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The organizational component of the hospital to which these Bylaws and the related manuals are addressed is called "The Medical Staff of The Westerly Hospital".

ARTICLE TWO: PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

2.1 **PURPOSES**

The purposes of this medical staff are:

2.1.1 To provide a mechanism for accountability to the Board of Trustees, through defined organizational components and positions, for the appropriateness of the patient care services, professional and ethical conduct of each individual practitioner appointed to the medical staff and each individual practitioner who, though not appointed to the medical staff, have privileges at the institution.

2.1.2 To serve as the peer review body through which individual practitioners may obtain prerogatives and clinical privileges at the hospital, through which they fulfill the obligations of staff appointment.

2.1.3 To provide, on behalf of the hospital an appropriate educational setting for continuing medical education programs for members of the medical staff.

2.1.4 To provide an orderly and systematic means by which staff members can give input to the Board of Trustees and Chief Executive Officer on medico-administrative problems and on the hospital's policy-making and planning processes.

2.2 **RESPONSIBILITIES**

To effectuate the purposes enumerated above, the responsibilities of the medical staff are:

2.2.1 To participate in the hospital's quality review and utilization management program by conducting all required and necessary activities for assessing, maintaining and improving the quality of medical care provided in the hospital, including without limitation:

(a) Evaluating practitioner and institutional performance through valid and reliable measurement systems based when appropriate on objective, clinically sound criteria.

(b) Engaging in the ongoing monitoring of patient care practices.

(c) Evaluating practitioner's credentials for appointment and reappointment to the medical staff and for the delineation of clinical privileges that may be exercised by each individual practitioner in the hospital.
(d) Promoting the appropriate use of the medical and health care resources at the hospital for meeting patients' medical, social and emotional needs.

2.2.2 To make recommendations through the Medical Executive Committee to the Board of Trustees concerning appointments and reappointments to the staff, including category and department assignments, clinical privileges, and corrective action.

2.2.3 To conduct and monitor medical education programs.

2.2.4 To develop and maintain Bylaws and related manuals and policies that is consistent with sound professional practices, organizational principles, and external requirements, and to enforce compliance with them.

2.2.5 To participate in the hospital's long range planning activity, to assist in identifying community health needs and to participate in developing and implementing appropriate institutional policies and programs to meet those needs.

2.2.6 To exercise through its officers, committees and other defined components the authority granted by these Bylaws and related manuals to fulfill these responsibilities in a timely and proper manner and to account thereon to the Board of Trustees.

The specific activities involved in carrying out these responsibilities are set forth in Part Two of the Medical Staff Organization Manual.

ARTICLE THREE: APPOINTMENT AND REAPPOINTMENT

3.1 GENERAL QUALIFICATIONS

Every practitioner who seeks staff appointment must, at the time of application and initial appointment and continuously thereafter, demonstrate to the satisfaction of the appropriate authorities of the medical staff and of the Board of Trustees the following qualifications and procedural requirements as are set forth in other sections of these Bylaws or in the Credentialing Procedure Manual.

3.1.1 LICENSURE

Every practitioner must have a currently valid license issued by the State of Rhode Island and/or the State of Connecticut if practice limited to that State. A practitioner may be a physician, dentist, podiatrist, certified registered nurse anesthetist, certified registered nurse practitioner, certified nurse midwife, or certified physician assistant.

Exception is made according to RI law 5-37-14 for practitioners who do not have an office location in Rhode Island but provide telemedicine consultative services to Rhode Island licensed providers.

3.1.2 DEFINITIONS
Advanced practice nurse means the status of qualified individuals who hold an active license as a registered nurse and an active license as a nurse in an advanced role as defined by Rhode Island General Laws.

1. Certified Registered Nurse Anesthetist (CRNA)

   The practice of certified registered nurse anesthesia means providing certain health care services under the supervision of anesthesiologists and licensed physicians which requires substantial specialized knowledge, judgment and skill related to the administration of anesthesia, including pre-operative and post-operative assessment of patients; administering anesthetics; monitoring patients during anesthesia; management of fluid in intravenous therapy and management of respiratory care.

2. Certified Registered Nurse Practitioner (RNP)

   Certified registered nurse practitioner means an advanced practice nurse utilizing independent knowledge of physical assessment and management of health care and illnesses. The practice includes prescriptive privileges, and collaboration with other licensed health care professionals, including, but not limited to, physicians, pharmacists, podiatrists, dentists and nurses.

3. Certified Nurse Midwife (CNM)

   The practice of nurse midwifery means the management of cases of normal childbirth, including prenatal, intrapartum, postpartum, and normal newborn care, and well woman care including the management of common health problems.

4. Certified Physician Assistant (PA)

   Physician assistant means a person who is qualified by academic and practical training to provide those certain patient services in which he or she is trained under the supervision, control, responsibility and direction of a licensed physician.

### 3.1.3 Supervision

Requirements for supervision of advanced practice nurses and physician assistants practicing at the hospital shall be delineated by these medical staff bylaws: supervision means overseeing the activities of, and accepting the responsibility for, the services rendered by these practitioners. Supervision shall be continuous and under the direct control of a licensed physician expert in the field of medicine in which the certified physician assistant, certified registered nurse anesthetist, certified registered nurse
practitioner, or certified nurse midwife practices. The constant physical presence of the supervising physician is not required. It is the responsibility of the supervising physician and practitioner to assure an appropriate level of supervision, depending upon the services being rendered. A signed agreement delineating the level of supervision provided and physician availability, as well as patient care responsibilities and procedures to be performed must be on file.

3.1.4 PROFESSIONAL EDUCATION AND TRAINING

(a) Physicians, Dentists and Podiatrists

Every practitioner must be a graduate of an approved allopathic or osteopathic medical school, or a dental or podiatric school, or certified by the Education Commission for Foreign Medical Graduates or have a Fifth Pathway. If a physician, he or she must document satisfactory completion of an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved postgraduate training program. If a dentist, he or she must document satisfactory completion of at least one year of an American Dental Association approved residency. If a podiatrist, he or she must document satisfactory completion of residency training at an institution approved by the Council on Podiatric Medical Education, and board certification/qualification in foot surgery by the American Board of Podiatric Surgery.

For purposes of this section, an "approved" school, respectively, is one fully accredited during the time of the practitioner's attendance by the Liaison Committee on Medical Education of the Association of American Medical Colleges and the American Medical Association; by the American Osteopathic Association; by the Commission on Dental Accreditation of the American Dental Association; by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or by a successor agency to any of the foregoing or by an equivalent professionally recognized accrediting body. An "approved" postgraduate training program, respectively, is one fully accredited throughout the time of the practitioner's training by the Accreditation Council for Graduate Medical Education; by the American Osteopathic Association; by the Commission on Dental Accreditation; by the Council on Podiatric Medical Education; or by a successor agency to any of the foregoing or by an equivalent professionally recognized national accrediting body. The requirement for satisfactory completion of approved postgraduate training shall be waived for any practitioner who was a member of the staff prior to the effective date of these Bylaws and may be waived by the Board of Trustees for any subsequent applicant if it deems such waiver to be in the best interest of patient care and if such waiver
is endorsed by the applicable department chairman, the Credentials Committee, and the Medical Executive Committee.

(b) Certified Registered Nurse Anesthetist, Certified Registered Nurse Practitioner, Certified Nurse Midwife, and Certified Physician Assistant
Every Certified Registered Nurse Anesthetist must be a graduate from a state approved basic nursing education program, and must be a graduate of an education program accredited by the American Association of Nurse Anesthetists Council on Accreditation of Nurse Anesthesia Educational Programs, which has as its objective preparation of nurses to practice nurse anesthesia.

Every Certified Registered Nurse Practitioner must be a graduate from a state approved basic nursing education program, and must be a graduate of a Board of Nurse Registration and Nursing Education approved course of study for nurse practitioners conducted within an accredited academic institution, the course of study including both a didactic component and a supervised clinical experience.

Every Certified Nurse Midwife must be a graduate from a state approved, and accredited educational program resulting in a master’s degree with a major in nursing, and a graduate from an academic and practical program of midwifery approved by the American College of Nurse-Midwives.

Every Certified Physician Assistant must be a graduate from a physician assistant training program accredited by the Accreditation Review Commission on Education for the Physician Assistant, which is recognized by the Council for Higher Education Accreditation.

(c) Continuing Education
All members of the medical staff must provide evidence of continuing educational credits earned, as specified by current requirements of the practitioner’s licensing body of the State of Rhode Island, Department of Health and/or the State of Connecticut, Department of Health. The current Rhode Island requirement is forty (40) continuing medical education credits every two (2) years. The current Connecticut requirement is fifty (50) continuing medical education credits every two (2) years.

3.1.5 CLINICAL PERFORMANCE
The Westerly Hospital subscribes to an evidence-based privileging process. Every practitioner who holds clinical privileges is subject to a focused professional practice

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evaluation on initial appointment and ongoing professional practice evaluations. Indicators of quality patient care are expected of all evaluation outcomes. A practitioner also may undergo a focused professional practice evaluation at any time should a concern arise about quality performance. A resolution of the concern and improvement of practitioner performance must be achieved.

(a) **Focused Professional Practice Evaluation**
The Focused Professional Practice Evaluation focuses on three specific aspects of performance: to evaluate competence on initial appointment, to confirm competence of a new privilege within the organization’s setting or a privilege new to the practitioner, and, to examine negative performance “triggers” (single incident or trend) that manifest during the course of the Ongoing Professional Practice Evaluation.

(b) **Ongoing Professional Practice Evaluation**
The Ongoing Professional Practice Evaluation is an objective measure of performance using a variety of data sets, and serves as the basis for an evidence-based privileging process.

### 3.1.6 COOPERATIVENESS

Every practitioner must demonstrate ability to work with and relate to other staff members, members of other health disciplines, hospital management and employees, the Board of Trustees, in a professional manner that is essential for maintaining an environment appropriate to quality patient care.

### 3.1.7 SATISFACTION OF MEMBERSHIP OBLIGATIONS

Every practitioner must demonstrate satisfactory compliance with the basic obligations accompanying appointment and reappointment to the staff as set forth in Section 3.2 of these Bylaws and equitable participation, as determined by the appropriate staff and board authorities, in the discharge of staff obligations specific to staff category.

### 3.1.8 PROFESSIONAL standards of medical and professional ethics.

### 3.1.9 DISABILITY

The practitioner must be free of or have under adequate control any significant physical or mental health impairment and to be free from abuse of any type of substance or chemical that affects cognitive, motor, or communication ability in a manner that interferes with, or presents a reasonable probability of interfering with, the qualifications required by Section 3.1.3 through 3.1.6.
3.1.10 VERBAL AND WRITTEN COMMUNICATION SKILLS
The practitioner must have the ability to understand, speak, write and read the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible manner.

3.1.11 PROFESSIONAL LIABILITY INSURANCE
Members of the medical staff are required to carry sufficient malpractice insurance, the level to be determined by the Board of Trustees from time to time. A lapse in coverage for any reason must be reported in writing to the medical staff office. A current "certificate of insurance" must be on file at all times in the practitioner’s credentials file.

3.1.12 EFFECTS OF OTHER AFFILIATIONS
No practitioner shall be automatically entitled to initial appointment merely because:
(a) He or she is licensed to practice in this or in any other state; or
(b) He or she is certified by any clinical board; or
(c) He or she is a member of a medical school faculty; or
(d) He or she had, or presently has staff appointment or privileges at another health care facility or in another practice setting.

3.1.13 NONDISCRIMINATION
No aspect of medical staff appointment or particular clinical privileges shall be denied on the basis of: age; sex; race; creed; color; national origin; a handicap unrelated to the ability to fulfill patient care and required staff obligations; or, any other criterion unrelated to the delivery of quality patient care in the hospital, to professional qualifications, to the hospital's purposes, needs and capabilities, or to community need.

3.1.14 BOARD CERTIFICATION
(a) Physicians, Dentists and Podiatrists

Initial Board Certification and subsequent required Recertification by a Board approved by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Dental Association (ADA), or equivalent Podiatric organization (American Board of Podiatric Surgery, American Board of Podiatric Orthopedics and Primary Podiatric Medicine, or the American Board of Podiatric Public Health) is required of all members of the Medical Staff.

Applicants for staff membership in any category must either be Board Certified or in the Board certification process (training completed with the intent to take the
certification examination) as a basic requirement to make an application to the Medical Staff. At the sole discretion of the MEC, a foreign board certification may be accepted to fulfill this requirement on a case-by-case basis.

If any one of the following periods has elapsed and board certification or required recertification has not been achieved, the Member’s membership to the Medical Staff may be withdrawn:

   a. Five years from the initial granting of Membership
   b. The certification process has ended and the Member is no longer eligible to sit for the board examination
   c. A candidate for Medical Staff reappointment fails to qualify for required recertification within five years of the required recertification date

A member or applicant who fails to meet the initial Board Certification or subsequent required recertification requirements as described in this section, shall be eligible for Medical Staff membership only if the Credentials Committee and the MEC recommend an exception. Such an exception may be recommended through the appointment or reappointment process only if the applicant can clearly demonstrate equivalent qualification. The burden of such demonstration shall rest solely upon the applicant or member.

(b) **Certified Registered Nurse Anesthetist, Certified Registered Nurse Practitioner, Certified Nurse Midwife, and Certified Physician Assistant**

A Certified Registered Nurse Anesthetist shall be initially certified by the Council on Certification of Nurse Anesthetists, and recertified by the Council on Recertification, National Board on Certification and Recertification of Nurse Anesthetists.

A Certified Registered Nurse Practitioner shall be certified through a national nursing body recognized by the Rhode Island Board of Nurse Registration and Nursing Education (e.g., American Nurses Credentialing Center) and recertified through a national nursing body recognized by the Rhode Island Board of Nurse Registration and Nursing Education (e.g., American Nurses Credentialing Center).

A Certified Nurse Midwife shall be certified by the American Midwifery Certification Board and recertified by the American Midwifery Certification Board.
A Certified Physician Assistant shall be certified by the National Commission on Certification of Physician Assistants.

3.1.15 NOTIFICATION REQUIREMENT
A Medical or HPA Staff member is required to advise the President of the Medical Staff or the Chief Executive Officer in writing immediately upon any of the following:

- Revocation of practitioner’s license to practice in any state;
- Restriction, limitation or suspension of practitioner’s license, Drug Enforcement Administration (DEA) permit or other controlled substances number, medical staff membership, or clinical privileges by any healthcare or governmental entity;
- Probation or reprimand by any licensing authority;
- Any change in professional liability insurance coverage

Failure to do so shall be grounds for corrective action, including possible immediate suspension of privileges. Practitioners involved in suspension as a result of any of these circumstances are not afforded an opportunity for hearing or appellate review.

3.2 BASIC OBLIGATIONS OF ACTIVE AND ACTIVE REFERRING STAFF MEMBERSHIP
Each medical staff member, as applicable of his/her assigned staff category, and each practitioner exercising temporary privileges under these Bylaws shall:

(a) Provide his or her patients with care at the level of quality generally recognized as appropriate at facilities such as the hospital;
(b) Abide by the Medical Staff Bylaws, Fair Hearing Plan, Credentials Manual and Departmental Rules and Regulations, the Bylaws of the corporation, and all other lawful standards, policies and rules of the Medical Staff;
(c) Discharge such staff, committee, department, and hospital functions for which he or she is responsible by staff category assignment, appointment, and election or otherwise.
(d) Maintain a consistent process for the completion of Medical Records as outlined in the Rules and Regulations. Specifically, a medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient’s medical record within 24 hours of admission. When the medical history and physical examination are completed within 30 days before admission, an updated medical record entry documenting an examination for any changes in the patient’s condition shall be completed. This updated examination must be completed and documented in the
patient’s medical record within 24 hours after admission and prior to any surgical procedure or procedure requiring anesthesia services.

(e) Pledge to provide or arrange for appropriate and timely medical coverage and care for patients for whom he or she is responsible.

Failure to satisfy any of these basic obligations is grounds, as warranted by the circumstances, for non-reappointment or for such other disciplinary action as deemed appropriate by the final action of the board pursuant to Article Six of these Bylaws.

### 3.3 TERM OF APPOINTMENT

Appointments to the Medical Staff and granting of clinical privileges are for a period of two years, except that:

New members of the medical staff are subject to an initial provisional period, or Focused Professional Practice Evaluation, as privileges are granted through an evidence-based privileging process. Upon satisfactory conclusion of this period, practitioners are placed in the appropriate reappointment cycle as determined by the hospital’s system of reappointment on the anniversary date of initial appointment. The Board of Trustees, after considering the recommendations of the applicable departments, the Credentials Committee, and the Medical Executive Committee, may set a more frequent reappraisal period for the exercise of particular privileges for a staff member who has an identified health disability, for a staff member who has been disciplined, or where a concern in performance has been identified. In these instances, the practitioner will undergo a Focused Professional Practice Evaluation to determine whether the practitioner’s performance is commensurate to which can reasonably be expected of a practitioner with similar training, experience and background. Disciplinary action involving membership and or clinical privileges may be initiated and taken prior to the end of a staff member's term of appointment or reappointment under the appropriate provisions of these Bylaws and related manuals.

### 3.4 PROVISIONAL PERIOD

#### 3.4.1 APPLICABILITY AND DURATION

All new appointees to the Medical Staff are considered provisional for the first 24 months after appointment, unless an extension is granted. Additionally, all grants of increased clinical privileges to existing members of the Medical Staff are similarly provisional for a 24 month period after grant, unless an extension is granted. During this provisional period, a practitioner’s performance will be reviewed and evaluated by the chairman of the department with which he/she has his/her primary affiliation and by the chairman of each other department in which he/she exercises his/her initial or increased privileges, or by other active Medical Staff members specifically delegated these tasks by such chairman. If the department chair is a contract member of the Medical Staff on
provisional status, the President of the Medical Staff will assume the performance review function.

3.4.2 STATUS AND PRIVILEGES DURING PROVISIONAL PERIOD

During the provisional period, a practitioner must demonstrate all of the qualifications, may exercise all of the prerogatives, and must fulfill all of the obligations of his/her staff category; and he/she may exercise all of the clinical privileges granted to him/her. A practitioner’s exercise of prerogatives and clinical privileges during the provisional period is subject to any conditions or limitations imposed as part of his/her appointment to the Medical Staff or grant of privileges, or as may be imposed during the term of the provisional period as a result of corrective action taken pursuant to Article Six of these Bylaws.

3.4.3 PROCEDURES FOR APPOINTMENT, REAPPOINTMENT AND CONCLUDING THE PROVISIONAL PERIOD

The mechanisms for submitting, evaluating and making final decisions on applications for initial appointment, for conducting periodic reappraisals for reappointment to the Staff, and for concluding or extending the initial period are outlined in Parts One, Two and Four of the Credentialing Procedures Manual, which are incorporated herein by reference.

3.5 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT

3.5.1 QUALIFICATIONS AND SELECTION

A practitioner who is or who will be providing professional services pursuant to a contract/employment with the hospital must meet the same appointment qualifications, must be evaluated for appointment, reappointment and clinical privileges in the same manner, and must fulfill all of the obligations of his/her category as any other applicant or staff member.

3.5.2 EFFECT OF APPOINTMENT TERMINATION OR CLINICAL PRIVILEGES RESTRICTION

Because practice at the hospital is contingent upon continued staff appointment and is also constrained by the extent of clinical privileges enjoyed, a practitioner's right to use hospital facilities is terminated when staff appointment expires or is terminated. Similarly, the extent of his/her clinical privileges is automatically limited to the extent that pertinent clinical privileges are restricted or revoked.

3.5.3 EFFECT OF CONTRACT/EMPLOYMENT EXPIRATION OR TERMINATION

(a) The effect of expiration or other termination of a contract/employment upon a practitioner's staff appointment and clinical privileges will be governed solely by
the terms of the practitioner's contract/employment with the hospital, if the same addresses the issue.

(b) If the contract/employment arrangement is silent on the matter, then contract/employment expiration or other termination alone will not affect the practitioner's appointment or clinical privileges, except that the practitioner may not thereafter exercise any clinical privileges for which exclusive contractual arrangements have been made.

3.6 MEDICO-ADMINISTRATIVE OFFICERS

3.6.1 DEFINED

A medico-administrative officer is a practitioner engaged by the hospital or medical staff either full or part time in an administratively responsible capacity whose activities also include clinical responsibilities such as direct patient care, teaching or supervision of the patient care activities of other practitioners under the officer's direction.

3.6.2 STAFF APPOINTMENT, CLINICAL PRIVILEGES AND OBLIGATIONS

A medico-administrative officer must achieve and maintain medical staff appointment and clinical privileges appropriate to his/her clinical responsibilities, and discharge staff obligations appropriate to his/her staff category, in the same manner applicable to all other staff members.

3.6.3 EFFECT OF REMOVAL FROM OFFICE OR ADVERSE CHANGE IN APPOINTMENT STATUS OR CLINICAL PRIVILEGES

(a) The effect of the removal from his/her medico-administrative office on the officer's staff appointment and clinical privileges, and the effect of an adverse change in an officer's staff appointment (less than total revocation) or clinical privileges on continuance in his/her medico-administrative office, will be governed solely by the terms of the contract between the officer and the hospital, if the contract addresses those points. An adverse change in appointment status or clinical privileges as specified in Section 1.1 of the Fair Hearing Plan that is not triggered by removal from a medico-administrative office entitles the officer to the internal remedies provided in Article Seven of these Bylaws and to the procedural rights contained in the Fair Hearing Plan.

(b) In the absence of a contract or where the contract is silent on the matter, removal from office alone will have no effect on appointment status or clinical privileges, except that the practitioner may not thereafter exercise any clinical privileges for which exclusive contractual arrangements have been made; continuance in office
following loss of staff appointment is impermissible under Section 3.7.2; and the effect of an adverse change in clinical privileges on continuance in office will be as determined by the Board of Trustees after soliciting and considering the recommendations of relevant components and officials of the staff.

3.7 ADMINISTRATIVE PHYSICIAN

3.7.1 DEFINED
Physician employed by Hospital on a contractual relationship to serve administrative functions, i.e. Vice President of Medical Affairs, Medical Director, or similar position. This position may have clinical privileges if they do not conflict with the administrative functions. This would be determined by the Medical Executive Committee.

3.7.2 STAFF APPOINTMENT AND OBLIGATIONS
The administrative physician must achieve and maintain Medical Staff and discharge staff obligations in the same manner applicable to other Staff members.

3.7.3 EFFECTIVE REMOVAL FROM OFFICE
Removal from office will not result in relinquishing of Medical Staff membership if credentialed in non-administrative areas. The prior administrative position will have no bearing on future applications to the Medical Staff on specific clinical privileging. Membership in administrative position by contractual relationship would not imply preference in terms of future application to the Medical Staff.

3.8 EXHAUSTION OF ADMINISTRATIVE REMEDIES
Every applicant to and member of the medical staff agrees that when corrective action is initiated or taken pursuant to Article Six of these Bylaws, or when the provisions of Section 11.4 of these Bylaws are implemented, or when an adverse ruling as defined in Section 1.1 of the Fair Hearing Plan is proposed or made, he/she will exhaust the administrative remedies afforded in the various Sections of these Bylaws, in the Credentialing Procedures Manual, and in the Fair Hearing Plan.

3.9 EXPEDITED CREDENTIALING
At the sole discretion of the Medical Staff, expedited board approval may be requested for the following Medical Staff actions:

- Initial appointment to the Medical Staff
- Reappointment to the Medical Staff
- Granting of additional privileges

The authority to render this expedited decision may be delegated by the Board to a committee of at least two voting members of the Board when the following criteria are met:

1. The applicant submits a complete application for initial appointment, reappointment or the granting of additional privileges.

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2. The Credentials Committee makes a final recommendation in favor of appointment, reappointment or the granting of additional privileges with no limitations; and

3. The Medical Executive Committee makes a final recommendation in favor of appointment, reappointment or the granting of additional privileges with no limitations.

An application is ineligible for the expedited process if any of the following has occurred:

1. The applicant submits an incomplete application; or
2. The Medical Executive Committee makes a final recommendation that is adverse or has limitations.

Other situations which shall be evaluated on a case-by-case basis include, but are not limited to the following, which usually result in a determination of ineligibility for the expedited process:

1. There is a current challenge or a previously successful challenge to licensure or registration; or
2. The applicant has received involuntary termination of medical staff membership at another hospital; or
3. The applicant has received involuntary limitation, reduction, denial or loss of clinical privileges; or
4. The Hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Expedited credentialing is within the sole discretion of the Medical Staff and the Board and/or their respective committees and sub-committees.

3.10 CONFLICT OF INTEREST POLICY
This policy serves as a guideline for the disclosure of and resolution of potential conflicts of interest of any medical staff members serving on committees of the medical staff and hospital. Elected officers, department chairs, and any other medical staff members appointed or elected to committees have a fiduciary obligation to represent the highest interests of the medical staff in upholding the quality of care provided at Westerly Hospital. It is important for members of committees or medical staff meetings to be aware of potential conflicts of interest that may arise from a person’s affiliations, activities, or compensation.

a. The chairs of all committees, including ad hoc task forces, are encouraged to consider and discuss potential conflicts of interest. Standing committees shall use the guidelines of disclosure as follows:

b. Committee members shall disclose the existence of:
1) Ownership by a member or their immediate family of material financial interests in any company that furnishes goods or services to the hospital or is seeking to provide good or services to the hospital;

2) Any honoraria, speaker’s fees, research grants or funding, or consulting fees (for example, from a pharmaceutical company or a managed care organization);

3) Personal compensation from the hospital especially if pertinent to discussion of certain programs or proposals;

4) Participation on other organizations with potential conflicts of interest (e.g. other hospitals, HMO’s, competing private healthcare businesses);

5) Other personal relationships, activities, or interests which may inappropriately influence a member’s decisions or actions; and/or

6) Gifts, including goods and services or honoraria, from vendors who sell to the hospital. (Note: An “honorarium” or a payment for consulting services is a gift in whole or part unless it can be demonstrated that the recipient provided services of an equivalent value.)

c. Members of the following standing committees shall make an annual disclosure by questionnaire to the chairs and will make disclosures as appropriate during meetings: Medical Executive Committee, Pharmacy and Therapeutics Committee, Department of Surgery, and Credentials Committee. Ad hoc committees and other standing committees shall decide at the first meeting and annually thereafter if an annual disclosure by questionnaire will be required.

d. A general requirement that committee members with any potential conflicts of interest be excused from discussion of an issue may diminish the ability of the committee to have full, informed debate. If a member’s ability to render a fair and independent decision is jeopardized by the conflict of interest, the member should ask to be excused from discussion and/or vote. If a member does make such a request, and the majority of the other committee members believe that the Member should be excused from discussion or vote, the chair shall require the member to do so.

e. If a member discloses a potential conflict of interest and seeks a deliberation as to whether abstention from participation in discussion or vote is warranted, he/she should
leave the room while the remaining members determine whether a conflict of interest exists.

f. If a committee member has reasonable cause to believe that another member has failed to disclose a potential conflict of interest, such member shall inform the chair who shall provide an opportunity for the member in question to address the committee about the expressed concerns. The committee shall then deliberate as above. Any member who is required to request to be excused from participation in deliberations will be given an opportunity to appeal to the committee in person.

g. The minutes of the meeting shall include the names of persons excused for conflicts of interest and whether any discussion of potential conflicts of interest occurred. The nature of the conflict shall also be identified in the minutes.

