



BYLAWS OF THE MEDICAL STAFF

CENTRAL MAINE MEDICAL CENTER

LEWISTON, MAINE

With updates adopted by the Medical Staff on

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Mark Adams Chair, CMMC Board of Trustees

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WHEREAS, the Central Maine Medical Center (“CMMC”) is a non-profit corporation organized under the laws of the State of Maine; and,

WHEREAS, CMMC’s purpose is to serve as a general hospital providing a uniform standard of patient care, education and research consistent with the mission, vision and value statement as set forth in the CMMC 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 CMMC, and the Governing Body are necessary to fulfill the Hospital’s obligations to its patients;

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 CMMC as a dentist, podiatrist, physician assistant, psychologist, nurse practitioner, certified registered nurse anesthetist, or certified nurse midwife, pursuant to ARTICLE 4. For purposes of clarity, Members of the Associate Professional Staff are not considered members of the Medical Staff, but may vote at medical staff meetings pursuant to article 13.
- 1.4 Associate Professional Staff Liaison has the meaning set forth in Section 4.4.A.6
- 1.5 CME means continuing medical education.
- 1.6 CMHC means the Central Maine Healthcare Corporation, the sole corporate member of CMMC.
- 1.7 CMMC has the meaning set forth in the Preamble.
- 1.8 CMMG means the unincorporated division of CMMC referred to as the “Central Maine Medical Group.”
- 1.9 Courtesy Medical Staff has the meaning set forth in Section 4.3.
- 1.10 Division has the meaning set forth in Section 10.1.A.
- 1.11 Division Chief has the meaning set forth in Section 10.2.A.
- 1.12 Division Vice Chief has the meaning set forth in Section 10.2.B.
- 1.13 Governing Body means the Board of Trustees of CMMC.
- 1.14 Hospital means the hospital of CMMC, including all associated treatment areas, Divisions, Sections, and services included in the hospital license.
- 1.15 Investigation Committee has the meaning set forth in Section 7.1C.
- 1.16 Locum Tenens Allied Health Professional has the meaning set forth in Section 4.5.
- 1.17 Locum Tenens Physician has the meaning set forth in Section 4.5.
- 1.18 Locum Tenens Staff has the meaning set forth in Section 4.5.
- 1.19 Medical Staff has the meaning set forth in Section 2.1. For purposes of clarity, Medical Staff includes Active Medical Staff, Senior Active Medical Staff, Courtesy Medical Staff,

and Locum Tenens Physicians. Medical Staff does not include Associate Health Professionals or Locum Tenens Associate Professionals Staff.

- 1.20** Medical Staff Chief means the Physician elected by the Medical Staff to the office of Medical Staff Chief pursuant to Section 9.3.
- 1.21** Medical Staff President means the officer of the Medical Staff who will ordinarily be the person serving from time to time as President of CMMG.
- 1.22** Medical Staff Rules and Regulations has the meaning set forth in Article 16.
- 1.23** 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.
- 1.24** MMA means the Maine Medical Association.
- 1.25** Nominating Committee has the meaning set forth in Section 9.3.B.
- 1.26** Officers of the Medical Staff means the Medical Staff President, the Medical Staff Chief, and the Medical Staff Vice Chief.
- 1.27** Physician means an appropriately licensed allopathic or osteopathic physician or an appropriately licensed oral surgeon.
- 1.28** Practitioners means members of the Medical Staff, Associate Professional Staff, and Locum Tenens Allied Health Professionals.
- 1.29** President of CMMC means the individual who acts on behalf of the Governing Body with respect to the overall management of the Hospital.
- 1.30** Section has the meaning set forth in Section 10.1.A.
- 1.31** Section Chief has the meaning set forth in Section 10.2.C.
- 1.32** Senior Active Medical Staff has the meaning set forth in Section 4.2.
- 1.33** Special Committee means a committee formed on an “as needed” basis by the Medical Executive Committee or the Peer Review Committee. Special Committees are sometimes referred to as “*ad hoc*” committees.
- 1.34** Staff means Medical Staff, Associate Professional Staff, and Locum Tenens Allied Health Professionals.
- 1.35** Standing Committee has the meaning set forth in Section 11.3.
- 1.36** Subsection has the meaning set forth in Section 10.2.D.
- 1.37** Subsection Chief has the meaning set forth in Section 10.2.D.

- 1.38** 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 the service is provided and the distant site shall mean the site where the person providing the professional service is located.
- 1.39** Voting Medical Staff Members has the meaning set forth in Section 13.7
- 1.40** Admitting providers includes any member of staff who has been granted admitting privileges.

ARTICLE 2 NAME AND PURPOSES

2.1 Name

The name of this organization shall be the Medical Staff of the Central Maine Medical Center ("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 CMMC 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, Sections, 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 CMMC 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

3.2 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 qualifications¹, standards, and requirements set forth in these Bylaws, the Medical Staff Rules and Regulations and in any applicable Medical Staff policies. Qualifications, Conditions and Responsibilities

3.2.A Threshold Eligibility Criteria

To be eligible to apply for initial appointment or reappointment or clinical privileges an applicant must, as applicable:

- (a) have current, unrestricted license to practice in Maine that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees, and have never had a license to practice revoked, restricted or suspended by any state licensing agency;*1
- (b) Where applicable to their practice, have a current unrestricted DEA registration;
- (c) be geographically and otherwise available to meet the needs of patients and the Hospital. Whether a Physician is geographically and otherwise available shall be determined, in each case, by the Governing Body, after consultation with or recommendations by the Medical Executive Committee and/or the Credentials Committee. 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.
- (d) be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of inpatients and Emergency Department patients, in a prompt, efficient and conscientious manner (Appropriate coverage means coverage by another member of the Medical Staff with specialty-specific privileges equivalent to the practitioner for whom he/she is providing coverage.) Compliance with this eligibility requirement means that the provider must document his/her willingness and able to: 1) respond within in 10 minutes via phone to STAT pages from the Hospital and within 30 minutes via phone to all other pages; 2) appear in person to attend a patient within section specific time requirements if requested to do so
- (e) have appropriate coverage arrangement, as determined by the Credentials Committee, with other members of the medical staff for those times when the individual will be unavailable;

- (f) have current, valid professional liability insurance coverage in the forms and amount satisfactory to the hospital. *1
- (g) have never been convicted of, or entered plea of guilty or no contest to Medicare, Medicaid, or other federal or state governmental or private third party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;
- (h) are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care programs;
- (i) have never had medical staff or associate professional staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this hospital, or health plan for reasons related to clinical competence or professional conduct;
- (j) have never resigned Medical Staff appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;
- (k) since the beginning of medical training (e.g residency), have not been convicted of, or entered a plea of guilty or no contest, to any felony or misdemeanor related to: (i) controlled substances,(ii) illegal drugs,(iii) insurance or health care fraud(including Medicare, Medicaid or other federal or state governmental or private third-party payer fraud program abuse);(vi) violent acts;(v) sexual misconduct;(vi)moral turpitude;(vii) child or elder abuse
- (l) agree to fulfill all responsibilities regarding emergency call for their specialty;
- (m) document compliance with all applicable training and educational protocols that may be adopted by MEC and required by the Board, including but not limited to those involving electronic medical records or patient safety;
- (n) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought or granted;
- (o) if applying for privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in the contract;
- (p) demonstrate recent clinical activity in their primary area of practice, during the last two years;
- (q) have successfully completed;
 - a. a residency and, of applicable, fellowship training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association , the Canadian Medical Association , the Royal College of Physicians and Surgeons of Canada, London or England, or other post-doctoral medical training program in the specialty in which the applicant seeks clinical privileges; or

- b. a dental or oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association; or
 - c. a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;
- (r) be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties (ABMS), the AOA, the American Board of Oral and Maxillofacial Surgery or the ADA, the American Board of Podiatric Surgery ,as applicable. The applicants who are not board certified at the time of application but who have completed their residency or fellowship training must become certified within the eligibility timeframe established by the applicable specialty board and
- (s) maintain board certification and, to the extent required by the applicable specialty/ subspecialty board, satisfy recertification requirements;
- (t) 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 certificate can be used to meet this requirement.
- (u) health screening and immunizations as required

*Footnotes:

1. Notwithstanding the general requirement, members of the Locum Tenens staff need only demonstrate insurance coverage and State Licensure when they are working at CMMC or affiliated practice of hospital

2. On eligibility criteria- at the beginning of an application process all items may not yet be complete (e.g Maine license or Maine DEA) but must be in place before an application is considered complete and moved forward for approval

3.2.B Waiver of Threshold Criteria:

(a) Any individual who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider specific qualifications of the individual in question, input from the relevant section or division chief, the best interest of the Hospital and the community it serves. Additionally the Credentials Committee, may in its discretion, consider the application

form and other information supplied by the applicant. The Credentials committee recommendation shall be forwarded to the MEC. Any recommendation to grant a waiver must include specific basis for the recommendation.

(c) MEC shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(d) A determination that an individual is not entitled to a waiver is not a “denial of appointment or clinical privileges and is not a basis for appeal or other due process.

(e) The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals,

(f) An application for appointment that does not satisfy an eligibility criterion shall not be processed until the Board has determined that a waiver should be granted.3.2 C.

Factors for Evaluation:

The following factors shall be evaluated as part of the appointment and reappointments processes:

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgement, and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of their professions, continuous professional development, and responsible attitude toward patients, professional colleagues and their profession;

(c) good reputation and character;

(d) ability to safely and competently perform the clinical privileges requested;

(e) ability to work harmoniously with others, including but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

(f) recognition of the importance of, and the willingness to support, the Hospital’s and Medical Staff’s commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

3.2 D No entitlement to Appointment

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staff or to be granted particular clinical privileges merely because he or she;

(a) is licensed to practice a profession in this or any other state;

(b) is a member of any particular organization;

(c) has had in the past, or currently has Medical Staff appointment or privileges at any hospital or entity.

3.2.E. Non- discrimination

No individual shall be denied appointment or reappointment on the basis of gender, age, race, creed, national origin, physical or mental disability, which does not constitute an impairment to exercise requested privileges, and sexual orientation.

3.3 General Conditions of Appointment and Reappointment

3.3.A Burden of Providing Information:

(a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications.

(b) Individuals seeking appointment and reappointment have the burden of providing evidence that all statements made and information given on the application are accurate and complete.

(c) An application shall be completed when all questions on the application form have been answered, all supporting documentation has been supplied, and required information has been verified with primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

(d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

(e) Any misstatement in, or omission from the application, is grounds for the Hospital to stop processing the application. If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished. In either situation, there shall be no entitlement to a hearing or appeal.

3.4. APPLICATION

Application for appointment shall be in writing and shall be on the approved forms. Final action shall not be taken until all applicable threshold eligibility criteria are satisfied.

3.4.A. Information

Except as provided for in 4.1.D, applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's qualifications,

In addition to other information, the applications shall seek the following:

(a) information as to whether or not the applicants medical appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital or health care facility or are currently being investigated or challenged.

(b) Information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(c) information concerning the applicant's professional liability experience, including past and pending claims, final judgements, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the MEC, or the Board may request.

(d) current information regarding the applicant's ability to safely and competently exercise clinical privileges requested, including names of professional references and detailed procedures lists as requested; and

(e) a legible copy of government –issued photo identification

The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

3.4.B. Grant of Immunity and Authorization to Obtain/Release Information;

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this section:

(a) Immunity

To the fullest extent permissible by law, the individual releases from any and all liability, extends absolute immunity to and agrees not to sue the Hospital or the Board, any member of the Medical Staff or the Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties

The individual specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital if required by the Medical Staff or Hospital.

(c) Authorization to Release Information to Third Parties

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(d) Hearing and Appeal Procedures;

The individual agrees that the hearing and appeal procedures set forth in the Bylaws, Rules and Regulations or Policies shall be the sole and exclusive remedy with respect to any professional action taken by the Hospital.

(e) Legal Action

If an individual institutes legal action challenging any credentialing, privileging, or peer review action and does not prevail, he or she shall reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees and lost revenue.

(f) Scope of Section

All the provisions in this Section are applicable in the following situations:

(i) whether or not appointment or clinical privileges are granted;

(ii) throughout the term of any appointment or reappointment period and thereafter;

(iii) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and

(iv) as applicable, to any third party inquiries received after the individual leaves the Medical Staff about his/her tenure at the Hospital.

3.5 Conditions and Duration of Medical Staff Appointment

3.5 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.

3.5.B Term. Initial appointment to the Medical Staff, except for Locum Tenens Physicians, shall be for a period of at least a 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.

3.5.C Provisional. All initial appointments to any category of the Medical Staff or applications for enhancement of Clinical Privileges shall be provisional (“under supervision” of the applicable Section Chief) for a period of at least six (6) months , with the exception of appointments of staff members qualifying for active membership without clinical privileges under provisions of Article 4, Section 4.1.D. 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 be appointed to a specific Section and 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.

3.5 C.1 Division Chief and Section Chief Review. Before completion of the provisional period, or if review is not practicable before completion, then soon after completion of the provisional period, the appropriate Division Chief (or designee) and Section 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 3.5.C. As set forth in Section 5.3, the Division Chief or Section Chief (or their designee) will jointly recommend to the Credentials Committee either regular Medical Staff membership (in the appropriate category) or continuation of provisional status, subject to the three (3) year limitation. The Credentials Committee shall forward the recommendation of the Division Chief and Section Chief to the Medical Executive Committee for review and recommendation to the Governing Body, which shall take final action.

3.5.B.2 Notification of Adverse Recommendation. Any provisional appointee shall be notified in writing in a timely manner of any adverse recommendation from the Credentials Committee 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 Committee prior to the

Credentials Committee'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.

3.6 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 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 applicable Division Chief and/or Section Chief, as appropriate, 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 Committee.

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 B.4 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 membership from a Practitioner so terminated shall be submitted and processed in the manner specified for applications for initial appointment.

3.6.B.5 Return from Leave. Upon return from any leave of absence and upon request of the Section Chief, the Practitioner shall provide his/her Section 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 the Section Chief in assessing maintenance of competency for the Clinical Privileges the Practitioner holds.

