NEWPORT HOSPITAL
Newport, Rhode Island 02840-2299

BYLAWS
OF THE MEDICAL STAFF

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NEWPORT HOSPITAL
Newport, Rhode Island

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PREAMBLE

BECAUSE: Newport Hospital is operated under the laws of the State of Rhode Island to serve as a health care facility providing patient care and education with all of its activities subject to the ultimate authority of its Board of Trustees; and

BECAUSE: The principal purpose of the Hospital is to provide patient care at a level of quality and efficiency consistent with generally accepted standards and otherwise to fulfill professional and institutional obligations to patients, students and the community; and because physicians are charged with the ethical management of the delivery of quality healthcare; and

BECAUSE: Dedication to this purpose requires the cooperative efforts of the practitioners practicing in the Hospital and Board of Trustees and Hospital President, with well-defined lines of communication, responsibility and authority throughout the organizational structure; and

BECAUSE: The laws, regulations, customs and generally recognized professional standards that govern the Hospital require that all practitioners practicing at the Hospital (except those exercising temporary privileges) be appointed to the Medical Staff and that the Board of a Hospital must delegate to the Medical Staff certain responsibilities relating to, and exact accountability for, the quality, efficiency and overall appropriateness of practitioner performance;

THEREFORE: These Bylaws and related manuals are created to set forth the framework, principles and procedures within which the Medical Staff shall function and carry out the responsibilities delegated to it, consistent with the Bylaws, policies and rules of the Hospital and the health system.

DEFINITIONS

The following definitions apply to the provisions of these Medical Staff Bylaws and related manuals. The definitions are presented in alphabetical order.

1. Allied Health Professional (AHP) is an individual who is qualified by academic and/or clinical training and by prior and continuing experience and current competence in a healthcare discipline which the Board has approved to practice in the Hospital. The group contains designated independent and non-independent health care professionals who function in a medical support role with varying levels of direction and supervision of a practitioner.

2. Board of Trustees (BOT) is the governing body of the Hospital, the Board of Trustees of Newport Hospital. As appropriate to the context and consistent with the Bylaws of the Hospital and delegations of authority made by the Board, it may also mean any committee of the Board or any individual authorized by the Board to act on its behalf on certain matters.

3. "Day(s)" means a business day unless otherwise specified herein.

4. Dentist is an individual who is fully licensed to practice dentistry pursuant to the laws of the State of Rhode Island.

5. Ex Officio is service as a member of a body by virtue of office or position held. When an individual is appointed ex officio to a committee or other group, the provision or resolution designating the membership must indicate whether it is with or without vote.

6. "Hospital" is Newport Hospital of Newport, Rhode Island.

7. "Hospital Administration" means, collectively, all directors, administrative directors, vice presidents, and the president.

8. Licensed Independent Practitioner (LIP) is any individual permitted by law and by the organization to provide care, treatment, and services, without direction or supervision.

9. "Lifespan Affiliate" shall be those licensed hospitals under common control of and partnership with the Lifespan Corporation and includes, but is not be limited to: Emma Pendleton Bradley Hospital located in East Providence, Rhode Island; Rhode Island Hospital located in Providence, Rhode Island; The Miriam Hospital located in Providence, Rhode Island; and, Newport Hospital, located in Newport, Rhode Island.

10. The "Medical Executive Committee" means the Executive Committee of the Medical Staff.

11. Medical Staff is the organizational component of the Hospital that includes all practitioners who are appointed to membership in the Active, Courtesy, Consulting, Doctoral, Associate, and Honorary Staffs and Research Scientists.

12. Medical Staff Bylaws and related manuals or Bylaws are any one or more the following documents as appropriate to the context:
    - Bylaws of the Medical Staff
    - Medical Staff Credentialing Procedures Manual
    - Medical Staff Organization Manual

- General Rules and Regulations of the Medical Staff

The Bylaws establish the fundamental principles by which the Medical Staff is governed. The Bylaws' related manuals delineate the administrative details that may be necessary to more specifically implement the general principles found in these Bylaws. These related manuals consist of the Medical Staff Rules and Regulations, the Credentialing Procedures Manual, and the Medical Staff Organization Manual.

13. Medical Staff Member in good standing, or member in good standing, is a practitioner who has been appointed to the Medical Staff or to a particular category of the Medical Staff, as the context requires, and who is not under either a full appointment suspension or a full or partial suspension of voting, office-holding or other prerogatives imposed by operation of any section of these Bylaws and the related manuals or any other policies of the Medical Staff or the Hospital.

14. Medical Staff Services Office shall mean that Hospital entity which supports the medical staff, is responsible for medical staff appointments, and oversees all medical staff functions.

15. Medical Staff Year is the 12-month period commencing on January 1 of each year and ending on December 31 of the same year.

16. "Notice" means written notice delivered personally to the addressee, sent by fax, e-mail, interoffice mail or United States mail, first-class postage prepaid, to the addressee at the last address as it appears in the office records of the Medical Staff Services Office of the Hospital.

17. "Physician" means an individual licensed to practice allopathic or osteopathic medicine pursuant to the laws of the State of Rhode Island.

18. "Podiatrist" means an individual licensed to practice podiatric medicine pursuant to the laws of the State of Rhode Island.

19. "Practitioner" unless otherwise expressly provided, is any credentialed provider who (a) is applying for appointment to the Hospital with or without clinical privileges; or (b) currently holds appointment to the Hospital with or without clinical privileges; or (c) is applying for or is exercising temporary privileges.

20. Prerogative is a participatory right granted, by virtue of Medical Staff category or otherwise, to a Medical Staff member, or Allied Health Professional, and exercisable subject to the ultimate authority of the Board of Trustees and to the conditions and limitations imposed in the Medical Staff Bylaws and related manuals and in other Hospital and Medical Staff policies.

21. "President " means the individual appointed by the Board of Trustees to act in its behalf in the overall management of the Hospital and shall be known as the President of the Hospital.

22. Referring Associate is an individual who desires Hospital association without clinical privileges, active operational involvement, or Medical Staff membership, if applicable. Practitioners in this category shall not have clinical privileges.

23. "Special Notice" means written notice delivered by certified or registered mail, return receipt requested, or by personal delivery by a service with signed acknowledgement of receipt to the most recent known address as it appears in the office records of the Medical Staff Services Office of the Hospital. Documented personal delivery by the President of the Hospital, or designee, may also serve as special notice.

24. "Vice President of Medical Affairs and Chief Medical Officer and Chief Medical Officer ("VPMA/CMO") means a practitioner appointed by the President of the Hospital to serve as a liaison between the Medical Staff and the Hospital administration. The VPMA/CMO may be designated by the President of the Hospital to act on his/her behalf.

ARTICLE ONE: PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

1.1 Purposes

The purposes of the Medical Staff of Newport Hospital are:

1.1-1 To provide a mechanism for accountability to the Board, through defined organizational components and positions, for the appropriateness of the patient care services, and professional and ethical conduct of each individual practitioner appointed to the Medical Staff, to the end that patient care provided at the Hospital facilities is maintained at that highest level of quality, safety, and efficiency.

1.1-2 To serve as the collegial body through which individual practitioners may obtain prerogatives and clinical privileges at the Hospital, through which practitioners fulfill the obligations of Medical Staff appointment, and through which the medical activities of the Hospital are directed and coordinated to create an environment that promotes high quality, safe, and efficient patient care services.

1.1-3 To provide appropriate educational experiences and opportunities for practitioners, students, nurses, technicians and others to study the causes and prevention of diseases and other health conditions in order to maintain scientific standards and aid in the advancement of professional knowledge and skill.

1.1- 4 To provide an orderly and systematic means by which practitioners may give input to the Board and President of the Hospital on medical-administrative issues and on the Hospital's policy-making and planning processes.

1.1-5 To initiate and maintain a system of self-governance of the Medical Staff.

Except as otherwise provided herein, these Bylaws are equally applicable to all Medical Staff Members regardless of any financial arrangements with the Hospital.

1.2 Responsibilities

1.2-1 To participate in the Hospital's performance evaluation and improvement program, patient safety program, risk management program, and utilization management program by conducting required and necessary activities for assessing, maintaining and improving the quality, safety, and efficiency of medical care provided in the Hospital, including, without limitation:

(a) Evaluating practitioner and institutional performance based on objective, clinically-sound criteria;

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

(c) Evaluating practitioners' credentials for appointment and reappointment to the Medical Staff and for the delineation of clinical privileges that may be exercised by each practitioner in the Hospital; and

(d) Promoting the appropriate use of the medical and health care resources at the Hospital for meeting patients' medical, social and emotional needs, consistent with sound health care resource utilization practices.

1.2-2 To participate in the development, conduct, and monitoring of medical education programs relevant to clinical practice at the Hospital.

1.2-3 To develop and maintain bylaws and policies that are consistent with sound professional practices, sound organizational principles, and external requirements, and to enforce compliance with them.

1.2-4 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.

1.2-5 To exercise through the appropriate officers, committees, departments, sections and other organizational components as identified in these Bylaws, the authority granted by these Bylaws to fulfill the above responsibilities in a timely and proper manner and to account for such responsibilities to the Board of Trustees.

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

ARTICLE TWO: MEDICAL STAFF CATEGORIES

2.1 Overview of Staff Categories

2.1.1 General Description

The Medical Staff of the Hospital shall consist of the following categories: the Active Staff; the Courtesy Staff; the Consulting Staff; the Doctoral Staff; the Associate Staff; the Honorary Staff; and Research Scientists.

2.1.2 Basic Obligations

Each Medical Staff Member who possesses a staff appointment and/or clinical privileges, and each practitioner exercising temporary privileges, shall:

(a) Provide his/her patients with care at the current level of quality and efficiency generally recognized by appropriate practice standards and guidelines applicable to facilities such as the Hospital;

(b) Abide by these Bylaws and related manuals and all other lawful standards and policies;

(c) Discharge such Medical Staff, committee, department, section, and Hospital functions for which the practitioner is responsible by virtue of Medical Staff category, assignment, appointment, election, or otherwise;

(d) Prepare and complete in a timely fashion all medical and other required patient records;

(e) When the primary attending, ensure that a medical history and physical examination is 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. If the medical history and physical examination was completed within 30 days, an update documenting any changes in the patient's condition is completed within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia. The medical history and physical examination shall comply with the general and unit specific elements delineated in the Rules and Regulations.

(f) Pledge to provide or arrange for appropriate and timely medical coverage and care for patients for whom the practitioner is responsible; and

(g) Inform the Medical Staff Services Office of any changes to any personal or professional information that was provided upon application, including but not limited to health status, certifications, licensure, office and home addresses, and contact information within ten (10) days of being on notice that the change is in effect.

Failure to satisfy any of these basic obligations may be grounds for termination of Medical Staff appointment or for such disciplinary action as may be deemed appropriate by the Medical Executive Committee.

2.1.3 Requests for Changes of Categories

A request to change from one staff category to any other staff category, or within a staff category, shall be submitted by the Medical Staff Member to the Medical Staff Services Office for processing. The request will be forwarded to the applicable Department Chair, the Credentials Committee, and the Medical Executive Committee for review and recommendation, and to the Board of Trustees for final approval.

2.2 Active Staff

2.2.1 Defined

The Active Staff shall consist of physicians, dentists, and podiatrists who contribute significantly to the care of patients consistent with the mission of the Hospital. Members of the Active Staff must be Board Certified or Board Qualified in accordance with the application requirements of Article III Section 3.8.

2.2.2 Privileges

The extent of a Medical Staff Member's privileges shall be set forth in the terms of his/her appointment or reappointment.

2.2.3 Prerogatives

Members of the Active Staff are:

(a) Eligible to vote at Medical Staff meetings and hold office on the Medical Staff;

(b) Eligible to serve on Medical Staff committees and vote on matters before such committees;

(c) Required to pay Medical Staff dues as determined by the Medical Executive Committee; and

(d) Expected to attend annual, regular, and special meetings of the Medical Staff and assigned department.

2.2.4 <u>Obligations</u>

In addition to meeting the basic obligations set forth in Section 2.1.2, members of the Active Staff shall contribute to the organizational and administrative activities of the Medical Staff, including service in Medical Staff, department, and section offices, as well as on Hospital and Medical Staff committees. The Medical Staff Member shall faithfully perform the duties of any office or position to which he/she may be elected or appointed.

Members of the Active Staff shall also participate equitably in the discharge of Medical Staff functions by:

(a) being assigned to the on-call roster as determined by the rules and policies of each department;

(b) when on-call, accepting responsibility for providing care to any patient referred to the applicable service;

(c) when on-call, ensuring appropriate follow-up according to current standards of care;

(d) providing consultation to other Medical Staff Members consistent with delineated privileges;

(e) participating in peer review activities; and

(f) fulfilling such other Medical Staff functions as may from time to time be reasonably required, e.g., attending patient-safety education seminars or cooperating with IS system requirements.

2.2.5 <u>Senior Active Status</u>

Members of the Medical Staff who have been on the Active Staff for at least fifteen (15) years and who have reached the age of sixty (60) may apply for Senior Active Status, pursuant to the procedures set forth in Section 2.1.3. Members with Senior Active Status shall not be required to provide on-call coverage, provided it would not adversely impact patient care coverage as determined by the applicable Department Chair. Members with Senior Active Status shall be required to meet the same qualifications and have the same prerogatives and other obligations as set forth in Sections 2.2.3 and 2.2.4, unless such requirements are waived by the Medical Executive Committee. Senior Active Status may be modified in extraordinary circumstances.

2.3 <u>Courtesy Staff</u>

2.3.1 <u>Defined</u>

The Courtesy Staff shall consist of physicians, dentists, and podiatrists who wish to exercise clinical activity but are anticipated to have fewer than 15 patient encounters per year. Certain Medical Staff Members are exempt from the volume limit if the clinical activity is related solely to coverage situations. Courtesy Staff must be Board Certified or Board Qualified in accordance with the application requirements of Article III.

2.3.2 Privileges

The extent of a Medical Staff Member's privileges shall be set forth in the terms of his/her appointment or reappointment.