ARTICLE FOUR: APPOINTMENT CATEGORIES

The medical staff member appointment categories are Active, Active Referring, Consulting, Affiliate, and Honorary.

4.1 ACTIVE STAFF

4.1.1 QUALIFICATIONS
An Active Staff member:
(a) Must have office(s) close enough to the hospital to provide continuing care to his or her patients, and to assure availability within a reasonable time frame when the patient's condition requires prompt attention, as applicable to staff category. Each department shall determine any specific time frames applicable to its members and state such specific time frames within its departmental rules and regulations.
(b) Must regularly admit patients to, or otherwise be regularly involved in the care of patients in the hospital facilities, or demonstrate by way of other substantial involvement in the activities of the medical staff or hospital a genuine concern and interest in the hospital.
(c) Must have demonstrated satisfactory performance through Focused Professional Practice Evaluation during the first year of appointment.

4.1.2 PREROGATIVES
An Active Staff member:
(a) May request admitting privileges, except as otherwise limited in the medical staff rules, the hospital Bylaws, and as applicable to staff category.
(b) May vote on all matters presented at general and special meetings of the medical staff and of the departments and committees of which he or she is a member, except as provided in these Bylaws or by resolution of the Medical Executive Committee.

(c) May hold office at any level in the staff organization and be chairman of a committee provided he or she satisfies the specific qualifications for the position involved and except as otherwise provided by these Bylaws or by resolution of the Medical Executive Committee.

(d) May exercise such clinical privileges as are granted to him or her.

(e) Active Staff members may apply for exemption from Emergency Department call, and committee assignments. Such exemptions may be granted based upon the hospital, medical staff and community needs for specific services, and will be approved by the appropriate department chairperson, the Credentials Committee, and the Medical Executive Committee.

(f) May advance to Senior Status, at age 65 or after 25 years of service at The Westerly Hospital, which may exempt the physician from Emergency Department call and Committee assignments if so desired.

### 4.1.3 OBLIGATIONS

An Active Staff member, in addition to meeting the basic obligations set forth in Section 3.2:

(a) Must contribute to the organizational and administrative and medico-administrative (including quality review, risk management and utilization management) activities of the medical staff, including service in medical staff and department offices and on hospital and medical staff committees, faithfully performing the duties of any office or position to which elected or appointed.

(b) Must participate equitably in the discharge of staff functions by: participating in the hospital's continuing education programs; providing consultation to other staff members consistent with his or her delineated privileges; reviewing the performance of practitioners during focused professional practice evaluation and ongoing professional practice evaluation; and fulfilling such other staff functions as may reasonably be required. Medical staff members, as applicable to staff category, must serve on the Emergency Department call schedules for the purpose of assignment to patients presenting at the Emergency Department who require urgent care, who require back-up specialty coverage, and for those patients who do not have a current physician-patient relationship.

(c) Must pay all Staff dues and assessments as specified in Section 13.3 of these Bylaws.
(d) Must meet patient contact requirements sets forth in 2.2 of the Credentials Manual.

4.2 **ACTIVE REFERRING STAFF**

4.2.1 **QUALIFICATIONS**

An Active Referring staff member must meet the basic qualifications set forth in Section 3.1.

4.2.2 **PREROGATIVES**

An Active Referring staff member:

(a) Shall relate to the hospital primarily through the direct referral of patients to the active medical staff for admission and/or evaluation.

(b) Shall be permitted to visit patients, review medical records, but shall have no admitting privileges nor be permitted to write independent orders, progress notes, or participate actively in the direct provision of inpatient care.

(c) May exercise such clinical privileges as are granted to him or her.

(d) May vote on all matters presented at general and special meetings of the medical staff and of the departments and committees of which he or she is a member, except as provided in these Bylaws or by resolution of the Medical Executive Committee.

(e) May hold office at any level in the staff organization and be chairman of a committee provided he or she satisfies the specific qualifications for the position involved and except as otherwise provided these Bylaws or by resolution of the Medical Executive Committee.

(f) May attend continuing medical education activities.

(g) May apply to the active medical staff.

(h) May advance to Senior Status at age 65 or after 25 years of service at The Westerly Hospital, which may exempt the physician from Emergency Department call and committee assignments if so desired.

4.2.3 **OBLIGATIONS**

(a) Must contribute to the organizational and administrative and medico-administrative (including quality review, risk management and utilization management) activities of the medical staff, including service in medical staff and department offices and on hospital and medical staff committees, faithfully performing the duties of any office or position to which elected or appointed.

(b) Must participate equitably in the discharge of staff functions by: participating in the hospital's continuing education programs and fulfilling such other staff functions as may reasonably be required. Active Referring staff members, as applicable to staff category, must be listed on the Emergency Department call...
4.3 CONSULTING STAFF

4.3.1 QUALIFICATIONS
A Consulting Staff member:
(a) Must be certified or eligible for certification in the consultant’s specialty/subspecialty
(b) Must have a recognized ability in his or her specialty or subspecialty
(c) Must pay all Staff dues and assessments as specified in Section 13.3 of these Bylaws.
(d) Must abide by the requirements of the Medical Staff Bylaws, Credentialing and Procedures Manuals and General Rules and Regulations for the Medical Staff.

The Active Referring Member must also provide the Medical Staff Office with a current and valid letter of intent from a member of the Hospitalist Group who is willing to provide inpatient admission coverage for the Active Referring Member’s patients. Failure to provide a currently valid, signed letter of intent will result in administrative resignation at the time of the biannual reappointment.

4.3.2 PREROGATIVES
A Consulting Staff member:
(a) May have primary responsibility for surgical cases. The number of cases is determined by the department of surgery and approved by the MEC.
(b) May consult on request of the attending physician.
(c) It is the responsibility of the consulting physician to arrange coverage for inpatients for whom he/she has primary responsibility if that physician may be unavailable.
(d) May exercise such clinical privileges as are granted to him or her.

4.3.3 OBLIGATIONS
A Consulting Staff member, in addition to meeting the basic obligations provided in Section 3.2:
(a) Must satisfy the special appearance requirements of Section 11.4-2 of these Bylaws.
(b) Must, if he or she agrees to accept a committee assignment, carry out such assignment in the same manner as required of an active staff member.

4.4 TELEMEDICINE STAFF
4.4.1 Telemedicine is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications schedules solely for assignment to patients who do not have a current physician-patient relationship and require follow-up care after discharge from the hospital.
for the purpose of providing patient care, treatment and services. Teleradiology is subset of
telemedicine which refers to the practice of providing either official or preliminary readings of
images, tracings solely through a telecommunications link.

4.4.2 QUALIFICATIONS
(a) Must have recognized ability within his/her specialty.
(b) Must be a licensed physician in RI, and a RI office maintained for the purpose of
patient care.
OR
Must comply with RI law § 5-37-14, for licensure requirements pertaining to physicians
who do not have an office in RI, but who provide telemedicine or other consultation
services to RI license physicians.

4.4.3 PREROGATIVES
(a) May exercise such clinical privileges as granted to him/her. Telemedicine Staff
will not have primary responsibility for patients.
(b) May attend meetings of the department to which he/she is appointed.
(c) Are not eligible to hold office in the staff organization, nor vote at meetings of the
Medical Staff, departments or committees.
(d) Are not required to pay annual Medical Staff dues.

4.4.4 OBLIGATIONS
Must abide by all requirements of the Medical Staff Bylaws, Credentialing Procedures
Manual and General Rules and Regulation for the Medical Staff, except as provided in
4.4.3 Prerogatives.

4.5 AFFILIATE STAFF
4.5.1 QUALIFICATIONS
An Affiliate Staff member must satisfy all the requirements of the Credentialing
Procedures Manual except that found in section 2.2 requiring activity during the previous
two credentialing cycles.

4.5.2 PREROGATIVES
An Affiliate Staff member may attend staff meetings, attend continuing medical
education courses, visit patients in the hospital and attend other Medical Staff functions.
Affiliate Staff members have no clinical privileges and therefore are not allowed to
admit, consult, operate or vote.

4.5.3 OBLIGATIONS
Must abide by the requirements of Medical Staff Bylaws, Credentialing, Procedures
Manual and the General Rules and Regulations for the Medical Staff. If the Affiliate
Staff Member is a physician, he/she must also provide the Medical Staff Office with a
current and valid letter of intent from an Active Staff Member who is willing to provide
inpatient admission coverage for the Affiliate Staff Members’ patients or have an arrangement with the Hospitalist practice for inpatient care. Failure to provide a currently valid, signed letter of intent will result in administrative resignation at the time of the biannual reappointment.

4.6 HONORARY STAFF

Membership on the Honorary Staff is restricted to two classes of practitioners: (1) former staff members who, upon retirement from practice, the Medical Executive Committee recommends to the Board of Trustees for this status in recognition of long-standing service to the hospital or other noteworthy contributions to its activities; and (2) other practitioners with outstanding professional attainments. Honorary staff members may attend meetings of the staff, but they have no vote and none of the specific qualifications, prerogatives, obligations nor privileges provided for other staff categories.

4.7 OTHER CATEGORIES OF NON-PHYSICIAN MEDICAL STAFF

Other categories of non-physician medical staff may be credentialed and privileged through the medical staff office, applicable to medical staff category, such as, Clinical Psychologist, Speech Pathologist, Audiologist, Psychiatric Social Worker, Licensed Independent Social Worker, and Optometrist. This process will include examination of basic qualifications such as licensure, professional education and training, clinical performance and professional liability insurance, as well as assessment of professional ethics and conduct.

ARTICLE FIVE: DELINEATION OF PRACTICE PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

5.1.1 IN GENERAL

A practitioner providing clinical services at this hospital by virtue of medical staff appointment or in a temporary privileges situation may, in connection with such practice and except as otherwise provided in Section 5.7 in an emergency, exercise only those clinical privileges specifically granted to him by the Board of Trustees or as provided in Section 5.8 for temporary privileges. Regardless of the level of privileges granted, each practitioner must pledge to provide or arrange for appropriate and timely medical care for his/her patients in the hospital and to obtain consultation when necessary for the safety of his/her patient or when required by the rules or other policies of the staff, any of its clinical units, or the hospital.

5.1.2 EXPERIMENTAL, NEW, UNTRIED OR UNPROVED PROCEDURES / TREATMENT MODALITIES / INSTRUMENTATION

Experimental drugs or experimental procedures may be administered or performed only after approval of the protocols involved by the Institutional Review Board. Any
experimental procedure/treatment modality/instrumentation may be performed or used only after the regular credentialing process has been completed and the privilege granted to the individual practitioner. For the purposes of this paragraph, new procedure/treatment modality instrumentation is one that is not an established procedure/treatment modality/instrumentation.

5.2 BASIS FOR PRIVILEGES DETERMINATIONS
Clinical practice privileges shall be granted in accordance with prior and continuing education and training, prior and current experience, current health status, and demonstrated current competence and judgment to provide quality and appropriate patient care as documented and verified in each practitioner's credential file. Additional factors that may be used in determining privileges are: licensure to practice in this state; certification by any clinical board, member of a medical school faculty; staff appointment or privileges at another health care facility; geographic location of the practitioner; availability of qualified medical coverage in his/her absence; adequate level of professional liability insurance; performance in patient care activities in other hospitals or practice settings.

The basis for privileges for current staff members in connection with reappraisal, including conclusion of the provisional period, or with requested change in privileges also include observed clinical performance, documented results of the staff's quality review, risk management and utilization management activities, and in the case of additional privileges requested, evidence of appropriate training and experience supportive of the request.

5.3 PROCEDURE FOR DELINEATION OF PRIVILEGES
The procedures by which requests for clinical privileges are processed provided in Part Three of the Credentialing Procedures Manual.

5.4 SPECIAL CONDITIONS FOR ORAL SURGEONS, PODIATRISTS AND DENTISTS
Requests for clinical privileges from oral surgeons, dentists and podiatrists are processed in the manner specified in this Article. Surgical procedures performed by oral surgeons, podiatrists, and dentists are under the overall supervision of the chairman of the Department of Surgery. In all circumstances, a physician member of the medical staff must perform a basic medical appraisal on an oral surgical, podiatric, or dental patient, must determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient, and must be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization. When significant medical abnormality is present the final decision on whether to proceed with the surgery must be agreed upon by the oral surgeon or dentist and the physician consultant. The chairman of the Department of Surgery will decide the issue in case of dispute.
5.5 SPECIAL CONDITIONS FOR ALLIED HEALTH PROFESSIONAL SERVICES

The policies and procedures governing the granting and performance of specified patient care services by allied health professionals are set forth in Section 4.7 of these Bylaws.

5.6 PRIVILEGES IN EMERGENCY SITUATIONS

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, and any delay in administering treatment could add to that danger, any practitioner is authorized, when better alternative sources of care are not available within the necessary time frame, to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license but regardless of department affiliation, staff category or privileges. A practitioner providing services in an emergency situation that are outside his/her usual scope of privileges is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up care.

5.7 TEMPORARY PRIVILEGES

5.7.1 CONDITIONS

A practitioner requesting temporary privileges must agree in writing to abide by these Bylaws and all related manuals, rules, policies, and any special requirements of consulting or reporting imposed by the appropriate department chairperson.

5.7.2 CIRCUMSTANCES

Temporary privileges may be granted only for the following two circumstances:

(a) To fulfill an important patient need. A) Such as a situation where a physician becomes ill or takes a leave of absence and a physician would need to cover his/her practice until he/she returns; or B) A specific physician has the necessary skills to provide care to a patient that a physician currently privileged does not possess.

In this situation, temporary privileges may be granted by the Chief Executive Officer upon recommendation of either the applicable clinical department chairperson or the President of the Medical Staff, provided there is verification of both current licensure and current competence.

(b) When a new applicant with a complete, clean application is awaiting review and approval of the Medical Executive Committee and the Board of Trustees. The applicant must not have been subject to involuntary limitation, reduction, denial or loss of clinical privileges, nor been the subject of a previously successful challenge to licensure or registration.
In this situation, after demonstrating compliance with Section 1.1, 1.2, 1.3 and 1.4 of the Credentials Manual, privileges may be granted to the applicant for medical staff membership, while he/she is awaiting a review and recommendation by the Medical Staff Executive Committee and approval by the Board of Trustees. The Chief Executive Officer following recommendation of either the applicable clinical department chairperson or the President of the Medical Staff may grant temporary clinical privileges for a period of time, not to exceed 30 days. If needed, such temporary clinical privileges may be extended for three separate 30 day intervals, in each case following recommendation of the applicable clinical department chairperson, the President of the Medical Staff and the Chief Executive Officer, and approval by the Board of Trustees.

5.7.2.1 EMERGENCY EVENT

It is the policy of the medical staff of The Westerly Hospital to allow a volunteer licensed independent practitioner to provide care and treatment of patients seeking treatment at The Westerly Hospital in the event of an Emergency occurrence (disaster). The process is outlined in paragraph 1.5.11 of the Credentials Manual.

5.7.3 TERMINATION

The Chief Executive Officer, Medical Director, President of the Medical Staff, or chairman of the applicable department,

(a) may terminate any or all of a practitioners’ temporary privileges on the discovery of any information or the occurrence of any event of a nature which raises a question about a practitioner’s professional qualifications or ability to exercise any or all of the temporary privileges granted, and all qualifications or ability to exercise any or all of the temporary privileges granted, and

(b) must terminate any or all of a practitioners temporary privileges, provided that where the life or well-being of a patient is determined to be endangered, the termination may be effected by any person entitled to impose summary suspensions under these Bylaws. In the event of any such termination, the practitioner's patient then in the hospital will be assigned to another practitioner by the chairman responsible for supervision. The wishes of the patient will be considered, where feasible, in choosing a substitute practitioner.

5.7.4 RIGHTS OF THE PRACTITIONER

A practitioner is not entitled to the procedural rights afforded by these Bylaws and the Fair Hearing Plan because his/her request for temporary privileges is refused in whole, or in part, or because all or any portion of his/her temporary privileges are terminated, not renewed, restricted, suspended, or limited in any way.
ARTICLE SIX: CORRECTIVE ACTION

6.1 CRITERIA FOR INITIATING AN INVESTIGATION FOR POSSIBLE CORRECTIVE ACTION OTHER THAN SUMMARY OR AUTOMATIC SUSPENSION
If a practitioner with a staff appointment or clinical privileges engages in activity, makes statements, or exhibits demeanor or professional conduct that is, or is reasonably likely to be one of the following:
(a) contrary to the Bylaws and related manuals, rules, policies or standards of the hospital or medical staff; or
(b) detrimental to patient safety or to the delivery of quality patient care in the hospital; or
(c) disruptive to hospital operations such that the quality of patient care is, or is likely to be, adversely affected; then corrective action against the practitioner may be initiated by any of the following:
1. any general staff officer; or
2. the chairman of any department in which the practitioner holds appointment or exercises privileges, or
3. any chairman of a standing committee or subcommittee of the staff; or
4. the Chief Executive Officer; the Medical Director, or
5. the Medical Executive Committee of the Board of Trustees; or
6. the Board of Trustees.
The specific procedures for initiating and processing a routine corrective action matter other than a summary or automatic suspension are contained in Section 5.1 of the Credentialing Procedures Manual.

6.2 DISCRETIONARY INTERVIEW PRIOR TO CORRECTIVE ACTION
Prior to initiating or proceeding with corrective action against a practitioner, the initiating or acting party may, but is not obligated to, afford the practitioner an interview, at which the circumstances prompting the corrective action are discussed and the practitioner is permitted to present relevant information in his/her own behalf. An interview must be initiated by written notice to the practitioner, with copies transmitted to the president of the staff and the Chief Executive Officer. A written record reflecting the substance and conclusion of the interview must be made and transmitted to the practitioner and the peer review file. The president of the staff and one other member designated by the accused practitioner will be present as observers at an interview. If the practitioner declines to participate in an interview, corrective action must immediately proceed in accordance with Section 5.1 of the Credentialing Procedures Manual.

6.3 SUMMARY SUSPENSION
Whenever a practitioner's conduct requires that immediate action be taken to protect the life of any patients or to reduce the substantial likelihood of injury or damage to the health or safety of
any patient, employee or other person present in the hospital, any one of the following or their respective designated representative:
(a) the President of the Medical Staff; or
(b) the applicable department chairman; or
(c) the Chief Executive Officer; the Medical Director, or
(d) the medical executive committee; or
(e) the Medical Executive Committee of the Board of Trustees; or
(f) the Board of Trustees has the authority to summarily suspend the medical staff appointment or all or any portion of the clinical privileges of such practitioner. A summary suspension is effective immediately upon imposition and the person or group imposing the suspension is to follow it up promptly by giving special notice of the suspension to the practitioner.

The procedure for further action on summary suspension is set forth in Section 5.2.2 of the Credentialing Procedures Manual. A suspended practitioner's patients then in the hospital must be assigned to another practitioner by the applicable department chairman or his/her designee, considering the wishes of the patient, where feasible, in choosing a substitute practitioner.

### 6.4 VOLUNTARY RELINQUISHMENT OF MEDICAL PRIVILEGES FOR ADMINISTRATIVE REASONS
Whenever any of the actions specified in Sections 6.4-1, 6.4-2, 6.4-5 or 6.4-6 occur, the practitioner must immediately report it to the president of the staff and the chief executive officer. Failure to so report, without good cause, is ground for automatic and permanent revocation of staff appointment and clinical privileges. Practitioners involved in suspensions as a result of 6.4-1, 6.4-2, 6.4-4, 6.4-5 and 6.4-6 are not afforded any opportunity for hearing and appellate review.

#### 6.4.1 LICENSE
(a) **Revocation:** Whenever a practitioner's license to practice in this State is revoked, his/her staff appointment and clinical privileges are immediately and automatically revoked.

(b) **Restriction:** Whenever a practitioner's license is limited or restricted in any way, those clinical privileges that he/she has been granted that are within the scope of the limitation or restriction are similarly limited or restricted, automatically. Further action on the matter proceeds under 6.4.3.

(c) **Suspension:** Whenever a practitioner's license is suspended, his/her staff appointment and clinical privileges are automatically suspended effective upon and for at least the term of suspension. Further action on the matter proceeds under Section 6.4.3.
(d) **Probation:** Whenever a practitioner is placed on probation by his/her licensing authority, the terms of that probation will be honored by the hospital. Our actions will conform with whatever the licensing authority mandates. Further action on the matter proceeds under Section 6.4.3.

### 6.4.2 CONTROLLED SUBSTANCES NUMBER

(a) **Revocation:** Whenever a practitioner's Drug Enforcement Administration (DEA) or other controlled substances number is revoked, he/she is immediately and automatically divested of his/her right to prescribe medications covered by the number. Further action on the matter proceeds under Section 6.4.4.

(b) **Restriction:** Whenever a practitioner's use of his/her DEA or other controlled substances number is restricted or limited in any way, his/her right to prescribe medications covered by the number is similarly restricted or limited effective upon, for at least the term of, and consistent with any other conditions of the restriction or limitation. Further action on the matter proceeds under Section 6.4.3.

(c) **Suspension:** Whenever a practitioner's DEA or other controlled substances number is suspended, he is divested at least of his/her right to prescribe medications covered by the number effective upon and for at least the term of the suspension. Further action on the matter proceeds under Sections 6.4.3.

(d) **Probation:** Whenever a practitioner is placed on probation insofar as the use of his/her DEA or other controlled substances number is concerned, action on the matter proceeds under Section 6.4.3 below.

### 6.4.3 FURTHER ACTION

The procedures for further action on the matters set forth in Sections 6.4.1 (b) through (d), and 6.4.2 (a) through (d), are contained in Section 5.3 of the Credentialing Procedures Manual.

### 6.4.4 MEDICAL RECORDS

(a) **Timely Completion:** Medical Records not completed within the time frame requirement may subject the practitioner to a suspension as described in Rules and Regulations Section 7.11.

### 6.4.5 PROFESSIONAL LIABILITY INSURANCE

For failure to maintain the minimum amount of professional liability insurance, if any, required under Section 3.1.11 of these Bylaws, a practitioner's medical staff appointment and clinical privileges are immediately suspended. They may be reinstated as provided in Section 5.3.5 of the Credentialing Procedures Manual.

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6.4.6 **NO CLINICAL ACTIVITY**
Practitioners who have not had clinical activity in the Hospital (as defined in Section 2.2 of the Credentialing Procedures Manual) for a period of 2 years are not eligible for reappointment. This lack of activity will be considered a voluntary relinquishment of medical privileges for administrative reasons.

6.4.7 **TERMINATION OR REVOCATION OF MEDICARE OR MEDICAID STATUS**
Practitioners whose Medicare or Medicaid status is revoked by CMS shall have their clinical privileges immediately and automatically suspended. Clinical privileges may be reinstated upon reinstatement of practitioners’ Medicare and Medicaid status.

**ARTICLE SEVEN: PROCEDURAL RIGHTS**

7.1 **NECESSITY FOR ADVERSE ACTION**
All members of the Medical Staff may, during normal business hours of the hospital, review any information pertaining to himself/herself.

7.1.1 **BY MEDICAL EXECUTIVE COMMITTEE**
When a practitioner receives special notice of a Section 7.2 adverse recommendation made by the medical executive committee he is entitled, upon timely and proper request, to a hearing in accordance with the procedures set forth in the Fair Hearing Plan.

7.1.2 **BY THE BOARD OF TRUSTEES**
When a practitioner receives special notice of a Section 7.2 adverse decision made by the Board of Trustees, he/she is entitled, upon timely and proper request, to a hearing in accordance with the procedures set forth in the Fair Hearing Plan, so long as he/she has already not had a hearing in accordance with Section 7.1.1.

7.2 **ADVERSE ACTION**

7.2.1 **ADVERSE RECOMMENDATIONS AND ACTIONS DEFINED**
Subject to the exceptions set forth in Section 7.2.2 below, the following recommendations or actions are deemed adverse.
(a) Denial of initial staff appointment
(b) Denial of reappointment
(c) Suspension of staff appointment, provided that summary suspension entitles the practitioner to request a hearing only as specified in subsection (n) of this Section 7.2.1.

(d) Revocation of staff appointment

(e) Denial of requested appointment to or advancement in staff category

(f) Reduction in staff category.

(g) Suspension or limitation of the right to admit patients not related to the adoption or implementation of an administrative or medical staff policy within the hospital as a whole or within one or more specific departments.

(h) Denial of requested department affiliation

(i) Denial or restriction of requested clinical privileges

(j) Reduction of clinical privileges

(k) Suspension of clinical privileges, provided that summary suspension entitles the practitioner to request a hearing only as specified in subsection (n) of this Section 7.2.1.

