Medical Staff Bylaws, Rules and Regulations 2023

St. Joseph Healthcare
St. Joseph Hospital
A Member of Covenant Health

St. Joseph Hospital 360 Broadway, Bangor, Maine 04401
A Member of Covenant Health Systems – Founded by the Felician Sisters

TABLE OF CONTENTS

Medical Staff Bylaws, Rules and Regulations

St. Joseph Hospital
Bangor, Maine

PREAMBLE

WHEREAS St. Joseph Hospital is a nonprofit corporation organized and existing under the laws of the State of Maine, and,

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

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

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

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

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

Every member of the Medical Staff, by virtue of accepting such membership, shall demonstrate their voluntary intention to practice their profession in the Hospital in accordance with the Roman Catholic moral and ethical principles and values enunciated in the Ethical and Religious Directives for Catholic Health Care Services, 6th edition, as may be revised from time-to-time.

DEFINITIONS

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

Admit: Means to order the admission of a person to the Hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that they will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. For purposes of these Bylaws, admission does not include an Observation Stay.

Board: Board means the Board of Trustees of St. Joseph Hospital.

Hospital: Hospital means St. Joseph Hospital, of Bangor, Maine as well as its hospital-based and managed outpatient clinics.

Medical Care: Encompasses the field of total medical, dental, and other professional care, the evaluation and management of health as well as disease management, using supporting personnel, services, and facilities at the level of the Member and their patients.

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

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

Medical Staff: The formal organization that includes all Physicians and Allied Health Staff who may be granted clinical privileges at the Hospital.

Member: Member means any individual appointed to the Medical Staff by authority of the Board in accordance with these Bylaws, Rules and Regulations, and associated policies, and the Bylaws of the Hospital.

Observation Stay: Means a stay in the Hospital for no more than forty-eight (48) hours for the purpose of (a) evaluating a patient for possible admission; (b) treating patients expected to be stabilized and released in no more than twenty-four (24) hours; or (c) extended recovery following a complication of an outpatient procedure. Only rarely will an Observation Stay exceed twenty-four (24) hours in length.

Patient Care Encounter: Means acting in the capacity of the primary attending physician, in the capacity of a consulting physician, performing surgical procedures, and providing hospital-based services including, but not limited to pathology, radiology, or emergency services. A patient care encounter shall not, however, include orders for outpatient x-ray or laboratory testing which does not directly involve the ordering physician in the delivery of the service.

Physician: means a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD).

Practitioner: Practitioner means an appropriately licensed Physician or other licensed or registered health care professional who has maintained competency in a discipline which the Board has determined to grant clinical privileges to practice within the Hospital or in an outpatient setting.

Special Notice: Means written notification sent to the last known address of the recipient, as it appears in the records of the Hospital, postage pre-paid by United States certified mail, return receipt requested.

VPMA: VPMA means the Hospital's Vice President of Medical Affairs.

ARTICLE I

NAME

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

ARTICLE II

PURPOSES

The purpose of this organization shall be as follows:

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

b. To establish and maintain high professional and ethical standards in general conformity with all applicable statutory and regulatory requirements, accreditation standards, Medicare Conditions of Participation, the Ethical and Religious Directives for Catholic Health Care Services, 6th edition, as may be revised from time to time, and Hospital policies.

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

d. Upon request, to assist the Board in all matters pertaining to the wellbeing of the Hospital.

e. To serve as the primary means for accountability to the Board for the appropriateness of the Medical Staff's professional performance and ethical conduct.

f. To maintain a high level of performance by Medical Staff members through appropriate delineation of staff privileges, and the ongoing and focused evaluation of its members.

g. To provide a means whereby issues of a medical administrative nature may be discussed and resolved among the Medical Staff, the Board and Hospital administration.

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

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

j. To uphold and support the mission of St. Joseph Hospital, which is committed to wellness promotion and holistic healing, providing healthcare services which embody Compassion, Competence and Community. St. Joseph Hospital, under the sponsorship of Covenant Health Systems, is an extended ministry of Christ's healing and mercy. This healthcare ministry is rooted in the tradition of our Foundress Blessed Mary Angela's vision of spirituality - renewing society through compassionate caring of the whole person in all circumstances.

Therefore, St. Joseph Hospital believes in:

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

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

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

* Creating an atmosphere of respect and dignity.

* Encouraging personal and professional growth for all employees.

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

* Collaborating with others to enhance community healthcare services.

ARTICLE III

MEDICAL STAFF MEMBERSHIP

SECTION 1. Nature of Medical Staff Membership

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

SECTION 2. Qualifications for Membership

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

b. No individual shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that they are duly licensed to practice in this or any other State, or that they are a member of any professional organization, certified by any specialty board or have attained fellowship or membership in a specialty body or society or that they have had in the past, or presently have, such privileges at another hospital.

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

d. No applicant shall be denied appointment to the Medical Staff on the basis of age, gender, sexual orientation, race, creed, disability, national origin, religion, and health status.

SECTION 3. Member Ethics, Principles and Responsibilities

Acceptance of membership on the Medical Staff shall constitute the Member's agreement that they will strictly abide by and be accountable for the following ethics, principles and responsibilities.

a. To abide by the most recent edition of the Ethical and Religious Directives for Catholic Health Care Services, the Code of Medical Ethics of the American Medical Association or of the American Osteopathic Association as applicable, the Code of Ethics of each physician's medical specialty board, or other ethical principles established by the member's profession.

b. To abide by the Medical Staff Bylaws, Rules and Regulations and all other lawful standards, policies and rules of the Medical Staff and the Hospital.

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

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

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

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

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

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

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

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

k. To actively participate in and regularly cooperate with the Medical Staff in assisting the Hospital to fulfill its obligations relating to patient care and education including, but not limited to, patient safety, continuous quality improvement, peer review, utilization management, quality evaluation and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time.

l. To ensure no Member may delegate to a commercial or other referral service, or a professional corporation or any other legal entity, the staff privileges assigned to them, including but not limited to the admission of patients to the Hospital.

m. To not engage in disruptive behavior as it is inappropriate and unprofessional under any circumstances, whether or not it directly involves patient care and safety. All Members are expected to demonstrate the ability to work cooperatively with the Hospital, its staff and Medical Staff, and to refrain from disruptive behavior which could interfere with patient care, quality and safety, or the operation of the healthcare organization.

n. To complete continuing medical education (CME) that is appropriate and/or required by the Member's specialty or licensure.

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

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

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

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

SECTION 4. Medical Staff Rights

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

SECTION 5. Conditions and Duration of Appointment and Reappointment

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

b. Reporting Requirements
Members have a continuing obligation to promptly notify the Hospital President in writing immediately after and provide such additional information as may be requested regarding each of the following:

1. Revocation or suspension of their professional license or certification,
2. Imposition of terms of probation or other limitations or conditions of practice imposed by any State licensing authority,

3. Loss or suspension of staff membership at any hospital or other health care institution or after receiving any adverse disciplinary or corrective action at any hospital or health care facility,
4. Modification of any or all clinical privileges at any hospital or health care institution as a result of Professional Review Action, or the surrender of such privileges while under investigation by such institution in consideration for an agreement not to conduct such review or investigation,
5. Receipt of notice of a hearing to be held before the applicable State licensing authority to consider a complaint against the Member,
6. Filing of any civil action in any state, federal or foreign court in which medical malpractice is alleged to have been committed by the Member, but excluding any notice of claim that must, in accordance with applicable law, be filed prior to the commencement of a civil suit,
7. Being subject to a criminal complaint or indictment,
8. Revocation of DEA registration,
9. Payment or agreement to pay on their behalf or for their benefit any amount in full or partial settlement of a medical malpractice claim or action, including payments made under an insurance policy or self-insurance plan, or
10. Receipt of notice of any proposed, actual or pending debarment action, exclusion or other event that may make the Member ineligible to participate in any state or federal health care program.

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

SECTION 6. Leave of Absence

a. **Voluntary Leave of Absence.** A Member may request a voluntary leave of absence for any absence expected to exceed thirty (30) days by submitting a written request to the Medical Staff Office, for transmittal to the Medical Executive Committee, setting forth the reason for the leave and the proposed starting date and duration of the leave. During a leave of absence, which may not exceed one (1) year, the Member's clinical privileges and prerogatives shall be suspended, and all obligations shall be waived. The Member must provide evidence of current malpractice insurance coverage with occurrence coverage or tail coverage in the minimal amount required under these Bylaws during the leave of absence. A Member, requesting a voluntary leave of absence extending beyond their reappointment period, shall reapply for and be granted Medical Staff membership and clinical privileges consistent with the reappointment process set forth in Article VI of these Bylaws, prior to their return to service.

b. **Medical Executive Committee Action.** The Medical Executive Committee shall review the request for voluntary leave and recommend that the Board approve the leave for any reason acceptable to the Committee including, but not limited to, parental leave or leave to undertake

additional medical education or training. If the Medical Executive Committee recommends denial of the request, the Member may appeal the decision to the Board. The Board shall consider the appeal at its earliest opportunity and its decision shall be final.

c. **Termination of Voluntary Leave of Absence.** At least forty-five (45) days prior to the termination of a voluntary leave of absence, the Member may request reinstatement of their clinical privileges and prerogatives by submitting a written request for reinstatement to the Medical Staff Office for transmittal to the Medical Executive Committee. The request shall contain a brief written summary of their relevant activities during the leave. The Medical Executive Committee shall make a recommendation to the Board concerning the reinstatement of the Member's clinical privileges and prerogatives. Failure, without good cause, to request reinstatement in accordance with this section shall be considered a voluntary resignation of Medical Staff membership and clinical privileges and shall not entitle the Member to the procedural rights set forth in Article VIII of these Bylaws. A request for reinstatement of Medical Staff membership and clinical privileges following such voluntary resignation shall be submitted and processed in the same manner as an application for initial appointment.

d. **Medical Leave of Absence.** A Member may apply for a medical leave of absence if, as a consequence of a diagnosed physical or mental health condition, they are unable to carry out the duties and responsibilities of staff membership for a period of time that is likely to exceed three (3) months. The Member shall apply for a medical leave of absence using the format outlined for voluntary leaves of absence as set forth in these Bylaws. During the medical leave of absence, the Member's staff obligations shall be waived. The Medical Executive Committee shall determine whether conditions should be attached to the Member's reinstatement following the medical leave. A Physician's statement shall be provided prior to reinstatement, stating that the Member is able to return to their previous level of activity either without conditions or with appropriate practice limitations related to the Member's physical or mental health.

ARTICLE IV

MEDICAL STAFF CATEGORIES

SECTION 1. Categories

The Medical Staff shall be divided into Active, Active Outpatient, Courtesy, Consulting, Honorary Staff, and Allied Health categories.

SECTION 2. Active Staff

The Active Staff is comprised of Physicians.

a. **Qualifications.** Active Staff shall consist of Physicians who Admit, order Observation Stays, attend and provide a significant portion of their clinical work at the Hospital. In addition to the qualifications/responsibilities for Medical Staff membership set forth in Article III, Sections 2 and 3, each Active Staff member shall:

1. Reside or have a clinic office within close proximity of the Hospital to provide continuous care to their patients; and respond in a timely manner to meet patient care needs;
2. Participate in the on-call coverage requirements established for each specialty as determined by the Medical Executive Committee to assist in meeting the patient care needs of the community;
3. Serve on at least one Medical Staff committee if requested and participate, as necessary, in conducting Ongoing Professional Practice Evaluations and Focused Professional Practice Evaluations as assigned by the Medical Executive Committee; and
4. Have a minimum of twenty-four (24) Patient Care Encounters in a calendar year.

b. **Prerogatives of Active Staff Members.** The prerogatives of the Active Staff shall include:

1. Admitting patients to the Hospital and ordering Observation Stays without limitation,
2. Voting on all matters presented at general and special meetings of the Medical Staff, Medical Staff committees, and the Department of which they are a member,
3. Serving as an officer of the Medical Staff, and
4. Serving as Committee Chair, Department Chief or other position within the organized Medical Staff.

SECTION 3. Active Outpatient Staff

a. **Qualifications.** Active Outpatient Staff shall consist of Physicians who are regularly involved in outpatient care at the Hospital and who use the Hospital as the primary hospital for their patients requiring inpatient care. In addition to the qualifications/responsibilities for Medical Staff membership set forth in Article III, Sections 2 and 3, each Active Outpatient Staff member shall:

1. Make acceptable arrangements for coverage of their patients who are admitted to the Hospital; and
2. Participate, on an equitable basis, in providing care to unassigned patients requiring outpatient follow-up.

b. **Prerogatives.** The prerogatives of the Active Outpatient Staff shall include:

1. Ordering an Observation Stay without limitation,
2. Voting on all matters presented at general and special meetings of the Medical Staff, Medical Staff committees, and the Department of which they are a member,
3. Serving as an officer of the Medical Staff, and
4. Serving as Committee Chair, Department Chief or other position within the organized Medical Staff.

SECTION 4. Courtesy Staff

a. **Qualifications.** Courtesy Staff shall consist of Physicians who do not perform a significant portion of their clinical work at the Hospital. In addition to the qualifications/responsibilities for Medical Staff membership set forth in Article III, Section 2 and 3, each Courtesy Staff Member shall:

1. Maintain active staff privileges in good standing at another hospital; and
2. Have fewer than twenty-four (24) Patient Care Encounters in a calendar year. In the event a Courtesy Staff member exceeds twenty-four (24) patient care encounters in a calendar year, the Medical Executive Committee shall have the option of advancing the member to the Active Staff category which will require the Member to accept the responsibilities associated with that category.

b. **Prerogatives.** The prerogatives of the Courtesy Staff shall include:

1. Admitting patients to the Hospital and ordering Observation Stays for patients subject to the Patient Care Encounter limitation set forth in Article IV, Section 4 A.2 of these Bylaws. At times of full Hospital occupancy or of shortages of Hospital beds or other facilities, as determined by the Hospital President, the admitting privileges of Courtesy Staff Members shall be subordinate to those of Active Staff and Active Outpatient Staff Members, except for emergency admissions, and
2. Attending meetings of the Medical Staff, and of Committees, and the Department of which they are a member without voting rights or eligibility to hold Medical Staff office.

SECTION 5. Consulting Staff

a. **Qualifications.** Consulting Staff shall consist of Physicians who provide consultation in the diagnosis and treatment of patients and the administration of clinical services at the Hospital. Consulting Staff members shall meet the basic qualifications/responsibilities for Medical Staff membership set forth in Article III, Section 2 and 3.

b. **Prerogatives.** Consulting Staff shall not have admitting privileges or the prerogative to order an Observation Stay and shall not be entitled to vote, hold Medical Staff office, or serve on Medical Staff Committees. Consulting Staff are encouraged, but not required, to attend Medical Staff meetings, Department meetings and Medical Staff and Hospital educational programs.

SECTION 6. Honorary Staff

a. **Qualifications.** Honorary Staff shall consist of Members who have retired from active hospital practice, who are recognized for their outstanding reputation, noteworthy contributions, or previous longstanding service to the Hospital. Honorary Staff do not apply for appointment or reappointment The Medical Executive Committee or Medical Staff may nominate individuals to Honorary Staff and such nominations shall be forwarded to the Board. The Board may approve, deny or terminate Honorary Staff status and its decision is final and not subject to the hearing and appellate review requirements set forth in these Bylaws.

b. **Prerogatives.** Honorary Staff shall not be eligible to Admit, order an Observation Stay or treat patients, vote, or hold Medical Staff office, but may be invited to attend and serve on hospital and Medical Staff Committees except the Medical Executive Committee and those portions of meetings devoted to peer review.

SECTION 7. Allied Health Staff

a. **Qualifications.** Allied Health Staff shall consist of non-Physician Medical Staff members who have maintained competency in a discipline which the Board has determined to grant clinical privileges to practice within the Hospital or in an outpatient setting. Practitioners in this category have a recognized but limited scope of practice within medicine and are licensed or certified and permitted to provide patient care as delineated in the privileges granted, either independently (i.e. without supervision), or in a medical support role requiring supervision.

b. **Prerogatives.** The prerogatives of the Allied Health Staff shall include:

1. Attending meetings of the Medical Staff, Committees, and Department of which they are a member with voting rights but without eligibility to hold Medical Staff office.

c. **Additional Qualifications for Physician Assistants.** Graduation from a physician assistant program accredited by the American Medical Association Committee on Allied Health Education and Accreditation, or the Commission for Accreditation of the Allied Health Education Programs, or the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or their successors; and/or who has passed the certifying examination administered by the National Commission on Certification of Physician Assistants (NCCPA). Physician Assistants with less than four thousand (4,000) hours of documented clinical practice must have either a Maine Board of Licensure in Medicine or Board of Osteopathic Licensure approved collaborative practice agreement with a physician member of the Active Staff or, if employed by the Hospital, a scope of practice agreement with the Hospital.

d. **Additional Qualifications for Nurse Practitioners.** Be a graduate of a master's degree accredited program for advanced practice registered nurses (APRN); maintain active and valid Maine APRN licensure, maintain active and valid certification by the American Nurses Credentialing Center (ANCC), the American Academy of Nurse Practitioners (AANP), or equivalent nurse practitioner certifying body, submit a current Plan of Collaboration (POC) signed by a member of the hospital's Medical Active Staff who holds privileges covering the clinical activity the nurse practitioner performs within the Hospital, and obtain independent practice status through the Maine Board of Nursing once qualified.

e. Additional Qualifications for Physician-employed Surgical Assistant

Level I - A certified surgical technologist, a registered nurse or a licensed practical nurse.

1. Surgical Technologist – A graduate of an accredited school for surgical technologists or possess competence comparable to that of an individual who has graduated from an accredited school, at least two (2) years practical experience in activity area requested, and a current Plan of Supervision with a member of the hospital's Active Medical Staff. Candidates are expected to pursue certification by the Liaison Council of Certification for the Surgical Technologist, the National Assistant at Surgery Council, or similar organization, and to maintain such certification while a staff member.
2. Registered Nurse/Licensed Practical Nurse – Active and valid Maine nursing license, proficiency in perioperative nursing practice as scrub for at least two years, and a current Plan of Supervision with a member of the hospital's Active Medical Staff.

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

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

ARTICLE V

PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

SECTION 1. Application for Initial Appointment

a. **Application.** All applications for appointment to the Medical Staff shall be completed, signed by the applicant; submitted on a form approved by the Board upon recommendation of the Medical Executive Committee; and shall be administratively complete. A complete application for appointment will include a current copy of the following documents:

1. valid picture ID issued by a state or federal agency (for example, a driver's license),
2. State of Maine Professional License(s) and/or certifications,
3. Federal Narcotics License (DEA) (if applicable),
4. Certificate of Insurance, in an amount acceptable by the Board,
5. a resume or curriculum vitae, whichever is appropriate, with complete professional history in chronological order by month and year,
6. Diplomas and/or certificates documenting completion of education, as applicable, such as:
   a) graduation from an accredited and approved U.S. or Canadian medical or dental school,
   b) graduation from an accredited and approved foreign medical school and successful completion of an examination by the Educational Commission for Foreign Medical Graduates (ECFMG) or successor agency or by the National Board of Medical Examiners,
   c) successful completion of an internship, residency, and/or fellowship, and
   d) graduation from an accredited healthcare professional school,
7. for Physicians documentation of board certification (or indicating that the applicant is pursuing and on track to achieve) by a Board included in the American Board of Medical Specialties (ABMS); American Osteopathic Board (AOB); American Dental Association (ADA); or the Royal College of Physicians and Surgeons in Canada which must be maintained continuously while appointment is in effect unless not required by specialty (e.g. Pathology). All members of the Medical Staff, prior to January 1, 2014, shall be grandfathered from the board certification and recertification requirements. The Board may, upon request of the Department Chief and recommendations of the Credentials Committee and Medical Executive Committees, waive the requirement for board certification,
8. CME transcripts/certificates,
9. copies of training logs from residency and/or fellowship training programs, if training was completed within the past five (5) years. In the event the training program did not require logs or the training was completed more than five (5) years ago, a letter from the Director of the training program that attests to appropriate training for the privileges requested and clarifying applicant's competency to perform the requested privileges, and
10. all supplemental forms provided with the Application including the request for staff category, Service/Department assignment, and clinical privileges for which the applicant wishes to be considered.

b. **Peer Recommendations.** Peer recommendations provided by the applicant shall include written information regarding the applicant's current:

1. medical/clinical knowledge,
2. technical and clinical skills,
3. clinical judgment,
4. interpersonal skills,
5. communication skills, and
6. professionalism.

c. **Applicant's Burden.** The applicant shall have the burden of producing adequate information for a proper evaluation of their competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.

d. **Undertakings.** The Application shall contain the applicant's written agreement, as a condition of consideration of Application and as a condition of continued Medical Staff appointment or clinical privileges, if granted, that the applicant:

1. Shall promptly provide the Hospital with any new or updated information that is relevant to the information required by or provided in the Application;
2. Has had an opportunity to read a current copy of the Bylaws of the Hospital, and Bylaws and Rules and Regulations of the Medical Staff, and that the applicant agrees to be bound by the terms thereof in all matters relating to consideration of their Application without regard to whether or not they are granted appointment or reappointment to the Medical Staff or granted clinical privileges;
3. Shall, as requested, appear for personal interviews during consideration of their Application; and
4. Acknowledges that any misrepresentation or misstatement in or omission from the Application, whether intentional or not, may constitute cause for rejection of the Application resulting in denial of appointment or reappointment and clinical privileges. In the event that clinical privileges or an appointment or reappointment has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may result in summary suspension from the Medical Staff or other corrective action provided for under these Bylaws.

e. **Immunity; Release and Disclosure of Information.** Each applicant for appointment, reappointment, or clinical privileges, shall consent and agree to the following terms, which shall be set forth in the Application and which shall remain in full force and effect indefinitely, whether or not the Application is granted:

1. Immunity. To the fullest extent permitted by law, the applicant shall agree to release from any and all liability the Hospital, its authorized representatives, and any Third parties as defined herein, with respect to any acts or omissions, communications, documents, recommendations, or disclosures involving the applicant, including the following:
   a) applications for appointment, reappointment or clinical privileges, including temporary, locum tenens, emergency, disaster or telemedicine privileges,
   b) evaluations concerning reappointment or modifications of clinical privileges,

c) proceedings for suspension or reduction of clinical privileges, revocation of Medical Staff or Allied Health Staff appointment, or any other disciplinary action,
d) summary or automatic suspension,
e) hearings and appellate reviews,
f) medical care evaluations,
g) utilization reviews,
h) other activities relating to the quality of patient care or professional conduct, including, but not limited to, focused professional practice evaluations and ongoing professional practice evaluations,
i) matters or inquiries concerning the individual's professional qualifications, credentials, clinical competence, character, mental or emotional health, physical health, ethics, behavior, and/or
j) any other matter that might directly or indirectly have an effect on the applicant's competence, on patient care, or on the orderly operation of the Hospital or any other hospital or health care facility.

