HOSPITAL

MEDICAL STAFF

BYLAWS

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ARTICLE I

MEDICAL STAFF MEMBERSHIP

Preamble

These Bylaws, together with the Rules and Regulations of the Medical Staff promulgated from time to time by the Executive Committee, approved by the Governing Body and incorporated by reference into these Bylaws, provide for Medical Staff organization, access and membership, responsibilities and governance. Rules and Regulation revisions may be recommended by the Bylaws Committee to the Executive Committee. Upon recommendations of the Executive Committee, the revision(s) shall be forwarded to the Governing Body for approval and shall be effective when approved by the Governing Body.

Nature of the Medical Staff Membership

1.1 The Governing Body, acting through the Hospital President, may determine the size and composition of the Medical Staff based upon its assessment of the needs of the community served and the resources of the Hospital. Membership on the Medical Staff of the Hospital is a privilege which shall be extended only to physicians, dentists and podiatrists who continuously meet the qualifications, standards and requirements set forth in these Bylaws.

Qualifications for Membership

1.2 Only physicians, dentists and podiatrists licensed to practice in the Commonwealth of Massachusetts who can document their background, experience, training and competence, their adherence to the ethics of their profession, their good reputation, and their ability to work with others, with sufficient adequacy to assure the Medical Staff and Governing Body that any patient treated by them will be given quality medical care, shall be eligible to apply for membership on the Medical Staff.

1.3 Eligibility for application to the Medical Staff shall further be determined by the current written rules of the Credentials Committee; such rules to be approved by the Executive Committee and by the Governing Body.

1.4 No individual shall be eligible to apply or maintain membership on the Medical Staff or clinical privileges at the Hospital unless s/he maintains professional liability insurance coverage in such amounts and with such companies as the Governing Body, after consultation with the Executive Committee of the Medical Staff, may set from time to time. The professional liability insurance requirement may be waived by the Governing Body, upon recommendation of the Executive Committee of the Medical Staff for any physician who does not provide direct or indirect patient care at the Hospital.

Conditions and Duration of Appointment

1.5 Initial appointments, reappointments, and revocation of appointments to the Medical Staff shall be made by the Governing Body acting on recommendations from the Medical Executive Committee as provided in these Bylaws.

1.6 When in the opinion of the Governing Body, there has been an unwarranted delay on the part of the Medical Staff in matters of appointment; the Governing Body may act on an individual's appointment status without Staff recommendations, employing the same type of information usually considered by the Medical Staff. Prior to taking such actions, however, the Governing Body should notify the Medical Staff of its intent and should designate an action date prior to which the Medical Staff may still fulfill its responsibility.
Fundamental Responsibility of the Medical Staff

1.7 Members of the medical staff shall ensure that a medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

Members of the medical staff shall also ensure that an updated examination of the patient, including any changes in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

ARTICLE II

CATEGORIES OF THE MEDICAL STAFF AND NON-MEMBERS

THE MEDICAL STAFF

2.1 The Medical Staff shall be divided into the Member categories of Honorary, Active, Associate, Refer and Follow Active, Refer and Follow Associate and House Staff and the Non-Member category of Allied Health Professionals. The criteria for each category shall be established by the Executive Committee, approved by the Governing Body and set forth in Rules and Regulations of the Medical Staff.

ARTICLE III

PROCEDURE FOR APPOINTMENT, REAPPOINTMENT OR AFFILIATION

APPLICATION FOR APPOINTMENT, REAPPOINTMENT

3.1 All applications for appointment or reappointment either as a Member of the Medical Staff or an Allied Health Professional shall be in writing, and shall be submitted to the Medical Staff Office, as defined by the written Rules of the Credentials Committee, in a format prescribed by the Governing Body after consultation with the Executive Committee. The application form shall request, and the applicant shall provide, such documents and information as may be required by law, and such additional documents and information as may be requested in the current application form, including, but not limited to:
a. All information regarding the applicant's licensure in any state, including a copy of the applicant’s most recent application for licensure or renewal of licensure in Massachusetts, DEA registration in any location or state, controlled substance certification in any location, including any suspensions or revocations, voluntary or involuntary restrictions or relinquishments, disciplinary actions, or current or pending or previously successful challenges to any proposed actions involving the applicant's licensure in any state or DEA registration in any location or controlled substance certification in any location. Teleradiologists do not require a controlled substance certificate.

b. Voluntary or involuntary termination of medical staff membership in any hospital, clinic or other facility or voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital or any other health care facility, including residency training.

c. Involvement in a professional liability action, either pending or within the past ten years.

d. Suspension, sanction or restrictions from participation in any private, Federal, State or Health Insurance Program including but not limited to Medicare and Medicaid.

e. Information regarding any criminal convictions.

f. Evidence of current professional liability insurance in the amount to be determined by the Executive Committee.

g. Evidence of board qualification/board certification status for all new applicants. New applicants must attain board certification within five (5) years from the time of initial appointment if there is no time limit specified by their particular Board or within the time period dictated by their particular Board.

3.2 By applying for appointment or reappointment, each applicant thereby signifies willingness to appear for an interview and upon request to undergo a mental or physical examination by a practitioner designated by the applicant and acceptable to the Chairman of the Credentials Committee and the Chairman of the Executive Committee. The applicant agrees to provide evidence that any known physical or mental impairment does not interfere with his or her competence to practice medicine. If the applicant fails to designate a practitioner acceptable to the Executive Committee to perform a mental or physical exam within thirty (30) days following receipt of the request, the Executive Committee may designate a practitioner.

3.3 The applicant authorizes the Hospital to consult with members of the medical staff and officials of other health care entities with which the applicant has had employment, practice, or association for the purpose of providing patient care, or privileges, and with others who may have information relevant to the applicant's competence, character, health and ethical qualifications.

3.4 The applicant consents to the Hospital's inspection of all records and documents that may be material to an evaluation of professional qualifications, competence to carry out the clinical privileges requested, health, moral and ethical qualifications for Staff membership or affiliation.

3.5 The applicant must sign a release for information pertinent to the application in a format approved by the Executive Committee and the Governing Body and shall agree, in writing, to maintain an ethical practice and provide a plan for continuous care for all patients in accordance with the Rules and Regulations.
APPOINTMENT PROCESS

3.6 Upon receipt of a completed application, as defined by the Credentials Committee Rules, the application shall be forwarded to the Credentials Committee.

3.7 The Credentials Committee shall investigate the character, qualifications and professional standing of the applicant, and may interview the applicant. The Credentials Committee shall confer with the appropriate Chief in regard to the applicant's requested clinical privileges. The Credentials Committee may also interview and invite confidential comments from all Members of the Medical Staff who wish to be heard. The Credentials Committee shall make a recommendation to the Executive Committee that the applicant be either appointed to the Medical Staff, or rejected for Medical Staff Membership, or that the application is deferred for further consideration. If the Credentials Committee recommends rejection or deferral of the application, the practitioner shall not be granted temporary privileges, or if such temporary privileges were previously granted, the practitioner may not exercise such privileges pending final determination of his/her application.

3.8 A final recommendation shall be sent to the Executive Committee by the Credentials Committee within ninety (90) days from the date of the first meeting of the Credentials Committee following its receipt of the completed application. The Executive Committee shall either make a recommendation to the Governing Body, or defer a recommendation, pending further investigation and discussion.

3.9 When the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed-up within ninety (90) days with a subsequent recommendation for appointment with specific clinical privileges, or for rejection for Staff Membership.

3.10 When the recommendation of the Executive Committee is favorable to the practitioner, the Medical Staff President shall forward it together with all supporting documentation, to the Governing Body or a designated committee of the Governing Body.

3.11 When the recommendation of the Executive Committee is adverse to the practitioner, either in respect to appointment or clinical privileges, the Medical Staff President will promptly notify the practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the Governing Body until after the practitioner has exercised or has been deemed to have waived those rights to which he/she is entitled under Article VI of these Bylaws. The notice to the applicant shall include a statement of the basis for the decision.

3.12 If the practitioner waives rights, the recommendation shall be forwarded to the Governing Body for action.

3.13 If the practitioner's rights to a hearing are exercised, following the hearing procedure, after the Executive Committee has considered the report and recommendation of the Hearing Committee and the hearing record, if the Executive Committee's reconsidered recommendation is favorable to the practitioner, it shall be processed in accordance with Section 3.10.

3.14 If such recommendation continues to be adverse, the Medical Staff President shall promptly notify the practitioner by certified mail, return receipt requested. The President shall also forward such recommendation and documentation to the Governing Body, but the Governing Body shall not take any action thereupon until after the practitioner has exercised or has been deemed to have waived rights to an appellate review as provided in Article VI of these Bylaws.
3.15 At its next regular meeting after receipt of a favorable recommendation, or after the practitioner has been deemed to have waived rights to an appellate review as referenced Section 3.14, the Governing Body shall act on the matter. If the Governing Body's decision is adverse to the practitioner in response to either appointment or clinical privileges, the Hospital President shall promptly notify the applicant of such adverse decision by certified mail, return receipt requested, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived rights under Article VI of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

3.16 At its next regular meeting after all of the practitioner's rights under Article VI have been exhausted or waived, the Governing Body or its duly authorized committee shall make a decision either to appoint the practitioner to the Staff or to reject the applicant for Staff Membership. All decisions to appoint shall include a delineation of clinical privileges that the practitioner may exercise. The Governing Body's decision shall be final.

3.17 The Governing Body shall send notice of such decision through the Hospital President to the President of the Medical Staff, and by certified mail, return receipt requested, to the applicant.

3.18 The Chairman of the Credentials Committee, with the concurrence of the President of the Medical Staff and the President of the Hospital, may refuse to consider an application for Medical Staff privileges received from any applicant who has submitted a previous application which was denied by the Governing Body within two years prior to the date of submission of the current application.

**TERMS OF APPOINTMENT/REAPPOINTMENT**

3.19 All appointments and reappointments are for a period not to exceed two years, unless sooner canceled or terminated by the Governing Body in accordance with these Bylaws.

**REAPPOINTMENT PROCESS**

3.21 The Executive Committee shall review all pertinent information available on each practitioner scheduled for periodic reappointment, for the purpose of determining recommendation to the Medical Staff and for the granting of clinical privileges for the ensuing period. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

3.22 Each recommendation concerning the reappointment of a Medical Staff Member, and the clinical privileges to be granted upon reappointment, shall be based upon the information contained in the member's application for reappointment and such other information as the Credentials Committee, Department Chief or the Executive Committee may request, including, but not limited to, information pertaining to such Member's professional competence, and clinical judgment in the treatment of patients, ethics, conduct, and participation in Staff affairs, compliance with the Hospital and Medical Staff Bylaws, Rules and Regulations, cooperation with the Hospital personnel and appropriate use of the Hospital's facilities for patients, relations with other practitioners, and general attitude toward patients, the Hospital and the public, as defined in Rule W(b) of the Rules and Regulations of the Medical Staff. As part of the reappointment process, on request of the Department Chief, each candidate for reappointment shall submit reasonable evidence of health status to the Department Chief. Additional requirements for reappointment may be set forth in the Rules and Regulations.
3.23 Each candidate for reappointment shall also submit: evidence of current Massachusetts licensure; a copy of his/her most recent license application form; since the candidate’s previous appointment, any malpractice claims filed against the candidate; information regarding any suspensions or revocations, voluntary or involuntary restrictions or relinquishments, disciplinary actions, or current or pending or previously successful challenges from any governmental agency, professional organization or healthcare facility; information regarding criminal convictions; indictments or formal charges which have not yet been finally determined by a court; and an authorization for the Medical Liability carrier to release to the Medical Staff any information as to claims, actions, or damages whether or not there was a final disposition. The National Practitioner Data Bank will be queried.

3.24 Members requesting reappointment to the Active Staff shall demonstrate a commitment to the clinical and professional activities of the Hospital and Medical Staff and regular utilization of the Hospital in accordance with the nature of his/her practice.

3.25 Following receipt of a final recommendation from the Department Chief, the Executive Committee shall make recommendations to the Governing Body, through President of the Medical Staff, concerning the reappointment, non-reappointment and/or clinical privileges of each practitioner then scheduled for periodic appraisal. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendations shall be stated and documented.

3.26 Thereafter, the procedure provided in Sections 3.10 through 3.17, relating to recommendation on applications for initial appointment, shall be followed.

CONTINUING EDUCATION

3.27 All candidates for appointment and reappointment may be requested to present documented evidence of continuing medical education.