(l) Revocation of clinical privileges

(m) Individual application of, or individual changes in, mandatory consultation or concurrent supervision requirement

(n) Summary suspension of medical staff appointment or clinical privileges, provided that the recommendation of the medical executive committee or action by the Board of Trustees under Section 5.2 of the Credentials Procedures Manual is to continue the suspension or to take other action which would entitle the practitioner to request a hearing under this Section 7.2.1.

7.2.2 EXCEPTIONS TO HEARING RIGHTS

(a) Certain Actions or Recommendations: Notwithstanding any provision in these Medical Staff Bylaws, in the Credentialing Procedures Manual, or in the Fair Hearing Plan to the contrary, the following actions or recommendations do not entitle the practitioner to a hearing:

1. the issuance of a verbal warning;
2. the imposition of a monitoring or consultation requirement as a condition attached to the exercise of clinical privileges during a provisional period;
3. the imposition of a probationary period involving review of cases but with no requirement either for direct, concurrent supervision or for mandatory consultation;
4. the removal of a practitioner from a medico-administrative office within the hospital unless a contract or employment arrangement provides otherwise; and
5. any other action or recommendation not listed in Section 7.2.1 above.
(b) **Other Situations:** An action or recommendation listed in Section 7.2.1 above does not entitle the practitioner to a hearing when it is:
   1. voluntarily imposed or accepted by the practitioner,
   2. automatic pursuant to any provision of the Medical Staff Bylaws and related manuals, or
   3. taken or recommended with respect to temporary privileges.

### 7.3 PROCESS FOR HEARING AND APPELLATE REVIEWS

All hearings and appellate reviews will be conducted in accordance with the procedure and safeguards set forth in the Fair Hearing Plan.

**ARTICLE EIGHT: GENERAL STAFF OFFICERS**

#### 8.1 GENERAL OFFICERS OF THE STAFF

**8.1.1 IDENTIFICATION**

The general officers of the staff are:

- (a) President
- (b) President-elect
- (c) Immediate Past President
- (d) Secretary-Treasurer

**8.1.2 QUALIFICATIONS**

Each general officer must:

- (a) Be a member of the active staff at the time of nomination and election and remain a member in good standing during his/her term of office.
- (b) Have demonstrated executive and administrative ability through experience and prior constructive participation in staff activities and be recognized for a high level of clinical competence.
- (c) Have demonstrated a high degree of interest in and support of the medical staff and hospital by his/her staff tenure and his/her level of clinical activity in this hospital.
- (d) Agree to and, if elected, willingly and faithfully discharge the duties and exercise the authority of the office held and work with the other general and departmental
8.2 **TERM OF OFFICE**

The term of office of general staff officers is two medical staff years, subject to reconfirmation after one year. Confirmation vote is to be by secret ballot. Officers assume office on the first day of the medical staff year following their election, except that an officer elected or appointed to fill a vacancy assumes office immediately upon election or appointment. Each officer serves until the end of this term and until a successor is elected, unless he/she resigns or is removed from office.

8.3 **ELIGIBILITY FOR RE-ELECTION**

A general staff officer is eligible again for nomination and election to the position of President-elect after one year has elapsed since he/she held the office of immediate past president. The Secretary-Treasurer is eligible to succeed himself/herself in the same position.

8.4 **ATTAINMENT OF OFFICE**

8.4.1 **OF PRESIDENT AND IMMEDIATE PAST PRESIDENT**

The President attains office by automatic succession from the office of President-elect, subject to a confirmation vote prior to the annual staff meeting preceding his/her assumption of the office of President. This confirmation vote must be by secret ballot. The immediate Past President attains office by automatic succession from the office of President.

8.4.2 **OF PRESIDENT-ELECT AND SECRETARY-TREASURER**

(a) **Election:** The President-elect and Secretary-Treasurer are chosen, subject to Board of Trustee approval and from among the candidates nominated under paragraph (b) below, by election by majority vote cast by those active staff members in good standing prior to the annual meeting. Voting shall be by secret ballot. If no candidate for a given office receives a majority vote on the first ballot, a runoff election will be held immediately between the two candidates receiving the highest number of votes.

(b) **Nomination:** The Nominating Committee, as selected by the immediate Past President of the Medical Staff will convene prior to the annual meeting, at which an election of officers is to occur, for the purpose of nominating one or more qualified candidates for each of the offices of President-elect and Secretary-Treasurer. The list of nominees is then published at the annual meeting as the slate of officers. If, before the election, any of the individuals nominated either
refuse, are disqualified from, or otherwise are unable to accept nomination, then the nominating committee may submit substitute nominees, or accept nominations from the floor by active staff members in good standing. Election of any officer nominated in this matter is subject to Board of Trustee’s approval.

8.4.3 **RECONFIRMATION VOTES FOR SECOND YEAR OF TERMS**
The incumbent in each general officer position must be confirmed at the annual meeting in the year prior to the start of the second year of the term, such confirmation to be accomplished in the same manner as original election except that formal nominations shall not be required and the incumbent officers must be confirmed by secret ballot vote. If an officer fails to be confirmed, a vacancy will be declared to exist in the office and will be filled as provided in Section 8.5 below.

8.5 **VACANCIES**

8.5.1 **IN OFFICE OF PRESIDENT**
A vacancy in the office of the president is filled by automatic succession of the president-elect who serves the remainder of the unexpired term and his/her own full term as President.

8.5.2 **IN OFFICE OF PRESIDENT-ELECT OR SECRETARY TREASURER**
A vacancy in the office of president-elect or secretary-treasurer is filled by appointment of an acting officer by the Medical Executive Committee, subject to approval by the Board of Trustees. The acting officer serves pending the outcome of a special election to be conducted as expeditiously as possible and generally in the same manner as provided in Section 8.4, provided however that the medical executive committee may determine not to call a special election if a regular election for the office is to be held within 180 days in which case the acting officer serves only until the election results are final and the individual then elected assumes office immediately.

8.5.3 **IN OFFICE OF IMMEDIATE PAST PRESIDENT**
A vacancy in the office of immediate past president is filled for the remainder of the unexpired term by appointment by the Medical Executive Committee. Consideration should be given in filling the vacancy to prior staff Presidents.

8.6 **RESIGNATION AND REMOVAL FROM OFFICE**
8.6.1 RESIGNATION

Any general staff officer may resign at any time by giving written notice to the medical executive committee. Such resignation takes effect on the date of receipt or at any later time specified in it.

8.6.2 REMOVAL OF GENERAL STAFF OFFICER

(a) Authority and Mechanism: Removal of a general staff officer may be effected by a two-thirds majority vote by secret ballot of active staff members in good standing present at any regular medical staff or special meeting called for that purpose. A minimum of 50 active staff members must be present at that meeting. Any active medical staff member may move for the removal of any general staff officer. A letter to the president with a minimum of 10 cosignatories will initiate this. The President will promptly provide a copy of letter to the general staff officer. A vote must be taken at the next medical staff meeting occurring at least 10 days after notification of the officer. The officer who is subject to the removal action shall be afforded the opportunity to speak in his/her own behalf, as applicable, prior to the taking of any vote on his/her removal.

(b) Grounds: Permissible bases of removal of a general staff officer include, without limitation:

1. Failure to perform the duties of the position in a timely and appropriate manner.

2. Failure to continuously satisfy the qualifications for the position.

(c) Having an automatic or summary suspension imposed by operation of Section 6.3 or 6.4 of these Bylaws or a corrective action matter pursuant to Section 6.1 of these Bylaws resulting in a final decision other than to take no action.

(d) Physical or mental infirmity that renders the officer incapable of fulfilling the duties of his/her office.

8.7 DUTIES OF OFFICES

The responsibility and authority, including specific functions and tasks, of general staff officers are set forth in Part One of the Medical Staff Organization Manual, which is incorporated herein by reference. The overall duties of the general Staff officers are as provided in this Section.

8.7.1 DUTIES OF THE PRESIDENT OF THE STAFF

(a) The President of the staff is the primary officer of the Medical Staff, the chief administrative officer of the staff, and the staff’s representative in its relationships to others within the hospital.

(b) In the absence of another practitioner fulfilling the duties of the chief quality review and clinical officer, the president of the Staff, in conjunction with the
Medical Executive Committee, shall fulfill these duties by working jointly with the Chief Executive Officer in coordinating and overseeing the staff's quality review, risk management and utilization monitoring activities, by supervising the clinical organization of the staff, and by advising the Chief Executive Officer and Board of Trustees on these matters.

(c) The president should be a member of the medical executive committee, professional affairs committee and Board of Trustees with full voting rights.

8.7.2 DUTIES OF THE PRESIDENT-ELECT
Whenever the President of the staff is unable, temporarily or permanently, to fulfill the duties of his/her office by reason of illness, resignation, removal or other absence, the President-elect will succeed to the office of the president. The president-elect serves on the medical executive committee. He/she is also responsible for those duties delegated to him/her by the President of the staff or by the Medical Executive Committee.

8.7.3 DUTIES OF THE SECRETARY-TREASURER
As secretary, the secretary-treasurer is responsible for assuring that accurate and complete minutes of all meetings of the medical staff and of the medical executive committee is kept. As treasurer, the secretary-treasurer is responsible for supervising the collecting of Medical Staff dues and assessments and accounting for all funds of the Medical Staff. The secretary-treasurer serves on the medical executive committee and is also responsible for such other duties as are delegated to him/her by the president of the staff or by the medical executive committee.

8.7.4 DUTIES OF THE IMMEDIATE PAST PRESIDENT
The immediate past President will chair the Credentials Committee and act as an advisor to the President and to other officials and committees of the staff and shall serve as a member of the Medical Executive Committee.

8.8 SPECIAL STAFF OFFICERS

8.8.1 MEDICAL DIRECTOR
The Board of Trustees may determine that to fulfill the hospital's purposes, goals and objectives the office of president of the staff requires the assistance of another practitioner serving as medical director. When appointed, the medical director will assume the duties outlined in Section 8.7.1(b) of these Bylaws and the applicable section.
of the Medical Staff Organization Manual and such other duties as are provided in his/her contract or other arrangement with the hospital. His/her term of office shall also be governed by such contract or arrangement.

ARTICLE NINE: CLINICAL DEPARTMENTS

9.1 DESIGNATION

9.1.1 CURRENT CLINICAL DEPARTMENTS
The current clinical department and services are: Department of Medicine; Department of Surgery; Department of Obstetrics-Gynecology; Department of Pediatrics; Department of Radiology, Department of Pathology and Clinical Laboratory, Department of Anesthesia, and Department of Emergency Medicine.

9.1.2 FUTURE CLINICAL DEPARTMENTS AND SERVICES
The Medical Executive Committee will periodically restudy this structure and recommend to the Board of Trustees what action is desirable in creating new, eliminating or combining departments and/or services for better organizational efficiency and improved patient care. Action taken by the Board of Trustees pursuant to this Section 9.1.2 shall be effective on such date as determined by the Board of Trustees and shall not require formal amendment of these Bylaws.

9.2 REQUIREMENT FOR AFFILIATION WITH DEPARTMENTS AND SERVICES
Each department is a separate organizational component of the medical staff, and every staff member must have a primary affiliation with the department, where applicable, which most closely reflects his/her professional training, experience, and current practice. A practitioner may be granted clinical privileges in one or more of the other departments and his/her exercise of clinical privileges within the jurisdiction of any department is always subject to the rules and regulations of that department and the authority of the department chairman.

9.3 FUNCTIONS OF CLINICAL DEPARTMENT SERVICE
9.3.1 CLINICAL FUNCTIONS
Each department/service shall:
(a) establish, implement and monitor its members' adherence to clinical standards, policies, procedures and practices relevant to the various clinical disciplines under its jurisdiction;
(b) provide an inter-specialty and inter-departmental forum for matters of clinical concern and for resolving clinical issues arising out of the interface between its members' activities and the activities of other patient care and administrative services;
(c) develop consistency in the patient care data, standards, policies, procedures and practices within the department; and
(d) develop, with assistance from the various specialists and subspecialists, criteria for use in making credentials recommendations on initial appointments, reappointments, grants of clinical privileges, concluding the provisional period, and other credentials matters, and make recommendations on these templates as required by the Credentialing Procedures Manual.

9.3.2 ADMINISTRATIVE FUNCTIONS
Each department/service shall:
(a) Provide a forum for its members to contribute their professional views and insights to the formulation of the departmental, medical staff and hospital policies and plans;
(b) communicate, through its chairman, formulated policies and plans back to its members for implementation;
(c) coordinate, through its chairman, the professional services of its members with those of other departments and with hospital and medical staff support services; and
(d) make recommendations, through its chairman, to the medical executive committee, the Chief Executive Officer, and other components, as appropriate, concerning the short and long term allocation and acquisition of resources to and provision of services by the hospital and the department.

9.3.3 QUALITY REVIEW/UTILIZATION MANAGEMENT FUNCTIONS
Each Department/service shall:
(a) review quality review, risk management and utilization data and findings pertinent to the department, and make recommendations or take action as appropriate;
(b) review mortality and morbidity reports and special studies of input, processes and outcomes of care, perform specified monitoring activities, and otherwise...
participate as required in the quality review, risk management and utilization program; and
(c) report all findings of studies and other activities performed under paragraphs (a) and (b) immediately above to the medical quality review committee and any other relevant staff committees.

9.3.4 COLLEGIAL AND EDUCATION FUNCTIONS
Each department/service shall serve as the most immediate peer group for:
(a) providing clinical support among and between peers;
(b) teaching, continuing education and sharing new knowledge relevant to the practice of department members; and
(c) providing consultative advice in its area to other staff members.

9.4 OFFICERS OF CLINICAL DEPARTMENTS AND SERVICES

9.4.1 IDENTIFICATION
The officer positions in the clinical department and services are
(a) department or service chief

9.4.2 QUALIFICATIONS
Each department or chief must:
(a) be a member in good standing of the active staff (or associate staff if a contract physician) and of the department he/she is to head and remain in good standing throughout his/her term; and
(b) be recognized for his/her current clinical ability in the clinical area covered by the department; and
(c) have demonstrated executive and administrative abilities through experience and prior constructive participation in Medical Staff activities; and
(d) have demonstrated a high degree of interest and support of the Medical Staff and hospital by his/her staff tenure and his/her level of clinical activity at this hospital.
(e) agree to willingly and faithfully discharge the functions and exercise the authority of his/her office and work with the other general and department officers of the staff and with the Chief Executive Officer, and Board of Trustees and its committees.
(f) Contract physician department chiefs may serve on the Medical Executive Committee at time of appointment to the Associate Staff.

9.4.3 VOLUNTARY AND CONTRACT OFFICERS DISTINGUISHED
For purposes of these Bylaws, a department chief serving on a voluntary basis is referred to as a "voluntary officer", and one serving as such by contract or on some other full or
part time basis with the hospital is referred to as a "contract officer". The Emergency Room Department, and Pathology Department will be the only departments headed by contract physicians. All other departments will be headed by voluntary chiefs.

9.4.4 ATTAINMENT OF OFFICE
(a) A voluntary department chief is elected by majority vote by secret ballot of those members of the department in good standing who are eligible and qualified to vote for department officers and who are present at the regular final department meeting in any year in which the department chief is to be elected, and subject to the approval of the Board of Trustees. Nominations may be made and seconded at the meeting by any active staff member of the department in good standing, provided that evidence is presented to the meeting of the qualifications of the nominee and that the nominee accepts the nomination.
(b) If the Emergency Room Department and Pathology Department is directed by a contract chief, said chief is selected by the Board of Trustees or its designee after seeking and considering the advice of appropriate representatives of the Medical Staff and of the Chief Executive Officer.

9.4.5 TERM OF OFFICE AND ELIGIBILITY FOR RE-ELECTION
(a) The usual term of office of voluntary department chief is two years. A department chairman may succeed himself, but generally for no more than two consecutive terms. Voluntary chiefs assume office on the first day of the medical staff year following their election, except that an officer elected or appointed to fill a vacancy assumes office immediately upon election or appointment. Each voluntary chief serves until the end of his/her term and until a successor is elected, unless he/she sooner resigned or is removed from office.
(b) The term of office of a contract department chief of the Emergency Department and Pathology Department is as specified in his/her contract or employment arrangement with the hospital.

9.4.6 RESIGNATION OF OFFICERS
(a) A voluntary department chief may resign at any time by giving written notice to the medical executive committee. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any later time specified in it.
(b) Resignation of a contract chief is governed by the terms of the contract or other arrangement with the hospital. If the contract does not address the issue, a contract chief may resign by giving written notice to the Chief Executive Officer and the medical executive committee. Such resignation, which may or may not
be made contingent on formal acceptance, takes effect on the date of receipt or at any time specified in it.

9.4.7 REMOVAL OF OFFICERS

(a) Removal of a voluntary chief may be effected by a two-thirds majority vote of the active staff members in good standing of the applicable department/service if such vote is ratified by the medical executive committee. The chief who is the subject of the removal action shall be given ten days prior written notice of a special meeting of the medical executive committee at which the vote is to be taken and shall be afforded the opportunity to speak on his/her own behalf thereafter.

(b) Removal of a contract chief in the Emergency Room Department or Pathology Department is governed by the terms of the contract and by the provisions of Section 3.6 of these Bylaws, as applicable. The medical executive committee may undertake a review of the performance of a contract officer, transmitting a written report of its findings, conclusions and recommendations to the Board of Trustees. If the Board of Trustees disagrees with or is going to make a decision (including taking no action) contrary to the medical executive committee's recommendation, the matter will be submitted to the professional affairs committee for review and recommendation before the Board of Trustees makes a final decision.

(c) Grounds for Removal: Permissible bases of removal of a voluntary officer include those specified in Section 8.6.2(b) and 11.4.1 for removal of a general staff officer. Bases of removal of a contract officer are as specified in the contract or other arrangements with the hospital.

9.4.8 VACANCIES

(a) A vacancy in the office of a voluntary department chief is filled by secret ballot vote at the next meeting of the department.

9.5 RESPONSIBILITY, AUTHORITY AND REPORTING OBLIGATIONS OF OFFICERS

9.5.1 RESPONSIBILITY AND AUTHORITY

(a) Department/Service Chief: A department/service chief has the responsibility and authority to do everything necessary to carry out the functions delegated to him and to the department by the Board of Trustees, by the medical executive committee, and in these Bylaws or any of the related manuals. A department chief shall designate a qualified chief to temporarily assume all the responsibility and authority of the chairman in his/her temporary absence.
9.5.2 REPORTING OBLIGATIONS
Department/Service Chief: Each department chief shall report:
(a) As requested to special or regularly scheduled meetings of the medical executive committee, the department and medical staff on the activities of the department.
(b) Whenever necessary or requested to the medical staff president on matters involving coordination and monitoring of clinical services to maintain quality or to assure patient safety.
(c) To the medical staff president and the medical quality review committee on action taken in response to a suggestion, recommendation or finding from one of the medical staff’s quality review, risk management or utilization management committees.
(d) To the medical executive committee and the Chief Executive Officer on issues relating to the allocation and acquisition of resources for the various departments, budgetary items and similar concerns.

9.5.3 SPECIFIC DUTIES AND OBLIGATIONS
The specific duties and obligations of department chiefs are detailed in the Medical Staff Organization Manual.

ARTICLE TEN: FUNCTIONS AND COMMITTEES

10.1 FUNCTIONS OF THE STAFF
The required functions of the medical staff are as specified and described in Part Two of the Medical Staff Organization Manual. They shall be accomplished as indicated in these Bylaws and said manual through assignment to the staff as a whole, to departments, to staff committees, to staff officers or other individual staff members, or to interdisciplinary hospital committees with participation of medical staff members.

10.2 PRINCIPAL GOVERNING COMMITTEES

10.2.1 MEDICAL EXECUTIVE COMMITTEE AND OTHER COMMITTEES
There is a medical executive committee and such other standing and special committees of the staff, a department or other clinical unit, as are necessary and desirable to perform any of the functions listed in Part Two of the Organization Manual or elsewhere in these Bylaws or any of the related manuals. The composition, functions, reporting and meeting requirements of the medical executive committee are set forth in Section 10.3 of these Bylaws. The composition, functions, reporting and meeting requirements of the other standing staff-wide committees are set forth in Part Three of the Medical Staff
Organization Manual. The composition, functions, reporting and meeting requirements of special committees that are or may be required under any section of these Bylaws, the Credentialing Procedures Manual or the Fair Hearing Plan are as specified in said section. Any committee, whether staff-wide, department/other clinical unit based or whether standing or special, that is carrying out all or any portion of a function or activity required by these Bylaws or any of the related manuals is deemed a duly appointed and authorized committee of the medical staff.

10.2.2 REPRESENTATION ON HOSPITAL COMMITTEES AND PARTICIPATION IN CERTAIN HOSPITAL DELIBERATIONS
The medical staff, through its general and departmental officers or their respective designees will be represented and participate in any hospital deliberations affecting the discharge of medical staff responsibilities.

10.2.3 EX OFFICIO MEMBERS
The medical staff president and the Chief Executive Officer, or their respective designees, are ex officio members of all standing and special committees of the staff, and with or without vote as provided in the provision or resolution creating the committee.

10.2.4 ACTION THROUGH SUBCOMMITTEES
Any standing committee may elect to perform any of its specifically designated functions by constituting a subcommittee for that purpose, reporting such action to the medical executive committee in writing. Any such subcommittee may include individuals in addition to or other than members of the standing committee. Such additional members are appointed by the committee chairman after consultation with the medical staff president in the case of medical staff members, and with the approval of the Chief Executive Officer or his/her designee when administrative staff appointments are to be made.

10.2.5 COMPOSITION
A staff committee created in these Bylaws or any of the related manuals is composed as stated in the description of the committee. Any other committees that may be established to perform one or more of the staff functions required by these Bylaws or the related manuals will be composed of members of the active and associate staffs and may include members of the consulting staff; as required under Section 4.5.3(b) of these Bylaws, and where appropriate, allied health professionals and representation from management, nursing service, medical records, and such other hospital departments as are appropriate.
to the functions to be discharged. Each designated member of a committee participates with vote, unless the statement of the committee composition designates the position as non-voting.

10.2.6 APPOINTMENT OF MEMBERS AND CHAIRMAN
Except as otherwise expressly provided, the medical staff president appoints the members and chairman of any staff committee formed to accomplish staff functions. Each committee chairman must be an active staff member. Non-medical staff members of committees, if hospital employees are subject to the approval of the Chief Executive Officer or his/her designee. Where necessary to accomplish a function or task assigned to a committee, the committee chairman may call on outside consultants or on special advisors from clinical specialties or administrative or patient care departments with expertise in the subject matter involved, after consultation with the chief executive officer or his/her designee when hospital administrative or patient care departments or outside consultants are involved. Each committee chairman appoints a vice-chairman of the committee to chair any meeting from which the chairman is absent. Each committee chairman or other authorized person chairing a meeting has the right to participate in discussion of and to vote on issues presented to the committee.

10.2.7 TERM, PRIOR REMOVAL AND VACANCIES
Each committee member, except one serving ex officio, serves a two-year term, unless he sooner resigns or is removed from the committee or the staff. A medical staff member serving on a committee may be removed from the committee for failure to maintain himself in good standing as a member of the staff, for failure to satisfy the attendance requirements specified in these Bylaws, by action of the medical executive committee, or Board of Trustees as appropriate. Any ex officio member of a staff committee ceases to be such if he ceases to hold a designated position which is the basis of ex officio membership. A vacancy in any committee is filled for the unexpired portion of the term in the same manner in which original appointment is made.

10.3 MEDICAL EXECUTIVE COMMITTEE

10.3.1 COMPOSITION
The medical executive committee consists of: president of the staff, as chairman and with vote; president-elect, with vote; secretary-treasurer, with vote; immediate past president, with vote; Chief of Surgery, with vote; Chief of Medicine, with vote; Chief of Emergency Services, with vote; Chief of Anesthesia, with vote; Chief of Radiology, with vote; Chief of Pathology, with vote; Chief, Hospitalist, with vote; a single Non-physician
provider representative, with vote; and two members-at-large, who will be nominated from the floor and elected by majority vote at the annual meeting of the medical staff, with vote; Chief Executive Officer, without vote; Chairman of the Board of Trustees (or his/her designee), Chief Medical Officer without vote; VP for Patient Care Services, without vote; Medical Director, without vote.

10.3.2 DUTIES AND AUTHORITY
The duties and authority of the medical executive committee are to:

(a) act on all matters of medical staff business, except for election of general staff officers, removal of general staff officers, and adoption and amendment of these Medical Staff Bylaws;

(b) receive, coordinate and act upon, as necessary, the written reports and recommendations of the departments and the standing and special committees directly responsible to it and to hear oral reports from time to time as required or requested;

(c) coordinate, or oversee coordination of, the activities of and policies adopted by the staff, departments, other clinical units and committees;

(d) implement the approved policies of the medical staff, or monitor that such policies are implemented by the departments and other clinical units and committees;

(e) study and report to the medical staff on proposals for changes in these Bylaws;

(f) inform the medical staff on accreditation programs and the accreditation status of the hospital;

(g) review and approve the appointment of chairmen and members of standing committees, except as otherwise provided;

(h) recommend to the Board of Trustees, as required in these Bylaws, the Credentialing Procedures Manual and the Fair Hearing Plan, concerning matters relating to appointment and reappointment, category and department assignments, clinical privileges, and disciplinary actions;

(i) take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of staff members, including initiating investigations and initiating and pursuing disciplinary action, when warranted;

(j) account to the Board of Trustees by written report for the quality of medical care provided to patients in the hospital, including a summary of specific findings, action and follow-up; and
(k) make recommendations to the Chief Executive Officer on medico-administrative, hospital management and planning matters.

10.3.3 MEETINGS AND REPORTING
The medical executive committee meets at least monthly. It communicates its discussions and actions that affect or define staff policies, rules or positions by monthly written summary reports made available to all members of the medical staff. In this regard, it is the responsibility of the department chief to report at the monthly department meetings on such discussions and actions. The medical executive committee's other reporting obligations are as stated in the various sections of these Bylaws and the related manuals, and, in addition, copies of its minutes and reports are forwarded to the Chief Executive Officer, and, as appropriate, to the Board of Trustees.

