Medical Staff Bylaws

SMHC MEDICAL STAFF BYLAWS
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ARTICLE I – PREAMBLE

These Bylaws, Rules & Regulations, Associated Manuals, and policies are adopted, and periodically amended, to organize the Medical Staff of Southern Maine Health Care and to provide a framework for the Medical Staff to discharge the responsibilities delegated to it by the Board of Trustees for the quality of medical care at the hospital. All members of the organized Medical Staff shall agree to comply with the Medical Staff Bylaws, Rules & Regulations, Associated Manuals, and policies. Adoption or amendment of these Bylaws cannot be delegated. After adoption or amendment by the organized Medical Staff, the proposed Bylaws are submitted to the Board for action. Bylaws become effective only after governing Board approval; the Board will uphold these Bylaws, Rules & Regulations, Associated Manuals, and policies.

The organized Medical Staff will enforce the Medical Staff Bylaws, Rules & Regulations, Associated Manuals, and policies by recommending action to the governing Board in certain circumstances, and taking action in others, as described in these Bylaws.

The Medical Staff of the Southern Maine Health Care (SMHC) is established by the hospital Board to assist the hospital in meeting its mission and to carry out duties assigned to it by the Board in order to enhance the quality and safety of care, treatment, and services provided to patients.

ARTICLE II: MEDICAL STAFF MEMBERSHIP

2-1 ELIGIBILITY AND QUALIFICATION FOR MEMBERSHIP

Membership on the Medical Staff is a privilege granted only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws and Associated Manuals, and in Medical Staff and hospital rules, regulations, and policies.

To be eligible for initial appointment or reappointment to the Medical Staff of SMHC, applicants must hold a license in the state of Maine as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (DPM), Oral Surgeon (DMD or DDS) or Dentist (DMD or DDS).

Applicants to the Medical Staff have the burden of documenting to the satisfaction of the Board that they will contribute to meeting the mission of the hospital and have the ability to do so competently, safely, and collaboratively by providing requested information on their:

1. Background
2. Clinical experience
3. Education and training
4. Clinical judgment
5. Demonstrated current professional competence
6. Individual character and ability to work with others collaboratively

7. Physical and mental capabilities and ability to safely and competently exercise any clinical privileges requested
8. Intended practice plans, and
9. Adherence to the ethics of their profession.

Specifically, practitioners wishing to be on the Medical Staff and/or hold privileges must:

1. Have a current, unrestricted license to practice in Maine;
2. Where applicable to their practice, have a current, unrestricted DEA registration;
3. Have current valid professional liability insurance coverage issued by a carrier licensed by the state of Maine, in a form and in amounts satisfactory to the Board;
4. Have successfully completed an ACGME- or AOA-approved residency training program, a DDS or DMD post-graduate training program approved by the American Dental Association's Commission on Dental Accreditation, or a residency program approved by the Council on Podiatric Medical Education (CPME);
5. Have an active practice with the capability to provide timely and continuous care for their patients;
6. Be eligible to participate in Medicare, Medicaid, or other federal or state payer programs;
7. Disclose any conviction, plea of guilty, or no contest to any felony, and/or misdemeanor relating to controlled substances, alcohol, illegal drugs, insurance or health care fraud or abuse, or violence;
8. Not be seeking clinical privileges to treat patients or conditions for which the hospital lacks necessary equipment, facilities, or other resources, or for which there is no need based on the hospital's strategic or Medical Staff development plans;
9. Be able to demonstrate the ability to work cooperatively with others and to treat patients, staff and colleagues in a respectful and professional manner at all times;
10. Be able to demonstrate that they have no health issues which would compromise their ability to perform requested privileges safely;
11. Be seeking clinical privileges that are not subject to an exclusive contract at the hospital unless the applicant is a party to that contract;
12. Agree to comply with the health screening and physical examination requirements of the hospital before exercising any privileges that may be granted by the Board;
13. Agree to comply with training and education protocols established by the Medical Staff and/or hospital (e.g., electronic medical record, patient safety); and
14. Demonstrate recent clinical activity in primary area of practice during the last two years.

In addition, all applicants for initial appointment to the Medical Staff must meet the criterion which applies to their qualifying degree or specialty:

A. If an MD or DO, certified by a specialty board approved by the American Board of Medical Specialties (ABMS), by the American Osteopathic Association (AOA), or any similar foreign specialty board approved by the hospital Board that conducts comparable reviews of residency

or fellowship training with examination to achieve certification. A physician who is qualified to sit for the certifying examination by their specialty board is required to be board certified within the time frame established by the ABMS or AOA for the appropriate specialty board.

B. A podiatrist, who is certified or qualified to sit for the certifying examination administered by the American Board of Medical Specialties in Podiatry or the American Board of Podiatric Surgery must be board certified by one of these boards and is required to be board certified within the time frame period established by their respective board
C. An oral surgeon who is certified or qualified to sit for the certifying examination administered by the American Board of Oral and Maxillofacial Surgery, as recognized by the American Dental Association, must be board certified within the time frame established by their respective board.

Practitioners who were granted initial Medical Staff membership and privileges at Southern Maine Medical Center (SMMC) after September, 1996 or Goodall Hospital (GH) after May, 2001 must meet the following recertification or maintenance of certification requirements of at least one specialty board, where applicable. If a Medical Staff member was considered exempt at SMMC or Goodall Hospital he/she will be considered exempt under these Bylaws. Exemption for any one member does not imply an exemption for all.

A. A MD or DO who is currently board certified is required to maintain board certification by an ABMS or AOA specialty board. A physician applying for reappointment who is not board certified must become certified within the time frame established by their respective board. A physician who has failed to obtain or maintain board certification shall not be eligible to apply for reappointment.
B. Podiatrists and oral surgeons applying for reappointment shall maintain board certification by an appropriate specialty board (the American Podiatric Medical Specialties Board, the American Board of Podiatric Surgery, American Board of Oral and Maxillofacial Surgery, or American Dental Association). A podiatrist or oral surgeon who has failed to obtain or maintain board certification shall not be eligible to apply for reappointment.

Additional membership and privileging requirements, which are considered associated details, can be found in the Medical Staff Credentials Manual or in the Medical Staff delineation of privilege forms. The qualifications for membership must be documented by applicants with sufficient adequacy to satisfy the Medical Staff and Board that each has enough information to make a fully informed decision regarding appointment and the assignment of privileges.

No professional may be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the hospital merely by virtue of licensure to practice in Maine or any other state, membership in any professional organization, privileges at another hospital, or the demonstration of clinical competence.

The Board, after consultation with the Medical Executive Committee (MEC), may make exceptions or additions to any of the above qualifications and requirements.

2-2 NON-DISCRIMINATION

The hospital will not discriminate in granting Medical Staff membership and/or clinical privileges on the basis of gender, gender identity, sexual orientation, race, religion, age, national origin, disability, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

2-3 RESPONSIBILITIES OF MEMBERSHIP

Each member of the Medical Staff must continuously comply with the provisions of these Bylaws, Medical Staff and hospital manuals, rules, regulations, and policies. Members must:

1. Provide for the appropriate, continuous, and timely care to all patients for whom the practitioner has responsibility;
2. Provide, with or without request, new and updated information to the hospital as it occurs, pertinent to any question found on the initial application or reappointment forms;
3. Appear for personal interviews (in person or by teleconference) in regard to an application for initial appointment or reappointment as requested by the hospital;
4. Refrain from illegal fee splitting or other illegal inducements relating to patient referrals;
5. Refrain from deceiving patients as to the identity of any individual providing treatment or services;
6. Seek consultation whenever necessary to assure adequate quality of care;
7. Complete in a timely manner all medical and other required records, inputting all information required by the hospital;
8. Satisfy continuing medical education requirements for licensure and as may be required under policies adopted from time to time by the Medical Staff;
9. Supervise the work of any Advanced Practice Provider under his/her direction;
10. Assist other practitioners in the care of their patients when asked, in order to meet an urgent patient need or assure the well-being of a patient;
11. Treat employees, patients, visitors, and other physicians and professionals in a dignified and courteous manner at all times.

Furthermore, each member of the Medical Staff, by accepting Medical Staff appointment, agrees:

12. To abide by these Bylaws and associated manuals, Medical Staff policies, rules and regulations, and hospital policies and procedures;
13. That if there is any material misstatement in, or material omission from, an application for appointment or reappointment, the hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed by the Board to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal;

14. To participate in and collaborate with the peer review, risk management and performance improvement activities of the Medical Staff and hospital. These include monitoring and evaluation tasks performed as part of the Medical Staff and hospital efforts to meet quality standards such as those established by the Joint Commission, the Centers for Medicare and Medicaid Services (CMS), and other governmental agencies and private insurers;
15. To assist the hospital in fulfilling its responsibilities for providing emergency and charitable care in accordance with policies passed by the MEC and Board;
16. To provide patient care and management only within the parameters of his or her professional competence, as reflected in the scope of clinical privileges granted the practitioner by the Board;
17. To undergo any type of health evaluation, including 'for cause' drug testing, as requested by the officers of the Medical Staff, Chief Executive Officer (CEO), Chief Medical Officer (CMO), and/or MEC when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or Credentials Committee as part of an evaluation of the member's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and hospital policies addressing physician health or impairment;
18. To participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate that member's clinical privileges;
19. To hold harmless and agree to refrain from legal action against any individual, the Medical Staff, or hospital that appropriately shares peer review and performance information with a legitimate health care entity or state medical board assessing the credentials of the member;
20. To abide by any applicable codes of conduct adopted by the Medical Staff and/or hospital;
21. To abide by all local, state and federal laws and regulations, Joint Commission standards, and state licensure and professional review regulations and standards, as applicable to the practitioner's professional practice;
22. To maintain confidentiality according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and;
23. To maintain the capability for email communication with the hospital and members of the Medical Staff;
24. To utilize any electronic health record tools implemented by the hospital for use with hospitalized patients; and
25. To provide patients with a quality of care that meets at all times the professional standards and requirements of the Medical Staff and hospital.

ARTICLE III: CATEGORIES OF MEDICAL STAFF MEMBERSHIP

The Medical Staff shall be divided into the following categories: Active and Affiliate; the category status for each practitioner will be recommended by the MEC at appointment or reappointment and ratified by the Board, which will have ultimate discretion to assign each applicant to a staff category.

3-1 ACTIVE STAFF

3-1.1 Qualifications

Appointees to this category must:

Be in active practice within the hospital's service area and have a level of involvement in Medical Staff affairs, as determined by the MEC, to be sufficient to contribute to the governance of the Medical Staff. In general, those whose primary hospital affiliation is, or will be, SMHC, are candidates for the Active Staff. The MEC shall have the discretion to determine whether initial applicants would be expected to fulfill the requirements for Active Staff category and may, at any time, reconsider that decision. At any time, category status may be reevaluated by request of the Medical Staff member. Locum tenens practitioners and those who deliver their services via "Telemedicine" will not be eligible for appointment to the Active Staff. All privileged providers must participate in and cooperate with the peer review, quality monitoring and performance improvement activities of the Medical Staff and hospital in a manner determined from time to time by the MEC.

3-1.2 Prerogatives

Appointees to this category may:

A. Exercise those clinical privileges granted by the Board.
B. Vote on all matters presented at general and special meetings of the Medical Staff, and at meetings of committees to which he/she is appointed.
C. Hold office and sit on or be the Chair of any committee, unless otherwise specified elsewhere in these Bylaws.

3-1.3 Responsibilities

Appointees to this category must:

A. If granted clinical privileges by the Board, have sufficient patient encounters [defined as an admission, consultation, or procedure] per year as defined in the hospital's OPPE/FPPE policy, or provide quality data from another facility, acceptable to the Quality and Credentials Committees, that demonstrates current clinical competence. Those who do not have sufficient patient encounters or fail to provide acceptable quality data within the proscribed time frame, will be administratively changed to the Active Without Privileges category; see Section 3-3.
B. Meet the basic responsibilities of Medical Staff membership as defined in Section 2-3, above, and contribute to the organizational and administrative affairs of the Medical Staff.
C. Actively participate in recognized functions of staff appointment, including performance improvement, peer review, risk and utilization management, the monitoring of initial appointees, credentialing activities, medical records completion, and the discharge of other Medical Staff functions as may be required from time to time.
D. Comply with all applicable hospital and Medical Staff rules, regulations, manuals, policies and procedures.

E. Consistent with their granted clinical privileges, must participate in the on-call coverage of the Emergency Department, or in other hospital coverage programs, as determined by the MEC and the Board, after receiving input from the appropriate clinical specialty.
F. Perform such further duties as may be required under these Bylaws or Medical Staff policies, including any that may result from future changes in these documents.

3-2 AFFILIATE STAFF

3-2.1 Qualifications

Appointees to this category must:

A. If granted clinical privileges by the Board, have sufficient patient encounters [defined as an admission, consultation, or procedure] per year as defined in the hospital's OPPE/FPPE policy, or provide quality data from another facility, acceptable to the Quality and Credentials Committees, that demonstrates current clinical competence. Those who do not have sufficient patient encounters or fail to provide acceptable quality data within the proscribed time frame, will be administratively changed to the Affiliate Without Privileges category; see Section 3-3.
B. Be interested in the clinical affairs of the hospital and may hold privileges to actively manage or otherwise be involved in patient care and may refer and follow hospitalized patients. In general, members whose primary hospital affiliation are not, or will not be, SMHC are candidates for Affiliate Staff.
C. Engage in the active practice of medicine at some location, so that the Medical Staff and Board can assess the practitioner's compliance with membership and privileging requirements as stated under these Bylaws and Medical Staff policies. At each reappointment time, the Affiliate staff member may be asked to provide evidence of clinical performance at other hospitals or health care facilities where the member holds privileges. In addition, especially for those Affiliate Staff members who do not maintain appointment at another hospital, he or she shall provide other information as may be requested by the Medical Staff or Board in order to perform an appropriate evaluation of qualifications. Such information may include, but will not be limited to, data from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluations forms completed by referring/referred to physicians.