ARTICLE IV

CLINICAL PRIVILEGING

CLINICAL PRIVILEGES

4.1 Every practitioner practicing at this Hospital by virtue of Medical Staff Membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted by the Governing Body, excepting for Temporary Privileges which may be granted pursuant to Section 4.5.

4.2 Each department or division within a department shall establish procedure specific minimal training requirements which must be met by each practitioner seeking initial privileges. When two or more clinical departments or divisions may include practitioners holding privileges for the same procedure, those departments or divisions will collaborate in establishing minimal training requirements. All minimal training requirements will be subject to review by the Chiefs of departments or divisions and approved by the Executive Committee.

4.3 A practitioner may request additional clinical privileges at any time. Privileges for procedures commonly performed at this Hospital may be recommended by the Department Chief subject to approval by the Governing Body. Requests for privileges to perform procedures that are new to this Hospital must be in writing
and shall be made to the Chief of the Department in which the practitioner has privileges. The Department Chief will forward the request with a recommendation to the Executive Committee. At the next regular meeting after receipt of such a request, the Executive Committee shall accept, reject or modify the recommendation of the Department Chief. Any additional privileges granted to a practitioner shall be provisional with timely oversight by the Chief of the department or division for a period of not less than one year not more than two years. The Chief shall have the discretion to determine the appropriate oversight required on a case by case basis. When the practitioner requesting additional privileges is the Chief of the department or division, the Executive Committee or its designee shall determine the appropriate oversight requirements.

4.4 Temporary Privileges may be granted, in accordance with the Rules and Regulations of the Medical Staff, by the President of the Medical Staff on delegated authority from the Hospital President. Temporary Privileges may be granted only to individuals who would be eligible to become Members of the Medical Staff and with the approval of the appropriate department chief. The Medical Staff President may grant temporary/disaster privileges as referenced in the Disaster Policy.

4.5 Temporary Privileges may not be granted to any individual whose application for privileges has been rejected by the Credentials Committee or is involved in any of the hearing and appeal procedures established by these Bylaws. Such Temporary Privileges are automatically revoked if the recommendation of the Executive Committee to the Governing Body for Staff Membership is adverse to the applicant or if the vote of the Governing Body is adverse to the applicant.

4.6 The granting of Temporary Privileges does not imply entitlement to membership or association with the Medical Staff of the Hospital. Suspension or revocation of Temporary Privileges does not entitle the practitioner to the hearing and appeal rights set forth in Article VI.

ADMINISTRATIVE POSITIONS

4.7 Practitioners employed by the Hospital in a purely administrative capacity with no clinical duties need not be members of the Medical Staff.

4.8 Practitioners employed by the Hospital whose duties are medico-administrative in nature and include clinical responsibilities or functions with the Medical Staff involving their professional capability as physicians, dentists or podiatrists must be members of the Medical Staff, achieving this status by the same procedure provided for other Medical Staff members.

4.9 Practitioners whose engagement by the Hospital requires membership on the Medical Staff shall not have his/her Medical Staff privileges terminated without the Hearing and Appellate Review procedures in Article VI, unless otherwise stated in the contract or employment agreement which governs the engagement. Nothing contained herein, however, shall limit the right of the Hospital to terminate the employment of a physician, dentist or podiatrist without such procedures being followed.

ARTICLE V

CORRECTIVE ACTION

PROCEDURE

5.1 Criteria for Initiation
Whenever the professional activities or ethical conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations or injurious to the reputation of the Hospital, or otherwise deficient, corrective action against such practitioner may be requested by any member of the Medical Staff, a member of the Governing Body or the President of the Hospital. All requests for corrective action shall be in writing, shall be supported by reference to the specific activities or conduct which constitute the grounds for the request, and shall be sent to the President or the Vice President within two business days of receipt of a request for corrective action, the president or vice president of the medical staff or chief of the appropriate service will determine what, if any, actions need to be implemented to insure patient safety and communicate those actions to the appropriate parties.

5.2 Investigation

A copy of the complaint shall be sent to the practitioner and to the Department Chief wherein the practitioner has such privileges for investigation. If the complaint involves the Department Chief, the President of the Medical Staff shall investigate. If the complaint is made against a practitioner who is a member of the same physician group as the Department Chief, the Chief may, but shall not be required to defer to the President of the Medical Staff for investigation. The Department Chief or, if appropriate, the Medical Staff President within 10 business days of the request for corrective action shall, after investigation, including a meeting with the subject practitioner:

a. dismiss the complaint if in his/her opinion there is no basis for the complaint, or

b. address the complaint; or

c. assigns the complaint for review by an ad hoc committee of the Medical Staff, in consultation with the President of the Medical Staff. The ad hoc committee will provide a report to the Medical Executive Committee within 60 days of receipt of the request for corrective action. If there is a disagreement, the ruling of the Medical Executive Committee will prevail.

If a committee review is to be conducted, the Ad Hoc Committee will consist of not less than 3 members of the Medical Staff. The Ad Hoc Committee will be appointed by the Medical Staff President or, in the absence of the President, by the Vice President. One of the members so appointed shall be designated as Chairman. No staff member who is in direct economic competition with the affected practitioner shall be a member of the Ad Hoc Committee.

The Department Chief, President of the Medical Staff or an ad hoc Committee shall proceed with the investigation in a prompt manner in accordance with Rule W(a) of the Rules and Regulations of the Medical Staff and shall submit a written report of the investigation, including a review of any pertinent past complaints which are contained in the practitioner's Medical Staff File, to the Executive Committee as soon as feasible. The report may include recommendations for appropriate corrective action. Prior to the making of such report, the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the Department Chief, President of the Medical Staff or the ad hoc investigating committee, as appropriate. At such interview, the practitioner shall be informed of the reasons for the requested action. This interview shall not constitute a hearing, as defined in Article VI, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearing shall apply thereto.

5.3 Executive Committee Review and Report
Within a reasonable period of time, after receiving the investigative report and recommendations, the Executive Committee shall take action which may include, without limitation:

a. rejection or modification of the request for corrective action;

b. issuance of a warning, letter of admonition, or a letter of reprimand;

c. recommendation for terms of probation, or requirement for consultation or monitoring;

d. recommendation to reduce, suspend or revoke clinical privileges;

e. recommendation that already imposed suspension of clinical privileges be terminated, modified or sustained; or

f. recommendation that the practitioner’s staff membership be suspended or revoked.

5.4 The affected practitioner may be requested to make an appearance or the affected practitioner may request to appear before the Executive Committee prior to its taking action on the request. The Executive Committee may permit the practitioner to be accompanied by counsel who will not be permitted to participate in the interview process. The practitioner’s appearance before the Executive Committee shall not constitute a hearing as defined in Article VI, shall be preliminary in nature and none of the procedural rules provided in these Bylaws with respect to a hearing shall apply thereto. The Department Chief and the chairman of the ad hoc committee may be requested to appear before the Executive Committee to provide information or clarification of the investigatory report.

5.5 The President of the Medical Staff shall promptly notify the affected practitioner in writing of the final recommendation of the Executive Committee. Any final recommendation by the Executive Committee for reduction, suspension or revocation of clinical privileges or for suspension or expulsion from the Medical Staff or any action that is reportable to the Board of Registration in Medicine shall entitle the affected practitioner to the procedural rights in Article VI of these Bylaws. Notification of such adverse recommendation shall be in accordance with the procedural rights of Article VI of these Bylaws. The affected practitioner will receive copies of these reports.

SUMMARY SUSPENSION

5.6 Summary Suspensions means the immediate loss of all or any portion of the clinical privileges of the Practitioner. Summary suspension shall be effective immediately on imposition. If the interests of patient health and safety so require, the initial notification of a summary suspension may be made verbally. Thereafter, written notification will be provided in accordance with Section 5.8 below.

5.7 Any of the following shall have the authority, whenever action must be taken immediately in the best interest of patient care, to summarily suspend all or any portion of a practitioner’s clinical privileges: the Chairman of the Governing Body; the President of the Hospital; the President of the Medical Staff; the Vice President of the Medical Staff; or the Chief of the Department involved.

5.8 The Hospital President or designee shall immediately notify the practitioner in writing, certified mail, return receipt requested, or by hand delivery to the practitioner that Summary Suspension has been imposed including reasons therefor. A copy of such notice shall be forwarded to the Executive Committee of the Medical Staff. Immediately upon the imposition of Summary Suspension, the Chairman of the Executive
Committee or responsible Department Chief shall provide for alternative medical coverage for the patients of the suspended Practitioner still in the Hospital at the time of such suspension. The wishes of the patient shall be considered in the selection of such alternative practitioner.

5.9 The practitioner under Summary Suspension shall be entitled to a hearing and appellate review as set forth in Article VI.

AUTOMATIC SUSPENSION OR LIMITATION OF PRIVILEGES

5.10 A Practitioner’s clinical privileges will be automatically suspended or limited when:

a. the appropriate licensing Board revokes, suspends or limits the Practitioner’s professional license;

b. the practitioner fails to maintain or provide evidence of professional liability insurance in accordance with current Medical Staff policy;

5.11 A practitioner’s elective and non-emergent admitting and clinical privileges shall be voluntarily relinquished for (a) failure to complete medical records, including failure to record admission, history and physical examination within twenty-four hours of admission, or (b) failure to dictate operative reports immediately following surgery, or (c) failure to dictate discharge summaries, and (d) failure to complete education and training required by regulatory and accrediting bodies after notification by the President of the Medical Staff of such delinquency, in accordance with the Medical Staff Bylaws and Rules and Regulations. Such relinquishment shall continue until all records of the practitioner’s patients are no longer delinquent or the training has been completed. Failure to complete the medical records that caused relinquishment of clinical privileges after thirty (30) days from the relinquishment of privileges shall constitute a voluntary relinquishment of clinical privileges and resignation from the Medical Staff.

The practitioner whose privileges have been suspended or limited under this section shall not be entitled to a hearing and appellate review under Article VI of these Bylaws, but may apply for reinstatement of privileges following completion of medical records. Reinstatement of privileges will be determined by the Governing Body upon recommendation of the Executive Committee.

PEER REVIEW

5.12 Any standing, special or ad hoc committee which performs any of the following functions is designated as a Medical Peer Review Committee:

a. the evaluation and improvement of the quality of health care rendered by the providers in this Hospital;

b. the determination of whether health care services were performed in compliance with applicable standards of care and cost;

c. the determination of whether a health care provider's actions raise a question of such provider's fitness to provide health care services; or

d. the evaluation and assistance of health care providers impaired or allegedly impaired by reason of chemical substances, physical or mental disability.
This designation shall also apply to Officers of the Medical Staff, Department Chiefs and members of any Hospital department or division, the Executive Committee and any committees and meetings when performing peer review activities as described above.

**IMPAIRED PRACTITIONERS**

5.13 When the peer review, corrective action process and appellate review, if requested, involve a determination of drug or alcohol abuse or mental disability, the affected practitioner will be referred to the Physician Health Program of the Massachusetts Medical Society or a similar program for monitoring and counseling. Such arrangements will be reported to the Board of Registration in Medicine when required by law.

5.14 When a physician or licensed independent practitioner is impaired or allegedly impaired, they may be referred to or self refer to the Physician Health Committee of the Medical Staff. The Physician Health Committee of the Medical Staff provides a confidential, non-disciplinary process for dealing with physicians and licensed independent practitioners who are impaired or allegedly impaired by reason of alcohol, drugs, physical disability, and mental disability or otherwise.

5.15 When a physician or licensed independent practitioner is impaired or allegedly impaired they may be referred to or self refer to the Physician health Committee of the medical Staff. The Physician health Committee of the Medical Staff provides a confidential, non-disciplinary process for dealing with physicians and licensed independent practitioners who are impaired or allegedly impaired by reason of alcohol, drugs, physical disability, and mental disability or otherwise.

**QUALIFIED PATIENT CARE ASSESSMENT PROGRAM**

5.16 The Medical Staff will participate in the development of the Hospital Qualified Patient Care Assessment Plan to comply with current laws of the Commonwealth of Massachusetts Rules and Regulations of the Board of Registration in Medicine and Bylaws of the Hospital.

**ARTICLE VI**

**HEARING AND APPELLATE REVIEW PROCEDURE**

6.1 Right to Hearing

The following adverse actions or recommendations by the Executive Committee shall entitle the affected practitioner to a hearing before a Hearing Committee of the Medical Staff:

a. summary suspension pursuant to Article V;

b. corrective action pursuant to Article V;

c. reduction, suspension, alteration or revocation of clinical privileges;

d. adverse recommendation on reappointment to the Medical Staff pursuant to Article III, Section 3.11;
e. adverse recommendation on initial appointment pursuant to Article III, Section 3.11 if such adverse recommendation is based upon the practitioner's competence or professional conduct;

f. any adverse action or determination that is reportable to the Board of Registration in Medicine.