2. Authorization to Obtain Information. The applicant authorizes the Hospital and its authorized representatives to consult with any Third party who may have information bearing on the applicant's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical health, ethics, behavior, or any other matter reasonably having a bearing on the applicant's satisfaction of the criteria for initial or continued appointment to the Medical Staff or grant of clinical privileges. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of Third parties that may be relevant to such questions. The applicant also specifically authorizes such Third parties to release this information to the Hospital and its authorized representatives upon request.
3. Authorization to Release Information. The applicant authorizes the Hospital and its authorized representatives to release such information to other hospitals, health care entities, and their agents, who solicit such information for the purpose of evaluating the applicant's professional qualifications pursuant to the applicant's request for appointment or clinical privileges at such other hospitals or health care entities.
4. Definitions.
   a) As used in these Bylaws the following terms are defined as follows:
      i. "Hospital and its authorized representatives" means St. Joseph Hospital and any of its Board members, officers, employees, Medical Staff, and authorized representatives, including consultants and legal counsel, who have any responsibility for obtaining information relevant to, or for evaluating an applicant's credentials, or acting upon the applicant's application; participating in Professional Competence Review Activity; or serving as a member of or assisting a Professional Competence Committee in carrying out its responsibilities.
      ii. "Third party" means any person or entity that may have information bearing on the applicant's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical health, ethics, behavior, or any

other matter reasonably having a bearing on the applicant's satisfaction of the criteria for initial or continued appointment to the Medical Staff or grant of clinical privileges.

iii. "Professional Competence Review Activity" and as defined by Maine law 24 M.R.S. § 2502(4-B) means "...study, evaluation, investigation, recommendation or action, by or on behalf of a health care entity and carried out by a professional competence committee necessary to A. Maintain or improve the quality of care rendered in, through or by the health care entity or by physicians; B. Reduce morbidity and mortality; or C. Establish and enforce appropriate standards for professional qualification, competence, conduct or performance."

iv. "Professional Competence Committee" and as defined by Maine law, 24 M.R.S. § 2502(4) means "... any of the following when engaged in professional competence review activity: A. A health care entity; B. An individual or group, such as a medical staff officer, department or committee, to which a health care entity delegates responsibility for professional competence review activity; C. Entities and persons, including contractors, consultants, attorneys and staff, who assist in performing professional competence review activities; or D. Joint committees of 2 or more health care entities."

f. **Incomplete Applications.** An incomplete Application will not be processed. Any Application which remains incomplete for one hundred eighty (180) days from the date of receipt by the Medical Staff Office will be declared incomplete. If membership and clinical privileges are still desired, a new Application will be required. Rejection for this reason shall not be subject to any of the procedural rights to hearing or appellate review as set forth in Article VIII of these Bylaws.

SECTION 2. Procedure for Initial Appointment

a. **Submission of Application.** The Application shall be submitted to the Medical Staff Office as designee of the Hospital President. The Medical Staff Office shall verify current licensure, DEA registration (if applicable), education, relevant training, and current competence in writing from the primary source wherever feasible or from a credentials verification organization ("CVO"). The Medical Staff Office shall also query the National Practitioner Data Bank, OIG/EPLS, the applicant's professional liability carrier(s) for claims history at a minimum of the ten (10) most recent years, perform a background check, and request responses from the peer references listed in the Application. After receiving all verifying information and other information or materials deemed pertinent, the Medical Staff Office shall transmit the Application and all supporting documentation to the Credentials Committee for evaluation. The Application shall become incomplete if the need arises for new, additional or clarifying information anytime during evaluation.

b. **Department Chief Procedure.** Upon receipt, of the complete Application the Credentials Committee shall refer the Application to the Department Chief of each Department in which the applicant seeks clinical privileges. Within ten (10) days of receipt, the Department Chief shall

provide a written recommendation for appointment and specific written findings supporting the proposed delineation of the applicant's clinical privileges. The Department Chief may delegate this function to the Service Leader, Medical Director or Lead Physician of each Service ("Service Representative") to which the applicant requests assignment. The recommendation(s) shall be made part of the credentialing record and included in the Credentials Committee report to the Medical Executive Committee. As part of the evaluation the Department Chief, and/or Service Representative may meet with the applicant to discuss any aspect of the Application, qualifications and requested clinical privileges.

c. **Credentials Committee Procedure.** Upon receipt of the Department Chief/Service Representative recommendation, the Credentials Committee shall proceed to evaluate the Application in the following manner:

1. Review the Application and examine all evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing to determine whether the applicant has established and satisfied all of the necessary qualifications for the clinical privileges requested. The Committee shall also evaluate the following:
   a) challenges to the applicant's licensure or registration,
   b) voluntary or involuntary relinquishment of any license or registration,
   c) voluntary or involuntary limitation, reduction or loss of clinical privileges,
   d) any evidence of an excess number of professional liability actions resulting in a final judgment against the applicant,
   e) documentation as to the applicant's health status, and
   f) relevant practitioner-specific data as compared to aggregate data, when available.
2. On reasonable grounds, and in a manner consistent with the Americans with Disabilities Act and similar state laws, require a physical, psychomotor, and/or mental health examination of the applicant by a physician or physicians satisfactory to the Committee and require that the results be made available for the Committee's consideration.
3. If the recommendation for appointment and/or clinical privileges is favorable, recommend Department and/or Service assignment and delineation of initial clinical privileges.
4. At its option, require a meeting with the applicant, without legal counsel, to discuss any aspect of the Application, qualifications, or clinical privileges requested. An Active Staff member seeking to employ an Allied Health Staff applicant shall have the opportunity to appear before the Credentials Committee to discuss the proposed appointment and delineation of clinical privileges before the Committee makes its recommendation.
5. Within sixty (60) days of receipt of the application, complete its review of the Application and supporting documentation. The Committee may defer action on the Application for up to an additional sixty (60) days to obtain further information or clarification from the applicant or others deemed reasonably necessary by the Committee in considering its recommendation.
6. After completing its review, the Committee shall send its recommendation to the Medical Executive Committee.

d. Medical Executive Committee Procedure.

1. Within thirty (30) days of receipt of the Credentials Committee recommendation, the Medical Executive Committee shall review the recommendation as well as the Application, supporting documentation and the recommendations of the Department Chief/ Service Representative.
2. If, after reviewing the Credentials Committee's recommendation, the Medical Executive Committee's recommendation is favorable, it shall send its recommendation to the Board for consideration at its next regularly scheduled meeting and shall include the findings and recommendation of the Credentials Committee.
3. The Medical Executive Committee may defer action on the application for up to thirty (30) days to obtain additional information or clarification from the applicant, Credentials Committee, Department Chief/Service Representative, or others deemed reasonably necessary by the Medical Executive Committee in considering its recommendation.
4. If, after reviewing the Credentials Committee's recommendation, the Medical Executive Committee's recommendation is unfavorable and would entitle the applicant to a hearing pursuant to Article VIII, of these Bylaws, the Medical Executive Committee's recommendation shall be forwarded to the VPMA, who shall promptly provide Special Notice to the applicant. The VPMA shall then hold the Application until after the applicant has exercised or has been deemed to have waived the right to a hearing as provided in Bylaws, Article VIII, after which the VPMA shall forward the recommendation, together with the Application and all supporting documentation, to the Board.

e. <u>Board Procedure.</u>

1. The Board shall consider the Medical Executive Committee's recommendation at its next regularly scheduled meeting. The Board may, in whole or in part, adopt or reject a favorable recommendation of the Medical Executive Committee, or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral and setting a time limit within which the Medical Executive Committee shall reconsider its recommendation.
2. If the Board's decision is unfavorable to the applicant in respect to either appointment or clinical privileges, the President of the Hospital shall promptly provide Special Notice to the applicant of their right to appeal the Board's adverse decision. The Board shall only take final action on the Application after the applicant has exhausted or waived their procedural rights as provided in Article VIII of these Bylaws.

f. <u>Notice of Final Decision.</u>

1. Notice of the Board's final decision shall be given to the Medical Executive Committee and, through the Hospital President, to the applicant by Special Notice.
2. A favorable decision shall include:
   a) The staff category to which the applicant is appointed,
   b) Department/Service assignment,
   c) delineation of clinical privileges granted, and
   d) any special conditions attached to the appointment or clinical privileges.

g. **Reapplication after Adverse Appointment Decision.** An applicant who has received a final adverse decision regarding appointment shall not be eligible to re-apply to the Medical Staff for a period of three (3) years. Any such re-application shall be processed as an initial application.

SECTION 3. Procedure for Reappointment

a. **Procedure for Reappointment.** Medical Staff appointments shall be scheduled for reappointment on a two-year cycle, not to exceed 365 + 365 days based on the year/month the member was born with those born in odd years evaluated in odd years and those born in even years evaluated in even years. The Medical Staff Office, as designee of the Hospital President shall, at least ninety (90) days prior to the expiration date of each Medical Staff appointment, provide the member an Application for reappointment as provided in Section 1. Each member of the Medical Staff who desires reappointment shall, at least sixty (60) days prior to the expiration date of their appointment, submit, in accordance with Section 1, a completed Application for reappointment to the Medical Staff Office. Failure, without good cause, as determined solely at the discretion of the Medical Executive Committee, to submit a completed Application for reappointment within the time limits set forth herein may result in automatic termination of membership and clinical privileges at the expiration of the member's then current term. The affected member may reapply. However, such applications shall be treated as an application for initial appointment under Section 1.

b. **Required Documentation.** A completed application for reappointment shall include a current copy of the following documents:

1. Maine Professional License(s)/Certifications,
2. Federal Narcotics License (DEA) (if applicable),
3. Current Certificate of Insurance, in an amount acceptable by the Board, and
4. Any certifications or advancements in training since initial appointment.

c. **Verification of Information.** The Medical Staff Office, as designee of the Hospital President, shall verify the information provided in the Application for reappointment and collect any additional information deemed relevant, including information regarding the applicant's professional activities, performance and conduct in the Hospital. When collection and verification is accomplished, the Medical Staff Office shall send the information and supporting documentation to the Credentials Committee.

d. **Credentials Committee Procedures.** The Credentials Committee shall review the Application for reappointment and supporting documentation, including the results of Ongoing Professional Practice Evaluation and any Focused Professional Practice Evaluation. Following its review, the Committee shall send its recommendation to the Medical Executive Committee for consideration at its next regularly scheduled meeting. The Credentials Committee may recommend that appointment be:

1. renewed,
2. renewed with modified staff category,

3. renewed with changes in Department/Service affiliation,
4. renewed with modification of clinical privileges, or
5. denied.

e. **Medical Executive Committee Procedures.** The Medical Executive Committee shall review the recommendation of the Credentials Committee, the reappointment application and all supporting documentation. Following its review, it shall send its recommendation to the Hospital President for transmittal to and consideration by the Board. The Medical Executive Committee may recommend that appointment be either renewed, renewed with modified staff category, changes in Department/Service affiliation, and/or modification of clinical privileges, or denial of reappointment or clinical privileges.

f. **Board Procedures.** Upon receipt of the Medical Executive Committee's recommendation, the Board shall follow the procedures set forth in Sections 2.e and f.

SECTION 4. Requests for Modification of Appointment

A member of the Medical Staff may, either in connection with reappointment or at any other time, request modification of their staff category, Department/Service assignment, or clinical privileges by submitting a written request to the Credentials Committee. Such request shall be processed in substantially the same manner as an Application for reappointment under these Bylaws.

SECTION 5. Confidentiality and Reporting

Professional Competence Review Activity, including, but not limited to, actions taken, and recommendations made pursuant to this Article shall be treated as confidential in accordance with such policies regarding confidentiality as may be adopted by the Board. In addition, reports of actions taken pursuant to these Bylaws shall be made by the Hospital President to such governmental agencies as may be required by law.

SECTION 6. Professional Review Protection

All minutes, reports, recommendations, communications and actions made or taken in carrying out Professional Competence Review Activities pursuant to applicable law or these Bylaws are deemed to be covered by the provisions of 32 M.R.S. §§ 2599, 3293 and 3296, 24 M.R.S. §§ 2501-2511, 42 U.S.C. §§ 11101-11152, and/or the corresponding provisions of any subsequent federal or state statute providing protection to professional competence review or related activities.

SECTION 7. Employed or Contracted Members

Nothing contained in these Bylaws shall be construed to discriminate with regard to Medical Staff membership and/or clinical privileges on the basis of whether a Member is an employee of the Hospital or providing services to the Hospital pursuant to a professional services agreement. Provided, nevertheless, that this Section shall not affect the terms of any contract or written employment arrangement with the Hospital that provides that a Member’s membership and/or clinical privileges are

incident to or coterminous with the contract or employment arrangement or the Member's association with a group holding such contract.

SECTION 8. Focused Professional Practice Evaluation

a. **Focused Professional Practice Evaluation (FPPE).** FPPE is an extension of the Medical Staff credentialing process that entails a period of focused performance review.

b. **FPPE Procedures.** FPPE shall be conducted by the Professional Practice Evaluation Committee for the following:

1. newly appointed Members,
2. currently credentialed Members requesting new or additional privileges,
3. Members returning from a prolonged period of absence from practice, as determined by the Medical Executive Committee, or
4. whenever questions arise regarding a Member's professional performance that may affect the provision of safe, high-quality patient care.

c. **Evaluation Period.** The FPPE period for all newly appointed Members and currently credentialed Members requesting new or additional privileges is six (6) months. Upon the recommendation of the Credentials Committee, the Medical Executive Committee may, in its discretion, extend the evaluation period for a time not to exceed one year.

d. **Evaluation Process.** Information used for evaluation may be obtained through, but is not limited to, the following:

1. concurrent or targeted medical record review,
2. direct observation,
3. monitoring/proctoring of diagnostic, procedural, and/or treatment techniques,
4. discussion with other Members involved in the care of specific patients,
5. interviews with the Member,
6. sentinel event data, and/or
7. any applicable Professional Competence Committee data.

e. **Initially Requested Privileges.** For all newly appointed Members and all existing Members requesting new or additional privileges undergoing an initial period of FPPE, the following steps shall be taken:

1. Evaluations will be performed by an Active Staff member.
2. A Mentor with similar privileges from the same clinical department will conduct the evaluation based on pre-determined indicators.
3. The Mentor will complete the required forms and submit them to Professional Practice Evaluation Committee.
4. Evaluations should be completed within six (6) months of any new appointment. Any deviation from this timeframe will require a letter from the Mentor requesting more time.

f. **Mentoring of Specific Procedures.** Mentoring specific procedures will be determined on a case-by-case basis at the discretion of the Professional Practice Evaluation Committee. In the event a Mentor cannot be chosen from the Medical Staff due to an obvious or perceived potential conflict of interest, a Mentor may be assigned from another organization's medical staff.

g. Quality of Care Concerns.

1. FPPE of a Member's performance by the Professional Practice Evaluation Committee will occur only when issues are identified that may affect the provision of safe, high-quality medical care. One or more of the following criteria will trigger the need for an FPPE:
   a) aggregate, valid, or provider specific data that demonstrates a significant untoward variation from internal or external benchmarks or performance,
   b) a problematic pattern or trend identified as a result of the ongoing professional practice evaluation of the Member,
   c) a complaint or quality of care concern against the Member that is of a serious nature, or
   d) evidence of behavior, health, and/or performance issues that carry an immediate threat to the health and safety of the patient, public, other members of the health care team or Hospital.

h. **Recommendation to the Medical Executive Committee.** The Professional Practice Evaluation Review Committee shall report its FPPE recommendations to the Credentials Committee, the Credentials Committee will report the FPPE recommendations to Medical Executive Committee, recommending that it take one or more of the following actions:

1. Conclude the FPPE with one of the following actions:
   a) Take no further action,
   b) Require the Member to receive the education and/or training necessary to more competently perform the privileges in question, or
   c) Commence corrective action pursuant to Article VII of these Bylaws.
2. Continue the FPPE period for a determined period of time in order to acquire the information necessary to make an appropriate recommendation.

SECTION 9. Ongoing Professional Practice Evaluation

a. **Ongoing Professional Practice Evaluation (OPPE).** The Professional Practice Evaluation Committee shall conduct OPPE of each credentialed Member. OPPE is the continuous evaluation of a Member's professional performance, rather than an episodic evaluation. It is intended to identify and resolve potential professional practice trends and performance issues as soon as possible, as well as foster a more efficient, evidence-based privilege renewal process.

b. **OPPE Criteria.** Data collected for ongoing professional practice evaluation is used to make decisions to maintain, revise or revoke existing privileges, or to recommend expansion of privileges, at the time of application for reviewed or expanded privileges. If, as a result of OPPE, a pattern or trend affecting quality of care and patient safety is identified, performance

improvement activities may result, including an FPPE. OPPE criteria may include, but are not limited to the following:

1. An evaluation of the six general competencies: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and system-based practice,
2. Blood use (may include AABB transfusion criteria),
3. Prescribing of medications: prescribing patterns, trends, errors and appropriateness of prescribing for Drug Use Evaluations,
4. Surgical Case Review: appropriateness and outcomes for selected high-risk procedures as defined by the Medical Staff,
5. Specific department indicators that have been defined by the Medical Staff,
6. Anesthesia/Moderate Sedation Adverse Events,
7. Readmissions/unplanned returns to surgery (as defined),
8. Appropriateness of care for non-invasive procedures/interventions,
9. Utilization data,
10. Significant deviations from evidence-based professionally recognized standards of practice, and,
11. Timely and legible completion of patients' medical records. Any variant that should be analyzed for statistical significance.

c. **Reporting.** Data will be compiled and reported for each Member on a periodic basis. Individual profiles will be made available to each Member, their Department Chief, and the Credentials Committee.

d. **Member-Specific Profile.** A Member-specific profile shall be created and used to compile the OPPE data to be evaluated.

e. **Use of OPPE Information.** As a result of the evaluation, the Professional Practice Evaluation Committee make any of the following recommendations:

1. No action is necessary as the review demonstrates satisfactory performance by the Member.
2. Education and/or training may be required in order to improve the Member's performance in the indicator(s) measured.
3. FPPE may be required to better understand practice issues relative to the indicator(s) measured and/or to determine competency.
4. Refer issues to the Medical Executive Committee for consideration of corrective action pursuant to Article VII of these Bylaws.

f. **Use of OPPE Information at Reappointment.** OPPE Information shall be made available to the Credentials Committee at the time of the Member's reappointment and/or request for modification of privileges. It shall be considered in making the recommendation for reappointment and/or privileging.

ARTICLE VI

CLINICAL PRIVILEGES

SECTION 1. Exercise of Privileges

Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice in the Hospital. Each individual who has been appointed to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Board.

SECTION 2. Temporary Privileges

a. Temporary Privileges for Applicants and Members Requesting Additional or Modified Clinical Privileges.

1. In extraordinary situations the Senior VP and Hospital President, with the recommendation of the VPMA or the VPMA, as designee of the Hospital President, may grant temporary privileges to an applicant for a period of no more than one hundred twenty (120) days, if necessary to fulfill an important patient care, treatment, or service need or when an applicant for new privileges with a completed Application that raises no concerns is awaiting review and approval by the Medical Executive Committee and the Board. An "applicant for new privileges" shall include an individual who:
   a) Has submitted an initial application for Medical Staff membership and clinical privileges,
   b) Currently holds clinical privileges at the Hospital and who is seeking one or more additional clinical privileges, or
   c) Is in the reappointment process and is seeking one or more additional privileges.
2. Temporary privileges may be granted only upon receipt of a complete Application and a National Practitioner Data Bank Query of the applicant. The Application shall be verified as to current licensure, current competence, relevant training or experience, ability to perform the privileges requested, no current or previously successful challenge to licensure or registration, no subjection to involuntary termination of medical staff membership at another organization, no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges, and professional liability insurance coverage and history.
3. In exercising temporary privileges, the Practitioner shall act under the supervision of the Department Chief or the Service Chief of the Service in which the applicant has requested or holds clinical privileges.

b. **Temporary Clinical Privileges for Non-Applicants.** In order to fulfill an important patient care, treatment and service need, temporary admitting and/or clinical privileges for care of a specific patient or patients may be granted by the VPMA, as designee of the Hospital President, to a Practitioner who is not an applicant for appointment or reappointment, in the same manner and upon the same conditions as set forth in Article VI, Section 2.a of these Bylaws. Such privileges shall be restricted to the specific patients for which they are granted.

c. **Termination of Temporary Privileges.** On the discovery of any information or the occurrence of any event of a professionally questionable nature about a Practitioner's qualifications or ability to exercise any or all of the temporary privileges granted, the Hospital President, or VPMA may, after consultation with the responsible Department Chief or Service Chief, terminate any or all of a Practitioner's temporary privileges. With respect to Practitioner's holding temporary privileges while an initial or reappointment Application is pending, such temporary privileges shall be automatically terminated at such time as the Medical Executive Committee recommends denial of the Application. In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Department Chief or Service Chief with the consent of the substitute Practitioner and the patient.

d. **Procedural Rights of Temporary Privilege Applicants/Practitioners.** Practitioners or Members shall not be entitled to the procedural rights afforded in Article VIII of these Bylaws because of their inability to obtain temporary privileges or because of any termination or suspension of temporary privileges.