3-2.2 Prerogatives

Appointees to this category may:

A. Exercise those privileges granted by the Board.
B. Attend meetings of the Medical Staff in a non-voting capacity, except in committees to which the member is appointed. Affiliate members may attend all educational programs presented by the Medical Staff and/or hospital.
C. Not vote for officers nor serve as a Medical Staff officer, nor vote on Medical Staff Bylaws or other matters brought before the general Medical Staff.

3-2.3 Responsibilities

Appointees to this category must:

A. Meet the basic responsibilities of Medical Staff membership as defined in Section 2-3, above, and contribute to the organizational and administrative affairs of the Medical Staff.
B. Actively participate, when asked, in recognized functions of staff appointment, including performance improvement, peer review, risk and utilization management, the monitoring of initial appointees, credentialing activities, medical records completion, and the discharge other Medical Staff functions and obligations as may be required from time to time.
C. Comply with all applicable hospital and Medical Staff rules, regulations, manuals, policies and procedures.
D. Participate in providing Emergency Department call and other coverage arrangements as defined in policies adopted by the MEC and hospital Board.
E. Perform such further duties as may be required under these Bylaws or Medical Staff policies, including any that may result from future changes in these documents.

3-3 CHANGE IN STAFF CATEGORY

Pursuant to a request by the Medical Staff member and upon a recommendation by the Credentials Committee, or pursuant to its own action, the MEC may recommend a change in Medical Staff category of a member consistent with the requirements of these Bylaws. The Board shall approve any such change in category. Determinations regarding the assignment of staff category are not subject to review under the due process provisions of the Corrective Action and Fair Hearing section of these Bylaws.

3-4 LIMITATION OF PREROGATIVES

The prerogatives of Medical Staff membership set forth in these Bylaws are general in nature and may be subject to limitation or restriction by special conditions attached to a Medical Staff member's appointment, reappointment, and/or privileges, by state or federal law or regulations, by other provisions of these Bylaws, by other Medical Staff or hospital policies, or by commitment, contracts, or agreements of the hospital.

3-5 TEMPORARY CLINICAL PRIVILEGES

3-5.1 Circumstances

Temporary privileges shall be granted by the hospital CEO or designee, acting on behalf of the Board, and based on a recommendation by the President of the Medical Staff (or the Vice-President of the Medical Staff in the President's absence).

Temporary privileges may be granted to a practitioner for a limited time, up to 120 days. Temporary privileges may be granted to a practitioner who meets one of the following circumstances and the minimum criteria as defined below:

A. Pendency of a new application for Medical Staff membership and/or privileges: Temporary clinical privileges may be granted for new applicants for Medical or Advanced Practice Provider Staff membership and privileges, after positive recommendation by the Credentials Committee, provided the application is complete as defined by these Bylaws and the Medical & APP Credentialing Manual. Such temporary privileges will be valid until final action by the Board of Trustees, but not more than 120 days.

B. To fulfill an important patient care, treatment, and/or service need: In special circumstances, an appropriately licensed practitioner of documented competence may be granted temporary privileges for the care of one or more specific patients. The following documentation is required for temporary privileges:

1. A complete application;
2. Unrestricted Maine state license;
3. Relevant training and/or experience;
4. Current competence;
5. Ability to perform the privileges requested;
6. Other criteria required by the Medical Staff Bylaws (see Article IX)
7. No current or previously successful challenge to licensure or registration;
8. No subjection to involuntary termination of Medical Staff membership at another organization;
9. No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges;
10. Unrestricted DEA;
11. Current and verifiable professional liability insurance coverage issued by a carrier licensed by the State of Maine, in a form and amounts satisfactory to the Board;
12. Current standing from primary practicing facility, if applicable;
13. A query to and evaluation of National Practitioner Data Bank (NPDB) information; and
14. A written or verbal reference that establishes current competency.

C. Disaster Privileges: Disaster privileges may be assigned to individuals in accordance with the hospital policies on disasters and the associated credentialing and privileging details enumerated in the Medical Staff Credentials Manual.

3-5.2 Conditions

Before temporary privileges are granted, the practitioner must first acknowledge in writing that he/she has received and read copies of the Medical Staff Bylaws and all other Medical Staff and hospital

policies relevant to his/her performance of temporary privileges, and that he/she agrees to be bound by them.

3-5.3 Termination

On discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's professional qualification or ability to safely exercise any or all of the temporary privileges granted, the hospital CEO or the Medical Staff President may terminate any or all of such practitioner's temporary privileges, subject to the ultimate approval of the hospital Board. Where the life and well-being of a patient is determined to be endangered by continued treatment by a practitioner exercising temporary privileges, the termination may be effected by any person entitled to impose precautionary suspensions under the Bylaws. In the event of such termination, the patients of such practitioner then in the hospital shall be assigned to another practitioner by the President or his/her designee. Where feasible, the wishes of the patient shall be considered in choosing a substitute practitioner.

3-5.4 Procedural Rights

A practitioner shall not be entitled to procedural rights because of the denial of any request for temporary privileges, or because of any termination or suspension of temporary privileges, whether in whole or in part, unless based on a determination of demonstrated incompetence or unprofessional conduct.

ARTICLE IV: MEDICAL STAFF MEMBER RIGHTS

Members appointed to the Medical Staff shall have the following rights, in addition to the procedural due process rights enumerated in the Corrective Action and Fair Hearing section of these Bylaws:

4-1 AUDIENCE WITH MEC

Each member of the Medical Staff in the Active Staff category has the right to an audience with the MEC on matters relevant to the responsibilities of the MEC. In the event that such member is unable to resolve a matter of concern after discussion with the appropriate committee chair or other appropriate Medical Staff leader(s), that member may, upon written notice to the President of the Medical Staff, at least two weeks in advance of a regular meeting of the MEC, meet with the MEC or a subcommittee of the MEC to discuss the issue. The chair of the MEC will have discretion regarding the timing and placement of the issue on the MEC or subcommittee agenda.

4-2 INITIATE RECALL VOTE

Each member of the Active Medical Staff has the right to initiate a recall vote of Medical Staff officers or MEC members in accordance with the recall provisions provided in these Bylaws.

4-3 CALL SPECIAL MEDICAL STAFF MEETING

Each member in the Active Medical Staff category has a right to call a special meeting of the general Medical Staff to discuss a matter relevant to the Medical Staff if he believes the MEC has not acted on the matter satisfactorily. Upon presentation by the member of a petition signed by twenty percent (20%) of members of the Active Staff category, the President shall schedule a special meeting of the Medical Staff in a timely manner for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted at this meeting, and by majority vote, those in attendance may authorize a vote of the Medical Staff to resolve the issue(s) raised at the meeting. Such vote will be conducted through mail or electronic ballot sent to all members of the Medical Staff in the Active Staff category and a policy or action must receive the affirmative votes of at least fifty percent (50%) of the Active Medical Staff members to prevail. Votes not cast will not be considered. Decisions reached by such votes of the Medical Staff will override inconsistent decisions made by the MEC.

4-4 CHALLENGE RULES, REGULATIONS, OR POLICIES

Each member of the Medical Staff in the active category may raise a challenge to any rule, regulation, or policy established by the MEC. If presented by such member with a petition signed by twenty percent (20%) of the active members of the Medical Staff, the MEC will do one of the following:

A. Provide the petitioners with information clarifying the intent of such rule, regulation, or policy and the justifications for its adoption; and/or
B. Schedule a meeting with the petitioners to discuss the issues raised with regard to the rule, regulation, or policy.

4-5 APPLICABILITY OF 4-1 THROUGH 4-4

The above sections on Member Rights (4-1 through 4-4) do not pertain to issues involving individual peer review or performance evaluation (including focused and ongoing professional practice evaluation), formal Investigations of professional performance or conduct, denial of requests for appointment or privileges, restriction or conditions placed on appointment or privileges, or any other matter relating to individual membership or privileges. Recourse with regard to these matters is described in the Corrective Action and Fair Hearing section of these Bylaws. The rights enumerated in 4-1 through 4-4 serve to address conflicts which may arise within the Medical Staff between the MEC and Medical Staff members.

ARTICLE V: COLLEGIAL INTERVENTION AND INVESTIGATION

5-1 COLLEGIAL INTERVENTION

These Bylaws encourage Medical Staff leaders and hospital management to use progressive steps, beginning with collegial and education efforts, to address questions related to a practitioner's clinical

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

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

Following collegial intervention efforts, if the practitioner's performance and/or conduct remain unsatisfactory, the MEC will authorize an investigation (see 5-2) to determine whether sufficient evidence exists to support a recommendation to the Board that the practitioner's membership and/or privileges be restricted or revoked.

5-2 CRITERIA FOR INITIATION OF INVESTIGATION

While the collegial intervention is preferred, a formal investigation can be initiated as outlined below. Any person or committee may provide information to any member of the Medical Executive Committee (MEC) or other Medical Staff leader about the conduct, performance, or competence of medical staff members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct, reasonably likely to be:

A. Detrimental to patient safety or to the delivery of quality patient care within the Hospital;
B. Unethical or illegal;
C. Contrary to the Medical Staff Bylaws and its associated manuals, Hospital or Medical Staff rules, regulations, and/or policies;
D. Harassing or intimidating to staff, colleagues, patients or their families;
E. Disruptive of hospital or Medical Staff operations;
F. Below applicable professional standards as established or determined by the Medical Staff; or
G. A misrepresentation, falsification, or significant omission of information requested as part of the hospital's credentialing and peer review processes.

A request for an investigation or action against such member may be initiated by the Medical Staff President, MEC, CMO or designee, or CEO. The purpose of an investigation is to determine if an MEC recommendation to the Board for corrective action is warranted or to determine what additional information should be gathered prior to making such a recommendation. Routine peer review and performance monitoring (e.g. focused and ongoing professional practice evaluation) will not be considered "investigations" as described in this Article.

5-3 INITIATION

A request for an investigation must be submitted by one of the above parties to the MEC and supported by reference to the specific activities, concerns or conduct alleged to warrant the Investigation. If the MEC authorizes the investigation, it shall make a record of this action in its official minutes. An investigation will be automatically initiated by the MEC whenever it affirms that a practitioner should be subject to a summary or disciplinary suspension of privileges or membership as described in Article VI of these Bylaws.

5-4 PROCEDURE

If the MEC concludes an investigation is warranted, it shall direct an investigation to be undertaken. In the event the Board believes the MEC has incorrectly determined an investigation unnecessary, it may direct the MEC to proceed with an investigation. The MEC may conduct the investigation itself, or may assign the task to an appropriate Medical Staff officer, standing or ad hoc committee of the Medical Staff, or engage an external peer review consultant to carry out the task. Strong consideration should be given to use of external peer review if any of the following circumstances is present:

A. The MEC is presented with ambiguous or conflicting recommendations from Medical Staff reviewers or committees, or where there does not appear to be a strong consensus for a particular recommendation;
B. There is a reasonable probability that litigation may result in response to an MEC recommendation regarding the practitioner under review;
C. There is no one on the Medical Staff with expertise in the subject under review, or when the only practitioners on the Medical Staff with the requisite expertise are direct competitors, partners, or associates of the practitioner under review.

If the investigation is delegated to an individual or entity other than the MEC, the investigation shall proceed in a prompt manner and a written report of the investigation findings will be submitted to the MEC as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that the investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons knowledgeable about the practitioner under review, however, such

investigation shall not constitute a "hearing" as that term is used in this Corrective Action and Fair Hearing section of these Bylaws, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action it feels may be warranted by the circumstances to protect the hospital, its staff and its patients, including suspension or limitations on the exercise of privileges.

5-5 COMPLETION OF INVESTIGATION

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

5-6 REPORTING TO THE NATIONAL DATA BANK (NPDB) AND REGULATORY AGENCIES

If the practitioner under investigation resigns membership or privileges while the investigation is underway, or if the practitioner resigns membership or privileges in order to avoid an investigation, the MEC will inform the Medical Staff Office and a report will be made in accordance with the requirements governing such reporting to the National Practitioner Data Bank (NPDB). Reports regarding investigations and corrective actions will be made to state regulatory agencies as required under state regulations and statutes.

5-7 MEDICAL EXECUTIVE COMMITTEE ACTION

The MEC shall authorize a record of the investigation be placed in the practitioner's medical staff peer review file along with any actions the MEC undertakes as a result. As soon as practicable after the conclusion of the investigation, the MEC shall take action that may include, without limitation:

A. Determining no corrective action be taken.

B. Deferring action if the MEC believes more information is needed. However, such deferral should be consistent with the timelines described in Section 5.5, above.

C. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude Medical Staff or hospital leaders from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued,

the affected practitioner may make a written response, which shall be placed in the practitioner's Medical Staff peer review file.

D. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions and co-management of patients, mandatory consultation, or monitoring.

