and Procedure
- Patient Termination of Physician's Services Policy and Procedure
- Peer Review Clinical Case Review Policy and Procedure
- Procedures in Case of Abortion Policy and Procedure
- Reporting of Critical Values and Findings Policy and Procedure
- Sedation and Analgesia for Diagnostic Therapeutic, and Invasive Procedures Policy and Procedure
- Specifying the Consultant's Role Policy and Procedure
- Supervision of Fellows, Residents, and Medical Students Policy and Procedure
- Tissue Submission Policy and Procedure

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)

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