SECTION 3. Locum Tenens

The Hospital President or VPMA, as designee of the Hospital President, may grant an individual serving as locum tenens for a member of the Medical Staff temporary clinical privileges to attend patients of that Practitioner for a period not to exceed one hundred twenty (120) days and only after receipt of a complete Application for appointment. This grant of clinical privileges shall be considered in the same manner and upon the same conditions as set forth in Article VI, Section 2.a, c, and d.

SECTION 4. Disaster Privileges

a. **Declaration of Disaster or Emergency.** During a period when a medical emergency or disaster has been declared; the Hospital's emergency or disaster management plan has been activated; and the Hospital is unable to handle immediate patient care needs without additional support, it may be necessary for Practitioners who are not members of the Medical Staff to be granted clinical privileges to provide care at the Hospital.

b. **Granting Authority.** In such circumstances, the Hospital President or VPMA, may grant such privileges. In cases where neither the Hospital President nor VPMA, is available, the Medical Staff President, Department Chief or a Service Chief may grant such privileges.

c. **Identification.** The identity of the Practitioner being granted disaster privileges must be ascertained by obtaining a copy of the individual's valid government-issued photo identification (for example, a driver's license or passport) and any one of the following:

1. Current hospital picture ID,
2. Current license, certification, or registration to practice,
3. Identification indicating that the individual is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other state or federal response organization or group,

4. Identification from a federal, state, or municipal entity indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances, or
5. Representation by a current member of the Medical Staff with personal knowledge regarding the Practitioner's identity.

d. **Supervision.** The Hospital President, VPMA, the President of the Medical Staff or Department or Service Chief shall pair a currently credentialed Medical Staff member (in the same specialty or as close to that specialty as can be matched under the circumstances) with the Practitioner being granted disaster privileges who will act only under the direct supervision of the credentialed Medical Staff member.

e. **Verification Process.** Verification of the credentials of Practitioners granted disaster privileges must be carried out as soon as the disaster is under control or within seventy-two (72) hours of the Practitioner's commencement of providing disaster medical services, whichever occurs first. If primary source verification cannot be completed within seventy-two (72) hours due to extraordinary circumstances, it shall be completed as soon as possible. In such extraordinary circumstances the Hospital shall document the following:

1. The reason(s) why verification could not be performed within seventy-two (72) hours,
2. Evidence of the Practitioner's demonstrated ability to continue providing adequate care, treatment, and services, and
3. Evidence of the Hospital's attempt to perform primary source verification as soon as possible.

f. **ID Badges.** Practitioners granted disaster privileges must wear Hospital-issued identification at all times showing their disaster privileges.

g. **Termination.** Disaster privileges will automatically terminate when the disaster is declared over, the immediate situation is under control, and members of the Medical Staff are able to resume patient care duties without disaster assistance. Practitioners are not entitled to the procedural rights afforded by the Hearing and Appellate Review Procedures in Article VIII of these Bylaws because of their inability to obtain disaster privileges or because of any termination or suspension of disaster privileges.

SECTION 5. Emergency Privileges

In 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, to the degree permitted by their license/certification and regardless of Service, staff status or clinical privileges, is authorized to do everything possible to save the patient's life or to save the patient from serious or permanent harm. Emergency privileges exercised under this provision shall be for a maximum of seventy-two (72) hours and are not renewable. After termination of such privileges, the patient shall be assigned to an appropriate member of the Medical Staff. Emergency privileges may be granted to a Practitioner not holding clinical privileges at the

Hospital, provided that the identification, credentials verification and supervision requirements governing the grant of disaster privileges, as set forth in Article VI, Section 4 c, d, and e of these Bylaws are applied to such Practitioners.

SECTION 6. Telemedicine Privileges

a. **Verification Process.** Licensed independent Practitioners, or their employers, who provide medical information exchanged from distant sites to the Hospital, via electronic communications, for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment and services shall have an agreement with the Hospital pursuant to which they act as a contractor of services to the Hospital and that describes the services to be provided in a manner that permits the Hospital to be in compliance with the Medicare Conditions of Participation. Distant site Practitioners shall be credentialed and privileged in either of the following mechanisms:

1. Verification of credentials and competence to render telemedicine services by the methods outlined in these Bylaws, or
2. Delegated credentialing verification using credentialing information from the distant site if the distant site is accredited by a recognized accreditation body like The Joint Commission, and the hospital or ambulatory care organization maintains the credentialing decisions of the Hospital's Medical Staff and Board. The remote Practitioner must be privileged at the distant site for those services to be provided to the Hospital.

b. **Voting and Supervision.** Telemedicine Practitioners shall not be eligible to vote or to hold Medical Staff office. Any licensed independent Practitioner granted Telemedicine privileges shall be under the medical and administrative supervision of the Medical Staff. Telemedicine privileges shall be subject to the provisional appointment provisions of these Bylaws.

c. **Performance Review.** The Medical Staff shall review the performance of Practitioners exercising telemedicine privileges and shall provide the distant site with information that is useful in assessing the Practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, such information shall include:

1. Information regarding adverse outcomes related to sentinel events considered reviewable by the Hospital's accreditation body that result from telemedicine services provided, and
2. Complaints about the distant site Practitioner from patients, licensed independent Practitioners, or staff at the Hospital.

d. **Termination.** Upon termination of a telemedicine service agreement pursuant to which a Practitioner is providing services, or if the Practitioner's employment with the distant site is terminated, the Practitioner's telemedicine privileges shall terminate. Such termination shall not be subject to the fair hearing and appeal provisions set forth in Article VIII of these Bylaws.

ARTICLE VII

COMPLAINT RESOLUTION AND CORRECTIVE ACTION

SECTION 1. Complaint Resolution

a. **Complaint Resolution Process.** An optional Complaint Resolution Process ("CRP") may be used to address documented allegations or concerns regarding a Member's clinical performance, conduct or health that, upon initial identification, appear not to meet the criteria for corrective action. CRP provides an opportunity for preliminary review of certain complaints and may assist the Medical Executive Committee in determining whether further review or corrective action is warranted.

b. **Initiating a CRP.** Any complaint regarding a Member's competency, conduct, or health, may be submitted in writing to the Member's Department Chief, Medical Director, or designee. Only written and signed complaints shall be acted upon. The complainant shall be informed that their identity may be revealed to the affected Member during the CRP. The affected Member should understand that any retaliation against the complainant may be grounds for additional CRP or corrective action in accordance with the Bylaws.

c. **Department Chief Review and Recommendation.** The Department Chief shall review the complaint and make a preliminary recommendation whether the complaint should be managed through a CRP.

d. **CRP Meeting.** If the Department Chief determines that a CRP should be initiated, the Chief shall forward the complaint to the President of the Medical Staff, VPMA, or designee who shall provide a copy of the complaint to the affected Member and schedule a complaint resolution meeting with the affected Member, the Department Chief and any other persons that may be necessary or helpful in resolving the complaint. The goal of the meeting is to reach a resolution of the complaint.

e. **Notice of CRP Meeting.** The affected Member shall be given notice of the meeting at least five (5) working days prior to the meeting, or such shorter notice as may be mutually agreed upon by the affected Member and Department Chief.

f. **Option to Participate in CRP.** Affected Members shall be advised that they have the option not to participate in the CRP and to have the matter resolved through the corrective action process set forth in the Bylaws.

g. **Complaint Resolution Process Report.** After the CRP meeting, the Department Chief or VMPA shall record the results including any recommendations and forward a report to the Medical Executive Committee using the Complaint Resolution Process Report form, attached hereto as Attachment A and made a part of these Bylaws. The affected Member shall be informed of the results and recommendations of the Department Chief and may rebut or comment on them in writing to the Medical Executive Committee.

h. **Medical Executive Committee Review and Decision.** The Complaint Resolution Report shall be reviewed by the Medical Executive Committee at its next regularly scheduled meeting. The Committee shall approve or reject the Complaint Resolution Report. If approved, the disposition and documentation of the complaint shall be considered satisfactory and final. If rejected, the Medical Executive Committee shall notify the affected Member of its rationale for rejecting the Report and its alternative recommendations or actions.

i. **CRP Does Not Limit Medical Executive Committee Action.** The CRP findings and recommendations shall not limit the Medical Executive Committee from recommending or taking further action regarding the allegations/concerns.

SECTION 2. Corrective Action

a. **Criteria for Initiation of Corrective Action.** Corrective Action may be requested by the VPMA, Medical Staff President, a Department Chief or Board Chair whenever, on the basis of reasonable information and belief, the activities or professional conduct of any Member are considered to:

1. Be detrimental to patient safety or likely to affect adversely the delivery of quality patient care in the Hospital,
2. Violate bylaws, policies, rules or standards adopted by the Medical Staff, the Hospital or the Board,
3. Be disruptive to the operations of the Hospital or materially impede the orderly and efficient administration of the Hospital's affairs, including the inability or failure of the Member to work collegially with others, as more specifically defined in the Medical Staff's Code of Conduct and Statement of Values and the Hospital's Disruptive Medical Staff Member Policy, or
4. Fail to meet and satisfy the qualifications for staff status or to fulfill the responsibilities of staff status provided in these Bylaws.

b. **Request and Notice.** All requests for corrective action shall be in writing, submitted to the Medical Executive Committee, and supported by reference to the specific activities or conduct which constitute the grounds for the request. The President of the Medical Staff shall notify the VPMA, in writing, of all requests for corrective action and shall keep the VPMA fully informed of all actions taken in conjunction therewith.

c. **Medical Executive Committee Preliminary Review.** The Medical Executive Committee shall conduct a preliminary review of a request for corrective action at its next regularly scheduled meeting or at an earlier meeting called for that purpose. The Medical Executive Committee shall either reject the request for corrective action, if it determines that the request lacks a factual basis, or direct that an investigation concerning the grounds for the request be undertaken.

d. **Notice.** Within two (2) business days following the Medical Executive Committee's preliminary review, the President of the Medical Staff shall notify the affected Member of the Medical Executive Committee's preliminary decision by Special Notice.

e. **Investigation.** If the Medical Executive Committee determines to conduct an investigation it may conduct the investigation or may appoint an Investigating Committee to conduct the investigation.

f. **Conduct of the Investigation.** In order to evaluate the request for corrective action the investigation shall include the following:

1. Review of all documentation relevant to the request,
2. Interviews with the person(s) making the request,
3. Interviews with persons who may have knowledge bearing on the request, and
4. Pursuant to Section 2.h, a meeting with the affected Member.

g. **Investigating Committee.** If the Medical Executive Committee elects to impanel an Investigating Committee, the President of the Medical Staff or their designee shall assign three (3) Members from the affected Member's Department to serve as committee members. If assigning three (3) Members from the same Department is not possible, the President of the Medical Staff shall assign Members from another Department as necessary in order to impanel a three (3) person committee.

h. **Meeting with Member.** The investigation shall include a meeting with the affected Member. The Member will be given Special Notice of the meeting at least five (5) business days before such meeting unless the Member agrees to shorter notice. Notice shall include the date, time, and place of the meeting, a statement of the issue(s) involved, and a statement that the Member's appearance is requested. The meeting shall not constitute a hearing, shall be preliminary in nature, and need not be conducted according to the procedural rules provided with respect to hearings as set forth in Article VIII of these Bylaws, but shall afford the Member a fair opportunity to respond to questions and to address the allegations set forth in the request for corrective action. The interview shall constitute a peer-to-peer interaction and neither the affected Member nor the Investigating Committee shall be represented by counsel during the interview.

i. **Report of the Investigating Committee.** If an Investigating Committee is appointed, it shall send a written report of its investigation to the Medical Executive Committee as soon as practical after its investigation has been completed, but in no event later than sixty (60) days after referral by the Medical Executive Committee.

j. **Resources Available.** The Medical Executive Committee or the Investigating Committee, in conducting its investigation, shall have available the full resources of the Medical Staff and the Hospital, and the authority to use outside consultants as deemed necessary, if approved by the Medical Executive Committee and the Hospital President.

k. **Impartial Physical and/or Mental Evaluation.** If relevant to the issues raised in the request for corrective action, the Medical Executive Committee may require the affected Member to submit to an impartial physical and/or mental health evaluation. The Medical Executive Committee may require the Member to submit to such evaluation within thirty (30) days of its request subject to the following conditions:

1. Failure of the Member to submit to an impartial physical or mental evaluation without good cause shall result in immediate suspension of the Member's staff status and all clinical privileges until the evaluation is obtained and the results are reported to the Medical Executive Committee.
2. The impartial evaluator who will conduct the examination shall be selected by the Medical Executive Committee. However, the Medical Executive Committee shall consider input from the affected Member regarding its choice of the evaluator.
3. Fees for an evaluation under this Section shall be paid by the Hospital.
4. The evaluator's report shall be submitted to the President of the Medical Staff, who shall share the results with the Medical Executive Committee at its next meeting following receipt of the report.

l. **Medical Executive Committee Action.** The Medical Executive Committee shall act as soon as practical after the conclusion of the investigative process, but in no event later than ninety (90) days after receipt of the request for corrective action. Medical Executive Committee action may include, but is not limited to, the following:

1. Reconvening the Investigating Committee to address specific issues,
2. Rejecting the request for corrective action,
3. Modifying the request for corrective action,
4. Issuing, a letter of reprimand,
5. Recommending additional education and/or training,
6. Recommending individual medical/psychiatric treatment or counseling,
7. Recommending a retrospective review of cases and/or other review of professional behavior, but without special requirements of prior or concurrent or direct supervision,
8. Imposing terms of probation or a requirement for proctoring or consultation,
9. Recommending to the Board reduction, suspension, or revocation of any part or all of the clinical privileges granted, and/or
10. Recommending reduction, suspension, or revocation of staff membership.

SECTION 3. Summary Suspension

a. **Criteria and Initiation.** The President of the Hospital, the VPMA, the President of the Medical Staff or the Board Chair shall have the authority to summarily suspend all or a portion of the clinical privileges of any Member whenever they perceive that there is a substantial likelihood that failure to do so may result in: (1) injury or damage to the health or safety of any patient, employee or other person present in the Hospital or (2) disruption of the orderly operations of the Hospital. A summary suspension is precautionary in nature and shall not imply a final finding of responsibility for the matters giving rise to the suspension. Summary suspension shall

become effective immediately upon imposition. The President of the Hospital or designee shall promptly notify the affected Member by the most expeditious manner, including, but not limited to, in person, telephone call, or email, and shall also provide Special Notice of the summary suspension to the Member.

b. **Medical Executive Committee Action.** As soon as practical, but not more than ten (10) days after such summary suspension, a meeting of the Medical Executive Committee shall be convened to review and consider the action taken. The Medical Executive Committee may recommend modification, continuation or termination of the terms of the summary suspension.

c. **Procedural Rights.** Unless the Medical Executive Committee recommends immediate termination of the suspension and cessation of all further corrective action, the Member shall be entitled to the expedited procedural rights to a hearing as provided in Article VIII of these Bylaws. The terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final decision by the Board.

SECTION 4. Automatic Suspension

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

b. **Drug Enforcement Administration ("DEA").** Members who are required to have DEA number whose DEA number is revoked or suspended shall immediately and automatically be divested of their right to prescribe medications covered by such number. As soon as possible after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts under which the DEA number was revoked or suspended. The Medical Executive Committee may then take such further action as is appropriate to the facts disclosed in its investigation.

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

d. **Failure to Complete Medical Records.** A pattern of failure to complete medical records in a timely fashion as defined in the Bylaws, Rules and Regulations of the Medical Staff shall result in automatic suspension of the Member's privileges to perform non-emergent procedures and admit new patients which shall be effective until all delinquent medical records are completed. As an alternative to automatic suspension the affected Member may be subject to the complaint resolution process or corrective action as provided in Article VII of these Bylaws. For

the purpose of enforcing this Section 4.d, justified reasons for delay in completing medical records shall include, without limitation, the following mitigating circumstances:

1. The Member or any other individual contributing to the record is ill, on vacation, out of town, or otherwise unavailable for a period of time, or
2. The Member is awaiting the results of a late report which is necessary for completion of a discharge summary and establishment of a final diagnosis.

e. **Procedural Rights.** A Member under automatic suspension by operation of Section 4 shall not be entitled to the procedural rights provided in Article VIII of these Bylaws.

ARTICLE VIII

HEARING AND APPELLATE REVIEW PROCEDURE

SECTION 1. Hearings

a. **Hearing Right following an Adverse Recommendation.** Whenever a Member receives notice of an Adverse Recommendation, as defined in Section 2, they shall be entitled to a hearing before an ad hoc Hearing Committee of the Medical Staff established in accordance with Section 5.A. The affected Member shall have thirty (30) days following the date of the receipt of the notice of an Adverse Recommendation to request a hearing. The request for hearing shall be made in writing and shall be submitted to the President of the Hospital. In the event the affected Practitioner does not request a hearing within the time and in the manner as set forth above, they shall be deemed to have waived the right to the hearing and to have accepted the Adverse Recommendation. The Adverse Recommendation shall then be sent to the Board, and it shall become effective upon final approval by the Board. If the Adverse Recommendation following such hearing is still adverse to the Member, they shall then be entitled, upon request, to an appellate review by the Board before a final decision is rendered.

b. **Adverse Board Decision.** When the Board is considering taking Adverse Action that is either contrary to a favorable recommendation of the Medical Executive Committee under circumstances where no prior right to a hearing existed, or being made on the Board's own initiative without benefit of a prior recommendation by the Medical Executive Committee, the affected Member shall be entitled, upon request, to a hearing by an ad hoc Board Hearing committee appointed by the Board, in accordance with Section 5.b, before the Board takes final action or renders a final decision.

c. **Exceptions.** Actions or recommendations of the Medical Executive Committee or the Board that are not Adverse Actions, as defined in Section 2, shall not entitle the affected Member to a hearing or appellate review. Examples of actions or recommendations that do not trigger rights to a hearing or appellate review include, but are not limited to, the issuance of a warning, a letter of admonition, and a letter of reprimand.

SECTION 2. Adverse Actions or Recommendations

For purposes of these Bylaws the following recommendations or actions are deemed Adverse Actions:

a. Denial of initial Medical Staff appointment,

b. Denial of reappointment to the Medical Staff,

c. Suspension of Medical Staff membership,

d. Revocation of Medical Staff membership,

e. Denial of requested advancement in Medical Staff category,

f. Involuntary reduction in Medical Staff category,

g. Denial of requested clinical privileges,

h. Involuntary reduction of clinical privileges,

i. Suspension of clinical privileges, other than automatic suspensions pursuant to Article VII, Section 4,

j. Revocation of clinical privileges,

k. Proctoring that requires either or both the prior approval of the proctor or the presence of the proctor during the exercise of clinical privileges, and/or

l. Terms of probation.

SECTION 3. Initiation of Hearing

a. **Notice of Adverse Action.** The President of the Hospital or VPMA as designee shall be responsible for giving Special Notice of an Adverse Action and the right to a hearing to the affected Member. The notice shall include:

1. The nature of the proposed action and a statement of the Member's alleged acts or omissions, a list by number of the specific or representative patient records or subject matter forming the basis for the adverse recommendations or actions.
2. Notice that the Member has thirty (30) days after receiving notice to submit a request for a hearing and that such request must satisfy the conditions for such a request.
3. Notice that failure to request a hearing within the prescribed time and/or in the proper manner constitutes a waiver of rights to a hearing and to appellate review.

b. Waiver by Failure to Request a Hearing.

1. The failure of a Member to request a hearing to which they are entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of their right to such hearing and to any appellate review to which they might otherwise have been entitled on the matter.
2. When the waived hearing or appellate review relates to an adverse recommendation of the Medical Executive Committee or of a hearing committee appointed by the Board, the waiver shall become and remain effective against the Member in the same manner as a final decision of the Board provided for in Article VIII of these Bylaws. In either event, the President of the Hospital or VPMA as designee shall notify the affected Member of their status by Special Notice.

SECTION 4. Hearing Prerequisites

a. **Notice of Hearing.** Within ten (10) days after receipt of a request for a hearing the Medical Executive Committee or the Board, whichever is applicable, shall schedule and arrange for the hearing and shall, through the President of the Hospital or VPMA as designee, notify the Member of the time, place and date of the hearing by Special Notice. The hearing date shall not be less than ten (10) days nor more than sixty (60) days from the receipt of the request for hearing; provided, however, that a hearing for a Member who is under suspension which is then in effect shall be held as soon as arrangements therefore may reasonably be made, after receipt of the request for hearing.

b. **Statement of Charges.** The notice of hearing shall state in concise language the acts or omissions with which the Member is charged, a list of specific or representative charts being questioned, if relevant, and/or other reasons or subject matter that was considered in making the adverse recommendations or decision.