3.7 Basic Responsibilities of the Medical Staff and APS Membership

Unless otherwise provided in these medical staff bylaws, the ongoing responsibilities of each practitioner include:

- (a) Providing patients with care consistent with applicable professional standards of quality and appropriateness;
- (b) Abiding by the Medical Staff Bylaws and any applicable Service or Section rules, regulations or policies and applicable Medical Center policies and Medical Center bylaws;
- (c) Abiding by all applicable state and federal laws and regulations;
- (d) Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership;
- (e) Discharging such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Staff Executive Committee;
- (f) Abiding by the current Code of Ethics as adopted by the professional association applicable to the category or license of the provider.
- (g) Conducting oneself professionally in dealings with healthcare professionals, patients and all others so as not to adversely affect patient care as set forth in the Code of Conduct.
- (h) Disclosure of personal and professional Conflicts of Interest in fulfilling any of the functions of the Medical Staff (see Addendum IV to the Maine Physician Application, the Maine Professional Staff Application and the Maine Application for Reappointment);
- (i) Absence from conflict of interest that is determined to be inconsistent with the responsibilities of a member of the Medical Staff; or in the event of a conflict an appropriate management plan is in place
- (j) Making appropriate arrangements for coverage for his or her patients as outlined in the Bylaws or as determined by the Division Chief
- (k) Providing consultation services and/or care for emergency medical conditions on an on-call basis as outlined in the Bylaws or policy;
- (l) Serving as admitting and/or attending Physician/Dentist for patients for whom the Medical Center cannot identify an appropriate admitting/attending Physician on an on-call basis as determined by the as outlined in the Bylaws or MS policy
- (m) Paying Medical Staff Dues;
- (n) Wearing a visible CMH identification badge which is not obscured by tape or other means.
- (o) Being subject to and participating in applicable elements of the CMMC Quality improvement and the Patient safety plan.
- (p) Cooperating with hospital infection prevention and control personnel to reduce the incidence of healthcare associated infections by adherence to infection prevention

and control guidelines, including personal participation in immunizations and infectious disease screenings to the extent and on a schedule as recommended by the Infection Prevention and Control Committee and as approved by the Medical Staff Executive Committee.

- (q) Participating in hospital training relevant to the physician's specialty and Division, and demonstrating competency concerning use of hospital facilities, equipment and supplies, including but not limited to hospital information systems including the electronic medical record and others, and using such facilities, equipment and supplies in compliance with applicable Medical Center policy;
- (r) Partaking of continuing medical education programs that are at least in part related to the Medical Staff member's Privileges;
- (s) Participating in Medical Center educational programs for medical students, interns, residents, staff physicians, dentists, podiatrists, nurses or other personnel, unless otherwise exempted by their Division Chief or these Bylaws
- (t) Being subject to and participate in any meeting requested by the Division Chief of the Division the member is assigned to, the Chief Quality Safety Officer or the President of the Medical Staff or his/her designee.
- (u) Serving on Medical Staff committees as assigned;
- (v) Attending Medical Staff Meetings as well as Division and/or Section meetings as determined by the Division Chief;

If at any time the applicant, Medical Staff member or Associate Professional becomes aware of his/her inability to meet any of the requirements of Section 3.7, he/she shall report this to the Medical Staff Office as soon as possible and in no case later than fifteen (15) days.

3.7 B Medical Staff Dues and Assessments

General Requirements. All members of the Active and Courtesy Medical Staff and Associate Professional Staff shall pay dues and special 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. Other members or categories of staff such as members of the Senior Active Medical Staff, Locum Tenens Staff, Moonlighting Residents, and Telemedicine Providers will not be required to pay dues and special assessments.

3.7 C. 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.

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 of Appendix C of the Medical Staff Rules and Regulations, 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 both initial appointment to the Staff and upon application for reappointment.

Service Coverage Responsibilities.

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.

Section Policies. Individual Sections may 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 coverage 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.

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 Section 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.

3.8 Reporting Requirements

A member of the staff must report the following events to the Medical Staff Office as soon as practicable and in no case greater than fifteen (15) business days after receiving knowledge or notice of::

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

16 Receipt of letter of complaint or notice of final action taken by a professional licensing board.

17. Any discipline by a professional society or resignation from such a society while allegations were pending

18. Any event that changes information provided on the most recent application

The Manager or Director of Medical Staff Office, in concert with the chairperson of the Practitioner Health Committee or designee, will review all reports and triage based on significance and impact on patient safety or quality. Unless the event is covered by Article 7 automatic suspension, reports that are deemed significant will be referred to the Practitioner Health Committee for review and management.

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. Members of the Active Medical Staff shall be appointed to a specific Section.
- 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), their Section meetings (as set forth in Section 12.7), and their Division meetings when called. Active Medical Staff members shall provide call coverage services consistent with the requirements of Appendix C of the Medical Staff Rules and Regulations.
- 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.** Notwithstanding the provisions of 4.1.A and 4.1.B. the President of the Medical Staff, if also serving as the President of CMMG, may be appointed to the Active Medical Staff without being granted Clinical Privileges and without meeting the other requirements of those subsections, or staff requirements appropriate to members with Clinical Privileges, including the specifically the requirements in Article 5 and 6.

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 Senior Active Medical Staff

- 4.2.A **Qualifications and Requirements.** Members of the Active Medical Staff may be appointed to the senior active medical staff (“Senior Active Medical Staff”) if they meet either of the following requirements: (i) they have reached the age of sixty-five (65) years and have served on the Active Medical Staff for at least five (5) years or (ii) they have served on the Active Medical Staff for at least twenty-five (25) years.
- 4.2.B **Duties and Responsibilities.** Senior Active Medical Staff members shall have Admitting Privileges and shall be eligible to vote, hold office, and serve on Medical Staff committees. Senior Active Medical Staff members shall be exempt from providing

unassigned call coverage, unless required to do so by an employment agreement or other written agreement with the Hospital, in which case the provisions of Appendix C of the Medical Staff Rules and Regulations shall apply. Members of the Senior Active Medical Staff shall attend Medical Staff meetings (as set forth in Section 13.4), their Section meetings (as set forth in Section 12.7), and their Division meetings when called.

4.3 Courtesy Medical Staff

- 4.3.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 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, then member will be responsible for unassigned Emergency Department call for his/her specialty/section if required by his/her section/division.
- 4.3.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.
- 4.3.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 Active Medical Staff.
- 4.3.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 for each section by the applicable Section Chief, when necessary. Issues that arise and that cannot be settled in a timely manner at the section level shall be resolved by the Medical Executive Committee. A member of the Courtesy Medical Staff who is responsible for call coverage of an inpatient in the Hospital shall be available within the timeframe set forth in the applicable Medical Staff policy.

4.4 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., but may vote at medical staff meetings pursuant to Article 13.

- 4.4.A **Duties and Responsibilities.** Members of the Associate Professional Staff will have the duties and responsibilities set forth below.

- 4.4.A.1 **Meetings and Committees.** Members of the Associate Professional Staff may attend Medical Staff meetings and shall serve as members of Medical Staff committees when requested. Members of the Associate Professional Staff shall attend their Section meetings as set forth in Section 12.7 and their Division meetings if called.
- 4.4.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.
- 4.4.A.3 **Reporting requirements set out in Article 3.8, .** Members of the Associate Professional Staff shall notify the Medical Staff office as soon as practicable and in no case greater than 15 days for any of the events outlined
- 4.4.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.
- 4.4.A.5 **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 VII 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.

4.4.B Associate Professional Staff Liaison. The Associate Professional Staff shall elect a member of the Associate Professional Staff ("Associate Professional Staff Liaison") to serve on the Medical Executive Committee as set forth in Section 11.1.B.1. The APS Liaison may be removed by a two thirds (2/3) vote of Associate Professional Staff present and voting at a regular or special meeting of the Associate Professional Staff. Notwithstanding any provision of these Bylaws to the contrary, the Associate Professional Staff Liaison shall not be deemed to

be a representative of the Associate Professional Staff with regards to any issues that could be regarded as “terms and conditions of employment.” The Associate Professional Staff Liaison may raise issues related to clinical practice, quality of care, and credentialing to the Medical Executive Committee in his/her discretion.

4.4.B **The Associate Professional Staff Liaison** may convene a meeting of Associate Professional Staff members either before or after each meeting of the Medical Staff or at other times as may be determined by the Associate Professional Staff Liaison. The Associate Professional Staff Liaison may also convene meetings of the Associate Professional Staff within a particular Division or Section. These Associate Professional Staff meetings will serve as a forum where Associate Professional Staff members may discuss issues of clinical practice, quality of care, and credentialing.

4.4.C **Applicant Requirements.** Applicants to the Associate Professional Staff shall meet the threshold eligibility requirements for appointment set forth in Section 3.2 and Section 5.1 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 CMMC 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 categories outlined in the table below.

CATEGORY	RESPONSIBLE TO CHIEF OF
Certified Registered Nurse Anesthetist	Anesthesia Section
Psychologist	Psychiatry Section
Dentist	Oral and Maxillofacial Surgery Section
Certified Nurse Midwife Nurse Practitioner Physician Assistant	Appropriate Section Chief or Designee
Podiatrist	Orthopedic Surgery Section

4.4.D **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 CMMC directly or through CMMG. 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 office of Medical Affairs 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 office of Medical Affairs of his/her resignation. The supervised Practitioner shall be responsible for advising the office of Medical Affairs in writing of any change in supervising Physician status.

4.4.E Members Not Subject to Supervisory Requirement. Members of the Associate Professional Staff who are not subject to the supervisory requirement set forth in Section 4.4.D shall be responsible to the Section Chief of a specified Section of the Medical Staff 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."

4.4.F Podiatrists.

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

4.4.F.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).

4.4.F.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 (ii) hold board certification by the American Board of Podiatric Surgery (ABPS) within five (5) years of eligibility for that board examination.

4.4.F.2 Patient Care. As set forth in Section VI.F.8 of 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.

4.4.F.3 **Responsibility and Reappointment.** Podiatrists shall be responsible to the Section Chief of the General Surgery Section and will be reappointed in accordance with standard reappointment practices for the Associate Professional Staff.

4.4.G **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 11.3.D.2.a. 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 Committee, 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.

4.4.H **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.

4.5 Locum Tenens Staff

4.5.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.

4.5.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.

4.5.C **Duties and Responsibilities.** Locum Tenens Physicians will not be required to meet Medical Staff meeting attendance requirements or to be continuously insured or licensed during the period of their appointment so long as they demonstrate coverage on days actually worked at CMMC or an affiliated practice or hospital. 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 applicable Division Chief or Section Chief. Members of the Locum Tenens Staff are encouraged to attend educational conferences and appropriate Medical Staff meetings.

4.5.D **Transfers.** Locum Tenens Physicians may be transferred to the Active Medical Staff, Courtesy Medical Staff, or Consulting 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.

4.6 Moonlighting Residents

4.6.A Qualifications and requirements. The moonlighting residents staff shall consist of physicians who are within his/her final year of his/her residency in an approved ACGME program and have a current Maine license, malpractice insurance and DEA registration.

4.6.B Duties and Responsibilities. Members shall have the duties set forth below.

4.6.B.1 Must abide by the Medical Staff Bylaws, and all other applicable standards, policies, and rules of the Medical Staff and Medical Center. Practice under the supervision of a physician who is a member of the Active Medical Staff. May attend meetings of the Medical Staff in which he/she is a member. Is not eligible to hold office or vote at the Division, Section or Medical Staff meetings.

4.7 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, pursuant to Section 4.9.A below.

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, Section 3.2 regarding geographical availability.

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 CMMC 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 contract 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 Committee 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.

4.7.A. 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.

4.8 Other Clinical Staff

4.8.A. 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 administrative polices at the hospital.

4.8.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.

4.9 Retirees. At the discretion of the Medical Staff President or his designee, health care practitioners who are retired from active practice may attend medical staff events, meetings and serve on committees. If appointed to a committee, retirees may serve as a voting member. Retirees shall not however have voting privileges at the medical staff meetings.

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 CMMC;
- (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 , all applicants must pay application fee with the submission of the application.

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 office of Medical Affairs. The office of Medical Affairs 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; and
 - (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.

5.2 Appointment Process

- 5.2.A **Division Chief and Section Chief Review and Recommendation.** The Division Chief and Section Chief of every Division and Section in which the practitioner seeks Clinical Privileges shall provide the Credentials Committee with specific, written recommendations for delineating the practitioner’s Clinical Privileges, and these recommendations will be included in the Credentials Committee’s report.
- 5.2.B **Credentials Committee Review and Recommendation.** The Credentials Committee’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 11.3.2.D.2. The Credentials Committee shall determine, through its review and through information contained in references given by the applicant and other sources, including an appraisal by the

appropriate Division Chief and Section 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 Committee 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 Committee, the Medical Executive Committee shall promptly recommend to the Governing Body, through the President of CMMG or the designee, either provisional appointment, rejection, or deferral for further consideration. Except for those applicants qualifying for the active medical staff membership by virtue of the provisions of Article 4, 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, it may refer the matter for discussion and further recommendation to the Joint Conference Committee. The action of the Governing Body shall remain in effect, and shall not be stayed, pending a recommendation from the Joint Conference Committee. 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 Division Chief and Section Chief Review and Recommendation.** Before the expiration of any provisional appointment or reappointment, the Division Chief and Section Chief of the Division and Section to which the appointee was primarily assigned 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 the Division Chief and Section Chief, the Division Chief or Section Chief (or their designee) will make a joint written recommendation to the Credentials Committee.
- 5.3.B Credentials Committee Review and Recommendation.** The Credentials Committee 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 Committee 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 Committee 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 Committee 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, it may refer the matter for discussion and further recommendation to the Joint Conference Committee. The action of the Governing Body shall remain in effect, and shall not be stayed, pending a recommendation from the Joint Conference Committee. 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 Eligibility for Reappointment

All terms, conditions, requirements, procedures and waiver options listed under Article 3 relating to initial appointment shall apply to continued appointment and clinical privileges for reappointment

In addition to be eligible to apply for reappointment and renewal of clinical privileges, an individual must have during the previous appointment term:

(a) completed all medical records (b) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments

(c) had sufficient patient contacts to enable assessment of current clinical judgement and competence for privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and or a quality profile from a managed care company or insurer),. Compliance for submission of quality data for OPPE in the prior reappointment period is a requirement;

(d) Any individual seeking reappointment with clinical privileges shall have exercised those privileges in a CMH hospital or clinic and had some clinical activity in the prior appointment period and

(e) health screening and immunizations or vaccinations as required

5.4.B 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 4.7.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.
- C. The term of any moonlighting resident shall be limited to the duration of their training program.