6.2 Notice of Adverse Determination

The Medical Staff President shall give prompt written notice of any adverse recommendation or decision to an affected individual who is entitled to a hearing by certified mail, return receipt requested, delivery by courier or by any reputable overnight delivery service, to the individual at his/her address of record with the Hospital. Such notice shall:

a. summarizes the nature of the adverse action and the grounds upon which such action is based;

b. advises the individual of the right to a hearing pursuant to these Bylaws;

c. specifies that the individual shall have thirty (30) days following the date of receipt of such notice to file a written request for a hearing;

d. summarizes the hearing rights to which the affected member is entitled or provide a full text of the rights set forth in these Bylaws;

e. states that failure to request a hearing within the specified time shall constitute a waiver of the right to the same;

f. state that upon receipt of the request, the individual will be notified of the date, time and place for the hearing;

6.3 Notice of Hearing

After receipt of a request for hearing from an individual entitled to same, the President of the Medical Staff shall arrange for such a hearing and shall notify the individual and the Hospital President of the time, place and date so scheduled, as well as the names of the members of the committee.

The hearing date shall be not less than fifteen (15) days nor more than forty-five (45) days from the date of receipt of the request for hearing unless an earlier date is mutually agreed upon by the parties. Notwithstanding the foregoing, a hearing for a practitioner who is under summary suspension shall be held as soon as arrangement therefore may reasonably be made, but not later than fourteen (14) days from the date of receipt of such practitioner's request for hearing.

6.4 Waiver

Failure to request a hearing in the time and manner provided in this Article shall constitute a waiver of the right to a hearing and the adverse recommendation or decision shall become effective immediately.

6.5 Composition of Hearing Committee
The hearing shall be conducted by a Hearing Committee of not less than three (3) members of the Medical Staff. The Hearing Committee shall be appointed by the President of the Medical Staff in consultation with the Executive Committee; provided, however, if the adverse determination was made by the Governing Body, in consultation with the Chairman of the Governing Body. If the President of the Medical Staff has a conflict, the Vice-President of the Medical Staff shall appoint the Hearing Committee in consultation with the Executive Committee. One of the members so appointed shall be designated as Chairman. No staff member who is in direct economic competition or otherwise has a significant conflict of interest with the affected practitioner or who has actively participated in the consideration of the adverse recommendation shall be a member of the Hearing Committee.

6.6 **Conduct of Hearing**

6.6.1 **Presence of Hearing Committee Members**

There shall be at least a majority of the members of the Hearing Committee present when the hearing takes place and no member may vote by proxy.

6.6.2 **Record of Hearing**

An accurate record of the hearing must be kept. The method for keeping the record shall be established by the Hearing Committee. It may establish any method which will keep an accurate record. A copy of such record shall be made available to the affected individual upon payment of any reasonable charges associated with the preparation thereof.

6.6.3 **Postponement**

Requests for postponement of a hearing may be granted by the Hearing Committee upon a timely showing of good cause.

6.6.4 **Representation**

The person requesting the hearing shall be entitled to be represented at the hearing by an attorney or other person of his or her choice to examine witnesses and present his/her case. He/she shall inform the Hospital President in writing of the name of that person at least ten (10) days prior to the date of the hearing.

The body whose recommendation or determination has prompted the hearing, may appoint one of its members, some other Medical Staff Member or an attorney to represent it at the hearing, to present the facts in support of its adverse recommendation or determination, and to examine and cross-examine witnesses.

The Hearing Committee may request that the Medical Staff President appoint an attorney or other individual to serve as a parliamentarian or otherwise advise the Committee in the discharge of its duties.

6.6.5 **Presiding Officer**
The chairman of the Hearing Committee, shall preside over the hearing to determine the order of procedure during the hearing to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

6.6.6 Evidence

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 a civil or criminal action.

6.6.7 Written Statement

The Hearing Committee shall permit the practitioner for whom the hearing is being held to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become part of the hearing record.

6.6.8 Burden of Proof

The body whose recommendation or determination has prompted the request for a hearing shall present appropriate evidence in support of the adverse recommendation or decision. The affected practitioner shall thereafter present evidence that the adverse recommendation or decision lacks substantial factual basis or is otherwise arbitrary, unreasonable or capricious.

6.6.9 Hearing Rights

The affected practitioner and the Representative of the body whose determination prompted the hearing shall have the following rights: to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. If the practitioner does not testify, the practitioner may be called and examined as if under cross-examination. Witnesses may be called to testify on behalf of the affected practitioner or the body whose determination prompted the hearing, provided that written notice identifying the witness to be called shall be given by the party calling the witness, to the other party not less than three (3) business days, prior to the date on which the witness is to testify.

6.6.10 Hearing Report

Within thirty (30) days after the final adjournment of the hearing, or fourteen (14) days in the case of summary suspension, the Hearing Committee shall make a written report of findings and recommendations. The Hearing Committee shall forward the report to the affected practitioner and to the body whose recommendation or determination prompted the hearing. The report may recommend confirmation, modification, or rejection of the original determination or
6.7 Appeals to the Governing Body

6.7.1 Notice and Request for Review

Within seven (7) days after receipt of a Hearing Committee report that is adverse to the affected practitioner, the practitioner may make a written request to the Governing Body, delivered through the Hospital President, for an appellate review. Such notice may request that oral argument be permitted as part of the appellate review.

6.7.2 Waiver

If such appellate review is not requested within seven (7) days, the affected individual shall be deemed to have waived the right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately.

6.7.3 Notice of Appellate Review

Within thirty (30) days after receipt of a request for appellate review, the Governing Body shall schedule a date for such review, including a time and place for oral argument if such has been requested and shall, through the Hospital President, notify the affected practitioner of the same. The date of the appellate review shall not be more than sixty (60) days from the date of receipt of the request for appellate review, except that when the practitioner requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than twenty-one (21) days from the date of receipt of such notice.

6.7.4 Appellate Review Committee

The appellate review shall be conducted by a duly appointed committee of the Governing Body of not less than three (3) members. The Committee will be appointed by the Chairman of the Governing Body. No member of the committee shall be in direct economic competition or association with the affected practitioner.

6.7.5 Access to the Hearing Record

The affected practitioner shall have access to the report and record of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision.

6.7.6 Written Submission

The practitioner may submit a written statement detailing those factual and procedural matters which are being disputed. This written statement may cover any matters previously raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Appellate Review Committee at least five (5) business days prior to the scheduled date for the appellate review. A similar statement may be submitted by the body whose adverse determination or recommendation occasioned the review and shall be provided at least five (5) business days prior to the date of
such appellate review.

6.7.7 Record on Review

The Appellate Review Committee shall review the record created in the proceedings, and shall consider any written statements submitted to the Appellate Review Committee.

6.7.8 Oral Statements

The Appellate Review Committee may permit the parties or their representatives to personally appear and make oral statements and may limit the time permitted for such oral statements.

6.7.9 New or Additional Matters

New or additional matters not raised during the original hearing or in the Hearing Committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances, and the Appellate Review Committee shall in its sole discretion determine whether such new matters shall be accepted.

6.7.10 Standard of Review

The Appellate Review Committee may set aside the Hearing Committee's recommendation only if it determines that the recommendation was arbitrary, capricious or unsupported by evidence.

6.7.11 Report of the Appellate Review Committee

Within fourteen (14) days after the adjourned date of the appellate review, the Appellate Review Committee shall make a written report to the Governing Body which shall recommend that the Governing Body either:

a. (in the case of an adverse recommendation of the Executive Committee of the Medical Staff) accept (with or without modification) or reject the recommendation; or

b. (in the case of an adverse decision of the Governing Body) affirms, modify or reverse the Governing Body's prior decision.

6.7.12 Final Decision by the Governing Body

At its next regular meeting, after the conclusion of the appellate review, the Governing Body shall make its final decision in the matter and shall send notice thereof to the Executive Committee and through the Hospital President to the affected individual by certified mail, return receipt requested. The notice to the affected individual shall include a statement of the basis for the decision. This decision shall be immediately effective and final and shall not be subject to further hearing or appellate review.

6.7.13 One Hearing and One Review

Notwithstanding any other provisions of these Bylaws, a practitioner shall not be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the
subject of action by the Executive Committee, or by a duly authorized committee of the Governing Body, or by both.

**ARTICLE VII**

**OFFICERS OF THE MEDICAL STAFF AND ELECTIONS**

7.1 **Identification of Officers**

The elected officers of the Medical Staff shall be:

a. President of the Medical Staff
b. A Vice-President,
c. The Past President of the Medical Staff
d. A Secretary/Treasurer of the Medical Staff

7.2. **Qualifications of Officers**

To qualify for election as an officer an individual must be a member of the Active or Refer and Follow Active Medical Staff. In order to maximize representation on the Executive Committee, no person may serve as an officer who is concurrently serving as a Department Chief or as an At-Large Representative to the Executive Committee, and no person shall hold two Officer positions concurrently.

7.3. **Voting Members**

All members of the Active or Refer and Follow Active Medical Staff shall be voting members of the Medical Staff. Any voting member who will be unable to vote in person may vote by absentee ballot. Absentee ballots will be provided by the Medical Staff Office upon request, must be signed by the voting member personally, and received by the Medical Staff Office no later than the time of commencement of the Annual Meeting. Votes by proxy or designated representative will not be counted. Additional procedures for the orderly conduct of elections may be included in the Rules and Regulations.

7.4. **Election of President of the Medical Staff**

The Voting Members of the Medical Staff shall elect its President at the Annual Meeting of the Medical Staff in May, every other year. In the event that the President ceases to serve in that capacity prior to expiration of his/her two year term, the Vice President shall serve as President for the balance of the term of the President. A nominee for President shall be elected upon receiving a majority of the valid votes cast.

7.5. **Election of Vice-President of the Medical Staff**

The Voting Members of the Medical Staff shall elect its Vice President at the Annual Meeting of the Medical Staff in May. The Vice-President shall be elected upon receiving a majority of the valid votes cast.
7.6 **Election of Secretary/Treasurer of the Medical Staff**

The Voting members of the Medical Staff shall elect a Secretary/Treasurer, who shall serve for a term of two years, at the annual meeting of the Medical Staff in May. The Secretary/Treasurer shall be elected upon receiving a majority of the valid votes cast.

7.7 **Nominating Committee**

A Nominating Committee, which shall be composed of six members of the Active Medical Staff, shall be appointed for a term of two years by the Medical Staff President following the advice and subject to consent of the Executive Committee on or before the January meeting of the Medical Staff. The Nominating Committee will continue as a functioning committee during the entire two years of its election. The Nominating Committee shall present one or more nominations for:

a. the office of President

b. the office of Vice-President,

c. the Secretary/Treasurer

d. eight Members-at-Large elected by the Medical Staff,
   - one member-at-large with a primary affiliation to the Addison Gilbert Hospital campus having been a member of the Medical Staff for a period of greater than five years.
   - One member-at-large with a primary affiliation to the Addison Gilbert Hospital campus having been a member of the medical Staff for a period of less than five years
   - One member-at-large with a primary affiliation to the Addison Gilbert Hospital campus – length of service not defined
   - one member-at-large with a primary affiliation to the Beverly Hospital campus having been a member of the Medical Staff for a period of greater than five years.
   - One member-at-large with a primary affiliation to the Beverly Hospital campus having been a member of the medical Staff for a period of less than five years
   - One member-at-large with a primary affiliation to the Beverly Hospital campus – length of service not defined
   - One member-at-large with a primary affiliation to the BayRidge Hospital campus
   - One member-at-large with privileges in the Department of medicine, Division of Hospitalist Service.

In choosing nominees for the Members-at-Large, the Nominating Committee shall make an effort to nominate, from each of the Addison Gilbert and Beverly Hospitals, one Member-at-Large who has been a Member of the Medical Staff for more than five years and one Member-at-Large who has been a Member of the Medical Staff for less than five years. No person shall serve as a Member-at-Large who is concurrently serving as a Department Chief or as an Officer of the Medical Staff.

The recommendation of the Nominating Committee will be presented at the regular meeting of the Medical Staff in March or the next regularly scheduled meeting thereafter of that year. At the same meeting, additional nominations for the Officers may be made from the floor. No further nominations shall be in order following the adjournment of the regular March meeting of the Medical Staff except as provided for in Section 7.8 of this Article VII. A report of the Nominating Committee shall be widely posted two weeks before the
presentation of the nominations at the March Medical Staff meeting.