E. Recommending denial, restriction, modification, reduction, suspension or revocation of clinical privileges.

F. Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care.

G. Recommending suspension, revocation, or probation of Medical Staff membership.

H. Taking other actions deemed appropriate under the circumstances.

ARTICLE VI: IMPOSITION OF SUMMARY OR DISCIPLINARY SUSPENSION OF PRIVILEGES OR MEMBERSHIP

6-1 AUTHORITY TO SUSPEND PRIVILEGES

The President of the Medical Staff, the Chair of the Credentials Committee, Chief Medical Officer (or designee), the CEO, or the Board shall each have the authority to suspend all or any portion of the clinical privileges of a Medical Staff appointee or practitioner holding privileges whenever he/she perceives a reasonable possibility that failure to do so may pose danger to the health and/or safety of any individual or to the orderly operations of the hospital. Such suspension shall be deemed an interim action and not a professional review action. It shall not imply a final finding of responsibility for the situation that caused the suspension. Unless otherwise indicated, this suspension will take place immediately and the Chief Medical Officer (or designee), CEO, Board Chair, and the affected practitioner will be promptly informed. The imposition of the suspension will be affirmed by the MEC as soon as practicable, but in no more than 10 (ten) days.

Suspension undertaken to protect the well-being of patients are considered precautionary in nature and will be described as 'summary suspensions'.

6-2 ASSIGNMENT OF PATIENTS

Where any or all of the privileges of a Medical Staff member or practitioner are terminated, revoked, or restricted, such that she/he can no longer treat all or some of his/her patients at the hospital for any period of time, such patients who are then in the hospital shall be assigned for the period of such termination, revocation, or restriction to another practitioner by the Medical Staff President or

designee. Where feasible, the wishes of the patient shall be considered in choosing a substitute practitioner.

6-3 INTERVIEW

When a practitioner has had privileges or membership status temporarily suspended, the practitioner will be afforded an interview with the MEC if so requested. The interview shall not constitute a hearing, shall be informal in nature, and shall not be conducted according to the procedural rules provided with respect to hearings under these Bylaws or the Corrective Action and Fair Hearing section of these Bylaws. Requests to meet with the MEC must be made within five (5) business days of notification of the summary suspension of privileges and/or membership. The request must be made in writing and delivered to the President of the Medical Staff or designee within the designated timeframe. Meeting with the MEC will be scheduled as soon as practicable after imposition of the suspension.

6-4 MEDICAL EXECUTIVE COMMITTEE ACTION

No more than fourteen (14) days after the imposition of a summary suspension, the MEC shall recommend to the Board whether the suspension should be modified, continued or terminated, including whether further corrective action should be taken, or whether there is a need for further investigation. Unless the summary suspension was imposed by action of the Board, such recommended action by the MEC shall take immediate effect and remain in effect pending a final decision by the Board. The MEC shall give special notice to the affected Medical Staff member of its recommendations as soon as possible or within five (5) days of the adoption of such recommendation.

6-5 PROCEDURAL RIGHTS OF PRACTITIONERS SUBJECT TO SUMMARY SUSPENSION

Whenever a practitioner has been suspended for unprofessional conduct or concerns about clinical competence for more than fourteen days, or when the MEC makes a recommendation for suspension of more than fourteen days, the practitioner will be entitled to request a fair hearing as described these Bylaws and the Corrective Action & Fair Hearing section of these Bylaws.

6-6 DISCIPLINARY SUSPENSION

The MEC may, with approval of the Hospital CEO and the Chair of the Board or designees, institute one or more disciplinary suspensions of a practitioner for a cumulative period up to, but not to exceed, fourteen (14) consecutive days in a calendar year. A disciplinary suspension may be instituted under the following circumstances:

A. When the action that has given rise to the suspension relates to non-compliance with a Medical Staff or hospital policy on professional conduct; and,

B. When the affected practitioner is provided an opportunity to meet with the MEC as soon as practicable following the suspension to explain his/her noncompliance with expected professional conduct. Failure on the part of the practitioner to accept the MEC request of a meeting will constitute a violation of the Medical Staff Bylaws regarding "special meetings" described in Article XII, Section 12-1.9.

ARTICLE VII: AUTOMATIC SUSPENSION, LIMITATION, OR VOLUNTARY RELINQUISHMENT OR RESIGNATION OF MEDICAL STAFF MEMBERSHIP AND/OR PRIVILEGES

This article addresses automatic suspensions and limitations on membership and privileges and voluntary resignations/relinquishments of membership and privileges when these occur for administrative reasons relating to failure to meet eligibility requirements of membership or comply with additional requirements for membership or privileges found in the Medical Staff Bylaws and Medical Staff Manuals. These are not considered professional review actions, are not based on determinations of competence or unprofessional conduct, are not reportable to the National Practitioner Data Bank (NPDB), and do not entitle the member to the hearing or appeal procedures provided under the Medical Staff Bylaws and the Corrective Action & Fair Hearing section of these Bylaws.

7-1 REVOCATION OR SUSPENSION OF LICENSE

A Medical Staff member or practitioner with privileges whose license, certification, or other legal credential authorizing practice in the State of Maine is suspended shall be immediately suspended from practicing in the hospital pending final resolution and outcome by the licensing agency. During this time the practitioner will be considered ineligible for Medical Staff membership or privileges and will not be entitled to the procedural due process rights provided in the Bylaws and/or Corrective Action & Fair Hearing section of these Bylaws. If the licensing agency reinstates the practitioner without any limitations or conditions, the suspension will be lifted. If the licensing agency reinstates the practitioner's license with limitations or conditions, suspension will remain in effect pending an interview with the Credentials Committee and recommendation from the MEC for action by the Board.

If license, certification, or other legal credential authorizing clinical practice in the State of Maine is revoked, the practitioner shall immediately and automatically lose Medical Staff membership and/or privileges at the hospital. This will not be considered a professional review action, but an administrative action for noncompliance with the Medical Staff eligibility requirements for membership and/or privileges. The practitioner shall not be entitled to the procedural due process rights outlined in the Corrective Action & Fair Hearing Manual.

7-2 CONVICTION OF A FELONY OR MISDEMEANOR

A practitioner who has been charged with a felony or misdemeanor must report such charges to the MEC. A practitioner who has been convicted of, or entered a plea of guilty or no contest to a felony or

a significant misdemeanor such as those relating to controlled substances, illegal drugs, insurance or health fraud, or violence, will be immediately and automatically suspended from practicing in the hospital. Such suspension shall not entitle the affected Medical Staff member or practitioner with privileges to a hearing and the procedural rights in the Bylaws or the Corrective Action & Fair Hearing section of these Bylaws.

7-3 SUSPENSION FOR FAILURE TO COMPLETE MEDICAL RECORDS

A temporary suspension of privileges to admit new patients or to schedule new procedures shall be imposed for failure to complete medical records within the time periods established by the MEC. Such suspension shall not apply to patients already admitted or scheduled at the time of the suspension, to emergency patients, or to attendance at imminent deliveries. Temporary suspension shall be lifted upon completion of the delinquent records. The temporary suspension shall become an automatic permanent suspension for failure to complete all medical records within sixty calendar days. However, affected practitioners may request reinstatement during a period of thirty calendar days following permanent suspension if all delinquent records have been completed. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the Medical Staff and must reapply for membership and privileges.

7-4 FAILURE TO ATTEND SPECIALLY NOTICED MEETING WHEN REQUESTED

A practitioner who fails to appear at a meeting where his or her special appearance is required under the Medical Staff Bylaws shall automatically be suspended from exercising all clinical privileges unless he/she can establish good cause to the satisfaction of the President of the Medical Staff for missing the meeting. Failure to appear for a rescheduled meeting on more than one occasion shall be considered a voluntary resignation from the Medical Staff. Unless the practitioner was under formal investigation at time of this voluntary resignation, there will be no entitlement to the fair hearing and appeals procedures provided in these Bylaws and the Corrective Action & Fair Hearing section of these Bylaws.

7-5 REVOCATION OR SUSPENSION OF DEA NUMBER

A Medical Staff member whose Drug Enforcement Administration (DEA) number is revoked or suspended shall immediately and automatically be divested of his privilege to prescribe drugs covered by such number/license within the hospital. This is not a professional review action and the practitioner shall not be entitled to procedural due process as described in the Corrective Action & Fair Hearing section of these Bylaws. As soon as practicable, the MEC shall investigate the facts under which the staff member's DEA number was revoked or suspended, and may take further corrective action if indicated.

7-6 FAILURE TO MAINTAIN LIABILITY INSURANCE

A practitioner's Medical Staff appointment and/or privileges shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required by the Board. Affected practitioners may request reinstatement during a period of ninety calendar days following suspension upon presentation of proof of adequate insurance. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff and must reapply for Medical Staff membership and/or privileges.

7-7 EXCLUSION FROM FEDERAL OR STATE INSURANCE PROGRAMS OR CONVICTION FOR INSURANCE FRAUD

If a practitioner appears on the list of Excluded Individuals/Entities maintained by the HHS Office of Inspector General, or is excluded from any federal insurance programs, the practitioner shall be considered to have automatically resigned from Medical Staff membership and/or privileges. Similarly, any practitioner convicted of violations of the federal False Claims Act or of insurance fraud shall be considered to have automatically relinquished his/her Medical Staff membership and/or privileges.

7-8 FAILURE TO PARTICIPATE IN AN EVALUATION OR ASSESSMENT

A practitioner who fails or refuses to participate in an evaluation or assessment of his or her qualifications for Medical Staff membership and/or privileges as required under these Bylaws shall be automatically suspended. Such evaluations or assessments can be to determine clinical competence, physical fitness to exercise privileges or to evaluate the practitioner's behavioral/mental health and must be undertaken with professionals identified by or acceptable to the President of the Medical Staff or MEC. If, within thirty days of the suspension the practitioner agrees to and participates in the evaluation or assessment, the practitioner shall be reinstated. After thirty days, the practitioner will be deemed to have voluntarily resigned his or her Medical Staff membership and/or privileges.

7-9 FAILURE TO BECOME BOARD CERTIFIED OR TO MAINTAIN BOARD CERTIFICATION

Where applicable under the Medical Staff Bylaws, whenever a practitioner's time period in which to become board certified expires without achieving certification, that individual will not be eligible for reappointment of membership and/or privileges. Where applicable under these Bylaws, where a practitioner does not maintain board certification in at least one specialty, that individual will not be eligible for reappointment of membership and/or privileges. Such ineligibility may be waived at the discretion of the Board after consideration of the relevant quality and access implications.

7-10 FAILURE TO NOTIFY HOSPITAL OF DISCIPLINARY OR FINAL MALPRACTICE ACTIONS

A practitioner who knowingly fails to notify the President of the Medical Staff and the CEO in writing within ten (10) days of any of the following may be automatically suspended if:

A. His/her privileges in any hospital have been revoked or limited in any way;
B. Proceedings have been initiated to revoke or limit privileges in any way at another health care facility or institution;
C. A professional malpractice action has been resolved in an adverse outcome;
D. There is a change in his/her license (including any consent decrees or probation imposed by a state board of medicine) to practice medicine or prescribe drugs in any state;
E. He/she is removed from or not renewed as an insurance plan provider due to quality of care issues;
F. Any state or federal agency or agent commences a formal investigation involving the practitioner, or
G. He/she fails to notify the hospital of any action taken by any state Medical Board against the practitioner.

The suspension shall be lifted by the MEC when the practitioner provides adequate documentation to the MEC of the circumstances that triggered the suspension. Failure to provide this information in fourteen (14) days may be considered a voluntary resignation of Medical Staff membership and/or privileges.

7-11 FAILURE TO RETURN FROM A LEAVE OF ABSENCE

If a practitioner granted a leave of absence (LOA) does not request reinstatement or an extension before the LOA expires, he or she will be considered to have voluntarily resigned his or her Medical Staff membership and/or privileges as of the date he/she was to have returned.

ARTICLE VIII: CORRECTIVE ACTION & FAIR HEARINGS

It is the policy of the Medical Staff of Southern Maine Health Care (SMHC) to work collegially with its members to assist them in delivering safe and good quality medical care, to continually improve their clinical skills, to comply with Medical Staff and hospital policies, and to meet all performance expectations as established from time to time by the Medical Staff and hospital. These Medical Staff Bylaws, Medical Staff policies, including those on peer review, performance improvement, professional conduct, and physician health and impairment describe some of the collegial interventions available to Medical Staff leaders in working with colleagues whose clinical performance or professional conduct is problematic. The provisions of this Article describe the steps that the Medical Staff and hospital will undertake when such collegial efforts fail or are insufficient to protect the well-being of patients, staff, and colleagues, or to assure the effective and efficient operating of the hospital.

8-1 ADDITIONAL EXCEPTIONS TO HEARING RIGHTS

8-1.1 Impact of Exclusive Contracts

Privileges can be reduced or terminated as a result of a decision by the Board to limit the exercise of clinical privileges to practitioners engaged by the hospital under the terms of an exclusive contract. If

a practitioner holding privileges is not a party to such an exclusive contract, his or her privileges covered by the exclusive contract will automatically terminate as of the effective date of the exclusive contract. If the member of the Medical Staff so affected loses all privileges as a result of the implementation of an exclusive contract, he or she will be considered to have automatically relinquished membership on the Medical Staff. These actions are not considered professional review actions and are not based on a determination of incompetence or unprofessional conduct. There is no right to a hearing or appeal of the loss of privileges or membership resulting from implementation of an exclusive contract.