5.4.C Division Chief and Section Chief Review and Recommendation. Each Division Chief and Section Chief shall review the reappointments of all Practitioners within his/her Division or Section and transmit his/her comments to the Credentials Committee.

5.4.D Credentials Committee Review and Recommendation. The Credentials Committee 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 Committee shall transmit such recommendations, in writing, to the Medical Executive Committee. In the event that the Credentials Committee recommends non-reappointment or a change in Clinical Privileges, the Credentials Committee shall document its reasons for such recommendation.

- 5.4.D.1 **Basis for Recommendations.** The Credential Committee'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) Ethics and conduct;
 - (c) Compliance with the bylaws of CMMC, these Bylaws, the Medical Staff Rules and Regulations, and Medical Staff and Hospital policies;
 - (d) Participation in Medical Staff duties, including attendance at staff and section meetings, committee assignments, emergency call, consultation requests, participation in quality improvement and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;
 - (e) The results of the Hospitals performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner specific information as compared to aggregate information concerning other individuals in the same or similar specialty(provided that, other practitioners shall not be identified)
 - (f) Any focused professional practice evaluations;
 - (g) Verified complaints received from patients and/or staff
 - (h) Proper medical use of the Hospital's facilities for his/her patients;
 - (i) Adherence to Code of Conduct expectations ;
 - (j) General attitude toward patients, the Hospital, and the public;
 - (k) Report of liability experience, which must be reviewed each time a Practitioner is evaluated for reappointment;
 - (l) 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;

- (m) Certification that the applicant is not impaired by any form of substance abuse;
- (n) Record of the applicant's professional performance and conduct at other institutions where he/she holds or has held privileges to practice;
- (o) Results of the National Practitioner Data Bank query; and

Regarding clause (a), above, outside peer review will be used when, in the judgment of the Medical Staff President, or President of CMMC, 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 CMMC 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 (s), above, may be limited to experience since the date of the most recent reappointment.

- 5.4.E **Medical Executive Committee Review and Recommendation.** After receipt of the application and the report and recommendation of the Credentials Committee, 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.F **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.G **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.H **Joint Conference Committee Review.** If the Governing Body concludes that its action substantially conflicts with the recommendation of the Medical Executive Committee, it may refer the matter for discussion and further recommendation to the Joint Conference Committee. The action of the Governing Body shall remain in effect, and shall not be stayed, pending a recommendation from the Joint Conference Committee. 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.

5.6 Failure of Reappointment

- 5.6.A Any member of the Staff who is not reappointed due to not meeting eligibility criteria shall not be eligible to apply for a new appointment to the staff until at least 2 years have expired from the date the previous appointment terminated or expired

ARTICLE 6 CLINICAL PRIVILEGES

6.1 Delineation of Clinical Privileges

Except as provided for in 4.8.B, only members of the Staff shall be entitled to exercise Clinical Privileges in the Hospital. A Staff member, or individual eligible for privileges pursuant to the provisions of section 4.8.B of these bylaws, 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 in the case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, and any delay in administering treatment could add to the danger, any member of the Medical Staff or Allied Health Staff is authorized to do everything possible to save the patient from serious harm to the degree permitted by the members' license, but regardless of Service affiliation Staff category or Privileges.

- 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 Section Chief of every Section in which Clinical Privileges are sought. 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 **Proctoring:** Medical Staff members and APS staff who meet all criteria to be credentialed for Core privileges in their section except the necessary volume requirements (within the last 2 years), may be able to be proctored by someone on the Medical Staff with the current privilege. If a provider desires to be proctored, they should submit their request to the Credentialing Committee prior to initiating any proctoring. Please refer to the Medical Staff Proctoring Plan for further details.
- 6.1.D **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.E **New Services.** Any request for Clinical Privileges that are new to the Hospital shall be individually granted based on a review of relevant criteria for competence, training, experience and any necessary equipment, staffing, space and financial resources needed to support the privilege. Any new service must be specifically approved by the Board.

6.1.F **Investigational Techniques.** Any request for Clinical Privileges that may include an investigational or experimental technique must be approved by the Institutional Review Board. If approved by the IRB, the request can then be considered under the provision of this Article.

6.2 Temporary Admitting and Clinical Privileges

6.2.A Temporary privileges may be granted by the President of the Hospital, upon recommendation of the President or Chief of the Medical Staff, to:

6.2.A.1 Applicants for initial appointment whose complete application is pending review by the MEC and Board, following a favorable recommendation of the Credentials committee. In order to be eligible for temporary clinical privileges, an applicant must have demonstrated ability to perform the clinical privileges requested and have had no (i) current or previously successful challenge to licensure or registration or (ii) involuntary restriction, reduction, denial or termination of membership or clinical privileges at another facility.

6.2.A.2 Non-applicants, where there is an important patient care, treatment, or service need, including the following:

- (i) The care of a specific patient
- (ii) When necessary to prevent lack of services in a needed specialty area
- (iii) Proctoring or
- (iv) When serving as a locums tenens for a medical staff member

The following verified information will be considered prior to the granting of any temporary clinical privileges: (i) completed application, (ii) verification of active status of Maine licensure, (iii) verification of current professional liability insurance and past claims history, (iv) verification of acceptable competence and training to perform the functions for which Clinical Privileges would be granted, (v) results of a National Practitioner Data Bank query.

6.2.B Prior to any temporary clinical privileges being granted, the individual must agree in writing that he/she is subject to and shall abide by Bylaws, policies, and the Rules and Regulations of the Medical Staff and Hospital and any revisions or amendments thereto.

6.2.C **Duration of Clinical Privileges.** The granting of temporary clinical privileges will not exceed 120 days.

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 The granting of temporary clinical privileges is a courtesy that may be withdrawn by the President of the Hospital at any time, after consulting with the President or Chief of the medical Staff, the chair of Credentials Committee or Division Chief.

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

6.2.E.2 **Patients.** The appropriate Section 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.F **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 CMMC.

6.2.F.1 **General.** Clinical Privileges may be granted under this Section 6.2.F to an appropriately licensed practitioner by the President of CMMC, the Medical Staff President or their designee upon the basis of information available which may be reasonably relied upon. The individual granting such temporary privileges will utilize information gathered as outlined in the organizational policy covering responsibility for Disaster Privileging. At a minimum, initial verification will include government issued photo identification as well as a second source document as outlined in the policy. The individual granting such temporary Clinical Privileges shall make reasonable attempts to verify active State of Maine licensure. 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. Primary source verification process must begin once the immediate situation is under control and should be completed within 72 hours from the time the volunteer practitioner presents to the organization. This will follow the process as outlined in 6.2.A. Temporary privileges and will include verification of 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.

6.2.F.2 **Duration of Clinical Privileges.** Clinical Privileges granted under this Section 6.2.G are for the duration of the disaster. The President of the Hospital or designee determine the duration of the disaster. In addition, privileges can be terminated prior to the end of the disaster upon revocation of such Clinical Privileges by any individual having the authority to grant Clinical Privileges.

6.3 Reduction or Surrender of Clinical Privileges and Resignation

- 6.3.A **Submission of Written Request.** At any time, a Practitioner or individual holding clinical privileges, may voluntarily reduce his/her Clinical Privileges or resign from the Medical Staff by submitting an electronic or written 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, unless otherwise state in the request provided that no corrective action is pending.
- 6.3.B **Absence from Medical Staff.** Absence from the Medical Staff for greater than forty (40) days, as provided in Section 3.6 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.
- 6.3.C **Other voluntary relinquishment of privileges.** 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. 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 the Locum Tenens Staff shall not be appointed for a term that is long than two (2) years. If the term of the contract is cancelled or expires, privileges shall be considered to be voluntarily relinquished.
- 6.3.D **Pending Corrective Action.** If corrective action is pending at the time of a voluntary surrender of Clinical Privileges under Sections 6.3.A or 6.3.B, the Governing Body shall decide whether to accept or reject such voluntary surrender of Clinical Privileges.

ARTICLE 7 INVESTIGATION AND CORRECTIVE ACTION

7.1 Collegial, Educational, and /or Informal Proceedings

7.1.A Criteria for Initiation

These bylaws encourage medical staff leaders and hospital management to use progressive steps, beginning with collegial and educational efforts, to address questions related to a practitioner's clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions that have been raised. All collegial intervention efforts by Medical Staff leaders and hospital management shall be considered confidential and part of the hospital's performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged but are not mandatory, and shall be at the discretion of the appropriate medical staff leaders and hospital management. When any observations arise suggesting opportunities for a practitioner to improve, the matter should be referred to peer review in accordance with the peer review and performance improvement policies adopted by the medical staff and hospital. Collegial intervention efforts may include, but are not limited to the following:

- A. Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and timely and adequate completion of medical records.
- B. Following up on any questions or concerns raised about the clinical practice and/or conduct of privileged practitioners with review or inquiry and recommending such steps as proctoring, monitoring, consultation, and letters of guidance.
- C. Sharing summary comparative quality, utilization, and other relevant information to assist individuals to conform their practice to appropriate norms.

Following collegial intervention efforts, if the practitioner's performance and/or conduct remains unsatisfactory, or the performance places patients in danger or compromises the quality of care, or in cases where it appears that patients may be placed in harm's way while collegial interventions are undertaken, the Medical Executive Committee(MEC) will authorize an investigation for the purposes of gathering and evaluating any evidence and its sufficiency

7.2 Investigation

- 7.2.A **Initiation of Investigation.** Any person or committee may provide information to any member of the Medical Executive Committee (MEC) or other Medical Staff leader about the conduct, performance, or competence of medical staff members. A request for an investigation must be submitted in writing by a medical staff officer, committee chair, Hospital President or Board Chair to MEC. The request must be supported by references to the activities or conduct of concern. If MEC itself initiates an investigation, it shall appropriately document its reasons. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be detrimental to patient safety or to the delivery of quality patient care within the hospital,

unethical or illegal, contrary to Medical Staff bylaws and its associated rules, policies or standards of the Medical Staff or Hospital, disruptive of hospital or medical staff operations, an investigation may be requested.

7.2.B Investigation Procedure

If MEC decides an investigation is warranted, it shall direct an investigation to be undertaken. The MEC may conduct the investigation itself or may assign the task to an appropriate Medical Staff Officer, standing or ad-hoc committee of the Medical Staff, or engage an external peer review consultant to carry out the task.

If the investigation is delegated to a committee other than MEC, such committee shall proceed with its investigation promptly and forward a written report of its findings, conclusions and recommendations to the MEC as soon as feasible. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems necessary and such action is approved by the MEC. The investigating body shall notify the practitioner, by special notice, of the allegations that are the basis for the investigation and provide the practitioner an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The meeting between the investigating body and the involved practitioner shall not constitute a “hearing”, as that term is used in the hearing and appeals section in corrective action. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the medical staff engage external consultation. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including recommending suspension, termination of the investigative process, or other action.

An external peer review consultant should be considered when:

- A. The MEC is presented with ambiguous or conflicting information from medical staff reviewers or body or where there does not seem to be a strong consensus for a particular action.
- B. There is no one on the Medical Staff with expertise in the subject under review, or when the only practitioner on the medical staff with the expertise may have a conflict of interest by being a direct competitor, partner or associate of the practitioner being investigated or
- C. The MEC or investigating body feels this action is appropriate.

7.2.C Completion of Investigation

When the individual or body carrying out the investigation submits its written report, the MEC will determine if it is complete and sufficient for the MEC to make a determination of its action. If this investigation is triggered by imposition of precautionary summary suspension, the results of the investigation should be submitted to MEC for its consideration within 14 days from the suspension's imposition. In all other cases the investigation should be concluded as soon as practicable and within 90 days. If MEC believes extenuating circumstances require longer to complete the investigation, it may authorize up to an additional 90 days in which to receive its report.

7.2.D MEC Action

As soon as feasible after the conclusion of the investigation, the MEC shall take action that may include, without limitation:

- A. Determining no corrective action is warranted, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information from the practitioner's file;
- B. Issuing letters of education, admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee or department chairs from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected practitioner may make a written response which shall be placed in the practitioner's file;
- C. Recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring;
- D. Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges;
- E. Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
- F. Recommending suspension, revocation, or probation of medical staff membership; or
- G. Taking other actions deemed appropriate under the circumstances which shall be placed in the practitioner's file;

7.2.E Subsequent Action

- 7.2.E.1 If the MEC recommends any termination or restriction of the practitioner's membership or privileges for a period longer than

fourteen (14) days and is due to a reason of competence or conduct, the affected practitioner will be offered the fair hearing and appeal rights in these bylaws.

7.2.E.2 If the practitioner waives the right to a fair hearing and subsequent appeal, the MEC recommendation will be forwarded to the Board for action.

7.2.E.3 If the practitioner exercises his/her right to the fair hearing and appeal process, the process delineated in these bylaws will be followed.

7.3 Corrective Action

7.3.A Automatic Suspension

In the following triggering circumstances, the practitioner's privileges and/or membership will be considered relinquished, or limited as described, and the action shall be final without a right to hearing provided, however, the practitioner's privileges may be reinstated by the MEC in specific instances in which the triggering circumstances have been rectified or are no longer present or are reinstated automatically when specified below.

Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible and may reinstate the practitioner's privileges or membership after determining that the triggering circumstances have been rectified or are no longer present. If the MEC has not agreed to reinstate the practitioner within sixty (60) days of the triggering event, the practitioner will have to reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these bylaws whenever any of the following actions occur:

1. Licensure

A. Revocation and suspension: Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, medical staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.

B. Restriction: Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted at this hospital that are within the scope of said limitation or restriction shall be automatically limited

or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

C. Probation: Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

2. Medicare, Medicaid, Tricare (a managed-care program that replaced the former Civilian Health and Medical Program of the Uniformed Services), or other federal programs

Whenever a practitioner is sanctioned or barred from Medicare, Medicaid, Tricare, or any other federal programs, medical staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her privileges.