ARTICLE ELEVEN: MEETINGS

11.1 MEDICAL STAFF YEAR
For purposes of the business of the medical staff, the business year commence on the first day of January of each year and end on the last day of December of the same year.

11.2 MEDICAL STAFF MEETINGS

11.2.1 REGULAR MEETINGS
A regular annual staff meeting will be held in November of each year. The medical staff will set the number of meetings for the ensuing year at the time of the annual meeting.

11.2.2 SPECIAL MEETINGS
A special meeting of the medical staff may be called by the medical staff president on his/her own motion, and must be called by the president at the written request of the Board of Trustees, the medical executive committee or one fourth of the members of the active staff in good standing.

11.3 CLINICAL DEPARTMENT AND COMMITTEE MEETINGS

11.3.1 REGULAR MEETINGS
Clinical departments/services and committees may, by resolution, provide the time for holding regular meetings and no notice other than such resolution is then required.
Department meetings may be held monthly or no less than every three months, depending upon business requirements and/or the discretion of the chief of department/service. The frequency of committee meetings is as required by these Bylaws or the Organization Manual for each committee.

11.3.2 SPECIAL MEETINGS
A special meeting of any department/service or committee may be called by the chairman or chief thereof, and must be called by the chairman or chief at the written request of the Board of Trustees, the medical executive committee, the medical staff president, or one third of the group's current members in good standing but not less than two.

11.3.3 EXECUTIVE SESSION
The regular medical staff, any committee or department/service may call itself into executive session at any time during a regular or special meeting. Only the voting members of the applicable group may be present during said session unless the presiding officer thereof invites, with the approval of a majority of the group, other individuals to attend. Accurate and complete minutes must be kept of any executive session.

11.4 ATTENDANCE REQUIREMENTS

11.4.1 GENERALLY
In addition to satisfying the special appearance requirement of Section 11.4.2, each member of the active and associate staffs is expected to attend the annual staff meeting, meetings of his/her department, and meetings of committees on which he serves. The number of absences will be evaluated as part of each staff member’s biannual reappraisal or more frequently if circumstances so warrant.

11.4.2 SPECIAL APPEARANCE OR CONFERENCES
(a) A practitioner whose patient's clinical course of treatment is scheduled for case discussion as part of regular quality review activities at a staff, department or committee meeting will be so notified and invited to present the case.
(b) Whenever a staff or department education program or clinical conference is prompted by findings of quality review, risk management, patient care, or like monitoring activities, the practitioners whose patterns of performance prompted the program will be notified of the time, date and place of the program, of the subject matter to be covered, and of its special applicability to the practitioner's practice. Attendance is mandatory. Failure to attend, unless excused by the medical executive committee upon a showing of good cause, may result in such
corrective action as deemed necessary by the medical executive committee or Board of Trustees.

(c) Whenever actual, apparent or suspected deviation from standard practice is identified with respect to a practitioner's performance, the medical staff president or the applicable department chief may require the practitioner to confer with him or with a standing or ad hoc committee that is considering the matter. The practitioner will be given written notice of the conference at least 14 days prior to it, including the date, time and place, a statement of the issue involved, and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any such conference, unless excused by the medical executive committee upon a showing of good cause, will result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the medical executive committee may direct. A suspension under this section will remain in effect until the matter is resolved by subsequent action of the medical executive committee and the professional affairs committee or the Board of Trustees, as appropriate.

11.5 MEETING PROCEDURES
Notice, quorum, minutes and agenda requirements for meetings are set forth in Part Five of the Medical Staff Organization Manual.

ARTICLE TWELVE: CONFIDENTIALITY, IMMUNITY AND RELEASES

12.1 SPECIAL DEFINITIONS
For purposes of this Article only, the following definitions shall apply:

(a) Information means records of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearings, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data and other disclosures or communications whether in written or oral form relating to any of the subject matter specified in Section 12.5.

(b) Malice means the dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.

(c) Practitioner means a staff member or applicant, or allied health professional.

(d) Representative means: the Board of Trustees of directors of the hospital corporation and any director or committee thereof; the Chief Executive Officer or his/her designees; registered nurses and other employees of the hospital; the medical staff organization and any member, officer, clinical unit or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use or disseminating functions.
12.2 AUTHORIZATIONS AND CONDITIONS

By submitting an application for staff appointment or reappointment or applying for or exercising clinical privileges or providing specified patient care services at the hospital, a practitioner:

(a) authorizes representatives to solicit, provide and act upon information bearing on his/her professional ability, utilization practices and other qualifications; and

(b) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article; and

(c) acknowledges that the provisions of this Article are express conditions to his/her application for, or acceptance of, staff membership and the continuation of such membership and to his/her exercise of clinical privileges or provision of specified patient care services at the hospital.

12.3 CONFIDENTIALITY OF INFORMATION

Information submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating, monitoring or improving the quality of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, or determining that health care services are professionally indicated or were performed in compliance with the applicable standard of care shall, to the fullest extent permitted by law, be confidential. Said information shall not be disseminated to anyone other than a representative or other health care facility or organization of health professionals engaged in an official, authorized activity for which the information is needed, nor be used in any way except as provided herein or except as otherwise specifically required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular 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 membership and clinical privileges or specified services.

12.4 IMMUNITY FROM LIABILITY

12.4.1 FOR ACTION TAKEN

No representative shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his/her duties as a representative, if such representative acts in good faith and without malice within the scope of his/her function, has made a reasonable effort to obtain the facts of

(e) Third Parties mean any individual or organization providing information to any representative.
the matter as to which he acts, and acts in the reasonable belief that the action is warranted by such facts and was in the furtherance of quality or efficient health care.

12.4.2 FOR PROVIDING INFORMATION
No representative and no third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any other health care facility or organization of health professionals concerning said practitioner who is or has been an applicant to or member of the staff or who did or does exercise clinical privileges or provide specified services at this hospital, provided that such representative or third party acts in good faith and without malice within the scope of his/her function and has made a reasonable effort to obtain the facts of the matters to which he is providing information and provided further that such information is related to the performance of the duties and functions of the recipient and is reported in a factual manner.

12.5 ACTIVITIES AND INFORMATION COVERED

12.5.1 ACTIVITIES
The confidentiality and immunity provided by this Article applies to all information or disclosures performed or made in connection with this or any other health care facilities or organization's activities concerning, but not limited to:
(a) applications for appointments, clinical privileges or specified services
(b) periodic reappraisals for reappointment, clinical privileges or specified services
(c) corrective or disciplinary actions
(d) hearings and appellate reviews
(e) quality review program activities
(f) utilization review and management activities.
(g) claims reviews
(h) profiles and profile analysis
(i) risk management activities
(j) other hospital, committee, department, or staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

12.5.2 INFORMATION
The information referred to in this Article may relate to a practitioner's professional licensure or certification, education, training, clinical ability, judgment, utilization practices, character, physical or mental health, emotional stability, professional ethics, or
any other matter that might directly or indirectly affect the quality, efficiency or appropriateness of patient care provided in the hospital.

12.6 RELEASES
Each practitioner shall, upon request of the hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith and the exercise of reasonable effort to ascertain truthfulness, as may be applicable under relevant Rhode Island and federal law. Failure to execute such releases shall result in an application for appointment, reappointment or clinical privileges being deemed incomplete and to have been voluntarily withdrawn, and it shall not be further processed. Failure to execute such releases in connection with conclusion of the provisional period shall be deemed a voluntary resignation of staff membership or particular clinical privileges as appropriate to the context.

12.7 CUMULATIVE EFFECT
Provisions in these Bylaws and in application forms relating to authorization, confidentiality of information and immunities from liability are in addition to other protections provided by relevant Rhode Island and federal law and not in limitation thereof. A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provision or any other provision.

ARTICLE THIRTEEN: GENERAL PROVISIONS

13.1 STAFF RULES AND REGULATIONS
Subject to approval by the Board of Trustees, the medical executive committee shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found in these Bylaws. The principles outlined in Article Fourteen of these Bylaws shall be followed in the adoption and amendment of the rules and regulations.

13.2 DEPARTMENT RULES
Each department will formulate written rules for the conduct of its affairs and the discharge of its responsibilities, all of which must be consistent with these Bylaws and the related manuals, the general staff rules, and hospital Bylaws and policies. These rules must be approved by the medical executive committee, subject to approval of said rules and regulations at the next staff meeting, and the Board of Trustees.

13.3 STAFF DUES

Printed copies are for reference only and are uncontrolled. Please refer to the electronic copy for the latest version.
The medical staff will establish the amount, if any, of annual dues by majority vote. Notice of dues will be given to the staff at the annual meeting and posted. Dues are payable on or before the last day of December of each year. If dues are not paid by the last day of January a special notice of delinquency is sent to the practitioner and he is given an additional 30 days to make payment. Failure to render payment at that point shall, unless excused by the medical executive committee for good cause, result in summary suspension of staff membership and clinical privileges until the delinquency is remedied.

All new staff members will be billed pro rata for the current year upon their appointment to the staff. Special assessments may be voted by majority action of the medical staff, and rules of payment similar to those described above in terms of time frame will apply. The following groups of practitioners are exempt from payment of dues and assessments: Honorary Staff; staff member on an approved leave of absence for one year or more.

ARTICLE FOURTEEN: ADOPTION AND AMENDMENT

14.1 MEDICAL STAFF AUTHORITY AND RESPONSIBILITY
The Board of Trustees holds the medical staff responsible for the development, adoption, and periodic review of Medical Staff Bylaws and related manuals, all of which must be consistent with hospital policies and applicable laws and other requirements. The Medical Staff Bylaws and related manuals shall be reviewed at least periodically by the medical staff committee responsible for the Bylaws review function, and may be reviewed more frequently when deemed necessary by the medical staff or appropriate authorities thereof. Suggestions for changes in the Bylaws shall be referred to the staff committee responsible for the Bylaws review function which shall present its recommendations in timely fashion to the medical executive committee for review and referral to the staff. Except as provided in Section 14.4, the adoption and amendment of Medical Staff Bylaws require the actions specified in Section 14.2 and 14.3.1. The principles and procedures expressed herein shall also apply to the adoption and amendment of the Rules and Regulations, as well as related manuals developed to implement, and cross-referenced in, various Sections of these Bylaws.

The Medical Staff has the ability to propose Medical Staff Bylaws, Rules and Regulations, and Policies, including Amendments thereto, and to propose them directly to the Board – and thus bypass the need for MEC approval, if it can document to the Board that it has achieved 60% approval of the entire Medical Staff on the proposals.

14.2 MEDICAL STAFF ACTION
The affirmative vote is required of a majority of the active staff members in good standing present at a regular or special staff meeting at which a quorum is present. A copy of the proposed
documents will be distributed to the entire Medical Staff at least 30 days prior to a regular or special Medical Staff meeting. The bylaw change would be voted upon at that meeting.

14.3 BOARD OF TRUSTEES ACTION

14.3.1 FOLLOWING MEDICAL STAFF RECOMMENDATION
Medical staff recommendations are approved upon the affirmative vote of a majority of the Board of Trustees. The effective date of such approved recommendations is on the date approved or at such later date as the Board of Trustees may specify.

14.4 TECHNICAL AND EDITORIAL AMENDMENTS
The medical executive committee shall have the power to adopt such amendment to the Bylaws as are, in its judgment, technical or legal modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if approved at the next regular meeting of the Medical Staff. The action to amend may be taken by motion acted upon in the same manner as any other motion before the medical executive committee. After approval, such amendments shall be communicated by some reasonable mechanism and in writing to the staff and to the Board of Trustees. When there is a significant concern regarding compliance with federal, state or regulatory requirements, the MEC may recommend urgent amendments directly to the Board of Directors without consulting the Medical Staff. The Medical Staff is immediately notified and has the opportunity for retrospective review and comment on the provisional amendments. If the Medical Staff later objects to an amendment approved by this expedited process, the matter can be addressed through the conflict resolution process (Article 15.1).

14.5 BOARD OF TRUSTEES AMENDMENT
No amendment to the Medical Staff Bylaws may be made, or approved, by the Board of Trustees without Medical Staff action as specified in Section 14.2 of these Bylaws.

ARTICLE FIFTEEN: CONFLICT RESOLUTION

15.1 The Medical Staff and the Board of Directors will make best efforts to address and resolve all conflicts in the best interest of patients, Westerly Hospital and the Medical Staff.

When the MEC, the Medical Staff, or the Board of Directors considers acting in a manner contrary to a recommendation made by the MEC, the Medical Staff, or the Board, the Medical Staff Officers shall meet as soon as possible with the Board, or designated committee of the Board and Administration, to seek to resolve the conflict through informal discussions.
If these informal discussions fail to resolve conflict, the Medical Staff President, a majority of the voting members of the Medical Staff, the President of the Hospital, or the Chair of the Board may request initiation of a formal resolution process.

The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within 30 calendar days of the initiation of the formal process. The Medical Staff representatives to this Committee shall at a minimum include the three officers of the Medical Staff and three other Medical Staff members, recommended by the officers and elected by the Medical Staff.

If after 60 days from the date of the initial request for the formal conflict resolution process, the Joint Conference Committee is unable to resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue which gave rise to the conflict.

If the Board determines, in its sole discretion, that action must be taken in a shorter time period than allowed through this formal conflict resolution process due to an urgent issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Board may take action that will remain in effect until the conflict resolution process is completed. This Article XV shall not be construed to constitute a waiver by any party or any remedies otherwise available under applicable law.
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PART ONE: ADMISSION OF PATIENTS

1.1 TYPES OF PATIENTS
The hospital accepts all patients for care and treatment except for the following categories where facility and personnel are limited:
   (a) Psychiatric patients requiring locked ward treatment
   (b) Head trauma requiring urgent or immediate surgery
   (c) Extensive third or second degree burns
   (d) Chemical dependency rehabilitation
Patients are admitted without regard to race, creed, color, sex, sexual preference, disability, age, national origin, or source of payment. Admission of any patient is contingent on adequate facilities and personnel being available to care for the patient, as determined by the chief executive officer after consultation with the applicable department chief.

1.2 ADMITTING PREROGATIVES
1.2.1 GENERALLY
Only a member in good standing of the active or associate category of the Medical Staff may admit patients to the hospital, subject to the conditions provided below and to all other official admitting policies of the hospital as may be in effect from time to time. Names of members not in good standing are submitted to the admitting office by the Medical Staff office.

1.2.2 LIMITATIONS FOR DENTISTS AND PODIATRISTS
Dentist and podiatrist members of the staff may admit patients to the hospital, but a physician member of the active Medical Staff must perform a basic medical appraisal (including history and physical examination) for each dental and podiatric patient immediately prior to admission and must perform an evaluation of the overall medical risk and effect of any planned operation or procedure on the patient's health.

1.3 ADMISSION INFORMATION
A patient will not be admitted to the hospital until the practitioner requesting admission provides a provisional diagnosis. Other required documentation or information specific to the type of admission involved should be in the record within a reasonable time.
following admission not to exceed 24 hours. This information must be based on an in-
person evaluation of the patient within twelve (12) hours prior to admission. The
admitting practitioner must communicate the following information concerning a patient
to be admitted: any source of communicable or significant infection; behavioral
characteristics that would disturb or endanger others; need for protecting the patient from
self-harm.

1.4 TIMELY VISITATION AFTER PATIENT ADMITTED
The attending practitioner or his/her designee must see the patient within 24 hours from
the time of admission, or sooner if the patient’s condition requires it.

PART TWO: ASSIGNMENT AND ATTENDANCE OF PATIENTS

2.1 ATTENDANCE OF PATIENTS
Each patient admitted to the hospital shall be attended to by the practitioner of his/her
own choice, provided said practitioner is a member of the Active Medical Staff and has
the appropriate clinical privileges. A patient who is to be admitted and who has no
personal practitioner may request any practitioner who is a member of the Active
Medical Staff and who has appropriate clinical privileges. When no such request is
made, or when the requested practitioner chooses not to undertake the care of the patient,
a member of the Active Medical Staff with the requisite privileges (hereinafter called the
original admitting physician) will be assigned to the patient according to the on-call
schedule of the applicable department.

That patient's follow-up care will be the responsibility of the original admitting physician
for 30 days from the date of hospital discharge. If the patient returns to the hospital
within those 30 days and requires hospital admission, the original admitting physician is
responsible for the care of the patient which falls within that physician’s specialty.
Patient follow-up care can also be transitioned to another physician or facility that has
agreed to provide follow-up care for the patient.

If the original admitting physician does not wish to provide follow-up care for the patient,
he/she should note this in the medical record and notify the patient, both verbally and in
writing, of the recommendations that have been made regarding follow-up.
If arrangements have been made for another physician or facility to provide follow-up
care for the patient, it is the responsibility of the original ordering physician to make the
physician/facility providing such follow-up aware of the cause for admission, significant
findings and occurrences during the hospitalization, and the treatment rendered.
If the patient's follow-up care has transitioned to another physician who is not a member of the Active Medical Staff, then if the patient returns to the hospital and requires hospital admission within the 30-day period, the original admitting physician will be responsible for that hospital care which falls within his/her specialty during that admission.

If the patient signs out of the hospital against medical advice, the physician shall no longer be responsible for the care of the patient.

Self Treatment of Immediate Family Members: In accordance with the AMA Code of Ethics, Medical Staff cannot provide care to a hospitalized, immediate family member. In emergency/life threatening settings, or where no other qualified physician is available, the treating physician is permitted to treat their family member until another qualified physician becomes available.

2.2 PARTICIPATION IN THE ON-CALL ROSTER
Unless specifically exempted by the applicable department for good cause shown, each member of the active and associate staffs agrees that, when he/she is the designated practitioner on call, he/she will accept responsibility during the time specified by the published schedule for providing care to any patient in any unit of the hospital referred to the service for which he/she is providing on-call coverage.

2.3 POLICY FOR PHYSICIAN COVERAGE
It is the responsibility of attending and consulting Medical Staff members to provide continuous coverage for inpatients either personally or by formally designating an alternative physician. The alternate physician must be a member of the Medical Staff of equal or greater clinical privileges.

It is the responsibility of all Medical Staff members to provide coverage for out of hospital and emergency clinical needs including hospital admissions. The covering physician must be a member of the Westerly Hospital Medical Staff with equal or greater clinical privileges.

2.4 POLICY FOR ADDRESSING NON-AVAILABILITY
First Instance Of Non-Availability
   a. Evaluation by Department Chair

Second Incident
   a. Reviewed by Department Chair and President of the Medical Staff
   b. Documentation maintained in credentials file
Third Incident
   a. Reviewed by Department Chair and President of the Medical Staff
   b. Suspension of admitting and procedure privileges for 14 days
   c. Notification of Medical Executive Committee
   d. Permanent record in credentials file

Additional Episode
   As above, plus 30-day suspension

Recurrence
   Medical Staff member is subject to dismissal from the Medical Staff.

2.5 PEER REVIEW PROCESS
Purpose and Responsibility

   The sole responsibility for peer review rests with the Peer Review Committee. Its
   function is to evaluate and improve the quality of care or to determine that services
   rendered were professionally indicated and were performed in compliance with the
   applicable standard of care.

Process

   The peer review process is initiated through notification by Risk Management to the
   Chairman of the Peer Review Committee of a matter to be considered for review. Matters
   subject to review include but are not limited to clinical situations such as a return
   to the operating room, the unplanned transfer of a patient to the ICU, unexpected death,
   medication errors and events that are reportable to the Department of Health pursuant to
   R.I.G.L. § 23-17-40. In addition, the peer review process shall allow for Quality/Risk
   Management and Medical Staff to identify records for review based on objective
   indicators.

   Once a matter has been submitted to the Peer Review Committee for review, the
   Chairman of the Committee may designate one or more authorized personnel to perform
   a preliminary review of the case. Once completed, the findings of this first level of peer
   review are presented to the Committee. If any questions remain after the first level of
   peer review, the Committee may issue a formal request for additional information to the
   attending physician or other member of the medical staff. This formal request may
include an invitation to the medical staff member to attend the Peer Review Committee meeting to address specific questions or to provide additional information.

Confidentiality

The peer review activities described herein are intended to be conducted in a confidential manner in accordance with the applicable statutory and regulatory law.

PART THREE: GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

3.1 GENERALLY

A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of those portions of the medical record for which he/she is responsible, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner, if any, and to relatives of the patient. Primary practitioner responsibility for these matters belongs to the admitting practitioner except when transfer of responsibility is affected pursuant to Section 3.2.

3.2 TRANSFER OF RESPONSIBILITY

When primary responsibility for a patient's care is transferred from the admitting or current attending practitioner to another staff member, a note covering the transfer of responsibility and acceptance of the same must be entered on the order sheet and progress notes.

3.3 ALTERNATE COVERAGE

Each practitioner must assure timely, adequate professional care for his/her patients in the hospital by being available or designating a qualified alternative practitioner with whom prior arrangements have been made and who has the requisite clinical privileges at this hospital to care for the patient. Each member of the staff who will be out of town or unavailable in case of emergency must indicate in writing on the order sheet the name of the practitioner who will be assuming responsibility for the care of the patient during his/her absence. In the absence of such designation, the Chief Executive Officer, the President of the Medical Staff or the applicable department chief has the authority to call any member of the staff with the requisite clinical privileges. Failure of an attending practitioner to meet these requirements may result in loss of staff membership or such other disciplinary action, as the Medical Executive Committee deems appropriate.
3.4 **DENTISTS, PODIATRISTS AND ALLIED HEALTH PROFESSIONALS**

Dentists, podiatrists and allied health professionals may treat patients under the conditions provided in Section 5.4, 5.5 and 5.6 of the Medical Staff Bylaws and in Section 1.2.2 of these Rules and Regulations. Each dentist, podiatrist and allied health professional is responsible for documenting in the medical record, in timely fashion, a complete and accurate description of the services he/she provides to the patient. More specifically, dentist and podiatrist members of the staff are responsible for the following:

- **(a)** A detailed dental/podiatric history and description of the dental/podiatric problem documenting the need for hospitalization and any surgery;
- **(b)** A detailed description of the examination of the oral cavity/foot and a preoperative diagnosis;
- **(c)** A complete operative report, describing the findings, technique, specimens removed and postoperative diagnosis;
- **(d)** Progress notes as are pertinent to the dental/podiatric condition;
- **(e)** Pertinent instructions relative to the dental/podiatric condition for the patient and/or significant other at the time of discharge; and,
- **(f)** Clinical resume of final summary note.

3.5 **POLICY CONCERNING IMMEDIATE QUESTIONS OF CARE**

If a nurse or other health care professional involved in the care of a patient has any reason to doubt or question the care provided to that patient or feels that appropriate consultation is needed and has not been obtained, and whose concerns have not been resolved after discussion with the attending physician, such individual shall bring the matter to the attention of the attending physician who, in turn, may refer the matter to the director of the hospital department. If warranted, said director may bring the matter to the attention of the chairman of the department wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the department chairman may request a consultation.

3.6 **CONSULTATIONS**

3.6.1 **RESPONSIBILITY**

The good conduct of medical practice includes the proper and timely use of consultation. The attending practitioner is primarily responsible for calling a consultant from a qualified staff member when indicated or required pursuant to the guidelines in Section 3.6.2 below. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment generally rests with
the attending practitioner.
When a consultation is required under these Rules or when the best interests of the patient will be served, any of the following may direct that a consultation be held and, if necessary, arrange for it: the applicable department chief, the President of the Medical Staff, the Medical Director. If the attending practitioner disagrees with the necessity for consultation, the matter shall be brought immediately to the President of the Medical Staff or the applicable department chief for final decision and direction.

3.6.2 GUIDELINES FOR CALLING CONSULTATIONS
Unless the attending practitioner's expertise is in the area of the patient's problem, consultation with a qualified physician is required in the following cases:
(a) When required by state law.
(b) When the rules of any clinical unit, including any intensive or special care units, of the staff require it.
(c) When requested by the patient or family.

3.6.3 QUALIFICATIONS OF CONSULTANT
Any qualified practitioner may be called as a consultant regardless of his/her staff category assignment. A consultant must be a recognized specialist in the applicable area as evidenced by certification by the appropriate specialty or subspecialty board or by a comparable degree of competence based on equivalent training and extensive experience. In either case, a consultant must be demonstrated the skill and judgment requisite to evaluation and treatment of the condition or problem presented and have been granted the appropriate level of clinical privileges.

3.6.4 DOCUMENTATION
(a) Consultation Request: When requesting consultation, the attending practitioner must indicate in writing on the consultation record the reason for the request.
(b) Consultant's Report: The consultant must make and sign a report of his/her findings, opinions and recommendations that reflects an actual examination of the patient and the medical record. Such report shall become part of the patient's medical record.
PART FOUR: TRANSFER OF PATIENTS

4.1 TRANSFER TO ANOTHER FACILITY

4.1.1 GENERAL REQUIREMENTS
A patient shall be transferred to another medical care facility only upon the order of the attending practitioner, only after arrangements have been made for admission with the other facility, including its consent to receiving the patient, and only after the patient is considered sufficiently stabilized for transport. All pertinent medical information necessary to insure continuity of care must accompany the patient.

4.1.2 DEMANDED BY EMERGENCY OR CRITICALLY ILL PATIENT
A transfer demanded by an emergency or critically ill patient or his/her family or significant other is not permitted until a physician has explained to the patient or his/her family or significant other the seriousness of the condition and generally not until a physician has determined that the condition is sufficiently stabilized for safe transport. In each such case, the appropriate release form is to be executed. If the patient or agent refuses to sign the release, a completed form without the patient's signature and a note indicating refusal must be included in the patient's medical record.

PART FIVE: DISCHARGE OF PATIENTS

5.1 REQUIRED ORDER
A patient may be discharged only on the order of the covering practitioner. The attending practitioner is responsible for documenting the principal diagnosis, secondary diagnosis, co-morbidities, complications, principal procedures, and additional procedures in of the patient's medical record within 72 hours of discharge.