In selecting potential nominees for election as an Officer of the Medical Staff or Members-at-Large, the Nominating Committee shall consider the capabilities of the potential candidates, including knowledge of the issues facing the Medical Staff and the Hospital, and the need to maintain reasonable geographic and departmental representation shall be considered.

7.8 Withdrawal of Nominee

In the event that a nominee for Officer of the Medical Staff prior to the Annual Meeting becomes unable to perform the functions of the office if elected, such nomination may be withdrawn at the Annual Meeting, and a different nomination or nominations may be presented by the Nominating Committee and also accepted from the floor. The election for such office may be delayed at the discretion of the President for a period not to exceed two weeks.

7.9 Term of Elected Office

The President, Vice President, Secretary/Treasurer and Members at Large shall be elected for a term of two years, commencing on the first day of July. All Officers and Members-at-Large shall hold the same office for no more than two consecutive terms.

7.10 Duties of the President

The President shall serve as the Chief Administrative Officer of the Medical Staff to:

a. act in coordination and cooperation with the Hospital President in all matters of mutual concern within the Hospital;

b. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

c. serves as Chairman of the Executive Committee of the Medical Staff;

d. serves as ex-officio member of all other Medical Staff Committees without vote;

e. appoints the members and chairman of Medical Staff Committees, unless otherwise specified in these Bylaws:

f. represents the views, policies, needs and grievances of the Medical Staff to the Governing Body and to the Hospital President;

g. is the spokesman for the Medical Staff in its external professional and public relations, in cooperation and coordination with the Hospital President.

7.11 Duties of the Vice-President

The Vice-President will:
a. perform the duties of President in the President’s absence; and

b. performs other such duties as may be delegated by the President.

7.12 Duties of the Secretary/Treasurer

The Secretary/Treasurer, utilizing the resources of the Medical Staff Office, shall keep or cause to be kept accurate records of all meetings of the Medical Staff, shall be responsible for all correspondence concerning the Medical Staff as a group, and shall maintain a copy of these Bylaws and other Rules and Regulations pertaining to the Medical Staff. All funds of the Medical Staff as a group shall be the responsibility of Secretary/Treasurer to maintain records of the same and report to the Medical Staff with respect thereto at least annually. In March of each year, the President shall appoint two Voting Members to audit the accounts of the Medical Staff Office and a report of such audit shall be made to the Medical Staff at its Annual Meeting.

7.13 Removal of Elected Officers

Elected officers of the Medical Staff may be removed from office by a two-thirds vote of those present and voting at a special meeting of the Medical Staff as defined in Article X, Section 10.3. Grounds for removal shall include: mental and/or physical impairment or inability and/or unwillingness to perform the duties and responsibilities of the office; and/or professional misconduct that has resulted in disciplinary action (as defined in Board of Registration in Medicine regulations) by any Medical Society, organized Medical Staff, or hospital.

7.14 Vacancies

In the event that the Vice President or the Secretary/Treasurer shall for any reason be unable to perform the functions of the office during the term thereof, a successor shall be appointed by the Medical Executive Committee to hold office thereafter. In the case of the President that successor shall be the Vice President.

ARTICLE VIII

CLINICAL DEPARTMENTS AND DIVISIONS

ORGANIZATION AND FUNCTIONS OF CLINICAL DEPARTMENTS

8.1 Identification of Departments

There may be the following Clinical Departments (“Departments”): Medicine, Surgery, Pediatrics, Obstetrics and Gynecology, Anesthesiology, Pathology, Emergency Medicine, Psychiatry, Family Practice, Orthopedics, Radiology, and such other Departments as the Executive Committee may recommend and as the Governing Body may approve.

8.2 Identification of Divisions

a. Within the Departments there may be subspecialty divisions in accordance with the provisions of the Rules and Regulations of the Medical Staff. In the event that such Divisions are established,
a Division Chief shall be appointed in accordance with the Rules and Regulations and shall have such duties and responsibilities as are set forth in those Rules and Regulations.

8.3 Functions of Departments

Each Department shall:

a. Establish its own criteria, consistent with the Rules and Regulations of the Medical Staff, the policies of the Medical Staff and of the Governing Body as approved by the Executive Committee of the Medical Staff and the Governing Board, for delineation of clinical privileges.

b. Review clinical work performed under its jurisdiction to assess quality and initiate improvement. Such review may include the review of completed records of discharged patients and other pertinent departmental sources of medical information relating to patient care such as selected deaths, unimproved patients, patients with infections, complications and errors in diagnosis.

c. participate and cooperate in a timely fashion with on-going quality assurance activities of the Medical Staff and the Hospital.

d. participate in the Hospital quality improvement programs and activities.

e. submit reports to the Executive Committee and such other quality review committees as the Executive Committee may designate, detailing such departmental analysis of patient care.

f. establish written rules and regulations for the operation of the Department, including provisions for timely response to emergency treatment and, consistent with applicable laws and regulations, designation of “Qualified Medical Providers” as that term is used in the Emergency Medical Treatment and Active Labor Act.

Each Department shall meet separately at least six (6) times per year to review and analyze the clinical work of the Department.

8.4 Voting

With respect to department matters, a physician may vote in each Department, in which s/he is credentialed.

8.5 Identification and Selection of Chiefs

There shall be a Chief for each Department appointed by the Governing Body on the recommendation of that particular Department and affirmation by the Executive Committee. A nominating committee may be selected by the members of the Department to nominate candidates for Department Chief. The Department's recommendation shall be made by the voting members of the Department by ballot voting and reported at the Annual Meeting of the Medical Staff in May. Any voting member who will be unable to vote in person may vote by absentee ballot. Absentee ballots will be provided by the Medical Staff Office upon request, must be signed by the voting member personally, and received by the Medical Staff Office no later than the time of commencement of the Department Meeting at which the election is to be held. Votes by proxy or designated representative will not be counted. Additional Rules for the orderly conduct of elections may be included in the Rules and Regulations. The Medical Staff President shall report the aforesaid recommendations and affirmation
of the Executive Committee to the Governing Body prior to its June Meeting and, unless an appointment is to fill an unexpired term, the appointment for the Chiefs of Departments shall be for a period of two years, to expire on June 30.

It shall be the obligation of the voting members of each Department to recommend a physician Department Chief based on training, experience, administrative ability and aptitude for the position. Each Department Chief shall be a member of the Active Medical Staff, board certified by an appropriate specialty board or have demonstrated comparable competency through the credentialing process. No person shall serve as a Department Chief who is concurrently serving as an Officer of the Medical Staff or as a Member-At-Large of the Medical Executive Committee.

8.6 **Duties of Chiefs**

Each Department Chief shall:

a. oversee the professional and clinical activities within the Department at all clinical sites;

b. be a member of the Executive Committee, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding the Department in order to assure quality patient care;

c. be responsible for administrative oversight of the Department and enforcement of the Hospital Bylaws and of the Medical Staff Bylaws and Rules and Regulations within the Department; and

d. be responsible for implementation within the Department of actions taken by the Executive Committee of the Medical Staff; and

e. recommend clinical privileges for each Department member.

f. participate and cooperate in a timely fashion with on-going quality assurance activities as defined in Rule W(b) of the Rules and Regulations of the Medical Staff.

g. in the event that necessary clinical services pertinent to the Department are not available in the Hospital, recommend off site sources for those services.

h. coordinate the activities of the Department with those other clinical Departments/Divisions.

i. develop or cause to be developed policies and procedures as needed to provide guidance to Department activities.

j. each department chief shall provide a practitioner specific on-call schedule to the medical staff office before the end of the proceeding month.

8.7 **Removal of Department Chief**

Removal of a Department Chief during the term of office may be initiated by a two-thirds majority vote of all Active Staff Members of the Department, or two-thirds majority of all voting members of the Executive Committee or the Governing Body. However, no such removal shall be effective unless and until it has been
ratified by the Executive Committee and by the Governing Body. Grounds for removal shall include: mental and/or physical impairment or inability and/or unwillingness to perform the duties and responsibilities of the office; and/or professional misconduct that has resulted in disciplinary action (as defined by the Board of Registration in Medicine Regulations) by any Medical Society, organized Medical Staff or hospital.

8.8 Vacancies

If a vacancy shall occur in any of the offices enumerated in this Article VIII because of the death, resignation or prolonged disability of the holder thereof, a temporary appointment to fill the same shall be made by the President of the Medical Staff until a permanent appointment has been made for the unexpired term. The permanent appointment may be made by the Governing Body pursuant to the procedures set forth herein for such office but, in any event, such permanent appointment shall be made within one hundred and eighty (180) days after such vacancy shall have occurred.

8.9 Clinical Directors

Clinical directorships may be established upon recommendation of the Executive Committee and approval of the Governing Body. Clinical Directors shall be appointed by the Governing Body on the recommendation of the Executive Committee and may be site specific.

ARTICLE IX

COMMITTEES

EXECUTIVE COMMITTEE

9.1 Composition

The Executive Committee shall consist of:

a. the President of the Medical Staff who shall be the Chairman;

b. the Chiefs of the Departments of Medicine, Surgery, Anesthesia, Emergency Medicine, Family Practice, Ob/Gyn, Pathology, Pediatrics, Psychiatry and Radiology;

c. the Vice-President of the Medical Staff;

d. the Secretary/Treasurer of the Medical Staff;

e. the Past President of the Medical Staff;

f. a physician representative from the AGH Operations Committee selected by that Committee;
g. the President of the Hospital or a designee who shall be an ex-officio non-voting member;

h. Vice-President of Medical Affairs who shall be an ex-officio non-voting member;

i. eight Members-at-Large elected by the Medical Staff.
   - one member-at-large with a primary affiliation to the Addison Gilbert Hospital campus having been a member of the Medical Staff for a period of greater than five years.
   - one member-at-large with a primary affiliation to the Addison Gilbert Hospital campus having been a member of the medical Staff for a period of less than five years
   - one member-at-large with a primary affiliation to the Addison Gilbert Hospital campus – length of service not defined
   - one member-at-large with a primary affiliation to the Beverly Hospital campus having been a member of the Medical Staff for a period of greater than five years.
   - one member-at-large with a primary affiliation to the Beverly Hospital campus having been a member of the medical Staff for a period of less than five years
   - one member-at-large with a primary affiliation to the Beverly Hospital campus – length of service not defined
   - one member-at-large with a primary affiliation to the BayRidge Hospital campus
   - one member-at-large with privileges in the Department of medicine, Division of Hospitalist Service.

9.2 Officers of the Executive Committee

The Officers of the Executive Committee shall be the Medical Staff President, the Vice-President, the Secretary/Treasurer and the Past President. In the absence of the Chairman, the Vice-President shall act as Chairman of the meetings of the Executive Committee and in other capacities as designated by the President of the Medical Staff.

9.3 Functions

The Executive Committee of the Medical Staff shall be the principal and primary Committee of the Medical Staff, empowered to act in the interests of the Medical Staff, in accordance with these Bylaws between meetings of the Medical Staff and shall be responsible for the enforcement of these Bylaws and for the direction and leadership of the Medical Staff. In carrying out its functions this Committee may issue such rules and regulations applicable to the Medical Staff (“Rules and Regulations of the Medical Staff”) not inconsistent with these Bylaws as it may deem necessary and desirable. The Executive Committee shall receive a report of the minutes of Medical Staff Departmental and Committee Meetings and review and act upon all of their recommendations. More particularly, the Executive Committee shall:

a. review the credentials of all applications for privileges and make recommendations on behalf of the Medical Staff in all matters relating to staff appointment and reappointment, assignment to departments, delineation of clinical privileges and forwarding recommendations to the Governing Body.

b. continuously assess and take appropriate actions to improve the quality of medical and surgical care rendered by each Member of the Medical Staff and utilize the reports of pertinent Departments, Divisions and Committees for this purpose;
c. act as a channel of communication and coordination between the Medical Staff and the Governing Body;

d. participate in the development of all Medical Staff and Hospital policy, practice and planning;

e. meet at least 10 times per year and maintain a permanent record of its proceedings and actions.

f. determine if any individual, acting or appointed under these Bylaws in any specific matter, is in a situation of conflict of interest. If so determined, the Executive Committee shall name another individual to perform the duties required of that person in that matter.

g. Set the amount of annual dues for each category of Staff membership and determine the manner of expenditure of the funds received. The amount of dues may vary among Staff categories.