3. Controlled substances

Whenever a practitioner's United States Drug Enforcement Agency (DEA) registration is revoked, limited, suspended or not renewed, the practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the registration, as of the date such action becomes effective and throughout its term.

4. Medical record completion requirements

A practitioner will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever she/he fails to complete medical records within time frames established by the MEC. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. The relinquished privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

5. Professional liability insurance

Failure of a practitioner to maintain professional liability insurance in the amount required by state regulations and medical staff and Board policies shall result in immediate automatic relinquishment of a practitioner's clinical privileges. If this is corrected and evidence is provided to the Hospital within 60 days of adequate insurance coverage (including coverage for any period during which insurance was not maintained), the practitioner's privileges are automatically reinstated. If within 60 calendar days of the relinquishment, the practitioner does not provide evidence of required professional liability insurance (including tail coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the medical

staff. The practitioner must notify the medical staff office immediately of any change in professional liability insurance carrier or coverage.

6. Medical Staff dues/special assessments

Failure to promptly pay medical staff dues or any special assessment shall be considered an automatic relinquishment of a practitioner's appointment and clinical privileges. If this is corrected within 60 days, the practitioner's privileges are automatically reinstated. If within 60 calendar days, after written warning of the delinquency, the practitioner does not remit such payments, the practitioner shall be considered to have voluntarily resigned membership of the medical staff.

7. Felony conviction

A practitioner who has been convicted of or pled "guilty" or "no contest" or its equivalent to a felony involving a charge related to violence, physical or sexual abuse, insurance or healthcare fraud or abuse, or drug offenses in any jurisdiction shall automatically relinquish medical staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary.

8. Failure to satisfy the special appearance requirement

A practitioner who fails without good cause to appear at a meeting where his/her special appearance is required in accordance with these bylaws shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored when the practitioner complies with the special appearance requirement, provided it is within 30 days. Failure to comply within 30 calendar days will be considered a voluntary resignation from the medical staff.

9. Failure to participate in an evaluation

A practitioner who fails to participate in an evaluation of his/her qualifications for medical staff membership or privileges as required under these bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall be considered to have automatically relinquished all privileges. These privileges will be restored when the practitioner complies with the requirement for an evaluation, provided it is within 30 days. Failure to comply within 30 calendar days will be considered a voluntary resignation from the medical staff.

10. Failure to become board certified

A practitioner who fails to become board certified or maintain board certification as required by these bylaws or applicable medical staff credentialing policies will be deemed to have immediately and voluntarily relinquished his or her medical staff

appointment and clinical privileges, unless an exception is granted, for good cause, by the Board upon recommendation from the MEC.

- 7.3.A.1 **MEC Deliberation:** As soon as feasible after action is taken or warranted as described above, the MEC shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in these bylaws.

7.3.B Precautionary (Summary) Restriction or Suspension

- 7.3.B.1 Precautionary suspension is used when there is a need to make sure no harm arises while leadership determines if the practitioner may pose a risk to others. Precautionary suspension does not imply any final finding of responsibility for the situation that gave rise to the precautionary suspension. Investigation follows the use of this type of suspension, which, if it results in an adverse professional review recommendation, will permit the physician to exercise the right to request a hearing.
- 7.3.B.2 Criteria for initiation: A precautionary restriction or suspension may be imposed when a good faith belief exists that immediate action must be taken to:
- 7.3.B.2.a Protect the life or well-being of patient(s)
 - 7.3.B.2.b Reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when medical staff leaders(defined as a MEC member) and/or the Hospital President determines that there is a need to carefully consider any event, concern, or issue that ,if confirmed has the potential to affect patient or employee safety or the effective operation of the institution; or
 - 7.3.B.2.c Prevent or mitigate the actual substantial likelihood of intentional, wrongful disclosure of any confidential identifying patient health information
- 7.3.B.3 Under such circumstances two of the following (Hospital President or designee, President of the Medical Staff or designee, Division Chief or the MEC) may restrict or suspend the medical staff membership or clinical privileges of such practitioner as a precaution.
- 7.3.B.4 Under such circumstances two of the following (Hospital President or designee, President of the Medical Staff or designee, Division Chief or the MEC) may restrict or suspend the medical staff membership or clinical privileges of such practitioner as a precaution.

- 7.3.B.5 Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written special notice to the practitioner, the MEC, the Hospital President. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The precautionary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension.
- 7.3.B.6 Unless otherwise indicated by the terms of the precautionary restriction or suspension, the practitioner's patients shall be promptly assigned to another medical staff member by the President of the Medical Staff or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner
- 7.3.C MEC Action: As soon as feasible and within 14 calendar days after such precautionary suspension has been imposed, the MEC shall meet to review and consider the action and, if necessary, begin the investigation process as noted in Section 2.2 above. Upon request and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event it shall furnish the practitioner with notice of its decision.
- 7.3.D Procedural rights: Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of any investigation described above, the member shall be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days.

ARTICLE 8 HEARING AND APPEAL PROCEDURES

8.1 Initiation of Hearing

8.1.A Grounds for Hearing:

(a) A member or applicant to Active, Senior Active Medical Staff and Associate professional staff is entitled to request a hearing whenever the MEC makes one of the following recommendations:

- (i) Denial of initial appointment to the Medical Staff
- (ii) Denial of reappointment to the Medical Staff;
- (iii) Revocation of appointment to the Medical Staff;
- (iv) Denial of requested clinical privileges;
- (v) Revocation of clinical privileges;
- (vi) Suspension of clinical privileges for more than 14 days;
- (vii) Mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or
- (viii) Denial of reinstatement from a leave of absence if the reasons relate to clinical competence or professional conduct.

(b) No other recommendations shall entitle the individual to a hearing, but the MEC or Board may, in its sole discretion, choose to grant a hearing or appellate review to any staff member.

(c) If the Board makes any of these determinations without an adverse recommendation by the MEC, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "MEC" shall be interpreted as a reference to the Board.

8.1.B Actions Not Grounds for Hearing:

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

- (a) Issuance of a letter of guidance, counsel, warning, or reprimand;
- (b) Imposition of conditions, proctoring, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
- (c) Termination of temporary privileges;
- (d) Automatic relinquishment of appointment or privileges;
- (e) Imposition of a requirement for additional training or continuing education;
- (f) Denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to professional competence or conduct;
- (g) Determination that an application is incomplete;
- (h) Determination that an application shall not be processed due to a misstatement or omission; or
- (i) Determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

8.2 THE HEARING

8.2.A Notice of Recommendation:

The Chief of the Medical Staff shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

- (a) A statement of the recommendation and the general reasons for it;
- (b) A statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
- (c) A copy of this Article.

8.2.B Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request shall be made in writing to the Chief of the Medical Staff and shall include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing shall constitute a waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

8.2.C Notice of Hearing and Statement of Reasons:

(a) The hearing shall begin no later than 180 days after request for hearing is received, unless both parties specifically agree in writing to a mutual meeting date. The Chief of the Medical Staff shall schedule the hearing and provide, by special notice, the following:

- (i) The time, place, and date of the hearing;
- (ii) A proposed list of witnesses who may give testimony at the hearing and a brief summary of the anticipated testimony;
- (iii) The names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and
- (iv) A statement of the reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications. If new matters are presented or arise during the hearing, the individual or the MEC shall be entitled to submit a written response and supporting documentation within ten days after the hearing.

(b) The hearing shall begin no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

8.2.D Witness List:

(a) At least 10 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list shall include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

8.2 E Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The Chief of the Medical Staff shall appoint a Hearing Panel in accordance with the following guidelines:

- (i) The Hearing Panel shall consist of at least three members and may include any combination of the following, provided, however, that persons licensed and actively engaged in the practice of medicine in this state shall constitute a majority of the panel.
- (ii) any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level, shall be eligible to participate.
- (iii) knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.
- (iv) employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.
- (v) the Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.
- (vi) the Panel shall not include any individual who is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing.
- (vii) the Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(b) Presiding Officer:

The Chief of the Medical Staff shall appoint a Presiding Officer, who may be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing. The Presiding Officer shall:

- (i) Allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
- (ii) Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
- (iii) Maintain decorum throughout the hearing;
- (iv) Determine the order of procedure;
- (v) Rule on all matters of procedure and the admissibility of evidence;
- (vi) Conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.

The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure. The Board may be advised by legal counsel to the Hospital.

The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

(c) **Objections:**

Any objection to any member of the Hearing Panel, or the Hearing Officer, or the Presiding Officer shall be made in writing, within ten days of receipt of notice, to the Chief of the Medical Staff. A copy of such written objection must be provided to the Chief of the Medical Staff and must include the basis for the objection. The Chief of the Medical Staff shall be given a reasonable opportunity to comment. The Chief of the Medical Staff shall rule on the objection and give notice to the parties. The Chief of the Medical Staff may request that the Presiding Officer make a recommendation as to the validity of the objection.

8.2.F Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.

8.3 PRE-HEARING PROCEDURES**8.3.A General Procedures:**

The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply.

8.3.B Time Frames:

The following time frames, unless modified by mutual written agreement of the parties, shall govern the timing of pre-hearing procedures:

- (a) The pre-hearing conference shall be scheduled at least 14 days prior to the hearing;
- (b) The parties shall exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and
- (c) Any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

8.3.C Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense.

The provision of this information is not intended to waive any privilege under Maine law.

(b) The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense.

The provision of this information is not intended to waive any privilege under Maine law.

(c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Medical Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

(d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

(e) Neither the individual, nor any other person acting on behalf of the individual, may contact Medical Staff members whose names appear on the MEC's witness list or any Hospital employee in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who requested the hearing once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by, or on behalf of, the individual who requested a hearing.

8.3.D Pre-Hearing Conference:

The Presiding Officer shall require the individual or a representative (who may be counsel) for the individual and for the MEC to participate in a pre-hearing conference, which shall be held no later than 14 days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

8.3.E Stipulations:

The parties and counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live-testimony is reasonably required.

8.3.F Provision of Information to the Hearing Panel:

The following documents shall be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference, (without the need for authentication); and (c) stipulations agreed to by the parties.

8.4. HEARING PROCEDURES

8.4.A Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

- (i) To call and examine witnesses, to the extent they are available and willing to testify;
- (ii) To introduce exhibits;
- (iii) To cross-examine any witness on any matter relevant to the issues;
- (iv) To have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and
- (v) To submit proposed findings, conclusions, and recommendations to the Hearing Panel.

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

8.4.B Record of Hearing:

A recording and transcript of the hearing will occur. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

8.4.C Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

8.4.D. Presence of Hearing Panel Members:

It is expected the majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

8.4.E Persons to be Present:

The hearing shall be restricted to those individuals involved in the proceeding, the President of the Medical Staff, the Chief of Staff and the President of the Hospital. In addition, administrative personnel may be present as requested by the President of the Hospital, President of the Medical Staff or the Chief of Staff.

8.4.F Order of Presentation:

The MEC shall first present evidence in support of its recommendation. Thereafter, the individual who requested the hearing may present evidence.

8.4.G Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence need not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

8.4.H Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

8.4.I Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the President of the Hospital on a showing of good cause.

8.5. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

8.5.A Basis of Hearing Panel Recommendation:

The MEC has the burden of proof to support the recommendation. The Hearing Panel shall recommend in favor of the MEC if it finds that the recommendation is supported by a preponderance of the evidence.

8.5.B Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. Thereafter, the Hearing Panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

8.5.C. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the Chief of the Medical Staff. The Chief of the Medical Staff shall send by special notice a copy of the report to the individual who requested the hearing. The Chief of the Medical Staff shall also provide a copy of the report to the MEC.

8.6 APPEAL PROCEDURE

8.6.A Time for Appeal:

(a) Within ten days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the Hospital President either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within ten days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

8.6.B Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) There was substantial failure by the Hearing Panel to comply with this Policy and/or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; and/or

(b) The recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

8.6.C Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board shall schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

8.6.D Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three members of the Board.

b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(c) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or

confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

8.7 **BOARD ACTION**

8.7.A **Final Decision of the Board:**

(a) Within 30 days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter. Thereafter, the Board shall take final action. The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure. The Board may be advised by legal counsel to the Hospital.

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.

8.7.B **Further Review:**

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

8.7.C **Right to One Hearing and One Appeal Only:**

No member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board, upon recommendation of the Medical Staff Executive Committee, provides otherwise.