8-1.2 Impact of Privilege Eligibility Requirements or Closure of Services

Where a practitioner is not eligible to apply for, or must relinquish, a privilege because he/she does not meet, or no longer meets, the established criteria for that privilege as established by the MEC and Board, the practitioner will not be entitled to a hearing or appeal. Where a practitioner is not eligible to exercise a privilege in a particular location or on a particular service of the hospital because a Medical Staff or Board policy makes him/her ineligible to do so, the practitioner will not be entitled to a hearing or appeal under these Medical Staff Bylaws.

8-2 REPORTING REQUIREMENTS

8-2.1 Reporting to the National Practitioner Data Bank

Professional review actions based on reasons related to professional competence or conduct adversely affecting clinical privileges for longer than thirty (30) days, or voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation must be reported to the National Practitioner Data Bank (NPDB). The report must be made to the NPDB within fifteen (15) days of the final decision of the Board. Precautionary suspensions lasting longer than thirty (30) days must be reported to the NPDB within fifteen (15) days of the MEC action. The practitioner involved will be notified prior to its submission that a data bank report is required and will be made.

8-2.2 Additional Reporting Requirements

Reports of professional review actions will be made to state and regulatory entities as required by federal and state laws or regulations.

8-3 INITIATION OF HEARING

8-3.1 Grounds for Hearing

Except as otherwise provided in this manual, a recommendation by the MEC for one or more of the following adverse actions, or their imposition, if based on a determination of clinical incompetence or unprofessional conduct, shall constitute grounds for a hearing:

A. Denial of initial appointment to the Medical Staff;
B. Denial of reappointment to the Medical Staff;
C. Revocation of appointment to the Medical Staff;
D. Denial of some or all requested clinical privileges;
E. Revocation of some or all clinical privileges;
F. Suspension of some or all privileges for more than 14 days; or
G. Restriction of some or all privileges for more than 14 days (e.g. mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual Medical Staff member.)

The following will not constitute grounds for a hearing:

A. Having a letter of guidance, warning, or reprimand issued to the practitioner or placed in the credentials or performance file of the practitioner;
B. Automatic relinquishment of privileges or membership as described in Article VII, above;
C. Imposition of a precautionary or disciplinary suspension that does not last for more than fourteen days;
D. Denial of a request for a leave of absence or for an extension of a leave of absence;
E. Determination by the Hospital that an application for appointment or reappointment is untimely or incomplete for failure to submit all requested information;
F. A decision not to process an application under the available procedures for expedited review;
G. Imposition of a proctoring or monitoring requirement where such does not include a restriction on privileges;
H. Failure to process a request for a privilege when the applicant/member does not meet the eligibility requirements to hold that privilege;
I. Conduct of focused peer review (including external peer review) or a formal investigation;
J. Requirement to appear for a special meeting under the provision of the Medical Staff Bylaws;
K. Termination or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;
L. Determination that an applicant for membership does not meet the requisite qualifications or criteria for membership;
M. Ineligibility to request membership or privileges or continue the exercise of privileges because a relevant specialty is closed under a Medical Staff development plan adopted by the Board or covered under an exclusive provider agreement approved by the Board;
N. Termination of any contract with, or employment by, the hospital;
O. Any recommendation voluntarily accepted by the member as a result of collegial peer review;

P. Removal or limitation of Emergency Department call obligations;
Q. Any requirement by the MEC or Board to complete an educational assessment;
R. Any requirement by the MEC or Board to undergo a mental, behavioral, or physical evaluation to determine fitness for practice;
S. Appointment or reappointment for a term of less than 24 months;
T. Notification that the practitioner is on probation or is being granted a conditional reappointment, where such conditions or probation do not restrict or terminate the practitioner's privileges;
U. Actions taken by the affected practitioner's licensing agency or any other governmental agency or regulatory body.

8-3.2 Notice to Practitioner

A practitioner subject to adverse action listed in Section 8-3.1 (above) shall promptly be given special notice thereof by the President of the Medical Staff or, if such notice was prompted by action of the Board, by the Chair of the Board. This special notice will include a description of the adverse action and the reasons for it, a copy of the Medical Staff Bylaws, and an offer to provide the practitioner a hearing. The notice will also inform the practitioner that the adverse action or recommendation, if finally adopted by the Board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank. The practitioner shall have thirty (30) days following the date of receipt of such notice within which to request a hearing.

8-3.3 Practitioner's Request for Hearing

A practitioner's request for a hearing shall be made by means of written special notice delivered either in person or by certified or registered mail to the CEO.

8-3.4 Waiver of Hearing By Practitioner

A practitioner who fails to request a hearing within the time required and in the manner specified waives any right to a hearing to which he/she might otherwise have been entitled. Such waiver in connection with:

A. A decision or proposed decision by the Board shall constitute acceptance of such decision, which shall thereupon become effective as the final decision of the Board and will be reported as required by law.
B. A recommendation by the MEC shall constitute acceptance of such recommendation, which shall thereupon become and remain effective pending the final decision of the Board and which will be reported as required by law.
C. The practitioner may also waive the right to a hearing by signed statement submitted to the CEO.

8-3.5 Stay of Adverse Decision

A request for a hearing does not automatically operate to stay any adverse recommendation of the MEC or adverse decision of the Board, including the imposition of a precautionary suspension, and such recommendation or decision shall remain effective pending the final decision of the Board.

8-4 HEARING PREREQUISITES

8-4.1 Notice of Time and Place for Hearing

Upon receipt of a timely request for hearing, the CEO shall inform the President of the Medical Staff, MEC and Board. Within thirty (30) days after receipt of such request, the CEO, shall schedule and arrange for a hearing. At least thirty (30) days prior to the hearing, the practitioner will be sent a special notice of the time, place, and date of the hearing, together with a statement of the matters to be considered and a list of witnesses (if any) expected to testify at the hearing on behalf of the MEC and the Board. The hearing date shall be not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request for hearing, unless the affected practitioner and CEO mutually agree to a different date. Once the date is set, the CEO and practitioner shall mutually agree to any change in the hearing date, however, neither party may change the date more than one time.

8-4.2 Statement of Issues and Events

As part of, or together with, the notice of the hearing, there shall be provided a written statement, in concise language, of the acts or omissions which support the decision to impose or recommend an adverse action against the Medical Staff member, and the identification of any medical records (by chart or patient number where available) or other information or data which form the basis for the action. This statement and the list of supporting information may be amended or enhanced at any time, including during the hearing if the additional material is relevant to the continued appointment or clinical privileges of the practitioner requesting the hearing, and that practitioner and his/her counsel have sufficient time to study the material and rebut it.

8-4.3 Limited Right of Discovery

There shall be no right to discovery except as specifically provided in these Medical Staff Bylaws.

A. The CEO will provide the names of any hearing panel members, hearing officer, or presiding officer to the practitioner requesting the hearing within five days of their appointment;
B. Either party shall have the right to require up to twenty-four (24) hours before the scheduled date of the hearing, production of any documents or charts that are to be used as evidence at the hearing;
C. The CEO shall have the right to request, by special notice, a list of witnesses who will give testimony or evidence in support of the opposing party at the hearing. A party receiving such request shall, within ten (10) days of receipt of the request, furnish a list, in writing, of the names

and addresses of the individuals, to the extent then reasonably known, who will be called as witnesses on his/her behalf and a brief summary of the nature of the anticipated testimony;

D. There shall be no right to discover the name of any individual who has produced evidence relating to the charges made against the practitioner who requested the hearing unless such individual is to be called as a witness at the hearing or unless the deposition or other written statement of such individual is to be evidence at the hearing;

E. There shall be no right to the discovery of credentials or quality files of other members of the Medical Staff, or peer review minutes of any Medical Staff committee or activity unless specifically created and limited to addressing the competence and/or conduct concerns of the practitioner requesting the hearing.

8-5 HEARING PANEL, PRESIDING OFFICER, HEARING OFFICER

8-5.1 Appointment of Hearing Panel Members

The CEO, after consultation with the President of the Medical Staff, shall appoint a hearing panel and a presiding officer or a hearing officer. A hearing panel shall be composed of not fewer than three (3) voting members who meet the qualifications below. If the presiding officer is not a physician, he/she will not have voting privileges on the panel. The practitioner requesting the hearing will be notified of the hearing panel members appointed by the CEO and will have five (5) days from receipt of notice to lodge, in writing, with the CEO any objections to any appointee. Final authority to appoint panel members, a presiding officer, or a hearing officer will rest with the CEO, and the practitioner requesting the hearing is not entitled to veto any appointee's participation.

8-5.2 Qualifications of Members

Voting members of the hearing panel shall be licensed physicians who shall not have previously participated in the deliberations on the matter involved. If the practitioner requesting the hearing is other than an MD/DO, at least one (1) member of the hearing panel shall be of the same specialty and need not be a Medical Staff member or a privileged practitioner at the hospital.

Knowledge of the matter involved shall not preclude a person from serving as a member of the hearing panel. No member of the hearing panel may be a direct competitor of the member under review. The CEO shall have discretion to determine whether a potential panel member is a direct competitor of the member under review.

8-5.3 Presiding Officer

The CEO, after consultation with the President of the Medical Staff, will appoint a presiding officer to chair the panel, set procedure for the hearing, and conduct all business before the panel. If this individual is not a licensed physician, he/she will not be a voting member of the panel but may take part in its deliberations and support it in an advisory capacity. The presiding officer may be a physician on the Medical Staff, an active or retired judge or attorney, experienced physician executive,

experienced human resources director, or any individual deemed by the CEO to have the capacity to manage the hearing effectively and efficiently.

8-5.4 Hearing Officer

The CEO, after consultation with the President of the Medical Staff, may appoint a single hearing officer in lieu of a hearing panel where the issue triggering the hearing is unprofessional conduct rather than clinical incompetence. The hearing officer may be a lawyer, physician executive, or other individual familiar with due process. The hearing officer may not be legal counsel to the hospital, any individual who is in direct economic competition with the practitioner requesting the hearing, and cannot have been previously involved in the deliberations triggering the hearing. The hearing officer will not act as a prosecuting officer or as an advocate for either side at the hearing. In the event that a hearing officer is appointed instead of a hearing panel, all references in this Corrective Action and Fair Hearing Article to "hearing panel" or "presiding officer" shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise. The cost of utilizing a hearing officer will be borne by the hospital.

8-6 HEARING PROCEDURE

8-6.1 Personal Presence

The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails, without good cause, to appear and proceed at such hearing shall be deemed to have waived his/her rights and thereby to have voluntarily accepted the adverse action that triggered the hearing.

8-6.2 Presentation

The hearings provided for in this manual are for the purpose of intra-professional resolution of matters bearing on professional conduct or competency. Accordingly, the presiding officer shall have the discretion to limit the role of legal counsel for either side. This means that the presiding officer may rule that the person requesting the hearing shall be required to have his case presented at the hearing only by a practitioner who is licensed to practice medicine in the State of Maine and who, preferably, is a member in good standing of the Medical Staff. Where this is the case, the CEO shall appoint a representative from the Medical Staff to present its recommendation and to examine witnesses. The foregoing shall not be deemed to deprive the practitioner or hospital of the right to utilize legal counsel, at their own expense, in preparation for the hearing and such counsel may be present at the hearing, advise his or her client, and participate in resolving procedural matters.

8-6.3 Presiding Officer

The presiding officer shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present appropriate oral and documentary evidence, subject to reasonable limits, on the number of witnesses and duration of direct and cross examination, applicable

to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process. The presiding officer shall act to ensure that decorum is maintained throughout the hearing and to prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, abusive, or that causes undue delay. The presiding officer shall be entitled to determine the order of procedure during the hearing, and shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on all matters of procedure, including the admissibility of evidence. The presiding officer may conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel.

In addition, the presiding officer will act in such a way that the hearing panel, in formulating its recommendations, considers all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing. The presiding officer may seek legal counsel when he or she feels it is appropriate and may use the hospital legal counsel for such advice.

8-6.4 Hearing Officer

Where a hearing officer is employed instead of a hearing panel, this individual shall have the same authority as a presiding officer to determine the manner in which the hearing will be conducted and rule on all matters of procedure and evidence.

8-6.5 Pre-Hearing Conference

The presiding officer or hearing officer may require a representative (who may be counsel) for the individual and for the MEC to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer or hearing officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and the time to be allotted to each witness's testimony and cross-examination.

8-6.6 Record of Hearing

The hearing panel shall maintain a complete record of the hearing by having a certified court reporter present to make a record of the hearing. The cost for the certified court reporter shall be borne by the hospital. The presiding officer may, but shall not be required to, order that evidence shall be taken only upon oath or affirmation administered by any person entitled to notarize documents in Maine. The record of the hearing may be requested by the practitioner requesting the hearing and will be forwarded to him/her by the hospital upon payment of reasonable reproduction costs.

8-6.7 Rights of Parties

The practitioner shall have a limited right, as determined by the presiding officer, to inquire as to possible biases of the hearing panel. The presiding officer has discretion to respond to such inquiries in a manner he/she believes will provide for fair deliberations. Inquiry shall not be allowed into the

medical qualifications or expertise of hearing panel members. During a hearing, in accordance with procedures established by the presiding officer, each of the parties shall have the right to:

A. Call and examine witnesses;
B. Introduce exhibits;
C. Cross-examine any witness on any matter relevant to the issues;
D. Impeach any witness; or
E. Rebut any evidence.