SECTION 5. Composition of Hearing Committee

a. **Medical Executive Committee.** When the hearing relates to an Adverse Action of the Medical Executive Committee the hearing shall be conducted by an ad hoc Hearing Committee of not less than three (3) Members appointed by the President of the Medical Staff in consultation with the Medical Executive Committee. One of the Members so appointed shall be designated as Chair by the President of the Medical Staff. No Member who has actively participated in the consideration of the Adverse Action shall be appointed as a member of the Hearing Committee unless it is otherwise impossible to select a representative group. In no case shall any individual who is in direct economic competition with the affected Member serve on the Hearing Committee. Practitioners who are not Members but are members of the medical staff of another Maine hospital may be appointed to serve on the Hearing Committee, if it is not possible to appoint a sufficient number from the Medical Staff.

b. **By the Board.** When a hearing is related to an Adverse Action of the Board that is contrary to the recommendation of the Medical Executive Committee, the Board shall appoint an ad hoc Board Hearing Committee to conduct such hearing and shall designate one of the members of the committee as Chair. The committee shall be made up of at least three (3) voting members, two of whom shall be Board members. At least one representative from the Medical Staff shall be included on this committee, if feasible. In no case shall a Member who is in direct economic competition with the affected Member or who participated in the Adverse Action recommendation serve as a member of the ad hoc Board Hearing Committee. Practitioners who are not Members may be appointed, if necessary, to assure that no Member who is in direct competition with the affected Member or who participated in the adverse recommendation serves on the committee.

SECTION 6. Hearing Procedure

a. **Committee Presence.** All members of the ad hoc Hearing Committee or the ad hoc Board Hearing Committee must be present when the hearing takes place, and no member may vote by proxy.

b. **Records.** An accurate record of the hearing must be kept. The mechanism for recording the hearing shall be established by the ad hoc Hearing Committee or ad hoc Board Hearing Committee and may be accomplished by use of a court reporter, electronic recording unit, or by detailed transcription.

c. **Personal Presence.** The personal presence of the affected Member shall be required. A Member who fails without good cause to appear and proceed at such hearing shall be deemed to have waived their rights in the same manner as provided in Section 3.b.1 and to have accepted the Adverse Action recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in Section 3.b.2.

d. **Postponement.** Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the ad hoc Hearing Committee or ad hoc Board Hearing Committee. Granting such postponements shall only be for good cause shown and in the sole discretion of the hearing committee.

e. **Presiding Officer.** The Chair of the hearing committee shall preside over the hearing. In the alternative a hearing officer may be appointed by the hearing committee after consultation with the President of the Medical Staff or Board Chair, as applicable. The hearing officer may or may not be an attorney at law but must be a person familiar with medical staff organization, governance and corrective action with documented experience participating as an advocate in medical staff corrective action hearings or serving as a hearing officer in such hearings. The hearing officer shall act in an impartial manner. If requested by the hearing committee, the hearing officer may participate in its deliberations, but shall not be entitled to vote. The presiding officer or hearing officer, as applicable, shall preside over the hearing, determine the order of procedure, assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence and maintain decorum.

f. **Representation.** The affected Member shall be entitled to be represented by an attorney or other person of the Member's choice. Likewise, the Board or Medical Executive Committee may in its discretion, seek counsel and representation by an attorney.

g. **Rights of Parties.** During the hearing, the parties shall have the right to:

1. Call, examine and cross-examine witnesses,
2. Introduce and present evidence determined to be relevant by the presiding officer or hearing officer without regard to its admissibility in a court of law,
3. Question any witness on any matter relevant to the issue of the hearing (If an affected Member does not testify in their own behalf, they may be called and examined as if under cross examination),
4. Challenge any witness,

5. Rebut any evidence, and
6. Submit a written statement at the close of the hearing within a time period prescribed by the presiding officer or hearing officer.

h. Procedure and Evidence.

1. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action.
2. The Medical Executive Committee, when its action has prompted the hearing, shall appoint one of its members, another Member, or legal counsel to represent it at the hearing to present the facts in support of its adverse recommendation and to examine witnesses. The Board, when its action has prompted the hearing, shall appoint one of its members or legal counsel to represent it at the hearing to present the facts in support of its adverse decision and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the Adverse Action recommendation or proposed decision. The affected Member shall thereafter be responsible for supporting their challenge to the Adverse Action recommendation or proposed decision, by an appropriate showing that the Adverse Action recommendation or proposed decision lacks sufficient factual basis or is arbitrary, unreasonable or capricious.

i. **Recesses and Adjournment.** The ad hoc Hearing Committee or ad hoc Board Hearing Committee may recess and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of the presentation of oral and written evidence, and upon expiration the time period within which the parties were allowed to submit written statements in accordance with Section 6.g.6, the hearing record shall close, and the hearing shall adjourn. The ad hoc Hearing Committee or ad hoc Board Hearing Committee shall, within ten (10) days after adjournment of the hearing, conduct its deliberations outside the presence of the parties.

j. **Number of Reviews.** Notwithstanding any other provisions of these Bylaws, no Member shall be entitled as a matter of right to more than one hearing before either an ad hoc Hearing Committee or an ad hoc Board Hearing Committee and to one appellate review with respect to review of an Adverse Action recommendation.

SECTION 7. Hearing Committee Report and Further Action

a. **Hearing Committee Report.** Within ten (10) days after adjournment of the hearing, the ad hoc Hearing Committee or ad hoc Board Hearing Committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation considered by it, to the Medical Executive Committee or to the Board, whichever appointed it. The report may recommend affirmation, modification, or rejection of

the original Adverse Action recommendation of the Medical Executive Committee or the proposed Adverse Action decision of the Board.

b. **Action on Hearing Committee Report.** Within thirty (30) days after receipt of the report of the ad hoc Hearing Committee or ad hoc Board Hearing Committee, the Medical Executive Committee or the Board, as the case may be, shall consider the same and affirm, modify, or reverse its prior recommendation or action in the matter. The Medical Executive Committee or Board shall forward its recommendation, together with the hearing record, the ad hoc committee report, including copies of any documentary evidence included in the hearing record, to the President of the Hospital.

c. **Notice.** The President of the Hospital shall promptly send a copy of the report and recommendation to the affected Member by Special Notice with copies to the Board Chair.

d. Effect of Decision Favorable to the Member.

1. Adopted by the Board. If the Board affirms an ad hoc Board Hearing Committee report favorable to the Member, the recommendation becomes a final decision of the Board and is not subject to further consideration.
2. Adopted by the Medical Executive Committee. The Board may adopt or reject the Medical Executive Committee's recommendation, made pursuant to Section 7.b, in whole or in part or may refer the matter back to the Medical Executive Committee for further consideration. The referral shall be in writing and shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may require that: (i) an additional hearing by the ad hoc Hearing Committee be conducted to consider additional evidence or clarify issues that are in doubt, or (ii) the Medical Executive Committee carry out other proceedings or take other actions that the Board may require. The Medical Executive Committee shall then forward its reconsidered recommendation to the President of the Hospital and Board Chair. The President of the Hospital shall promptly send an affected Member Special Notice, informing the Member of the Medical Executive Committee's reconsidered recommendation. If, after review of the Medical Executive Committee's recommendation or reconsidered recommendation, the Board's decision is favorable to the affected Member, its decision shall be final, and not subject to further consideration. If the Board's decision is adverse to the affected Member, the President of the Hospital shall inform the affected Member by Special Notice of their right to request appellate review as provided in Sections 8 and 9.

SECTION 8. Initiation and Prerequisites of Appellate Review

a. **Request for Appellate Review.** A Member shall have fifteen (15) days following receipt of an Adverse Action recommendation under Sections 7.b or 7.d.2 to file a written request for appellate review. Such request shall be delivered to the President of the Hospital either in person or by Special Notice and may include a request for a copy of the report and record of the ad hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the Adverse Action recommendation. The request for appellate review may include a

request to file a written memorandum in support of the appeal and/or to present oral argument to the Board during the appellate review.

b. **Waiver by Failure to Request Appellate Review.** A Member who fails to request appellate review within the time and in the manner specified in Section 8.a waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 3.b.

c. **Notice of Time and Place for Appellate Review.** Upon receipt of a timely request for appellate review, the President of the Hospital shall deliver such request to the Board. Within fifteen (15) days after receipt for such request, the Board shall schedule and arrange for such review, including a time and place for oral argument, if such has been requested, which shall not be less than twenty-five (25) days nor more than sixty (60) days from the date of receipt of the appellate review request; provided, however, that an appellate review for a Member who is under suspension then in effect shall be held as soon as the arrangements for it may reasonably be made. At least five (5) days prior to the appellate review, the Hospital President shall notify the Member by Special Notice of the time, place and date of the review. The time for appellate review may be extended by the Board for good cause.

d. **Appellate Review Panel.** The appellate review shall be conducted by the Board or at the Board's discretion by an Appellate Review Panel composed of at least three (3) Board members, appointed by the Board Chair. If a Panel is appointed, one of its members shall be designated as Chair.

SECTION 9. Appellate Review Procedure

a. **Nature of Proceedings.** The appellate review shall be based upon the record of the hearing before the ad hoc Hearing Committee or ad hoc Board Hearing Committee, as the case may be, the committee's report and recommendation, and all subsequent recommendations or actions by the Medical Executive Committee or Board thereon. The Board or Appellate Review Panel shall also consider any written statements submitted pursuant to Section 9.b, oral argument allowed under Section 9.d, and/or such other materials as may be presented and accepted under Section 9.e.

b. **Written Statements.** A Member seeking review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which they disagree, and their reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the Board or Appellate Review Panel through the President of the Hospital at least fifteen (15) days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the Medical Executive Committee or by the Board, and if submitted, the President of the Hospital shall provide a copy thereof to the Member at least seven (7) days prior to the scheduled date of the appellate review.

c. **Presiding Officer.** The Chair of the appellate review body shall be the presiding officer. The Chair shall determine the order of the procedure during the review, make all required rulings, and maintain decorum.

d. **Oral Argument.** The Board or Appellate Review Panel, in its sole discretion, may allow the parties or their representatives to personally appear and make oral argument in favor of their respective positions. Any party or representative so appearing shall be required to answer questions put to them by any member of the Board or Appellate Review Panel.

e. **Consideration of New or Additional Matters.** New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only under unusual circumstances. The Board or Appellate Review Panel, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

f. **Recesses and Adjournment.** The Board or Appellate Review Panel may recess the appellate review and reconvene without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral argument, if allowed, the appellate review shall be closed. The Board or Appellate Review Panel thereupon, at a time convenient to itself, shall conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

g. Action Taken.

1. If the appellate review is conducted by the Board, it may affirm, modify, or reverse its prior decision or, in its discretion, refer the matter back to the Medical Executive Committee for further review and recommendation within fifteen (15) days. Such referral may include a request that the Medical Executive Committee arrange for a further hearing to resolve specified disputed issues.
2. If the appellate review is conducted by an Appellate Review Panel, the Panel shall, within seven (7) days after adjournment of the appellate review, either make a written report to the Board recommending that the Board affirm, modify, or reverse its prior decision, or refer the matter back to the Medical Executive Committee for further review and recommendation within fifteen (15) days. Such referral may include a request that the Medical Executive Committee reconsider its recommendation or consider taking such further action as the Appellate Review Panel requests. Within ten (10) days after the Appellate Review Panel's receipt of the Medical Executive Committee's reconsidered recommendation the Panel shall make its recommendation to the Board as provided above.

SECTION 10. Final Decision by Board

a. **Final Decision.** Within thirty (30) days after the conclusion of the appellate review, the Board shall make its final decision in the matter and shall forward it to the Medical Executive Committee and, through the President of the Hospital, to the affected Member by Special

Notice. If the decision is in accordance with the Medical Executive Committee's last recommendation in the matter, the decision shall be immediately effective and final and shall not be subject to further hearing or appellate review. If the decision is contrary to the Medical Executive Committee's last recommendation, before the decision is made final, the Board shall refer the matter to the Joint Conference Committee for further review and recommendation.

b. **Joint Conference Committee Review.** Within fifteen (15) days of its receipt of a matter referred to it by the Board pursuant to Section 10.a, the Joint Conference Committee shall convene to consider the matter and shall submit its recommendation to the Board. At its next meeting following the receipt of the Joint Conference Committee's recommendation, the Board shall make its final decision which shall be immediately effective and final and subject to no further hearing or appellate review. The President of the Hospital shall send Special Notice of this final decision to the affected Member.

SECTION 11. Time Frames

All reasonable steps will be taken to adhere to the time frames set forth in this Article. However, the times may be deviated from for good cause as determined by the Medical Executive Committee or the Board in the exercise of sound discretion. The Medical Executive Committee or Board may delegate the authority to deviate from these time frames in appropriate circumstances to the President of the Hospital, the President of the Medical Staff, an ad hoc hearing committees or others who have responsibilities under these Bylaws. The affected Member may request a deviation and such a request may be granted for good cause.

ARTICLE IX

OFFICERS

SECTION 1. Officers of the Medical Staff

The Officers of the Medical Staff shall be:

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

SECTION 2. Qualifications of Officers

Officers must be Members of the Active or Active Outpatient Staff at the time of nomination and election and must remain Members in good standing during the term of office.

SECTION 3. Election of Officers

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

b. The President of the Medical Staff shall appoint a Nominating Committee. The Committee shall consist of five members of the Active Staff and/or Active Outpatient Staff, including three past-presidents of the Medical Staff, whenever possible

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

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

e. The candidate for each office receiving the plurality of votes for that office shall be thereby elected to that office; provided, however, that at least a majority of the votes making up the plurality are cast by members of the Active Medical Staff and/or Active Outpatient Staff.

f. The Secretary/Treasurer of the Medical Staff will be moderator of the tabulation of the votes.

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

SECTION 4. Term of Office

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

SECTION 5. Resignation and Removal from Office

An officer may resign at any time by giving written notice to the Medical Executive Committee. Such resignation shall be effective as of the date such notice is delivered to the Medical Executive Committee or at such later time specified in the written notice.

SECTION 6. Vacancies in Office

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

SECTION 7. Duties of the Officers

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

1. Act in coordination with the Hospital President and the VPMA in all matters of mutual concern within the Hospital;
2. Preside at General Medical Staff meetings;
3. Preside at Medical Executive Committee meetings;
4. Serve as ex-officio member of all other Medical Staff committees, without vote;
5. Be responsible for enforcement of Medical Staff Bylaws, Rules and Regulations, and associated policies and procedures for implementation of sanctions where indicated, and for the Medical Staff's compliance with the procedural safeguards where corrective action has been requested;
6. Present the views, policies, needs and grievances of the medical staff to the Hospital President, VPMA, and to the Board;
7. Serve on the Board, ex officio, including as past-Medical Staff President for an additional two years;
8. Receive and interpret the policies of the Board to the Medical Staff;
9. Be spokesman for the Medical Staff in its external professional and public relations; and
10. Act as Chief of Staff, overseeing the clinical work and being responsible for the clinical organization of the Hospital.

b. **Medical Staff Vice-President** shall:

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

c. **Medical Staff Secretary/Treasurer** shall:

1. Preside at meetings of the Bylaws Committee;
2. Perform such other duties as ordinarily pertain to their office;
3. Keep accurate account of the financial status and financial transactions of the Medical Staff organization with assistance from the Medical Staff Office;
4. Render financial reports at the annual meeting of the Medical Staff; and
5. Oversee collection of Medical Staff dues as conducted by the Medical Staff Office.

ARTICLE X

CLINICAL DEPARTMENTS

SECTION 1. Departments

The Medical Staff shall be divided into Departments. The following is a list of the approved Departments and those Services assigned to each Department:

a. Department of Anesthesiology:

1. Anesthesiology
2. Pain Management

b. Department of Emergency Medicine

c. Department of Medicine/Family Practice:

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

d. Department of Orthopedics:

1. Orthopedic Surgery
2. Podiatry

e. Department of Pathology

f. Department of Radiology

g. Department of Surgery:

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

SECTION 2. Organization of Clinical Departments

Each Department shall have a Department Chief who shall be responsible for the overall supervision of the clinical work within the Department. All Members shall be assigned to the appropriate Department and/or Service that most closely reflects their professional training and experience, and the clinical area in which their practice is concentrated. A Member may be granted clinical privileges in one or more Departments or Services, and their exercise of clinical privileges is subject to the rules and regulations of that Department or Service and the authority of the Department Chief

SECTION 3. Department Chiefs

a. A Department Chief is a Physician qualified for the position through certification by an appropriate specialty board or comparable clinical competence (affirmatively established through the credentialing process), training and experience within their specialty area and appropriate clinical privileges delineated in the Department so as to qualify for a leadership position. Each Department Chief shall be a member of the Active Staff, shall be nominated by the Medical Executive Committee, and appointed by the Board.

b. When a Department Chief's position is vacant or to be vacated, a search committee shall be appointed by the President of the Medical Staff. It shall consist of at least four (4) Members, to include the President of the Medical Staff and the Chairman of the Credentials Committee. The committee shall first seek out and consider candidates for the position. In its deliberation, the Search Committee shall consider the recommendations of the Department involved. When the committee has concluded its search, it shall make specific recommendations to the Medical Executive Committee. The Medical Executive Committee shall then forward its recommendation for approval by the Board.

c. The Medical Executive Committee, through appointment of an acting chief, shall fill an unexpected vacancy or absence of the Department Chief. This appointee shall act as the Department Chief until the search for a chief has concluded and is approved by the Board.

d. Each Department Chief shall serve for a term of two years. Continued appointment may be based on the results of 360 evaluations performed in conjunction with the reappointment process.

e. The 360 evaluation includes a survey of various individuals, including members of individual Departments/Services. If the 360 tool is used, the results are included as part of the reappointment evaluation. Recommendations for continued appointment will be made by the Medical Executive Committee, which will in turn make a recommendation to the Board.

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

g. Removal of a Department Chief during their term may be initiated by a two-thirds (2/3) majority vote of all the Active Staff and Active Outpatient Staff of the Department, or by a two-thirds (2/3) majority vote of the Medical Executive Committee. No removal shall be effective unless and until it has been ratified by the Medical Executive Committee and the Board. Removal of a Department Chief during their term of office shall not otherwise affect their status on the Medical Staff. Permissible grounds for removal include, but are not limited to, failure to perform the functions of the position in a timely and appropriate manner, and failure to continuously satisfy the qualifications for the position, and failure to adhere to the Medical Staff Bylaws, Rules and Regulations.

SECTION 4. Functions of a Department Chief

The Department Chief shall:

a. Be accountable to the Medical Executive Committee and through it to the Board for all professional and administrative activities within their Department unless otherwise provided for by the Hospital. The Department Chief shall ensure that minutes are taken at all Department and Service meetings and that such minutes are referred to the Medical Executive Committee for review.

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

c. Be accountable for enforcement of Hospital and Medical Staff Bylaws, Rules and Regulations within their Department in concert with the Medical Executive Committee and Medical Staff President.

d. Be responsible for implementation within their Department of actions taken by the Medical Executive Committee.

e. Document, for Credentials Committee review at the time of initial appointment and reappointment, their recommendations for membership and clinical privileges for each Department Member based on qualifications and current clinical competence relevant to the care provided in the Department.

f. Develop and maintain criteria for clinical privileges for their Department.

g. Work with Hospital Administration including the President of the Hospital and VPMA to ensure that each Member of their Department fulfills their responsibilities to the Hospital. This shall include timely completion of medical records and attendance at Department, general Medical Staff, and committee meetings.

h. Assess and recommend to the relevant Hospital authority off-site sources for needed patient care and education services not provided by the Department or the Hospital.

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

j. Determine the qualifications and current competence of Department or Service personnel who are not licensed independent practitioners and who provide patient care and education services.

k. Assist in the appropriate orientation to the Hospital and Medical Staff for each of their Department Members and provide for the continuing education of all persons in the Department, as appropriate.

l. Assist Hospital Administration in determining the space and other resources needed by the Department members.

m. Access the services of the VPMA to support their duties as listed above.

n. Designate a member of the Department to function in their absence.

SECTION 5. Functions of Departments

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

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

SECTION 6. Future Departments and Services

Upon recommendation of the Medical Executive Committee, the Board may add or remove Departments or Services.

SECTION 7. Regular Meetings

a. Departments shall hold regular meetings at least four (4) times per year to review and evaluate the clinical work of Members practicing in the Department.

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

c. If a Member fails to meet attendance requirements as outlined in their Medical Staff obligations, the Department Chief shall notify the Member and the Medical Executive Committee in writing.

d. A Member who has attended a patient whose case is to be presented for clinical discussion shall be notified at least seven (7) days in advance of such meeting by the Department Chief and shall be requested to be present.

SECTION 8. Special Meetings

A special meeting of the Department may be called by or at the request of the Department Chief, the President of the Medical Staff, or by one third (1/3) of the Department's Members, but not by less than two (2) Members.

SECTION 9. Quorum

Fifty percent (50%) of the voting Members of a Department, but not less than two (2) Members, one being a Physician, shall constitute a quorum at any Department or Service meeting.

SECTION 10. Manner of Action

a. The action of a majority of the Members present at a meeting at which a quorum is present shall be the action of the Department.

b. Action may be taken without a meeting by unanimous written consent of the Department's Members.

SECTION 11. Minutes

a. Minutes of each regular and special Department and/or Service meeting shall be prepared and shall include a record of the attendance of Members and the vote taken on each matter.