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 will ordinarily be the person serving as President of CMMG. Notwithstanding the provisions of 9.2 below or any other provisions of these Bylaws, the President, if also serving as President of CMMG, may be appointed to the Active Medical Staff without holding any clinical privileges. 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 or Senior Active Medical Staff at the time of appointment or nomination and election and must remain members of the Active Medical Staff or Senior 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 or Senior 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 or Senior 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 March 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 June 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 or Senior 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 Medical Staff President, the President of Central Maine Healthcare shall appoint a replacement in the role of the President of CMMG. If such appointment is not made within 30 days, the Medical Executive Committee shall appoint an acting Medical Staff President until such time the President of Central Maine Healthcare 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 CMMC 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 on Standing Committees as required by these Bylaws;

- (d) Serve as Chair of the Medical Executive Committee; or with his/her concurrence the Chief of Staff may chair the committee.
- (e) Consult with the Medical Staff Chief in the appointment of Standing Committee members and Chairs;
- (f) Have the right to attend all Standing Committee meetings in his/her discretion;
- (g) 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;
- (h) 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;
- (i) In coordination with the Medical Staff Chief, serve as an official spokesperson for the Medical Staff;
- (j) Attend meetings of the Governing Body to provide effective communication among the Medical Staff, Hospital administration, and the Governing Body; and
- (k) 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 on Standing Committees as required by these Bylaws;
- (d) Appoint committee members to all Standing Committees in consultation with the Medical Staff President (unless delegated to the Chair of the applicable Standing Committee as set forth in Section 11.2.A);
- (e) Select the Chair of each Standing Committee in consultation with the Medical Staff President, except as set forth in Section 11.3.F.1.d;

- (f) Represent the views, policies, needs, and grievances of the Medical Staff to the Governing Body and the Hospital administration, including the President of CMMC;
- (g) In coordination with the Medical Staff President, serve as an official spokesperson for the Medical Staff;
- (h) Attend meetings of the Governing Body to provide effective communications among the Medical Staff, Hospital administration, and Governing Body; and
- (i) 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.
- (j) To serve as chair of MEC 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) Serve on Standing Committees as required by these Bylaws;
- (b) Assume the duties and authority of the Medical Staff Chief in the event of a vacancy in the office of Medical Staff Chief; and
- (c) 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 STAFF

10.1 Organization of Divisions and Sections

- 10.1.A **General Organization.** The Medical Staff shall be organized into divisions (each, a “Division”) and sections (each, a “Section”) which shall correspond to the divisions and sections of CMMG. Notwithstanding the foregoing, in the event that a section of CMMG has fewer than three (3) members, such section will not be a Section of the Medical Staff, and the Medical Staff may contain Sections in addition to the sections of CMMG at the discretion of the Medical Executive Committee. Each member of the Medical Staff shall be assigned membership in at least one Division and Section, except for those members exempt by virtue of qualifying for active staff membership through the provisions of Article 4, Section 4.1.D..
- 10.1.B **Policy Making.** Each Division and Section may establish its own policies directly pertaining to professional medical care, consistent with the policies of the Medical Staff and of the Governing Body, which shall be approved by the Medical Executive Committee.
- 10.1.C **Current Divisions and Sections.** The current Divisions and Sections of the Medical Staff are as follows:
- 10.1.C.1 Hospital-Based Care Division, with the following Sections:
 - 10.1.C.1.a Adult Hospitalist and Palliative care Section,
 - 10.1.C.1.b Emergency Medicine Section,
 - 10.1.C.1.c Intensive Care Section,
 - 10.1.C.2 Primary Care Division, with the following Sections:
 - 10.1.C.2.a Family Practice Residency and Sports Medicine Section,
 - 10.1.C.2.b Family Practice , Internal Medicine and Psychiatry Section,
 - 10.1.C.2.c Pediatrics Inpatient and Outpatient Section
 - 10.1.C.3 Specialty Care Division, with the following Sections:
 - 10.1.C.3.a Gastroenterology, Infectious Disease, Allergy, Nephrology, Pulmonary/Sleep, Endocrinology and Rheumatology Section
 - 10.1.C.3.b Neurology, Dermatology, Physical Medicine & Rehab and Radiology Section;
 - 10.1.C.4 Oncology Services Division, with the following section:
 - 10.1.C.4.a Hematology/Oncology and Radiation Oncology Section;

10.1.C.5 Surgical Care Division, with the following Sections:

10.1.C.5.a Anesthesia and Pain Section,

10.1.C.5.b General Surgery, Bariatric Surgery and Trauma Section,

10.1.C.5.c Obstetrics and Gynecology Section,

10.1.C.5.d Orthopedic Surgery Section,

10.1.C.5.e Pathology Section,

10.1.C.5.f Subspecialty Surgery Section (ENT, Ophthalmology, Plastic Surgery, Urology, Urogynecology, Breast Surgery, Neurosurgery, Surgical Oncology, Oral and Maxillofacial,);

10.1.C.6 Heart and Vascular Division, with the following Sections:

10.1.C.6.a Cardiothoracic Surgery, Vascular Surgery and Cardiology Section

10.2 Division and Section Leadership

10.2.A **Division Chiefs.** Each Division will be supervised by a Chief (“Division Chief”) who will ordinarily be the Chief of the corresponding division of CMMG or such other Physician appointed by the Hospital. At least once per year, the Medical Staff President shall solicit feedback from Staff members of each Division on the performance of the applicable Division Chief. The Medical Staff President shall determine the term of each Division Chief’s appointment and will have the sole authority to remove Division Chiefs.

10.2.B **Section Chiefs.** Each Section will be supervised by a Chief (“Section Chief”) who will ordinarily be the Managing Doctor or the Medical Director of the corresponding section of CMMG. In the event that there is no corresponding section of CMMG or the corresponding section of CMMG is not supervised by a Director or Medical Director, the Medical Staff President and the Medical Staff Chief shall jointly appoint a Section Chief after soliciting from members of the applicable Section recommendations of qualified candidates for the position of Section Chief.

10.2.C **Subsection Chiefs.** The Section Chief of a Section with multiple subspecialties, with the consent of the Medical Staff President and the applicable Division Chief, may designate a subsection (“Subsection”) for one (1) or more of such subspecialties and appoint a lead Physician (“Subsection Chief”) to assume responsibility of the Subsection under the direction of such Section Chief. The Section Chief will have the authority, with the consent of the Medical Staff President and the applicable Division Chief, to determine the term of appointment for each such Subsection Chief and remove such Subsection Chiefs.

10.2.D **Qualifications.** Division Chiefs and Section Chiefs shall be board certified in their specialties (as set forth in Section 3.2.B), shall be members of the Active Medical Staff or Senior Active Medical Staff. Notwithstanding the foregoing, a Physician who is not board certified may serve as a Division Chief or Section Chief if he/she has recognized clinical competency, training, and experience within his/her specialty areas with commensurate Clinical Privileges delineated in the applicable Division or Section so as to qualify him/her for the position of Division Chief or Section Chief.

10.3 Functions and Responsibilities of Division Chiefs

Within each Division, the Division Chief or the Division Chief's designee shall be responsible for the functions and responsibilities set forth below in this Section 10.3.

10.3.A **Division Oversight.** The Division Chief shall oversee the operations and clinical and administrative activities of his/her Division.

10.3.B **Management of Section Chiefs.** The Division Chief shall oversee and manage the Section Chiefs in his/her Division.

10.3.C **Division Meetings.** The Division Chief shall be responsible for calling and chairing Division meetings.

10.3.D **Reporting.** The Division Chief shall report to the Medical Executive Committee.

10.4 Functions and Responsibilities of Section Chiefs

Within each Section, the Section Chief or the Section Chief's designee shall be responsible for the functions and responsibilities set forth below in this Section 10.4.

10.4.A **Clinical Activity.** The Section Chief shall be responsible for all clinically related activities of the Section.

10.4.B **Administrative Activity.** The Section Chief shall be responsible for all administratively related activities of the Section, unless otherwise provided for by the Hospital, including assisting in the preparation of such annual reports and budget planning as may be required by the Medical Executive Committee, the President of CMMC, or the Governing Body.

10.4.C **Reviewing Professional Performance.** The Section Chief shall be responsible for continuing surveillance of the professional performance of all individuals in the Section who have a provisional appointment to the Staff or have delineated Clinical Privileges. This responsibility shall include, without limitation, (i) conducting a review of provider-specific clinical performance improvement information per the OPPE plan, (ii) implementing a mechanism for providing feedback to each member of the Section, and (iii) reporting on the performance of Section members to the Medical Executive Committee, the Peer Review Committee, the applicable Division Chief, or others as appropriate. The Section Chief shall be available to members of the Section to provide advisory guidance on the overall clinical policies of the Hospital and to make specific

recommendations regarding his/her own Section to ensure quality patient care. Outside peer review will be used in the judgment of the Section Chief when there is not adequate expertise within the Hospital, when there may be a conflict of interest, or in any situation where the Section Chief deems that an outside review would be in the best interests of, and would promote the safe and effective operations of, the Hospital.

- 10.4.D **Recommending Clinical Privileges Criteria.** At the request of the applicable Division Chief, the Section Chief shall be responsible for recommending to the Medical Executive Committee and such Division Chief the criteria for Clinical Privileges that are relevant to the care provided in the applicable Section.
- 10.4.E **Recommending Appointment and Reappointment.** The Section Chief shall be responsible for recommending to the Medical Executive Committee the initial appointment, reappointment, Staff category and Clinical Privileges for each member of the Section, based upon qualifications and documented clinical competence.
- 10.4.F **Orientation and Education.** The Section Chief shall be responsible for the orientation and continuing education of all Practitioners in the Section or service.
- 10.4.G **Quality Improvement.** The Section Chief shall be responsible for the continuous assessment and improvement of the quality of care, treatment and services provided in the Section, including determining CME requirements based on performance improvement activities. The Section Chief shall also be responsible for the maintenance of quality control programs, as appropriate.
- 10.4.H **Patient Safety.** The Section Chief shall provide leadership for measuring, assessing, and improving patient safety within the Section.
- 10.4.I **Patient Education.** The Section Chief shall oversee the education of patients and their families on topics related to patient care and patient rights.
- 10.4.J **Assessing and Recommending Sources of Patient Care Services.** The Section Chief shall be responsible for assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Section or the Hospital.
- 10.4.K **Coordination and Integration.** The Section Chief shall be responsible for the integration of the Section or service into the primary functions of the Hospital and the coordination and integration of inter-Section and intra-Section services.
- 10.4.L **Policies and Procedures.** The Section Chief shall be responsible (i) for making recommendations to the Medical Executive Committee and the applicable Division Chief on the development of policies and procedures and (ii) for the implementation and enforcement of policies and procedures that guide and support the provision of care, treatment, and services, including those developed within the Section or arising out of actions taken by the Medical Executive Committee.

- 10.4.M **Recommending Staffing.** The Section Chief shall be responsible for (i) making recommendations to the Medical Executive Committee or the applicable Division Chief for a sufficient number of qualified and competent persons to provide care, treatment and services; and (ii) the determination of the qualifications and competence of Section or service personnel who are not licensed independent Practitioners and who provide patient care, treatment and services.
- 10.4.N **Recommending Resources.** The Section Chief shall be responsible for making recommendations to the Medical Executive Committee or the applicable Division Chief for supplies, space, and other resources needed by the Section or service, including, without limitation, recommendations for the appointment of a Subsection Chief as set forth in Section 10.2.D.
- 10.4.O **Enforcing Bylaws and Rules and Regulations.** The Section Chief shall be responsible for the enforcement of the bylaws of CMMC, these Bylaws, and the Medical Staff Rules and Regulations.
- 10.4.P **Coordination and Cooperation.** The Section Chief shall act in coordination and cooperation with the Medical Executive Committee and the applicable Division Chief. At the request of the Medical Executive Committee or the applicable Division Chief, the Section Chief shall discuss specific issues with the Medical Executive Committee or such Division Chief, including, without limitation, quality and patient safety issues.
- 10.4.Q **Reporting.** The Section Chief shall report to the applicable Division Chief and perform other duties as requested by such Division Chief.

10.5 Functions and Responsibilities of Sections

- 10.5.A **Criteria for Clinical Privileges and Holding Office.** Each Section shall establish its own criteria, consistent with the policies of the Medical Staff and of the Governing Body, for the recommending of Clinical Privileges and for the holding of office in such Section.
- 10.5.B **Performance Improvement.** Each Section shall participate in performance improvement activities using objective criteria to evaluate various aspects of care rendered to patients. These performance improvement activities shall include, but are not limited to, case specific review and mortality and morbidity. Dimensions of performance such as appropriateness, availability, timeliness, effectiveness and continuity, among others, will be assessed.
- 10.5.C **Meetings.** Each Section shall meet as needed to conduct business as determined by the Section Chief.
- 10.5.D **Recommend CME.** Each Section shall recommend CME programs based on changes within the field of practice and findings from any peer review activities or performance improvement initiatives.

10.5.E **Records.** Each Section, if appropriate, shall maintain a permanent record of its findings, proceedings and actions.

10.6 Assignment to Sections and Delineation of Clinical Privileges

Members of the Staff may, by virtue of their education, training, experience, and demonstrated competency, request Clinical Privileges in more than one (1) Section. Assignment to Sections and delineation of Clinical Privileges for Staff members will occur in the following manner:

- (a) Consideration of the Staff application, including privilege application form, by the appropriate Section(s) and Chief(s), who will make a recommendation to the Credentials Committee;
- (b) Review by the Credentials Committee and recommendation to the Medical Executive Committee;
- (c) Review by the Medical Executive Committee and recommendation to the Governing Body; and
- (d) Review and approval by the Governing Body.

ARTICLE 11 COMMITTEES AND MEETINGS

11.1 Medical Executive Committee

11.1.A **Chair.** The Medical Staff President or if delegated, the Chief of Medical Staff 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, (iii) the Medical Staff Vice Chief, (iv) the Division Chiefs, (v) the Associate Professional Staff Liaison, and (vi) Two-elected members of the Medical Staff from different Divisions. Such elected members of the Medical Staff will be chosen by vote of the Medical Staff from a slate of qualified members at large nominated by the Medical Executive Committee or a Special Committee formed by the Medical Executive Committee to nominate such Medical Staff members.

11.1.B.2 **Non-Voting Members.** The non-voting membership of the Medical Executive Committee shall consist of (i) the President of CMMC or their designee, (ii) the senior Hospital administrator responsible for quality, (iii) the Chief Nursing Officer (iv), the senior Hospital administrator responsible for risk management (v) 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.B.4 **Removal.** Elected Members of the MEC may be removed by a two thirds (2/3) vote of the Active Medical Staff present and voting at any regular or special meeting of the Active Medical Staff. Removal of Medical Staff Chief or Vice Chief shall be governed by the provision of Section 9.6. Removal of APS Liaison shall be governed by the provisions of section 4.4.A.6.

11.1.C **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 receive, review, and act upon reports and recommendations from Division Chiefs and Section Chiefs, committees, and Officers of the Medical Staff, 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 coordinate the activities and general policies of the various Divisions and Sections and to approve Division and Section policies;
- (d) To implement and amend policies of the Medical Staff not otherwise the responsibility of the Divisions and Sections;
- (e) To amend, on behalf of the Voting Medical Staff Members, the Medical Staff Rules and Regulations pursuant to Section 17.1.D.1.a;
- (f) To develop and maintain methods for the protection and care of patients and others in the event of internal or external disaster;
- (g) In coordination with the Division Chiefs and Section Chiefs, 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 and to assist in developing programs to achieve these objectives;
- (h) To provide for the preparation of all programs, either directly or through delegation to a program committee or other suitable agent;
- (i) To create the appropriate Medical Staff committee structure to carry out necessary duties, including by designating Special Committees as appropriate;
- (j) To oversee the activities of all Standing Committees 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, which may include costs for legal counsel, hired in consultation with hospital president;
- (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 CMMC and the Governing Body;
- (q) To recommend action to the President of CMMC on matters of a medico-administrative nature;
- (r) To make recommendations on Hospital management to the Governing Body through the President of CMMC;
- (s) To recommend to the Peer Review Committee 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 request that the Peer Review Committee conduct a corrective action investigation when the conduct or competence of a Practitioner is inconsistent with good patient care or the effective operation of the Hospital;
- (w) 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;
- (x) To implement a process to identify and manage matters of individual health for Practitioners, in accordance with Section 11.1.F, which is separate from actions taken for disciplinary purposes and which includes making referrals to the MMA Medical Professionals Health Program, as appropriate;
- (y) To establish a mechanism for dispute resolution between and among members of the Staff involving the care of a patient;

- (z) To report at general Medical Staff meetings;
- (aa) 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
- (bb) 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 Standing Committees, Special Committees, Divisions, Sections, and other activity groups; and (ix) sources of clinical services to be provided by consultation, contractual arrangements, or other agreements.