2.3.3 Prerogatives

Members of the Courtesy Staff are:

(a) Not eligible to vote at Medical Staff meetings or hold office on the Medical Staff;

(b) Eligible to serve on Medical Staff committees and vote on matters before such committees;

(c) Required to pay Medical Staff dues as determined by the Medical Executive Committee; and

(d) Invited to attend annual, regular, and special meetings of the Medical Staff and assigned Department.

2.3.4 Obligations

Under extraordinary circumstances, as defined by the process in the Credentialing Procedures Manual, in addition to meeting the basic obligations set forth in Section 2.1.2, members of the Courtesy Staff may be subject to one or more of the Active Staff obligations delineated in Section 2.2.4.

2.4 Consulting Staff

2.4.1 Defined

The Consulting Staff shall consist of physicians, dentists, and podiatrists who possess special expertise or whose services are required for unique clinical or educational needs. Members of the Consulting Staff who exercise clinical activity must be Board Certified or Board Qualified in accordance with the application requirements of Article III Section 3.8.

2.4.2 Privileges

The extent of a Medical Staff Member's privileges shall be set forth in the terms of his/her appointment or reappointment. Members of the Consulting Staff may have clinical privileges, but shall not have admitting privileges. They may have assigned duties and responsibilities, and may provide teaching and consultative services.

2.4.3 Prerogatives

Members of the Consulting Staff are:

(a) Not eligible to vote at Medical Staff meetings or hold office on the Medical Staff;

(b) Eligible to serve on Medical Staff committees and vote on matters before such committees;

(c) Required to pay Medical Staff dues as determined by the Medical Executive Committee; and

(d) Invited to attend annual, regular, and special meetings of the Medical Staff and assigned Department.

2.5 Doctoral Staff

2.5.1 Defined

The Doctoral Staff shall consist of clinical psychologists who hold advanced doctoral degrees of PsyD or PhD.

2.5.2 Privileges

The extent of a Medical Staff Member's privileges shall be set forth in the terms of his/her appointment or reappointment. Members of the Doctoral Staff may have clinical privileges, but shall not have admitting privileges.

2.5.3 Prerogatives

Members of the Doctoral Staff with clinical privileges are:

(a) Eligible to vote at Medical Staff meetings but not hold office on the Medical Staff;

(b) Eligible to serve on Medical Staff committees and vote on matters before such committees;

(c) Required to pay Medical Staff dues as determined by the Medical Executive Committee; and

(d) Expected to attend annual, regular, and special meetings of the Medical Staff and assigned Department.

2.6 Associate Staff

2.6.1 Defined

The Associate Staff shall consist of physicians, dentists, and podiatrists who wish to affiliate with the Hospital as members of the medical staff but who do not desire clinical activity.

2.6.2 Privileges

Members of the Associate Staff shall not have clinical privileges. They may not write orders or notes in the patient medical record but may visit their patients, access their patients' medical record, and receive access to the Hospital's clinical information system.

2.6.3 Prerogatives

Members of the Associate Staff are:

(a) Not eligible to vote at Medical Staff meetings or hold office on the Medical Staff;

(b) Eligible to serve on Medical Staff committees and vote on matters before such committees;

(c) Required to pay Medical Staff dues as determined by the Medical Executive Committee; and

(d) Invited to attend annual, regular, and special meetings of the Medical Staff and assigned Department.

2.7 Honorary Status

2.7.1 Defined

Honorary Status is limited to Medical Staff members who are retired from practice and who have contributed in an extraordinary way to the growth, development, and programs of the Hospital. Recommendations for Honorary Status designation shall be forwarded to the Credentials Committee for consideration and recommendation to the Medical Executive Committee for review and recommendation to the Board for final approval. Once granted this status, Honorary Staff are not granted clinical privileges and no longer participate in the medical staff credentialing process. Honorary Status may be revoked by the Board.

2.7.2 Privileges

Practitioners with Honorary Status shall not have clinical privileges and may not participate in direct patient care.

2.7.3 Prerogatives

Practitioners with Honorary Status are:

(a) Not eligible to vote at Medical Staff meetings or hold office on the Medical Staff;

(b) Eligible to serve on Medical Staff committees and vote on matters before such committees;

(c) Not required to pay Medical Staff dues; and

(d) Invited to attend annual, regular, and special meetings of the Medical Staff.

2.8 Research Scientists

2.8.1 Defined

Research Scientists shall consist of physicians and persons holding advanced doctoral degrees, such as Sc.D or PhD, who do not render patient care and whose sole activity is to conduct research and/or education.

2.8.2 Privileges

Research Scientists shall not have clinical privileges and shall not write orders. The member shall be under the overall supervision of the Department Chair, or designee, of a clinical department in which the position is assigned.

2.8.3 Prerogatives

Research Scientists are:

(a) Not eligible to vote at Medical Staff meetings or hold office on the Medical Staff;

(b) Eligible to serve on Medical Staff committees and vote on matters before such committees;

(c) Required to pay Medical Staff dues as determined by the Medical Executive Committee; and

(d) Invited to attend annual, regular, and special meetings of the Medical Staff and assigned Department.

ARTICLE THREE: MEDICAL STAFF APPOINTMENT

3.1 Appointment not Automatic – Practitioners are not automatically entitled to the granting of staff appointment or particular clinical privileges merely because of licensure to practice in this or any other state; certification by any clinical or specialty board; membership of a medical, dental or other professional school faculty; or present or past staff membership or privileges at another health care facility, including another Lifespan affiliate.

3.2 Initial Appointment: Qualifications

3.2.1 Education

(a) In order to be initially appointed to the Active, Courtesy, Consulting, or Associate Staff, an individual shall:

(i) Be a graduate of an approved medical (allopathic or osteopathic), dental or podiatric school reviewed and recommended by the Medical Executive Committee and approved by the Board of Trustees; or

(ii) Be certified by the Educational Council for Foreign Medical Graduates; or

(iii) Have a Fifth Pathway certification and have successfully completed the Foreign Medical Graduate Examination in Medical Sciences; and

(iv) Have satisfactorily completed an approved residency reviewed and recommended by the Medical Executive Committee and approved by the Board of Trustees.

(b) In order to be initially appointed to the Doctoral Staff, an individual shall be a graduate of a recognized graduate program in psychology and shall have satisfactorily completed a clinical internship in psychology reviewed and recommended by the Medical Executive Committee and approved by the Board of Trustees.

(c) In order to be initially appointed as a Research Scientist, an individual shall hold an advanced doctoral degree from a recognized graduate program in a field of research reviewed and recommended by the Medical Executive Committee and approved by the Board of Trustees.

3.2.2 Licensure

(a) In order to be initially appointed to the Active, Courtesy, Doctoral, or Associate Staff, an individual shall have an active, unrestricted license to practice medicine, dentistry, podiatry or psychology in the State of Rhode Island.

(b) In order to be initially appointed to the Consulting Staff and exercise clinical privileges, an individual will have an active, unrestricted license to practice medicine, dentistry, or podiatry in the State of Rhode Island. In order to be initially appointed to the Consulting Staff and only be involved in educational or research activities, an individual shall have an active, unrestricted license to practice medicine, dentistry, or podiatry in the state in which he/she primarily practices.

(c) In order to be initially appointed to the Active, Courtesy, Doctoral, Consulting, or Associate Staff under an external resource sharing agreement, or equivalent, with a military or other federal service organization, an individual shall have an active, unrestricted license to practice medicine, dentistry, podiatry, or psychology in any state.

3.2.3 **Board Certification and Qualification** – In order to be initially appointed to the Active, Courtesy, or Consulting Staff, an individual shall be Board Qualified or Board Certified in accordance with Section 3.8.

3.2.4 **Clinical Competence** - In order to be initially appointed to the Active, Courtesy, Consulting, or Doctoral Staff (with the exception of members of the Doctoral Staff who do not provide patient care), an individual must demonstrate clinical competence and physical and mental status sufficient to demonstrate that he/she is able to provide quality care to patients.

3.2.5 **Duty of Cooperation** – An applicant for initial appointment to the Medical Staff must attest to his/her intent to comply with all recognized standards of medical and professional ethics and to abide by the Medical Staff code of conduct. An applicant must have the ability to function in a cooperative and reasonable manner with others in the Hospital environment. This ability is essential to providing quality medical care to patients in a safe and effective manner and shall be considered as part of the application process.

3.2.6 **Insurance** - In order to be initially appointed to all categories of the Medical Staff, except Honorary Staff and Research Scientists, an individual shall be insured for professional liability by a reputable insurer, as determined by the Board, in such amounts as the Board

from time to time shall establish.

3.2.7 **Required Disclosures** – In addition to information specifically requested on the application, an applicant for initial appointment to the Medical Staff must disclose any fact that could reasonably be expected to have a negative impact on the applicant's candidacy. This shall include, but not be limited to, any information about whether the applicant's enrollment, certification, membership status, clinical privileges, or license to practice any profession have ever been voluntarily or involuntarily revoked, denied, relinquished, suspended, limited, reduced or not renewed by any healthcare or other entities, including but not limited to:

(a) Specialty board;

(b) State or federal jurisdiction;

(c) Medicare, Medicaid or state or federal Drug Enforcement Agency;

(d) Healthcare entity;

(e) Education institution or program; or

(f) Local, state or national professional organizations.

In addition, an applicant must disclose the following information:

(g) Evidence of current professional liability insurance coverage and the amounts thereof;

(h) Any involvement as a defendant in any malpractice or professional liability lawsuit during the preceding ten (10) years;

(i) Any substance abuse issues, and physical or mental health conditions that may adversely impact the ability to perform requested clinical privileges;

(j) Any current misdemeanor or felony criminal charges pending against the applicant, and any past misdemeanor or felony charges, including the resolution of such charges; and

(k) Any current or pending state or federal investigation.

3.2.8 **Authorization to Obtain Information –** The applicant shall be required to sign a statement authorizing the Hospital to obtain and review information concerning his/her qualifications for Medical Staff membership from any source, and releasing from liability any party that in good faith provides such information. This authorization shall include permission for the Hospital to conduct a criminal background check. The information provided in the application, including but not limited to the applicant's licensure, specific training, experience, and current competence, shall be verified. The Hospital will seek from the National Practitioner Data Bank all information in its possession about each applicant.

3.2.9 **Consideration of Resources** – In acting upon an application, consideration shall be given to the ability of the Hospital to provide adequate facilities and support services for the applicant and his/her patients, as well as to patient care requirements of Staff Members with the applicant's qualifications. Factors to be considered are:

(a) The extent of the Hospital's needs and available resources in the applicant's specialty;

(b) Whether the applicant's specialty is adequately represented on the Medical Staff as determined by the Board;

(c) Whether the applicant possesses special competence which would enhance or complement the work of the department to which he/she is applying; and

(d) Whether the applicant is willing and qualified to contribute to teaching, research or clinical practice at the Hospital.

3.2.10 **Policy of Non-Discrimination** - Criteria for Medical Staff membership shall be uniformly applied to all applicants. Gender, sexual orientation, race, creed, color, religion, and national origin shall not be considered.

3.2.11 **Discretion of Board** - Any qualifications, requirements, or limitations in this Article which are neither required by law nor by any governmental regulation, may be waived on the recommendation and approval of the Board, upon determination that such waiver will serve the best interests of the Hospital and its patients.

3.3 Initial Appointment: Procedure

3.3.1 **No Contractual Relationship** - Under no circumstances shall these Bylaws, or the appointment or reappointment process discussed herein, create a contractual relationship between the applicant and the Medical Staff or the Hospital. Furthermore, no contractual rights for an applicant, or any contractual obligations for the Medical Staff or the Hospital, shall be created hereunder.

3.3.2 **Timing of Application Review** - All individuals and groups required to act on an application for Medical Staff appointment should do so in a timely and good faith manner. The specified review time periods shall not create any rights for a practitioner to have an application processed within the precise periods.

3.3.3 Pre-Application

A request for an application to the Medical Staff must be submitted to the Medical Staff Services Office. In response, a pre-application form may be forwarded to the practitioner requesting information to determine eligibility for a Medical Staff application. The information requested may include the following:

(a) Office and residence address;

(b) Staff category and clinical department requested;

(c) Extent of anticipated practice at the Hospital;

(d) Current/anticipated medical staff appointments and hospital affiliations; and

(e) Copies of the following documents, as applicable:
  i. Current active, unrestricted license to practice.

ii. Federal Drug Enforcement Agency and Rhode Island controlled substances registration.
iii. Proof of professional liability insurance.
iv. Proof of successful completion of residency training program.
v. Proof of current board certification.

3.3.4 Application – An application for Medical Staff membership will be made available electronically or forwarded to the applicant on a prescribed form.

(a) The application shall state the education, experience, current medical, dental and other professional licensures, permits or certifications, and Drug Enforcement Administration and other controlled substance registrations, and professional references of the applicant.

(b) The application shall contain a request for the department, staff category, and specific clinical privileges being sought. Criteria for the delineation of clinical privileges shall be developed by the appropriate department, through its Chair. Evaluations of requests for clinical privileges shall be based on information in the application, continuing education and training, utilization practice patterns, references, evaluations, currently demonstrated competence, and judgment.

(c) The applicant shall complete the information requested and submit the application with supporting documentation to the Medical Staff Services Office for processing. The applicant shall furnish such other information as may be requested and shall have the burden to produce adequate information for a proper evaluation.