**AGH OPERATIONS COMMITTEE**

9.4 **Composition**

There will be an Operations Committee at the Addison Gilbert Hospital campus consisting of not more than six physicians appointed by the Executive Committee, in accordance with procedures set forth in the Rules and Regulations, from among those physicians who actively practice at Addison Gilbert Hospital, giving consideration to the leadership capabilities of the candidates as well as their knowledge of the issues facing the Addison Gilbert Hospital. The Executive Committee will appoint the six physician representatives from among the candidates recommended to the Executive Committee in accordance with the Rules and Regulations. All such physician members recommended to the Executive Committee in accordance with the Rules and Regulations shall be appointed by the Executive Committee unless the Executive Committee, by vote of two-thirds of all of its voting members, denies appointment of one or more of the physicians so recommended. Also included in the AGH Operations Committee are the President of the Hospital or his designee, the President of the Medical Staff or the Vice President if designated by the President, and the Vice President of Medical Affairs

9.5 **Functions**

The purpose of the AGH Operations Committee is to provide a forum for discussion among physicians practicing predominately at AGH, Medical Staff leadership, and hospital management in which matters of clinical operation and practice at the AGH may be discussed and from which recommendations may be developed for presentation to the Executive Committee or to Hospital Administrative bodies.

**CREDENTIALS COMMITTEE**

9.6 **Composition**

The Credentials Committee shall consist of at least five (5) Active Staff members appointed by the President of the Medical Staff. The Chairman of the Credentials Committee will be elected by members of the committee. The Chairman may permit such additional persons as he/she deems appropriate to attend the committee meetings.

9.7 **Functions**

The duties of the Credentials Committee shall be to review and evaluate the qualifications and
credentials of all applicants for appointment or reappointment to the Medical Staff, to interview, if necessary, new applicants, and to make recommendations to the Executive Committee for appointment, reappointment, membership or affiliation in compliance with these Bylaws. Those recommendations shall include specific consideration of the evaluation by the Departments in which applicants request privileges. A member from those Departments may be present at the review meeting. The Credentials Committee shall also be responsible for developing, in consultation with the appropriate Department Chief, the specific criteria which must be satisfied before an individual practitioner’s privileges may be expanded to include additional procedures or the use of new technology. Once those criteria have been established, the Credentials Committee, upon recommendation of the Department Chief, will review a request for additional privileges and forward its recommendation to the Medical Executive Committee in the usual course in accordance with Rule W(b) of the Rules and Regulations of the Medical Staff.

9.8  **Review of Process**

The Credentials Committee shall be responsible for the on-going review of the application and credentialing processes for new applicants to the Medical Staff and all applicants for reappointment and shall make appropriate recommendations when necessary to the Executive Committee and/or to the Bylaws Committee if modifications of the procedures are deemed appropriate to assure compliance with State or Federal Regulations, the requirements of the Joint Commission on Accreditation of Healthcare Organizations or otherwise to improve the credentialing process.

9.9  **Meetings**

The Committee will meet as often as necessary at the call of the Chairman, and shall maintain a permanent record of its proceedings and actions.

**MEDICAL RECORDS COMMITTEE**

9.10  **Composition**

The Medical Records Committee shall consist of physician representatives and representatives from Nursing Service and the Health information Management Department. The members and chairman of the committee shall be appointed by the President of the Medical Staff.

9.11  **Functions**

The Medical Records Committee shall be responsible for assuring the Executive Committee that all medical records meet the highest standards of patient care usefulness and of historical validity. The Medical Staff representatives shall be specifically responsible for assuring the Executive Committee that the medical records reflect realistic documentation of medical events. The clinical pertinence of the record is reviewed retrospectively and concurrently by Medical Records personnel and the results of such review are shared with the Medical Records Committee at its regular meetings. The Committee shall conduct an ongoing review of currently maintained medical records and notify Medical Staff members of deficiencies in documentation.

9.12  Individuals who perform the medical record review function may determine the format of the medical record, the forms used in the medical record, and the use of electronic data processing and storage systems for medical record purposes.
9.13 **Meetings**

The Committee shall meet at least quarterly and shall maintain a permanent record of its proceedings and activities and report to the Executive Committee.

**PHARMACY AND THERAPEUTICS COMMITTEE**

9.14 **Composition**

Physician membership shall be appointed by the President of the Medical Staff and shall consist of at least three (3) representatives of the Medical Staff and one each from the Pharmaceutical Service, the Nursing Service, and from Hospital Management. The Chair shall be a physician appointed by the President of the Medical Staff.

9.15 **Functions**

This Committee shall be responsible for recommendations concerning the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard. The Committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital. The Committee will review:

a. cases of adverse drug reactions and will make recommendations concerning adverse drug interactions;

b. appropriateness of drug use and will approve and review the Hospital Formulary;

c. antibiotic usage and make appropriate recommendations.

9.16 **Meetings**

This Committee shall meet at least quarterly and will forward reports to the Executive Committee.

**MEDICAL EDUCATION COMMITTEE**

9.17 **Composition**

The Medical Education Committee shall be composed of the Chairman who is the Director of Medical Education and a member of the Active Medical Staff, representatives from the different specialties, and the librarians. The physician members shall be appointed by the President of the Medical Staff.

9.18 **Duties**

The Medical Education Committee shall organize and implement the continuing education programs for the members of the Medical Staff, coordinate the university affiliations, stimulate clinical research projects, supervise the operation of the libraries, and recommending long-range plans which relate to the Medical Staff and the role of the Hospital in education. The Committee shall keep the Director of Medical Education fully informed of all activities and be responsive to recommendations.
9.19 Meetings

The Medical Education Committee will meet at least quarterly with records and reports of the meetings to be forwarded to the Executive Committee.

CANCER COMMITTEE

9.20 Composition

The Cancer Committee and its chairman shall consist of appropriate members of the Medical Staff and Hospital services and shall be appointed by the President of the Medical Staff.

9.21 Functions

The Cancer Committee will coordinate the quality of patient care, chemotherapy, nursing education, patient education, screening services, and the Hospice Program.

9.22 Meetings

The Cancer Committee will meet at least quarterly to make policy decisions and patient care evaluations. Minutes will be kept and forwarded, with recommendations, to the Executive Committee.

BYLAWS COMMITTEE

9.23 Composition

The Bylaws Committee shall consist of two Co-chairman, one of whom has a primary clinical affiliation to the AGH campus and who are Active members of the Medical Staff, and representatives from the Medical Staff appointed by the President of the Medical Staff. The Hospital Legal Counsel and the Vice President of Medical Affairs will serve as non-voting members.

9.24 Function

The function of the Bylaws Committee will be to conduct a periodic review of the Bylaws, Rules and Regulations and other documents pertaining to the Medical Staff; submit recommendations to the Executive Committee and Governing Body for changes in these documents and receive and evaluate recommendations for modification.

9.25 Meetings

The committee will meet on the call of the Chairman but at least every two years and report its activities and recommendations to the Executive Committee.

ETHICS COMMITTEE

9.26 Composition
The Ethics Committee will consist of a Chairman and at least two other members of the active staff appointed by the President of the Medical Staff. The President of the Medical Staff may appoint a Chaplain and a Trustee as additional members with vote and such other additional members as the Chairman deems appropriate. The President of the Hospital or designee shall be a member without vote.

9.27  Function

The function of the Ethics Committee will be to review in-patient medical policies or practices of the Hospital or Medical Staff as necessary. Recommendations for policy review may come from the Executive Committee. Recommendations of the Ethics Committee will be directed to the Executive Committee. The Committee may also provide Ethics consultations, which shall be advisory for guidance purposes only, when requested by any member of the medical or nursing staff concerning ethical dilemmas in patient care.

9.28  Meetings

The Committee will meet on the call of the Chairman and report its activities and recommendations to the Executive Committee.

INFECTION CONTROL COMMITTEE

9.29  Composition

The Infection Control Committee is an inter-disciplinary team comprised of representatives from the following departments: Administration, Sterilization Services, Nutrition Services, Employee Health Service, Facilities/Engineering, Medicine/Infectious Disease, Microbiology, Pharmacy, Environmental Services, Nursing and Surgical Services. A representative from additional services/departments will be requested on an as needed basis. A committee quorum consists of (5) committee members including one physician. The Hospital Epidemiologist serves as Chairman of the Committee.

9.30  Functions

The purpose of the Infection Control Committee is monitoring, oversight and implementation of processes to continually decrease the incidence of infections at Northeast Hospitals.

9.31  Meetings

The Committee shall meet at least five times annually and shall maintain a permanent record of its proceedings and activities and report to the Executive Committee.

UTILIZATION REVIEW COMMITTEE

9.32  Composition

The Utilization Review Committee will consist of the following suggested physicians appointed by the President of the Medical Staff:
Chairman along with specialists from the Departments/Divisions of:

a. Medicine  
b. Surgery  
c. Hospitalist  
d. Emergency Services  
e. Cardiology  

Non-physician members of the committee shall be allowed to participate in discussions during meetings, but may not vote on matters which the physician members determine to be areas of medical decisions.

9.33 Functions  
The purpose of the Utilization Review Committee is to assure effective and efficient utilization of hospital facilities and services of patients by means of admission reviews, continued stay reviews and discharge planning; to assist in the promotion of evidence based care through analysis, review and evaluation of clinical practices within the hospital; assist in the identification of opportunities to improve quality care, patient safety and reduce risk; improve continuity of care by extending health service to our patients across the continuum and to comply with requirements of CMS (42 CRF, 482.30) Department of Public Health, Joint Commission and MassPRO.

9.34 Meetings  
The full Utilization Review Committee shall meet every other month with additional meetings called as necessary by the chairman.

COMMITTEES FOR SPECIAL SERVICES AND/OR FUNCTIONS  

9.32 The Executive Committee of the Medical Staff shall establish such committees for special services and/or functions as it deems necessary for the interests of the Hospital. The Executive Committee shall appoint the Chairman and Members that will be appropriate to the service and/or function for which it is appointed. Each such committee will keep on file, in the Medical Staff Office, a description of its organization and function. This shall include frequency of meetings, reports to the Executive Committee, and maintenance of minutes.

SPECIAL MEETINGS  

9.34 A special meeting of any committee or department may be called by or at the request of the Chairman or Chief thereof, by the President of the Medical Staff, or by one-third of the group's members, but not less than two members.

ARTICLE X  

MEDICAL STAFF AND DEPARTMENT MEETINGS  

MEDICAL STAFF  

10.1 Frequency of Meetings  

The Medical Staff shall meet at least four (4) times a year on dates set by the Medical Staff President for the purpose of election of officers, dissemination of information and conducting business as appropriate. The
spring meeting shall be designated as the Annual meeting.

10.2 Elections

All elections for Officers of the Medical Staff and all elections by the Voting Members of a Department shall be conducted in accordance with Sections 7.3 and 8.5. Voting by absentee ballot is permitted. The individual receiving a majority of the votes cast at an election shall be the elected officer or the candidate recommended to the Board. In the event that no nominee for officer or candidate receives a majority of the votes on the first ballot, further balloting shall immediately follow eliminating the candidate with the lowest vote total on the preceding ballot until a nominee receives a majority. In the case of elections called for in Section 8.5, if, after five (5) ballots, no nominee has obtained a majority, the results shall be reported to the Governing Board who shall appoint a Chief. In the case of elections called for in Sections 7.4 or 7.5 or 7.6, if, after five (5) ballots no nominee has obtained a majority, the results of the third fifth ballot shall be reported to the Executive Committee who shall appoint a President, Vice President, or Secretary/Treasurer.

10.3 Special Meetings

Special meetings of the Medical Staff may be called by the President, the Governing Body, the Executive Committee, or by written petition signed by any ten Voting Members and presented to the President of the Medical Staff. At any special meeting, no business shall be transacted except for such business as is specifically set forth in the written notice of such meetings given at least four (4) business days prior to each such special meeting.

10.4 Quorum

A quorum for Medical Staff meetings requiring a vote is fifteen (15) Voting Members or greater present.

DEPARTMENT MEETINGS

10.5 Attendance Requirements

Attendance and participation at department meetings is required in accordance with the Rules and Regulations.

10.6 Robert's Rules of Order Revised shall be applicable at all meetings of the Medical Staff and Departments.

ARTICLE XI

AMENDMENTS & ADOPTION

11.1 An amendment to the Medical Staff Bylaws may be proposed by any member of the Medical Staff. Proposed amendments shall be submitted to the Bylaws Committee, in writing, for review and comment. The Bylaws Committee shall review the proposed amendment and if approved, refer it to the Executive Committee for further action. If the Bylaws Committee does not recommend the proposed amendment, it will not be forwarded to the Executive Committee unless thirty (30) Medical Staff members petition the Executive Committee for further consideration. Should the Medical Executive Committee not approve the proposed
amendment, the conflict management process may be called to order on petition of more than 16 voting members of the Medical Staff. This five-member, ad-hoc committee shall consist of a chairman and an equal number of Medical Executive Committee members and voting members of the Medical Staff appointed by the President of the medical Staff. The results of the ad hoc committee will be submitted to the Medical Staff for vote.