If the practitioner who requested the hearing does not testify in his/her own behalf, such practitioner may be called and examined as if under cross-examination. Either party has the right to submit a written statement at the close of the hearing.

8-6.8 Admissibility of Evidence

The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence may be admitted by the presiding officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law, unless such evidence is deemed by the presiding officer be to cumulative. Hearsay is admissible and shall be sufficient to support the decision of the hearing panel. The hearing panel may question witnesses or call additional witnesses if it deems appropriate.

8-6.9 Official Notice

The presiding officer shall have the discretion to take official notice of any generally accepted technical or scientific matter relating to the issues under consideration or of any other matter that may be judicially noticed by the courts of the State of Maine. Participants in the hearing shall be informed of the matters to be officially noticed, and such matters shall be noted in the record of the hearing. Any party shall have the opportunity, upon timely request, to ask that a matter be officially noticed or to refute the noticed matters by relevant evidence or by written or oral presentation of authority in a manner determined by the hearing panel. Reasonable or additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

8-7 BURDEN OF PRODUCTION OR PROOF

8-7.1 Burden of Production

In all cases in which a hearing is conducted, it shall be incumbent on the body whose action or decision prompted the hearing (i.e., the MEC or Board) to come forward initially with evidence in support of its action or decision. Thereafter, the burden shall shift to the practitioner who requested the hearing to come forward with evidence in his/her support.

8-7.2 Burden of Proof

In all cases in which a hearing is conducted, after all the evidence has been submitted by both parties, the hearing panel shall rule against the practitioner who requested the hearing unless it finds that such person has proved, by clear and convincing evidence, that the factual allegations against the practitioner are untrue in total or in substantial part or unless it concludes, based on its findings of fact, that the action of the entity whose decision prompted the hearing was arbitrary, unreasonable, or appears to be unfounded or unsupported by credible evidence. It is the burden of the practitioner requesting the hearing to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and/or clinical privileges, and that he/she complies with all Medical Staff and hospital policies.

8-7.3 Presence of Panel Members and Vote

A majority of the members of the hearing panel must be present throughout the hearings and deliberations, provided, however, that, at the discretion of the presiding officer, if a member is absent from an insubstantial part of the hearing, such member may be allowed to read the entire transcript of the proceedings and, after doing so, may thereafter participate in the deliberations of the panel.

8-7.4 Recesses and Conclusions

The presiding officer may recess the hearing and reconvene the same at any time for the convenience of the participants, without additional notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing panel shall then conduct its deliberations outside the presence of either party to the hearing.

8-7.5 Postponements and Extension

Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by anyone, but shall be permitted only if the hearing panel, or its presiding officer acting on its behalf, determines that good cause has been shown.

8-8 HEARING PANEL REPORT AND FURTHER ACTION

8-8.1 Hearing Panel Report

Within ten (10) days after the conclusion of the hearing, the hearing panel shall make a detailed written report signed by each panel member and setting forth separately each charge against the practitioner, a summary of the evidence that supports or rebuts such charges, its findings on each fact at issue, and recommendations based on such findings with respect to the matter. This report, together with the hearing record and all other documentation considered by it, will then be forwarded to the body whose recommendation or decision prompted the hearing (MEC or Board). All findings and recommendations by the hearing panel shall be supported by reference to the hearing record and relevant documentation considered by the committee. If the panel's decision is not unanimous, a minority report or reports

may be issued. The practitioner requesting the hearing has the right to receive the written recommendation of the panel, including a statement of the basis for the recommendation.

8-8.2 Action on Hearing Panel Report

Within thirty (30) days after receipt of the report of the hearing panel, the MEC or Board, as the case may be, shall consider the same and affirm, modify or reverse its previous recommendation, decision or proposed decision in the matter. It shall indicate its action in writing, and shall transmit a copy of its written recommendation together with the hearing record, the report of the hearing panel, and all other relevant documentation, to the MEC or Board. The practitioner requesting the hearing has the right to receive the written decision of the MEC or Board, including a statement of the basis for the decision.

8-9 NOTICE AND EFFECT OF RESULTS

8-9.1 Notice of Action Taken

The notice of the action taken shall be given to the President of the Medical Staff and, by special notice, to the affected practitioner.

8-9.2 Effect of Favorable Result

A. Adopted by the Board:

   If the Board's action is favorable to the practitioner, such action shall constitute the final decision of the Board and the matter shall be considered finally closed.

B. Adopted by the MEC:

   If the MEC action is favorable to the practitioner, it shall be promptly forwarded, together with all supporting documentation, to the Board for its decision. The Board shall either adopt or reject the MEC recommendation, in whole or in part, or refer the matter back to the MEC for further reconsideration. Any such referral shall include a statement of the reasons therefore and set a time limit within which a subsequent recommendation to the Board must be made. After receipt of such subsequent recommendation, the Board shall render its decision. The practitioner will be sent a special notice informing him or her of each action taken. A favorable decision shall constitute the final action of the Board, and the matter shall be considered finally closed. If the Board's decision is adverse, the special notice shall inform the practitioner of his or her right to request an appellate review by the Board as provided in these Bylaws.

8-9.3 Effect of Adverse Action

If the action of the Board or MEC continues to be adverse to the practitioner, the special notice required shall inform the practitioner of his/her right to request an appellate review by the Board.

8-10 INITIATION AND PREREQUISITE OF APPELLATE REVIEIW

8-10.1 Request for Appellate Review

Within ten (10) days after receipt of the notice given, the practitioner who requested the hearing may request in writing an appellate review by the Board. Such request shall be delivered to the CEO or designee, either in person or by certified or registered mail. The written request for an appeal shall also include a brief statement of the reasons for appeal.

8-10.2 Waiver by Failure to Request Appellate Review

If such appellate review is not requested within the time and in the manner specified in Section 8-10.1, the practitioner shall be deemed to have waived his right to appeal and to accept the action so noticed, and it shall thereupon become final and effective immediately.

8-10.3 Notice of Time and Place

In the event of any appeal to the Board, the Board shall, within thirty (30) days after the receipt of such notice of appeal, schedule and arrange for an appellate review. The Board shall cause the practitioner to be given special notice of the time, place and date of the appellate review. The date of the appellate review shall be not less than fourteen (14) days nor more than sixty (60) days from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is made by a member who is under a suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than thirty (30) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Board for good cause.

8-10.4 Appellate Review Body

The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an Appellate Review Committee of not less than three (3) members of the Board appointed by the Chairman of the Board. The Chairperson of the Board or designee shall be the presiding officer and shall have the same responsibilities as the presiding officer at the initial hearing. If such committee is appointed, the Board shall delegate to such committee full authority to render a final decision on behalf of the Board. Members of the review panel may not be direct competitors of the practitioner under review, and should not have participated in any formal Investigation or deliberations leading to the recommendation for corrective action under consideration.

8-11 APPELLATE REVIEW PROCEDURE

8-11.1 Grounds for Appeal

The grounds for appeal to the Board shall be limited to the following:

A. There was substantial failure to comply prior to the hearing with the provisions contained in the Medical Staff Bylaws so as to deny basic fairness or reasonable due process; or
B. The recommendation of the hearing panel was made arbitrarily, capriciously, or with prejudice; or
C. The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

In making this assessment, the Board will consider the record of the hearing before the hearing panel and any written statements submitted by parties to the hearing.

8-11.2 Written Statements

Each party shall have the right to present a written statement in support of its position on appeal, provided that such statement is submitted to the Board or the committee of the Board, at least fifteen (15) days prior to the date of the appellate review, unless otherwise provided by the Board or the committee of the Board. A copy of each submitted written statement shall be provided to the opposing party at least seven (7) days prior to the date of the appellate review.

8-11.3 Submission of Additional Evidence

The appellate review panel may, but is not required to, accept additional oral or written evidence subject to the same cross-examination and admissibility provisions adopted at the hearing panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence, and that any opportunity to admit it at the hearing was denied.

8-11.4 Oral Statement

The Board or the committee of the Board may, at its sole discretion, allow the parties and/or their representatives to personally appear and make a time-limited thirty (30) minute oral argument. Any party or representative so appearing shall be required to answer questions put to him/her by any member of the appellate review committee. This time restriction may be extended at the sole discretion of the presiding officer of the appellate review body.

8-11.5 Recesses and Adjournment

At the conclusion of the oral argument, if allowed, the appellate review shall be closed. The Board or the committee of the Board, may thereupon, at a time convenient to itself, conduct deliberations outside the presence of the parties and their representatives. At the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

8-11.6 Action

The Board or the committee of the Board, may affirm, modify or reverse the action which is the subject of the appeal, or refer the matter back to the MEC for further review and recommendation. If the matter is referred back to the MEC for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the Board or the committee of the Board, in accordance with the instructions given to the Board or the committee of the Board. This further review process shall, in no event, exceed thirty (30) days in duration, except as the parties may otherwise stipulate.

8-11.7 Final Board Decision

Within ten (10) days after the conclusion of the proceeding before the Board or the committee of the Board, the Board or the committee of the Board shall render a final decision in writing and shall deliver copies thereof to the MEC and, by special notice, to the practitioner. This decision shall be effective immediately and shall not be subject to further review.

8-12 GENERAL PROVISIONS

8-12.1 Exhaustion of Administrative Remedies

By applying for membership on the Medical Staff or for privileges, each applicant agrees that, in the event of any adverse action or decision with respect to the Medical Staff membership and/or privileges, the applicant or Medical Staff member shall fully exhaust the administrative remedies afforded by the Medical Staff Bylaws before resorting to formal legal action.

8-12.2 Limit of One Appellate Review

Except as otherwise provided in this section, no applicant or member shall be entitled as a matter of right to more than one appellate review in total before the Board or the committee of the Board on any single matter which may be the subject of an appeal, without regard to whether such subject is the result of action by the MEC or the Board, or the committee of the Board or a combination of actions by such bodies.

8-12.3 Waiver

If, at any time after receipt of special notice of an adverse recommendation, action or result, a practitioner fails to make a required request or appearance or otherwise fails to comply with these Bylaws, or to proceed with the matter, he/she shall be deemed to have consented to such adverse recommendation, action, or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Medical Staff Bylaws then in effect with respect to the matter involved.

ARTICLE IX: CREDENTIALING AND THE DETERMINATION OF PRIVILEGES

9-1 APPOINTMENT AND REAPPOINTMENT OF MEDICAL STAFF MEMBERSHIP

The following steps describe the process for credentialing (appointment and reappointment) of Medical Staff members. Associated details may be found in the Medical Staff Credentials Manual.

A. Individuals interested in appointment to the Medical Staff may request an application and eligibility criteria from the hospital. Eligible practitioners will be sent an application for appointment by the hospital's contracted credentials verification organization (CVO).
B. Upon completion of the verification conducted by the CVO, and submission of the application to the hospital, a designated individual will verify the contents and confirm that the applicant is eligible to have the application processed further. If the application shows the applicant is not eligible for membership, he/she will be notified that no further evaluation or action will occur regarding the application. Applicants who do not meet criteria for Medical Staff membership and/or privileges are not eligible for due process. An incomplete application will not be forwarded for consideration by the Medical Staff or Board. An application that remains incomplete for more than 60 days after written notification by the hospital that information is missing will be considered to have been voluntarily withdrawn.
C. A completed and verified application will be reviewed by the appropriate Quality & Safety Service leader, who will make a recommendation regarding Medical Staff membership and/or clinical privileges. This recommendation will be forwarded by the hospital to the Medical Staff Credentials Committee.
D. The Credentials Committee will review the application, seeking the input of appropriate subject matter experts when it deems necessary. Following its review, the Credentials Committee will forward its recommendation on the applicant to the Medical Executive Committee (MEC).
E. The MEC will review the application and forward its recommendation to the hospital Board regarding membership and, if appropriate, staff category, and privileges. The MEC may also refer an application back to the Credentials Committee if it feels more information or evaluation concerning the applicant is necessary before it can render a recommendation to the Board.
F. Upon receipt of a recommendation from the MEC, the hospital Board will review the application and determine whether to refer the matter back to the MEC for further deliberation, grant the applicant membership, and whether any restrictions or conditions should be attached to a grant of membership or clinical privileges. Membership and/or privileges will be effective upon action by the Board granting membership and/or privileges.
G. Applicants may appeal recommendations by the MEC and decisions made by the Board in accordance with provisions in the Medical Staff Corrective Action and Fair Hearing section of these Bylaws.

9-2 GRANTING OF CLINICAL PRIVILEGES

The following steps describe the process for granting clinical privileges to qualified practitioners. Associated details may be found in the Medical Staff Credentials Manual and on Medical Staff

delineation of privileges documents. Practitioners shall be entitled to exercise only those privileges specifically granted to them by the hospital Board. The Medical Staff may recommend clinical privileges for practitioners who are not Medical Staff members but who hold a license to practice independently and who are considered eligible to practice independently at the hospital by the Board. Such practitioners include: Certified Registered Nurse Anesthetists, and Clinical Psychologists.