3.3.5 Conditions of Application - By applying for appointment to the Medical Staff, each applicant:

(a) Signifies a willingness to appear for interviews in regard to his/her application;

(b) Authorizes the Hospital to consult with insurance carriers, other hospitals, and educational institutions, with which the applicant has been associated, and with others who may have information bearing on the applicant's competence, character, or ethical qualifications;

(c) Consents to the Hospital's inspection of all records and documents (excluding those specific to individual patients) that may be material to an evaluation of the applicant's professional qualifications, competence to hold clinical privileges, and his/her moral and ethical qualifications for Medical Staff membership;

(d) Deems to have read and to have agreed to abide by these Bylaws and related manuals;

(e) Agrees to abide by all other requirements and policies of the Hospital and Medical Staff;

(f) Recognizes that his/her performance will be subject to an individualized professional practice evaluation process if clinical privileges are granted;

(g) Understands that he/she may formally withdraw the application up to the time of Board consideration;

(h) Acknowledges that the only circumstance that may be appealed is if the application, or any associated requested clinical privileges, is denied by the Board;

(i) Releases from any liability all representatives of the Hospital for acts performed in good faith in connection with evaluating the applicant and his/her credentials; and

(j) Agrees that any lawsuit that the applicant brings against the Hospital, Medical Staff or any individual or organization providing information to the Hospital or Medical Staff, shall be brought under the laws of, and in a federal or state court in the county in which the Hospital is located, whether single or multiple defendants are named.

3.3.6 **Notification of Inconsistencies or Omissions** - Applicants shall be promptly notified by the Medical Staff Services Office by telephone, mail, or electronic mail, of any inconsistencies or omissions that arise during the application verification process. This notice will state the nature of the additional information the applicant is to provide. If the applicant does not respond within ten (10) days following such notification, a second notification shall be sent to the applicant by Special Notice. Failure of the applicant to respond in a satisfactory manner, within ten (10) days, without good cause as determined by the Vice President of Medical Affairs and Chief Medical Officer, may be deemed a voluntary withdrawal of the application.

3.3.7 **Department Review and Assessment** – The Medical Staff Services Office shall forward the application for section assessment, when applicable.

(a) Section Chief Review – The applicable section chief, or designee, shall have twenty (20) days from receipt to complete his/her review and submit a written assessment to the Medical Staff Services Office for forwarding to the applicable Department Chair. The section chief, or designee, may request an additional twenty (20) day extension to complete the assessment if further information is requested or if other special circumstances arise.

(i) Time Period for Additional Information – In the event the section chief, or designee, requires the applicant to provide additional information or execute a release/authorization allowing the Hospital to obtain additional information, the Medical Staff Services Office shall provide the applicant with Special Notice. The notice must state with specificity the additional information being sought and that the applicant has ten (10) days in which to respond. Failure to respond in a satisfactory manner within this timeframe, without good cause as determined by the Vice President of Medical Affairs and Chief Medical Officer, may be deemed a voluntary withdrawal of the application.

(ii) Failure to Respond – If the section chief's, or designee's, written assessment is not received at the end of the twenty (20) day period (or conclusion of a requested extension), the application shall be deemed accepted by the section chief and shall be referred to the Department Chair.

(b) Department Chair review – Upon completion of the section review and recommendation, or in the event that one is not required, the application shall be

forwarded to the chair of the department in which privileges are being sought. In the event of an applicant who has been selected to be a department chair, the application shall be forwarded to the President of the Medical Staff (or his/her designee) and the Vice President of Medical Affairs and Chief Medical Officer. The Department Chair, or designee, (or the President of the Medical Staff, or designee, and the Vice President of Medical Affairs and Chief Medical Officer) shall have twenty (20) days from receipt to complete his/her review and written assessment of the application. The Department Chair, or designee, (or the President of the Medical Staff, or designee, and the Vice President of Medical Affairs and Chief Medical Officer) may request from the Medical Executive Committee an extension of an additional twenty (20) days to submit the written recommendation if additional information is requested or if other special circumstances arise.

(i) Time Period for Additional Information – In the event the Department Chair, or designee, (or the President of the Medical Staff, or designee, and the Vice President of Medical Affairs and Chief Medical Officer) requires the applicant to provide additional information or execute a release/authorization allowing the Hospital to obtain additional information, the Medical Staff Services Office shall provide the applicant with Special Notice. The notice must state with specificity the additional information being sought and that the applicant has ten (10) days in which to respond. Failure to respond in a satisfactory manner within this timeframe, without good cause as determined by the Vice President of Medical Affairs and Chief Medical Officer, may be deemed a voluntary withdrawal of the application.

(ii) Favorable Assessment – A favorable assessment for applicant appointment by the Department Chair, or designee, (or the President of the Medical Staff, or designee, and the Vice President of Medical Affairs and Chief Medical Officer) shall include, where appropriate, a recommendation for the clinical privileges to be granted. Pursuant to individualized professional practice evaluation requirements, the assessment shall delineate special circumstances of review, identify the proposed proctor, if required, and whether the evaluation will be concurrent or retrospective.

(iii) Unfavorable Assessment – An unfavorable or adverse assessment by the Department Chair, or designee, (or the President of the Medical Staff, or designee, and the Vice President of Medical Affairs and Chief Medical Officer) must set forth the reasons for the conclusion and shall include supporting documentation.

(iv) Completed Application and Assessment – The completed application and written assessment of the Department Chair, or designee, (or the President of the Medical Staff, or designee, and the Vice President of Medical Affairs and Chief Medical Officer) –- and the section chief where applicable -- shall be forwarded to the Credentials Committee for review and recommendation at its next regularly scheduled meeting.

3.3.8 <u>Credentials Committee Review and Recommendation</u> –

(a) Process for Review – Upon receipt of the completed application, the Credentials Committee shall:

(i) Review the applicant's character and qualifications;

(ii) Review the application and any assessments in reference to the factors set forth in Section 3.2 and other pertinent criteria; and

(iii) Within thirty (30) days, submit a written report of its findings and recommendations to the Medical Executive Committee.

If the Credentials Committee requires further information, it may defer submitting its report and must notify the applicant, the Department Chair, and the President of the Medical Staff in writing of the deferral and the grounds for such deferral.

(b) Process for Additional Information – In the event the Credentials Committee requires the applicant to provide additional information or execute a release/authorization allowing the Hospital to obtain additional information, the Medical Staff Services Office shall provide the applicant with Special Notice. The notice must state with specificity the additional information being sought and that the applicant has ten (10) days in which to respond. Failure to respond in a satisfactory manner within this timeframe, without good cause, may be deemed a voluntary withdrawal of the application.

3.3.9 **<u>Medical Executive Committee Review and Recommendation</u>** – Upon receipt of the recommendation of the Credentials Committee, the Medical Executive Committee shall review and evaluate the recommendation at its next regularly scheduled meeting, and shall make its own findings and recommendations. The Medical Executive Committee's recommendation for approval or denial of the application shall be forwarded to the Board for review and final action at its next regularly scheduled meeting.

3.3.10 **<u>Board Review and Final Action</u>** – Following receipt of the recommendation of the Medical Executive Committee, the Board shall review the recommendation and take final action at its next regularly scheduled meeting.

(a) If the Board approves the application, written notification of the term of the appointment, staff category designation, and the clinical privileges granted shall be sent to the applicant within ten (10) days.

(b) If the application is denied by the Board, the applicant shall be notified within five (5) days by Special Notice and shall have all of the hearing rights in Section 3.3.11 enumerated.

(c) The Board shall be the final adjudicator of all applications.

3.3.11 **<u>Right to a Hearing</u>** – In the event that the application is denied by the Board, the applicant shall have the right to a hearing, which shall be conducted in accordance with Article VIII of these Bylaws. The applicant shall have twenty (20) days following receipt of the notice of denial to request a hearing in writing. The request shall be submitted to the Hospital President. Failure to do so shall constitute a waiver of the applicant's right to a hearing on, or an appeal of, the denial. A lapse by the Hospital in notifying an applicant of the denial of his/her application shall not waive the applicant's right to a hearing.

3.3.12 **<u>Appointment Limitation</u>** - Appointment to the Medical Staff shall confer on the applicant

only such prerogatives as may be provided for in these Bylaws or in the terms of staff category appointment granted to the applicant.

3.3.13 **Scope of Privileges** – Each Medical Staff Member shall exercise only those clinical privileges granted to him/her by the Board. In the case of an emergency in which serious harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, a Medical Staff Member is authorized, when better alternative sources of care are not reasonably available, to do everything possible to save the patient from death or serious harm to the degree permitted by the Medical Staff Member's license regardless of any limitations of his/her privileges. The Medical Staff Member shall summon consultative assistance and arrange for appropriate follow-up care.

3.3.14 **Continuity of Care** – Each Medical Staff Member shall provide or arrange for continuous medical care for his/her patients in the Hospital and obtain consultation when necessary for the safety of those patients, or when otherwise required by the rules and policies of the Medical Staff or Hospital.

3.3.15 **Term of Initial Appointment** – Initial appointments shall be for a term not to exceed two (2) years.

3.4 Provisional Status

3.4.1 **Provisional Period** – The first year of all initial appointments to the Active, Courtesy, Consulting, and Doctoral Staff will be a provisional period. During the provisional period, a Medical Staff Member may exercise all of his/her granted privileges and prerogatives, subject to any conditions or limitations imposed as part of the appointment process. All of the provisions of these Bylaws applicable to Medical Staff Members shall apply during the provisional period or any extension thereof.

3.4.2 **Conditions of Provisional Review** – Each department shall, subject to approval of the Credentials Committee, the Medical Executive Committee, and the Board, establish specific review, monitoring, and/or supervision conditions for the provisional period, including but not limited to an individualized professional practice evaluation process.

3.4.3 **Extension of Provisional Review** – A Medical Staff Member whose caseload at the Hospital is inadequate to satisfy the requirements of the provisional period review with respect to all or part of the granted clinical privileges may request an extension of the period from the Department Chair. This request must include a statement describing the circumstances of his/her practice that is expected to change and enable him/her to meet the requirements if an extension is granted. A Medical Staff Member who anticipates that his/her clinical volume at the hospital will always be limited may request an extension of the provisional period through the conclusion of the initial staff appointment. The Medical Staff Member will then be considered for reappointment using the criteria for low volume practitioners as outlined in Section 3.6.1.

3.4.4 **Board Certification Requirement** – Subject to the provisions of Section 3.8, members of the Active, Courtesy, and Consulting Staff must also attain Board Certification in order to conclude the provisional period.

3.4.5 **Review and Conclusion** – Prior to the conclusion of the first year provisional period, the applicable Department Chair shall review the Medical Staff Member's file and submit a written recommendation to the Credentials Committee to conclude or extend the Medical Staff Member's provisional period for up to one (1) additional year. The Credentials

Committee recommendation is forwarded to the Medical Executive Committee and Board of Trustees for action consistent with Sections 3.3.9 and 3.3.10.

3.5 Reappointment: Qualifications

3.5.1 Licensure

(a) An applicant for reappointment to the Active, Courtesy, Doctoral, or Associate Staff shall have an active, unrestricted license to practice medicine, dentistry, podiatry or psychology in the State of Rhode Island.

(b) An applicant for reappointment to the Consulting Staff who will exercise clinical privileges will have an active, unrestricted license to practice medicine, dentistry, or podiatry in the State of Rhode Island.

(c) An applicant for reappointment to the Consulting Staff who will only be involved in educational or research activities shall have an active, unrestricted license to practice medicine, dentistry, or podiatry in the state in which he/she primarily practices.

(d) An applicant for reappointment to the Active, Courtesy, Doctoral, Consulting, or Associate Staff under an external resource sharing agreement, or equivalent, with a military or other federal service organization shall have an active, unrestricted license to practice medicine, dentistry, podiatry, or psychology in any state.

3.5.2 Board Certification and Qualification – An applicant for reappointment to the Active, Courtesy, or Consulting Staff shall be Board Qualified or Board Certified in accordance with Section 3.8.

3.5.3 Insurance - An applicant for reappointment to all categories of the Medical Staff, except Honorary Staff and Research Scientists, shall be insured for professional liability by a reputable insurer, as determined by the Board, in such amounts as the Board from time to time shall establish.

3.5.4 Required Disclosures – In addition to information specifically requested on the application, a Medical Staff Member seeking reappointment to the Medical Staff must disclose any fact that could reasonably be expected to have a negative impact on his/her candidacy. This shall include, but not be limited to, any information about whether the applicant's enrollment, certification, membership status, clinical privileges, or license to practice any profession have ever been voluntarily or involuntarily revoked, denied, relinquished, suspended, reduced or not renewed by any entities, including but not limited to:

(a) Specialty board;

(b) State or federal jurisdiction;

(c) Medicare, Medicaid or state or federal Drug Enforcement Agency;

(d) Healthcare entity;

(e) Education institution or program; or

(f) Local, state or national professional organizations.

In addition, the Medical Staff Member must disclose the following information:

(g) Evidence of current professional liability insurance coverage and the amounts thereof;

(h) Any involvement as a defendant in any malpractice or professional liability lawsuit during the preceding two (2) years;

(i) Any substance abuse issues, and physical or mental health conditions that may adversely impact the ability to perform requested clinical privileges;

(j) Any current misdemeanor or felony criminal charges pending against the applicant, and any past misdemeanor or felony charges, including the resolution of such charges; and

(k) Any current or pending state or federal investigation.

3.6 Reappointment: Procedure

3.6.1 Application

(a) Not less than ninety (90) days in advance of the date of expiration of a Medical Staff Member's appointment, the Medical Staff Services Office shall forward an application for reappointment to the Medical Staff Member. The Medical Staff Member shall, within thirty (30) days of receipt, complete and submit a signed application for reappointment, as well as all materials necessary for processing the application. The information provided in the application for reappointment shall be verified.

(b) The application shall include the specific clinical privileges (if applicable) and staff category being requested, along with any changes thereto. Each Medical Staff Members' clinical privileges shall be reevaluated in conjunction with the reappointment process.

(c) Low Volume Providers – Applicants with limited activity at the Hospital are required to provide a written recommendation from a practitioner who has firsthand knowledge of the applicant and, when available, who practices in the same professional discipline. This recommendation must refer to relevant training and/or clinical experience, current competence for privileges requested, and fulfillment of medical staff membership obligations. In addition, the applicant may be requested to submit a clinical case list and/or clinical quality data from another facility that is pertinent to the requested clinical privileges. Additional information may be requested by the Department Chair.