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

c. Each Department and Service shall maintain a permanent file of the minutes of each meeting.

ARTICLE XI

COMMITTEES

SECTION 1. Purpose

Committees are delegated to perform such functions and to carry out such responsibilities of the Medical Staff as outlined in these Bylaws and to provide a forum for the ongoing review of clinical care rendered by the Medical Staff. Committees also assist the Medical Staff and the Board in complying with the goals and objectives of Hospital-wide and Medical Staff quality improvement plans. Unless otherwise provided for in these Bylaws, all committees shall report to the Medical Executive Committee, which shall provide general oversight of all such committees.

SECTION 2. Meetings

A special meeting of any committee may be called by, or at the request of, the Chairman, the President of the Medical Staff, or one-third (1/3) of the Committee's members, but not by less than two (2) members.

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

SECTION 3. Quorum

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

SECTION 4. Manner of Action

The action of a majority of the voting members present at a meeting at which a quorum is present shall be the action of the committee. Action may be taken without a meeting by unanimous written consent of the committee's members, which may be obtained electronically.

SECTION 5. Rights of Ex-Officio Members

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

SECTION 6. Minutes

Minutes of each regular and special meeting of a committee shall be prepared and include a record of attendance and the vote taken on each matter. The minutes shall document discussion, decisions, votes, remedial actions, follow up to all issues and report all activities and findings. The minutes shall be sent

to the Medical Executive Committee. A permanent file of the minutes shall be maintained for each committee.

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

SECTION 7. Attendance Requirements

Each committee member shall be assigned attendance obligations appropriate to their level of activity at the Hospital.

SECTION 8. Appointment

Except as otherwise provided in these Bylaws, the Medical Executive Committee shall make appointments to all committees and designate the chairperson. Initial committee appointments shall be for a period of two (2) years. The chairperson of each committee shall be a Physician. The President of the Medical Staff and the President of the Hospital, or their designees, shall be ex-officio, non-voting members of all committees, except that the President of the Medical Staff shall be a voting member of the Medical Executive Committee.

SECTION 9. Standing Committees of the Medical Staff

There shall be the following standing committees:

1. Bylaws Committee
2. Credentials Committee
3. Infection Prevention and Control Committee
4. Medical Executive Committee
5. Covenant Health Pharmacy and Therapeutics Committee
6. Professional Practice Evaluation Committee
7. Radiation Safety Committee
8. Utilization Management
9. Tissue and Transfusion Committee
10. Antimicrobial Stewardship

SECTION 10. Medical Executive Committee

a. Membership

1. The executive authority of the Medical Staff shall be vested in the Medical Executive Committee which shall have the duty of coordinating the professional activities and general policies of the various Departments and have such other functions and responsibilities as are provided in these Bylaws and the Bylaws of the Hospital. The majority of Medical Executive Committee membership shall be Members of the Active and/or Active Outpatient Staff.

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

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

3. The four (4) members-at-large shall be elected by the Medical Staff as provided in Article IX, Section 3 of these Bylaws.
4. If the President of the Medical Staff is the Department Chief, and thus serving on the Medical Executive Committee by virtue of both positions, the Department may elect an additional member to the Medical Executive Committee for the term of office of the President.
5. There shall also be the following non-voting, ex-officio members:
   a) The President of the Hospital or designee,
   b) The VPMA, and
   c) The Chief Nursing Officer or designee.
6. Any member of the Medical Executive Committee may resign at any time by giving written notice to the President of the Medical Staff. Such resignation takes effect on the date of receipt or at any later time specified in the written notice.

b. **Duties.** The duties of the Medical Executive Committee shall be as follows:

1. To represent and act on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as provided in these Bylaws.
2. To coordinate the activities and general policies of the various Departments/Services.
3. To review and act on reports of all Medical Staff committees, Departments, Services and other assigned activity groups.
4. To implement policies of the Medical Staff not otherwise the responsibility of the Department/Service.
5. To provide liaison between the Medical Staff, the President of the Hospital, and the Board.
6. To recommend action to the President of the Hospital on matters of a medical administrative nature.
7. To fulfill the Medical Staff's accountability to the Board for the medical care rendered (quality and patient safety) to patients in the Hospital.

8. To make recommendations regarding the mechanism designed to review credentials applications and delineate individual clinical privileges.
9. To review credentialing applications and requests for delineation of clinical privileges of applicants for appointment and reappointment to membership of the Medical Staff and to make recommendations to the Board for membership, assignments to Departments/Services, and delineation of clinical privileges.
10. To organize the Medical Staff's performance improvement activities and establish a mechanism designed to conduct, evaluate and revise such activities.
11. To annually approve the written Quality Assessment/Performance Improvement Plan and ensure it is an integral part of the Hospital's Performance Improvement Plan.
12. To annually approve the following key guiding Plans, Assessments & Goals for the upcoming year: Quality and Patient Safety Plan (which includes the Medical Staff Quality Plan), Infection Prevention Plan, Utilization Management Plan, and to submit their recommendations to the Board for final approval.
13. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all Members, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted.
14. To be responsible for investigation of any reports of breach of Bylaws, Rules and Regulations, associated policies and procedures, ethics, standards of professional behavior, clinical competence or other deviations from standards of practice.
15. Report activities during each meeting of the General Medical Staff.
16. Assure Medical Staff participate in system wide committees and other system wide policies, such as Utilization Management.

c. **Meetings.** The Medical Executive Committee shall meet at least ten (10) times a year and send minutes in a timely manner to the Board for review.

SECTION 11. Credentials Committee

The Credentials Committee has the primary responsibility of reviewing and making recommendations on each Application, including initial appointment, reappointment and modification of clinical privileges, for Medical Staff membership and clinical privileges. It develops, reviews and recommends the criteria for each clinical privilege. It is responsible for reviewing questions of clinical competence and the behavior of all Members and making recommendations to the Medical Executive Committee following such reviews.

a. Membership

1. The Credentials Committee shall include at least six (6) Members of the Active and/or Active Outpatient Staff representing various specialty areas, and one Member of the Allied Health staff. Department Chiefs/Service Leaders shall not be members of the Credentials Committee.
2. The chairperson of the Credentials Committee shall be the Vice President of the Medical Staff.

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

b. Duties

1. The Credentials Committee shall be an investigational and advisory body only. It shall investigate the credentials and qualifications of each applicant for membership on the Medical Staff. The committee may interview the applicant and shall recommend to the Medical Executive Committee whether the application should be accepted, modified, deferred, or rejected as elsewhere provided in these Bylaws. It shall recommend the category, classification, departmental assignment and delineation of privileges in conformity with these Bylaws.
2. It shall investigate the qualifications of Members in consideration of reappointment, and each request for modification of clinical privileges, and shall make appropriate and specific recommendations to the Medical Executive Committee in these matters.

SECTION 12. Tissue and Transfusion Committee

a. **Membership.** The Tissue and Transfusion Committee shall consist of at least five (5) Members of the Active and/or Active Outpatient Staff from various areas such as general surgery, orthopedics, gynecology, pathology, anesthesiology, the inpatient care/hospitalist Service, and emergency medicine, and one (1) member of the Allied Health Staff. It shall also include the blood bank supervisor, Director of Quality/PI or their designee, and representatives from nursing services and administration.

b. Duties

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

c. **Meetings.** The Tissue and Transfusion Committee shall meet at least quarterly and on call of the chairperson.

SECTION 13. Bylaws Committee

a. **Membership.** The Bylaws Committee shall consist of at least five (5) Members of the Active and/or Active Outpatient Staff, one (1) member of the Allied Health Staff, and a representative from Administration.

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

c. **Meetings.** The Bylaws Committee shall meet at least quarterly and upon the call of the chairperson.

SECTION 14. Professional Practice Evaluation Committee

a. Membership

1. The Professional Practice Evaluation Committee members shall consist of the Department Chief of Surgery or designee, Department Chief of Medicine/Family Practice, Medical Director of St. Joseph Internal Medicine (or designee), a non-employed member of the Medical Staff, one member of the Allied Health Staff, and the Medical Director of Quality Improvement who shall serve as the chairperson. The Director of Quality/PI will serve as a non-voting member. The Medical Executive Committee may appoint an appropriate designee for any committee member should the need arise.
2. Additional Members may be requested to provide consultation to the committee during a review should their expertise be required to ensure a thorough and objective evaluation. External peer review services may be utilized by the committee if deemed appropriate.
3. Partners, associates or relatives of a Member under review shall not participate in the final disposition.

b. Duties

1. It shall have the responsibility to develop and implement a Professional Practice Review Plan to ensure open and honest communication and full review of available information and to ensure the proceedings of the Professional Practice Evaluation Committee be protected from disclosure, as required by state and federal law and regulations.
2. It shall assess the performance of Members and use the results of such assessments to improve patient safety, quality and efficiency of health care services provided by the Hospital as outlined in the Medical Staff Professional Practice Review Policy.

c. Meetings

1. The Professional Practice Evaluation Committee shall meet at least quarterly and on call of the chairperson and submit minutes of each meeting in a timely manner to the Credentials Committee for review.

2. Whenever a suspected deviation from standard clinical or professional practice is identified, the committee chair may require the Member to confer with the committee regarding the alleged deviation.

SECTION 15. Quality Senate

The Quality Senate provides oversight of the organization-wide Quality Management System (QMS). The Quality Senate receives and evaluates reports for outcomes and effectiveness for QAPI, internal audits, patient safety and organization quality outcome reports via dashboards, scorecards and presentations.

SECTION 16. Infection Prevention and Control Committee

a. **Membership.** As outlined in the current Infection Prevention and Control Plan policy.

b. Duties

1. It shall have the responsibility of investigating infections occurring among patients and personnel, and of making recommendations for the control of such infections and any other situations which might contribute to hospital hazards for patients and personnel. It shall develop a practical system for reporting, evaluating, and keeping records to ensure that endemic levels, and well as epidemic levels of infection will be brought to the attention of the Medical Executive Committee.
2. It shall provide assistance in the development of the Hospital's personnel health programs.
3. It shall recommend standards of sanitation and medical asepsis, as well as the procedures used for isolation.

c. Meetings

1. The Infection Prevention and Control Committee shall meet at least quarterly and on call of the chairperson.
2. The Chairperson and the Infection Preventionist meet routinely to ensure the Infection Prevention & Control meetings are addressing relevant issues.

SECTION 17. Radiation Safety Committee

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

b. Duties

1. Discussing any radiation safety problems requiring a general solution.
2. Determining whether current procedures are maintaining exposures ALARA.

3. Considering new proposals for the use of radionuclides and evaluating the safety of those uses and the qualifications of the users.
4. Auditing the Radiation Safety Program to ensure that it meets all goals and all pertinent regulations.
5. The duties and functions of this Committee will be consistent with the guidelines specified by the Nuclear Regulatory Commission.

c. **Meetings.** The Radiation Safety Committee shall meet at least quarterly and upon call of the chairperson. A quorum must include the Radiation Safety Officer and the Administration representative.

SECTION 18. Medical Staff Health and Advocacy Committee

a. **Composition.** The Medical Executive Committee shall appoint at least four (4) Members as the Medical Staff Health & Advocacy Committee.

b. **Duties.** The Medical Staff Health & Advocacy Committee shall meet as necessary, and shall carry out the following objectives:

1. Education of Medical Staff on issues related to Member health and impairment,
2. Encouraging, initiating, or assisting any endeavor to improve the health and well-being of all Members, and
3. Identifying and providing assistance to any Member whose ability to provide safe and/or competent medical care to patients may be compromised due to personal or work-related stress, medical or psychological impairment, alcohol, chemical or substance abuse/dependency, or other potentially impairing condition.

c. **Purpose.** The purpose of this process is assistance, rather than discipline, in order to aid a Member in retaining or regaining optimal professional functions, consistent with protection of patients. Nothing in this Section is intended to preclude or limit the use of the regular corrective action process under these Bylaws whenever such action is deemed necessary and appropriate.

d. **Referrals.** The Medical Staff Health & Advocacy Committee may receive referrals from any source, including self-referral. Upon receipt of the referral, a subcommittee of two members of the Committee who have no, or limited conflict of interest, will be delegated to review the referral. This review shall include:

1. Contact with the referral source(s) to learn specific details of the precipitating event(s), including names of witnesses, if any, who will be contacted, and
2. A discussion of the referral with the identified Member.

e. **Report.** Upon completion of its review the subcommittee shall prepare a detailed written report, which shall be reviewed by the Committee. If after review of the subcommittee report, the Committee determines that the facts support a conclusion of a Member health issue causing an impairment, or potentially impairing condition, in clinical performance or actions/activities

which impact others, sufficient to compromise, or threaten to compromise, patient, staff, or public safety, or lower the quality of care below prevailing standards, or support a conclusion of impairment, a referral will be made to the Maine Medical Association Medical Professionals Health Program or other appropriate resource. The Committee may also recommend further remedial action.

f. **Remedial Action.** The Committee may implement remedial action or recommend that it be implemented by the President of the Hospital, without engaging in the corrective action process, through execution of a confidential written agreement with the affected Member. The agreement shall provide that any breach of the agreement may result in summary suspension and corrective action under the terms of these Bylaws. The agreement may be modified by agreement of all parties upon recommendation of the Medical Staff Health & Advocacy Committee. The agreement shall remain in effect until the Medical Staff Health & Advocacy Committee recommends change or discontinuation. If either is recommended, a written agreement for review and monitoring of activities will be substituted including a detailed delineation of the monitoring process. Final discontinuation of remediation will be recommended by the Medical Staff Health & Advocacy Committee and shall be subject to approval by the Medical Executive Committee.

G. If a Member refuses to comply with the agreement or if the Medical Staff Health & Advocacy Committee determines that the Member has failed to comply with the terms of the agreement, it shall immediately notify the President of the Hospital. In accordance with the terms of the agreement, clinical privileges may be summarily suspended, and a corrective action process initiated as provided in these Bylaws.

H. **Records.** All records of the Committee shall be kept in a separate secure file in the Medical Staff office. Such files shall be maintained separately from Credentials or Personnel files. Confidentiality will be maintained except as limited by law, ethical obligation, or when the safety of a patient is threatened and access to this file will be limited to members of the Medical Staff Health & Advocacy Committee for as long as written remedial agreements are not breached. If a breach occurs, the file may be reviewed as a part of the corrective action process.

SECTION 19. Joint Conference Committee

a. **Membership.** The Joint Conference Committee shall consist of the President of the Medical Staff, the Chairman of the Board, and the Hospital President. Other committee members will have equal representation of Medical Staff members appointed by the Medical Staff President, and non-physician members of the Board appointed by the Chairman of the Board. The VPMA may be a member, without vote, at the discretion of the Medical Staff President and Chairman of the Board.

b. Duties

1. Acting as a medical-administrative-governance liaison committee between the Board, the Medical Staff, and Hospital Administration;

2. Acting as the deliberative body on matters of policy, Medical Staff Bylaws, Rules and Regulations, including resolution by supermajority vote of any conflict between the Board and the Medical Staff regarding the adoption or revision of Medical Staff Bylaws, Rules and Regulations. A supermajority vote shall require the affirmative vote of at least three (3) members of the Committee;
3. Acting as a forum for reviewing and identifying issues requiring collaboration between the Board and the Medical Staff and referring such issues to appropriate Medical Staff or Board Committees for further action;
4. Acting as a source of education on topics which may have significance to Hospital/Medical Staff relationships; and
5. Acting on agenda items from the Chairperson of the Board, President of the Medical Staff, and Hospital President.

c. **Minutes.** Minutes will be maintained.

SECTION 20. Future Committees

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

b. Special Committees

1. The Medical Executive Committee and the President of the Medical Staff may appoint special committees from time to time for such purposes, as it may deem appropriate. Tenure and authority of such committees shall be defined at the time of appointment, but their tenure shall not exceed one year.
2. Such committees shall confine their work to the fulfillment of their purpose for which they were created and shall report to the Medical Executive Committee. They shall have no power of action unless authority of the Executive Committee specifically grants such. Minutes shall be kept of all meetings of such committees and submitted in a timely manner to the Medical Executive Committee for review.

ARTICLE XII

MEDICAL STAFF MEETINGS

SECTION 1. Regular Meetings

The Medical Staff shall hold two regular meetings each year. The regular meetings shall be held in April and October, unless the President of the Medical Staff, with approval of the Medical Executive Committee, designates that either meeting be held during a different month.

SECTION 2. The Annual Meeting

Generally, the regular meeting held in October shall serve as the Annual Meeting of the Medical Staff.

SECTION 3. Special Meetings

a. Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, at the request of the Board, the Medical Executive Committee or upon the written request of any ten (10) Members.

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

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

SECTION 4. Notice of Meetings

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

SECTION 5. Participation and Quorum

Members may participate either in person or via tele/video conference. Those Members in attendance shall constitute a quorum.

SECTION 6. Action of Medical Staff Meetings

Upon the adoption of motions at regular and special meetings of the Medical Staff, all such decisions shall be forwarded to the Board through the Medical Executive Committee for action.

SECTION 7. Attendance at Meetings

Attendance at Medical Staff meetings is strongly encouraged.

ARTICLE XIII

AMENDMENTS TO RULES AND REGULATIONS, EXHIBITS, AND APPENDICES

SECTION 1. Rules and Regulations of the Medical Staff

Subject to approval by the Board, the Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each Member. Such rules and regulations shall be a part of these Bylaws, except that they may be amended or repealed at any regular Medical Staff meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by a two-thirds (2/3) vote of those Members present and eligible to vote. Such changes shall become effective when approved by the Board.

ARTICLE XIV

ADOPTION OF AND AMENDMENTS TO MEDICAL STAFF BYLAWS

SECTION 1. Regular Review of Bylaws

These Bylaws shall be reviewed by a Bylaws Committee appointed by the Medical Executive Committee not less than once every two (2) years for consideration of revisions that may be necessary or advisable.

SECTION 2. Authority to Propose Amendments

The Medical Executive Committee, Bylaws Committee, Officers of the Medical Staff, and voting Members shall have the authority to propose amendments to these Bylaws Rules and Regulations, and policies of the Medical Staff.

SECTION 3. Medical Executive Committee Review and Recommendation

Proposed amendments shall be referred to the Medical Executive Committee which shall review and make a recommendation to the Medical Staff for approval, rejection, or modification.

SECTION 4. Medical Staff Approval of Recommendation

Affirmation or rejection of a Medical Executive Committee recommendation to amend the Bylaws shall require a majority vote of the voting Members. Affirmation or rejection of a Medical Executive Committee recommendation to amend Medical Staff Rules and Regulations or Medical Staff Policies, shall require a majority vote of the voting Members present at any regular or special Medical Staff meeting at which a quorum is present.

SECTION 5. Urgent or Technical Action by Medical Executive Committee

In the event of a documented need for a technical clarification or an urgent amendment to the Medical Staff Bylaws and Rules and Regulations is necessary to comply with law or regulation, the Medical Executive Committee may provisionally approve such urgent amendments and submit such to the Board for provisional approval without prior notification to the Medical Staff. The Medical Executive Committee shall then notify the Medical Staff immediately after submitting any such technical clarification or urgent amendment and seek Medical Staff approval pursuant to Section 4.

SECTION 6. Medical Staff Disagreement with Medical Executive Committee Action

The voting Members may propose revisions to any amendment provisionally approved pursuant to Section 5.

SECTION 7. Medical Executive Committee and Medical Staff Disagreement

Should the Medical Staff, at a meeting at which a quorum is present, and acting by a two-thirds (2/3) vote for Bylaws amendment or a majority vote for Medical Staff Rules and Regulations and Policies amendments, reject the recommendations of the Medical Executive Committee made pursuant to Section 5, the matter shall be referred by either the Medical Staff or the Medical Executive Committee to the Joint Conference Committee for further consideration.

SECTION 8. Medical Staff Authority to Adopt

The Medical Staff has the right to adopt Medical Staff Bylaws, Rules and Regulations, and Policies, and amendments thereto, and to propose them directly to the Board without review or recommendation from the Medical Executive Committee. Such direct action requires approval by a two-thirds (2/3) vote of the voting Members for Bylaws changes or a majority vote of the voting Members for Medical Staff Rules and Regulations and Policies changes.

SECTION 9. Board Approval

Upon approval of amendments to the Bylaws, Rules and Regulations, or Medical Staff policies, the President, acting on behalf of the Medical Staff, shall propose such amendments directly to the Board. Such amendments shall be effective only when approved by the Board. In the event that the Board does not approve such proposed amendments, the matter will be referred to the Joint Conference Committee for further deliberations and recommendations.

SECTION 10. Board Amendment Initiation

The Medical Staff Bylaws, Rules and Regulations, or policies shall not be unilaterally amended by either the Board or the Medical Staff.

ARTICLE XV

RULES AND REGULATIONS

SECTION 1. Admission and Discharge of Patients

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

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

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

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

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

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

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

h. The attending practitioner is required to document the medical need for hospitalization of each patient. The daily progress notes must reflect the need for continued hospitalization. Failure of compliance with this policy will be brought to the attention of the appropriate Department Chief, Service Leader, Medical Director or Lead Physician for suitable action.

i. Patients shall be discharged only on an order of a physician or his/her Allied Health practitioner, as appropriate. Should a patient choose to leave the hospital against the advice of the attending physician or without proper discharge, he/she will be asked to sign a Release from Responsibility Discharge and Procedure form stating such, and a notation shall be made in the patient's

medical record. If the patient refuses to sign the form, that fact shall be noted in the medical record as well. (See Nursing Administration policy #1-003.)

j. In the event of a hospital death the deceased shall be pronounced dead by the attending practitioner or his/her designee. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the medical staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to local law.