11.1.D Meeting Frequency. The Medical Executive Committee shall hold meetings monthly. The Medical Executive Committee shall meet in consultation with the Governing Body as requested.

11.1.E Voting Member Subcommittee. There shall be a Voting Member Subcommittee of the Medical Executive Committee consisting of the voting members of the Medical Executive Committee.

11.1.E.1 Purpose. The Voting Member Subcommittee shall be empowered to meet between meetings of the Medical Executive Committee and implement the responsibilities and activities of the Medical Executive Committee. The Voting Member Subcommittee shall report to the Medical Executive Committee on all actions that the Voting Member Subcommittee takes upon delegated authority.

11.1.E.2 Reporting. At each monthly Medical Executive Committee meeting, the Voting Member Subcommittee shall provide minutes of the meetings it has held, and full disclosure of the actions it has taken, since the last full Medical Executive Committee meeting.

11.1.F Manner of action. The action of a majority of the voting members present at a Medical Executive Committee shall be the action of the Committee. Action may be taken without a meeting by the affirmative action of two-thirds of the Committee members voting as long as at least fifty (50) percent of such members have responded (in writing or electronically).

11.1.G Practitioner 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(x). 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(x), the Medical Executive Committee, including any Special Committee formed pursuant to Section 11.1.F.1, 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(x) 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 11.1.F 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.

11.2 Standing Committee Membership and Voting

- 11.2.A **Membership.** All Standing Committees shall consist of the following members: (i) ex officio members, if any, as set forth in Section 11.3; and (ii) appointed members whose selection is subject to the Standing Committee composition requirements set forth in Section 11.3. Appointed Standing Committee members will be appointed by the Medical Staff Chief in consultation with the Medical Staff President, provided, however, that the Medical Staff Chief and the Medical Staff President may jointly agree to delegate appointment authority to the Chair of the applicable Standing Committee. The Medical Staff Chief in consultation with the Medical Staff President shall select the Chair of each Standing Committee. Notwithstanding the foregoing, the Peer Review Committee will have elected members, in addition to ex officio and appointed members, as set forth in Section 11.3.H. The Medical Staff President may attend the meetings of any Standing Committee, including Standing Committees of which he/she is not a member, in his/her discretion. Except as otherwise provided in these Bylaws, a majority of the members of any Standing Committee shall be members of the Active Medical Staff or Senior Active Medical Staff.
- 11.2.B **Term.** Members of the Standing Committees shall serve for two (2) successive years from their appointment or election date or until a successor is appointed or elected.

- 11.2.C **Removal.** Except for members of the Governing Body, members of Standing Committees may be removed by two-thirds (2/3) vote of the Medical Executive Committee.
- 11.2.D **Meeting Frequency.** Standing Committees shall meet at least nine (9) times per year unless otherwise set forth in Section **Error! Reference source not found..**
- 11.2.E **Voting.** Except as otherwise provided in these Bylaws, all Standing Committee members shall have voting rights; provided, however, that a majority of Medical Staff and APS members present at a Standing Committee meeting must vote in favor of an action for such action to be deemed approved by the Standing Committee.

11.3 Standing Committees

The committees (“Standing Committees”) set forth below in this Section 11.3 shall be duly-authorized committees of the Medical Staff reporting to the Medical Executive Committee.

11.3.A Cancer Care Committee and Tumor Board.

- 11.3.A.1 **Composition.** The Cancer Care Committee shall include the following members: (i) at least one (1) Division Chief; (ii) representatives of the specialties of diagnostic radiology, medical oncology, pathology, radiation oncology, and surgery; (iii) representatives from Hospital administration, Cancer Liaison Program, Cancer Registry, Nursing, Quality Improvement, and Social Services; and (iv) other representatives as appropriate, such as a primary care Physician.
- 11.3.A.2 **Duties.** The Cancer Care Committee shall have the following duties:
- (a) Meeting the requirements of the most current American College of Surgeons Commission on Cancer “Cancer Program Standards,” including maintaining and providing leadership for the required cancer program;
 - (b) Assuming responsibility and accountability for all clinical cancer program activities of the Hospital;
 - (c) Developing annual goals and objectives for clinical, community outreach, quality improvement, and programmatic endeavors related to cancer care and monitoring and evaluating these goals on an annual basis;
 - (d) Offering at least one (1) cancer-related educational activity per year;
 - (e) Implementing two (2) improvements per year that directly affect patient care;
 - (f) Supervising a quality management and improvement program;

- (g) Maintaining and supervising a Tumor Board as set forth in Section 11.3.A.3;
- (h) Overseeing a program of public education, prevention and detection, including a formal mechanism to educate patients about cancer-related clinical trials;
- (i) Providing professional education and support for the Staff; and
- (j) Maintaining and managing a cancer registry database by selecting members who will act as Physician advisors to identify and choose sites to be studied, to verify quality of data and to provide recommendations for changes as necessary.

11.3.A.3 Tumor Board.

11.3.A.3.a **Composition.** The composition of the Tumor Board shall be multidisciplinary and shall include, but not be limited to, the following members: (i) representatives of the specialties of surgery, oncology (radiation and medical), radiology, pathology, and family practice; (ii) representatives from nursing, social work, and cancer registry; and (iii) other allied health professionals as appropriate.

11.3.A.3.b **Duties.** The Tumor Board shall have the following duties: (i) providing for multidisciplinary concurrent case review and educational presentations for the Medical Staff; (ii) addressing at least all major anatomical cancer sites occurring at CMMC annually; and (iii) documenting all conferences according to the guidelines set forth by the American College of Surgeons Commission on Cancer.

11.3.A.3.c **Meetings.** The Tumor Board shall meet weekly or at such other interval as required by applicable regulatory agencies or accreditation bodies.

11.3.A.4 **Meetings.** The Cancer Care Committee shall hold meetings at least quarterly, as specified in the American College of Surgeons Commission on Cancer "Cancer Program Standards." The Cancer Care Committee shall submit written reports or minutes to the Medical Executive Committee. The Cancer Care Committee shall have the authority to hold site-specific conferences, in its discretion.

11.3.B Clinical Ethics Committee.

11.3.B.1 Composition.

- 11.3.B.1.a **Ex Officio.** The Medical Staff Chief (or designee) shall serve as members of the Clinical Ethics Committee.
- 11.3.B.1.b **Appointed.** The Clinical Ethics Committee shall include the following additional members: (i) at least one (1) member of the clergy; (ii) one (1) psychologist; (iii) at least one (1) attorney; (iv) a representative from nursing; (v) a representative from Risk Management; (vi) one (1) or more Physicians representing the Medical Staff; and (vii) other allied health professionals as appropriate.
- 11.3.B.2 **Duties.** The Clinical Ethics Committee shall have the duties set forth below.
- 11.3.B.2.a **Case Review.** Upon request of an affected Hospital party, the Clinical Ethics Committee shall provide timely advice and consultative services to improve understanding, facilitate deliberation, and assist in the resolution of specific clinical ethical issues and value conflicts. The Clinical Ethics Committee is not a decision-making body and shall act in an advisory capacity only.
- 11.3.B.2.b **Assisting Patients and Related Parties.** The Clinical Ethics Committee shall assist patients, family members, and significant others with issues related to patient rights when patients, family members, or significant others request a meeting. Such patient rights issues may include, without limitation, patient privacy and safety, the formulation of advanced directives, decisions to withhold resuscitative services, decisions to forego or withdraw life-sustaining treatment, or decisions related to end of life care.
- 11.3.B.2.c **Educational Programs.** The Clinical Ethics Committee may organize educational programs on ethics issues for the benefit of the Medical Staff, Associate Professional Staff, the Hospital and the wider community.
- 11.3.B.2.d **Recommendations.** The Clinical Ethics Committee may review and make recommendations on policies and procedures and on addressing patients' rights and organizational ethics, including recommendations that would address chronic or recurring ethical issues of a systematic nature. Such policies may include determinations of death, orders not to resuscitate, and policies on foregoing life-sustaining treatment, supportive care (limited therapy) and treatment of handicapped newborns.

11.3.B.2.e **Formulation of Procedures.** The Clinical Ethics Committee may formulate procedures, consistent with these Bylaws, which delineate the types of cases it may consider, how cases may be brought before it and the confidentiality of its deliberations and decisions.

11.3.B.3 **Meetings.** The Clinical Ethics Committee shall hold meetings at least quarterly to discuss education and policy and as needed for urgent matters.

11.3.B.4 **Reporting and Documentation.** The Clinical Ethics Committee shall maintain written reports and minutes of its activities and shall submit such reports and minutes to the Medical Executive Committee for review.

11.3.C Clinical Excellence / Quality and Safety Committee.

11.3.C.1 Composition.

11.3.C.1.a **Ex Officio.** The Clinical Excellence / Quality and Safety Committee shall include the following members: (i) the Medical Staff President (or designee), (ii) the President of CMMC (or designee), (iii) the Chair of the Quality and Patient Safety Committee of the Governing Body (or designee), (iv) the senior Hospital administrator responsible for Quality, (v) the Chief Nursing Officer (or designee), (vi) the senior hospital administrator responsible for risk management.

11.3.C.1.b **Appointed.** The Clinical Excellence / Quality and Safety Committee shall include the following additional members: (i) a minimum of three (3) representatives from the Medical Staff with demonstrated interest in quality improvement and outcomes measurement, at least one (1) of whom is a member of the Medical Executive Committee; (ii) a member of the Associate Professional Staff; (iii) representatives from Divisions and Sections, as appropriate; and (iv) other Hospital representatives, including a pharmacist and a laboratory representative. A majority of the members of the Clinical Excellence / Quality and Safety Committee will be Physicians, and the Medical Staff President shall appoint additional members to the committee from time to time in accordance with this Section 11.3.C.1.b to ensure that Physicians constitute a majority.

11.3.C.1.c **Staff.** Members of the Hospital administrative department responsible for quality shall support the Clinical Excellence /

Quality and Safety Committee in coordination with the President of the Medical Staff.

11.3.C.2 **Duties.** The Clinical Excellence / Quality and Safety Committee shall have the following duties:

- (a) Ensuring the existence of a Medical Staff and Hospital wide Performance Improvement Plan that is approved annually by the Medical Staff and Governing Body and which clearly states accountabilities for reporting of Performance Improvement Plan elements;
- (b) Coordinating and overseeing the elements, processes and functions related to quality improvement and identifying opportunities for improvement in quality of care and clinical performance;
- (c) Providing a forum for the Medical Staff to assess the quality, appropriateness and efficacy of treatment services at the Hospital and acting as the coordinating body for interdisciplinary quality concerns;
- (d) Directing and coordinating review activities, including a review of patient complaints, incident reports and other matters involving quality of care and clinical performance;
- (e) Where problems or potential problems relating to quality of patient care are identified, (i) referring to the appropriate Section Chief or the Peer Review Committee as appropriate, (ii) ensuring that appropriate action is taken, and (iii) assessing the effectiveness of actions taken;
- (f) Ensuring that quality issues are addressed and brought to closure in a timely way and that documents are coherent and consistent, including individual cases reviewed at the Section or committee level;
- (g) Reviewing information from multiple sources and suggesting areas for focused review;
- (h) Functioning as the Risk Management Committee and Utilization Review Committee, provided, however, that the Clinical Excellence / Quality and Safety Committee may appoint one (1) or more subcommittees to perform risk management and/or utilization review functions;
- (i) Providing effective mechanisms for reviewing and evaluating patient care to identify patterns in resource utilization, including screening of

appropriateness and medical necessity of continued stay, patient admission, length of stay, and discharge practices against established criteria;

- (j) Observing, assessing and reporting on utilization patterns and identifying utilization issues where more in-depth study is required;
- (k) Promoting optimum documentation and certification for Hospital services;
- (l) Identifying problems that have the potential of elevating the disagreement rate between CMMC and the fiscal intermediary;
- (m) Ensuring the results of review activities are reported on a regular basis to the Medical Executive Committee and the Governing Body and are reported to others as appropriate; and
- (n) Appointing subcommittees and delegating duties to these subcommittees as appropriate.

11.3.C.3 **Meetings.** The Clinical Excellence / Quality and Safety Committee shall hold at least six (6) meetings per year.

11.3.C.4 **Reporting and Documentation.** The Clinical Excellence / Quality and Safety Committee shall maintain written reports and minutes of its activities and shall submit such reports and minutes to the Medical Executive Committee and, as appropriate, to the Peer Review Committee. The Clinical Excellence / Quality and Safety Committee shall maintain a flow sheet of the CMMC Performance Improvement Plan.

11.3.D Credentials Committee.

11.3.D.1 Composition.

11.3.D.1.a **Ex Officio.** The Credentials Committee shall include the following members: Medical Staff President (or designee), the Medical Staff Vice Chief, the senior Hospital Administrator responsible for quality and the senior Hospital Administrator responsible for Risk.

11.3.D.1.b **Appointed.** The Credentials Committee shall include the following additional members: (i) at least four (4) members representing the four (4) Divisions (Hospital Based Care Division, Primary Care Division, Specialty Care Division, and Surgical Care Division); (ii) other Division or Section members

as appropriate; and (iii) a member of the Associate Professional Staff.

11.3.D.1.c **Staff.** Members of the Hospital administrative department responsible for credentialing shall support the Credentials Committee in coordination with the President of the Medical Staff.

11.3.D.1.d **Voting.** Only the Medical Staff President, the Medical Staff Vice Chief, members of the Active Medical Staff and Senior Active Medical Staff and the Associate Professional Staff member may vote on the Credentials Committee.

11.3.D.2 **Duties.** The Credentials Committee shall have the duties set forth below.