3.6.2 **Voluntary Non-renewal** – Failure of the Medical Staff Member to submit the required reappointment application and other materials in sufficient time to permit completion of the reappointment process shall be considered a voluntary non-renewal of staff appointment and clinical privileges. This voluntary resignation from the Medical Staff shall not entitle the Medical Staff Member to a hearing or appeal as enumerated in Section 3.6.7. A subsequent request for Medical Staff membership submitted by a Medical Staff Member who has voluntarily resigned in this manner shall be treated as an application for initial appointment.

3.6.3 **Department Review and Assessment** – The Medical Staff Services Office shall forward the application for reappointment for section assessment, when applicable.

(a) Section Chief Review – The applicable section chief, or designee, shall have fifteen (15) days from receipt to complete his/her review and submit a written assessment to the Medical Staff Services Office for forwarding to the applicable Department Chair. The section chief, or designee, may request an additional twenty (20) day extension to complete the assessment if further information is requested or if other special circumstances arise.

(i) Time Period for Additional Review – In the event the section chief, or designee, requires the applicant to provide additional information or execute a release/authorization allowing the Hospital to obtain additional information, the Medical Staff Services Office shall provide the applicant with Special Notice. The notice must state with specificity the additional information being sought and that the applicant has ten (10) days in which to respond. Failure to respond in a satisfactory manner within this timeframe, without good cause as determined by the Vice President of Medical Affairs and Chief Medical Officer, may be deemed a voluntary withdrawal of the application.

(ii) Failure to Respond – If the section chief's, or designee's, written assessment is not received at the end of the fifteen (15) day period (or conclusion of a requested extension), the application shall be deemed accepted by the section chief and shall be referred to the Department Chair.

(b) Department Chair Review – Upon completion of the section, or designee, review and assessment, or in the event that one is not required, the application shall be forwarded to the applicable Department Chair. With respect to reappointment of department chairs, the application shall be forwarded to the President of the Medical Staff (or his/her designee) and the Vice President of Medical Affairs and Chief Medical Officer. The Department Chair, or designee, (or the President of the Medical Staff, or designee, and the Vice President of Medical Affairs and Chief Medical Officer) shall have twenty (20) days from receipt to complete his/her review and written assessment of the application. The Department Chair, or designee, (or the President of the Medical Staff, or designee, and the Vice President of Medical Affairs and Chief Medical Officer) may request from the Medical Executive Committee an extension of an additional twenty (20) days to submit the written assessment if additional information is requested or if other special circumstances arise.

(i) Time Period for Additional Information – In the event the Department Chair, or designee, (or the President of the Medical Staff, or designee, and the Vice President of Medical Affairs and Chief Medical Officer) requires the applicant to provide additional information or execute a release/authorization allowing the Hospital to obtain additional information, the Medical Staff Services Office shall provide the applicant with Special Notice. The notice must state with specificity the additional information being sought and that the applicant has ten (10) days in which to respond. Failure to respond in a satisfactory manner within this timeframe, without good cause as determined by the Vice President of Medical Affairs and Chief Medical Officer, may be deemed a voluntary withdrawal of the application.

(ii) Scope of Review – In making an assessment, the Medical Staff Member's clinical performance while on staff, including the results of ongoing individualized professional practice evaluations, observed clinical performance during patient care activities at the Hospital, other quality assessments, peer review activities, risk management and utilization management activities, recommendations from the Medical Staff Member's peers, and documentation received in the reappointment process shall be considered. Any further education, training, or clinical experience which the Medical Staff Member has acquired during the previous term of appointment shall also be considered.

(iii) Unfavorable Assessment – An unfavorable or adverse assessment by the Department Chair, or designee, (or the President of the Medical Staff, or designee, and the Vice President of Medical Affairs and Chief Medical Officer) must set forth the reasons for the conclusion and shall include supporting documentation.

(iv) Completed Application and Assessment – The completed application for reappointment and written assessment of the Department Chair, or designee, (or the President of the Medical Staff, or designee, and the Vice President of Medical Affairs and Chief Medical Officer) --and the section chief where applicable -- shall be forwarded to the Credentials Committee for review and recommendation at its next regularly scheduled meeting.

3.6.4 <u>**Credentials Committee Review and Recommendation**</u> – Upon receipt of the application for reappointment, the Credentials Committee shall review and evaluate this information, as well as review the standing and qualifications of the Medical Staff Member. If the Department Chair's, or designee's, assessment of the Medical Staff Member's reappointment was unfavorable, the Credentials Committee may request additional information for review and/or conduct its own investigation. The Credentials Committee shall arrive at a recommendation within sixty (60) days and forward a written recommendation to the Medical Executive Committee at its next regularly scheduled meeting.

3.6.5 <u>**Medical Executive Committee Review and Recommendation**</u> – Upon receipt of the recommendation of the Credentials Committee, the Medical Executive Committee shall review and evaluate the recommendation, and shall make its own findings and recommendations. The Medical Executive Committee's recommendation for approval or denial of reappointment shall be forwarded to the Board for review and final action at its next regularly scheduled meeting.

3.6.6 <u>**Board Review and Final Action**</u> – Following receipt of the recommendation of the Medical Executive Committee, the Board shall review the recommendation and take final action at its next regularly scheduled meeting.

(a) If the Board approves the reappointment, written notification of the term of the appointment and the clinical privileges granted shall be sent to the Medical Staff Member within ten (10) days.

(b) If reappointment is denied by the Board, the Medical Staff Member shall be notified within five (5) days by Special Notice and shall have all of the hearing rights enumerated in Section 3.6.7.

(c) The Board shall be the final adjudicator of reappointment.

3.6.7 **Right to a Hearing** – In the event reappointment is denied by the Board, the Staff Member shall have the right to a hearing, which will be conducted in accordance with Article VIII of these Bylaws. The Medical Staff Member shall have thirty (30) days following receipt of the notice of denial to request a hearing in writing. The request shall be submitted to the Hospital President. Failure to do so shall constitute a waiver of the Medical Staff Member's right to a hearing on, or appeal of, the denial. A lapse by the Hospital in notifying the Medical Staff Member of the denial of reappointment shall not waive the Medical Staff Member's right to a hearing.

3.6.8 **Appointment Limitation** - Reappointment to the Medical Staff shall confer on the Medical Staff Member only such prerogatives as may be provided for in these Bylaws or in the terms of staff category appointment granted to the Medical Staff Member.

3.6.9 **Scope of Privileges** – Each Medical Staff Member shall exercise only those clinical privileges granted to him/her by the Board. In the case of an emergency in which serious harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, a Medical Staff Member is authorized, when better alternative sources of care are not reasonably available, to do everything possible to save the patient from death or serious harm to the degree permitted by the Medical Staff Member's license regardless of any limitations of his/her privileges. The Medical Staff Member shall summon consultative assistance and arrange for appropriate follow-up care.

3.6.10 **Continuity of Care** – Each Medical Staff Member shall provide or arrange for continuous medical care for his/her patients in the Hospital and obtain consultation when necessary for the safety of those patients, or when otherwise required by the rules and policies of the Medical Staff or Hospital.

3.6.11 **Term of Reappointment** – Reappointment to the Medical Staff shall not exceed two years.

3.7 **Requests for Additional Privileges**

3.7.1 **Request for Additional Privileges** – In the event a Medical Staff Member requests additional clinical privileges, the Medical Staff Member shall submit a written request to the applicable Department Chair. The request shall be handled in accordance with the appointment procedures set forth in Sections 3.2.7 through 3.2.10.

3.7.2 **Consideration of Requests for Additional Privileges** - Factors to be considered in acting upon requests for increased privileges include:

(a) whether other members of the Medical Staff having such privileges adequately provide for the Hospital's patient care needs,

(b) the Hospital's ability to provide adequate facilities, support services and other resources should the Medical Staff Member's request be granted, and

(c) documentation of the Medical Staff Member’s training, experience, and competence.

3.7.3 <u>Granting of Additional Privileges</u> – A Medical Staff Member who is granted additional clinical privileges shall be subject to an individualized professional practice evaluation process related to the additional privileges granted.

3.8 <u>Board Qualification and Certification</u>

3.8.1 <u>Board Qualification and Certification Requirement</u> – An applicant for initial appointment or reappointment to the Active, Courtesy, or Consulting Staff must be Board Qualified or Board Certified in the field in which he/she is seeking primary clinical privileges.

(a) Upon appointment to the Medical Staff, a Medical Staff Member who is Board Qualified shall be required to register and take the next board examination for which he/she is eligible.

(i) Should the Medical Staff Member fail to attain Board Certification at that time, he/she shall be required to register and take the next board examination for which he/she is eligible.

(ii) Should the Medical Staff Member fail to attain Board Certification at that time, he/she may appeal to the applicable Department Chair for the opportunity to register and take the next board examination. The Department Chair may in his/her discretion grant this opportunity.

(iii) Should the Medical Staff Member fail to obtain Board Certification at that time, or should the Department Chair deny the Medical Staff Member the additional opportunity, he/she may appeal to the Medical Executive Committee for the opportunity to register and take the next board examination, setting forth the specific reasons and circumstances as to why such an opportunity is warranted. The Medical Executive Committee, in its discretion, may grant this opportunity.

(iv) All Medical Staff Members granted a final attempt to attain Board Certification by the Medical Executive Committee will be subject to an individualized professional practice evaluation process.

(b) Should a Medical Staff Member fail to become Board Certified after the final allowed extension and is not granted a waiver pursuant to Section 3.7.2, then the Medical Staff Member shall be ineligible for clinical privileges.

(i) The member may submit a written request to change staff category to the Associate Staff to maintain a relationship with the Hospital. Should the member attain Board Certification in the future, he/she may request a modification of staff category and clinical privileges at that time.

(ii) If the staff member is not granted a waiver and does not desire to be a member of the Associate Staff, his/her staff membership shall cease.

(iii) Other than documenting the staff member’s request, no further action will be required on the part of the Medical Staff to effect the request for conversion to Staff Associate or the cessation of staff membership.

(iv) The Medical Staff Member shall have no right to a hearing on, or appeal of, the eligibility for clinical privileges or the change in staff category.

3.8.2 Waiver of Board Certification

(a) Under extraordinary circumstances, the Medical Executive Committee, on the recommendation of the applicable Department Chair, may waive the requirement of Board Certification on the basis of appropriate qualification, training, or special clinical experience, and the Hospital's need for physicians in the applicant's specialty.

(b) The Medical Executive Committee may also waive the requirement of Board Certification for Medical Staff Members appointed prior to the Board Certification requirement who are no longer eligible to attain Board Certification.

(c) Medical Staff Members in either of these circumstances must demonstrate current competence by documented clinical performance and continuing medical education pertinent to their specialty area in order to remain eligible for Medical Staff appointment.

(d) In the event (i) an initial applicant seeking primary clinical privileges in one department requests clinical privileges in one or more additional departments, or (ii) a Medical Staff Member having an existing clinical privileges in one department applies for clinical privileges in one or more additional departments, then the Medical Executive Committee, upon recommendation of the Chair of the additional department(s), may waive the requirement of Board Certification in the specialty of the additional department(s).

3.8.3 Board Recertification Requirement – In the event that an applicant or Medical Staff Member is required by his/her specialty board to obtain recertification and fails to obtain recertification, the applicant or Medical Staff Member may petition for an extension to obtain recertification pursuant to the procedures set forth in Section 3.8.1.

3.9 Reapplication Following an Adverse Decision

In the event of a final adverse decision regarding appointment, reappointment, or additional privileges, the applicant may re-apply when the reason(s) for the adverse decision is fully and satisfactorily addressed.

3.10 Leaves of Absence

3.10.1 Initiation of Leave of Absence – A leave of absence may be requested by a Medical Staff Member in good standing by submitting a written request to the applicable Department Chair. The request must state the reason(s) for the leave of absence and the anticipated length of the leave, which may not exceed one (1) year.

3.10.2 Extension for Leave of Absence – A Department Chair may request an extension of a leave of absence on behalf of the member, up to a maximum second year, by submitting a written request for consideration through the Credentials Committee.

3.10.3 Routing Leave of Absence Request – The Department Chair shall make a recommendation to grant the leave of absence (or extension), through the Credentials Committee and

Medical Executive Committee for review and recommendation, and to the Board for final action.

3.10.4 <u>Member Status During Leave of Absence</u>

(a) Effect on Clinical Privileges – During the leave of absence, the Medical Staff Member shall not exercise clinical privileges at the Hospital and will not have access to Hospital clinical information systems. All other Medical Staff membership rights and duties shall be inactive including the ability to hold office or serve as chair of a Committee or Department during the leave. Provisions relating to hearings and appeals shall not apply to the granting or lapse of leaves of absence.

(b) Expiration of Appointment During Leave – If the member's medical staff appointment will expire during the leave of absence, the member must apply for reappointment immediately prior to the anticipated return. Failure to apply for reappointment under these circumstances will be interpreted as a voluntary non-renewal of staff appointment and clinical privileges.

(c) Duration of Leave – Leaves of absence cannot exceed two continuous years. Medical Staff Members who are unable to conclude a leave of absence at the end of two continuous years shall be deemed to have relinquished his/her Medical Staff appointment effective on the leave's two year anniversary date.

3.10.5 <u>Termination of Leave of Absence</u>

(a) Required Reinstatement – The member must request reinstatement to terminate the leave of absence. Failure to request reinstatement or extension prior to the expiration of the leave shall constitute a voluntary relinquishment of staff appointment and clinical privileges.

(b) Process of Reinstatement – The written request for reinstatement from a leave of absence must include a summary of activities during the leave of absence. The request is submitted through the applicable Department Chair to the Credentials Committee. The Department Chair may request a physical, mental health, or other clinical evaluation if pertinent to the reason(s) for the leave to ensure that the Medical Staff Member's current health status will not impact his/her ability to provide appropriate patient care.

3.10.6 <u>Routing Termination Request</u>

(a) Department Chair Recommendation – The Department Chair shall make a recommendation to terminate the leave of absence, and any associated stipulations related to the member's return, through the Credentials Committee and Medical Executive Committee for review and recommendation, and to the Board for final action.

(b) Approval of Request – Favorable action by the Board of Trustees is required prior to the member being permitted to exercise medical staff membership and clinical privileges.