A. Practitioners initially applying for Medical Staff membership or for reappointment must complete the appropriate forms to request specific privileges. Practitioners ineligible for Medical Staff membership, but eligible for privileges, will complete the appropriate request forms. These forms are available from the hospital.
B. Upon completion and submission of the appropriate forms to the hospital, a designated individual will confirm that the applicant is eligible to have the requests processed further. Privilege requests that do not demonstrate compliance with eligibility requirements will not be processed further.
C. Completed privilege request forms will be reviewed by the appropriate Quality & Safety Service leader, who will make a recommendation regarding Medical Staff membership and/or clinical privileges. This recommendation will be forwarded by the hospital to the Medical Staff Credentials Committee.
D. The Credentials Committee may seek the input of appropriate subject matter experts when it deems such input necessary.
E. The Credentials Committee will recommend a specific action on requested privileges to the Medical Executive Committee (MEC).
F. The MEC will review the privileging requests and recommend specific actions on them to the hospital Board.
G. The hospital Board will review the privileging requests and either reject the requests, modify them, and return the application to the MEC for further deliberation, or grant the privileges being sought.
H. Applicants may appeal adverse recommendations by the MEC and adverse decisions made by the Board in accordance with provisions in the Medical Staff Corrective Action & Fair Hearing Manual of these Bylaws.

9-3 TIME PERIODS FOR PROCESSING

Applications for Medical Staff appointment and/or privileges shall be considered in a timely and good faith manner by all individuals and groups required by the Medical Staff Bylaws or policies to act upon them, and shall be processed whenever possible within the time periods specified in this section. Any incomplete application after six (6) months shall be considered voluntarily withdrawn.

Within sixty (60) days after the receipt of a completed application for membership and/or privileges, the Credentials Committee or its Chair shall submit a written recommendation to the Medical Executive Committee.

Within sixty (60) days after receipt of recommendations from the Credentials Committee or its Chair, the MEC shall submit a recommendation regarding appointment and/or clinical privileges to the hospital Board.

The hospital Board will act upon recommendations from the MEC at its next regularly-scheduled meeting.

The time periods in this section are guidelines and deviations will not entitle the applicant to any procedures due process rights.

9-4 MEDICAL STAFF CREDENTIALS MANUAL

Associated details elaborating on the credentialing and privileging process can be found in the Medical and Advanced Practice Provider Credentials Manual, which will be adopted and modified from time to time by action of the Medical Executive Committee and approval by the Board.

ARTICLE X: OFFICERS

10-1 OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be:

A. President
B. Vice-President
C. Immediate Past President

10-2 QUALIFICATIONS

Officers of the Medical Staff must satisfy the following criteria at the time of nomination and continually throughout the term of their office:

A. Be an appointee to the Active staff;
B. Report to the Nominations Committee any actions pending before or taken by the state Board of Medicine;
C. Have constructively participated in Medical Staff activities, including, but not limited to, activities such as performance improvement, risk management, and professional peer review;
D. Be willing to discharge faithfully the duties and responsibilities of the position;
E. Have experience in a leadership position, or other involvement in performance improvement functions for at least two years;
F. Must attend continuing education programs relating to Medical Staff leadership and/or credentialing functions prior to or during the term of office;

G. Be in compliance with any and all policies of the Medical Staff and hospital regarding conflicts of interest; and,
H. Must have demonstrated an ability to work well with others.

10-3 SELECTION

The Nominating Committee as outlined in Article 12-4 of these Bylaws shall select nominees for placement on the election ballot for officers. The Past President will automatically assume the position of Immediate Past President whenever he or she leaves the office of President, unless he or she has been removed for cause.

10-4 ELECTION

A. Officers of the Medical Staff shall be elected using a secret ballot which may be distributed to eligible voting members of the Medical Staff at a general Medical Staff meeting, or by a show of hands, by mail, or electronically. The mechanics of distributing ballots and counting votes will be determined by the MEC in consultation with the professionals staffing the Medical Staff Office. Only members of the Active Medical Staff shall be eligible to vote and the winner of an election shall be the individual who receives the greatest number of votes. Voting by proxy is not permitted.
B. Officers shall be eligible to assume office once the hospital Board has ratified their election. Such ratification cannot be unreasonably withheld.
C. Elections will take place as scheduled by the Medical Staff Office under procedures approved by the MEC.

10-5 TERM

All elected officers shall take office on the first day of January following their election and will serve a term of three years and/or until their successors are elected and ratified by the Board. The President and Vice President may serve one successive term, and the Immediate Past President only one term.

10-6 DUTIES OF ELECTED OFFICERS

A. President of the Medical Staff

The President shall serve as the chief administrative officer and principal elected official of the Medical Staff. As such, she or he shall be responsible for implementing the general responsibilities of the Medical Staff, including, without limitation:

1. Aiding and coordinating Medical Staff activities with the activities and concerns of the hospital Board, Administration of the hospital, Nursing, and other patient care services.

2. Accounting to the hospital Board and Medical Staff in conjunction with the MEC and the respective Service Leaders for the quality, efficiency and performance of patient care services within the hospital.
3. Developing and implementing, in coordination with other Medical Staff leaders and experts, continuing education programs, utilization review activities, performance improvement programs, and methods for credentials review, delineation of privileges, and the monitoring of the quality of patient care.
4. Communicating and representing the concerns and recommendations of the Medical Staff to the hospital Board, the Chief Executive Officer, and other leaders of the Medical Staff.
5. Assuming responsibility for the enforcement of these Bylaws, hospital policies, and Medical Staff rules, regulations or policies, and for implementation of appropriate sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where appropriate, as provided under these Bylaws.
6. Calling, setting the agenda, and presiding at all general and special meetings of the Medical Staff and of the MEC.
7. Serving as chair of the MEC, and as an ex-officio member of all Medical Staff committees, with the right to vote.
8. Unless provided for otherwise in these Bylaws, appointing, after consultation with the MEC, the members of all standing and special Medical Staff committees, except the MEC, and all Medical Staff representatives to hospital committees.
9. Serving as an ex-officio, non-voting member of the hospital Board and reporting to this body on quality of care and performance improvement issues as recommended by the Medical Staff.
10. Representing the Medical Staff in its professional and community relations.
11. Performing all other functions as may be assigned to the President of the Medical Staff by these Bylaws, the Medical Staff, MEC, or the Board.

B. Vice-President

The Vice-President shall be a member of the MEC and shall be required to assist the President and to perform such duties as may be assigned to him/her by the President. In the absence of the President, or upon the occurrence of a vacancy in the office of President, the Vice-President shall assume the responsibilities, exercise the authority, and perform the duties assigned to the President until the President returns or that office is filled. The Vice-President will serve as the chair of the Medical Staff Quality Improvement Committee.

C. Immediate Past President

The Immediate Past President shall be a member of the MEC and shall serve as an advisor to the President and perform those functions delegated by the President.

10-7 REMOVAL

A. A recall election of an officer shall be held if requested through a petition signed by no fewer than 25 percent (25%) of the members of the Active Medical Staff, a request signed by at least two-thirds

of the members of the MEC, or a request made by the hospital Board of Trustees. Officers may be removed by an affirmative vote of two-thirds of the Active Medical Staff present and voting at any general or special meeting, subject to the approval of the hospital Board, in circumstances where the Medical Staff and Board believe removal is necessary to protect the interests of the Medical Staff and/or hospital. The following conditions, including but not limited to, constitute a reasonable basis for removal of an officer from office:

1. Failure to comply with or support enforcement of the Medical Staff Bylaws, Medical Staff rules, regulations, or policies.
2. Failure to perform the required duties of the office;
3. Failure to adhere to professional ethics;
4. Abuse of office;
5. Conduct unbecoming a Medical Staff member and officer; and
6. Failure to continuously meet the qualifying criteria to be an officer as set forth above in these Bylaws.

B. At least ten (10) days prior to the initiation of any removal action, the individual shall be given special notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the Medical Staff prior to a vote on removal.

C. Automatic removal will occur (without need for a vote) in the event any of the following affects the officer in question:

1. Loss or suspension of the officer's medical license in the State of Maine;
2. Ineligibility for membership in the Active category of the Medical Staff;
3. Recommendation by the MEC to the Board for the imposition of corrective action, or the acceptance of such recommendation by the Board.

D. Where the President is removed from that position, she/he shall be ineligible to hold the office of Immediate Past President.

10-8 VACANCIES

When a vacancy occurs in the office of the President, the Vice President will assume this position for the remainder of the existing term. The Medical Executive Committee shall appoint a Vice President to complete the term whenever this position is vacated. If the Immediate Past President resigns or is not eligible to hold this position, due to any cause, or is unable or unavailable to serve, the position may remain vacant, or the MEC may invite a qualified member of the Medical Staff who has served on the MEC in the past to complete the term.

If the President resigns during the term of his/her elected office he or she will not be considered the Immediate Past President during the balance of such term.

ARTICLE XI: CLINICAL ORGANIZATION OF THE MEDICAL STAFF

11-1 CLINICAL ORGANIZATION OF THE MEDICAL STAFF

The Medical Staff is a non-departmentalized organization that carries out its responsibilities through committees and individuals assigned specific tasks. The Medical Staff may be assisted in meeting these responsibilities by optional clinical services if formed as specified in section 11-2, below.

ARTICLE XII: MEDICAL STAFF COMMITTEES AND LIAISONS

12-1 TYPES OF COMMITTEES

There shall be an Executive Committee of the Medical Staff (referred to in these Bylaws as the Medical Executive Committee or MEC) and such other standing and special committees of the Medical Staff, accountable to the MEC, as may be established in these Bylaws or created by the President or MEC to accomplish Medical Staff functions. Current standing committees are the MEC, Credentials Committee, and the Medical Staff Quality Improvement Committee. The Nominations Committee is a special committee convened periodically to carry out the responsibilities listed in Section 12.4, below. Special committees are generally time-limited and/or ad hoc in nature to address specific matters which may occur episodically or on a recurring basis with relative infrequency.

12-1.1 Conduct of Meetings

Meetings may be face-to-face, or, if the business to be conducted warrants it, by mail, e-mail, survey, or other electronic means acceptable to the committee.

12-1.2 Regular Meetings

Committees may, by resolution, establish the time for holding regular meetings without providing members notice other than by announcement of such resolution in meeting minutes. Meetings will be run in a manner determined by the chair or designee who shall preside. Compliance with rules of parliamentary procedure is not required.

12-1.3 Special Meetings

A special meeting of any committee may be called by or at the request of its chair, by the President of the Medical Staff, or by written request signed by twenty-five percent (25%) of the current voting members of the Committee, but not by fewer than two (2) such members.

Written or oral notice stating the place, day and hour of any special meeting shall be provided to each member of the committee that is to meet, not less than five (5) days before the time of such meeting. If mailed, the notice of the meeting shall be posted to the member, at his/her address as it appears on the records of the Medical Staff, at least seven (7) days before the meeting.

12-1.5 Quorum

Unless otherwise specified in these Bylaws, a quorum will be those voting members present, but not fewer than two (2) members.

12-1.6 Manner of Action

Unless otherwise stated in these Bylaws or its associated manuals, the action of a majority of the voting members present or participating electronically at a meeting, at which a quorum is present, shall be the action of that committee. Action may be taken without a meeting by unanimous consent in writing, setting forth the action so taken and signed by each member who would be entitled to vote at that meeting.

12-1.7 Minutes

Minutes of required committees and any special meetings shall be prepared, including a record of the members in attendance or participating and the results of any votes taken at the meeting. The minutes shall be signed by the chair or presiding designee and copies thereof shall be available to the attendees for approval. All minutes shall be made available to the MEC. Each committee shall maintain a permanent file in the Medical Staff Office or Quality Department of the minutes of each meeting. Minutes containing peer review material or decisions shall be considered confidential to the full extent permitted under the law.

12-1.8 Attendance Requirements

Members of the MEC, Credentials and Medical Staff Quality Improvement Committees are expected to attend at least 75 percent of committee meetings held each year. Failure to attend at least 75 percent of the meetings may makes the Medical Staff member ineligible for re-election and/or appointment to the committee for a period of three years. The President of the Medical Staff may remove any appointed member from a committee assignment based on non-compliance with attendance requirements.

12-1.9 Mandatory Special Appearance Requirement

Whenever suspected deviation from standard clinical or professional practice is identified, a practitioner may be required to attend a meeting of a standing or ad hoc committee considering the matter. The practitioner will be given special notice of the meeting, including the date, time and place, a statement of the issue involved, and a statement that the practitioner's appearance is mandatory. Failure to attend a meeting when asked, unless excused by the President upon showing good cause, shall be considered an immediate and voluntary relinquishment of privileges.

12-1.10 Committee Chair

A. Selection

Unless designated otherwise in these Bylaws, the chair of each standing or special committee shall be appointed by the President, subject to the approval of the Medical Executive Committee. The President shall serve as Chair of the Medical Executive Committee.

B. Term

Unless specified otherwise in these Bylaws, each committee chair shall be appointed to a term of two (2) years and may be appointed to successive terms.

12-1.11 Membership and Appointment

A. Eligibility

1. Members of the Active Staff shall be eligible for appointment to any standing or special committee of the Medical Staff established to perform one or more of the functions required by these Bylaws.
2. Members of the Affiliate Staff shall be eligible for appointment to any standing or special committee of the Medical Staff established to perform one or more of the functions required by these Bylaws, with the exception of the Nominating Committee and MEC.
3. Members of the Active APP Staff shall be eligible for appointment to any standing or special committee of the Medical Staff.
4. Where specified in these Bylaws, or where the Medical Executive Committee deems it appropriate to the functions of a committee of the Medical Staff, representatives from various services of the hospital, including, without limitation, Administration, Laboratory, Nursing, Information Management and Pharmacy Services, shall be eligible for appointment to specific committees of the Medical Staff.