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

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

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

SECTION 2. Medical Records

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

hospitalization, to support the diagnosis, to describe the patient's progress, and to describe the patient's response to medication, interventions, and services, in planning the patient's care, and in making decision on the provision of care to the patient.

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

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

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

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

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

The history and physical shall include:

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

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

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

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

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

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

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

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

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

Brief operative notes include:

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

Dictated operative reports will include:

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

12. a detailed report of the surgical technique and findings;
13. Prosthetic devices, grafts, tissues, transplants or devices implanted, if any;
14. post-operative diagnosis; and
15. disposition of the patient.

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

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

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

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

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

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

p. All records are the property of the hospital and shall not otherwise be removed from hospital property. Records may be removed from the hospital's jurisdiction and safekeeping only in

accordance with a court order and in the custody of the custodian of records/Director of Health information Management. In the case of readmission of a patient, all previous records shall be available for use of the attending practitioner. This shall apply whether the patient is attended by the same physician or by another. Unauthorized removal of charts from the hospital is grounds for suspension of a physician for a period to be determined by the Medical Executive Committee.

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

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

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

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

u. The Health Information Department will advise the appropriate Department Chief, Service Leader, Medical Director, or Lead Physician, along with the non-compliant practitioner of any failure to complete records for two consecutive weeks after which they were due and will also note any excuse claimed. Approval of excuses is at the discretion of the Department Chief, Service Leader, Medical Director, or Lead Physician.

v. If the Department Chief, Service Leader, Medical Director, or Lead Physician determines that any practitioner has significantly deviated from the requirements noted above, or has failed to complete any available discharge summary for more than fifteen (15) days or any available record for more than thirty (30) days, then he/she shall seek such corrective action as may be reasonable under the circumstances as provided elsewhere in these Bylaws.

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

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

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

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

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

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

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

SECTION 3. General Conduct of Care

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

alternative treatments, will be referred to the physician. Specific procedures for obtaining informed consent are detailed in Hospital policies.

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

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

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

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

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

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

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

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

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

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

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

Administration of the following drugs will be stopped automatically as indicated unless a definite number of doses or a definite period of time has been specified in the orders:

1. Class II - Narcotics - 48 hours
2. Intravenous Anticoagulants - 48 hours
3. Class III, IV and V drugs - 7 days
4. Antibiotics - 7 days
5. Steroids - 7 days (given intravenously)

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

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

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

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

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

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

SECTION 4. General Rules Regarding Surgical Care

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

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

desirable before the emergency operative procedure is undertaken. Such consultation shall be appropriately documented.

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

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

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

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

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

h. Surgeons must be in the operating room and ready to begin operations at the time scheduled.

i. All practitioners utilizing the services of the surgical suite shall conform to the policies, rules and regulations that are formulated by the Governance Council and approved by the Medical Executive Committee and Board of Trustees.

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

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

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

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

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

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

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

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

SECTION 6. General Rules Regarding Emergency Services

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

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

c. The physicians in the Emergency Department will not be responsible to be the attending physician after a patient has been admitted to the hospital.

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

1. adequate patient identification,
2. identification of primary care physician,
3. information concerning the time of the patient's arrival, means of arrival, and by whom transported,
4. whether the patient left against medical advice,

5. pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to arrival at the hospital,
6. description of significant clinical laboratory and x-ray findings,
7. diagnosis,
8. treatment given,
9. condition of the patient on discharge or transfer,
10. final disposition including instructions given to the patient and/or family relative for necessary follow-up care,
11. a notation that a copy of the record is available to the primary care physician or medical organization providing follow-up care, treatment and/or services.

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

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

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

SECTION 7. General Rules Regarding Critical Care Unit

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

SECTION 8. Mass Casualties

Rules and regulations regarding the care of mass casualties at the time of a major disaster shall be based upon the hospital's current disaster plan.

SECTION 9. Responsibilities for Residents and Medical Students

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

a. Resident Responsibilities:

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

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

    a) The resident may evaluate the supervising physician's patients in the Emergency Department provided the sponsoring physician also evaluates the patient and cosigns the Emergency Department record prior to admission to the hospital or discharge from the Emergency Department.
    b) For those patients admitted to the hospital, the sponsoring physician shall evaluate the patient in person and be in a position to confirm the findings of the resident and discuss the care plan in the following time table: as soon as possible for an unstable and deteriorating patient; within one hour for a patient in the Intensive Care Unit; or within four hours for a stable medical patient admitted to a general hospital bed.
    c) The sponsoring physician confirms the subjective and objective findings of the resident, reviews the differential diagnosis, and discusses patient care management with the resident.
    d) At least on a daily basis (more often as the needs of the individual patient may dictate), the resident and the sponsoring physician will review progress of the patient, make the necessary modification in the care plan, plan family conferences as needed, and agree on the type and scope of documentation for the medical record.
    e) The sponsoring physician must cosign all orders written by the resident.
    f) When a medical patient develops a condition that the resident feels is potentially critical for that patient, the resident will contact the sponsoring physician and report these developments. The resident may identify the need for the physician to see the patient at an agreed upon time to assist in the evaluation and treatment of such a patient.
    g) As the level of skill and knowledge increases for individual residents, sponsoring physicians may delegate increasing levels of responsibilities and allow increasing levels of participation in patient care, excluding the performance of invasive procedures.
    h) At the time of discharge, the sponsoring physician may delegate some of the discharge planning to the resident, and should review any discharge documents generated by the resident and must sign any attestation statements required.
    i) The sponsoring physician should insure the completeness of the medical record by offering suggestions to the resident or by making additional comments in the progress notes.
    j) The principal documents of each hospital stay that are prepared by the residents, (the history and physical and the discharge summary, for example), must be reviewed for completeness by the sponsoring physician and pertinent suggestions should be offered to the resident about form, content or both.

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

b. <u>Medical Student/Physician Assistant Student Responsibilities</u>

1. Any active member of the medical staff agreeing to sponsoring a student, either a medical student or a physician assistant student, must notify Administration at least two-weeks prior to the student's arrival. The student must be currently enrolled in an accredited U.S. medical school and have completed one year of basic clinical rotations. The student must also provide the institution with proof of medical liability insurance.
2. Students are expected to interact with patients at St. Joseph Hospital with their permission, and under the direct supervision of active members of the medical staff at all times.
3. Key specific responsibilities of the sponsoring physician and of the student are listed below:

    a) For those patients admitted to the hospital, the student may enter a history and physical examination or consultation into the written record for educational purposes only. The sponsoring physician must still dictate an authenticated history and physical examination or consultation.
    b) The student may write orders in the presence of the sponsoring physician and that physician must immediately cosign those orders before the orders can be acted upon. The student may not dictate telephone orders.
    c) The student may assist the sponsoring physician in the emergency room or in the operating room to include wound closure in suturing of skin. The sponsoring physician must be physically present in the emergency room or in the operating room at all times. The student may first assist only on cases previously approved by the Chief of Surgery. It is the sponsoring physician's responsibility to obtain the necessary approval. Approval from the President or his/her designee, with input from the Department Chief, must be obtained for student involvement in any invasive procedure. It is the sponsoring physician's responsibility to obtain the necessary approval from the President or his/her designee.
    d) The student may round, with the patients' consent, with the sponsoring physician on hospitalized patients.

<u>SECTION 10. Responsibility for Non-Covered Patients in Event Physician Loses Privileges</u>

In the event a practitioner loses privileges, the Department Chief or the President of the Medical Staff shall promptly assign the member's patients to another service member. Whenever feasible, the wishes of the patient in the choice of a substitute member will be considered, unless otherwise indicated by the terms of the summary restriction or suspension.

DAHL-CHASE DIAGNOSTIC SERVICES

EXHIBIT 1-1

Document Title: Specimens Not Required for Submission to Pathology Laboratory Document Number: SP.371		
Written By: Robert Clukey		
Manual(s):	Surgical Pathology Manual	
Linked Documents:		
Effective Date:	December 2003	
Authorized:	David Renedo M.D.	Authorized Date: December 2003
Last Approval or Periodic Review Completed 5/9/18		**Next Periodic Review Needed On or Before 5/20/20**

PRINCIPLE:

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

PROCEDURE:

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

a. Teeth, removal must be recorded in the medical record.
b. Orthopedic hardware.
c. Toenails and fingernails that are grossly unremarkable.
d. Cataract lenses, iris, and muscle fragments.
e. Ear ossicles (staples, incus, malleus).
f. Intrauterine devices.
g. Grossly unremarkable foreskin from circumcision of a newborn.
h. Bullets, missiles and weapons; removal must be recorded in the medical record.
i. Foreign objects/foreign body.

j. Donor organs for transplantation.
k. Placentas without medical indications.
l. Products of conception/fetus when family or clinician does not request an exam and there is no suspicion of ectopic pregnancy or anomalies
m. Pacemakers and other medical devices.
n. Normal skin from plastic surgery procedures.
o. Fat removed by liposuction.
p. Aspirated and/or impacted food or foreign material.
q. Oral hardware
r. Medical devices not contributing to patient illness, injury or death (e.g. gastrostomy tubes, stents, sutures).
s. Intravascular catheters
t. Normal rib removed for surgical access (provided no history of malignancy).
u. Eyelid tissue removed for cosmetic surgery only.
i. Extra digits.
w. Nasal septal cartilage and/or bone.
x. Meniscus.
y. Tissue from acromio-clavicular joint surgery.
z. Tissue from rotator cuff repair. aa. Vaginal mucosa for repair.
bb. Bunions/claw toes/hammertoes.
cc. Surgical specimens obtained from an arthroscopic knee procedure where documentation exists of the pathologic changes confirming the indications for the procedure and the presence of disease, (ex. permanent photographic or video record).
dd. Mucosa, bone, and cartilage removed during plastic surgical procedures for non neoplastic disease (ex. septoplasty and uvulectomy).
ee. Tissue removed from joint replacement surgery, for osteoarthritis, rheumatoid arthritis, and reconstructive purposes.
ff. Traumatically amputated digits.[1]
gg. Tissue such as ligamentum flavum, intervertebral disc fragments, and bone removed during routine spinal surgery[2]
hh. Blood Clot
ii. Amputated limbs due to trauma, non-union, and/or dysfunction
jj. Varicose veins[3]

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

REFERENCES: Specimens which need not be sent to pathology Anthony

Whittemore M.D. Brigham and Women's Hospital, August 2003

DAHL-CHASE DIAGNOSTIC SERVICES

REVISIONS:

[1] Traumatic amputation digits was added to the list (Michael Tan 12/9/2011)

[2] Added spinal surgery specimens (Michael Tan 4/18/2012)

[3] Added blood clot, amputated limbs ganglion cyst, and varicose veins (Michael Tan 2/3/2016)

EXHIBIT 1-2

Document Title: Gross Only Specimens		**Document Number:** SP.180
Written By: Donna Dooman		
Manual(s):	Surgical Pathology Manual	
Linked Documents:		
Effective Date:	August 24, 2009	
Authorized:	Jay Ye M.D.	Authorized Date: August 24, 2009
Last Approval or Periodic Review Completed 4/25/2018 Next Periodic Review Needed On or Before 4/25/2020		

PRINCIPLE:
This a list of specimens that out lab considers "Gross Only". The gross only examination will consist of macroscopic examination, description and gross diagnosis of the material received (no sections are submitted for histology).

PROCEDURE:
1. The following is a list of specimens that are examined only grossly unless clinical information or gross examination dictates otherwise.
   1.1 Accessory bones and digits.

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

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

   <u>To Request a Gross Only Exam</u>:

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

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

REFERENCES: Zarbo RJ and Nakhleh RE. Specimens for Gross Exam Only or Exempt From Submission 97-02. Q Probe Program, College of American Pathologists, 1997.

EXHIBIT 2

ST. JOSEPH HOSPITAL
BANGOR, MAINE 04401

SUBCOMMITTEE FOR PRACTITIONER HEALTH GUIDELINES

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

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

PURPOSE

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

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

PROCEDURE:

The Subcommittee will receive referrals from any source, including self-referral. Upon receipt of the information, two members, who do not have any conflict of interest; will be delegated to perform an investigation. At this time consultation may be sought from the Maine Medical Association's (MMA) Medical Professionals Health Program (MPHP). This investigation will include contact with the complainant with an inquiry about the specific details of the precipitating event or events and names of any other witnesses of the event(s) who will also be contacted.

If it is determined the complaint has merit, the identified practitioner will be notified of the general nature of the complaint and the subsequent investigation. The practitioner will be provided the opportunity to present a written report of his/her view of the event(s), which will be included in the final report to the Chairperson.

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

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

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

a. recommend the practitioner voluntarily take a leave of absence, during which time he or she would participate in a rehabilitation or treatment program to address and resolve the impairment;
b. recommend appropriate conditions or limitations be placed on the practitioner'spractice;
c. recommend the practitioner voluntarily agree to refrain from exercising some or all privileges in the hospital until rehabilitation or treatment has been completed or an accommodation has been made to ensure the practitioner is able to practice safely and competently;
d. recommend some or all of the practitioner's privileges be suspended if the practitioner does not voluntarily agree to refrain from practicing in thehospital.

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

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

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

The purpose of this process is assistance and rehabilitation, rather than discipline, in order to aid a practitioner in retaining or regaining optimal professional functions, consistent with

protection of patients. Nothing in this policy is intended to preclude or limit the use of the

regular corrective action process, under Article VII of the Medical Staff Bylaws, when this is deemed necessary.

Reinstatement:

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

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

a. the nature of the practitioner's condition:
b. whether the practitioner is participating in a rehabilitation or treatment program and a description of the program;
c. whether the practitioner is in compliance with all of the terms of the program;
d. to what extend the practitioner's behavior and conduct need to be monitored;
e. whether the practitioner is rehabilitated;
f. whether an after-care program has been recommended to the practitioner and, if so, a description of the after-care program; and
g. whether the practitioner is capable of resuming medical practice and providing continuous, competent care to patients.

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

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

a. the practitioner must identify at least one practitioner who is willing to assume responsibility for the care of his or her patients in the event of the practitioner's inability or unavailability; and
b. the practitioner shall be required to provide periodic reports to the Subcommittee from his or her attending physician, for a period of time specified by the Subcommittee, stating the practitioner is continuing rehabilitation or treatment, as appropriate, and his or her ability to treat and care for patients in the hospital is not impaired. Additional conditions may also be recommended for the practitioner's reinstatement.

The final decision to reinstate a practitioner's clinical privileges must be approved by the Chief Executive Officer in consultation with the President of the Medical Staff and/or the Chairperson of the Credentials Committee.

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

Commencement of an Investigation:

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

Documentation and Confidentiality

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

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

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

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

If at any time it becomes apparent the matter cannot be handled internally, or jeopardizes the safety of the practitioner or others, the Chief Executive Officer, the President of the Medical

Staff and/or the chairperson of the Credentials Committee may contact law enforcement authorities or other governmental agencies.
All requests for information concerning the impaired practitioner shall be forwarded to the Chief Executive Officer for response.

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

REFERENCES:

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

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

ATTACHMENTS:

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

RESCISSION: None

APPENDIX A

ST. JOSEPH HOSPITAL
BANGOR, MAINE
04401

Subcommittee for Practitioner Health Guidelines

Consent for Release of Information Pertaining to Evaluation

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

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

Date:_____ Signature of Practitioner: _____

APPENDIX B

ST. JOSEPH HOSPITAL BANGOR, MAINE 04401

Subcommittee for Practitioner Health Guidelines

Consent for Release of Information

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

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

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

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

Date _____

Signature of Practitioner_____

Exhibit 3

Complaint Resolution Process Report

Practitioner ID #:_____ Date Allegation/Concern was identified:
Date Department Chief was notified:
Date CRP Meeting was held:
Participants:

Summary of Meeting:

Finding: _ Concern/Allegation Substantiated
_ Lack of Evidence to either Support or Reject the Concern/Allegation
_ Concern/Allegation Unsubstantiated

Recommendation:

_____
Department Chief
Date: _____

Medical Executive Committee Review

The Medical Executive Committee reviewed this CRP Report on_____and:
_ approved the resolution of the concern/allegation;
_ decided to pursue further review and action through the corrective action process;
or
_ rejected the CRP resolution of this concern/allegation (Document reason below)
Comments:

EXHIBIT 4

Ethical and Religious Directives for Catholic Health Care Services

Sixth Edition

UNITED STATES CONFERENCE OF CATHOLIC BISHOPS

This sixth edition of the *Ethical and Religious Directives for Catholic Health Care Services* was developed by the Committee on Doctrine of the United States Conference of Catholic Bishops (USCCB) and approved by the USCCB at its June 2018 Plenary Assembly. This edition of the *Directives* replaces all previous editions, is recommended for implementation by the diocesan bishop, and is authorized for publication by the undersigned.

Msgr. J. Brian Bransfield,
STD General Secretary,
USCCB

Digital Edition, June 2018

Contents

Preamble

Health care in the United States is marked by extraordinary change. Not only is there continuing change in clinical practice due to technological advances, but the health care system in the United States is being challenged by both institutional and social factors as well. At the same time, there are a number of developments within the Catholic Church affecting the ecclesial mission of health care. Among these are significant changes in religious orders and congregations, the increased involvement of lay men and women, a heightened awareness of the Church's social role in the world, and developments in moral theology since the Second Vatican Council. A contemporary understanding of the Catholic health care ministry must take into account the new challenges presented by transitions both in the Church and in American society.

Throughout the centuries, with the aid of other sciences, a body of moral principles has emerged that expresses the Church's teaching on medical and moral matters and has proven to be pertinent and applicable to the ever-changing circumstances of health care and its delivery. In response to today's challenges, these same moral principles of Catholic teaching provide the rationale and direction for this revision of the *Ethical and Religious Directives for Catholic Health Care Services.*

These Directives presuppose our statement *Health and Health Care* published in 1981.[1] There we presented the theological principles that guide the Church's vision of health care, called for all Catholics to share in the healing mission of the Church, expressed our full commitment to the health care ministry, and offered encouragement to all those who are involved in it. Now, with American health care facing even more dramatic changes, we reaffirm the Church's commitment to health care ministry and the distinctive Catholic identity of the Church's institutional health care services.[2] The purpose of these *Ethical and Religious Directives* then is twofold: first, to reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person; second, to provide authoritative guidance on certain moral issues that face Catholic health care today.

The *Ethical and Religious Directives* are concerned primarily with institutionally based Catholic health care services. They address the sponsors, trustees, administrators, chaplains, physicians, health care personnel, and patients or residents of these institutions and services. Since they express the Church's moral teaching, these Directives also will be helpful to Catholic professionals engaged in health care services in other settings. The moral teachings that we profess here flow principally from the natural law, understood in the light of the revelation Christ has entrusted to his Church. From this source the Church has derived its understanding of the nature of the human person, of human acts, and of the goals that shape human activity.

The Directives have been refined through an extensive process of consultation with bishops, theologians, sponsors, administrators, physicians, and other health care providers. While providing standards and guidance, the Directives do not cover in detail all of the

complex issues that confront Catholic health care today. Moreover, the Directives will be reviewed periodically by the United States Conference of Catholic Bishops (formerly the National Conference of Catholic Bishops), in the light of authoritative church teaching, in order to address new insights from theological and medical research or new requirements of public policy.

The Directives begin with a general introduction that presents a theological basis for the Catholic health care ministry. Each of the six parts that follow is divided into two sections. The first section is in expository form; it serves as an introduction and provides the context in which concrete issues can be discussed from the perspective of the Catholic faith. The second section is in prescriptive form; the directives promote and protect the truths of the Catholic faith as those truths are brought to bear on concrete issues in health care.

General Introduction

The Church has always sought to embody our Savior's concern for the sick. The gospel accounts of Jesus' ministry draw special attention to his acts of healing: he cleansed a man with leprosy (Mt 8:1-4; Mk 1:40-42); he gave sight to two people who were blind (Mt 20:29- 34; Mk 10:46-52); he enabled one who was mute to speak (Lk 11:14); he cured a woman who was hemorrhaging (Mt 9:20-22; Mk 5:25-34); and he brought a young girl back to life (Mt 9:18, 23-25; Mk 5:35-42). Indeed, the Gospels are replete with examples of how the Lord cured every kind of ailment and disease (Mt 9:35). In the account of Matthew, Jesus' mission fulfilled the prophecy of Isaiah: "He took away our infirmities and bore our diseases" (Mt 8:17; cf. Is 53:4).

Jesus' healing mission went further than caring only for physical affliction. He touched people at the deepest level of their existence; he sought their physical, mental, and spiritual healing (Jn 6:35, 11:25-27). He "came so that they might have life and have it more abundantly" (Jn 10:10).

The mystery of Christ casts light on every facet of Catholic health care: to see Christian love as the animating principle of health care; to see healing and compassion as a continuation of Christ's mission; to see suffering as a participation in the redemptive power of Christ's passion, death, and resurrection; and to see death, transformed by the resurrection, as an opportunity for a final act of communion with Christ.

For the Christian, our encounter with suffering and death can take on a positive and distinctive meaning through the redemptive power of Jesus' suffering and death. As St. Paul says, we are "always carrying about in the body the dying of Jesus, so that the life of Jesus may also be manifested in our body" (2 Cor 4:10). This truth does not lessen the pain and fear, but gives confidence and grace for bearing suffering rather than being overwhelmed by it. Catholic health care ministry bears witness to the truth that, for those who are in Christ, suffering and death are the birth pangs of the new creation. "God himself will always be with them [as their God]. He will wipe every tear from their eyes, and there shall be no more death or mourning, wailing or pain, [for] the old order has passed away" (Rev 21:3-4).