5.2 LEAVING AGAINST MEDICAL ADVICE
If a patient desires to leave the hospital against the advice of the attending practitioner or without proper discharge, the attending practitioner shall be notified and the patient will be requested to sign the appropriate release form. If a patient leaves the hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident must be made in the patient's medical record.
5.3 DISCHARGE OF MINOR PATIENT

Any individual who cannot legally consent to his/her own care shall be discharged only to the custody of parents, legal guardian, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he shall so state in writing, and the statement must be made a part of the patient's medical record.

PART SIX: ORDERS

GENERAL REQUIREMENTS

6.1 All orders for treatment or diagnostic tests must be written clearly, legibly and completely and signed by the practitioner responsible for them. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood by the nurse or pharmacist. Orders for diagnostic tests, which necessitate the administration of test substances or medications, will be considered to include the order for this administration.

6.2 STANDING ORDERS

All standing orders shall be listed on an instruction and order sheet that must be included in the patient's medical record and signed and dated by the attending practitioner. Standing orders shall be considered as a specific order by the attending practitioner for that patient and shall be followed in the absence of other specific orders by the attending practitioner, insofar as the proper treatment of the patient will allow. All standing orders must be reviewed at least annually and revised as necessary under the direction of the department chairman.

6.3 VERBAL ORDERS

6.3.1 BY WHOM AND CIRCUMSTANCE

A registered nurse or pharmacist as authorized in the policies and procedure manual of the Hospital may take telephone or verbal orders. Verbal and telephone orders may be accepted and executed by the following within their scope of practice as defined by their State of RI licensure:

- Registered nursing staff
- Licensed practical nurses
- Registered pharmacists
- Respiratory care practitioners
Registered physical therapists
Registered occupational therapists
Licensed speech-language pathologists
Licensed audiologists
Radiologic technologists
Registered Sonographers
Registered Nuclear Medicine Technologists
Registered Dieticians

Verbal orders shall be authenticated as required by State and Federal law and regulations.

### 6.3.2 DOCUMENTATION

All verbal and telephone orders shall be transcribed in the proper place in the medical record, shall include the date, time, name and signature of the person transcribing the order and the name of the practitioner, and shall be countersigned by the prescribing practitioner within 24 hours.

### 6.4 ORDERS BY ALLIED HEALTH PROFESSIONALS

An allied health professional who is a registered nurse practitioner, certified registered nurse anesthetist, certified nurse midwife, or physician assistant may write orders consistent with the scope of services individually defined for the specific profession, the providers’ granted privileges and applicable state laws. If a practitioner is on Provisional Staff, all orders must be co-signed by their supervising physician until transfer to Active Medical Staff.

- The Medical Staff requires direct supervision for all new graduates (i.e. received license within one year of initial appointment) for the initial 90 days following appointment to the Medical Staff. The supervising physician must be physically present, or within an immediate distance on the hospital campus, and available to respond to the needs of the practitioner; the supervising physician gives specific instructions on all assignments; work is reviewed for completeness and accuracy.

- The Medical Staff requires direct supervision of all new appointees (who have prior hospital practice experience greater than one year) for the initial 30 days following appointment. The supervising physician must be physically present, or within an immediate distance on the hospital campus, and available to respond to the needs of the practitioner; the supervising physician gives specific instructions on all assignments; work is reviewed for completeness and accuracy.
• The Medical Staff requires intermittent supervision on non-physician providers beyond the initial period of required direct supervision. The supervising physician makes assignments by defining objectives, priorities and deadlines, and assists the non-physician provider with unusual situations that do not have clear objectives. The non-physician provider plans and carries out successive steps and resolves problems and deviations in accordance with instructions, policies, and accepted practices. The supervising physician reviews the work for technical adequacy and conformance with standard clinical practice policy.

6.5 AUTOMATIC CANCELLATION OF ORDERS
All previous orders are automatically discontinued when the patient goes to surgery or is transferred to another service or another level of service. The medical record shall be flagged to indicate this has occurred. The attending practitioner must write new orders, re-institute all or some of the orders, or refer to another practitioner for a decision on whether or not to re-institute all or particular orders.

6.6 BLOOD TRANSFUSIONS AND INTRAVENOUS INFUSIONS
Blood transfusions and intravenous infusions must be started by the attending physician or by a registered nurse who has the requisite training and has been credentialed to do so in the hospital. The order must specifically state the rate of infusion.

6.7 SPECIAL ORDERS
6.7.1 PATIENTS OWN DRUGS AND SELF-ADMINISTRATION
Drugs brought into the hospital by a patient may not be administered unless the drugs have been identified and there is a written order from the attending practitioner to administer the drugs. Self-administration of medications by a patient is permitted on a specific written order by the authorized prescribing practitioner and in accordance with established hospital policy.

6.7.2 DO NOT RESUSCITATE
In the case of a patient with an irreversible, terminal condition, a "Do Not Resuscitate" order is acceptable. The attending physician must write the order on the order sheet and progress notes. Adequate documentation, including any consents/authorizations, and any notices required shall be accomplished in accordance with the hospital's "Do Not Resuscitate" policy.
### 6.8 FORMULARY AND INVESTIGATIONAL DRUGS

#### 6.8.1 FORMULARY

The hospital formulary lists drugs available for ordering from stock. Each member of the Medical Staff assents to the use of the formulary as approved by the Pharmacy Committee. All drugs and medications administered to patients shall be those listed in the latest edition: United States Pharmacopoeia; National Formulary, New and Non-Official Drugs; American Hospital Formulary Service; or AMA Drug Evaluations.

#### 6.8.2 INVESTIGATIONAL DRUGS

Use of investigational drugs must be in full accordance with all Regulations of the Food and Drug Administration and must be approved by the Institutional Review Committee. Investigational drugs shall be used only under the direct supervision of the principal investigator. The principal investigator shall be responsible for receiving all necessary consents and completing all necessary forms and shall prepare and clarify directions for the administration of investigational drugs as to untoward symptoms, special precautions in administration, proper labeling of the container, proper storage of drug, methods of recording doses when indicated, and method of collection and recording specimens of urine and/or other specimens.

### PART SEVEN: INPATIENT MEDICAL RECORDS

#### 7.1 REQUIRED CONTENT

The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. The record's content shall be pertinent, accurate, legible, timely and current. The record shall include:

- a) Identification data
- b) Personal and family medical histories
- c) Description and history of present complaint and/or illness
- d) Physical examination report
- e) Diagnostic and therapeutic orders
- f) Evidence of appropriate informed consent
- g) Treatment provided
- h) Progress notes and other clinical observations, including results of therapy
- i) Special reports, when applicable (such as clinical laboratory, radiology, radiotherapy, EEG, EKG, consultation, pre and post anesthesia, operative and other diagnostic and therapeutic procedures, etc.)
- j) Pathological findings
- k) Final diagnosis without the use of symbols or abbreviations
1) Condition on discharge, including instructions, to the patient or significant other on post-hospital care.
   m) Autopsy report, when available.

7.2 HISTORY AND PHYSICAL EXAMINATION

7.2.1 GENERALLY
Maintain a consistent process for the completion of Medical Records as outlined in the Rules and Regulations. Specifically, a medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient’s medical record within 24 hours of admission. When the medical history and physical examination are completed within 30 days before admission, an updated medical record entry documenting an examination for any changes in the patient’s condition shall be completed. This updated examination must be completed and documented in the patient’s medical record within 24 hours after admission and prior to any surgical procedure or procedure requiring anesthesia services.

7.2.2 USE OF REPORTS PREPARED PRIOR TO CURRENT ADMISSION
   a) External to Hospital: If a qualified member of the hospital's Medical Staff has obtained a complete history or has performed a complete physical examination prior to admission, based on the allowable timeframe, 30 days, stated in CMS Rules and Regulations prior to the patient's admission to the hospital, a durable, legible copy of the report may be used in the patient's hospital medical record, provided that an interval admission note is recorded that includes all additions to the history and any changes in the physical findings subsequent to the original report.

7.3 PREOPERATIVE DOCUMENTATION

7.3.1 HISTORY AND PHYSICAL EXAMINATION
A relevant history and physical examination is required on each patient having surgery. Except in an emergency so certified in writing by the operating practitioner, surgery or any other potentially hazardous procedure shall not be performed until after the pre-operative diagnosis, history, physical examination, and required laboratory tests have been recorded in the chart. If the history and physical examination have been dictated but are not on the chart at the time of
surgery, a written note must be entered before surgery stating the basic nature of the proposed surgery/procedure and the condition for which it is to be done, the condition of the heart and lungs, allergies known to be present, other pertinent pathology and information relating to the patient, and that the history and physical have been dictated. If not recorded, the anesthesiologist shall not allow the surgery to proceed. In cases of emergency, the responsible practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of the procedure, and the history and physical examination shall be recorded immediately after the emergency surgery has been completed. All cases in which the requirements of this section are not met shall be acted upon in accordance with Section 6.4.4 of the Medical Staff Bylaws and Section 5.3.4 of the Credentialing Procedures Manual.

7.3.2 LABORATORY TESTS
Appropriate advance lab tests must be performed within 30 days prior to admission for elective surgery and for outpatient or same day surgery and the results in the chart prior to induction of anesthesia.

7.3.3 PREOPERATIVE ANESTHESIA EVALUATION
The anesthesiologist must conduct and document in the record a pre-anesthesia evaluation of the patient including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent anesthetic problems, ASA patient status classification, and orders for preoperative medication. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered.

7.4 PROGRESS NOTES
7.4.1 GENERALLY
Pertinent and legible progress notes must be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending practitioner. Whenever possible, each of the patients clinical problems must be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes by the attending practitioner must be written at least daily on all patients. Progress notes written by a physician-directed allied health professional must be countersigned within 24 hours and supplemented every 24 hours by the responsible supervising practitioner.
7.5 OPERATIVE SPECIAL PROCEDURE AND TISSUE REPORTS

7.5.1 OPERATIVE AND SPECIAL PROCEDURE REPORTS
Operative and special procedure reports must contain, as applicable, a detailed account of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, and the name of the primary performing practitioner and any assistants. If the report is dictated and not immediately transcribed or not written in the record immediately after the procedure, the practitioner must enter a comprehensive operative progress note in the medical record immediately after the procedure providing sufficient and pertinent information for use by any practitioner who is required to attend the patient. The complete report must be written or dictated immediately following the procedure, filed in the medical record as soon after the procedure as possible, and promptly signed by the primary performing practitioner.

7.5.2 TISSUE EXAMINATION AND REPORTS
All tissue, foreign bodies, artifacts and prostheses removed during a procedure, except those specifically excluded by policy, shall be properly labeled, packaged in preservative as designated, identified as to patient and source in the operating room at the time of removal, and sent to the pathologist. The pathologist shall document receipt and make such examination as is necessary to arrive at a pathological diagnosis. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. An authenticated report of the pathologist's examination shall be made part of the medical record.

7.5.3 POST-OPERATIVE ANESTHESIA EVALUATION
A post-operative anesthesia evaluation must be performed and documented on inpatients within 48 hours after a procedure requiring anesthesia services.

7.6 DISCHARGE SUMMARY
The principal diagnosis, any secondary diagnoses, co-morbidities, complications, principal procedure and any additional procedures must be recorded in full, and must be dated and signed by the attending practitioner within 72 hours of the patient's discharge. The following definitions are applicable to the terms used herein:

a) Principal diagnosis: The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
b) Secondary diagnosis (if applicable): A diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the attending practitioner considers of sufficient significance to warrant inclusion for investigative medical studies.

c) Co-morbidities (if applicable): A condition that coexisted at admission with a specific principal diagnosis, and is thought to increase the length of stay by at least one day.

d) Complications (if applicable): An additional diagnosis that describes a condition arising after the beginning of hospital observation and treatment and modifying the course of the patient's illness or the medical care required, and is thought to increase the length of stay by at least one day.

e) Principal Procedure (if applicable): The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes or was necessary to take care of a complication.

f) Additional Procedures (if applicable): Any other procedures, other than principal procedure, pertinent to the individual stay.

g) In General: A discharge summary must be recorded for all patients. The summary must recapitulate concisely the reason for hospitalization, the significant findings including complications, the procedures performed and treatment rendered and the condition of the patient on discharge stated in a manner allowing specific comparison with the condition on admission.

7.6.1 INSTRUCTIONS TO PATIENTS
The discharge summary or final progress note must indicate any specific instructions given to the patient and/or significant other relating to physical activity, medication, diet and follow up care. If no instructions were required, a record entry must be made to that effect.

7.7 AUTHENTICATION
All clinical entries in the patient's record must be accurately dated and individually authenticated. Authentication means to establish authorship by written signature, identifiable initials or electronic signature.

7.8 USE OF SYMBOLS AND ABBREVIATIONS
Symbols and abbreviations may be used only when the Medical Executive Committee has approved them. An official record of approved symbols and abbreviations is available at each nursing station and in the medical records department.
7.9 FILING
No medical record shall be filed until it is complete and properly signed. In the event that a chart remains incomplete by reason of the death, resignation or other inability or unavailability of the responsible practitioner to complete the record, the department chairman shall complete the necessary documentation of the medical record.

7.10 TIMELY COMPLETION OF MEDICAL RECORDS
All medical records must be completed within 30 days of review and notation of deficiencies by the Clinical Information Department. On a weekly basis, medical staff members with incomplete records will be placed on one of three lists and notified by letter.

List A: Reminder: Deficiencies are less than 21 days old and in compliance.

List B: Alert: Deficiencies are 21-29 days old and in danger of delinquency.

List C: Delinquent: Deficiencies are 30 or more days old. If more than nine (9) delinquencies occur within four (4) quarters, the Chief of the Department will be notified; if more than nine (9) delinquencies have occurred in the four (4) quarters preceding reappointment, the reappointment will be for a period of eight (8) months during which time delinquent records will be monitored; if during the next six (6) month period, delinquencies continue to exceed the average of less than ten (10) for four (4) quarters, the practitioner will be requested to attend the Board of Directors Meeting.

7.11 OWNERSHIP AND REMOVAL OF RECORDS
All original patient medical records, including x-ray films, pathological specimens and slides, are the property of the hospital and may be removed only in accordance with a court order, subpoena or statute, or with the permission of the Chief Executive Officer. Copies of records, films, slides, etc. may be released to another staff physician in order to maintain continuity of care. Unauthorized removal of a medical record or any portion thereof from the hospital is grounds for disciplinary action, including immediate and permanent revocation of staff appointment and clinical privileges, as determined by the appropriate authorities of the Medical Staff and Board of Trustees.
7.12 ACCESS TO RECORDS
7.12.1 BY PATIENT
A patient may, upon written request to the hospital, have access to all information contained in his/her medical records according to hospital policy, unless access is specifically restricted or prohibited by law.

7.12.2 ON READMISSION
In the case of readmission of a patient, all previous records shall be available for use by the current attending practitioner.

7.12.3 TO FORMER MEDICAL STAFF MEMBERS
Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted access to information from the medical records of their patients for all periods during which they attended such patients in the past.

7.12.4 PATIENT CONSENT REQUIRED UNDER OTHER CIRCUMSTANCES
Written consent of the patient or legally qualified representative is required for release of medical information to persons not otherwise authorized by law to receive this information.

PART EIGHT: CONSENTS
8.1 GENERAL
Each patient's medical record must contain evidence of the patient's or his/her legal representative's general consent for treatment during hospitalization.

8.2 INFORMED CONSENT
8.2.1 WHEN REQUIRED
The performing and/or attending practitioner, where applicable, is responsible for obtaining the patient's or his/her legal representative's informed consent for the procedures and treatments listed below:
   a) Anesthesia;
   b) Surgical and other invasive procedures;
   c) Use of experimental drugs;
   d) Organ donation;
   e) Chemotherapy;
   f) Autopsy;
   g) Photography;
   h) Blood Transfusions.
8.2.2 DOCUMENTATION REQUIRED

The informed consent must be documented in the patient's medical record or on a form appended to the record and must include at least the following information:

a) Patient identity
b) Date and time when patient was informed
c) Nature of the procedure or treatment proposed to be rendered.
d) Name(s) of the individual(s) who will perform the procedure or administer the treatment.
e) Authorization for any required anesthesia.
f) Indication that the risks and complications of the procedure or treatment and of the alternatives available, if any, and the risks of foregoing the proposed or alternative procedures or treatments have been explained to the patient, or the patient's legal representative, in terms that a patient would reasonably consider material to the decision whether or not to undergo the procedure or treatment.
g) Authorization for removal of any tissue or body parts as indicated.
h) Name of the practitioner who informs the patient and obtains the consent.

8.2.3 SIGNATURES

An informed consent must be signed by the patient, or on the patient's behalf by the patient's authorized representative, and witnessed by a legally competent third party.

8.2.4 EMERGENCIES

If circumstances arise where it is deemed medically advisable to proceed with a procedure or treatment specified in Section 8.2.1 without first obtaining informed consent as required therein, such circumstances must be explained in the patient's medical record.

PART NINE: SPECIAL SERVICES UNITS AND PROGRAMS

9.1 DESIGNATION

Special services units and programs include, but are not limited to, the following:

a) ICU-CCU Unit
b) Emergency Room and Convenience Care
c) Operating Room
d) Post Anesthesia Care Unit
e) Ambulatory Care Unit
9.2 POLICIES
Appropriate officers, committees, and representatives of the Medical Staff and its departments will develop, in coordination with applicable hospital departments, specific policies for the special services units and programs, covering, when applicable, such subjects as the responsibility for care of patients in the unit/program, criteria for patient admission to the unit/program, consultation requirements, admission/discharge/transfer protocols, direction of the unit/program, authority of the physician director of the unit/program/special record keeping requirements, scheduling of patients, etc. The policies of the various units and programs are subject to approval of the medical executive committee and the chief executive officer.

PART TEN: HOSPITAL DEATHS AND AUTOPSIES

10.1 HOSPITAL DEATHS
10.1.1 PRONOUNCEMENT
In the event of a hospital death, the deceased shall be pronounced dead by the attending physician or his/her designee within a reasonable period of time.

10.1.2 REPORTABLE DEATHS
Reporting deaths to the Medical Examiner's Office shall be carried out when required by and in conformance with local law.

10.1.3 DEATH CERTIFICATE
The attending physician must sign the death certificate unless the death is a Medical Examiner's case in which event the death certificate may be issued only by the Medical Examiner. When a reported case is declared "No Jurisdiction" or "Jurisdiction Terminated" by the Medical Examiner, the attending physician issues the death certificate.

10.1.4 RELEASE OF BODY
The body may not be released until an entry has been made and signed in the deceased's medical record by a physician member of the Medical Staff. In a Medical Examiner's case, the body may not be released to other than Medical Examiner personnel or to police officers, except upon the receipt of an "Order to Release Body" form issued by the Medical Examiner. All other policies with respect to the release of dead bodies shall conform to local law.

10.2 AUTOPSIES
Members of the Medical Staff are encouraged to secure autopsies whenever possible in all cases of unusual deaths and those of medical-legal and educational interest – deaths in which patient sustained or apparently suffered an injury while hospitalized; deaths known
or suspected to have resulted from environmental or occupational hazards; deaths of patients that have participated in clinical trials approved by the IRB. Proper consent for an autopsy shall be in accordance with applicable state law. All autopsies shall be performed by the hospital pathologist, or by his/her qualified designee. The provisional anatomic diagnosis must be recorded on the medical record within 72 hours; and the complete protocol shall be made a part of the medical record within 60 days. These rules do not apply to cases which according to law must be referred to the Medical Examiner's Office.
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PART ONE: APPOINTMENT PROCEDURES

1.1 APPLICATION

An application for staff membership must be submitted by the applicant in writing and on such form as approved by the Medical Staff. Prior to the application being submitted, the applicant will be provided a copy of the corporate bylaws, the medical staff bylaws and related manuals, the rules and regulations of the departments. The application must be forwarded to the applicant within two weeks of the request.

1.2 APPLICATION CONTENT

Every application must furnish complete information concerning at least the following:

(a) Undergraduate, medical school, and postgraduate training, including the names of each institution, degrees granted, program completed, dates attended, and for all postgraduate training, names of practitioners responsible for monitoring the applicant's performance.

(b) All past and currently valid medical, dental, podiatric and other professional licensure or certifications, and Drug Enforcement Administration (DEA) and any other controlled substance registrations, with the date and number of each. A copy of the current Rhode Island and/or Connecticut license(s) and DEA and Rhode Island and/or Connecticut controlled substance certificate(s) must accompany the application (with the exception of Telemedicine), or if in the process of obtaining same, will submit copy when available. The Credentials Committee may waive the requirement upon request of the applicant if the Committee deems such request to be clinically appropriate.

(c) Specialty or subspecialty Board certification, re-certification, or eligibility status as defined by the applicable Board to sit for its examination

(d) Any previous or current health problem or disability that affects or that may be expected to affect the applicant's ability in terms of skill, attitude or judgment to perform professional and medical staff duties fully; hospitalizations or other institutionalization for any such health problem or disability during the past ten year period; if any such health problem or disability in the past is currently controlled by therapy or is resolved but may reoccur, date of last health examination with name and address of performing physician and findings related to that problem or disability.

(e) Professional liability insurance coverage and information on malpractice claims and experience (suits and settlements made, concluded, pending), including the names of present and past insurance carriers.

(f) Any pending or completed action involving denial, revocation, suspension, reduction,
limitation, or probation of any of the following: license or certificate to practice any profession in any state or country; Drug Enforcement Administration or other controlled substances registration; membership or fellowship in local, state or national professional organizations; faculty membership at any medical or other professional school; appointment or employment status, prerogatives or clinical privileges at any other hospital, clinic or health care institution or organizations; professional liability insurance.

(g) Any instances of non-renewal, relinquishment (by resignation or expiration), limitation, or withdrawal or failure to proceed with an application for any of the items listed in (f) above in order to foreclose or terminate actual or possible investigation or disciplinary or adverse action.

(h) Location of offices; names and addresses of other practitioners with whom the applicant is or was associated and inclusive dates of such association; names and location of all other hospitals, clinics or health care institutions or organizations where the applicant had or has any association, employment, protégés or practice with the inclusive dates of each affiliation, status held, and general scope of clinical privileges; and a complete listing of employment or activities for each year following medical school.

(i) Department assignment, staff category, and specific clinical privileges requested.

(j) Any current criminal charges (other than motor vehicle violations) pending against the applicant and any past charges including their resolution, and any current and past charges involving a drug or alcohol-related offense.

(k) References as required by Section 1.3 below.

(l) Evidence of the applicant's agreement with the authorization, confidentiality, immunity, and release provisions of the medical staff bylaws and this credentialing procedures manual.

(m) Documentation that the applicant is free of active tuberculosis as outlined in Section 13.10 Health Screening (or its successor) of the State of Rhode Island Rules and Regulations for Licensing of Hospitals. This requirement is not applicable to those applying for Telemedicine.

1.3 REFERENCES

The application must include the names of at least 3 medical or health care professionals, one of whom should be in the same specialty, who are not newly associated or about to become partners with the applicant in professional practice or personally related to him/her, who have personal knowledge of the applicant's current clinical ability, ethical character, health status and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from Medical Staff or Board of Trustee authorities.

The named individuals must have acquired the requisite knowledge through recent observation.
of the applicant's professional performance over a reasonable period of time.

1.4 EFFECT OF APPLICATION

The applicant must sign the application and in so doing:

(a) Attest to the correctness and completeness of all information furnished and acknowledges that any material misstatement in or omission from the application constitutes grounds for denial of appointment or for summary dismissal from the staff;

(b) Signifies his/her willingness to appear for interviews in connection with his/her application;

(c) Agrees to abide by the terms of the bylaws and related manuals, rules, policies and procedures manuals of the medical staff and those of the hospital if granted appointment and/or clinical privileges, and to abide by the terms thereof in all matters related to consideration of the application without regard to whether or not membership and/or privileges are granted;

(d) Agrees to maintain an ethical practice and to provide continuous care to his/her patients;

(e) Agrees to immediately notify the Medical Staff President and the Chief Executive Officer of any change made or proposed in the status of his/her professional license to practice, DEA or other controlled substances registration, professional liability insurance coverage, and appointment or employment status at, affiliation with, or clinical privileges at other institutions or organizations, and on the status of current or initiation of new malpractice claims;

(f) Authorizes and consents to hospital representatives consulting with prior associates or others who may have information bearing on professional or ethical qualifications and competence and consents to their inspecting all records and documents that may be material to evaluation of said qualifications and competence;

(g) Releases from any liability all those who, in good faith and without malice, review, act on or provide information regarding the personal ethics, utilization practice patterns, character, health status, and other qualifications for staff appointment and clinical privileges.

1.5 PROCESSING THE APPLICATION

1.5.1 APPLICANT’S BURDEN

The applicant has the burden of producing adequate information for a proper evaluation of his/her experience, training, current competence, utilization practice patterns, ability to work cooperatively with others, and health status, and of resolving any doubts about these or any of the qualifications required for staff appointment or the requested staff
category, department assignment, or clinical privileges, and of satisfying any requests for
information or clarification (including health examinations) made by appropriate staff or
Board of Trustee authorities.

1.5.2 VERIFICATION OF INFORMATION

The applicant submits the application to the medical staff office, which notifies the
applicable department chief of its receipt. Representatives of the medical staff office,
working with the credentials committee chairman organize and coordinate the collection
and verification of the references, licensure and other qualification evidence submitted
and promptly notify the applicant of any gaps in or any problems in obtaining the
information required. This must be a written notice and must indicate the nature of the
information the applicant is to provide and the time frame for response. Failure, without
good cause, to respond in a satisfactory manner by that date is deemed a voluntary
withdrawal of the application. The medical staff office will promptly respond to inquiries
by the applicant regarding the status of the application. Verification shall include in
addition to comprehensive inquiries to agencies, organizations and individuals identified
in the application:

(a) Requesting specific information regarding his/her experience and competence in
exercising the privileges requested.
(b) Requesting from the Secretary of the Department of Health and Human Services or
the alternative agency designated by the Secretary information regarding a
practitioner that has been reported pursuant to the Health Care Quality
(c) Submitting a "Request for Physician Profile to the American Medical Association
Physician Master File. When collection and verification is accomplished, the
medical staff office transmits the application and all supporting materials to the
chief of each department in which the applicant seeks privileges.
(d) Query the National Practitioner Data Bank.
(e) Verify state licensure through the Rhode Island Department of Health.
(f) Query previous and current malpractice insurance carriers regarding previous or
ongoing litigation, claims or settlements.
(g) Perform a background criminal check.