(c) Action by the Board of Trustees to deny a request to terminate a Leave of Absence and resume medical staff membership and clinical privileges shall be

considered a revocation of medical staff appointment and clinical privileges and shall entitle the Medical Staff Member to a hearing regarding the matter. The Medical Staff Member shall be notified of the action within five (5) days by Special Notice and shall have all of the hearing rights enumerated in Section 3.6.7.

3.10.7 **Resuming Clinical Activity** – An individualized professional practice evaluation process may be instituted upon the member's return at the discretion of the Medical Executive Committee.

3.11 **Temporary Privileges**

3.11.1 **Circumstances for Temporary Privileges** - Temporary privileges may be granted for a demonstrated, important patient care need under the following circumstances:

(a) To a practitioner who is not a member of the Medical Staff, and who does not have an application pending to become a member of the Medical Staff, when necessary to fulfill an important patient care need that may be individual patient specific, practitioner specific , or specialty specific.

(b) To a new applicant to the Medical Staff, with a completed application that raises no concerns, when the new applicant is awaiting review and approval of the Credentials Committee, the Medical Executive Committee, or the Board of Trustees and there is a demonstrated, important patient care need that has been validated by the Vice President of Medical Affairs and Chief Medical Officer.

3.11.2 **Temporary Privileges for Non-Applicant** - When the welfare of a patient is such that consultation and/or treatment of that patient should be obtained from a physician, dentist, podiatrist, or other doctoral level professional not presently a member of, or applicant to, the Medical Staff, but who has the unique skills or training necessary for the care of the patient, then a Staff Member may request that a practitioner be granted temporary privileges through the appropriate Department Chair. A similar process is followed for practitioner specific or specialty specific coverage needs.

3.11.3 **Temporary Privileges for New Applicant** - An applicant whose completed application for initial appointment raises no concerns and is pending before the Credentials Committee, Medical Executive Committee, or Board of Trustees may be granted temporary privileges if a demonstrated, important patient care need that has been validated by the Vice President of Medical Affairs requires the clinical services of the applicant.

3.11.4 **Temporary Privilege Requirements** - Temporary privileges shall only be granted upon verification of a completed application for temporary privileges or regular staff appointment. The application for temporary privileges will, at a minimum, verify the following information:

(a) Request for specific privileges.

(b) Unrestricted license to practice medicine, dentistry, podiatry, or psychology in the State of Rhode Island;

(c) Federal DEA registration and Rhode Island Controlled Substances Registration (as applicable)

(d) Professional liability insurance in such amounts and with such insurers as the Board has required of staff members; and

(e) Query and evaluation of the National Practitioner Data Bank.

(f) Relevant education, training, and experience;

(g) Clinical competence based on current, similar privileges at another healthcare facility or through a training program;

(h) Positive reference attesting to clinical competency from either a medical staff authority at the practitioner's current hospital affiliation or clinical peer; and

(i) Successful criminal background check.

3.11.5 Temporary Privilege Process

(a) Submission of a Request – The request for temporary privileges will be submitted in writing and explicitly state the demonstrated patient care need for the practitioner's services. The request will be generated and endorsed by the Department Chair and forwarded to the Vice President of Medical Affairs and Chief Medical Officer for validation of the demonstrated patient care need. The request will then be forwarded to the Credentials Committee Chair, the Medical Staff President (or designee), and the Hospital President (or designee) for consideration. If received favorably, the Hospital President may grant such temporary privileges on behalf of the Board of Trustees.

(b) Notification to Applicant of Approval – Once granted, the practitioner notification will specify the privileges and/or scope of practice to be granted, the duration of the temporary privileges, and whether an individualized professional practice evaluation process will be associated with the temporary privileges.

(c) The Credentials Committee will be informed of all practitioners granted temporary privileges since the previous meeting. The Committee will subsequently inform the Medical Executive Committee and the Board of Trustees through meeting minutes/reports so that all involved in the credentialing and privileging process are notified.

3.11.6 Temporary Privilege Duration – Temporary privileges will be granted for an initial term of up to 30 days. Two additional extensions, each not to exceed 30 days, may be requested based on a continued demonstrated patient care need. Requests for temporary privilege extensions shall follow the process set forth in Section 3.11.5.

3.11.7 Temporary Privilege Termination – Temporary privileges expire automatically at the conclusion of the appointment term. Temporary privileges may be suspended or revoked at any time and for any reason by the Hospital President (or designee). There shall be no right to a hearing or appellate review for any practitioner who has temporary privileges denied, suspended, or revoked. Privileges that are suspended or revoked due to quality of care or clinical competency concerns will be reported to the Rhode Island Department of Health.

3.12 Disaster Privileges

3.12.1 Granting Disaster Privileges

(a) Activation of Emergency Management Plan – Disaster Privileges may be granted any time the Hospital's Emergency Management Plan is activated and the Hospital is unable to handle immediate patient needs, as determined by the Incident Commander, in conjunction with the designated Medical Director. The Incident Commander and designated Medical Director will determine what types of providers are needed.

(b) Disaster Privileges may be granted by the Incident Commander based upon recommendation of the designated Medical Director and upon presentation of a valid government-issued photo identification and any one of the following:

(i) A current picture identification card from a healthcare organization that clearly identifies the individual's professional designation;

(ii) A current unrestricted license to practice or primary source verification of a current unrestricted license to practice;

(iii) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;

(iv) Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances; or

(v) Presentation or confirmation by a current Staff Member with personal knowledge regarding practitioner's identity and competence.

3.12.2 **Exercising Disaster Privileges** - Practitioners granted Disaster Privileges shall wear identification badges denoting their status as a volunteer practitioner and be assigned to a credentialed licensed independent practitioner for oversight of the patient care rendered. The designated Medical Director shall arrange for the appropriate concurrent or retrospective monitoring. Based on the continued activation of the Emergency Management Plan and the performance of the volunteer practitioner, the Hospital shall determine within seventy-two (72) hours of the practitioner's arrival whether to continue the granted disaster privileges.

3.12.3 **Verifying Credentials**

(a) Primary Source Verification – The Medical Staff Services Office shall begin primary source verification of state licensure of volunteer practitioners who receive Disaster Privileges as soon as the immediate emergency situation is under control or within seventy-two (72) hours of arrival – whichever comes first.

(b) Extraordinary Circumstances – If extraordinary circumstances do not permit license verification within seventy- two (72) hours, it shall be done as soon as possible.

(i) The Medical Staff Services Office will document the reason(s) that the primary source verification could not be accomplished; evidence of the

volunteer practitioner's demonstrated ability to continue to provide adequate care, treatment, and services, and evidence that the Hospital attempted to perform primary source verification as soon as possible.

(ii) If the volunteer practitioner has not provided care, treatment, or services under the disaster privileges, primary source verification of licensure is not required.

3.12.4 **Disaster Privileges Termination** – Disaster privileges expire automatically at the conclusion of the emergency situation. Disaster privileges may be suspended or revoked at any time and for any reason by the Incident Commander or the Hospital President (or designee). There shall be no right to a hearing or appellate review for any practitioner who has disaster privileges denied, suspended, or revoked. Privileges that are suspended or revoked due to quality of care or clinical competency concerns will be reported to the Rhode Island Department of Health.

3.13 **Telemedicine Privileges –** For the purposes of these Bylaws, telemedicine shall be defined as the provision of clinical services to patients by practitioners from a distance via electronic communications.

3.13.1 **Applicability** – This section applies to those practitioners not appointed to the Medical Staff who will have total or shared responsibility for the direct clinical care of a patient at the Hospital through the use of a telemedicine link or who will provide official or preliminary readings of images, tracings, or specimens through a telecommunications link. Direct care responsibility is evidenced by the practitioner having the authority to formally consult, implement medical orders, and/or direct patient care, treatment, or services.

3.13.2 **Granting of Privileges -** Telemedicine privileges shall be granted by one of the processes set forth in this section, depending upon the service rendered and arrangements available with the distant-site.

(a) Credentialing and privileging may occur in accordance with Sections 3.3 through 3.9 of these Bylaws; or

(b) Credentialing and privileging may utilize the credentialing information from the distant-site telemedicine entity, provided that the following conditions are met:

(i) A written agreement exists identifying the distant-site telemedicine entity as an independent contractor of services to the Hospital and as such, furnishes contracted services in a manner that permits the Hospital to comply with the Centers for Medicare and Medicaid Services' conditions of participation for the contracted services;

(ii) The distant-site telemedicine entity meets the Centers for Medicare and Medicaid Services' credentialing and privileging requirements;

(iii) The distant-site telemedicine entity provides a current list of the practitioner's privileges at that site;

(iv) The distant-site practitioner possesses an active, unrestricted license to practice in the State of Rhode Island and that license is primary source verified; and

(v) The distant-site practitioner's performance is monitored by the Hospital and the Hospital reports are forwarded to the distant-site telemedicine entity for consideration during the distant-site's credentialing process. At a minimum, the Hospital report must include all adverse events that result from the telemedicine services provided by the practitioner to the Hospital's patients and all complaints about the distant-site practitioner received by the Hospital.

(c) The approval process shall follow Sections 3.3.7 through 3.3.10 and 3.6.3 through 3.6.6, as applicable.

(d) The contract with the distant-site telemedicine entity will specify that the distant-site telemedicine entity will provide timely updates with respect to the contracted practitioner's status following any change in the practitioner's status.

(e) The Hospital shall review and update the staff appointment and clinical privileges for the practitioner consistent with medical staff credentialing standards and also concurrent with any updates provided by the distant-site telemedicine entity.

3.13.3 **Prerogatives** – Practitioners privileged pursuant to this section shall not be considered members of the Medical Staff and as such, shall not be afforded the provisions relating to hearings, appeals, and appellate review.

ARTICLE FOUR: OFFICERS AND MEETINGS OF THE MEDICAL STAFF

4.1 Elected Officers of the Medical Staff

4.1-1 Identification

The elected officers of the Medical Staff are:

(a) President
(b) President-Elect
(c) Secretary-Treasurer

4.1- 2 Qualifications

Each elected officer must:

(a) Be a member of the Active Staff at the time of nomination and election and remain in good standing continuously during his/her term of office.

(b) Have demonstrated executive and administrative ability through experience and prior constructive participation in Medical Staff activities at this Hospital. Ideally, candidates would have previously served actively and effectively on at least two standing committees and, preferably, as Chair of a committee or in some other leadership position within this or another medical staff.

(c) Be recognized as having a high level of clinical competence.

(d) Have demonstrated a high degree of interest in and support of the Medical Staff and Hospital by Medical Staff tenure and level of clinical activity at this

Hospital.

(e) Agree to faithfully discharge the duties and exercise the authority of the office held and work with the other general, department and section officers of the Medical Staff and with the Hospital President, his/her designees and the Board of Trustees, and, while in office, carry out this agreement.

4.2 Term of Office

The term of office of elected officers of the Medical Staff is two Medical Staff years. Elected 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 the elected term and until a successor is elected, unless removed or resigns from office.

4.3 Eligibility for Re-election

The President of the Medical Staff is once again eligible for nomination and election to a Medical Staff office two years after last holding a general office. An exception may be granted to fill an immediate vacancy in the office of the President of the Medical Staff occurring in the two years after leaving office.

4.4 Attainment of Office

4.4-1 President of the Medical Staff

The President of the Medical Staff attains office by automatic succession from the office of President-Elect, subject to a confirmation vote at the Annual Medical Staff Meeting prior to assuming the office of President. This confirmation vote may be by resolution and voice vote.

4.4-2 President-Elect and Secretary-Treasurer

(a) Election: The President-Elect and Secretary-Treasurer are elected, from among the candidates nominated and approved under Section 4.4-2 (b) below, by majority vote cast by those Active, Senior Active, and Doctoral Staff members in good standing who are present at the Annual Medical Staff Meeting during which an announced election is held. Voting shall be by secret ballot. If no candidate for a given office receives a majority vote on the first ballot, one or more runoff elections are held immediately with the candidate receiving the fewest number of votes being dropped from each successive ballot until one of the candidates receives a majority vote.

(b) Nomination: The Nominating Committee shall convene two months prior to the Annual Medical Staff Meeting for the purpose of nominating one or more qualified candidates for the offices of President-Elect and Secretary-Treasurer. This list is promptly published for all Active, Senior Active, and Doctoral Staff members in good standing. Additional nominations may be submitted by written petition signed by at least five (5) Medical Staff members other than the practitioner being nominated, filed with the Chair of the Nominating Committee at least twenty (20) days in advance of the Annual Medical Staff Meeting and accompanied by evidence of the candidate's qualifications and willingness to be nominated. The Nominating Committee finalizes the slate, including the names of those nominated by written petition. The list of candidates must be posted at least ten (10) days in advance of

the election.

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 submits substitute nominees at the Annual Medical Staff Meeting. Nominations from the floor, offered and seconded by Active and Senior Active Staff members in good standing, will be accepted. All such nominations must be presented with evidence of the candidate's qualifications and of his willingness to be nominated.

4.5 Vacancies

4.5-1 Office of the President of the Medical Staff

A vacancy in the office of the President of the Medical Staff is filled by succession of the President-Elect. If the remaining term in the vacated office is 15 months or less, the President-Elect serves the remainder of the term and his/her own full term as President, subject to any regular reconfirmation votes as are applicable. If the remaining term is more than 15 months, the President-Elect serves only the remainder of the term, subject to any regular reconfirmation vote as is applicable. Circumstances might arise when the position is vacated very early in the term in which the immediate past president is best able to resume the position and can be considered when filling the vacancy.

4.5-2 Offices of President-Elect and Secretary-Treasurer

A vacancy in the office of President-Elect or Secretary-Treasurer is filled by the appointment of an acting officer by the Medical Executive Committee. The acting officer serves pending the outcome of an expeditiously conducted special election generally carried out in the same manner as provided in Section 4.4. The Medical Executive Committee may determine that a special election is not required if a regular election for the office is to be held within 128 days. In that instance, the acting officer serves only until the regular election results are final and the newly elected individual assumes office immediately thereafter.

4.6 Resignation and Removal from Office

4.6-1 Resignation

Any elected officer of the Medical Staff 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 tie specified in it.