11.2 Following approval by the Executive Committee, written notification of the Bylaws amendment(s) shall be available at the Medical Staff Office in appropriate time to review the recommended Bylaws revision(s).

11.3 The proposed amendment(s) shall be brought to the next regular or special meeting of the Medical Staff or a special meeting called for that purpose. The Medical Staff shall vote to accept or reject the proposed amendment at that time. An amendment shall be adopted upon receiving two-thirds of the valid votes cast and shall be effective when approved by the Governing Body.

11.4 In the case of a documented need for an urgent amendment to the Bylaws and Rules and Regulations, the Medical Executive Committee may provisionally adopt by a three-quarter majority of those present and voting provided there is a quorum and the governing body may provisionally approve an urgent amendment without prior notification or approval of the medical staff. In such cases, the Medical Staff will be immediately notified by the Medical Executive Committee and must vote on this amendment at a Medical Staff Meeting to be held within eight weeks following provisional approval by the Governing Body, otherwise the amendment expires.

Adopted by the Medical Staff on: May 31, 2005

Medical Staff President

Approved by the Governing Body on: June 21, 2005

Chairman, Governing Body

Effective Date: July 1, 2005
APPENDIX A

HOSPITAL

MEDICAL STAFF

RULES AND REGULATIONS

Approved: June 21, 2005
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RULES AND REGULATIONS OF THE MEDICAL STAFF

A. MEDICAL STAFF APPLICATION FOR APPOINTMENT/REAPPOINTMENT

As part of the application process, the applicant shall agree, in writing, to maintain an ethical practice and provide continuous care for all patients. The applicant must be familiar with the Bylaws and Rules and Regulations of the Medical Staff and of the Hospital, must be familiar with the application process and the Rules of the Credentials Committee, and must attest to this in writing. The applicant shall also agree, in writing, to participate in the Hospital's Patient Care Assessment Program and any other risk management, quality improvement or utilization review programs established by the Hospital.

Upon advice of the Credentials Committee, the Executive Committee may establish a non-refundable fee to accompany all applications. Monies obtained from such fees shall be paid to the Treasury of the Medical Staff. Appointment/Reappointment to the Medical Staff will be contingent upon all dues and fees being paid in full.

B. RULES OF THE CREDENTIALS COMMITTEE

The Credentials Committee, when considering an appointment/reappointment to the Medical Staff, shall consider at least the following criteria:

a. Consideration of the proper size and composition of the Medical Staff, in light of the needs of the community served and the resources of the Hospital as determined by the Governing Body.

b. Education and experience required for an applicant in a particular specialty.

c. Ability to maintain a responsible relationship with the Hospital, patients and employees.

d. Availability to provide proper patient care in a timely manner.

e. Interest in practicing at the Hospital.

f. For applicants graduating from medical school on or after January 1, 1985, a requirement that the applicant has completed an approved residency training program as determined by the Credentials Committee. Applicants after September 1, 2003 must be Board Certified or Board Eligible to apply to the Medical Staff. For applicants applying to the Medical Staff after September 1, 2003, they must maintain their Board Eligibility or Board Certification to be reappointed to the Medical Staff.

g. No physician, dentist or podiatrist shall be entitled to membership on the Medical Staff or to exercise particular clinical privileges in the Hospital merely by virtue of licensure to practice medicine, dentistry, or podiatry, respectively in this or any other state or of membership in any professional organization or of past or present privileges at this or any other hospital or any other health care organization or by certification by any particular specialty board.
h. No applicant shall be denied Medical Staff membership or privileges on the basis of sex, race, creed, color, or national origin, sexual orientation or disability, when such disability does not interfere with the applicant's ability to perform the essential functions of his/her profession in a hospital setting.

C. CATEGORIES OF THE MEDICAL STAFF

a. Honorary Staff

The Honorary Staff shall consist of physicians, dentists and podiatrists who are not active in the Hospital or who have reached emeritus position. These may be physicians, dentists or podiatrists who have retired from active hospital practice or who are of outstanding reputation and not necessarily residing in the community. Honorary Staff members shall not be eligible to admit patients, to vote, to consult, or to hold staff office. They are not required to serve on committees or pay Medical Staff dues.

b. Active Medical Staff

The Active Medical Staff shall consist of fully licensed physicians, dentists and podiatrists who demonstrate a commitment to the clinical and professional activities of the Hospital and Medical Staff and regularly utilize the Hospital in accordance with the nature of their practice. Members of the Active Staff may admit and attend patients, may provide consultations, and are eligible to vote, hold office and serve on committees. A physician must be an Active Member of the Medical Staff before being qualified to hold an office in a service or department or eligible to hold an elective office of the Medical Staff, except where both the Executive Committee and Governing Body, by separate majority votes concurs.

c. Associate Medical Staff

The Associate Medical Staff shall consist of fully licensed physicians, dentists and podiatrists qualified for staff membership, who only occasionally admit or consult on patients or who provide limited coverage as part of an organized program. Associate Medical Staff members may admit and attend patients and provide consultations; are permitted to serve as voting members of committees, but are ineligible to vote at Department or Staff Meetings or hold staff office.

d. Refer and Follow – Active Staff

The Refer and Follow Active Medical Staff shall consist of fully licensed physicians, dentists and podiatrists qualified for staff membership, who refer and follow patients through the use of the Hospitalist Program. Refer and Follow Active Staff members may hold specific limited privileges. They must meet meeting attendance requirements and are permitted to serve as voting members of committees, are eligible to vote and hold office.
e. **Refer and Follow – Associate Staff**

The Refer and Follow Associate Medical Staff shall consist of fully licensed physicians, dentists and podiatrists qualified for staff membership, who refer and follow patients through the use of the Hospitalist Program. Refer and Follow Active Staff members may hold specific limited privileges. Refer and Follow Associate Staff members are permitted to serve as voting members of committees, but are ineligible to vote at Department or Staff Meetings or hold staff office.

d. **House Physician Staff**

The House Physician Staff shall consist of licensed physicians employed for the purpose of In-Hospital patient coverage. The House Physician shall work under the supervision of the attending physician. They shall not admit patients under their own names.

House Physicians are not required to attend Medical Staff Meetings, to serve on Medical Staff committees or to be responsible for Medical Staff dues.

House Physicians are not eligible to vote or hold Medical Staff office. House Physicians will conform to the Rules and Regulations of the Medical Staff.

House Physicians are exempted from the requirement in Section B., of these Rules and Regulations requiring completion of an approved residency program but must presently be active in a residency or fellowship program.

D. **CLINICAL DIVISIONS**

Clinical Divisions may be established within any Department in accordance with the process set forth below. A current list of Clinical Divisions is attached to these Rules and Regulations as “Addendum A”. The Division Chief of each Clinical Division will be elected for a term of two (2) years, or until the next election of the Medical Staff Officers, by the members of that Division. A Physician may vote in division elections in each division in which s/he is credentialed.

The Chief of any Department may submit a proposal in writing to the Medical Executive Committee for the establishment of a new Clinical Division or the elimination of an existing Clinical Division within that Department. Such submission must contain the rationale for the proposal and may be submitted only after an affirmative vote by the affected Department approving the establishment or removal, as the case may be, of the Clinical Division.

The decision of the Medical Executive Committee concerning the establishment or elimination of a Clinical Division shall be final.

Promptly following a Medical Executive Committee decision to establish or eliminate a Clinical Division, Addendum A to these Rules and Regulations will be amended to reflect accurately the then current listing of Clinical Divisions.
E. **CLINICAL PRIVILEGES**

Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the records of patients treated in this or other hospitals and review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care in accordance with Rule W(b) of the Rules and Regulations of the Medical Staff. The records of the Hospital and the Medical Staff Quality Improvement activities shall be included in the review. Such review shall be the responsibility of the Chief of the Department in which the practitioner has privileges. This review shall be performed during the appointment and/or reappointment process in accordance with Rule W(b) of the Rules and Regulations of the Medical Staff.

Each department or division within a department shall establish procedure specific minimal training requirements which must be met by each practitioner seeking initial privileges for that procedure. When two or more clinical departments or divisions may include practitioners holding privileges for the same procedure, those departments or divisions will collaborate in establishing minimal training requirements. All minimal training requirements will be subject to review by the Chief of the department or division and approved by the Executive Committee.

**ADDITIONAL PRIVILEGES**

A practitioner may request additional clinical privileges at any time. The Department Chief subject to approval by the Governing Body may recommend privileges for procedures commonly performed at this Hospital. Requests for privileges to perform procedures that are new to this Hospital must be in writing and shall be made to the Chief of the Department in which the practitioner has privileges. The Department Chief will forward the request with a recommendation to the Executive Committee. At the next regular meeting after receipt of such a request, the Executive Committee shall accept, reject or modify the recommendation of the Department Chief. Any additional privileges granted to a practitioner shall be provisional with timely oversight by the Chief or designee of the department or division for a period of not less than one year not more than two years, as defined in Rule W(a) of the Rules and Regulations of the Medical Staff. When the practitioner requesting additional privileges is the Chief of the department or division, the Executive Committee or its designee shall determine the appropriate oversight requirements.

**TEMPORARY PRIVILEGES**

No individual who is applying for staff membership shall be granted Temporary Privileges for more than one hundred and twenty 120 days in any calendar year under this provision. Temporary Privileges may be granted to an individual in the process of applying for Medical Staff Membership pending the completion of this process, provided that his/her application is complete and has been reviewed by the Credentials Committee or designee.

In addition, Temporary Privileges may be granted in the following circumstances:

a. On the request of a member of the Medical Staff, with the approval of the appropriate Department Chief, an individual may be granted Temporary Privileges for a specific period of time (not to exceed 30 days in a calendar year),
to assist in the care of a patient or patients who shall be named in the request.

b. When unusual circumstances prevent a department or division from providing adequate coverage of clinical responsibilities, an individual may be granted temporary privileges for a specific period of time, (not to exceed 30 days in a calendar year), to assist the department or division in meeting its clinical responsibilities.

F. LEAVE OF ABSENCE

The Executive Committee may recommend to the Governing Body that a member of the Medical Staff be granted a leave of absence without affecting classification or privileges. Leave of absence will be granted for a maximum of twelve months unless the absence is due to obligated military service or illness.

As a condition of receiving leave of absence recommendation from the Executive Committee, the staff member must show evidence of professional liability coverage for prior acts, which coverage will remain in force for the duration of the leave of absence.

Upon termination of the leave of absence, the practitioner may be required to show evidence of current health status and current clinical competence. The Executive Committee will determine when medical staff dues will be paid prior to, during and after the leave of absence.

G. MEDICAL STAFF DUES

The Executive Committee shall have the power to set the amount of annual dues for each practitioner and to determine the manner of expenditure of funds received. The amount of annual dues may vary among practitioner categories. Failure to pay dues by the designated due date will result in a late payment fee to be determined by the Medical Executive Committee. Reappointment to the Medical Staff will be contingent upon payment of Medical Staff dues.

H. NON MEMBERS OF MEDICAL STAFF

Allied Health Professionals

Allied Health Professionals shall not be deemed members of the Medical Staff. Consideration for appointment as an Allied Health Professional will be made on recommendation of the appropriate Department Chief, Credentials Committee and the Rules and Regulations of the Medical Staff pertaining to Allied Health Professionals. They shall be appointed by the Governing Body upon the recommendation of the Executive Committee of the Medical Staff.

Allied Health Professionals will consist of individuals who, by license, are authorized to provide a defined discipline of health services, these are:

a. Individuals with a doctorate in psychology from an accredited college or university and licensed by the Commonwealth of Massachusetts.

b. Individuals with a degree of doctor of education appropriately trained and
licensed as neuropsychologists.

c. Any Nurse Midwife, Nurse Practitioner, Nurse Anesthetist, or Clinical Nurse Specialist who is authorized to practice as a Nurse in the Expanded Role by the Board of Registration of Nursing and as provided for in M.G.L. ch.112 80B and practicing in accordance with regulations of the Board of Registration in Nursing, 244 CMR 4.00 et. Seq.

d. Any Physician’s Assistant licensed pursuant to M.G.L. c.112 sec. 9C and practicing in accordance with the regulations of the Board of Registration of Physician Assistants, 263 CMR. 5.00 et. Seq.