When collection and verification is accomplished, the medical staff office transmits the
application and all supporting materials to the chief of each department in which the
applicant seeks privileges.

1.5.3 MEDICAL STAFF INPUT

Any medical staff member may submit in writing to the applicable department chief or to
the Credentials Committee a written statement containing relevant information regarding
an applicant's qualifications for membership or the privileges requested. Any such member may request or may be requested to confer with the department chief or the credentials committee to discuss his/her statement.

1.5.4 **DEPARTMENT EVALUATION**

The chief of each department in which the applicant seeks privileges shall review the application and its supporting documentation, and forward a report and recommendation to the Credentials Committee. All information sought or acquired by the chief, as part of his/her evaluation must be included with these reports.

If a department chief requires further information, he/she may defer transmitting his/her report but overall the combined deferral time should not generally exceed 30 days, except for good cause. In case of a deferral, the applicable department chief must notify, through the medical staff office, the applicant, the chairman of the Credentials Committee, and the President of the Staff in writing of the deferral and the grounds. If the applicant is to provide the additional information or a specific release/authorization to allow hospital representatives to obtain information, the notice to him/her must so state, must be a written notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application.

1.5.5 **CREDENTIALS COMMITTEE EVALUATION**

The Credentials Committee shall review the application, the supporting documentation, and the reports from the department chief and any other relevant information available to it. The Credentials Committee may conduct an interview with the applicant. The credentials committee shall prepare its written report and recommendations and transmit it to the Medical Executive Committee.

1.5.6 **MEDICAL EXECUTIVE COMMITTEE ACTION**

As part of any of its actions outlined below, the Medical Executive Committee or the Board of Trustees may, at its discretion, conduct an interview with the applicant or designate one or more individuals to do so on its behalf. If the Medical Executive Committee or Board of Trustees determines that it requires further information, it may defer action but generally not for more than 30 days except for good cause, and it shall notify the applicant and the President of the Medical Staff in writing of the deferral and the grounds. If the applicant is to provide additional information or a specific release/authorization to allow hospital representatives to obtain information, the notice to him/her must so state, must be a written notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for
response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application.

(a) The Medical Executive Committee may adopt or reject, in whole or in part, a favorable Credentials Committee recommendation or refer the recommendation back to the Credentials Committee for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made back to the Medical Executive Committee. If the Credentials Committee's subsequent recommendation after a referral back is adverse to the applicant, the application shall be processed as provided in Section 1.5.5 above, and a report submitted back to the Medical Executive Committee.

(b) If the Medical Executive Committee's action pursuant to this provision is favorable to the applicant, it shall be effective as its final decision, subject only to change by the Board of Trustees as provided below. If the Medical Executive Committee's action, is adverse to the applicant in any respect, the Chief Executive Officer shall inform the applicant by written notice as provided in Section 1.2 of the Fair Hearing Plan, and is entitled, upon proper and timely request, to the procedural rights provided in said plan. If the Board of Trustees, on receipt of a Medical Executive Committee report of favorable action, modifies that action, it must comply with the requirements of Section 1.5.8 if applicable. If, after doing so, its decision is adverse to the applicant in any respect, the Chief Executive Officer shall inform the applicant by written notice as provided in Section 1.2 of the Fair Hearing Plan, and he is then entitled, upon proper and timely request, to the procedural rights provided in said plan.

(c) Adverse Medical Executive Committee or Board Action Defined: For the purposes of this Section 1.5.6, "adverse action" by the medical executive committee or Board of Trustees is as defined in Section 1.1 of the Fair Hearing Plan.

1.5.7 CONTENT OF REPORT AND BASIS FOR RECOMMENDATION AND ACTION

Each individual or group providing a recommendation or acting on an application shall have available the full resources of the medical staff and hospital as well as the authority to use outside consultants as deemed necessary. The report of each individual or group required to act on an application must include recommendations as to approval or denial of, and any special limitations on staff appointment, category of staff appointment and prerogatives, department affiliation, and scope of clinical privileges. All documentation and information received by an individual or group, during or as part of the evaluation process must be included with the application as part of the individual's central credentials file and, as appropriate or requested, transmitted with reports and
recommendations. The reasons for each recommendation or action to deny, restrict or otherwise limit must be stated, with reference to the completed application and all other documentation considered.

1.5.8 CONFLICT RESOLUTION
Whenever the Board of Trustees determines that it will act in a matter contrary to the recommendation of the Medical Executive Committee, the matter will be submitted to the Professional Affairs Committee, composed of an equal number of members each from the medical staff and the Board of Trustees appointed respectively by the President of the Medical Staff and the Chairman of the Board, for review and recommendation before the Board of Trustees makes its decision.

1.5.9 NOTICE OF FINAL DECISION
(a) Notice of the final decision is given through the Chief Executive Officer or his/her designee to the applicant by written notice and to the Medical Staff President, the Credentials Committee, and the applicable department chief
(b) A decision and notice to appoint includes: (1) the staff category to which the applicant is appointed; (2) the department to which he/she is assigned; (3) the clinical privileges he/she may exercise; and (4) any special conditions attached to the appointment.
(c) Staff appointment and activation of privileges will become effective only after submitting written acceptance of said appointment and privileges. The Medical Staff Office must receive written acceptance of the granted privileges and appointment to the medical staff within thirty days. Failure, without good cause of the applicant to complete this final step in the application process is deemed a voluntary withdrawal of the application.

1.5.10 TIME PERIOD FOR PROCESSING
All individuals and groups required to act on an application for staff appointment must do so in a timely and good faith manner and, except for obtaining required information or for other good cause, each application should be processed expeditiously.
(a) The Medical staff office shall forward the application and supporting information to the appropriate Department Chairperson as soon as the application is complete. Prior to completion, the Medical Staff Office will provide a status report to the Credentials and Medical Executive Committees every 30 days.
(b) The Department Chairperson will have 30 days to process the application after receiving material from the medical staff office
(c) The Credentials Committee will process the application and make recommendations at the next monthly Credentials Committee meeting after receiving reports from (a) and (b). The Credentials Committee may request
additional information and delay its recommendation until the additional
information has been received and processed.

d) The Medical Executive Committee will make its recommendation at the next
regular meeting after receiving the report from (c).

These time periods are to be deemed guidelines and are not directives such as to create
any rights for a practitioner to have an application processed within these precise periods.
If the provisions of the Fair Hearing Plan are activated, the time requirements provided
there govern the continued processing of the application. If action does not occur in a
particular step in the process and the delay is without good cause, the next higher
authority may immediately proceed to consider the application and all the supporting
information or may be directed by the president of the medical staff on behalf of the
credentials committee or by the Chief Executive Officer on behalf of the Board of
Trustees to so proceed.

1.5.11 DISASTER PRIVILEGING

During an emergency event, the CEO, medical staff president or their designee(s) has the
option to grant disaster privileges when the disaster plan has been implemented and the
immediate needs of the patients cannot be met. The ED physician-in-charge or their
physician designee may grant disaster privileges during off hours, nights and weekends.
This option to grant disaster privileges to volunteer practitioners is made on a case-by-
\-case basis in accordance with the needs of the hospital and patients, and on the
qualifications of the volunteer practitioners.

Disaster privileges are granted only when the following two conditions are present:
- the emergency management plan has been activated
- the hospital is unable to meet immediate patient needs.

Even in a disaster, two parts of the usual credentialing and privileging process are maintained:
1. Verification of licensure
2. Oversight of the care, treatment and services provided

Volunteers considered eligible to act as licensed independent practitioners in the hospital
must, at a minimum, present a valid government-issued photo identification issued by a
state or federal agency (e.g., driver’s license or passport) and at least one of the
following:
- A current picture hospital ID card that clearly identifies professional designation
- A current license to practice
- Primary source verification of the license
The volunteer practitioner will complete the Disaster Privileges Application and this will be forwarded to the Medical Staff Office. A temporary identification badge will be issued.

Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the hospital. This process is identical to the process already established by Medical Staff Bylaws for the granting of temporary privileges.

If primary source verification of a volunteer licensed independent practitioner’s licensure cannot be completed within 72 hours of the practitioner’s arrival due to extraordinary circumstances, all of the following must be documented.

a. Reason(s) it could not be performed within 72 hours of the practitioner’s arrival  
b. Evidence of the licensed independent practitioner’s demonstrated ability to continue to provide adequate care, treatment, and services  
c. Evidence of the hospital’s attempt to perform primary source verification as soon as possible

If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner’s arrival it is performed as soon as possible. Primary source verification is not required if the practitioner did not provide care, treatment, or services under the disaster privileges.

The mechanism for oversight of the professional performance of volunteer practitioners will include one or more of the following: direct observation, mentoring and/or clinical record review.

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The hospital makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

All disaster privileges shall immediately terminate once the disaster is over and these privileges may be terminated at any time without cause or reason and without right to hearing or review.

PART TWO: REAPPOINTMENT PROCEDURES

2.1 INFORMATION COLLECTION AND VERIFICATION

2.1.1. FROM STAFF MEMBER

On or before three months prior to the date of expiration of a medical staff member's appointment, the medical staff office shall notify him/her of the date of expiration and send him/her an application for reappointment to be completed. At least 60 days prior to the expiration date, the member shall furnish, in writing, on the application for reappointment: (a) complete information and all documents necessary to bring his/her file current on the terms listed in Section 1.2 of this manual, including current license and DEA and state controlled substance registration, professional liability insurance coverage and experience, other institutional affiliations and status thereat, Board certification status, disciplinary actions pending/completed, health status changes; (b) provide documentation of continuing training and education external to the hospital during the preceding period (Rhode Island State Licensing Board requirement for CME will be accepted as proof of CME activity for reappointment); (c) requests for changes in staff category or department assignments; (d) evidence of being free of active tuberculosis through the process described in The State of Rhode Island Rules and Regulations for Hospitals Section 13.10, Health Screening or its successor. The Staff member must sign the reappointment application and in so doing accepts the same conditions as stated in Section 1.4 in connection with the initial application.

If the staff member has not returned his/her completed application for reappointment or requested an extension prior to the expiration date, the Chief Executive Officer shall send him/her written notice that his/her application/extension request has not been received and that he has a 7-day grace period in which to submit the application/extension request. Failure, without good cause, to provide the fully complete reappointment application with all of the above information prior to or within the grace period is deemed a voluntary resignation from the staff and results in automatic termination of appointment at the
expiration of the current term, unless the staff member requests an extension prior to or within the grace period and time for return of the reappointment form is explicitly extended for not more than 30 days. A practitioner whose appointment is so terminated is entitled to the procedural rights provided in the Fair Hearing Plan for the sole purpose of determining the issue of good cause.

The medical staff office verifies the information provided on the reappointment application, and notifies the staff member of any information inadequacies or verification problems. This must be a written notice and must indicate the nature of the additional information the staff member is to provide and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application. A practitioner whose application is voluntarily withdrawn in this manner is entitled to a hearing for the sole purpose of determining the issue of good cause.

If the staff member's level of clinical activity at this hospital is not sufficient to permit the applicable staff and Board authorities to make an informed judgment as to his/her competence in exercising the clinical privileges requested, the staff member shall have the burden of providing evidence of clinical performance at his/her principal institution in such form as may be required by said authorities.

The medical staff office transmits the reappointment application and the supporting information and the staff member's credentials file, or relevant portions thereof, with the information required by Section 2.1.2 below, to the chief of the department in which the staff member has requested privileges.

2.1.2 FROM INTERNAL SOURCES

The Chairman of the Credentials Committee, or his/her designee, collects for each staff member's credentials file all relevant information regarding the individual's professional and collegial activities, performance and conduct in this hospital. Such information, which together with the information obtained under Section 2.1.1 above shall form the basis for recommendations and actions, shall include, without limitation: (a) patterns of care and utilization as demonstrated in the findings of quality review, risk management and utilization management activities; (b) participation in relevant continuing education activities; (c) level/amount of clinical activity (patient care activity) at the hospital; (d) sanctions imposed or pending and other problems; (e) health status, (f) attendance at medical staff, department and committee meetings; (g) participation as a staff official, committee member/chairman and proctor, and in on-call coverage rosters; (h) timely and
2.2 MINIMUM CONTACT REQUIREMENTS

For purposes of this Section, a ""contact" may be on an inpatient or outpatient basis and includes an admission, a major surgical or other procedure, or a consultation in a specialty area required by the patient's condition or by staff or hospital rules. In evaluating Active staff members for reappointment to staff membership the minimum required number of contacts is an average of 12 per year. Application for exceptions to minimum levels may be made for certain specialties and may be granted by the Board of Trustees after consultation with the Medical Executive Committee.

2.3 DEPARTMENT EVALUATION

Each chief of each department in which the staff member has privileges shall review the reappointment application and its supporting information, the information gathered under Section 2.1.2 above, and other pertinent aspects of the staff member’s file and evaluate the information for continuing satisfaction of the qualifications for staff appointment, the category of assignment and the privileges requested. If a department chief requires further information, he shall notify, through the Medical Staff Office, the Credentials Committee Chairman in writing of the information required. If the staff member is to provide the additional information, the notice to him/her must be a written notice and must include a request for the special information required and the time frame for response. Failure without good cause to respond in a satisfactory manner by the time specified is deemed a voluntary resignation of membership and all clinical privileges. A practitioner whose membership and/or privileges are terminated in this manner is entitled to a hearing for the sole purpose of determining the issue of good cause.

Each applicable chief forwards to the Credentials Committee a written report with recommendations for, and any special limitations on, reappointment or non-reappointment and staff category, department and clinical privileges. If no such recommendations are made, the reason therefore must be stated. Included in any chiefs report must be any action or information contained in the department files that were not previously transmitted for inclusion in the staff member’s membership or category obligations, or satisfaction of any other qualifications for appointment or the clinical privileges granted.

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### 2.4 CREDENTIALS COMMITTEE EVALUATION

The Credentials Committee shall review and evaluate the reappointment application and its supporting information, the information gathered under section 2.1.2 above, other pertinent aspects of the staff member's file, the chairperson's reports and all other relevant information available to it. If the Credentials Committee requires further information, it shall notify, through the Medical Staff Office, the staff member in writing of the information required. If the staff member is to provide the additional information, the notice to him/her must be a written notice and must include a request for the specific information required and the time frame for response. Failure without good cause to respond in a satisfactory manner by the time specified is deemed a voluntary resignation of membership and all clinical privileges. A practitioner whose membership and privileges are terminated in this manner is entitled to a hearing for the sole purpose of determining the issue of good cause.

The Credentials Committee shall prepare a written report with recommendations for, and any special limitations on, reappointment or non-reappointment and staff category, department assignment, and requested clinical privileges. If no such recommendations are made, the reasons therefore must be stated. The Credentials Committee's report is transmitted with the chief’s reports and supporting documentation, as required, to the Medical Executive Committee.

### 2.5 FINAL PROCESSING

Final processing of reappointments follows the procedure set forth in Section 1.5. For purposes of reappointment, the terms "applicant" and "application" as used in said Sections shall mean, respectively, "staff member" and "reappointment".

### 2.6 BASES FOR RECOMMENDATIONS AND ACTIONS

Each individual or group providing a recommendation or acting on a reappointment shall have available the full resources of the medical staff and hospital as well as the authority to use outside consultants as necessary. The report of each such individual or group required to act on a reappointment shall state the reasons for each adverse recommendation made or action taken, with specific reference to the member's credentials file and all other documentation considered. In addition to any other information contained in a credentials file that may support a non-reappointment recommendation or action, any individual or group required to act on a reappointment may consider none or very minimal involvement in patient care at the hospital by a staff member over the last period of appointment, as grounds for a recommendation/action to not reappoint. Any dissenting views at any point in the process must be documented including the reason for the differing view and the information on which it is based and the alternative.
recommendation, if any. Any minority position must be transmitted with the majority report. All
documents referred to in this paragraph will be available to the affected practitioner upon request
in a timely manner.

2.7 **TIME PERIODS FOR PROCESSING**
Transmittal of the notice to a staff member and his/her providing updated information is to be
carried out in accordance with Section 2.1.1 of this manual. Thereafter and except for good
cause, all persons and groups required to act must complete such action so that all reappointment
reports and recommendations are acted on by the Medical Executive Committee prior to the
expiration date of staff membership of the member whose appointment is being processed.

PART THREE: SYSTEMS AND PROCEDURES FOR DELINEATING CLINICAL
PRIVILEGES

3.1 **DEPARTMENT RESPONSIBILITY TO DEFINE APPROACH TO DELINEATING
PRIVILEGES**
Each department must define, in writing, the operative, invasive and other special procedures,
the conditions and the problems that fall within its clinical area, including different levels of
severity or complexity and different age groupings when appropriate and the requisite training,
experience or other qualifications required. These definitions must be incorporated into the
instruments used for the requesting and granting of privileges and must be approved by the
Credentials Committee and Medical Executive Committee. The definitions and delineating
instruments must be periodically reviewed and revised as necessary to reflect new procedures,
instrumentation, and treatment modalities and like advances or changes. When
definitions/delineation instruments are renewed, by additions or deletions or the adoption of new
forms, all staff members holding privileges in the department must, as appropriate to the
circumstances, complete the new forms, request and be processed for privileges added, or
comply with the fact that a privilege was deleted.

3.2 **CONSULTATION AND OTHER CONDITIONS**
There may be attached to any grant of privileges, in addition to requirements for consultation in
specified circumstances provided for in the Bylaws and related manuals, or in the policies of the
staff, any of its clinical units or the hospital, special requirements for consultation as a condition
to the exercise of particular privileges. It is expected of each practitioner that in dealing with
cases outside his/her training and usual area of practice he will seek appropriate consultation or
refer to a practitioner who has expertise in such cases and acknowledges that his/her request for
and exercise of privileges are circumscribed by hospital and medical staff polices as may from
time to time be in force.

3.3 **TELEMEDICINE**

The initial appointment of practitioners to the Telemedicine Staff may be based upon:

- The practitioner’s full compliance with The Westerly Hospital Medical Staff credentialing and privileging standards.

OR

- The Westerly Hospital Medical Staff’s standards, but relying on Credentialing information provided by the setting at which the practitioner routinely practices or is employed by that performs the primary source credentialing and agrees to provide a comprehensive report of the practitioner’s current qualifications and demonstrated competencies.

Reappointment of the Telemedicine Staff member’s privileges will be based upon:

- The Westerly Hospital Medical Staff’s credentialing / privileging standards,
- Performance at this hospital and,
- Relying on credentialing information provided by the setting at which the practitioner routinely practices or is employed by that performs the primary source credentialing and agrees to, if insufficient information is available, to provide a comprehensive report of their current qualifications and demonstrated competencies.

3.4 **ANESTHESIA SERVICES PRIVILEGING**

3.4.1 Anesthesia services are organized under the Department of Anesthesia. The Department of Anesthesia is responsible for oversight of anesthesia services provided in the hospital and for maintaining policies covering anesthesia service including:

1. Pre- & post anesthesia evaluation, care and documentation
2. Supervision of Certified Registered Nurse Anesthetist
3. Monitoring
4. Standards for non-anesthesiologist providers

3.4.2 Anesthesia services may be provided by privileged providers who have completed an accredited Anesthesiology Residency or Nurse Anesthesiology Program. These services include, but not limited to, general anesthesia, regional anesthesia and MAC (Monitored Anesthesia Care). In addition, Deep Sedation may be provided by privileged Emergency Department providers in the Emergency Department and Qualified Critical Care providers in the Critical Care setting.

3.4.3 Moderate Sedation (“Conscious Sedation”) may be also provided by non-anesthesia professionals subject to certain privileging.

- Completion of a Critical Care Medicine Fellowship
3.5 PROCEDURES FOR DELINEATING PRIVILEGES:
3.5.1 REQUESTS
Each application for appointment and reappointment to the medical staff must contain a request for the specific clinical privileges desired by the applicant or staff member. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappraisals.

3.5.2 PROCESSING REQUESTS
All requests for clinical privileges, except those for temporary privileges, are processed according to the procedures outlined in Parts One and Two of this manual, as applicable. Requests for temporary privileges are processed according to Section 5.7 of the Medical Staff Bylaws.

3.6 PRIVILEGES IN TWO OR MORE DEPARTMENTS
Whenever a practitioner requests a privilege, which overlaps two or more clinical departments, that privilege must be approved of by each department chief. This approval shall be in writing.

PART FOUR: CONCLUSION AND EXTENSION OF PROVISIONAL PERIOD
4.1 REQUIREMENTS FOR SUCCESSFUL CONCLUSION
The requirement for, applicability and duration of, and status of the practitioner in the provisional period are set forth in Section 3.4 of the Medical Staff Bylaws. It is the responsibility of the quality assurance process and department chief to review the clinical activity of the practitioner on provisional status.

On or before 30 days prior to the end of the practitioner's provisional period in connection with either initial appointment to the staff or the granting to him/her of increased privileges, the medical staff office shall notify the department chief of the practitioner’s department of the date on which the provisional period will end.

The medical staff office shall submit the results of the proctor's reviews/observations to the chief of each department in which the practitioner was granted the initial or increased privileges. The
evaluation process to be followed shall be as set forth in Section 2.3, 2.4, and 2.5 of this manual.

4.2 **EXTENSION**

A staff member whose practice at the hospital or at his/her principal hospital did not satisfy the requirements of the provisional period with respect to all or part of the clinical privileges granted may request an extension of the period for the particular privileges involved. This request must include a statement describing his/her caseload and the circumstances of his/her practice that he expects will enable him/her to meet the requirements if an extension is granted. This request must be submitted prior to the end of the provisional period. Any extension granted must be for a defined period of time not to exceed one additional year and will be granted at the discretion of the Credentials Committee. Any extension granted must be for a defined period of time not to exceed one additional year and will be granted at the discretion of the Credentials Committee.

4.3 **PROCEDURAL RIGHTS**

Whenever a provisional period, including any period of extension, concludes with an adverse recommendation or action or whenever an extension is denied, the Chief Executive Officer shall provide the practitioner with written notice as provided in Section 1.2 of the Fair Hearing Plan, and he shall be entitled, upon proper and timely request, to the procedural rights provided in said plan. For purposes of concluding the provisional period, an "adverse recommendation" by the Medical Executive Committee or Board of Trustees is as defined in Section 1.1 of the Fair Hearing Plan. All documents referred to in this paragraph will be available to the affected practitioner upon request in a timely manner.

PART FIVE: CORRECTIVE ACTION PROCEDURES

5.1 **CORRECTIVE ACTION OTHER THAN SUMMARY OR AUTOMATIC SUSPENSION**

5.1.1 **INITIATION, REQUESTS AND NOTICES**

The criteria for initiating corrective action other than a summary or automatic suspension and procedures for a conference prior to initiating such action are contained in Section 6.1 and 6.2 of the Medical Staff Bylaws. All requests for corrective action must be in writing, submitted to the Medical Executive Committee, and supported by reference to the specific activities or conduct which constitute the grounds for the request. The chairman of the Medical Executive Committee will promptly notify the Chief Executive Officer in writing of all requests, and shall notify the practitioner involved by written notice of any such request. All documents referred to in this paragraph will be available to the affected practitioner upon request in a timely manner.
5.1.2 INVESTIGATION

After deliberation, the Medical Executive Committee shall either act on the request or direct that investigation concerning the grounds for the corrective action request be undertaken. The Medical Executive Committee may conduct such investigation itself or may assign this task to a medical staff general or department/section officer, a department, a standing or ad hoc committee, or any other medical staff component. This investigative process is not a "hearing" as that term is used in the Fair Hearing Plan. It may include a conference with the practitioner involved and with the individual or group making the request and with other individuals who may have knowledge of the events involved. If the investigation is accomplished by a group or individual other than the Medical Executive Committee, that group or individual must forward a written report of the investigation to the Medical Executive Committee as soon as is practicable after the assignment to investigate has been made. The Medical Executive Committee may, at any time within its discretion, and shall by the request of the Board of Trustees, terminate the investigative process and proceed with action as provided below.

The Medical Executive Committee or other investigating group or individual shall have available the full resources of the medical staff and the hospital as well as the authority to use outside consultants as deemed necessary. As part of the investigation, the Medical Executive Committee or other investigating group or individual may require the practitioner involved to procure an impartial physical or mental evaluation within a specified time and pursuant to the guidelines set forth below. Failure to do so, without good cause, shall result in immediate suspension of his/her medical staff appointment and all clinical privileges until such time as the evaluation is obtained, the results are reported to the Medical Executive Committee or other investigating group or individual, and the Board takes final action. The Medical Executive Committee or other investigating group or individual shall name the practitioner who will conduct the examination. Fees for an evaluation shall be paid by the hospital.

5.1.3 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the investigative process, if any, but in any event within 30 days after receipt of the request for corrective action, the Medical Executive Committee shall act upon such request. Its action may include, without limitation:

(a) Recommending rejection of the request for corrective action
(b) Recommending a verbal warning or formal letter of reprimand
(c) Recommending additional education and/or training

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(d) Recommending individual medical/psychiatric treatment
(e) Recommending a probationary period of prescribed duration with retrospective review of cases and/or other review of professional behavior but without special requirements of prior or concurrent consultation or direct supervision
(f) Recommending suspension of appointment prerogatives that do not affect clinical privileges
(g) Recommending an individually imposed requirement of prior or concurrent consultation or direct supervision
(h) Recommending an individually imposed limitation of the right to admit patients
(i) Recommending reduction, suspension or revocation of all or any part of the clinical privileges granted
(j) Recommending suspension or revocation of staff appointment.
A Medical Executive Committee recommendation pursuant to Section 5.1.3 (d) through (j) is transmitted to the Board of Trustees together with all supporting documentation.

5.1.4 PROCEDURAL RIGHTS
A Medical Executive Committee recommendation pursuant to Section 5.1.3 entitles the practitioner, upon timely and proper request, to the procedural rights contained in the Fair Hearing Plan, when applicable.