B. Selection

Unless otherwise provided in these Bylaws, Medical Staff members of any Medical Staff committees other than the MEC shall be appointed by the President in consultation with the MEC. Where applicable, the Chief Executive Officer or designee shall appoint hospital staff members to Medical Staff committees which require representation from hospital services.

C. Chief Executive Officer

Unless otherwise provided in these Bylaws, the Chief Executive Officer or his/her designee shall serve as an ex-officio member, without a vote, of all Medical Staff committees.

D. Voting

Medical Staff members in the Active and Affiliate categories may vote on Medical Staff committees, unless specified otherwise in these Bylaws or in Medical Staff policies or manuals.

E. Term

Unless specified otherwise in these Bylaws, each Medical Staff committee member shall be appointed to a term of two (2) years, and may be reappointed as often as the individual or party responsible for such reappointment may deem advisable.

F. Quorum

For committee meetings, a quorum shall consist of at least two voting members. For Medical Executive, Credentials, and Quality Committees, a quorum shall consist of fifty percent (50%) of the voting members.

12-2 MEDICAL EXECUTIVE COMMITTEE

A. Membership

All Active Medical Staff members and Active APP members are eligible for Medical Executive Committee (MEC) membership.

B. Composition

The MEC shall consist of the following ten voting members:

1. President of the Medical Staff
2. Vice-President of the Medical Staff
3. Immediate Past President of the Medical Staff. The Immediate Past Presidents will serve one three-year term.
4. Six elected at-large members of Active Medical Staff.
5. One elected at-large member of the Active APP Staff.

The following will be ex-officio, non-voting members of the MEC:

1. Hospital CEO
2. Associate CMO

C. Election, Appointment and Term of MEC Members

The general Medical Staff exercises its authority over the MEC through the election of its membership. Officers serving on the MEC will be members as long as they hold their officer positions. The term of at-large members will be staggered in a manner determined by the MEC. Any eligible member in the Active category of the Medical Staff or the Active APP Staff may run for an at-large position by notifying the Nominating Committee as outlined in Section 12-4(C).

D. Removal From the MEC

Officers serving on the MEC will lose their committee membership if removed from their position as an officer, as described elsewhere in these Bylaws as outlined in Article 10, Section 10-7. At-large members of the MEC may be removed by an affirmative vote of a majority of the MEC membership, or by majority vote of the Medical Staff following a specially called Medical Staff meeting. Grounds for removal include, but are not limited to:

1. Failure to meet the attendance requirements for MEC members;
2. Disruptive conduct at MEC meetings; and
3. Failure to carry out assigned duties as an MEC member.

Members of the MEC will be considered to have voluntarily resigned from the committee if any of the following occur:

1. Termination or suspension of the member's license to practice in the state of Maine;
2. Loss of membership on the Active category of the Medical Staff or the Active APP Staff;
3. The MEC recommends to the Board that the member be subject to corrective action.

If there is a vacancy occurs in an at-large position, it will be filled by the MEC until the next regularly scheduled election to complete the remaining term.

E. Quorum

A quorum for the MEC shall consist of at least fifty percent (50%) of the current voting membership of the committee in attendance, either in person or via telephonic or electronic means.

F. Responsibilities

1. The MEC shall represent the Medical Staff, assume responsibility for the effectiveness of all medical activities of the Medical Staff, act on matters of concern and importance to the Medical Staff and act at all times as the authorized delegate of the Medical Staff in regard to general and specific functions of the Medical Staff.
2. The MEC is empowered to act for the Medical Staff, including intervals between general Medical Staff meetings.
3. The MEC receives and acts on reports and recommendations from Medical Staff committees, clinical service lines, hospital committees, consultants, and other relevant individuals.
4. The MEC consults with hospital administrators on quality-related aspects of contracts for patient care service with entities outside the hospital.
5. The MEC adopts policies on behalf of the Medical Staff which it deems prudent and informs members of the Medical Staff of such policies.
6. The MEC carries out investigations in accordance with the Corrective Action & Fair Hearing section of these Bylaws before making recommendations to the Board to terminate, limit, or restrict a practitioner's membership or privileges.
7. The MEC is responsible for making Medical Staff recommendations directly to the governing body, via its established protocol, for its approval. Such recommendations pertain to at least the following:

    a) The Medical Staff's structure;
    b) The mechanism used to review credentials and to delineate individual clinical privileges;
    c) Recommendations of individuals for Medical Staff membership;
    d) Recommendations for delineated clinical privileges for each eligible practitioner;
    e) The participation of the Medical Staff in organization performance improvement activities;

f) In the event that specific problems are identified regarding physician performance improvement activities, the mechanism by which Medical Staff membership may be terminated;
g) The mechanism for fair-hearing procedures; and
h) The MEC's review of and actions on reports of Medical Staff committees, ~~Departments~~, and other assigned activity groups.

G. Meetings

The MEC shall meet monthly and at least ten times per year and shall maintain a permanent record of all proceedings and actions at its meetings. The President or designee will preside at all meetings of the MEC.

H. Call of Special Meeting

The President may call special meetings of the MEC at any time. Such meetings may be held in person or through telephonic or electronic conferencing.

I. Notice

Notice of a Special Meeting of the MEC shall be by means of facsimile, telephone, posting of notice or e-mail.

12-3 CREDENTIALS COMMITTEE

A. Composition:

The Credentials Committee shall consist of the President and Vice President of the Medical Staff and at least six (6) members of the Active and/or Affiliate Staff. The Chair and members will be appointed to three-year terms by the President. The Chief Executive Officer or designee, the CMO (or designee), and the Vice President of Quality (or equivalent) shall serve as ex-officio members, without vote. A member of the Board of Trustees may be included as an ex-officio member, without vote.

B. Responsibilities:

The Credentials Committee shall be responsible for the performance of Medical Staff functions relating to credentialing as enumerated in theses Bylaws, the Medical Staff Credentials Manual, and associated Medical Staff policies. These duties include:

1. Reviewing and evaluating the credentials and qualifications of each applicant for initial appointment, reappointment or modification of appointment and for particular privileges.
2. Submitting reports to the MEC in accordance with the procedures set forth in the Medical Staff Credentials Manual regarding the committee's review and evaluation of the qualifications of each applicant for Medical or Advanced Practice Provider Staff membership and/or for particular privileges.

3. Investigating, reviewing and reporting on matters concerning the professional or ethical conduct of any practitioner assigned or referred to the committee by the President, MEC or Medical Staff Quality Improvement Committee.
4. Making recommendations to the MEC regarding the adoption of credentialing policies and procedures.
5. Making recommendations to the MEC regarding the adoption of privileging criteria and delineation of privileges forms.

C. *Meetings:*

1. The Credentials Committee shall meet monthly and at least ten times per year to carry out its functions.
2. The Committee shall maintain a permanent record of its proceedings and actions and shall report to the MEC on all of its activities.

D. Quorum:

A quorum for the Credentials Committee shall consist of at least fifty percent (50%) of the current voting membership of the committee in attendance, either in person or via telephonic or electronic means.

12-4 NOMINATING COMMITTEE

A. Composition:

The Nominating Committee is an ad hoc committee. When needed, it shall consist of:

1. Three members of the Active medical staff appointed by the MEC and who are not running for any elected office. The MEC will designate one of its appointees to serve as Chair. In making appointments, the MEC will take into consideration the following: The desirability of committee members having had previous experience as a medical staff officer or member of the MEC; the desirability of having diverse committee members with respect to specialty, site of practice, age, gender, and race;
2. The President of the Medical Staff;
3. The CEO or designee in a non-voting capacity.

B. Responsibilities:

The Nominating Committee shall be responsible for identifying nominees for officers of the Medical Staff and at-large MEC members when elections are held for these positions.

C. Procedures:

1. The Nominating Committee will meet at least 90 days prior to the General Staff Meeting at which the results of the election will be announced. The Nominating Committee shall circulate its list of nominees to the Active members of the Medical Staff at least sixty (60) days prior to scheduled voting.

2. In order for a nomination to be placed on the ballot the following criteria must be met:

   a) Candidates must have been members of the active staff category at Southern Maine Health Care for at least two years and meet any other qualifications listed in these Bylaws for the position to which they wish to be elected. The Nominating Committee will have discretion to determine if these criteria have been met. In considering candidates, the Nominating Committee will seek to provide for representation by practice type, location, employed and independent physicians, and specialty.
   b) Candidates must be approved by the Nominating Committee for placement on the ballot to assure they meet the requisite qualifications to hold office.
   ~~c)~~ Members of the Active staff who are not initially chosen by the Nominating Committee and wishing to have their names included on the election ballot must submit the signatures of ten percent (10%) of the Active Staff in support of their nomination. Eligible members of the Medical Staff, who wish to be included on the ballot, must file the required supporting signatures with the Medical Staff Office at least 45 days prior to the General Staff Meeting at which the election will be held.

3. The Nominating Committee shall notify each Active Staff member of the final slate of nominees for the positions set forth, not less than thirty (30) days before voting in the election is to commence.

12-5 MEDICAL STAFF QUALITY IMPROVEMENT COMMITTEE

A. Composition:

The Medical Staff Quality Improvement Committee shall consist of the President and Vice President of the Medical Staff and at least six (6) additional members of the Active and/or Affiliate Staff. Members will be appointed to three-year terms by the President after consultation with, and approval by, the MEC. The Vice-President of the Medical Staff will serve as chair of the committee. The Chief Executive Officer or designee and the hospital CMO or designee shall serve as ex-officio members, without vote. A member of the Board of Trustees may be included as an ex-officio member, without vote. The Vice President of Quality and/or hospital staff who support the Medical Staff peer review and performance improvement activities will also be non-voting committee members.

B. Responsibilities:

The Medical Staff Quality Improvement Committee is responsible to the MEC and Board for the overall operation of Medical Staff peer review and performance improvement activities and for collaborating with hospital administration and its quality and performance improvement structure, as needed, to improve quality of care, treatment and services, and patient safety. These responsibilities of the committee include, but are not limited to:

1. Instituting activities for measuring, assessing, and improving care and processes that primarily depend on the actions of one or more privileged practitioners and reporting results of quality measures and performance improvement plans to the governing board via the Medical Executive Committee.

2. Providing on-going measurement, assessment, analysis, and improvement of the:
   a) Medical assessment and treatment of patients;
   b) Use of medications;
   c) Use of blood and blood components;
   d) Use of operative and other procedures;
   e) Appropriateness of clinical practice patterns;
   f) Significant departures from established patterns of clinical practice;
   g) Education of patients and families;
   h) Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient;
   i) Accurate, timely and legible completion of patients' medical records;
   j) Process of analyzing and improving patient satisfaction; and
   k) The use of developed criteria for autopsies.

3. Review of sentinel event data and patient safety data collected by the hospital staff.

4. Establishment of peer review policies and protocols for implementation by clinical Service Lines and Medical Staff committees to assure reliability and consistency across specialties; and coordinate interdisciplinary approaches to peer review.

5. Review of the findings of the assessment processes that are relevant to an individual's performance. The organized Medical Staff is responsible for determining the use of this information in the ongoing evaluations of a practitioner's competence.

6. Creation and implementation of, or recommendation to, the MEC plans for collegial intervention with practitioners who are identified through peer review activities as in need of such interventions.

7. Drawing conclusions, making recommendations, and taking action and following-up based upon the assigned responsibilities and duties.

C. Meetings:

The Medical Staff Quality Improvement Committee shall meet monthly and at least ten (10) times per year. Committee actions will be reported to the MEC.

D. Quorum:

A quorum for the Quality Committee shall consist of at least fifty percent (50%) of the current voting membership of the committee in attendance, either in person or via telephonic or electronic means.

12-6 SPECIAL OR AD HOC COMMITTEES

The President of the Medical Staff or the MEC may appoint ad hoc committees to address specific issues or concerns on behalf of the Medical Staff. In establishing such committees, there will be a notation made in the minutes of the MEC enumerating the ad hoc committee's purpose and charge, timeframes for its work, and the duration of its appointment. Such committees will report to, and be accountable to, the MEC.

12-7 MEDICAL STAFF REPRESENTATION ON HOSPITAL COMMITTEES

In order to further carry out the functions of the Medical Staff and to provide Medical Staff input where appropriate, the President, subject to the approval of the CEO or designee, may appoint members to hospital committees. The hospital Board and its subcommittees are not considered hospital committees under this article. When Medical Staff members sit on a hospital committee the minutes of that committee shall be available to the MEC for its review. The MEC is not required to approve the minutes of hospital committees. It shall be the responsibility of the Medical Staff member(s) sitting on a hospital committee to bring to the attention of the MEC or a Medical Staff officer any matter brought before such committee that requires the attention of or action by the Medical Staff leadership.

12-8 MEDICAL STAFF LIAISONS

When the Medical Staff is required by regulatory bodies or internal policies to collaborate with hospital staff in carrying out a particular function, the President may appoint a member of the Medical Staff to serve as a formal liaison for that work. The liaison will report periodically to the MEC or other appropriate Medical Staff committee when matters require the attention of Medical Staff leaders.

ARTICLE XIII: GENERAL MEDICAL STAFF MEETINGS

13-1 GENERAL MEDICAL STAFF MEETINGS

The Medical Staff will meet at least four times each year. The meeting schedule will be developed and published by the Medical Executive Committee. Written notice of the meeting shall be sent in a manner determined by the Medical Staff Office to all Medical Staff members. The MEC shall determine the time and place at which the meeting shall be held. The President or MEC may call additional general meetings for any reason they deem appropriate, including: to promote communication with the Medical Staff, provide a forum for discussion on matters of Medical Staff interest, review quality and safety data and concerns, present educational programs, or address proposed changes to the Medical Staff Bylaws.