4.6-2 Removal of Elected Officers of the Medical Staff

(a) Authority and Mechanism: Removal of an elected officer of the Medical Staff may be effected either: (1) by the Board of Trustees; or (2) by a two-thirds vote of Active, Senior Active, and Doctoral Staff members in good standing taken by secret ballot at a special meeting called for that purpose and subsequently ratified by the Medical Executive Committee.

When the Board of Trustees is contemplating action to remove an officer of the Medical Staff, it will refer the matter to a special combined committee composed of

three Board members appointed by the Chair of the Board and three Active and Senior Active Staff members selected by the highest ranking officer of the Medical Staff not the subject of the removal action. For purposes of this Section, the rank of the elected officers is as they are listed in Section 4.1-1. The Hospital President also participates in this special committee as an ex officio, non-voting member.

As soon as reasonably practicable after the referral to it, the special committee will submit its written report to the Board of Trustees. The Board action taken after receiving the special committee's report is the final decision in the matter.

(b) Grounds: Permissible bases for removal of an elected officer of the Medical Staff 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;

(3) Having an automatic or precautionary suspension imposed by Article VII of these Bylaws or an intervention pursuant to Article VII of these Bylaws resulting in a final decision other than to take no action;

(4) Conduct or statements inimical or damaging to the best interests of the Medical Staff or the Hospital or to their goals, programs or public image; and

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

4.7 Duties of Elected Officers of the Medical Staff

The responsibilities and authority, including specific functions and tasks, of elected officers of the Medical Staff are set forth in the Medical Staff Organization Manual.

4.8 Immediate Past President of the Medical Staff

4.8-1 Attaining Designation

Upon successful completion of the elected term as President of the Medical Staff, the individual becomes the Immediate Past President.

4.8-2 Duties of the Immediate Past President

The responsibilities and duties of the Immediate Past President are set forth in the Medical Staff Organization Manual.

4.9 Medical Staff Meetings

4.9-1 Annual Meeting

An Annual Medical Staff Meeting will be held in the last quarter of each year. The President of the Medical Staff shall determine the date of that meeting at least 75 days prior to the meeting and forward a notice specifying the place, date and time for the meeting at least 30 days prior to the meeting. The notice shall be posted and provided in writing to

Medical Staff members.

4.9-2 Regular Meetings

The Medical Staff shall hold its Annual Meeting and at least one additional regular meeting a year and any other regular meetings the MEC may call. All such regular meetings shall be held at such day and hour, as the President of the Medical Staff shall designate in the notice of such meetings. Notice shall be sent be posted and provided in writing to Medical Staff members.

4.9-3 Special Meetings

A special meeting of the Medical Staff may be called by the President of the Medical Staff, and must be called by the President within ten (10) days of a written request from the Board, the Medical Executive Committee, or one-fourth of the members of the Active, Senior Active, and Doctoral Staff in good standing. Notice shall be posted and provided in writing to Medical Staff members.

4.10 Medical Staff Meeting Attendance Requirements

4.10-1 General

In addition to satisfying the special appearance requirements of Section 4.10-2, each Active, Senior Active, and Doctoral Staff Member is required to attend the General Medical Staff Meetings. Excused absences are granted by the President of the Medical Staff or the Medical Staff Services Office for reasons of illness, absence from the area, a clinical care conflict, or personal emergency. Unless reason for missing a meeting is provided to the Medical Staff Services Office, the absence will be deemed unexcused. Courtesy Staff, Consulting Staff, and all other credentialed practitioners are invited to the Medical Staff meetings but are not required to attend.

Meeting attendance will be assessed annually by the Chair of each Medical Staff Department and conveyed to the member. When practitioners who have not satisfied the attendance requirements during the previous privileging cycle are considered for reappointment, they will be notified of the need to improve their meeting attendance. Failure to improve may result in an invitation to a Medical Executive Committee meeting to explain the reason(s) why they were unable to adhere to their meeting attendance requirements. The Medical Executive Committee shall determine whether an intervention is deemed necessary for failure to fulfill Medical Staff obligations. If the Practitioner fails to attend the designated Medical Executive Committee meeting, due process may be initiated to address the issue.

4.10-2 Special Appearance or Conferences

Medical Staff Member participation in the following general Medical Staff activities is mandatory:

(a) A practitioner whose patient's clinical course of treatment is scheduled for special case discussion as part of quality review activities by the Medical Executive Committee will be so notified and invited to present the case.

(b) Whenever a Medical Staff educational program or clinical conference is prompted by findings of review, evaluation and monitoring activities, the

practitioner(s) 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.

(c) Whenever a formal investigation of the practitioner's clinical practice is initiated by the Medical Executive Committee.

4.11 Medical Staff Meeting Procedures

Notice, quorum, minutes, and agenda requirements for meetings are set forth in the Medical Staff Organization Manual.

4.12 Medical Staff Dues

4.12-1 The Medical Executive Committee will establish the amount and applicability of Medical Staff dues, which will be administered and maintained by the Medical Staff Services Office.

(a) Medical Staff dues will be assessed for all Active, Courtesy, Doctoral, and Senior Active Medical Staff Members.

(b) Medical Staff dues will not be assessed for all Consulting, Honorary, and Associate Medical Staff Members.

(c) Medical Staff dues will not be assessed for Allied Health Professionals or Referring Associates as these individuals are not Medical Staff Members.

ARTICLE FIVE: MEDICAL STAFF DEPARTMENTS AND SECTIONS

5.1 Designation

5.1-1 Clinical Departments and Sections

The Medical Executive Committee will periodically review the department and section structure and recommend desirable action to the Board regarding creating, eliminating or combining departments and/or sections for better organizational efficiency and improved patient care. Action taken by the Board pursuant to this section shall be effective on the date determined by the Board and shall not require formal amendment of these Bylaws. The criteria set forth in Sections 5.1-3 and 5.1-4 below and such others as may be deemed appropriate shall be used by the Medical Executive Committee and the Board in making recommendations and taking action with respect to department and section designations.

5.1-2 Specialty Sections Within a Department

The Medical Executive Committee shall determine, subject to the approval of the Board and after consulting with the department Chair and other appropriate members of the department, what, if any, specialty sections will exist as distinct organizational components within each department. A listing of current sections shall be maintained in the Medical Staff Services Office and the Medical Staff Organization Manual.

5.1-3 Criteria to Qualify as a Department

The following criteria shall apply in making department designations:

(a) The area of practice represents a major general, distinct field of medical practice at this Hospital; and

(b) The level of clinical activity at this Hospital is substantial enough to warrant imposing the responsibility to accomplish the functions assigned to departments; and

(c) The practitioners to be assigned to the department agree to and, in fact, carry out the meetings, reviews and other activities required of departments at this Hospital.

5.1- 4 Criteria to Qualify as a Specialty Section

The following criteria shall apply in making section designations:

(a) The area of practice is an established, professionally recognized, discreet specialty/subspecialty field within the general field of the department and is a significant area of practice at the Hospital. "Significant" means that specialists in that area devote a substantial portion of their time to that specialty and the numbers and/or activity level in that area are such to require a chief specifically responsible for coordination of services, quality control and day-to-day problem resolution.; and

(b) The level of clinical activity is substantial enough to warrant imposing the responsibility to accomplish the functions assigned to sections; and

(c) The practitioners to be assigned to the section agree to and, in fact, carry out the meetings, reviews and other activities required of sections at this Hospital.

5.2 Requirements for Affiliation with Departments and Sections

Each department and section is a separate organizational component of the Medical Staff, and every Medical Staff member must have a primary affiliation with the department and, if applicable, section which most closely reflects his/her professional training, experience, and current practice. A practitioner may be granted clinical privileges in other departments or sections. Exercising the clinical privileges within the jurisdiction of any department or section is always subject to the rules and regulations of that department or section and the authority of the department Chair and section chief.

5.3 Functions of Departments

5.3-1 General

The departments fulfill certain clinical, administrative, quality review/risk management/utilization management, and collegial and education functions as set forth below. Each department must meet as required under Section 5.6 of these Bylaws to review and evaluate the quality and efficiency of care provided to patients served by the department and carry out the functions required below.

5.3-2 Clinical Functions

Each department 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) Participate in and/or provide an inter-specialty and inter-department 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 standards, policies, procedures and practices within the department and across its constituent sections; and

(d) Develop, with assistance from the various sections, specialists and subspecialists, criteria for use in making credentials recommendations on initial appointments, reappointments, grants of clinical privileges, conclusion of the provisional period, and other credentials matters, and make recommendations on these matters as required by these Bylaws and the Credentialing Procedures Manual.

5.3- 3 Administrative Functions

Each Department shall:

(a) Provide a forum for its members to contribute their professional views and insights to the formulation of the department, Medical Staff and Hospital policies and plans;

(b) Communicate, through its Chair, formulated policies and plans back to its members for implementation;

(c) Coordinate, through its Chair and the President of the Medical Staff, the professional services of its members with those of other departments and sections and with Hospital support services;

(d) Make recommendations, through its Chair, to the Medical Executive Committee, the Hospital President, 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; and

(e) Review the department's rules, regulations, and other policies and recommend revisions as necessary.

Each department may formulate written rules for the conduct of affairs and the discharge of responsibilities that are not adequately delineated in the Bylaws and related manuals. Department rules and policies must be consistent with the Bylaws and related manuals, the general Medical Staff rules, the Hospital Bylaws, and Hospital and health system policies. The Medical Executive Committee must approve these rules.

5.3- 4 Quality Review/Risk Management/Utilization Management

Each Department shall:

(a) Review quality, risk management, and utilization management data pertinent to the Department, and make recommendations or take action as appropriate;

(b) Conduct or participate in mortality and morbidity reviews and special studies of inputs, processes and outcomes of care, perform specified monitoring activities, and otherwise participate as required in the quality risk management, and utilization management programs; and

(c) Report all findings of studies and other activities performed to the appropriate Staff-wide committee(s) as defined in the Medical Staff Organization Manual.

5.3-5 Collegial and Education Functions

Each Department shall serve as the most immediate peer group for:

(a) Providing clinical support among and between peers;

(b) Providing continuing education and sharing new knowledge relevant to the practice of department members; and

(c) Providing consultative advice to members of other departments and sections.

5.4 Functions of Sections

A section that is a defined sub-unit of a department shall perform the same type of clinical, administrative, quality risk management/utilization management, and collegial/education functions delineated for departments in Section 9.3 as specifically assigned by the department Chair or Medical Executive Committee.

5.5 Department Chairs and Section Chiefs

5.5-1 Qualifications

Each department Chair and section chief must meet the same qualifications as set forth in Section 4.1-2 for elected officers of the Medical Staff. In addition, the individual must be a member in good standing of the applicable department or section remain in good standing throughout the term of service, and be recognized as a clinical role model within the department or section.

5.5-2 Term of Service and Eligibility for Reelection

Except as provided herein, the term of service of a department Chair or section chief is two Medical Staff years. A Chair or chief may succeed him/herself without term limit. These individuals assume their positions on the first day of the Medical Staff year following their election, except that a Chair or chief elected or appointed to fill a vacancy assumes office immediately upon election or appointment. If service in any of these positions is by contract or employment arrangement with the Hospital, the term of appointment is as provided in such contract/employment arrangement.

5.5-3 Attainment of Position

(a) Department Chair

For the normal appointment cycle, all nominations for Department Chair positions must be presented at the December Medical Executive Committee and Board meetings so that the Chair can assume his/her position at the start of the medical staff year.

(1) Process

i. Contracted Departments. The Department Chairs of Anesthesiology, Emergency Medicine, Pathology, Psychiatry, and Diagnostic Imaging are defined by contractual relationships. These Department Chairs shall be appointed by the Board of Trustees after consultation with the Medical Executive Committee.

ii. Non-contracted Departments. The Department Chairs of Medicine, Family Medicine, Obstetrics and Gynecology, Orthopedics, Pediatrics, and Surgery shall be nominated by their departments, recommended by the Medical Executive Committee, and approved by the Board of Trustees. The Department nomination shall be generated through election by majority vote cast by those Active, Senior Active, and Doctoral Staff members of the department present at the designated department meeting in any year in which election for Chair is to take place.

(b) Section Chief

(1) Contracted Section. If the position is one to be filled by contract or other salaried arrangement with the Hospital, the Board shall appoint the contracted chief after consultation with the applicable Department Chair and the Medical Executive Committee.

(2) Non-contracted Section. Each non-contract section chief is appointed by the applicable Department Chair, subject to the approval of the Medical Executive Committee.

5.5-4 Midterm Review

Each Department Chair and Section Chief will undergo a midterm performance evaluation by their department members and the Medical Executive Committee one year into each two year term of service. The evaluations will be coordinated by Medical Staff Services Office and reviewed by the President of the Medical Staff. Specific feedback will be provided as appropriate.

5.5-5 Resignation

(a) Contracted Department Chair or Section Chief Position. The terms of service and resignation must conform to and be consistent with the parameters outlined in the contract or employment arrangement.

(b) Non-Contracted Department Chair or Section Chief Position. A non-contracted Department Chair or Section Chief may resign at any time by giving written notice to the Medical Executive Committee, the Hospital President, and, as applicable to a

Section Chief, the Department Chair. The resignation may or may not be made contingent on formal acceptance and takes effect on the date specified in the notice.

5.5-6 Removal

(a) Contracted Department Chair or Section Chief Position. The grounds and procedure for and effect of removal of a Department Chair or Section Chief with a contract or employment arrangement with the Hospital is governed by the terms of the contract/employment arrangement.

(b) Non-Contracted Department Chair or Section Chief Position. Removal of a non-contracted Department Chair or Section Chief may be effected either: (1) by the Board of Trustees; or, (2) by the Medical Executive Committee if ratified by the Board of Trustees; or, (3) by a two-thirds vote by secret ballot of the Active, Senior Active, and Doctoral Staff members of the constituent group in good standing present at a special meeting called for that purpose if such vote is ratified by the Medical Executive Committee and Board of Trustees.