5.2 SUMMARY SUSPENSION
5.2.1 CRITERIA FOR IMPOSING
The criteria for imposing a summary suspension and the parties authorized to do so are designated in Section 6.3 of the Medical Staff Bylaws.

5.2.2 MEDICAL EXECUTIVE COMMITTEE ACTION
As soon as possible, but in any event within 14 days after a summary suspension is imposed, the Medical Executive Committee convenes to review and consider the action taken. It may recommend modification, continuation or termination of the terms of the suspension. A Medical Executive Committee recommendation to continue the suspension or to take any other action entitles the practitioner, upon timely and proper request, to the procedural rights contained in the Fair Hearing Plan. A Medical Executive Committee recommendation to terminate the suspension or to modify it to a lesser sanction is transmitted immediately, together with all supporting documentation, to the Board of Trustees. The terms of the summary suspension as originally imposed remain in effect pending a final decision by the Board of Trustees.
5.3 **AUTOMATIC SUSPENSION (VOLUNTARY RELINQUISHMENT OF MEDICAL PRIVILEGES)**

5.3.1 **CIRCUMSTANCES**
The circumstances under which an automatic suspension may be imposed and the scope of said suspension are defined in Section 6.4 of the Medical Staff Bylaws.

5.3.2 **MEDICAL EXECUTIVE COMMITTEE DELIBERATION**
As soon as practicable (a) after a practitioner's license is suspended, restricted or placed on probation, or (b) after his/her DEA or state controlled substances number is revoked, restricted, suspended or made probationary, the Medical Executive Committee shall convene to review and consider the facts under which such action was taken. The Medical Executive Committee may then recommend such further corrective action as is appropriate to the facts disclosed in the investigation. Thereafter, the procedure in Section 5.1.4, is followed, but only with respect to any additional corrective action recommended by the Medical Executive Committee or Board of Trustees.

5.3.3 **PROFESSIONAL LIABILITY INSURANCE**
A practitioner whose staff appointment and clinical privileges are suspended for failure to maintain the minimum level of insurance required may request reinstatement of appointment and appropriate privileges by sending a written notice to the Chief Executive Officer along with a certified copy of the insurance certificate from the insurance company and a written statement explaining the circumstances of the previous insurance being canceled or not renewed and any limitations on the new policy. The staff member must submit a written summary of relevant activities during the period of suspension. The procedures in Section 1.5.4, 1.5.5, 1.5.6, 1.5.7, 1.5.8, 1.5.9 and 1.5.10 are followed thereafter.

**PART SIX: VOLUNTARY MODIFICATION OF APPOINTMENT STATUS OR PRIVILEGES, REAPPLICATION, AND REPORTING**

6.1 **VOLUNTARY MODIFICATION OF APPOINTMENT STATUS OR PRIVILEGES**
A staff member may, either in connection with reappointment or at any other time, request modification of his/her staff category, department assignment, or clinical privileges by submitting a written request to the medical staff office.

A modification request is processed according to the procedures outlined in Section 1.5 of this manual and must contain all pertinent information supportive of the request.

A staff member who determines to no longer exercise or to restrict or limit the exercise of
particular privileges which he/she has been granted shall send written notice to the appropriate department chief indicating the same and identifying the particular privileges involved and, as applicable, the restriction or limitation. This notice shall be included in the member's credentials file.

6.2 **REAPPLICATION AFTER ADVERSE CREDENTIALS DECISION**

Except as otherwise provided in the Medical Staff Bylaws or as determined by the credentials committee in light of exceptional circumstances, an applicant or staff member who has received a final adverse decision regarding, or who has voluntarily resigned or withdrawn an application for, appointment, staff category, department assignment, or clinical privileges is not eligible to reapply to the medical staff or for the denied/resigned/withdrawn category, department, or privileges for a period of one year from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such reapplication is processed in accordance with the procedures set forth in Section 1.5 of this credentialing procedures manual. The applicant or staff member must submit such additional information as the applicable authorities of the staff and the Board may reasonably require in demonstration that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed further. No applicant or staff member may submit or have in process at any given time more than one application for initial appointment, staff category, a particular department assignment, or the same clinical privileges.

6.3 **REPORTING REQUIREMENTS**

The hospital shall comply with any reporting requirements applicable under the Health Care Quality Improvement Act of 1986. The hospital shall comply with sections 5-37-9 (Reports Relating to Professional Conduct and Capacity), 5-37-9.1 (Requirements Relating to Professional Conduct) and 23-17-23(c) (Hospital Disciplinary Powers) of the Rhode Island General Laws, and report any action, disciplinary or otherwise, that affects a physician's privileges to practice, including resignations or withdrawals of applications for hospital privileges where such resignation or withdrawal relates to unprofessional conduct.

**PART SEVEN: LEAVE OF ABSENCE**

7.1 **LEAVE STATUS**

A staff member may, for good cause, obtain a voluntary leave of absence by giving written notice to the credentials committee and to the chief of the department in which he/she has his/her principal affiliation. After review and recommendation the notice is transmitted to the Medical
Executive Committee. The notice must state the approximate period of time of the leave, which may not exceed two years, except for military service. During the period of the leave, the staff member's clinical privileges, prerogatives and responsibilities are suspended. The Medical Executive Committee makes a report and recommendation on the leave to the Board of Trustees for its final action.

7.2 TERMINATION OF LEAVE
The staff member must, at least 30 days prior to the termination of the leave, or may at any earlier time, request reinstatement by sending a written notice to the medical staff office. The staff member must submit a written summary of relevant activities during the leave and provide evidence of current licensure, DEA and state controlled substance registration, and professional liability insurance coverage. The procedures in Section 1.5 of this manual, as applicable, are followed in evaluating and acting on the reinstatement request.
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PART ONE: RESPONSIBILITIES AND AUTHORITY OF OFFICERS

1.1 RESPONSIBILITIES AND AUTHORITY OF THE PRESIDENT OF THE STAFF

As the primary elected medical staff officer, the chief administrative officer of the staff and the staff’s representative in its relationships to others, the president of the staff has these responsibilities and authority:

1.1.1 AS THE STAFF'S REPRESENTATIVE TO OTHERS

(a) Transmit to the board of trustees and to the chief executive officer the views and recommendations of the medical staff and the medical executive committee on matters of hospital policy, planning, operations, governance, and relationships with external agencies, and transmit the views and decisions of the board of trustees and chief executive officer to the medical executive committee and the medical staff membership.

(b) Communicate and represent the opinions and concerns of the medical staff and its individual members on organizational and individual matters affecting hospital operations to the board of trustees and the chief executive officer.

(c) Serve as a member of the board of trustees, with vote.

(d) Oversee, in conjunction with the hospital's legal counsel, compliance on the part of the applicable medical staff authorities with the procedural safeguards and rights of individual staff members in all stages of the hospital's credentialing processes.

1.1.2 AS THE CHIEF ADMINISTRATIVE OFFICE

(a) Direct the operation and organization of the administrative policy-making and representative aspects of the medical staff organization, assist the chief executive officer in coordinating these with administration, nursing, support and other personnel and services, enforce compliance with the provisions of the Bylaws and related manuals, rules, policies and procedures of the staff and the hospital related to these matters and with regulatory and accrediting agencies' requirements.

(b) Preside at, and be responsible for the agenda of, all general and special meetings of the medical staff and of the medical executive committee.

(c) Unless otherwise provided in the Medical Staff Bylaws or this manual, appoint, subject to the medical executive committee approval, medical staff members to and the chairmen of staff committees formed to accomplish staff administrative, environmental or representative functions.

(d) Serve as chairman of the medical executive committee, and as an ex officio member of all other standing staff committees, with vote whence provided in the statement.
of the committee's composition.

(e) Review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the medical staff in their relations with each other, the board of trustees, hospital management, other professional and support staff, and the community the hospital.

1.1.3 AS THE CHIEF CLINICAL OFFICER

(a) Supervise the clinical organization of the staff, coordinate the delivery of services among the clinical services, and assist the chief executive officer in coordinating activities of administration, nursing, support and other personnel and services with medical staff clinical units.

(b) Advise the board of trustees, the chief executive officer and the medical executive committee on matters impacting on patient care and clinical services, including the need for new or modified programs and services, for recruitment and training of professional and support staff personnel and for staffing patterns.

1.2 RESPONSIBILITIES AND AUTHORITY OF THE PRESIDENT-ELECT

As the second ranking elected medical staff officer, the president-elect has these responsibilities and authority:

(a) Assume all of the duties and responsibilities and exercise all of the authority of the president of the staff when the latter is temporarily or permanently unable to accomplish the same.

(b) Serve as a member of the medical executive committee.

(c) Perform such additional duties and exercise such authority as may be assigned or granted by the medical staff president, by the medical executive committee, by the board of trustees or in the Medical Staff Bylaws and related manuals or in other staff or hospital policies.

1.3 RESPONSIBILITIES AND AUTHORITY OF THE SECRETARY/TREASURER

The secretary-treasurer has these responsibilities and authority:

(a) Serve as a member of the medical executive committee.

(b) Be responsible for reporting on meetings of the medical staff and the medical executive committee.

(c) Supervise the collection and accounting for any funds that may be collected in the form of dues, assessments, or otherwise and disburse these funds as directed by the medical executive committee.

(d) If funds are collected from dues, assessments, or otherwise, prepare an annual financial...
report for transmittal to the staff at its annual meeting, and any other interim reports that may be requested by the president of the staff or the medical executive committee.

(e) Perform such additional duties and exercise such authority as may be assigned or granted by the medical staff president, by the medical executive committee, or in the Medical Staff Bylaws and related manuals or in other medical staff or hospital policies.

1.4 RESPONSIBILITIES AND AUTHORITY OF THE IMMEDIATE PAST PRESIDENT

The immediate past president has these responsibilities and authority:

(a) Serve as a member of the medical executive committee and as an adviser to the president of the staff and other officials and committees of the staff.

(b) Perform such additional duties as may be assigned by the president of the staff, by the medical executive committee or in the Medical Staff Bylaws and related manuals or other medical staff or hospital policies.

(c) Serve on Community Health of Westerly (CHOW) Board.

1.5 RESPONSIBILITIES AND AUTHORITY OF DEPARTMENT/SERVICE CHIEFS

In assuring the accomplishment of the functions of a department as provided in Section 9.3 of the Medical Staff Bylaws and in meeting his/her responsibility for all professional and administrative activities within the department, a department/service chief has these specific responsibilities and authority:

(a) Participate on a continuous basis in managing the department/service through cooperation and coordination with the nursing and other patient care services, hospital management, and the medical staff president on all matters affecting patient care.

(b) Participate in planning with respect to the department/service personnel, equipment, facilities, services and budget.

(c) Communicate and implement within the department/service actions taken by the medical executive committee, the board of trustees, and other relevant authorities.

(d) Serve on the medical executive committee, give guidance to the medical executive committee on the medical policies of the hospital related to his department/service and make specific recommendations and suggestions regarding the department/service to the medical executive committee, hospital management, and the board of trustees.

(e) Assist in developing, implementing and supervising relevant medical staff components of the quality review, risk management and utilization management program as required in this manual in cooperation with president of the staff, the medical executive committee and the quality assurance committee.

(f) Maintain continuing review of patient care and the professional performance of practitioners and allied health professionals with clinical privileges or specified services in the department/service and present written reports, as appropriate, requested or required, to
the quality assurance committee concerning patterns of situations affecting patient care, and to the medical executive committee when appropriate or required.

(g) Review data/information forwarded from the various medical staff committees charged with quality review, risk management, or utilization management activities, respond to requests from and recommendations by said committees and make recommendations or take action as appropriate.

(h) Prepare and transmit to the appropriate authorities, as required by the Medical Staff Bylaws, the Credentialing Procedures Manual or other relevant protocols, recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners or allied health professionals exercising privileges or services in the department/service.

(i) Enforce the Corporate and Medical Staff Bylaws and related manuals, rules, policies, and procedures, within the department/service, including initiating corrective action and investigation of clinical performance and ordering consultations to be provided or sought when necessary.

(j) Unless otherwise provided in the Medical Staff Bylaws or this manual, assign individual department/service members and/or appoint department service committees as necessary to perform the functions of the department service and designate a chairman of each committee created.

(k) Preside over and prepare the agenda for all department meetings.

(l) Perform such other duties and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws or any of the related manuals, in other hospital or medical staff rules and policies, and, if applicable, in a contract with the hospital, and as may from time to time be reasonably requested by the president of the staff, the medical executive committee, or the board of trustees.

PART TWO: MEDICAL STAFF COMMITTEES

2.1 DESIGNATION

There will be a medical executive committee and the following standing committees responsible to the medical executive committee: bylaws, credentials, medical education, ICU-CCU, pharmacy and therapeutics, medical staff monitoring and evaluation, and cancer committee. The principle governing committees are provided in Section 10.2 of the Medical Staff Bylaws. The manner of and authority for the appointment of members and chairmen of committees are set forth in Section 10.2.6 of the Medical Staff Bylaws.
2.2 MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the medical executive committee are as set forth in Section 10.3 of the Medical Staff Bylaws. In addition, the medical executive committee supervises overall medical staff compliance with accreditation and other regulatory requirements applicable to the medical staff or any of its clinical unit.

(a) Receive, coordinate and act upon as necessary the written reports and recommendations from departments/services, committees, other groups and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities.

(b) Coordinate the activities of and policies adopted by the medical staff, departments/services, other clinical units and committees.

(c) Account to the board of trustees and to the medical staff by reports of overall quality of patient care in the hospital.

(d) Take reasonable steps to obtain professionally ethical conduct and competent clinical performance on the part of the staff members, including initiating investigations and initiating and pursuing corrective action, when warranted.

(e) Make recommendations on medico-administrative and hospital management matters.

(f) Inform the medical staff of the accreditation program and the accreditation status of the hospital.

(g) Act on all matters of medical staff business, except as otherwise provided in the Medical Staff Bylaws.

(h) Fulfill the reporting requirements of the Medical Staff Bylaws and such others as are defined for specific activities in related manuals.

(i) Receive credentials committee activity reports and makes recommendations to the Board of Trustees.

2.3 BYLAWS COMMITTEE

The bylaws committee fulfills staff responsibilities relating to review and revision of Medical Staff Bylaws and related manuals and assumes the responsibilities for investigating and providing recommendations on special projects and activities of concern to the staff as are referred by the medical executive committee.

Composition: (a) a chairman; (b) four additional medical staff members; (c) medical staff president, without vote; (d) medical director, without vote; and (e) chief executive officer, or designee, without vote, chief medical officer, without vote.

(a) Conduct a periodic review of the bylaws and the related manuals and forms promulgated in connection with them.

(b) Conduct at least an annual review of the clinical policies and rules.

(c) Submit written recommendations to the medical executive committee and medical staff for...
changes in these documents.

2.4 CREDENTIALS COMMITTEE

The credentials committee:
(a) Receives and analyzes applications and recommendations for appointment, reappointment, conclusion or extension of the provisional period, clinical privileges, and changes therein, and recommending action thereon to the medical executive committee;
(b) Integrates quality review, risk management and utilization management findings, membership and other relevant information into individual credential files;
(c) Develops or coordinates, periodic credentials reviews, and makes recommendation on the procedures and forms used in connection with each component of the credentialing process; recommends standards for the content, organization, and overseeing maintenance of the individual credential files.
(d) Designs and oversees implementation of the credentialing procedures for the medical staff;
(e) Evaluates credentials of medical staff members for the performance of new procedures and makes recommendation to the medical executive committee. The credentials committee meets monthly and reports to the medical executive committee.

The credentials committee includes: (a) Medical staff president, without vote; (b) Medical director, without vote; (c) Chief executive officer or designee, without vote; and (d) Chief Medical Officer, without vote, and (e) representative from medical staff office, and support staff without vote. (f) Four additional staff members chosen by the president/immediate past president.

2.5 MEDICAL EDUCATION COMMITTEE

The medical education committee:
(a) Shall develop and follow the mission statement adopted by the medical education committee in compliance with the ACCME.
(b) Oversees the operation of the medical staff library.

The medical education committee may meet quarterly or on an as needed basis and reports on its activities to the medical executive committee.

The medical education committee includes:
(a) a member of the medical staff appointed as chairman and with vote;
(b) four to six members of the medical staff representing the clinical departments, all with vote;
2.6 CRITICAL CARE COMMITTEE

The Critical Care Committee is responsible for formulating and periodically reviewing operational policies, protocols and treatment modalities, and other rules governing conduct and procedures in the ICU-CCU area. It also develops screening criteria to review the quality and appropriateness of care provided in the unit and reviews findings and makes recommendations for corrective action and/or education programs, as indicated.

The Critical Care Committee reviews all deaths in the unit. It is also charged with the responsibility of making recommendations relating to equipment, drugs, supplies and other items to be available in the unit.

The Critical Care Committee meets at least quarterly and reports to the medical executive committee.

The Critical Care Committee includes: (a) a chairman, with vote; (b) nursing representative from the unit, without vote; (c) four to six medical staff members to include at least one representative from anesthesia, surgery and internal medicine, with vote; (d) director of respiratory care or designee, without vote; (e) medical staff president, without vote; (f) medical director, without vote; (g) director of nursing or designee, without vote; (h) chief executive officer or designee, without vote and (i) chief medical officer, without vote.

2.7 PHARMACY AND THERAPEUTICS COMMITTEE

The pharmacy and therapeutics committee:

(a) Assists in the formation and review of policies regarding drug evaluation, appraisal, selection, procurement, storage, distribution, use, safety relating to drugs in the hospital.

(b) Makes recommendations concerning drugs to be stocked on the nursing unit.

(c) Develops a mechanism to identify and review reports on all untoward drug reactions.

(d) Evaluates clinical data concerning new drugs or preparations requested for use in the hospital.

(e) Review and development of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition.

(f) The pharmacy and therapeutics committee will meet at least quarterly. The pharmacy and therapeutics committee includes: (a) a chairman, with vote; (b) four to
six additional active staff members to be representative of the major clinical departments, with vote; (c) representative from pharmacy service, without vote; (d) representative from nursing service, without vote; (f) representative from dietary service, without vote; (h) quality assurance nurse, without vote; (i) medical staff president or designee, without vote; (j) chief executive officer or designee, without vote.

2.8 PEER REVIEW COMMITTEE

The medical staff peer review committee coordinates and reviews the ongoing monitoring activities associated with surgical case review, blood usage and transfusion reactions, patient infections, medical records review for completeness and clinical pertinence, antibiotic and other drug reviews, morbidity/mortality, pharmacy and therapeutics, clinical risk management indicators to review patterns of unexpected care events and identify areas for change to reduce liability, and utilization review to maintain appropriate, effective and efficient utilization of the diagnostic and therapeutic resources of the hospital, and review of medical decisions which may have ethical implications.

The medical staff peer review committee shall meet no less than four times per year or as needed and report to the medical executive committee.

The membership of the committee shall consist of the following, (a) a chairman, with vote; (b) 8 to 10 members representing surgery, medicine, pathology, emergency, infectious disease, and any other clinical departments, such as ambulatory care unit, with vote; (c) medical director without vote, quality management coordinator and risk manager as support staff, without vote, and chief medical officer, without vote.

2.9 CANCER COMMITTEE

The cancer committee shall maintain a cancer program that will benefit patients with cancer. The cancer committee is responsible for planning, initiating and assessing all cancer related activities in the institution.

Duties to include:
(a) Organize, publicize, conduct cancer conferences that are multidisciplinary, institution-wide and patient oriented.
(b) Make certain that consultative and rehabilitative services are available to all patients.
(c) Plan and complete a minimum of two patient care evaluation studies annually.
(d) Supervise the cancer registry.
(e) Publish and distribute an annual report.
(f) Meets at least quarterly.
The membership of the cancer committee shall consist of the following: (a) a chairman, with vote; (b) physician members representing, but not limited to, surgery, medical oncology, diagnostic radiology, radiation oncology, pathology, internal medicine and/or family practice, obstetrics/gynecology, with vote; (c) administrative support staff to include: cancer registrar, quality management, nursing and social services, with vote.

2.10 PHYSICIAN HEALTH COMMITTEE

The Physician Health Committee is responsible for providing education to hospital leaders and medical staff about licensed independent practitioner health; address issues of prevention for physical, psychiatric or emotional illness; facilitate confidential diagnosis, treatment and rehabilitation as appropriate. The committee’s goal is assistance and rehabilitation rather than discipline and to aid licensed practitioners in retaining or regaining optimal functioning.

The Physician Health Committee includes: (a) a chairman; and (b) three additional experienced active staff members to be representative of the major clinical departments, with vote;

The Physician Health Committee will be convened only on an ad hoc basis.

2.11 INFECTION PREVENTION & CONTROL COMMITTEE

The Infection Prevention & Control Committee shall maintain an Infectious Disease Program that will benefit all patients. The Infection Prevention & Control Committee is responsible for planning, initiating and assessing all Infection Control/Prevention related activities in the institution.

Duties to include:
(a) Assessing all Infection Prevention & Control related activities
(b) Provide performance improvement reports quarterly to the Medical Executive Committee and Quality Management Oversight Committee
(c) Meets monthly

The membership of the Infection Prevention & Control Committee shall consist of the following: (a) a chairman of any discipline, with vote; (b) if there is an Infectious Disease physician on staff, he/she should be a member of the committee, with vote; (c) physician members representing, but not limited to, surgery, anesthesia, diagnostic radiology, pathology, internal medicine and/or family practice, obstetrics/gynecology or pediatrician, with vote; (d) administrative support staff to include: quality management and nursing without vote, and wound care without vote.
PART THREE: MEETING PROCEDURES

3.1 NOTICE OF MEETINGS

Written notice of any regular general staff meeting, or of any regular committee or department meeting must be delivered by mail to each person entitled to be present approximately seven days before the stated time and date of the meeting. Notice of any special meeting of the staff, a department or a committee must be given orally or in writing at least 72 hours prior to the meeting. No business shall be transacted at any special meeting except that stated in the meeting notice.

3.2 QUORUM

Those members present constitute a quorum.

3.3 ORDER OF BUSINESS AT REGULAR STAFF MEETINGS

The order of business at a regular staff meeting is determined by the president of the staff. The agenda includes at least:
(a) Acceptance of the minutes of the last regular and all special meetings held since the last regular meeting.
(b) Administrative reports from the president, the chiefs of departments, chief medical officer, and chief executive officer.
(c) The election of officers and of representatives to staff and hospital committees, when required by the Medical Staff Bylaws.
(d) Reports by responsible officers, departments/services and committees as may be requested.
(e) New Business

3.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present is the action of the group.

3.5 MINUTES

Minutes of all meetings shall be prepared and include a record of attendance and the vote taken on each matter. Copies of said minutes must be approved by the attendees, and forwarded to the medical executive committee. Minutes shall be made available, upon request to and at the discretion of the president of the staff, to any member of the staff who functions in an official

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capacity within the hospital so as to have a legitimate interest in them. When access is approved, it shall be afforded in a manner consistent with the confidentiality policies of the hospital concerning medical staff minutes and activities. A permanent file of the minutes of each meeting shall be maintained.

### 3.6 PROCEDURAL RULES

Meetings of the staff, departments/services and committees, will be conducted according to the then current edition of Roberts’ Rules of Order. In the event of conflict between said Rules and any provision of the Medical Staff Bylaws or any of its related manuals, the latter are controlling. Initiating corrective action and investigation of clinical performance and ordering consultations to be provided or sought when necessary.
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PART ONE: INITIATION OF HEARING

1.1 TRIGGERING EVENTS

1.1.1 RECOMMENDATIONS OR ACTIONS

The following recommendations of the Medical Executive Committee or actions by the Board of Trustees, as discussed in Article Seven of the Medical Staff Bylaws, entitle the practitioner, hereinafter defined as any medical doctor, doctor of osteopathy, dentist or podiatrist applying for or exercising clinical privileges or providing other diagnostic or therapeutic services at The Westerly Hospital, to a hearing upon timely and proper request:

(a) Denial of initial medical staff appointment;
(b) Denial of reappointment to the medical staff;
(c) Suspension of medical staff appointment, provided that summary suspension entitles the practitioner to request a hearing only as specified in subsection (n) below;
(d) Revocation of medical staff appointment;
(e) Denial of requested appointment to or advancement in medical staff category;
(f) Reduction in medical staff category;
(g) Suspension or limitation of the right to admit patients not related to the adoption or implementation of an administrative or medical staff policy within the hospital as a whole or within one or more specific departments;
(h) Denial of requested department affiliation;
(i) Denial or restriction of requested clinical privileges;
(j) Reduction in clinical privileges, provided that summary suspension entitles the practitioner to request a hearing only as specified in subsection (n) below;
(k) Suspension of clinical privileges;
(l) Revocation of clinical privileges;
(m) Individual application of; or individual changes in, mandatory consultation or concurrent supervision requirement; or
(n) Summary suspension of medical staff appointment or clinical privileges, provided that the recommendation of the Medical Executive Committee or action by the Board of Trustees under Section 5.2 of the Credentials Procedures Manual is to continue the suspension or to take other action which would entitle the practitioner to request a hearing.

1.1.2 EXCEPTIONS TO HEARING RIGHTS

(a) Certain Actions: Notwithstanding any provision in this Fair Hearing Plan, in the
Medical Staff Bylaws, or in the Credentialing Procedures Manual to the contrary, the following events do not entitle the practitioner to a hearing:

1. The issuance of a verbal warning;
2. The imposition of a monitoring or consultation requirement as a condition attached to the exercise of clinical privileges during a provisional period;
3. The imposition of a probationary period involving review of cases but with no requirement either for direct, concurrent supervision or for mandatory consultation;
4. The removal of a practitioner from a medico-administrative office within the hospital unless a contract or employment arrangement provides otherwise;
5. Any other action or recommendation not listed in Section 1.1.1 above; and

(b) Other situations: An action or recommendation listed in Section 1.1.1 above does not entitle the practitioner to a hearing when it is:
1. Voluntarily accepted by the practitioner;
2. Automatic pursuant to any provision of the Medical Staff Bylaws (Section 6.4) of the General Staff Rules and Regulations;
3. Taken or recommended with respect to temporary privileges; or
4. Taken or recommended with respect to a practitioner who is a hospital-based physician whose department is the subject of an exclusive contract with The Westerly Hospital.