In faithful imitation of Jesus Christ, the Church has served the sick, suffering, and dying in various ways throughout history. The zealous service of individuals and communities has provided shelter for the traveler; infirmaries for the sick; and homes for children, adults, and the elderly.[3] In the United States, the many religious communities as well as dioceses that sponsor and staff this country's Catholic health care institutions and services have established an effective Catholic presence in health care. Modeling their efforts on the gospel parable of the Good Samaritan, these communities of women and men have exemplified authentic neighborliness to those in need (Lk 10:25-37). The Church seeks to ensure that the service offered in the past will be continued into the future.

While many religious communities continue their commitment to the health care ministry, lay Catholics increasingly have stepped forward to collaborate in this ministry. Inspired by the example of Christ and mandated by the Second Vatican Council, lay faithful are invited to a broader and more intense field of ministries than in the past.[4] By virtue of their Baptism, lay faithful are called to participate actively in the Church's life and mission.[5] Their participation and leadership in the health care ministry, through new forms of sponsorship and governance of institutional Catholic health care, are essential for the Church to continue her ministry of healing and compassion. They are joined in the Church's health care mission by many men and women who are not Catholic.

Catholic health care expresses the healing ministry of Christ in a specific way within the local church. Here the diocesan bishop exercises responsibilities that are rooted in his office as pastor, teacher, and priest. As the center of unity in the diocese and coordinator of ministries in the local church, the diocesan bishop fosters the mission of Catholic health care in a way that promotes collaboration among health care leaders, providers, medical professionals, theologians, and other specialists. As pastor, the diocesan bishop is in a unique position to encourage the faithful to greater responsibility in the healing ministry of the Church. As teacher, the diocesan bishop ensures the moral and religious identity of the health care ministry in whatever setting it is carried out in the diocese. As priest, the diocesan bishop oversees the sacramental care of the sick. These responsibilities will require that Catholic health care providers and the diocesan bishop engage in ongoing communication on ethical and pastoral matters that require his attention.

In a time of new medical discoveries, rapid technological developments, and social change, what is new can either be an opportunity for genuine advancement in human culture, or it can lead to policies and actions that are contrary to the true dignity and vocation of the human person. In consultation with medical professionals, church leaders review these developments, judge them according to the principles of right reason and the ultimate standard of revealed truth, and offer authoritative teaching and guidance about the moral and pastoral responsibilities entailed by the Christian faith.[6] While the Church cannot furnish a ready answer to every moral dilemma, there are many questions about which she provides normative guidance and direction. In the absence of a determination by the magisterium, but never contrary to church teaching, the guidance of approved authors can offer appropriate guidance for ethical decision making.

Created in God's image and likeness, the human family shares in the dominion that Christ manifested in his healing ministry. This sharing involves a stewardship over all material creation (Gn 1:26) that should neither abuse nor squander nature's resources. Through science the human race comes to understand God's wonderful work; and through technology it must conserve, protect, and perfect nature in harmony with God's purposes. Health care professionals pursue a special vocation to share in carrying forth

God’s life-giving and healing work.

The dialogue between medical science and Christian faith has for its primary purpose the common good of all human persons. It presupposes that science and faith do not contradict each other. Both are grounded in respect for truth and freedom. As new knowledge and new technologies expand, each person must form a correct conscience based on the moral norms for proper health care.

PART ONE

The Social Responsibility of Catholic Health Care Services

Introduction

Their embrace of Christ's healing mission has led institutionally based Catholic health care services in the United States to become an integral part of the nation's health care system. Today, this complex health care system confronts a range of economic, technological, social, and moral challenges. The response of Catholic health care institutions and services to these challenges is guided by normative principles that inform the Church's healing ministry.

First, Catholic health care ministry is rooted in a commitment to promote and defend human dignity; this is the foundation of its concern to respect the sacredness of every human life from the moment of conception until death. The first right of the human person, the right to life, entails a right to the means for the proper development of life, such as adequate health care.[7]

Second, the biblical mandate to care for the poor requires us to express this in concrete action at all levels of Catholic health care. This mandate prompts us to work to ensure that our country's health care delivery system provides adequate health care for the poor. In Catholic institutions, particular attention should be given to the health care needs of the poor, the uninsured, and the underinsured.[8] Third, Catholic health care ministry seeks to contribute to the common good. The common good is realized when economic, political, and social conditions ensure protection for the fundamental rights of all individuals and enable all to fulfill their common purpose and reach their common goals.[9]

Fourth, Catholic health care ministry exercises responsible stewardship of available health care resources. A just health care system will be concerned both with promoting equity of care—to assure that the right of each person to basic health care is respected—and with promoting the good health of all in the community. The responsible stewardship of health care resources can be accomplished best in dialogue with people from all levels of society, in accordance with the principle of subsidiarity and with respect for the moral principles that guide institutions and persons.

Fifth, within a pluralistic society, Catholic health care services will encounter requests for medical procedures contrary to the moral teachings of the Church. Catholic health care does not offend the rights of individual conscience by refusing to provide or permit medical procedures that are judged morally wrong by the teaching authority of the Church.

Directives

1. A Catholic institutional health care service is a community that provides health care to those in need of it. This service must be animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church.

2. Catholic health care should be marked by a spirit of mutual respect among caregivers that disposes them to deal with those it serves and their families with the compassion of Christ, sensitive to their vulnerability at a time of special need.

3. In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.

4. A Catholic health care institution, especially a teaching hospital, will promote medical research consistent with its mission of providing health care and with concern for the responsible stewardship of health care resources. Such medical research must adhere to Catholic moral principles.

5. Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment, and provide appropriate instruction regarding the Directives for administration, medical and nursing staff, and other personnel.

6. A Catholic health care organization should be a responsible steward of the health care resources available to it. Collaboration with other health care providers, in ways that do not compromise Catholic social and moral teaching, can be an effective means of such stewardship.[10]

7. A Catholic health care institution must treat its employees respectfully and justly. This responsibility includes: equal employment opportunities for anyone qualified for the task, irrespective of a person's race, sex, age, national origin, or disability; a workplace that promotes employee participation; a work environment that ensures employee safety and well-being; just compensation and benefits; and recognition of the rights of employees to organize and bargain collectively without prejudice to the common good.

8. Catholic health care institutions have a unique relationship to both the Church and the wider community they serve. Because of the ecclesial nature of this relationship, the relevant requirements of canon law will be observed with regard to the foundation of a new Catholic health care institution; the substantial revision of the mission of an institution; and the sale, sponsorship transfer, or closure of an existing institution.

9. Employees of a Catholic health care institution must respect and uphold the religious mission of the institution and adhere to these Directives. They should maintain professional standards and promote the institution's commitment to human dignity and the common good.

PART TWO

The Pastoral and Spiritual Responsibility of Catholic Health Care

Introduction

The dignity of human life flows from creation in the image of God (Gn 1:26), from redemption by Jesus Christ (Eph 1:10; 1 Tm 2:4-6), and from our common destiny to share a life with God beyond all corruption (1 Cor 15:42-57). Catholic health care has the responsibility to treat those in need in a way that respects the human dignity and eternal destiny of all. The words of Christ have provided inspiration for Catholic health care: "I was ill and you cared for me" (Mt 25:36). The care provided assists those in need to experience their own dignity and value, especially when these are obscured by the burdens of illness or the anxiety of imminent death.

Since a Catholic health care institution is a community of healing and compassion, the care offered is not limited to the treatment of a disease or bodily ailment but embraces the physical, psychological, social, and spiritual dimensions of the human person. The medical expertise offered through Catholic health care is combined with other forms of care to promote health and relieve human suffering. For this reason, Catholic health care extends to the spiritual nature of the person. "Without health of the spirit, high technology focused strictly on the body offers limited hope for healing the whole person."[11] Directed to spiritual needs that are often appreciated more deeply during times of illness, pastoral care is an integral part of Catholic health care. Pastoral care encompasses the full range of spiritual services, including a listening presence; help in dealing with powerlessness, pain, and alienation; and assistance in recognizing and responding to God's will with greater joy and peace. It should be acknowledged, of course, that technological advances in medicine have reduced the length of hospital stays dramatically. It follows, therefore, that the pastoral care of patients, especially administration of the sacraments, will be provided more often than not at the parish level, both before and after one's hospitalization. For this reason, it is essential that there be very cordial and cooperative relationships between the personnel of pastoral care departments and the local clergy and ministers of care.

Priests, deacons, religious, and laity exercise diverse but complementary roles in this pastoral care. Since many areas of pastoral care call upon the creative response of these pastoral caregivers to the particular needs of patients or residents, the following directives address only a limited number of specific pastoral activities.

Directives

10. A Catholic health care organization should provide pastoral care to minister to the religious and spiritual needs of all those it serves. Pastoral care personnel—clergy, religious, and lay

alike—should have appropriate professional preparation, including an understanding of these Directives.

11. Pastoral care personnel should work in close collaboration with local parishes and community clergy. Appropriate pastoral services and/or referrals should be available to all in keeping with their religious beliefs or affiliation.

12. For Catholic patients or residents, provision for the sacraments is an especially important part of Catholic health care ministry. Every effort should be made to have priests assigned to hospitals and health care institutions to celebrate the Eucharist and provide the sacraments to patients and staff.

13. Particular care should be taken to provide and to publicize opportunities for patients or residents to receive the sacrament of Penance.

14. Properly prepared lay Catholics can be appointed to serve as extraordinary ministers of Holy Communion, in accordance with canon law and the policies of the local diocese. They should assist pastoral care personnel—clergy, religious, and laity—by providing supportive visits, advising patients regarding the availability of priests for the sacrament of Penance, and distributing Holy Communion to the faithful who request it.

15. Responsive to a patient's desires and condition, all involved in pastoral care should facilitate the availability of priests to provide the sacrament of Anointing of the Sick, recognizing that through this sacrament Christ provides grace and support to those who are seriously ill or weakened by advanced age. Normally, the sacrament is celebrated when the sick person is fully conscious. It may be conferred upon the sick who have lost consciousness or the use of reason, if there is reason to believe that they would have asked for the sacrament while in control of their faculties.

16. All Catholics who are capable of receiving Communion should receive Viaticum when they are in danger of death, while still in full possession of their faculties.[12]

17. Except in cases of emergency (i.e., danger of death), any request for Baptism made by adults or for infants should be referred to the chaplain of the institution. Newly born infants in danger of death, including those miscarried, should be baptized if this is possible.[13] In case of emergency, if a priest or a deacon is not available, anyone can validly baptize.[14] In the case of emergency Baptism, the chaplain or the director of pastoral care is to be notified.

18. When a Catholic who has been baptized but not yet confirmed is in danger of death, any priest may confirm the person.[15]

19. A record of the conferral of Baptism or Confirmation should be sent to the parish in which the institution is located and posted in its baptism/confirmation registers.

20. Catholic discipline generally reserves the reception of the sacraments to Catholics. In

accord with canon 844, §3, Catholic ministers may administer the sacraments of Eucharist, Penance, and Anointing of the Sick to members of the oriental churches that do not have

full communion with the Catholic Church, or of other churches that in the judgment of the Holy See are in the same condition as the oriental churches, if such persons ask for the sacraments on their own and are properly disposed.

With regard to other Christians not in full communion with the Catholic Church, when the danger of death or other grave necessity is present, the four conditions of canon 844, §4, also must be present, namely, they cannot approach a minister of their own community; they ask for the sacraments on their own; they manifest Catholic faith in these sacraments; and they are properly disposed. The diocesan bishop has the responsibility to oversee this pastoral practice.

21. The appointment of priests and deacons to the pastoral care staff of a Catholic institution must have the explicit approval or confirmation of the local bishop in collaboration with the administration of the institution. The appointment of the director of the pastoral care staff should be made in consultation with the diocesan bishop.

22. For the sake of appropriate ecumenical and interfaith relations, a diocesan policy should be developed with regard to the appointment of non-Catholic members to the pastoral care staff of a Catholic health care institution. The director of pastoral care at a Catholic institution should be a Catholic; any exception to this norm should be approved by the diocesan bishop.

PART THREE

The Professional-Patient Relationship

Introduction

A person in need of health care and the professional health care provider who accepts that person as a patient enter into a relationship that requires, among other things, mutual respect, trust, honesty, and appropriate confidentiality. The resulting free exchange of information must avoid manipulation, intimidation, or condescension. Such a relationship enables the patient to disclose personal information needed for effective care and permits the health care provider to use his or her professional competence most effectively to maintain or restore the patient's health. Neither the health care professional nor the patient acts independently of the other; both participate in the healing process.

Today, a patient often receives health care from a team of providers, especially in the setting of the modern acute-care hospital. But the resulting multiplication of relationships does not alter the personal character of the interaction between health care providers and the patient. The relationship of the person seeking health care and the professionals providing that care is an important part of the foundation on which diagnosis and care are provided. Diagnosis and care, therefore, entail a series of decisions with ethical as well as medical dimensions. The health care professional has the knowledge and experience to pursue the goals of healing, the maintenance of health, and the compassionate care of the dying, taking into account the patient's convictions and spiritual needs, and the moral responsibilities of all concerned. The person in need of health care depends on the skill of the health care provider to assist in preserving life and promoting health of body, mind, and spirit. The patient, in turn, has a responsibility to use these physical and mental resources in the service of moral and spiritual goals to the best of his or her ability.

When the health care professional and the patient use institutional Catholic health care, they also accept its public commitment to the Church's understanding of and witness to the dignity of the human person. The Church's moral teaching on health care nurtures a truly interpersonal professional-patient relationship. This professional-patient relationship is never separated, then, from the Catholic identity of the health care institution. The faith that inspires Catholic health care guides medical decisions in ways that fully respect the dignity of the person and the relationship with the health care professional.

Directives

23. The inherent dignity of the human person must be respected and protected regardless of the nature of the person's health problem or social status. The respect for human dignity

extends to all persons who are served by Catholic healthcare.

24. In compliance with federal law, a Catholic health care institution will make available to patients information about their rights, under the laws of their state, to make

an advance directive for their medical treatment. The institution, however, will not honor an advance directive that is contrary to Catholic teaching. If the advance directive conflicts with Catholic teaching, an explanation should be provided as to why the directive cannot be honored.

25. Each person may identify in advance a representative to make health care decisions as his or her surrogate in the event that the person loses the capacity to make health care decisions. Decisions by the designated surrogate should be faithful to Catholic moral principles and to the person's intentions and values, or if the person's intentions are unknown, to the person's best interests. In the event that an advance directive is not executed, those who are in a position to know best the patient's wishes—usually family members and loved ones—should participate in the treatment decisions for the person who has lost the capacity to make health care decisions.

26. The free and informed consent of the person or the person's surrogate is required for medical treatments and procedures, except in an emergency situation when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment.

27. Free and informed consent requires that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all.

28. Each person or the person's surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decision of the person or the person's surrogate is to be followed so long as it does not contradict Catholic principles.

29. All persons served by Catholic health care have the right and duty to protect and preserve their bodily and functional integrity.[16] The functional integrity of the person may be sacrificed to maintain the health or life of the person when no other morally permissible means is available.[17]

30. The transplantation of organs from living donors is morally permissible when such a donation will not sacrifice or seriously impair any essential bodily function and the anticipated benefit to the recipient is proportionate to the harm done to the donor. Furthermore, the freedom of the prospective donor must be respected, and economic advantages should not accrue to the donor.

31. No one should be the subject of medical or genetic experimentation, even if it is therapeutic, unless the person or surrogate first has given free and informed consent. In instances of nontherapeutic experimentation, the surrogate can give this consent only if the experiment entails no significant risk to the person's well-being. Moreover, the greater the person's incompetency and vulnerability, the greater the reasons must be to perform any medical experimentation, especially nontherapeutic.

32. While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive expense to family or community.[18]

33. The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the patient.

34. Health care providers are to respect each person's privacy and confidentiality regarding information related to the person's diagnosis, treatment, and care.

35. Health care professionals should be educated to recognize the symptoms of abuse and violence and are obliged to report cases of abuse to the proper authorities in accordance with local statutes.

36. Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.[19]

37. An ethics committee or some alternate form of ethical consultation should be available to assist by advising on particular ethical situations, by offering educational opportunities, and by reviewing and recommending policies. To these ends, there should be appropriate standards for medical ethical consultation within a particular diocese that will respect the

diocesan bishop's pastoral responsibility as well as assist members of ethics committees to be familiar with Catholic medical ethics and, in particular, these Directives.

PART FOUR

Issues in Care for the Beginning of Life

Introduction

The Church's commitment to human dignity inspires an abiding concern for the sanctity of human life from its very beginning, and with the dignity of marriage and of the marriage act by which human life is transmitted. The Church cannot approve medical practices that undermine the biological, psychological, and moral bonds on which the strength of marriage and the family depends.

Catholic health care ministry witnesses to the sanctity of life "from the moment of conception until death."[20] The Church's defense of life encompasses the unborn and the care of women and their children during and after pregnancy. The Church's commitment to life is seen in its willingness to collaborate with others to alleviate the causes of the high infant mortality rate and to provide adequate health care to mothers and their children before and after birth.

The Church has the deepest respect for the family, for the marriage covenant, and for the love that binds a married couple together. This includes respect for the marriage act by which husband and wife express their love and cooperate with God in the creation of a new human being. The Second Vatican Council affirms:

> This love is an eminently human one. . . . It involves the good of the whole person. . . . The actions within marriage by which the couple are united intimately and chastely are noble and worthy ones. Expressed in a manner which is truly human, these actions signify and promote that mutual self-giving by which spouses enrich each other with a joyful and a thankful will.[21]
>
> Marriage and conjugal love are by their nature ordained toward the begetting and educating of children. Children are really the supreme gift of marriage and contribute very substantially to the welfare of their parents. . . . Parents should regard as their proper mission the task of transmitting human life and educating those to whom it has been transmitted. . . . They are thereby cooperators with the love of God the Creator, and are, so to speak, the interpreters of that love.[22]

For legitimate reasons of responsible parenthood, married couples may limit the number of their children by natural means. The Church cannot approve contraceptive interventions that "either in anticipation of the marital act, or in its accomplishment or in the development of its natural consequences, have the purpose, whether as an end or a means, to render procreation impossible."[23] Such interventions violate "the inseparable connection, willed by God . . . between the two meanings of the conjugal

act: the unitive and procreative meaning."[24]

With the advance of the biological and medical sciences, society has at its disposal new technologies for responding to the problem of infertility. While we rejoice in the potential for good inherent in many of these technologies, we cannot assume that what is technically possible is always morally right. Reproductive technologies that substitute for the marriage act are not consistent with human dignity. Just as the marriage act is joined naturally to procreation, so procreation is joined naturally to the marriage act. As Pope John XXIII observed:

> The transmission of human life is entrusted by nature to a personal and conscious act and as such is subject to all the holy laws of God: the immutable and inviolable laws which must be recognized and observed. For this reason, one cannot use means and follow methods which could be licit in the transmission of the life of plants and animals.[25]

Because the moral law is rooted in the whole of human nature, human persons, through intelligent reflection on their own spiritual destiny, can discover and cooperate in the plan of the Creator.[26]

Directives

38. When the marital act of sexual intercourse is not able to attain its procreative purpose, assistance that does not separate the unitive and procreative ends of the act, and does not substitute for the marital act itself, may be used to help married couples conceive.[27]

39. Those techniques of assisted conception that respect the unitive and procreative meanings of sexual intercourse and do not involve the destruction of human embryos, or their deliberate generation in such numbers that it is clearly envisaged that all cannot implant and some are simply being used to maximize the chances of others implanting, may be used as therapies for infertility.

40. Heterologous fertilization (that is, any technique used to achieve conception by the use of gametes coming from at least one donor other than the spouses) is prohibited because it is contrary to the covenant of marriage, the unity of the spouses, and the dignity proper to parents and the child.[28]

41. Homologous artificial fertilization (that is, any technique used to achieve conception using the gametes of the two spouses joined in marriage) is prohibited when it separates procreation from the marital act in its unitive significance (e.g., any technique used to achieve extracorporeal conception).[29]

42. Because of the dignity of the child and of marriage, and because of the uniqueness of the mother-child relationship, participation in contracts or arrangements for surrogate motherhood is not permitted. Moreover, the commercialization of such surrogacy denigrates the dignity of women, especially the poor.[30]

43. A Catholic health care institution that provides treatment for infertility should offer not only technical assistance to infertile couples but also should help couples pursue other solutions (e.g., counseling, adoption).

44. A Catholic health care institution should provide prenatal, obstetric, and postnatal services for mothers and their children in a manner consonant with its mission.

45. Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.

46. Catholic health care providers should be ready to offer compassionate physical, psychological, moral, and spiritual care to those persons who have suffered from the trauma of abortion.

47. Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.

48. In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.[31]

49. For a proportionate reason, labor may be induced after the fetus is viable.

50. Prenatal diagnosis is permitted when the procedure does not threaten the life or physical integrity of the unborn child or the mother and does not subject them to disproportionate risks; when the diagnosis can provide information to guide preventative care for the mother or pre- or postnatal care for the child; and when the parents, or at least the mother, give free and informed consent. Prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect.[32]

51. Nontherapeutic experiments on a living embryo or fetus are not permitted, even with the consent of the parents. Therapeutic experiments are permitted for a proportionate reason with the free and informed consent of the parents or, if the father cannot be contacted, at least of the mother. Medical research that will not harm the life or physical integrity of an unborn child is permitted with parental consent.[33]

52. Catholic health institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning.

53. Direct sterilization of either men or women, whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.[34]

54. Genetic counseling may be provided in order to promote responsible parenthood and to prepare for the proper treatment and care of children with genetic defects, in accordance with Catholic moral teaching and the intrinsic rights and obligations of married couples regarding the transmission of life.