Permissible bases for removal of a non-contracted Department Chair or Section Chief include the same as those for Medical Staff Officers and specified in Section 4.6-2 (b).

5.5-7 Vacancy

(a) Contracted Department Chair or Section Chief Position. A vacancy in a Department Chair or Section Chief position that is filled under the terms of a contractual or employment arrangement with the Hospital is filled by the Board, or its designee, through appointment of an acting Department Chair after seeking the advice of the Medical Executive Committee or Section Chief after seeking the advice of the applicable Department Chair. The acting Department Chair or Section Chief serves pending completion of the selection process specified in Section 5.5-3.

(b) Non-Contracted Department Chair Position. A vacancy in a non-contracted Department Chair position is filled by appointment of an acting Chair by the Medical Executive Committee after conferring with representatives of the department and subject to ratification by the Board. The acting Department Chair serves pending the outcome of a special election that is conducted as expeditiously as possible and in the same manner as provided in Section 5.5-3. However, the Medical Executive Committee may decide to not call a special election if a regular election for the position is to be held within 6 months. In this case, the acting Chair serves only until the regular election results are final. The newly elected individual then assumes the position immediately.

(c) Non-Contracted Section Chief Position. A vacancy in a non-contracted Section Chief position is filled by appointment of a new Section Chief by the Department Chair, after seeking the advice of the Section members and subject to the approval of the Medical Executive Committee. The new Section Chief serves for the balance of the vacated term.

5.5-8 Responsibility and Authority

(a) Department Chair. A Department Chair shall have the responsibility and authority to carry out the functions delegated to him/her and to the department by the Board, by

the Medical Executive Committee, by these Bylaws and the related manuals, by any other policies or rules of the Hospital or Medical Staff, and, where applicable, by contract or job description. The specific responsibility and authority is delineated in the Medical Staff Organization Manual.

Each Department Chair shall designate another qualified member of the department to temporarily assume all of the responsibility and authority of the Chair during a temporary absence.

(b) Section Chief. A Section chief shall have the responsibility and authority to carry out those duties and functions delegated to him/her by the Board, by the Medical Executive Committee, by the Department Chair, by these Bylaws and related manuals, by other policies and rules of the Hospital or Staff, and, where applicable, by contract or job description. The specific responsibility and authority is delineated in the Medical Staff Organization Manual.

Each Section Chief shall designate another qualified member of the section to temporarily assume all of the responsibility and authority of the Chief during a temporary absence.

5.5-9 <u>Reporting Obligations</u>

(a) Department Chair. Each Department Chair shall report:

(1) On the activities of the Department at regularly scheduled meetings of the Medical Executive Committee and the Department and, as requested, to special meetings of those same groups or to the Medical Staff.

(2) 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.

(3) To the Medical Staff President and Medical Performance Evaluation and Improvement Committee on action taken in response to a suggestion, recommendation, or finding from the Medical Staff's Performance Evaluation and Improvement Program.

(4) To the Hospital President, or designee, on issues relating to the Chair's administrative duties, if any, for supervision of Hospital personnel, proper functioning of equipment and efficient scheduling.

(5) To the Medical Executive Committee and the Hospital President on issues relating to the allocation and acquisition of resources for the department.

(b) Section Chief. Each Section Chief shall report:

(1) On the activities of the Section to the Department and Section at all regularly scheduled meetings.

(2) To the Medical Executive Committee through the Department Chair’s report at least quarterly or more frequently as may be necessary, and

(3) The matters indicated in Section 5.5-9 (a) (2) to (5) above to the Department Chair and the authorities specified therein.

5.6 Department and Section Meetings

5.6-1 Regular Meetings

Departments may determine, by resolution, the time and dates for holding regular meetings and no notice other than such resolution is then required. Each department and section must meet as a whole on at least a quarterly basis. The frequency of meetings should be sufficient to conduct department business.

5.6-2 Special Meetings

A special meeting of any department or section may be called by the Department Chair or Section Chief and must be called by the Chair or Chief within ten (10) days of a written request from the Board of Trustees, the Medical Executive Committee, the President of the Medical Staff, the Department Chair in the case of a Section meeting, or a petition from one-fourth of the group's current voting members in good standing requiring not fewer than two of the group's members.

5.7 Department and Section Meeting Attendance Requirements

5.7-1 General

In addition to satisfying the special appearance requirements of Section 5.6-2, each Active, Senior Active, and Doctoral Staff Member is required to attend at least 50 percent of the non-excused meetings of his/her primary department and section, if applicable. Excused absences are granted by the Department Chairman, Section Chief, or Medical Staff Services Office for reasons of illness, absence from the area, a clinical care conflict, or personal emergency. Unless reason for missing a meeting is provided to the Medical Staff Services Office, the absence will be deemed unexcused. Each Active Staff member with privileges in more than one department shall have sufficient knowledge of the department(s) in which secondary privileges are held to effectively communicate the standards of the department(s). Courtesy Staff members, Consulting Staff members, and all other credentialed practitioners may be invited to these meetings but do not have meeting attendance requirements.

Meeting attendance will be assessed annually by the Chair of each Medical Staff Department and conveyed to the member. When practitioners who have not satisfied the attendance requirements during the previous privileging cycle are considered for reappointment, they will be notified of the need to improve their meeting attendance. Failure to improve may result in an invitation to a Medical Executive Committee meeting to explain the reason(s) why they were unable to adhere to their meeting attendance requirements. The Medical Executive Committee shall determine whether an intervention is deemed necessary for failure to fulfill Medical Staff obligations. If the Practitioner fails to attend the designated Medical Executive Committee meeting, due process may be initiated to address the issue.

5.7-2 Special Appearance or Conferences

Medical Staff member participation in the following activities is mandatory:

(a) A practitioner whose patient's clinical course of treatment is scheduled for special case discussion as part of quality review activities at a Department or Section meeting will be so notified and invited to present the case.

(b) Whenever a Department or Section educational program or clinical conference is prompted by findings of review, evaluation and monitoring activities, the practitioner(s) 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.

5.8 Meeting Procedures

Notice, quorum, minutes, and agenda requirements for meetings are set forth in the Medical Staff Organization Manual.

ARTICLE SIX: MEDICAL STAFF COMMITTEES

6.1 Functions of the Medical Staff

The required functions of the Medical Staff are as specified and described in the Medical Staff Organization Manual. The functions shall be accomplished as indicated in these Bylaws and related manuals through assignment to the Medical Staff as a whole, to departments, sections or other clinical units, to Medical Staff committees, to Medical Staff officers or other individual Medical Staff members, or to interdisciplinary Hospital committees with participation of Medical Staff members.

6.2 Principle Governing Committees

6.2-1 Medical Executive Committee and Other Committees

There is a Medical Executive Committee and other standing and special committees of the Medical Staff as are necessary and desirable to perform any of the functions listed in the Medical Staff Organization Manual and elsewhere in these Bylaws and related manuals. The composition functions, reporting, and meeting requirements of the Medical Executive Committee are set forth in Section 6.3 of these Bylaws. The composition, functions, reporting and meeting requirements of the other standing Medical Staff-wide committees are set forth in 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 and related manuals are specified in the respective Section. Any committee, whether Medical Staff-wide or 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 and related manuals, is deemed a duly appointed and authorized committee of the Medical Staff.

6.2-2 Representation on Hospital Committees and Participation in Certain Hospital Deliberations

Medical Staff functions and responsibilities relating to liaison with the Board and Management, accreditation/licensure/certification, disaster planning, facility and services planning, financial management, and functional and physical plant safety which require participation of, rather than direct monitoring by, the Medical Staff shall be discharged in part by various officers and organizational components of the Medical Staff as described in

these Bylaws and related manuals and in part by Medical Staff representation on Hospital committees established to perform such functions. The Medical Staff, through its elected officers and Department Chairs, or their respective designees or through other organizational components, will be represented and participate in any Hospital deliberations affecting the discharge of Medical Staff responsibilities.

6.2-3 Ex Officio Members

The Hospital President and the President of the Medical Staff, or their respective designees, are ex officio members of all standing and special committees of the Medical Staff. Whether these individuals participate with or without vote is delineated in the provision or resolution creating the committee.

6.2-4 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. 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 Chair after consultation with the President of the Medical Staff in the case of Medical Staff members, and with the approval of the Hospital President, or designee, in case of Hospital staff members.

6.2-5 Composition

A Medical 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 Medical Staff functions required by these Bylaws and related manuals will be composed of members of the Active, Senior Active, or Doctoral Staff and may include, where appropriate, any other Medical Staff category members, Allied Health Professionals, Referring Associates and representation from Management, Nursing and Patient Care Services, Health Information Services, and such other Hospital departments appropriate to the function to be discharged. Each designated member of a committee participates with vote, unless the statement of committee composition designates the position as non-voting.

6.2-6 Appointment of Members and Chair

Except as otherwise expressly provided in these Bylaws and related manuals, the President of the Medical Staff appoints the Chairs and credentialed members of committees, except the Nominating Committee. Each committee Chair must be a Medical Staff member. Non-credentialed members are subject to the approval of the Hospital President or designee. Where necessary to accomplish a function or task assigned to a committee, the committee Chair may call on any hospital staff member with expertise in the involved subject matter to assist with the committee's work. If the use of outside consultants is necessary, consultation with the President of the Medical Staff and the Hospital President, or designee, is required prior to engaging outside resources. Each committee Chair appoints a committee member to chair any meeting from which the Chair is absent. Each committee Chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

6.2-7 Term, Removal and Vacancies

Except as otherwise expressly provided, each appointed committee member serves a two-year term, unless removed from the committee or the Medical Staff. Each member may be reappointed to the committee for an unlimited number of terms. To facilitate continuity of function, terms of committee members may be staggered so that complete turnover in committee membership does not occur at any given point in time. To create or maintain such a staggered term mechanism, the term of a committee member may be less than two years. Each Chair of a committee should have ideally served for at least a year on the committee or otherwise have experience in the functions assigned to the committee.

A Medical Staff member serving on a committee, except one serving ex-officio, may be removed from the committee for failure to maintain good standing as a Medical Staff member, for failure to satisfy the attendance requirements specified in these Bylaws, by action of the Medical Executive Committee, or by action of the Board. Any ex officio member of a Medical Staff committee ceases to be such if he/she ceases to hold the designated position that forms the basis of ex officio membership. A vacancy in any committee is filled for the remaining portion of the term in the same manner in which the original appointment is made.

6.3 Medical Executive Committee

6.3-1 Composition

The Medical Executive Committee consists of:

(a) President of the Medical Staff, as Chair and with vote.

(b) President-Elect, with vote.

(c) Secretary-Treasurer, with vote.

(d) Immediate Past President of the Medical Staff, with vote.

(e) Chairs of the Clinical Departments, with vote.

(f) Three members at-large, with vote, to be nominated and selected in the same manner as provided in Section 4.4-2 and for a term of two years.

(g) One member at large, with vote, who is a physician assigned to Naval Health Clinic New England-Newport, to be appointed by the Commanding Officer, Naval Health Clinic New England, for a term of two years; provided, however, that the External Resource Sharing Agreement between Newport Hospital and the Department of the Navy remains in effect.

(h) Hospital President, or designee, Vice President of Medical Affairs and Chief Medical Officer, Vice President of Nursing and Chief Nursing Officer, and Administrative Director, Allied Patient Care Services, all without vote.

6.3 -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 Medical Staff officers, removal of general Medical 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 Medical 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, other clinical units and committees;

(e) Study and report to the Medical Staff on proposals for changes in these Bylaws and related manuals;

(f) Inform the Medical Staff on Joint Commission and other accreditation programs and the accreditation status of the Hospital;

(g) Review and approve the appointment of the Chairs of standing committees, except as otherwise provided;

(h) Recommend to the Board, as required in these Bylaws and the Credentialing Procedures Manual, appointments and reappointments, category, and department and section assignments, clinical privileges, and disciplinary action;

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

(j) Account to the Board of Trustees by written report on the quality and efficiency of medical care provided to patients in the Hospital, including a precautionary of specific findings, action and follow-up; and

(k) Make recommendations to the Hospital President on medical-administrative, Hospital management, and planning matters including consulting with administration on quality related aspects of contracts for patient care services with entities outside of the Hospital.

6.3 -3 Meetings and Reporting

The Medical Executive Committee meets at least monthly. It communicates its discussions and actions that affect or define Medical 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 Chairs to report at each regular department meeting on such discussions and actions. The Medical Executive Committee's other reporting obligations are as stated in the various sections of these Bylaws and related manuals. In addition, copies of reports are forwarded to the Board of Trustees.

6.4 Nominating Committee

6.4-1 Purpose and Meetings

The Nominating Committee shall nominate, when required under the provisions of these Bylaws, one or more qualified candidates for the offices of President-Elect and Secretary-Treasurer and for each of the three at-large positions on the Medical Executive Committee. It shall meet as required under Sections 4.4-2 (b) of these Bylaws and otherwise as necessary to accomplish its function.

6.4-2 Composition

The Nominating Committee shall be composed of Active, Senior Active, or Doctoral Staff members consisting of the current President of the Medical Staff, the Immediate Past President of the Medical Staff, the Department of Surgery Chair, the Department of Medicine Chair, and the Medical Director of the Hospitalist program. The current President of the Medical Staff shall serve as the committee chair.

6.5 Committee Meetings

6.5-1 Regular Meetings

The frequency of standing committee meetings is as required by these Bylaws or the Medical Staff Organizational Manual for each committee, or as established by the resolution creating the committee.

6.5-2 Special Meetings

A special meeting of any committee may be called by the respective Chair and must be called by the Chair within ten (10) days of a written request from the Board of Trustees, the Medical Executive Committee, the President of the Medical Staff.

6.6 Committee Meeting Attendance Requirements

6.6-1 General and Special Meetings

Each practitioner that accepts a committee assignment must attend at least 75 percent of the non-excused meetings of the assigned committee(s). Excused absences are granted by the meeting Chairman or Medical Staff Services Office for reasons of illness, absence from the area, a clinical care conflict, or personal emergency. Unless reason for missing a meeting is provided to the Medical Staff Services Office, the absence will be deemed unexcused.