1.2 NOTICE OF ADVERSE RECOMMENDATION OR ACTION
The Chief Executive Officer shall, within 30 days of receiving written notice of an adverse action or recommendation under Section 1.1, give the practitioner written notice, return receipt requested, thereof. The notice shall:
(a) Advise the practitioner of the grounds of the proposed recommendation or action and of his or her right to a hearing upon timely and proper request pursuant to Section 1.3 below;
(b) Specify that the practitioner has 30 days after receiving the notice within which to submit a request for a hearing and that the request must satisfy the conditions of Section 1.3;
(c) State that failure to request a hearing within that time period and in the proper manner constitutes a waiver of rights to any hearing or appellate review on the matter that is the subject of the notice;
(d) State that any higher authority required or permitted under this plan to act on the matter following a waiver pursuant to Section 1.4 is not bound by the adverse recommendation or action that the practitioner has accepted by virtue of the waiver, but may take any
action it deems warranted by the circumstances; and

(e) state that upon receipt of his hearing request, the practitioner will be notified of the date, time and place of the hearing, and the grounds upon which the adverse recommendation or action is based.

1.3 REQUEST FOR A HEARING

The practitioner shall have 30 days after receiving a notice under Section 1.2 to file a written request for a hearing. The request must be delivered to the Chief Executive Officer by written notice return receipt requested. If the practitioner wishes to be represented by an attorney at the hearing, his or her request for a hearing must so state.

1.4 WAIVER BY FAILURE TO REQUEST A HEARING

A practitioner who fails to request a hearing within the time and in the manner specified in Section 1.3 waives his or her right to any hearing or appellate review to which he or she might otherwise have been entitled. Such waiver shall apply only to the matters that were the basis for the adverse action or recommendation triggering the Section 1.2 notice. The Chief Executive Officer shall as soon as reasonably practical send the practitioner written notice of each action taken under any of the following Sections and shall notify the President of the Medical Staff of each such action. The effect of a waiver is as follows:

1.4.1 EFFECT OF WAIVER AFTER ADVERSE ACTION BY THE BOARD OF TRUSTEES

A waiver shall constitute acceptance of the adverse action, which shall immediately become effective as the final decision of the Board of Trustees.

1.4.2 EFFECT OF WAIVER AFTER ADVERSE RECOMMENDATION BY THE MEDICAL EXECUTIVE COMMITTEE:

A waiver shall constitute acceptance of the Medical Executive Committee’s adverse recommendation, which then shall become and remain effective immediately pending the decision of the Board of Trustees. The Board of Trustees shall consider such adverse recommendation as soon as practicable following the waiver. The Board of Trustees is not bound by an adverse recommendation of the Medical Executive Committee, but may take any action it deems warranted by the circumstances, which may include referring the matter to the Professional Affairs Committee for its recommendations as set forth in Section 6.3, or taking action which may accord in all respects with the Medical Executive Committee’s adverse recommendation, or be more or less severe, but in any event shall then become effective immediately as the final decision of the Board of Trustees.
1.5 ADDITIONAL INFORMATION OBTAINED FOLLOWING WAIVER

If the practitioner has additional information which was not available or reasonably discoverable as of the date the right to a hearing was waived, and provided fewer than seven (7) days have elapsed since the date the right to a hearing was waived, the practitioner is entitled to request a hearing in accordance with Section 1.3 to submit additional information.

The hearing shall be limited in scope to findings of fact surrounding the additional information and the findings, actions, and recommendations of the Board of Trustees or the Medical Executive Committee made prior to the practitioner’s initial waiver. Said additional information shall not be considered unless the party making the initial adverse recommendation or action concludes that the information was not available or reasonably discoverable in time for presentation to or consideration by the party making the initial adverse recommendation or action.

Said additional information shall be submitted to, and the decision whether said additional information shall be considered shall be made by, the body other than that whose adverse recommendation or action has prompted the matter, e.g., if an adverse recommendation by the Medical Executive Committee has prompted the matter, then the practitioner shall submit additional information to the Board of Trustees, who shall decide whether the additional information shall be considered.

If the matter has been occasioned by an adverse action of the Board of Trustees, and the Medical Executive Committee decides that the Board of Trustees shall consider said additional information, the Board of Trustees shall reconsider the matter in light of the additional information, and render its decision, which shall be the final decision of the Board of Trustees.

If the matter has been occasioned by an adverse recommendation of the Medical Executive Committee, and the Board of Trustees decides that the Medical Executive Committee shall consider said additional information, the matter shall be referred back to the Medical Executive Committee for reconsideration in light of the additional information. The Medical Executive Committee shall render a follow-up recommendation within 30 days. The Medical Executive Committee’s follow-up recommendation following consideration of said additional information shall become effective immediately pending the decision of the Board of Trustees, whose decision will be effective immediately as its final decision.
PART TWO: FAIR HEARING PREREQUISITES

2.1 NOTICE OF TIME AND PLACE FOR FAIR HEARING
Upon receiving a timely and proper request for hearing, the Chief Executive Officer shall deliver it to the President of the Medical Staff or the Chairperson of the Board of Trustees, depending on whose recommendation or action prompted the hearing request. The President of the Medical Staff or Chairperson of the Board of Trustees, as appropriate, shall then schedule a hearing before the Fair Hearing Committee and notify the Chief Executive Officer of that hearing date, immediately upon scheduling that hearing. The Chief Executive Officer shall, within 3 days of being informed of the hearing date, send the practitioner notice, return receipt requested, of the time, place and date of the hearing. The hearing date shall be set for neither less than 14 nor more than 30 days after the Chief Executive Officer received the hearing request. However, the hearing for a practitioner who is under suspension then in effect must be held as soon as the arrangements may reasonably be made, but not later than 15 days after the Chief Executive Officer received the hearing request.

2.2 STATEMENT OF ISSUES AND EVENTS
The notice of hearing must contain a concise statement of the practitioner’s alleged acts or omissions, a list by number of the specific or representative patient records in question, and/or the other reasons or subject matter(s) forming the basis for the adverse action(s) or recommendation(s) which is (are) the subject of the hearing.

2.3 SERVICE ON AND APPOINTMENT OF FAIR HEARING COMMITTEE

2.3.1 SERVICE ON FAIR HEARING COMMITTEE
The Fair Hearing Committee shall be composed either of members of the Medical Staff (including physicians employed by The Westerly Hospital and its affiliates) or other practitioners who are not competitors with the affected practitioner, or a combination of such persons. A Medical Staff member or other person is not disqualified from serving on a Fair Hearing Committee merely because he or she has heard of the case or has knowledge of the facts involved or what he or she supposes the facts to be.

2.3.2 APPOINTMENT OF FAIR HEARING COMMITTEE FOLLOWING ADVERSE RECOMMENDATION BY MEDICAL STAFF
A hearing occasioned by an adverse Medical Executive Committee recommendation is conducted by a Fair Hearing Committee appointed by the President of the Medical Staff and composed of at least 5 members of the Medical Staff (including physicians employed by The Westerly Hospital and its affiliates) or other practitioners who are not competitors with the affected practitioner, none of whom has had prior involvement in the
2.3.3 APPOINTMENT OF FAIR HEARING COMMITTEE FOLLOWING ADVERSE ACTION BY THE BOARD OF TRUSTEES

A hearing occasioned by an adverse action of the Board of Trustees is conducted by a Fair Hearing Committee appointed by the Chairperson of the Board of Trustees and composed of 5 members of the Medical Staff (including physicians employed by The Westerly Hospital and its affiliates) or other practitioners who are not competitors with the affected practitioner, provided that no such person has had prior involvement in the practitioner’s matter, and further provided that no such person practices in the same specialty area as the practitioner. However, a member of the Medical Staff or other practitioner (including physicians employed by The Westerly Hospital and its affiliates) is not disqualified from serving on a Fair Hearing Committee under this Subsection merely because he or she has heard of the case or has knowledge of the facts involved or what he or she supposes the facts to be. The Chairperson of the Board of Trustees shall designate one of the appointees as Chairperson of the Fair Hearing Committee.

2.4 LIST OF WITNESSES; PREHEARING MEMORANDA

At least ten days prior to the scheduled date for commencement of the hearing, each party shall give the other party by written notice a list of the names of the individuals who, as far as is then reasonably known, will give testimony or evidence in support of that party at the hearing. No outside expert witness (as opposed to a Fair Hearing Committee member with familiarity of the subject which the expert witness shall address) shall be permitted to give testimony or evidence in support of a party at the hearing unless the expert witness shall agree to cross-examination. Such list shall be amended as soon as possible when additional witnesses are identified. The Fair Hearing Committee may permit a witness who has not been listed in accordance with this Section 2.4 to testify if it finds that the failure to list such witness was justified, that such failure did not prejudice the party entitled to receive such list, or that the testimony of such witness will materially assist the Fair Hearing Committee in making its report and recommendation under Section 4.1 below.
The parties shall be permitted to submit memoranda concerning any issue of law or fact prior to or during the hearing, as stated in Section 3.5, below.

PART THREE: FAIR HEARING COMMITTEE PROCEDURE

3.1 PERSONAL PRESENCE

The personal presence of the practitioner is required throughout the hearing, unless such personal presence is excused for any specified time by the Fair Hearing Committee. The presence of the practitioner’s counsel or other representative does not constitute the personal presence of the practitioner. A practitioner who fails without good cause to be present throughout the hearing, unless excused, or who fails to proceed at the hearing in accordance with this Fair Hearing Plan, shall be deemed to have waived his or her rights in the same manner and with the same consequence as provided in Section 1.4 of this Plan.

3.2 PRESIDING OFFICER

The Fair Hearing Committee Chairperson shall be the presiding officer. The presiding officer shall maintain decorum and assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence. He or she shall determine the order of procedure during the hearing and make all rulings on matters of law, procedure, and the admissibility of evidence. The presiding officer shall not act as a prosecuting officer or as an advocate to any party to the hearing. The Chairperson of the Fair Hearing Committee shall be entitled to vote.

3.3 REPRESENTATION

The practitioner may be accompanied and/or represented at the hearing by a member of the Medical Staff in good standing or by a member of his or her local professional society. The Medical Executive Committee, or Board of Trustees, depending on whose recommendation or action prompted the hearing, shall appoint an individual to represent it. Representation of the Board of Trustees, Medical Executive Committee, the affected practitioner, the Fair Hearing Committee, and the Professional Affairs Committee by an attorney at law is permitted and governed by Section 7.1 of this Plan.

3.4 RIGHTS OF PARTIES

During the hearing, each party shall have the following rights, subject to the rulings of the presiding officer on matters of law, procedure and the admissibility of evidence, and provided that such rights shall be exercised in a manner so as to permit the hearing to proceed efficiently and expeditiously:

(a) call and examine witnesses;
(b) introduce exhibits;
(c) cross-examine any witness on any matter relevant to the issues;
(d) impeach any witness; and
(e) rebut any evidence.

Even if the practitioner does not testify on his or her own behalf, he or she may be called and examined as if under cross-examination.

3.5 PROCEDURE AND EVIDENCE
The hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. In the discretion of the presiding officer, any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Each party shall be entitled, prior to or during the hearing, to submit memoranda concerning any issue of law or fact, and those memoranda shall become part of the hearing record. The Fair Hearing Committee may require such memoranda to be filed at a time specified by the Fair Hearing Committee. The Fair Hearing Committee may ask questions of witnesses, call additional witnesses or request documentary evidence if it deems it appropriate. The presiding officer may, but is not required to, order that oral evidence be taken only on oath or affirmation administered by any person designated by him or her and entitled to notarize documents in the state where the hearing is held.

3.6 OFFICIAL NOTICE
In reaching its decision, the Fair Hearing Committee may take official notice, either before or after submission of the matter of decision, of any generally accepted technical or scientific matter relating to the issues under consideration, and/or any facts that may be judicially noticed by the courts of the state where the hearing is held. Participants in the hearing shall be informed of the matters to be noticed, and those matters must be noted in the hearing record. Either party shall have the opportunity to request that a matter be officially noticed and to refute any officially noticed matter by written or oral presentation of authority in a manner to be determined by the Fair Hearing Committee. The Fair Hearing Committee is also entitled to consider all other information that can be considered under the Medical Staff Bylaws in connection with credentials matters.

3.7 BURDEN OF PRODUCTION
The body whose adverse action or recommendation occasioned the hearing shall have the burden of coming forward with evidence in support thereof. The practitioner then has the burden of
coming forward with evidence that the adverse action or recommendation lacks any substantial factual basis or is otherwise arbitrary, unreasonable or capricious.

3.8 HEARING RECORD
A record of the hearing shall be kept. The Fair Hearing Committee shall determine the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. Both the practitioner and the Fair Hearing Committee have the right to representation by an attorney (or, with respect to the practitioner, another person of the practitioner’s choice) at the hearing, and to have a record made of the proceedings, copies of which may be obtained by the practitioner upon request and payment of any reasonable charges associated with the preparation thereof. Representation of either party by an attorney at law is permitted and governed by Section 7.1 of this Plan.

3.9 POSTPONEMENT
Requests for postponement or continuances of a hearing may be granted by the presiding officer of the Fair Hearing Committee only upon a timely showing of good cause.

3.10 PRESENCE OF FAIR HEARING COMMITTEE MEMBERS AND VOTE
A majority of the Fair Hearing Committee must be present throughout the hearing and deliberations. If a Fair Hearing Committee member is absent from a major part of the hearing or deliberations, the presiding officer, in his or her discretion, may rule that such member not participate further in the hearing or deliberations or in the decision of the Fair Hearing Committee.

3.11 RECESSES AND ADJOURNMENT
The Fair Hearing Committee may recess and reconvene the hearing without written notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. The Fair Hearing Committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

PART FOUR: FAIR HEARING COMMITTEE REPORT AND FURTHER ACTION

4.1 FAIR HEARING COMMITTEE REPORT
Within 14 days after adjournment of the hearing, the Fair Hearing Committee shall make a written report of its findings and recommendations, with such reference to the hearing record and other documentation and items considered as it deems appropriate. The Fair Hearing Committee
shall forward the report along with the record and other documentation to the body whose adverse action or recommendation occasioned the hearing, and to the practitioner at the same time.

4.2 ACTION ON FAIR HEARING COMMITTEE REPORT
Within 14 days after receiving the Fair Hearing Committee report, the body whose adverse recommendations or action occasioned the hearing shall consider said report and shall determine its result, which may be to affirm, modify or reverse its recommendation or action. It shall transmit the result, together with the hearing record, the Fair Hearing Committee report and all other documentation considered, to the Chief Executive Officer and to the practitioner at the same time.

4.3 NOTICE AND EFFECT OF RESULT

4.3.1 EFFECT OF FAVORABLE RESULT
(a) Admitted by the Board of Trustees: If the Board of Trustees’ result under Section 4.2 is favorable to the practitioner, it shall become effective immediately as the final decision in the matter; and the practitioner shall be so informed in writing.

(b) Admitted by the Medical Executive Committee: If the Medical Executive Committee’s result is favorable to the practitioner, the Chief Executive Officer shall forward it as soon as practicable, together with all supporting documentation including the report of the Fair Hearing Committee, to the Board of Trustees which may adopt or reject the result in whole or in part, or refer the matter back to the Medical Executive Committee for further consideration. Any referral back shall state the reasons, set a time limit within which a subsequent recommendation must be made, and may include a directive for an additional hearing. After receiving a subsequent recommendation and any new evidence, the Board of Trustees shall take action. Favorable action by the Board of Trustees shall become effective as the decision of the Board of Trustees and the matter shall proceed as provided in Section 4.3.1 (a) above. If the Board of Trustees action is adverse, the written notice shall be sent return receipt requested, and shall inform the practitioner of his right to request an appellate review by the Professional Affairs Committee. As soon as practicable, the Chief Executive Officer shall send the practitioner written notice return receipt requested informing him or her of each action taken under this Section.

4.3.2 EFFECT OF ADVERSE RESULT
For purposes of this Fair Hearing Plan, the term “adverse result” shall mean any action or
recommendation by the Board of Trustees or Medical Executive Committee listed in Section 1.1.1(a)-(n), above.

(a) of Board of Trustees: If the result of the Board of Trustees under Section 4.2 continues to be adverse to the practitioner, the written notice shall inform him or her of his or her right to an appellate review, upon proper and timely request, as provided in Part Five of this Plan.

(b) of Medical Executive Committee: If the result of the Medical Executive Committee under Section 4.2 continues to be adverse to the practitioner, the Chief Executive Officer shall forward it as soon as practicable, together with all supporting documentation including the report of the Fair Hearing Committee, to the Board of Trustees. The Board of Trustees shall consider such adverse recommendation as soon as practicable thereafter. The Board of Trustees is not bound by an adverse recommendation of the Medical Executive Committee, but may take any action it deems warranted by the circumstances, including taking action which accords in all respects with the Medical Executive Committee’s adverse recommendation, or is more or less severe, but in any event shall then become effective immediately as the final decision of the Board. If the Board of Trustees action remains adverse, the written notice, which shall be sent return receipt requested, shall inform the practitioner of his right to request an appellate review by the Professional Affairs Committee. As soon as practicable, the Chief Executive Officer shall send the practitioner written notice, return receipt requested, informing him or her of each action taken under this Section.

PART FIVE: INITIATION AND PREREQUISITES OF APPELLATE REVIEW BY THE PROFESSIONAL AFFAIRS COMMITTEE

5.1 REQUESTS FOR APPELLATE REVIEW
A practitioner shall have 14 days after receiving written notice under Section 4.3 to file a written request for an appellate review. The request must be delivered to the Chief Executive Officer by written notice, return receipt requested. If the practitioner will be represented by an attorney at any appellate review appearance that may be granted under Section 6.5, his or her request for appellate review must so state and must advise the Chief Executive Officer at least one week prior to the appellate review appearance.
5.2 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW
A practitioner who fails to request an appellate review within the time and in the manner specified shall have waived any right to a review. The waiver has the same force and effect as provided in Section 1.4.

5.3 NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW
The Chief Executive Officer shall deliver a timely and proper request for appellate review to the Chairperson of the Board of Trustees. As soon as practicable, the Chairperson of the Board of Trustees shall schedule an appellate review to commence not less than 14 days nor more than 30 days after the Chief Executive Officer received the request; provided, however, that an appellate review for a practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may be reasonably made, but not later than 30 days after the Chief Executive Officer received the request. At least 14 days prior to the appellate review, the Chief Executive Officer shall send the practitioner written notice of the time, place and date of the review, as well as a copy of the Fair Hearing Committee report and record and all other material, favorable or unfavorable, if not previously forwarded, that was considered in taking the adverse recommendation or action. The time may be extended by the Chairperson of the Board of Trustees or the Professional Affairs Committee for good cause.

PART SIX: APPELLATE REVIEW PROCEDURE BEFORE THE PROFESSIONAL AFFAIRS COMMITTEE AND FINAL ACTION

6.1 NATURE OF PROCEEDINGS
The proceedings by the Professional Affairs Committee are a review based upon the prior hearing record(s), the Fair Hearing Committee’s report(s), all subsequent results and actions, the written statements, if any, provided below and any other material that may be presented and accepted under Section 6.5.

The practitioner has the burden of coming forward and proving with evidence that the adverse action or recommendation lacks any substantial factual basis or is otherwise arbitrary, unreasonable or capricious. The body whose adverse action or recommendation occasioned the hearing shall then have the burden of coming forward with evidence in support thereof. The practitioner has the burden of proving that the body whose adverse action or recommendation occasioned the hearing lacks any substantial factual basis or is otherwise arbitrary, unreasonable or capricious.
6.2 WRITTEN STATEMENTS

The practitioner may submit a written statement detailing the findings or fact, conclusions and procedural matters with which he or she disagrees and his or her reasons. This written statement may cover any matters raised at any step in the hearing(s) process. The statement shall be submitted to the Professional Affairs Committee (and to the group whose adverse recommendation or action occasioned the appellate review) through the Chief Executive Officer at least 7 days prior to the scheduled date of the review, except if the time limit is waived by the Professional Affairs Committee’s presiding officer. Copies of all documents which have been forwarded to the Professional Affairs Committee will also be sent to the practitioner.

6.3 PROFESSIONAL AFFAIRS COMMITTEE

The Professional Affairs Committee shall serve as the appellate review body under this Plan (and may issue a report to the Board of Trustees per its request as provided in Section 1.4.2 of this Plan). The Professional Affairs Committee shall consist of six individuals, appointed annually by the Chairperson of the Board of Trustees. Three such members of the Professional Affairs Committee shall be independent members of the Board of Trustees, as defined in Article I, Section 2(g) of The Westerly Hospital Amended and Restated Bylaws. The other three members of the Professional Affairs Committee shall be members of the Medical Staff (including physicians employed by The Westerly Hospital and its affiliates), or other practitioners not in competition with the affected practitioner or practicing in the same specialty area as the practitioner. However, if a Medical Staff member of the Professional Affairs Committee (or other practitioner, including a physician employed by The Westerly Hospital or its affiliates) is required to recuse himself or herself because of prior involvement in the practitioner’s matter, because he or she is in competition with the affected practitioner, or because he or she practices in the same specialty area as the practitioner, the Chairperson of the Board of Trustees shall appoint another individual to replace the recused person(s) in accordance with Article VI, Section 15 of The Westerly Hospital Amended and Restated Bylaws.

The chairperson of the Board of Trustees shall appoint the Chairperson of the Professional Affairs Committee.

6.4 PRESIDING OFFICER

The Chairperson of the Professional Affairs Committee is the presiding officer. He or she shall determine the order of procedure during the review, make all required rulings, and maintain decorum.
6.5 **ORAL STATEMENTS**

The Professional Affairs Committee, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative appearing shall be required to answer questions put by any member of the Professional Affairs Committee.

6.6 **CONSIDERATION OF NEW OR ADDITIONAL MATTERS**

New or additional matters or evidence not raised or presented during the original hearing(s) or in the Fair Hearing Committee report and not otherwise reflected in the record may not be introduced at the appellate review unless the information was not available or reasonably discoverable in time for presentation to or consideration by the Fair Hearing Committee, as determined by the Professional Affairs Committee.

6.7 **PRESENCE OF MEMBERS AND VOTE**

A majority of the Professional Affairs Committee members must be present throughout the review and deliberations. If a member is absent from a major part of the proceedings, the Chairperson of the Professional Affairs Committee may rule that the member shall not be permitted to participate further in the deliberations or in the decision of the Professional Affairs Committee.

6.8 **RECESSES AND ADJOURNMENTS**

The Professional Affairs Committee may recess and reconvene the proceedings without written notice for the convenience of the participants. At the conclusion of the oral statements, if allowed, the appellate review shall be adjourned. The Professional Affairs Committee shall then, at the time convenient to itself, conduct its deliberations outside the presence of the parties.

6.9 **ACTION TAKEN**

Within 30 days after adjournment pursuant to Section 6.8 above, the Professional Affairs Committee shall prepare its report and findings. The Chief Executive Officer shall send notice of each action taken under this Section to the practitioner by written notice and to the Medical Staff President for transmittal to the appropriate staff authorities. The Professional Affairs Committee shall review the hearing record(s), the Fair Hearing Committee’s report(s), all subsequent and prior results and actions, the written statements, if any, provided to the Fair Hearing Committee and any material which was accepted at the hearing before it, to determine whether there is a substantial factual basis for the decisions previously made, and whether those decisions are or are not otherwise arbitrary, unreasonable or capricious, and issue its report and findings.
6.10 BOARD ACTION FOLLOWING RECEIPT OF PROFESSIONAL AFFAIRS COMMITTEE REPORT AND FINDINGS
The Professional Affairs Committee’s report and recommendation shall be forwarded to the Board of Trustees for its decision, which decision shall then be effective as the final decision in the matter.

The CEO shall notify the practitioner of the Board of Trustees’ final decision under this Section.

PART SEVEN: GENERAL PROVISIONS

7.1 ATTORNEYS
7.1.1 AT HEARINGS
If the practitioner desires to be represented by an attorney at any hearing or appellate review, his or her request for the fair hearing or appellate review must declare his or her desire to be so represented. The practitioner involved has the right to representation by any attorney or other person of the practitioner’s choice and to have a record made of the proceedings, copies of which may be obtained by the practitioner upon request and payment of reasonable charges associated with the preparation thereof.

7.1.2 EQUAL REPRESENTATION AND PREPARATION ASSISTANCE
Regardless of whether the practitioner is represented by an attorney at any hearing or appellate review, the Medical Executive Committee, the Board of Trustees, the Fair Hearing Committee, the Professional Affairs Committee and any other party involved in the practitioner’s matter shall be allowed the right to legal counsel and representation, including but not limited to the right to legal counsel in connection with preparation for a hearing or any appellate review.

7.2 NUMBER OF HEARINGS AND REVIEWS; DECISION BY MAJORITY
Notwithstanding any other provision of the Medical Staff Bylaws, of the Credentialing Procedures Manual, or of this Plan, no practitioner is entitled as a matter of right to request more than one hearing before the Fair Hearing Committee and one appellate review before the Professional Affairs Committee with respect to the subject matter that is the basis of the adverse recommendation or action triggering the right. All decisions by the Fair Hearing Committee and the Professional Affairs Committee shall be by majority.

7.3 RELEASE
By requesting a hearing or appellate review under this plan, a practitioner agrees to be bound by the provisions of the Medical Staff Bylaws relating to immunity from liability.
7.4 INCORPORATION INTO MEDICAL STAFF BYLAWS
This Fair Hearing Plan is hereby incorporated into the Medical Staff Bylaws and shall be attached as an Appendix to same.

7.5 PROVISION OF NOTICE AND PERFORMANCE OF OTHER RESPONSIBILITIES BY DESIGNEES
If any party obliged to provide notice or perform other responsibilities under this Fair Hearing Plan is absent from the Westerly area or otherwise unavailable when obliged to do so, then his or her designee shall perform such duties during that unavailability.