PART FIVE

Issues in Care for the Seriously Ill and Dying

Introduction

Christ's redemption and saving grace embrace the whole person, especially in his or her illness, suffering, and death.[35] The Catholic health care ministry faces the reality of death with the confidence of faith. In the face of death—for many, a time when hope seems lost—the Church witnesses to her belief that God has created each person for eternal life.[36]

Above all, as a witness to its faith, a Catholic health care institution will be a community of respect, love, and support to patients or residents and their families as they face the reality of death. What is hardest to face is the process of dying itself, especially the dependency, the helplessness, and the pain that so often accompany terminal illness. One of the primary purposes of medicine in caring for the dying is the relief of pain and the suffering caused by it. Effective management of pain in all its forms is critical in the appropriate care of the dying.

The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life. We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options.

The task of medicine is to care even when it cannot cure. Physicians and their patients must evaluate the use of the technology at their disposal. Reflection on the innate dignity of human life in all its dimensions and on the purpose of medical care is indispensable for formulating a true moral judgment about the use of technology to maintain life. The use of life-sustaining technology is judged in light of the Christian meaning of life, suffering, and death. In this way two extremes are avoided: on the one hand, an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death.[37]

The Church's teaching authority has addressed the moral issues concerning medically assisted nutrition and hydration. We are guided on this issue by Catholic teaching against euthanasia, which is "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated."[38] While medically assisted nutrition and hydration are not morally obligatory in certain cases, these forms of basic care should in principle be provided to all patients who need them, including patients diagnosed as being in a "persistent vegetative state" (PVS), because even the most severely debilitated and helpless patient retains the full dignity of a human person and must receive ordinary and proportionate care.

Directives

55. Catholic health care institutions offering care to persons in danger of death from illness, accident, advanced age, or similar condition should provide them with appropriate opportunities to prepare for death. Persons in danger of death should be provided with whatever information is necessary to help them understand their condition and have the opportunity to discuss their condition with their family members and care providers. They should also be offered the appropriate medical information that would make it possible to address the morally legitimate choices available to them. They should be provided the spiritual support as well as the opportunity to receive the sacraments in order to prepare well for death.

56. A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.[39]

57. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.

58. In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") who can reasonably be expected to live indefinitely if given such care.[40] Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed." [41] For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort.

59. The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching.

60. Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for

pain and other symptoms so that they can live with dignity until the time of natural death.[42]

61. Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.

62. The determination of death should be made by the physician or competent medical authority in accordance with responsible and commonly accepted scientific criteria.

63. Catholic health care institutions should encourage and provide the means whereby those who wish to do so may arrange for the donation of their organs and bodily tissue, for ethically legitimate purposes, so that they may be used for donation and research after death.

64. Such organs should not be removed until it has been medically determined that the patient has died. In order to prevent any conflict of interest, the physician who determines death should not be a member of the transplant team.

65. The use of tissue or organs from an infant may be permitted after death has been determined and with the informed consent of the parents or guardians.

66. Catholic health care institutions should not make use of human tissue obtained by direct abortions even for research and therapeutic purposes.[43]

PART SIX

Collaborative Arrangements with Other Health Care Organizations and Providers[44]

Introduction

In and through her compassionate care for the sick and suffering members of the human family, the Church extends Jesus' healing mission and serves the fundamental human dignity of every person made in God's image and likeness. Catholic health care, in serving the common good, has historically worked in collaboration with a variety of non-Catholic partners. Various factors in the current health care environment in the United States, however, have led to a multiplication of collaborative arrangements among health care institutions, between Catholic institutions as well as between Catholic and non-Catholic institutions.

Collaborative arrangements can be unique and vitally important opportunities for Catholic health care to further its mission of caring for the suffering and sick, in faithful imitation of Christ. For example, collaborative arrangements can provide opportunities for Catholic health care institutions to influence the healing profession through their witness to the Gospel of Jesus Christ. Moreover, they can be opportunities to realign the local delivery system to provide a continuum of health care to the community, to provide a model of a responsible stewardship of limited health care resources, to provide poor and vulnerable persons with more equitable access to basic care, and to provide access to medical technologies and expertise that greatly enhance the quality of care. Collaboration can even, in some instances, ensure the continued presence of a Catholic institution, or the presence of any health care facility at all, in a given area.

When considering a collaboration, Catholic health care administrators should seek first to establish arrangements with Catholic institutions or other institutions that operate in conformity with the Church's moral teaching. It is not uncommon, however, that arrangements with Catholic institutions are not practicable and that, in pursuit of the common good, the only available candidates for collaboration are institutions that do not operate in conformity with the Church's moral teaching.

Such collaborative arrangements can pose particular challenges if they would involve institutional connections with activities that conflict with the natural moral law, church teaching, or canon law. Immoral actions are always contrary to "the singular dignity of the human person, 'the only creature that God has wanted for its own sake.'"[45] It is precisely because Catholic health care services are called to respect the inherent dignity of every human being and to contribute to the common good that they should avoid, whenever possible, engaging in collaborative arrangements that would involve them in contributing to the wrongdoing of other providers.

The Catholic moral tradition provides principles for assessing cooperation with the wrongdoing of others to determine the conditions under which cooperation may or may not be morally justified, distinguishing between "formal" and "material" cooperation. *Formal* cooperation "occurs when an action, either by its very nature or by the form it takes in a concrete situation, can be defined as a direct participation in an [immoral] act . . . or a sharing in the immoral intention of the person committing it."[46] Therefore, cooperation is formal not only when the cooperator shares the intention of the wrongdoer, but also when the cooperator directly participates in the immoral act, even if the cooperator does not share the intention of the wrongdoer, but participates as a means to some other end. Formal cooperation may take various forms, such as authorizing wrongdoing, approving it, prescribing it, actively defending it, or giving specific direction about carrying it out. Formal cooperation, in whatever form, is always morally wrong.

The cooperation is *material* if the one cooperating neither shares the wrongdoer's intention in performing the immoral act nor cooperates by directly participating in the act as a means to some other end, but rather contributes to the immoral activity in a way that is causally related but not essential to the immoral act itself. While some instances of material cooperation are morally wrong, others are morally justified. There are many factors to consider when assessing whether or not material cooperation is justified, including: whether the cooperator's act is morally good or neutral in itself, how significant is its causal contribution to the wrongdoer's act, how serious is the immoral act of the wrongdoer, and how important are the goods to be preserved or the harms to be avoided by cooperating. Assessing material cooperation can be complex, and legitimate disagreements may arise over which factors are most relevant in a given case. Reliable theological experts should be consulted in interpreting and applying the principles governing cooperation.

Any moral analysis of a collaborative arrangement must also take into account the danger of scandal, which is "an attitude or behavior which leads another to do evil."[47] The cooperation of a Catholic institution with other health care entities engaged in immoral activities, even when such cooperation is morally justified in all other respects, might, in certain cases, lead people to conclude that those activities are morally acceptable. This could lead people to sin. The danger of scandal, therefore, needs to be carefully evaluated in each case. In some cases, the danger of scandal can be mitigated by certain measures, such as providing an explanation as to why the Catholic institution is cooperating in this way at this time. In any event, prudential judgments that take into account the particular circumstances need to be made about the risk and degree of scandal and about whether they can be effectively addressed.

Even when there are good reasons for establishing collaborative arrangements

that involve material cooperation with wrongdoing, leaders of Catholic healthcare institutions must assess whether becoming associated with the wrongdoing of a collaborator will risk undermining their institution's ability to fulfill its mission of providing health care as a witness to the Catholic faith and an embodiment of Jesus' concern for the sick. They must do everything they can to ensure that the integrity of the Church's witness to Christ and his Gospel is not adversely affected by a collaborative arrangement.

In sum, collaborative arrangements with entities that do not share our Catholic moral tradition present both opportunities and challenges. The opportunities to further the mission of Catholic health care can be significant. The challenges do not necessarily preclude all such arrangements on moral grounds, but they do make it imperative for Catholic leaders to undertake careful analyses to ensure that new collaborative arrangements—as well as those that already exist—abide by the principles governing cooperation, effectively address the risk of scandal, abide by canon law, and sustain the Church's witness to Christ and his saving message.

While the following Directives are offered to assist Catholic health care institutions in analyzing the moral considerations of collaborative arrangements, the ultimate responsibility for interpreting and applying of the Directives rests with the diocesan bishop.

Directives

67. Each diocesan bishop has the ultimate responsibility to assess whether collaborative arrangements involving Catholic health care providers operating in his local church involve wrongful cooperation, give scandal, or undermine the Church's witness. In fulfilling this responsibility, the bishop should consider not only the circumstances in his local diocese but also the regional and national implications of his decision.
68. When there is a possibility that a prospective collaborative arrangement may lead to serious adverse consequences for the identity or reputation of Catholic health care services or entail a risk of scandal, the diocesan bishop is to be consulted in a timely manner. In addition, the diocesan bishop's approval is required for collaborative arrangements involving institutions subject to his governing authority; when they involve institutions not subject to his governing authority but operating in his diocese, such as those involving a juridic person erected by the Holy See, the diocesan bishop's *nihil obstat* is to be obtained.
69. In cases involving health care systems that extend across multiple diocesan jurisdictions, it remains the responsibility of the diocesan bishop of each diocese in which the system's affiliated institutions are located to approve locally the prospective collaborative arrangement or to grant the requisite *nihil obstat*, as the situation may require. At the same time, with such a proposed arrangement, it is the duty of the diocesan bishop of the diocese in which the system's headquarters is located to initiate a collaboration with the diocesan bishops of the dioceses affected by the collaborative arrangement. The bishops involved in this collaboration should make every effort to reach a consensus.
70. Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide, and direct sterilization.[48]
71. When considering opportunities for collaborative arrangements that entail material

cooperation in wrongdoing, Catholic institutional leaders must assess whether scandal[49] might be given and whether the Church's witness might be undermined. In some cases, the risk of scandal can be appropriately mitigated or removed by an explanation of what is in fact being done by the health care organization under Catholic auspices. Nevertheless, a collaborative arrangement that in all other respects is morally licit may need to be refused because of the scandal that might be caused or because the Church's witness might be undermined.

72. The Catholic party in a collaborative arrangement has the responsibility to assess periodically whether the binding agreement is being observed and implemented in a way that is consistent with the natural moral law, Catholic teaching, and canon law.
73. Before affiliating with a health care entity that permits immoral procedures, a Catholic institution must ensure that neither its administrators nor its employees will manage, carry out, assist in carrying out, make its facilities available for, make referrals for, or benefit from the revenue generated by immoral procedures.
74. In any kind of collaboration, whatever comes under the control of the Catholic institution—whether by acquisition, governance, or management—must be operated in full accord with the moral teaching of the Catholic Church, including these Directives.
75. It is not permitted to establish another entity that would oversee, manage, or perform immoral procedures. Establishing such an entity includes actions such as drawing up the civil bylaws, policies, or procedures of the entity, establishing the finances of the entity, or legally incorporating the entity.
76. Representatives of Catholic health care institutions who serve as members of governing boards of non-Catholic health care organizations that do not adhere to the ethical principles regarding health care articulated by the Church should make their opposition to immoral procedures known and not give their consent to any decisions proximately connected with such procedures. Great care must be exercised to avoid giving scandal or adversely affecting the witness of the Church.
77. If it is discovered that a Catholic health care institution might be wrongly cooperating with immoral procedures, the local diocesan bishop should be informed immediately and the leaders of the institution should resolve the situation as soon as reasonably possible.

Conclusion

Sickness speaks to us of our limitations and human frailty. It can take the form of infirmity resulting from the simple passing of years or injury from the exuberance of youthful energy. It can be temporary or chronic, debilitating, and even terminal. Yet the follower of Jesus faces illness and the consequences of the human condition aware that our Lord always shows compassion toward the infirm.

Jesus not only taught his disciples to be compassionate, but he also told them who should be the special object of their compassion. The parable of the feast with its humble guests was preceded by the instruction: “When you hold a banquet, invite the poor, the crippled, the lame, the blind” (Lk 14:13). These were people whom Jesus healed and loved.

Catholic health care is a response to the challenge of Jesus to go and do likewise. Catholic health care services rejoice in the challenge to be Christ’s healing compassion in the world and see their ministry not only as an effort to restore and preserve health but also as a spiritual service and a sign of that final healing that will one day bring about the new creation that is the ultimate fruit of Jesus’ ministry and God’s love for us.

1. United States Conference of Catholic Bishops, *Health and Health Care: A Pastoral Letter of the American Catholic Bishops* (Washington, DC: United States Conference of Catholic Bishops, 1981).
2. Health care services under Catholic auspices are carried out in a variety of institutional settings (e.g., hospitals, clinics, outpatient facilities, urgent care centers, hospices, nursing homes, and parishes). Depending on the context, these Directives will employ the terms "institution" and/or "services" in order to encompass the variety of settings in which Catholic health care is provided.
3. *Health and Health Care,* p. 5.
4. Second Vatican Ecumenical Council, *Decree on the Apostolate of the Laity* (*Apostolicam Actuositatem*) (1965), no. 1.
5. Pope John Paul II, Post-Synodal Apostolic Exhortation *On the Vocation and the Mission of the Lay Faithful in the Church and in the World* (*Christifideles Laici*) (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 29.
6. As examples, see Congregation for the Doctrine of the Faith, *Declaration on Procured Abortion* (1974); Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980); Congregation for the Doctrine of the Faith, *Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation: Replies to Certain Questions of the Day* (*Donum Vitae*) (Washington, DC: United States Conference of Catholic Bishops, 1987).
7. Pope John XXIII, Encyclical Letter *Peace on Earth* (*Pacem in Terris*) (Washington, DC: United States Conference of Catholic Bishops, 1963), no. 11; *Health and Health Care,* pp. 5, 17-18; *Catechism of the Catholic Church,* 2nd ed. (Washington, DC: Libreria Editrice Vaticana–United States Conference of Catholic Bishops, 2000), no. 2211.
8. Pope John Paul II, *On Social Concern, Encyclical Letter on the Occasion of the Twentieth Anniversary of "Populorum Progressio"* (*Sollicitudo Rei Socialis*) (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 43.
9. United States Conference of Catholic Bishops, *Economic Justice for All: Pastoral Letter on Catholic Social Teaching and the U.S. Economy* (Washington, DC: United States Conference of Catholic Bishops, 1986), no. 80.
10. The duty of responsible stewardship demands responsible collaboration. But in collaborative efforts, Catholic institutionally based health care services must be attentive to occasions when the policies and practices of other institutions are not compatible with the Church's authoritative moral teaching. At such times, Catholic health care institutions should determine whether or to what degree collaboration would be morally permissible. To make that judgment, the governing boards of Catholic institutions should adhere to the moral principles on cooperation. See Part Six.
11. *Health and Health Care,* p. 12.
12. Cf. *Code of Canon Law,* cc. 921-923.
13. Cf. ibid., c. 867, § 2, and c. 871.
14. To confer Baptism in an emergency, one must have the proper intention (to do what the Church intends by Baptism) and pour water on the head of the person to be baptized, meanwhile pronouncing the words: "I baptize you in the name of the Father, and of the Son, and of the

Holy Spirit."

15. Cf. c. 883, 3º.

16. For example, while the donation of a kidney represents loss of biological integrity, such a donation does not compromise functional integrity since human beings are capable of functioning with only one kidney.

17. Cf. directive 53.

18. *Declaration on Euthanasia,* Part IV; cf. also directives 56-57.

19. It is recommended that a sexually assaulted woman be advised of the ethical restrictions that prevent Catholic hospitals from using abortifacient procedures; cf. Pennsylvania Catholic Conference, "Guidelines for Catholic Hospitals Treating Victims of Sexual Assault," *Origins* 22 (1993): 810.

20. Pope John Paul II, "Address of October 29, 1983, to the 35th General Assembly of the World Medical Association," *Acta Apostolicae Sedis* 76 (1984): 390.

21. Second Vatican Ecumenical Council, *Pastoral Constitution on the Church in the Modern World* (*Gaudium et Spes*) (1965), no. 49.

22. Ibid., no. 50.

23. Pope Paul VI, Encyclical Letter *On the Regulation of Birth* (*Humanae Vitae*) (Washington, DC: United States Conference of Catholic Bishops, 1968), no. 14.

24. Ibid., no. 12.

25. Pope John XXIII, Encyclical Letter *Mater et Magistra* (1961), no. 193, quoted in Congregation for the Doctrine of the Faith, *Donum Vitae,* no. 4.

26. Pope John Paul II, Encyclical Letter *The Splendor of Truth* (*Veritatis Splendor*) (Washington, DC: United States Conference of Catholic Bishops, 1993), no. 50.

27. "Homologous artificial insemination within marriage cannot be admitted except for those cases in which the technical means is not a substitute for the conjugal act but serves to facilitate and to help so that the act attains its natural purpose" (*Donum Vitae,* Part II, B, no. 6; cf. also Part I, nos. 1, 6).

28. Ibid., Part II, A, no. 2.

29. "Artificial insemination as a substitute for the conjugal act is prohibited by reason of the voluntarily achieved dissociation of the two meanings of the conjugal act. Masturbation, through which the sperm is normally obtained, is another sign of this dissociation: even when it is done for the purpose of procreation, the act remains deprived of its unitive meaning: 'It lacks the sexual relationship called for by the moral order, namely, the relationship which realizes "the full sense of mutual self-giving and human procreation in the context of true love"' " (*Donum Vitae,* Part II, B, no. 6).

30. Ibid., Part II, A, no. 3.

31. Cf. directive 45.

32. *Donum Vitae,* Part I, no. 2.

33. Cf. ibid., no. 4. (Washington, DC: United States Conference of Catholic Bishops, 1988), no. 43.

34. Cf. Congregation for the Doctrine of the Faith, "Responses on Uterine Isolation and Related Matters,"

July 31, 1993, *Origins* 24 (1994): 211-212.

35. Pope John Paul II, Apostolic Letter *On the Christian Meaning of Human Suffering* (*Salvifici Doloris*) (Washington, DC: United States Conference of Catholic Bishops, 1984), nos. 25-27.

36. United States Conference of Catholic Bishops, *Order of Christian Funerals* (Collegeville, Minn.: The Liturgical Press, 1989), no. 1.

37. See *Declaration on Euthanasia.*

38. Ibid., Part II.

39. Ibid., Part IV; Pope John Paul II, Encyclical Letter *On the Value and Inviolability of Human Life* (*Evangelium Vitae*) (Washington, DC: United States Conference of Catholic Bishops, 1995), no. 65.

40. See Pope John Paul II, Address to the Participants in the International Congress on "Life- Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (March 20, 2004), no. 4, where he emphasized that "the administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*." See also Congregation for the Doctrine of the Faith, "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration" (August 1, 2007).

41. Congregation for the Doctrine of the Faith, Commentary on "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration."

42. See *Declaration on Euthanasia*, Part IV.

43. *Donum Vitae,* Part I, no. 4.

44. See: Congregation for the Doctrine of the Faith, "Some Principles for Collaboration with non-Catholic Entities in the Provision of Healthcare Services," published in *The National Catholic Bioethics Quarterly* (Summer 2014), 337-40.

45. Pope John Paul II, *Veritatis Splendor*, no. 13.

46. Pope John Paul II, *Evangelium Vitae*, no. 74.

47. *Catechism of the Catholic Church*, no. 2284.

48. While there are many acts of varying moral gravity that can be identified as intrinsically evil, in the context of contemporary health care the most pressing concerns are currently abortion, euthanasia, assisted suicide, and direct sterilization. See Pope John Paul II's Ad Limina Address to the bishops of Texas, Oklahoma, and Arkansas (Region X), in *Origins* 28 (1998): 283. See also "Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals" (*Quaecumque Sterilizatio*), March 13, 1975, Origins 6 (1976): 33-35: "Any cooperation institutionally approved or tolerated in actions which are in themselves, that is, by their nature and condition, directed to a contraceptive end . . . is absolutely forbidden. For the official approbation of direct sterilization and, a fortiori, its management and execution in accord with hospital regulations, is a matter which, in the objective order, is by its very nature (or intrinsically) evil." This directive supersedes the "Commentary on the Reply of the Sacred Congregation for the Doctrine of the Faith on Sterilization in Catholic Hospitals" published by the National Conference of Catholic Bishops on September 15, 1977, in *Origins* 7 (1977): 399-400.

49. See *Catechism of the Catholic Church*: "Anyone who uses the power at his disposal in such a way that it leads others to do wrong becomes guilty of scandal and responsible for the evil that he has directly or indirectly encouraged" (no. 2287).

MEDICAL STAFF BYLAWS, RULES AND REGULATIONS

The foregoing Medical Staff Bylaws, Rules and Regulations were approved and adopted by resolution of the Board of Trustees of St. Joseph Hospital after considering the Medical Staff's recommendation and in accordance with and subject to the St. Joseph Hospital's charter, bylaws and rules and regulations.

The overall responsibility for the management and control of St. Joseph Hospital rests with the Board of Trustees. Therefore, to the extent that these bylaws differ from or are inconsistent with the charter, bylaws or any rule or regulation of the Board of Trustees, the Board of Trustees' charter, bylaws or rules or regulations shall take precedence and prevail.

APPROVED THIS 29ST DAY OF December, 2022 AD

FOR THE MEDICAL STAFF MEMBERSHIP

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