13-2 SPECIAL MEETINGS OF THE MEDICAL STAFF

13-2.1 Call of Special Meeting

A special meeting of the Medical Staff may be called at any time by the President, and shall also be called at the request of the hospital Board, the MEC or in response to a petition presented to the President and signed by twenty percent (20%) of the Active Staff. No business shall be transacted at any special meeting, except that for which the meeting is called and stated in the notice of such meeting.

13-2.2 Notice

Notice stating the time, place and purpose(s) of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff in a manner determined by the Medical Staff Office at least seven (7) days before the date of such meeting.

13-3 ATTENDANCE AT MEETINGS

Members of the Medical and Advanced Practice Provider (APP) Staffs are encouraged to attend Medical Staff meetings.

13-4 QUORUM

Those Active Staff members present and voting (in person or through electronic communication, if available and offered, shall constitute a quorum at any meeting, unless otherwise specified in these Bylaws.

13-5 MINUTES

Minutes of each regular and special meeting of the Medical Staff shall be prepared and shall include a record of the attendance of members and any votes taken on matters presented at the meeting. The minutes shall be signed by the presiding officer and maintained in a permanent file in the Medical Staff Office. Minutes shall be made available to any Medical Staff member upon request.

13-6 CONDUCT OF MEETINGS

Meetings of the Medical Staff will be run in a manner determined by the President or designee who shall preside. Compliance with rules of parliamentary procedure is not required.

ARTICLE XIV: CONFIDENTIALITY, IMMUNITY, AUTHORIZATIONS AND RELEASES

14-1 AUTHORIZATIONS AND RELEASES

Each practitioner shall, when requested by the hospital, execute general and specific releases and provide documents when requested by the President, chair of the Credentials or Medical Staff Quality Improvement Committees, the hospital CEO, or their respective designees. Failure to execute such releases or provide requested documentation shall result in an application for appointment, reappointment, and/or clinical privileges being deemed voluntarily withdrawn, and it shall not be further processed. By submitting an application for Medical Staff appointment or reappointment, or by applying for or exercising privileges or providing specified patient care services within the hospital, all practitioners, without limitation:

A. Authorize representatives of the hospital and of the Medical Staff to solicit, procure, provide, and/or act upon information bearing on or reasonably believed to bear upon the practitioner's professional abilities and qualifications;
B. Agree to be bound by the provisions of these Bylaws and Medical Staff rules, regulations and policies regardless of whether membership or clinical privileges are granted or subsequently restricted;
C. Acknowledge that the provisions of this Article are express conditions to an application for, or acceptance of, staff membership, and the continuation of such membership and/or the exercise of clinical privileges or provision of specified patient care services at the hospital;
D. Agree to release from legal liability and hold harmless the hospital or its affiliates, its Medical Staff, and any representative of the hospital or Medical Staff who acts to carry out Medical Staff or hospital policies or functions, including all persons engaged in credentialing, peer review and performance improvement activities. In addition, all practitioners agree that their sole remedy for any credentialing, corrective action or peer review action taken or recommended by the MEC for failure to comply with or meet the requirements of these Bylaws or Medical Staff or hospital policies, will be the right to seek injunctive relief, but only after they have exhausted the administrative remedies in these Bylaws;
E. Agree to release from legal liability and hold harmless any individual who or entity which provides information (including peer review information) regarding the practitioner to the hospital or its representatives; and
F. Subject to the requirements and provisions of the Americans with Disabilities Act and Maine Human Rights Act, agree to submit to an independent health evaluation upon request of the Medical Staff President, hospital CEO, or hospital CMO or designee, whenever there are reasonable grounds to believe the practitioner may not safely and competently exercise, with or without reasonable accommodation, the clinical privileges granted and/or requested.

14-2 CONFIDENTIALITY

Information submitted with respect to any practitioner, which has been collected or prepared by any representative for the purposes of peer review shall, to the fullest extent permitted by law, be considered confidential. Such information shall not be disseminated by SMHC to anyone other than representatives of other health care facilities and organizations of health professionals, or governmental agencies engaged in an official activity or regular proceedings for which the information

is needed, provided the confidentiality of such information is maintained to the extent feasible, nor shall such information be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided to SMHC by third parties. Such information shall not become part of any patient's record. It is expressly acknowledged by each practitioner that violation of the confidentiality provided herein is grounds for immediate and permanent revocation of Staff appointment and/or clinical privileges or specified services.

14-3 IMMUNITY FROM LIABILITY

14-3.1 For Actions Taken

Representatives of the hospital and the Medical Staff shall have absolute release from any and all liability in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of their duties as such representatives and which were undertaken in good faith.

14-3.2 Providing Information

Representatives of the hospital, the Medical Staff and any third party shall have absolute release from any and all liability in any judicial proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of the hospital or of the Medical Staff or to any other hospital, organization or health professionals, or other health-related organizations, concerning practitioners who are or have been an applicant to or member of the staff or who did or does exercise privileges or provide specified services at this hospital.

14-4 ACTIVITIES AND INFORMATION COVERED

A. Activities:

The provisions of this Article shall apply to acts, communications, reports, evaluations, recommendations, or disclosures in connection with this or any other health-related institution or organization's activities concerning, but not limited to:

1. Applications for appointment, clinical privileges or specified service;
2. Periodic reappraisals for reappointment, clinical privileges or specified services;
3. Disciplinary measures, including warnings and reprimands;
4. Corrective actions;
5. Hearings and appellate reviews;
6. Performance Improvement activities including the creation and dissemination of performance profiles;
7. Peer review activities, including external peer review;
8. Utilization and claims reviews; and
9. Other hospital or committee activities related to monitoring and maintaining of quality patient care and appropriate professional conduct.

B. Information:

The acts, communications, reports, letters, evaluations, performance data, disclosures and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical or procedural abilities, judgment, character, physical and mental health, emotional stability, professional ethics, professional conduct or any other matter that might directly or indirectly affect patient care and/or the effective and efficient operation of the hospital and Medical Staff.

14-5 CUMULATIVE EFFECT

Provisions in these Bylaws and in application forms relating to authorizations, releases, confidentiality of information and immunities from liability shall be in addition to other protections provided by local, state and federal law and not in limitation thereof.

ARTICLE XV: GENERAL PROVISIONS

15-1 MEDICAL STAFF RULES, REGULATIONS, AND POLICIES

Subject to approval by the hospital Board or its designee, the Medical Executive Committee shall adopt such rules, regulations and policies as may be necessary to carry out the responsibilities and functions of the Medical Staff and implement its operations. There shall be no substantive distinction between rules, regulations, and policies.

15-2 PEER REVIEW BODY

The Medical Executive Committee, the hospital Board, Medical Staff committees, or any group or body of Medical Staff members and/or hospital personnel which monitors, evaluates, and/or takes action to review the credentials of practitioners or to improve the delivery, quality, safety and/or efficiency of services provided by members of the Medical Staff and other practitioners credentialed by the hospital shall be considered, for purposes of protecting confidential information and providing immunity from liability under applicable law, a peer review body as defined under Maine law.

The files, records, findings, opinions, recommendations, evaluations, and reports of such committees and bodies, information provided to, or obtained by, such committees and bodies, and the identity of persons providing information to such committees or bodies, to the fullest extent permitted by law, shall be considered to be privileged and confidential information.

The members of such committees and bodies, persons acting as staff to such committees and bodies, persons who participate with or assist such committees or bodies, and such committees and bodies themselves, to the fullest extent permitted by law, shall be immune from liability for actions taken or recommendation made within the scope of the functions of the committee or body.

15-3 PAYMENT OF DUES AND FEES

Annual Medical Staff dues may be recommended by the Medical Executive Committee. Payments will be managed by the Medical Staff Office and disbursements will be authorized by vote of the MEC. Signatories to the Medical Staff account will be the President and/or Vice President of the Medical Staff, and the President will give an annual accounting to the MEC and Medical Staff. Failure to pay dues may result in ineligibility for reappointment.

15-4 CONFLICT OF INTEREST

All members of the Medical Staff are expected to comply with any Conflict of Interest policies which may be adopted from time to time by the Medical Executive Committee or the Board.

15-5 JOINT CONFERENCE

Whenever the Board's proposed decision will be contrary to the MEC's recommendation, the Board shall submit the matter to a Joint Conference of an equal number of Medical Staff and Board members for review and recommendation before making its final decision and giving notice of final decision. Individuals participating in a Joint Conference will be appointed by the Medical Staff President and Chair of the Board. The MEC or the Board may also request the convening of a Joint Conference to discuss any matter of controversy or concern that would benefit from enhanced dialogue between Medical Staff and Board leaders.

15-6 HISTORIES AND PHYSICALS

A medical history and physical examination must be completed no more than 30 days before or 24 hours after admission or registration, but prior to surgery, an interventional diagnostic procedure, or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral/maxillofacial surgeon, or other qualified licensed individual with privileges to do so, in accordance with state law and hospital policy.

An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery, an interventional diagnostic procedure, or a procedure requiring anesthesia services, when the medical history and physical examination is 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, an oral/ maxillofacial surgeon, or other qualified licensed individual with privileges to do so, in accordance with state law and hospital policy.

15-7 COMMUNICATION

Communication between members of the Medical Staff and the hospital, Medical Staff, and their representatives will be via electronic mail (email) and all members of the Medical Staff are required to maintain an email account through which such communication can be carried out.

ARTICLE XVI: ADOPTION AND AMENDMENT OF MEDICAL STAFF GOVERNING DOCUMENTS

16-1 REVIEW, REVISION, ADOPTION, AND AMENDMENT OF BYLAWS

The Medical Staff shall have the responsibility to review its governing documents at least every 36 months. The Medical Staff can exercise this responsibility through its elected and appointed leaders, a committee, or through direct vote of its membership. Neither the Medical Staff nor the Board shall unilaterally amend the Medical Staff Bylaws.

Proposed amendments to these documents may be made by the MEC, a Medical Staff committee, or by a petition signed by 20 percent of the members of the Active Staff, as outlined in Section 4-4 of these Bylaws. When proposed by the MEC, there will be communication of the proposed amendment to the Medical Staff for approval prior to presentation to the Board of Trustees for final approval.

16-1.1 Proposing Amendments

Amendments to these documents may be proposed by the MEC or by a petition signed by 20 percent of the members of the Active Staff, as outlined in Section 4-4 of these Bylaws.

16-1.2 Voting and Adoption of Amendments

The MEC shall vote on proposed amendments at a regular meeting or at a special meeting called for such purpose. Following an affirmative vote by the MEC, all members of the Active Medical Staff shall receive a description of the proposed amendment(s) by email. At least thirty days following this dissemination of the proposed amendment, all eligible members of the Medical Staff will be able to vote on the proposed amendment(s). This vote may be conducted at a regular or special meeting of the Medical Staff, or via printed or electronic ballot in a manner determined by the MEC. Votes in favor of amendment(s) or those that are not returned will be considered affirmative votes in support of the MEC recommendations for amendment(s). To be adopted, the proposed amendment(s) must be affirmed by a majority of the members of the Active Medical Staff and the hospital Board must subsequently ratify the amendment. Once approved by the Board, the Medical Staff will be notified of the revisions.

16-1.3 Urgent Amendments

In cases of documented need for an urgent bylaws amendment in order to comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve, such urgent amendment without prior notification of the Medical Staff. In such cases the Medical Staff will be immediately notified by the MEC and a Medical Staff vote on the amendment will be held as soon as practicable.

16-2 METHODS OF ADOPTION AND AMENDMENT TO THE MEDICAL STAFF CREDENTIALS MANUAL, ADVANCED PRACTICE PROVIDER (APP) MANUAL, RULES AND REGULATIONS, POLICIES AND PROCEDURES

16-2.1 Reviewing Proposed Amendments

All proposed amendments to the Credentials Manual, Advanced Practice Provider (APP) Manual, Rules and Regulations, or other Medical Staff manuals, policies and procedures, whether originated by members of the Medical Staff, MEC or another standing committee, must be reviewed and discussed by the MEC prior to MEC vote.

16-2.2 Voting and Adoption of Amendments

The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, any of these documents may be adopted, amended or repealed, in whole or in part and such changes shall be effective when approved by the Board.

16-3 TECHNICAL/LEGAL CHANGES TO MEDICAL STAFF DOCUMENTS

The MEC may adopt such amendments to Medical Staff Bylaws, manuals, rules, regulations, and policies that are, in the committee's judgment, technical modifications or clarifications, consist of reorganization or renumbering of material, or are needed due to punctuation, spelling, or other errors of grammar or expression. Such amendments need not be ratified by the Board. The MEC may also adopt minor language changes necessary to bring these Bylaws into strict compliance with laws or regulations. Such amendments must be ratified by the Board.

Adopted by:
MEC: October 17, 2013
Medical Staff: December 19, 2013
Hospital Board of Directors: December 9, 2013

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MEC: August 21, 2014
Full Medical Staff: September 18, 2014
Board of Trustees: October 6, 2014

Revised:
MEC: January 22, 2016
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Revised:

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Full Medical Staff: January 26, 2017
Board of Trustees: February 6, 2017