11.3.D.2.a **General Review Criteria.** The Credentials Committee shall conduct its reviews and evaluations in accordance with the then-current credentialing and privileging standards of regulatory agencies and accreditation bodies. The Credentials Committees' 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 Committee 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.

11.3.D.2.b **Recommendations for Appointment and Reappointment.** The Credentials Committee shall review the credentials of all applicants, including specific consideration of the recommendations from the Section in which the applicant requests Clinical Privileges, 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 Committee shall ensure that Clinical Privileges granted are supported by evidence of appropriate current clinical experience and competence.

11.3.D.2.c **Reviewing Reappointments.** The Credentials Committee shall be responsible for reviewing individual reappointments as recommended by the applicable Section Chief. The

Credentials Committee's review shall include a review of peer review information from the Peer Review Committee, Practitioner-specific quality assurance and quality improvement activities, complaints, remedial actions, recommendations from Sections and any other pertinent information. The Credentials Committee shall forward its recommendations to the Medical Executive Committee and shall include delineation of any changes in a member's Clinical Privileges or status.

11.3.D.2.d **Evaluating Provisional Appointees.** The Credentials Committee 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.

11.3.D.2.e **Forms, Processes, and Procedures.** The Credentials Committee shall develop, review and revise credentialing and privileging forms and processes and review and approve credentialing procedures.

11.3.D.3 **Meetings.** The Credentials Committee shall meet monthly and when called, at least within thirty (30) days after receiving an application for appointment or change in status.

11.3.D.4 **Reporting and Documentation.** The Credentials Committee shall maintain written reports and minutes of its activities and shall submit such reports and minutes to the Medical Executive Committee for review and action.

11.3.E Critical Care Committee.

11.3.E.1 Composition.

11.3.E.1.a **Ex Officio.** The Critical Care Committee shall include the following members: (i) the Medical Staff President (or designee) and (ii) the Hospital administrators responsible for the specialties of coronary/intensive care, neonatal care, and emergency.

11.3.E.1.b **Appointed.** The Critical Care Committee shall also include members from the following specialties: hospital based care, trauma surgery, neurosurgery, general surgery, cardiology, anesthesiology, emergency medicine, neonatology, critical care medicine, and pulmonary medicine, and other specialties, as appropriate.

11.3.E.1.c **Chair.** The Chair of the Critical Care Committee will be a clinical leader from the medical and surgical critical care specialties.

11.3.E.2 **Duties.** The Critical Care Committee shall have the following duties:

- (a) Establishing policies regarding the care of critically ill patients throughout the Hospital, including, but not limited to, policies and standards of care for the intensive care unit, the single stay unit, the emergency department, stepdown units, the neonatal intensive care unit, and other units where critically ill patients receive care;
- (b) Making recommendations, when indicated, to the Medical Executive Committee and/or administration of the Hospital on matters affecting operation of the intensive care unit, the single stay unit, the emergency department, stepdown units, the neonatal intensive care unit, and other units where critically ill patients receive care;
- (c) Reviewing Hospital-wide resuscitation efforts, including, without limitation, “code blues” and rapid response team calls;
- (d) Reviewing quality data regarding standards of care for process and outcomes measures related to critical care; and
- (e) Identifying and implementing the key quality and safety metrics and overseeing the performance improvement work necessary to achieve these outcomes.

11.3.E.3 **Meetings.** The Critical Care Committee shall meet as often as necessary to perform its functions.

11.3.E.4 **Reporting and Documentation.** The Critical Care Committee shall maintain written reports and minutes of its activities and shall submit such reports and minutes to the Medical Executive Committee and, as appropriate, to the Peer Review Committee.

11.3.F Infection Prevention and Control Committee.

11.3.F.1 **Composition.**

11.3.F.1.a **Ex Officio.** The Infection Prevention and Control Committee shall include the following members: the senior Hospital administrator responsible for quality, the hospital infection control team, and the Chief of the Section of Infection Control.

- 11.3.F.1.b **Appointed.** The Infection Prevention and Control Committee shall include the following additional members: (i) representatives from various medical specialties, as appropriate (e.g., pathology, critical care, anesthesia, emergency medicine, and surgery); and (ii) representatives from various Hospital departments, as appropriate (e.g., administration, nursing, microbiology, environmental services, central supply, employee/occupational health, surgical services, respiratory therapy, pharmacy, and health information management).
- 11.3.F.1.c **Consultants.** Other representatives, including representatives from state or local health departments, may serve as consultants as needed.
- 11.3.F.1.d **Chair.** The Chief of the Section of Infection Prevention and Control will serve as the Chair of the Infection Control Committee.
- 11.3.F.2 **Duties.** The Infection Prevention and Control Committee shall have the following duties:
- (a) Reviewing and assessing the effectiveness of the Hospital Infection Prevention and Control Program in establishing and operating a practical system for identifying, reporting and evaluating infections in patients and personnel;
 - (b) Distinguishing between nosocomial and community acquired infections;
 - (c) Attempting to identify the reservoir, source and method of transmission of each outbreak of nosocomial infection and initiating appropriate measures to limit further spread from the identified source of contagion;
 - (d) Making definitive provision for adequate isolation policies and procedures;
 - (e) Making certain that all personnel are educated regarding all components of the Infection Prevention and Control Program, including such issues as the proper practice of medical and surgical asepsis and how, given their respective roles and responsibilities, prevention, transmission and control of nosocomial infections are managed;
 - (f) Analyzing data on infections regularly, evaluating current trends and experiences, and undertaking such control measures as may be indicated;

- (g) Ensuring that the Infection Prevention and Control Program demonstrates compliance with regulatory agency requirements;
- (h) Reviewing all applicable infection control procedures to ensure their adequacy and compatibility with institutional policies;
- (i) Reviewing practices and procedures which tend to compromise patients' resistance to infection, such as antibiotic and invasive procedures;
- (j) Providing infection prevention and control input to appropriate Hospital committees (e.g., the Pharmacy/Transfusion Committee for antibiotic use, the Value Analysis Committee for product use, and the Safety Management Committee);
- (k) Reporting notifiable infections to health authorities;
- (l) Preparing an annual review and update of the Infection Prevention and Control Program policies and plan; and
- (m) Assisting in reducing the cost of care by being cognizant of cost and employing effective interventions at a reasonable cost.

11.3.F.3 **Meetings.** The Infection Prevention and Control Committee shall hold at least six (6) meetings per year.

11.3.F.4 **Reporting and Documentation.** The Infection Prevention and Control Committee shall maintain written reports and minutes of its activities and shall submit such reports and minutes to the Medical Executive Committee and, as appropriate, to the Peer Review Committee.

11.3.G **Joint Conference Committee.** The Medical Staff shall participate in the Joint Conference Committee established by the bylaws of CMMC. The Joint Conference Committee shall constitute a forum for the discussion of matters of Hospital and Medical Staff policy, practice and planning, including discussions and, if necessary, informal dispute resolution regarding (i) disputes between the Hospital and Medical Staff, the Governing Body and the Medical Executive Committee, or the Medical Staff and the Medical Executive Committee; or (ii) any other disputes creating substantial internal conflict. The Joint Conference Committee shall exercise other responsibilities set forth in these Bylaws and the bylaws of CMMC.

11.3.H **Peer Review Committee.**

11.3.H.1 **Composition.**

- 11.3.H.1.a **Ex Officio.** The Peer Review Committee will include the following members: (i) the Medical Staff Chief or designee, (ii) the Division Chiefs, (iii) the Senior Hospital Administrator responsible for quality or designee, (iv) the Senior hospital administrator responsible for Risk or designee.
- 11.3.H.1.b **Appointed.** The Medical Staff Chief in consultation with the Medical Staff President will appoint at least one (1) member of the Associate Professional Staff to serve on the Peer Review Committee.
- 11.3.H.1.c **Elected.** In addition to the ex officio and appointed members, the Peer Review Committee will include no less than five (5) elected members of the Medical Staff. The Medical Executive Committee may increase or decrease the number of elected members of the Medical Staff from time to time in its discretion; provided, however, that the elected members of the Medical Staff will hold a majority of the seats on the Peer Review Committee at all times, and the Peer Review Committee shall have no less than five (5) elected Members of the Medical Staff at all times. Elected members of the Medical Staff serving on the Peer Review Committee will be chosen by vote of the Medical Staff from a slate of candidates nominated by the Medical Executive Committee or a Special Committee formed by the Medical Executive Committee to nominate such candidates. The Medical Executive Committee or the Special Committee, as the case may be, shall nominate candidates that broadly represent the various specialties of the Medical Staff.
- 11.3.H.1.d **Chair.** The Chair of the Peer Review Committee will be appointed by the Medical Staff President.
- 11.3.H.1.e **Staff.** Members of the Hospital administrative department responsible for quality shall support the Peer Review Committee in coordination with the chief hospital administrator responsible for quality
- 11.3.H.1.f **Voting.** Only the Medical Staff Chief, the Division Chiefs, the members of the Associate Professional Staff, and the elected members of the Medical Staff may vote on the Peer Review Committee.
- 11.3.H.1.g **Invited Guests.** At the request of the Peer Review Committee, other representatives of the Hospital and Section Chiefs may attend Peer Review Committee meetings.
- 11.3.H.2 **Duties.** The Peer Review Committee shall have the following duties:

- (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 Medical Executive Committee;
- (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 Divisions and Sections, the Clinical Excellence / Quality and Safety Committee, Hospital administration, and Staff regarding priorities for care redesign, performance improvement, and the use of technology;
- (e) To make recommendations to the Clinical Excellence / Quality and Safety Committee and 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 Committee 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; and
- (h) To perform such other functions as specified in these Bylaws.

11.3.H.3 **Meetings.** The Peer Review Committee shall meet as often as necessary to perform its functions, including meeting on an urgent basis as needed. In no event will the Peer Review Committee meet less than nine (9) times per year.

11.3.H.4 **Reporting and Documentation.** In addition to the reporting requirements set forth in Section 11.3.H.2, the Peer Review Committee shall maintain written reports and minutes of its activities and shall regularly submit such reports and minutes to the Medical Executive Committee.

11.3.H.5 **Professional Competence Committee.** The Peer Review Committee shall serve as a professional competence committee pursuant to the Maine Health Security Act (Me. Rev. Stat. tit. 24, §§ 2501–2511).

11.3.I **Pharmacy/Transfusion Committee.**

11.3.I.1 **Composition.**

11.3.I.1.a **Ex Officio.** The Pharmacy/Transfusion Committee shall include the following members: the Medical Staff President (or designee); one of the Division Chiefs; the blood bank supervisor; the microbiology supervisor; pharmacy director, pharmacy clinical coordinator and the senior hospital administrator, or designee, overseeing pharmacy and lab.

11.3.I.1.b **Appointed.** The Pharmacy/Transfusion Committee shall include the following additional members: eight (8) members of the Active Medical Staff, including an infectious disease specialist and at least one (1) representative from each of the four (4) Divisions (Hospital Based Care Division, Primary Care Division, Specialty Care Division, and Surgical Care Division); a pathologist; and representatives from nursing, Risk Management, Quality and Infection Control.

11.3.I.2 **Duties.** The Pharmacy/Transfusion Committee shall have the duties set forth below.

11.3.I.2.a **Recommend Standard Formulary.** The Pharmacy/Transfusion Committee shall recommend and oversee a recognized standard formulary for Hospital use. Formulary oversight will include evaluating clinical data on medications requested for addition to the formulary and regularly evaluating medications on the formulary for possible deletion from the formulary. Evaluation criteria shall include indication for use, effectiveness, risks (including propensity for medication errors, abuse potential and sentinel events), costs, pharmaceutical availability and duplication.

11.3.I.2.b **Survey Drug Prescribing Patterns.** The Pharmacy/Transfusion Committee shall survey patterns of drug prescribing, ordering and use within the Hospital, making inquiries when necessary into apparent inappropriate use.

11.3.I.2.c **Proper Practices.** The Pharmacy/Transfusion Committee shall provide oversight for the entire medication management process (including selection and procurement, storage, ordering and transcribing, preparing and dispensing, administering and monitoring) across the continuum of care.

Oversight shall include evaluating the medication management system for risk points and identifying areas to improve safety.

11.3.I.2.d **Review Clinical Use and Monitoring.** The Pharmacy/Transfusion Committee shall ensure that review of the clinical use and monitoring of medications (antibiotics and other drugs, including adverse drug reactions) are conducted routinely for inpatients, ambulatory care patients, and emergency care patients. Such reviews shall include the development of written criteria for the prophylactic, empiric and therapeutic drug/antibiotic use in known or suspected areas. Departures from these criteria shall be reviewed. A final report of all medication usage reviews will be submitted to the Pharmacy/Transfusion Committee and, as appropriate, to the Peer Review Committee.

11.3.I.2.e **Review of Blood and Blood Product Components.** The Pharmacy/Transfusion Committee shall review all blood and blood product components including ordering practices, distribution, handling, dispensing, administration and indications for clinical use. Such review shall include assessments of confirmed transfusion reactions. Written criteria will be developed to conduct blood and blood product component monitoring and departures from these criteria shall be reviewed. A final report of all monitoring activities will be generated and submitted to the Peer Review Committee.

11.3.I.3 **Meetings.** The Pharmacy/Transfusion Committee shall meet at least nine (9) times per year.

11.3.I.4 **Reporting and Documentation.** The Pharmacy/Transfusion Committee shall maintain written reports and minutes of its activities and shall submit such reports and minutes to the Medical Executive Committee.

11.3.J Trauma Operations Committee.

11.3.J.1 Composition.

11.3.J.1.a **Ex Officio.** The Trauma Committee shall include the following members: the Division Chief of the Surgical Care Division, the Senior Hospital Administrator responsible for quality or designee, the Trauma Medical Director, and the Trauma Coordinator.

11.3.J.1.b **Appointed.** The Trauma Committee shall include five (5) members from the Medical Staff (from a variety of specialties involved in trauma care) and the following additional members:

(i) a member of the CMMC senior administrative team; (ii) representatives from nursing, the laboratory and blood bank, radiology, respiratory therapy and other ancillary departments; (iii) social workers; and (iv) other representatives from specialties involved in the delivery of trauma care.