Requirements

In addition to the requirements as set forth above, the qualifications for Allied Health Professionals shall include, but are not limited to the following:

a. Shall be licensed by the Commonwealth of Massachusetts.

b. Shall provide documentation of participation in continuing medical education.

c. Shall participate in Quality Improvement Programs and are subject to review of their patient care activities.

d. Shall furnish evidence of professional liability insurance coverage in such amounts and with such companies as the Governing Body, after consultation with the Executive Committee of the Medical Staff, may set from time to time.

e. Must have a recommendation from a current Active/Associate Member of the Medical Staff.

Responsibilities

The responsibilities of Allied Health Professionals shall include, but are not limited to:

a. May provide patient care services within the limits of their professional skills and abilities. The degree of participation of Allied Health Professionals in patient care shall be according to the Delineation of Responsibilities recommended by the Medical Executive Committee and approved by the Governing Body.

b. In the case of Physician Assistants, Nurse Practitioners, Surgical First Assists, Certified Nurse Midwives and Certified Registered Nurse Anesthetists they must at all times be practicing under the supervision of an Active, Associate, Refer and Follow Active or Refer and Follow Associate Member of the Medical Staff who is readily identifiable and present within the facility at the times at which the Physician Assistant is practicing. The name of supervising physician shall be readily ascertainable from records kept in the ordinary course of business, which are available to patients. The supervising physician of record is ultimately responsible for ensuring that each task performed by a Physician Assistant is properly supervised.
c. Shall not admit patients under their own names.

d. May perform and record the history and physical examination, write progress notes and write orders and discharge summaries without the need of a countersignature by the Attending Physician in accordance with the policies and procedures developed by the Department.

e. Exercise independent judgment in their areas of competence provided that the Governing Body approves such exercise and provided that an Active or Associate Member of the Medical Staff shall have the ultimate responsibility for patient care.

f. Record reports and progress notes in the patient's medical record.

g. May serve, if requested, on appropriate committees of the Medical Staff without voting privileges.

h. May be invited to attend Medical Staff Meetings, and may be required to attend meetings involving the clinical review of patient care in which they participated.

**Appointment/Reappointment**

a. Applications for appointment/reappointment and delineation of responsibilities as an Allied Health Professional shall be processed in accordance with the procedures set forth in the Medical Staff Bylaws and Rules and Regulations, Guidelines for Appointment/Reappointment of the Allied Health Professional Staff, the requirements and recommendations established by the Credentials Committee.

b. Recommendations for reappointment to the Allied Health Professional Staff will be based on evaluation of professional performance, judgment and clinical and/or technical skills and the relevant results of quality assessment and improvement activities. Objective evidence of relevant assessment of the individual's performance through medical staff review activities will be considered in the reappointment recommendation. If the applicant has no clinical activity at the Hospital as the basis for reappointment, evidence of a hospital level of clinical activity, competency and technical skills will be required.

c. The Employer of the individual seeking approval as an Allied Health Professional shall present a written statement of the clinical duties and responsibilities of said individual through the Chief of the appropriate Department and to the Credentials Committee for review. On the advice of the Credentials Committee, the Executive Committee of the Medical Staff shall review and approve both the individual concerned and the clinical activities and responsibilities requested by the individual and employer.

If recommended by the Executive Committee, the application shall be transmitted to the Governing Body for review and approval.

d. The Employer or a designated individual (s) of the employing group of the Allied Health Professional shall assume full responsibility and be fully accountable for the conduct of
said individual within the Hospital. It is the further responsibility of the employer of the Allied Health Professional to acquaint said individual with the applicable Rules and Regulations of the Medical Staff and Hospital, as well as appropriate members of the Medical Staff and Hospital personnel with who said individual shall have contact at the Hospital. Said employer shall furnish evidence of professional liability insurance coverage for such individuals in amounts specified by the Executive Committee.

e. In circumstances where the individual designated by the health care delivery system responsible for the Allied Health Professional is no longer associated with the organization, then a new designee shall be immediately submitted to the Credentials Committee for review and recommendation to the Executive Committee. An Allied Health Professional shall not be allowed to practice when there is no approved supervising physician to assume responsibility for said professional.

**Resident and Fellow Staff**

The Resident Staff shall consist of physician graduates of recognized professional schools who hold, at a minimum, limited license under the laws of the Commonwealth of Massachusetts to practice in the Hospital and who are participating in an approved Resident training program.

The Fellow Staff shall consist of physicians who are actively enrolled in an accredited subspecialty fellowship program and whose activities at the Hospital are pursuant to that Program.

Each Member of the Resident or Fellow Staff is considered to be in training and shall provide professional services at the Hospital only under the supervision of Members of the Medical Staff.

The Resident and Fellow Staff shall not be Members of the Medical Staff, and are not eligible to hold Medical Staff or committee office.

The Resident Staff shall not admit patients under their own names.

The Resident Staff shall provide professional services in compliance with applicable Medical Staff Bylaws and Rules and Regulations.

**I. ADMISSION AND DISCHARGE OF PATIENTS**

a. Patients shall have an assigned attending physician at all times.

b. If any Staff Member shall be temporarily unavailable to care for a patient, the physician shall designate another physician to care for the patient during the period of unavailability and shall make known the transfer of responsibility. If unavailable for more than seventy-two (72) hours, the physician shall transfer the patient to a designate and record this transfer on the chart.

c. No patient shall be admitted or transferred to the service of another physician without the knowledge and consent of the patient and the other physician.
d. No patient shall be admitted to the Hospital except by a member of the Medical Staff. All practitioners shall be governed by the official admitting policy of the Hospital. All patients admitted to the Hospital shall receive a medical history and physical performed or reviewed within 24 hours, by a staff physician.

e. When a patient of a medical staff member needs care in a facility in the Northeast Hospital Corporation where that medical staff member has privileges, the medical staff member must either personally treat the patient or arrange for someone else to care for the patient.

f. A podiatric admission shall have an attending physician and podiatrist for care. The podiatrist shall be responsible for that part of the history and physical examination and patient care that is directly related to podiatric care and treatment. A staff physician shall be responsible for the remainder of the history and physical and any medical problem that may be present upon admission of the patient, or that may arise during the hospital stay.

g. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the completeness and accuracy of the medical record, including discharge instructions.

h. The admitting practitioner shall not withhold information necessary to insure the protection of a patient from self-harm and to assure the protection of others whenever a patient might be a source of danger.

i. Admissions to and transfers from ICU, CCU and other special care areas shall follow the Rules and Regulations established for these areas and so recorded.

j. Patient care orders for treatment and progress note documentation shall comply with the criteria approved by the Executive Committee. The attending practitioner shall anticipate the date of discharge and notify those responsible for discharge planning.

k. Patients shall be discharged only on order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, notation of the incident shall be made in the patient's medical record and in the final summary.

l. In the event of a Hospital death, it shall be the responsibility of the attending physician to assure that the deceased is pronounced by a physician within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased. The attending physician is always responsible for notification of the appropriate individuals of a patient's death. The Medical Examiner shall be notified when required by law.

J. AUTOPSY

Members of the Medical Staff will attempt to secure autopsies on their patients in the case of unusual deaths and cases of medical, legal and educational interest and inform the primary care physician of autopsies that the hospital intends to perform.
All autopsies at the Hospital shall be performed by a member of the Department of Pathology after a proper consent has been obtained from the next of kin by the requesting physician.

Upon notification of an autopsy request, the pathologist will contact the ordering physician to discuss the case, direct the emphasis of the autopsy and to discuss the time that the autopsy will be performed.

K. **MEDICAL RECORDS**

a. A patient's medical record shall be complete, accurate and legible and meet the current standards of the Medical Records Committee and the Center for Medicare and Medicaid Services. In all instances, the medical record shall contain sufficient information to identify the patient; support the diagnosis/condition; justify the care, treatment, and service; document the course and results of care, treatment, and service; and promote continuity of care among providers.

b. A list of prohibited abbreviations and symbols shall be reviewed by the Executive Committee. A list of commonly used abbreviations and symbols shall be maintained. Both lists shall be kept on-line in the hospital’s information system and in hard copy, stored in the Health Information Management Department. Additions and deletions shall be referred to the Pharmacy and Therapeutics and/or Medical Records Committees.

c. Medical record entries must be in ink or typewritten and are made by authorized individuals, are dated, timed and the author identified. Histories and physicals, operative reports, consultations and discharge summaries are authenticated by a written signature, electronic signature or computer key.

d. History and Physical Examinations will be documented according to the Medical Staff Bylaws, section 1.7 and hospital policy.

e. Diagnoses shall be recorded at the time of discharge. The patient’s principal diagnosis is defined as the diagnosis which after study was deemed to be the cause of the patient’s admission to the hospital.

f. A discharge or transfer order must be present for every inpatient leaving the hospital except in cases of patients leaving against medical advice or elopements.

g. A clinical resume (discharge summary) shall be written or dictated for all inpatients with the exception of patients hospitalized less than three (3) days, normal obstetrical deliveries and newborn infants.

h. Physicians with records greater than thirty days incomplete will have their names submitted to their Chief, the Medical Staff President and other Clinical and Department administrators and may face disciplinary action up to and including suspension of elective and emergency admitting and clinical privileges.

i. Unauthorized removal of charts from the Hospital in hard copy or electronic format is prohibited.
j. Practitioners shall sign the hospital agreement for electronic signature privileges and shall not delegate the use of their PIN# to another individual or otherwise allow another individual to use this identifier. A copy of this agreement shall be filed in the Medical Staff Office.

L. GENERAL CONDUCT OF CARE

All patients admitted to the hospital shall be given high quality medical care. No distinctions shall be made based on payer source or ability to pay for care.

a. A general consent form shall be obtained on admission.

b. Specific consent forms for surgery and certain diagnostic procedures that inform the patient of specific risks for certain surgical or diagnostic procedures shall be obtained.

c. All orders for treatment shall be written, signed, timed and dated. Members of the Medical Staff, Nurse Practitioners, Physicians Assistants, Physical Therapists, Respiratory Therapists, Occupational Therapists, Speech Therapists, Clinical Dietitians, CRNA and APRNs as well as Resident Staff are authorized to initiate written orders within the sphere of their responsibilities when consulted by the attending physician.

d. A telephone/verbal order may be dictated by a member of the Medical Staff or Allied Health Professional Staff to a Registered or Licensed Practical Nurse, Pharmacist, Respiratory Therapist, Physician Assistant, Radiology Technologist, Nuclear Medicine Technologist and Physical Therapists.

e. Registered Nurses, Nurse Practitioners, Respiratory Therapists, Physician Assistants, Occupational Therapists, Speech Therapists, Physical Therapists or Pharmacists may write orders or document patient care activities according to established protocols approved by the Executive Committee.

f. Telephone and verbal orders shall be signed by a responsible practitioner no later than 48 hours after it was received unless otherwise required by a medical staff, hospital policy or procedure.

g. The Executive Committee shall approve and establish rules regarding cancellation of orders when patients are transferred to surgery or special units. The current policy of the Executive Committee regarding the cancellation of orders for patients undergoing surgery shall be communicated to all involved services and individuals.

h. All Automatic Stop Orders for medications in effect shall be in accordance with the Northeast Hospital Corporation policy as approved by the Pharmacy and Therapeutics Committee and the Executive Committee of the Medical Staff.
M. **CONSULTATIONS**

The attending is primarily responsible for requesting consultations when indicated and for direct notification of a consultant. In an emergency another practitioner may request the consult. Medical consultation may be indicated in the following circumstances:

a. When the specific skills of another practitioner could improve care of the patient.

b. When a request is made by the patient for consultation.

c. When the rules of any clinical unit require consultation.

N. **EMERGENCY CARE**

All practitioners shall respond to a request for a consultation from an Emergency Department physician or an emergency request from a nursing unit or service area. Responses to such requests shall be made in a timely fashion.

The Executive Committee of the Medical Staff shall determine which Clinical Departments and/or Divisions will be required to provide 24 hour call coverage to the Hospital. Implementation of a practitioner specific call schedule assuring such coverage shall be the responsibility of the Department or Division Chief as appropriate.

Doctors of Medicine and Osteopathy and Qualified Medical Providers (non-physicians) defined as any individual who is licensed or certified and who has determined current competency may provide medical screening exams (PA, NP, CNMW and Labor and Delivery Resource Nurse). Members of the Resident Staff may work in the Hospital Emergency Department only under the supervision of an attending physician.

O. **SPECIAL TREATMENT PROCEDURES**

Special treatment procedures, including restraint and seclusion will be ordered and/or performed by physicians in accordance with the policies and procedures established by the Hospital and approved by the Executive Committee. The required use of special treatment procedures, such as restraint and seclusion or behavior modification shall be documented in the patient's medical record.

P. **CONTRACTED SERVICES**

Contracted providers of patient care services must meet applicable JCAHO standards.

Q. **OUTSIDE PEER REVIEW**

Practitioner specific data is shared with the practitioners by the department chiefs and can result in some discussion/disagreement about the decisions rendered. Should a practitioner, after review with their department chief, still have significant disagreement with the review, that practitioner has the right to request an “outside” evaluation of the rating. This will be arranged by the President of the Medical Staff and the Vice President of Medical Affairs. Additionally, any Officer of the Medical Staff, or the Vice President of Medical Affairs may arrange for an outside evaluation, which may include review of medical records whenever such Medical Staff
Officer or Vice President believes that an outside review is necessary to assure the quality of services provided by a practitioner.

A “peer” means an individual from the same discipline (for example, physician and physician, dentist and dentist) and with essentially equal qualifications.

R. DISAGREEMENT, GRIEVANCE AND COMPLAINT

a) All patient complaints involving Members of the Medical Staff shall be referred to the Vice President of Medical Affairs, or the President of the Medical Staff or his designee. Discussion may be held with the individuals and with the Chief of the Department involved and a report may be made to the Executive Committee of the Medical Staff. If there is indication that possible corrective action should be considered, the investigation will proceed according to Article V of the Medical Staff Bylaws.

b) All disagreements or complaints of Medical Staff Members with established departmental policies and procedures shall be resolved, if possible, by consultation with the Chief of the Department and Complainant. Failing this, the matter shall be brought to the Executive Committee of the Medical Staff.

c) All patient or Medical Staff Member complaints or disagreements concerning activities of Hospital Personnel related to medical care not included above, or policies, or procedures should be resolved through consultation with appropriate Hospital Departmental Heads and Administrative Personnel. Failing resolution, these complaints or disagreements may be brought to the Executive Committee of the Medical Staff.

d) Complaints not related to medical care may be referred to the Administration for resolution.

S. PRACTITIONER CODE OF CONDUCT

It is the expectation of the Governing Body and of the Medical Executive Committee that the Hospital professional environment be one of mutual respect, fostering interactions among Practitioners, professional and support staff, and patients which are courteous, professional and free from behaviors which are intimidating, demeaning, disruptive to patient care, or which otherwise contribute to a hostile work environment (“Disruptive Behaviors”). The specific purposes of this Code of Conduct are:

1) To promote quality patient care by encouraging a safe, cooperative and professional environment for patients, Practitioners, and staff at the Hospital.

2) To prevent and eliminate, to the extent possible, Disruptive Behaviors.

3) To provide a procedural framework for resolving allegations of Disruptive Behaviors brought against any Practitioner.

It is the policy of the Medical Staff that Disruptive Behaviors will not be tolerated.
**Definition:** Disruptive Behavior may include, but is not limited to:

a.) Any verbal or physical intimidation or attack, including shouting, berating, or hanging up the telephone or other communication of an inappropriate nature that is aimed at other members of the Hospital community, including other Practitioners, Hospital Staff, patients, visitors, families or volunteers.

b.) Any inappropriate written or verbal comment or communication which impugns the integrity or quality of services rendered by other Practitioners or Hospital employees.

c.) Sexual harassment, which shall mean sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when (i) submission to or rejection of such advances, requests or conduct may impact the employment prospects, advancement, or job functions of the individual to whom such advances are made, or (ii) such advances, requests or conduct that have the purpose or effect of unreasonably interfering with an individual’s work performance by creating an intimidating, hostile, humiliating, or sexually offensive work environment.

d.) Throwing objects or otherwise intentionally causing damage or destruction to Hospital property.

**Procedure:**

Allegations concerning Disruptive Behavior by a Practitioner may be made by other Practitioners, patients or their families, or any Hospital employee, must be in writing, must include a specific description of the events giving rise to the allegations and shall be sent to the President or Vice President of the Medical Staff. A Physician Health Committee is available to provide a confidential, non-disciplinary, educational, preventative and responsible manner for dealing with matters of physician health and Licensed Independent Practitioner Health. Please refer to the Physician Health Committee Policy of the Medical Staff. The President or Vice President, as the case may be, may choose to resolve the allegations informally, (for example through investigation and discussion with the Practitioner against whom the allegation is being brought, or may choose to request Corrective Action pursuant to Article V of the Bylaws of the Medical Staff. Nothing in this Section shall preclude any Member of the Medical Staff, the Governing Body or the President of the Hospital from requesting Correction Action pursuant to Article V of the Bylaws of the Medical Staff arising out of an allegation of Disruptive Behavior. If such a request is made, an investigation and resolution of the allegations shall occur in accordance with the provisions of Article V.

**T. PROCTORING**

Proctoring will be in accordance with the policies established and approved by the Executive Committee.

**U. DEPARTMENT MEETING REQUIREMENTS**

Members of the Active staff and Refer and Follow Active Staff must attend 1/3 of department meetings or greater as determined by the individual Department Chiefs. Non-compliance will result in a change of staff category from Active to Associate or Refer and Follow Associate status at the time of reappointment. Attendance at meetings may be achieved in person or via participation by means of conference telephone,
videoconferencing or any other means by which all persons participating in the meeting can hear each other at the same time.

V. CONFIDENTIALITY POLICY

In accordance with Massachusetts's law and the Health Insurance Portability and Accountability Act (HIPAA), and the declaration of patients' rights by the Hospital, patients are guaranteed certain rights regarding their treatment at our facilities. One of these is the right, "to confidentiality of all records and communications ... to privacy during medical treatment or other rendering of care."

The Hospital's Patient/Management Information System provides a very useful tool to enhance our abilities to serve our patients. However, use of the Hospital Information System is for the furtherance of patient care and administrative activities. Members of the Medical Staff may only access that information which is necessary for patient care, QA review or for appropriate administrative reasons consistent with the Hospital’s HIPAA privacy policies, a copy of which is available in the Medical Staff Office. They must not access the system for the purpose of curiosity or to obtain information on behalf of another. Inappropriate use of the Hospital Information System is inconsistent with our obligation to protect the confidentiality of our patients, and will therefore subject members of the Medical Staff to disciplinary action and to civil liability for violations of law.

The Medical Staff should be aware that periodic audits are conducted to review who accesses clinical information, the duration of access and the detail, which is accessed. This audit is done electronically and will therefore reveal when someone has viewed the information inappropriately.

Use of the facsimile machine

The Medical Staff should be wary of the use of fax machines for the transmission of patient and other confidential information. While the use of these devices has hastened our delivery of certain patient care services, it is not without risk. Before transmitting confidential information, the Medical Staff has the responsibility to ascertain the location of the receiver and whether or not others may have unnecessary access to the fax.

Reporting violations

All hospital staff and employees are responsible for following hospital procedures and policies for protecting the confidentiality of clinical information. If, in the course of performing his or her duties an employee identifies any circumstances, which appear to violate the norms of the hospital's confidentiality policy by a member of the Medical Staff, it is the employee's responsibility to promptly notify a Senior Manager. The Senior Manager will convey the information to the President of the Medical Staff or Vice President of Medical Affairs.

W. Professional Practice Evaluation

a. Focused Professional Practice Evaluation (FPPE)
Focused Professional Practice Evaluation (FPPE) provides a standardized process for initial evaluation of all practitioners during the time from initial appointment to reappointment, when new/additional privileges are requested and when a documented concern regarding competence exists. The process identifies what data will be reviewed, how often the data will be reviewed, how decisions concerning continuing, limiting or revoking privileges will be made and how this information will be included in an individual practitioner’s credentialing/quality file.

**Selection and Approval of FPPE Indicators**

The Department or Division Chief, in conjunction with the Performance Improvement Department will review the specific data and indicators to be collected and analyzed on an annual basis. The Department/Division Chief will present this information to their Department/Division for approval. Following approval by the Department/Division, these data elements and indicators will be presented to the Medical Executive Committee for approval. Data elements may include but not be limited to:

- Rate Based Indicators
- Rule Based Indicators
- Incident Reports
- Volume Data
- Complication Rates
- Benchmark Data

**Frequency of Focused Professional Practice Evaluation**

An FPPE report will be prepared by the Performance Improvement Department after 10 months for all practitioners who are new members of the Medical Staff and all practitioners requesting new/additional privileges, using the data elements that have been approved for each Department/Division. When there is a question of competence, the FPPE evaluation, including an External Review if indicated, will be conducted in accordance with Article V of the Medical Staff Bylaws.

**Use of the Focused Professional Practice Evaluation Data**

Upon review of the FPPE report for each individual practitioner, the Department/Division Chair will complete an evaluation that addresses:

- Patient Care
- Medical/Clinical Knowledge
- Practice Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems based Practice

The Department/Division Chair will review this individual data with each member of their Department/Division. The Department/Division Chair will recommend continuation of privileges, limitation of privileges or revocation of privileges.

If the recommendation is to continue privileges, no further action is required. If the decision is to limit or revoke privileges, the process will be followed according to Article V of the Medical Staff Bylaws (Corrective Action).
The individual FPPE report and evaluation form will be presented to the Credentials Committee and the Medical Executive Committee for their approval.

A copy of the FPPE report and evaluation form will be kept in the individual practitioner’s Quality/Credentialing file.

Peer Review

The intent of this data is for Peer Review and Continuous Performance Improvement. As such, this information is confidential and not available for court subpoenas in accordance with Massachusetts Revised Code Sections and Massachusetts case law.

b. Ongoing Professional Practice Evaluation (OPPE)

Ongoing Professional Practice Evaluation (OPPE) provides a standardized process for continuous evaluation of all practitioners during the time from initial appointment to reappointment and from reappointment to the next reappointment. The process identifies what data will be reviewed, how often the data will be reviewed, how decisions concerning continuing, limiting or revoking privileges will be made and how this information will be included in an individual practitioner’s credentialing/quality file.

Selection and Approval of OPPE Indicators

The Department or Division Chief, in conjunction with the Performance Improvement Department will review the specific data and indicators to be collected and analyzed on an annual basis. The Department/Division Chief will present this information to their Department/Division for approval. Following approval by the Department/Division, these data elements and indicators will be presented to the Medical Executive Committee for approval. Data elements may include but not be limited to:

- Rate Based Indicators
- Rule Based Indicators
- Incident Reports
- Volume Data
- Complication Rates
- Benchmark Data

Frequency of Ongoing Professional Practice Evaluation

An OPPE report will be prepared by the Performance Improvement Department every 10 months for all practitioners, using the data elements that have been approved for each Department/Division.

Use of the Ongoing Professional Practice Evaluation Data

Upon review of the OPPE report for each individual practitioner, the Department/Division Chair will complete an evaluation that addresses:

- Patient Care
- Medical/Clinical Knowledge
- Practice Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems based Practice
The Department/Division Chair will review this individual data with each member of their Department/Division. The Department/Division Chair will recommend continuation of privileges, limitation of privileges or revocation of privileges.

If the recommendation is to continue privileges, no further action is required. If the decision is to limit or revoke privileges, the process will be followed according to Article V of the Medical Staff Bylaws (Corrective Action).

The individual OPPE report and evaluation form will be presented to the Credentials Committee and the Medical Executive Committee for their approval.

A copy of the OPPE report and evaluation form will be kept in the individual practitioner’s Quality/Credentialing file.

Peer Review

The intent of this data is for Peer Review and Continuous Performance Improvement. As such, this information is confidential and not available for court subpoenas in accordance with Massachusetts Revised Code Sections and Massachusetts case law.

X. RULES AND REGULATIONS REVISIONS

a. The Bylaws Committee may make recommendations relating to revisions of the Rules and Regulations to the Executive Committee.

b. Upon recommendation of the Executive Committee, the revision(s) shall be forwarded to the Governing Body for approval and shall be effective when approved by the Governing Body.

Adopted by the Medical Staff on: January 21, 2014

_________________________________________
Medical Staff President

Approved by the Governing Body on: February 6, 2014

_________________________________________
Chairman, Governing Body

Effective Date: February 6, 2014
ADDENDUM A

CLINICAL DIVISIONS

Department of Medicine
Cardiology
Gastroenterology
Hospitalist Service
Nephrology
Neurology
Pulmonary Medicine

Department of Surgery
General Surgery
Ophthalmology
Otolaryngology
Plastic Surgery
Podiatry
Urology
Vascular Surgery

Department of Orthopedics
Podiatric Surgery