- 11.3.J.2 **Duties.** The Trauma Committee shall assess and address global trauma program issues. It shall oversee all trauma related processes and trauma program related services and work to correct overall program deficiencies to continue to optimize patient care.
- 11.3.J.3 **Trauma Quality Improvement Subcommittee.** In addition to the duties set forth above, the Trauma Committee shall maintain a Trauma Quality Improvement Subcommittee.
- 11.3.J.3.a **Composition.** The Trauma Quality Improvement Subcommittee shall consist of Trauma Medical Director, trauma surgeons who participate in the trauma call schedule, Trauma liaison physicians for Anesthesia, Emergency Medicine, Orthopedics, Neurosurgery and Radiology. In addition, the Trauma Coordinator and trauma registrar may attend as needed to support the activities. **Duties.** The Trauma Quality Improvement Subcommittee shall be responsible for conducting trauma peer review. Trauma peer review may include review of response times, appropriateness and timeliness of care, and evaluation of care priorities among specialists. The Trauma Quality Improvement Subcommittee may refer cases to the Peer Review Committee as appropriate.
- 11.3.J.3.b **Meetings.** The Trauma Quality Improvement Subcommittee shall hold meetings monthly.
- 11.3.J.3.c **Reporting and Documentation.** The Trauma Quality Improvement Subcommittee shall directly report to the Trauma Committee and shall indirectly report to the Peer Review Committee and the Clinical Excellence / Quality and Safety Committee. The Trauma Quality Improvement Subcommittee shall maintain written reports or minutes of its activities and shall submit such reports and minutes to the Trauma Committee and, as appropriate, to the Peer Review Committee and/or the Clinical Excellence / Quality and Safety Committee.
- 11.3.J.4 **Meetings.** The Trauma Operations Committee shall hold meetings at least four (4) times per year.

- 11.3.J.5 Reporting and Documentation. The Trauma Committee shall maintain written reports or minutes of its activities and submit such reports and minutes to the Medical Executive Committee and, as appropriate, the Peer Review Committee or Special Committees

The Medical Executive Committee and the Peer Review 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 formed by the Peer Review Committee shall be appointed by the Chair of the Peer Review Committee in consultation with the Medical Staff Chief. Members of Special Committees shall retain their appointments until discharged by the committee that formed the Special Committee.

ARTICLE 12 MEETING REQUIREMENTS FOR STANDING COMMITTEES AND SECTIONS**12.1 Regular Meetings**

Standing Committees shall hold meetings at the frequency set forth in Article 11. Sections shall hold meetings as needed to conduct business as determined by the Section Chief.

12.2 Special Meetings

Special meetings of any Standing Committee may be called by (i) the Chair of the committee, (ii) the Medical Staff President, or (iii) two (2) members of the Standing Committee. Special meetings of any Section may be called by (i) the Section Chief or (ii) the Medical Staff President.

12.3 Notice of Meetings

Written or oral notice stating the place and time of any regular or special meeting shall be given by the person or persons calling the meeting to each member of the Standing Committee or Section not less than five (5) days before the time of such meeting. In the case of regular meetings, the applicable Standing Committee Chair or Section Chief shall provide such written or oral notice.

12.4 Quorum

A quorum shall be presumed to exist at all Standing Committee and Section meetings. If a quorum count is requested, presence of twenty percent (20%) or more of the Voting Medical Staff Members assigned to the Standing Committee or Section shall constitute a quorum.

12.5 Manner of Action

The action of a majority of the members present at a Standing Committee or Section meeting at which a quorum is present shall be the action of that Standing Committee or Section. Action may be taken without a meeting by the affirmative action of two-thirds of Committee or Section members voting, so long as at least fifty (50) percent of such members have responded (in writing or electronically).

12.6 Minutes

Minutes of each regular and special meeting of a Standing Committee or Section shall be prepared and shall include a record of agenda, attendance of members, discussions, votes taken on each matter, remedial actions, and follow-up to all issues. The presiding Standing Committee Chair or Section Chief shall sign the minutes and copies shall be forwarded to the Medical Executive Committee. Each Standing Committee and Section shall maintain a permanent file of the minutes of each meeting, and there shall be a master file maintained by the Medical Executive Committee in the office of Medical Affairs.

12.7 Attendance

- 12.7.A **Expectations for All Practitioners.** Attendance and participation in Standing Committee and Section meetings is expected.
- 12.7.B **Active Medical Staff, Senior Active Medical Staff, and Associate Professional Staff Attendance at Standing Committee Meetings.** Each member of the Active Medical Staff, Senior Active Medical Staff and Associate Professional Staff shall be required to attend annually not less than fifty percent (50%) of all meetings of each Standing Committee on which such member serves.
- 12.7.C **Active Medical Staff, Senior Active Medical Staff, and Associate Professional Staff Attendance at Section Meetings.** Each member of the Active Medical Staff, Senior Active Medical Staff and Associate Professional Staff shall be required to attend annually not less than fifty percent (50%) of all meetings of each Section in which peer review (including, but not limited to, case-specific review and morbidity and mortality) is conducted and to which such Practitioner belongs.
- 12.7.D **Discussion of Patient's Clinical Course at Section Meetings.** A Practitioner whose patient's clinical course is scheduled for discussion at a regular Section meeting shall be so notified and shall be expected to attend such meeting. If such Practitioner is not otherwise required to attend the regular monthly Section meeting, the applicable Section Chief shall give the Practitioner advance written notice of the time and place of the meeting at which his/her attendance is expected.
- 12.7.E **Failure to Attend Mandatory Meetings.** Failure by a Practitioner to attend any meeting with respect to which he/she was given notice that attendance was mandatory, unless excused by the Medical Executive Committee upon a showing of good cause, shall result in such action as the Medical Executive Committee may direct. In the event that the Practitioner receives notice that attendance is mandatory and makes a timely request for postponement by an adequate showing that his/her absence will be unavoidable, such presentation may be postponed by the applicable Section Chief until not later than the next regular Section meeting. If the Practitioner does not make such timely request for postponement, the pertinent clinical information shall be presented and discussed as scheduled.

ARTICLE 13 MEDICAL STAFF MEETINGS

13.1 Regular Meetings

The Medical Staff shall hold at least four (4) meetings per year. To the extent possible, meetings should be spaced evenly throughout the year. The annual meeting shall occur on a date selected by the Medical Staff Chief in consultation with the Medical Staff President. 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 twenty percent (20%) or more of the Voting Medical Staff Members shall constitute a quorum.

13.4 Attendance Requirements

Each member of the Active Medical Staff and Senior 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 meeting shall be as follows:

As determined by the Medical Staff Chief in consultation with the Medical Staff President

13.6 Attendance Limited

Only members of the Active Medical Staff, Senior Active Medical Staff, Courtesy Medical Staff, Consulting Medical Staff, Honorary 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 (“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 Staff and APS Members as long as at least twenty-five such members have responded (in writing or electronically).

The intent is that amendments to Bylaws, Rule 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.

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 CMMC, 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 CMMC 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 who 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 Committee, Peer Review Committee, and Special Committee proceedings;

- (e) Medical care evaluations;
- (f) Utilization reviews;
- (g) Other Hospital, Division, Section, service, or committee activities related to quality patient care and inter-professional conduct;
- (h) The acts, communications, reports, recommendations, and disclosures referred to in this Article 13 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 General

Pursuant to Article 17, the Medical Executive Committee shall (i) adopt policies that are necessary or desirable for the proper conduct of the work of the Medical Staff and are not otherwise the responsibility of the Divisions and Sections, and (ii) approve policies adopted by the Divisions and Sections. Policies adopted or approved by the Medical Executive Committee shall be consistent with the bylaws of CMMC, these Bylaws, and the Medical Staff Rules and Regulations.

15.2 History and Physical

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 Medical 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 Medical Staff policies.

ARTICLE 16 RULES AND REGULATIONS

The Medical Staff shall adopt such rules and regulations (“Medical Staff Rules and Regulations”) as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. The Medical Staff Rules and Regulations shall relate to the proper conduct of Medical Staff organizational activities as well as to the level of practice that is to be required of each Practitioner in the Hospital. The Medical Staff Rules and Regulations may be amended pursuant to Article 17. The Credentials Committee may amend that portion of the Medical Staff Rules and Regulations consisting of the Policy and Procedure manual governing appointment and reappointment processes at any time.

**ARTICLE 17 AMENDMENTS TO BYLAWS, RULES AND REGULATIONS, AND
POLICIES**

17.1 Amendment Initiated by the Medical Staff or Medical Executive Committee

17.1.A **Regular Review of Bylaws.** These Bylaws will be reviewed not less than triennially for consideration of changes that may be necessary or advisable.

17.1.B **Authority to Propose Amendments.** The Medical Executive Committee, Officers of the Medical Staff, and Voting Medical Staff Members, through a written petition signed by 10% or more of the Medical Staff Members, will have the authority to propose amendments to these Bylaws, the Medical Staff Rules and Regulations, and Medical Staff policies.

17.1.C **Medical Executive Committee Review and Recommendation.** Except as provided for in Section 17.1.C.1 below, proposed amendments will be referred to the Medical Executive Committee or an *ad hoc* Bylaws Committee appointed by and reporting to the Medical Executive Committee. The Medical Executive Committee or the Bylaws Committee, as applicable, shall make a recommendation to the Medical Staff on the proposed amendments.

17.1.C.1 **Amendments Proposed Directly from the Medical Staff.**

In cases where an amendment is proposed by one or more members of the Medical Staff and is not recommended for approval by the Medical Executive Committee, the Medical Staff may propose the amendment directly to the Governing Body by calling a Special Meeting under the provision of Section 13.2. At the special meeting the amendment may be considered and will be approved for consideration of the Governing Body if approved by two-thirds of the members present and voting. If so approved, the amendment will be considered by the Governing Body at its regular meeting. An announcement of the action by the Medical Staff and the Governing Body will be made at the next regular meeting of the Bylaws Committee (if so appointed) and the Medical Executive Committee. Such amendments shall become effective when approved by the Governing Body.

17.1.D **Medical Staff Approval.**

17.1.D.1 **Medical Executive Committee Recommends Approval.** In the event that the Medical Executive Committee recommends that the Medical Staff approve the proposed amendments. The proposed amendments will be approved if there is an affirmative vote of a majority of Medical Staff and APS members present and voting at any regular or special Medical Staff meeting.

17.1.D.1.a **Medical Executive Committee Approval of Proposed Amendments.** Notwithstanding Section 17.1.D.1, the Medical

Executive Committee shall have the authority to approve proposed amendments to the Medical Staff Rules and Regulations and Medical Staff policies, without holding a vote of Voting Medical Staff Members, if the Medical Executive Committee believes that such proposed amendments are in the best interests of the Medical Staff. The Medical Executive Committee shall notify the Medical Staff of Medical Executive Committee approval of any such amendments prior to such amendments being submitted to the Governing Body for approval pursuant to Section 17.1.E.

17.1.D.1.b Urgent Action by Medical Executive Committee.

Notwithstanding anything to the contrary in Section 17.1.D.1.a, in the event of a documented need for an urgent amendment to the Medical Staff Rules and Regulations or Medical Staff policies necessary to comply with law or regulation, the Medical Executive Committee may provisionally approve such urgent amendment and submit such urgent amendment to the Governing Body for provisional approval without first notifying the Medical Staff. The Medical Executive Committee shall notify the Medical Staff immediately after submitting any such urgent amendment to the Governing Body.

17.1.D.1.c Medical Staff Disagreement with Medical Executive Committee Action. In the event that the Medical Staff disagrees with an amendment to the Medical Staff Rules and Regulations or Medical Staff policies approved by the Medical Executive Committee pursuant to Section 17.1.D.1.a or Section 17.1.D.1.b, the Voting Medical Staff Members may propose a revised amendment pursuant to Section 17.1.B.

17.1.D.2 Medical Executive Committee Recommends Rejection. In the event that the Medical Executive Committee recommends that the Medical Staff reject the proposed amendments, the following votes will be required for Medical Staff approval of the proposed amendments: (i) in the case of proposed amendments to these Bylaws, affirmative votes from two-thirds (2/3) of the Voting Medical Staff Members; and (ii) in the case of proposed amendments to the Medical Staff Rules and Regulations or Medical Staff policies, two-thirds (2/3) of the present Voting Medical Staff Members at any regular or special Medical Staff meeting.

17.1.D.3 Medical Executive Committee and Medical Staff Disagreement. Except as provided for in 17.1.C.1, above in the event that the result of the Medical Staff vote substantially conflicts with the recommendations of the Medical Executive Committee, the matter will be referred to the Joint Conference Committee for further deliberations involving the interested parties and recommendations. The result of the Medical

Staff vote will remain in effect, and will not be stayed, pending a recommendation of the Joint Conference Committee.

17.1.E Governing Body Approval for Bylaws and Rules and Regulations. Upon Medical Staff approval of proposed amendments to these Bylaws or the Medical Staff Rules and Regulations or Medical Executive Committee approval of proposed amendments to the Medical Staff Rules and Regulations, the Medical Staff President, acting on behalf of the Medical Staff, shall propose such amendments directly to the Governing Body. Proposed amendments to these Bylaws or the Medical Staff Rules and Regulations that have received Medical Staff or Medical Executive Committee approval, as applicable, shall be effective only when approved by the Governing Body. In the event that the Governing Body does not approve such proposed amendments in substantially the form recommended by the Medical Staff, the matter will be referred to the Joint Conference Committee for further deliberations involving the interested parties and recommendations.

17.2 Amendment Initiated by the Governing Body

The Governing Body may not unilaterally amend these Bylaws, the Medical Staff Rules and Regulations, or Medical Staff policies. Notwithstanding anything in this Article 17 to the contrary, the Governing Body may on its own motion, after consultation with the Medical Staff, amend these Bylaws or the Medical Staff Rules and Regulations, 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.

17.3 Notification of Changes

When significant changes to these Bylaws, the Medical Staff Rules and Regulations, or Medical Staff policies are enacted, all individuals with Clinical Privileges shall be provided with notification of such changes.

17.4 Conflict with CMMC Bylaws

To the extent practicable, the provisions of these Bylaws, the Medical Staff Rules and Regulations, and Medical Staff policies shall be construed so as to be consistent with the bylaws of CMMC, but in the event of any conflict or inconsistency, the bylaws of CMMC 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 CMMC, 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 CMMC, or the actions of any other Hospital officers or employees.