Meeting attendance will be assessed annually by the Chair of each Medical Staff Department and conveyed to the member. When practitioners who have not satisfied the attendance requirements during the previous privileging cycle are considered for reappointment, they will be notified of the need to improve their meeting attendance. Failure to improve may result in an invitation to a Medical Executive Committee meeting to explain the reason(s) why they were unable to adhere to their meeting attendance requirements. The Medical Executive Committee shall determine whether an intervention is deemed necessary for failure to fulfill Medical Staff obligations. If the Practitioner fails to attend the designated Medical Executive Committee meeting, due process may be initiated to address the issue.

6.7 Meeting Procedures

Notice, quorum, minutes, and agenda requirements for meetings are set forth in the Medical Staff

Organization Manual.

ARTICLE SEVEN: CONDUCT OF THE MEDICAL STAFF: INVESTIGATION AND INTERVENTION

7.1 Expectations of Conduct

7.1.1 The professional conduct of the Medical Staff shall be governed by the Medical Staff Code of Conduct and the Code of Medical Ethics of the member's applicable national organization. Professional conduct shall conform to all standards established by applicable governmental laws and regulations, and shall conform to all requirements provided elsewhere in these Bylaws and related manuals. Members of the Medical Staff shall be required to function in a cooperative and reasonable manner with other staff members and Hospital personnel and to conform to any Medical Staff, Hospital, and Lifespan policy on physician behavior.

7.1.2 The Medical Staff and Hospital have established processes linked to the peer review process to continually review the quality of care rendered. Additional processes are in place to monitor patient safety and professional behavior. These processes are established through Hospital policy, Bylaws related manuals, and other sources.

7.2 Collegial Intervention – The Medical Staff encourages the use of progressive steps by Medical Staff leaders and Hospital administration, beginning with collegial and educational efforts to address questions relating to a Medical Staff Member's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions on the part of the affected Medical Staff Member. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders. Collegial intervention does not apply when there is a concern for imminent risk to patient safety or disruption of Hospital operations.

7.3 Purpose – The purpose of this Article is to provide the Medical Staff with processes for investigating and addressing actions that may be contrary to the promotion of a safe, cooperative, professional environment and the best possible patient care. All actions taken under this Article are intended to be protected by applicable federal and state law. Under no circumstances shall these Bylaws, or the disciplinary process discussed herein, create a contractual relationship between a Medical Staff Member and the Medical Staff or the Hospital.

7.4 Definitions

7.4.1 Disciplinary Action – The term "disciplinary action" shall mean an educational, administrative, or other form of action commenced under these Bylaws for the purposes of:

(a) assisting a Medical Staff Member with the process of attaining an appropriate level of professional performance consistent with these Bylaws;

(b) requiring a Medical Staff Member to maintain professional performance within acceptable standards; or

(c) prohibiting a Medical Staff Member from engaging in conduct or behavior that is, or is perceived to be, disruptive or detrimental to the orderly running of the Hospital or to the safety of patients or others.

7.4.2 Investigation

The term "investigation" shall mean a focused professional peer review conducted by the Medical Staff or Hospital to determine if there is validity to the alleged concern and, if so, whether any action should be taken against a Medical Staff Member's clinical privileges or medical staff appointment. An investigation shall be conducted whenever the conduct or activities of a Medical Staff Member jeopardizes, or may jeopardize, the safety of a patient, visitor, other staff member, or Hospital personnel, or the quality of care provided at the Hospital. An investigation shall also be conducted when the Medical Staff Member's conduct or activities are contrary to these Bylaws or the related manuals, or raises a question regarding his/her competence, judgment, ethics, stability, or ability to work with others in the provision of safe and appropriate patient care and treatment.

7.5 Initial Inquiry

7.5.1 Process

An initial inquiry shall be undertaken when collegial intervention efforts have not resolved an issue or when a serious concern has been raised regarding any Medical Staff Member whose activities or professional conduct are, or are reasonably likely to be, detrimental to patient safety or the delivery of quality patient care, disruptive to Hospital operations, contrary to the Bylaws, below applicable professional standards, or damaging to the medical staff or Hospital reputation.

(a) The issue will be referred to the relevant Department Chair, the President of the Medical Staff, and the Vice President of Medical Affairs and Chief Medical Officer, who shall conduct sufficient inquiry to determine whether the issue raised represents a valid concern and whether an imminent risk to patient safety exists.

(b) If an issue raises a concern of imminent patient safety risk, any of the interventions noted in Section 7.2.2.3 may be undertaken pending completion of the initial inquiry.

(c) The initial inquiry process shall not be construed as a formal investigation.

7.5.2 Determinations and Interventions

(a) No Further Action Warranted – If it is determined that no further action is warranted, the process is concluded. Documentation of the initial inquiry will be maintained as peer review material.

(b) Further Action Warranted – If it is determined that further action is warranted, a written report shall be forwarded to the Medical Executive Committee, or delegated authority under its purview, for further consideration and action. The involved Medical Staff Member will be informed of the report.

(c) Imminent Risk to Patient Safety – If it is determined that further action is warranted, the individual(s) who conducted the initial inquiry must also determine whether concern for imminent risk to patient safety exists. If such concern exists, the Hospital President, the Vice President of Medical Affairs and Chief Medical Officer, the President of the Medical Staff, and the respective Department Chair shall discuss the patient safety implications of the reported event or concern. Provided that three of the four agree, one of the following

interventions shall be undertaken to temporarily remove the practitioner from practice pending a formal investigation:

(i) Voluntary Restriction of Practice – Under appropriate circumstances, Medical Staff Members may be given an opportunity to agree to voluntarily refrain from exercising any or all clinical privileges pending a formal investigation. This voluntary agreement must be documented in writing, indicate consequences for non-compliance, and be forwarded to the physician. Such a voluntary temporary agreement is not an adverse privileging action.

(ii) Administrative Leave – Immediately following notification of an egregious occurrence or sentinel event involving the actions or omissions of a Medical Staff Member, the Medical Staff Member may be placed on administrative leave while the Hospital and/or Medical Staff conducts either an initial inquiry or initiates a formal investigation.

(1) The pause in practice shall not exceed twenty (20) days while additional information is ascertained. The Medical Staff Member will not provide any clinical services at the Hospital during the administrative leave time.

(2) An administrative leave shall only be utilized during the time that the initial inquiry is being conducted or an investigation is initiated to determine what actions or conditions resulted in the event.

(3) If a Medical Staff Member refuses to accept an administrative leave, imposition of a precautionary suspension must be considered.

(4) An administrative leave should not be used as a substitute for a precautionary suspension and deliberations contemplating Administrative Leave shall consider whether an immediate precautionary suspension is required.

(5) A Medical Staff Member does not have the right to a hearing or appeal when an administrative leave is imposed. This action is not an adverse privileging action.

(iii) Precautionary Suspension – When other alternatives are considered to be insufficient to avert imminent danger to the health and/or safety of any individual or to the orderly operations of the hospital, all or any portion of a Medical Staff Member's clinical privileges may be suspended pending the results of an initial inquiry or formal investigation. Such precautionary suspension shall be deemed an interim precautionary step during a professional review activity.

(1) The action shall not imply any final finding of responsibility for the situation that caused the suspension.

(2) A precautionary suspension shall not entitle the physician to a hearing or appeal as it is a preliminary step to protect patients, while the matter is investigated.

(iv) Administrative leaves and precautionary suspensions shall become effective immediately upon imposition.

(1) The Hospital President, or designee, shall immediately communicate the action to the Medical Staff Member and provide written notification within five (5) days of initiation.

(2) The administrative leave or precautionary suspension shall remain in effect until the concern for patient safety is resolved or until definitive action is taken. Hospital staff will be informed of the action in accordance with standard clinical privilege reporting processes.

(3) Immediately upon the imposition of an administrative leave or precautionary suspension, the appropriate Department Chair or, if unavailable, the President of the Medical Staff, shall assign to another individual with appropriate clinical privileges the responsibility for care of the affected individual's hospital associated patients who may be impacted by the action and any other clinical service that the affected individual provides at the Hospital. The assignment shall be effective until such time as the patients are discharged, their care is completed, or the Medical Staff Member is reinstated. The wishes of the patient shall be considered in the selection of the assigned appointee.

7.6 Investigation – Whenever an initial inquiry determines that further action is warranted, the issue is referred to the Medical Executive Committee, or delegated authority under its purview, for further consideration and action.

7.6.1 Initial Determination – The Medical Executive Committee, or delegated authority under its purview, shall either act on the request without further investigation or direct that a formal investigation be undertaken. The Medical Executive Committee may conduct the investigation itself or may assign this task to an Officer of the Medical Staff, a standing or ad hoc committee, or a designated Medical Staff Member.

(a) The following individuals will not be involved in the investigative process: the Chair of any department in which the Medical Staff Member has an appointment and/or clinical privileges, anyone who has reported the concern for investigation, anyone involved in the situation to be investigated, and anyone who has an overt conflict of interest as determined by the Medical Executive Committee.

(b) The President of the Medical Staff shall immediately communicate the initiation of the investigation to the Medical Staff Member and provide written notification within five (5) days of initiation. Unless the Medical Staff Member has voluntarily agreed not to exercise clinical privileges or is under an administrative leave or precautionary suspension, the Member's clinical privileges remain intact during the investigation.

7.6.2 Process – The investigative process shall be initiated within ten (10) days of assignment and shall be completed within sixty (60) days of initiation.

(a) The process may include a conference with the involved Medical Staff Member, with the individual or group making the request, and with other individuals who may have knowledge of the circumstances/events involved.

(b) The Medical Staff Member shall not have legal counsel participate in the investigative process.

(c) 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 investigation is assigned. The report shall include a determination of whether the concern is founded or unfounded, and if determined to be founded, shall recommend the preferred corrective action.

(d) The Medical Executive Committee has the discretion to terminate the investigative process at any time and proceed with action as provided below.

(e) 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 external consultants as deemed necessary.

(i) As part of the investigation, the Medical Executive Committee or other investigating group or individual may require the Medical Staff Member to undergo an impartial physical or behavioral health evaluation within a specified time and pursuant to the guidelines set forth below.

(ii) The practitioner(s) who will conduct the examination(s) shall be named by the Medical Executive Committee or the investigating group or individual.

(iii) Fees for the requested evaluation(s) shall be paid by the Hospital.

7.6.3 **Non-compliance with the Investigation** – Failure of the Medical Staff Member to comply with the request, or failure to cooperate with any other aspect of the investigation, without good cause, shall result in immediate suspension of the Medical Staff Member's staff appointment and all clinical privileges until the clinical evaluation is obtained, the results are reported to the investigating group or individual, and/or the Board takes final action on the matter under investigation.

7.6.4 **Extension of Investigation** – If the investigation is not completed within 60 days of initiation, the investigating individual or group shall present a status report to the Medical Executive Committee. The report will be presented at a regularly scheduled, or specially convened, Medical Executive Committee meeting within 10 days of the conclusion of the 60 day period. The Medical Executive Committee will reevaluate the information and determine the need for continued action. The involved Medical Staff Member will be notified if an extension is granted.

7.6.5 **Review of Investigation Results** – The Medical Executive Committee shall consider the results and recommendations of the completed investigation at the next regularly scheduled, or specially convened, Medical Executive Committee meeting after the investigative report is available.

(a) If the Medical Executive Committee did not conduct the investigation, an investigation team member shall present the report.

(b) The Medical Executive Committee shall have the option to

(i) accept the recommendation(s),

(ii) modify the recommendation(s), or

(iii) request/conduct further investigation.

(c) The Medical Staff Member shall not have legal counsel participate in the Medical Executive Committee peer review process.

7.7 Medical Executive Committee Interventions

7.7.1 Medical Executive Committee Options – As soon as practicable after the conclusion of the investigative process, if any, but in any event within six (6) months after receipt of the request for further investigation or intervention, the Medical Executive Committee shall act upon the matter. Its action may include, without limitation, recommending:

(a) No further action or intervention;

(b) A verbal warning or admonition;

(c) A formal letter of reprimand;

(d) Additional education and/or training;

(e) Individual medical/psychiatric treatment, including referral to the Rhode Island Medical Society Physician Health Committee;

(f) 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;

(g) Suspension of appointment prerogatives that do not affect clinical privileges;

(h) A requirement of concurrent consultation, up to and including, direct supervision as part of a performance improvement plan;

(i) A consultation requirement to obtain permission to render treatment, with or without direct supervision component;

(j) Reduction, suspension or revocation of all or any part of the member's clinical privileges;

(k) Suspension or revocation of Staff appointment.

7.7.2 Medical Executive Committee Actions: Non-adverse Interventions – The Medical Executive Committee can, without Board approval, execute options (a) through (h) in Section 7.4.1, which are not considered to be adverse actions. If the Medical Executive Committee opts to pursue one or more of these interventions, the President of the Medical

Staff shall send written notice to the Medical Staff Member of the intervention(s) taken within five (5) days. The notice shall include the following information:

(a) That a professional review of a complaint or external action was completed;

(b) The final action of the Medical Executive Committee and the reasons therefore;

(c) The actions expected from the Medical Staff Member, including specific stipulations; and

(d) If applicable, notice that the Medical Staff Member may appeal the final Medical Executive Committee action to the Board as follows:

i. A written appeal must be submitted to the Board via the Hospital President within ten (10) days of the date that the Medical Staff Member receives notification of the final action taken by the Medical Executive Committee.

ii. If the Medical Staff Member does not submit a written appeal of the Medical Executive Committee decision within ten (10) days of notification, then the Medical Staff Member shall be deemed to have waived his/her right to appeal and the action taken by the Medical Executive Committee shall become final.

7.7.3 <u>Medical Executive Committee Actions: Adverse Interventions</u> – Recommendations for options (i), (j), and (k) in Section 7.4.1 are considered to be adverse actions and must be forwarded to the Board for consideration and final action. If the Medical Executive Committee opts to pursue one of these interventions, the President of the Medical Staff shall send written notice to the Medical Staff Member within five (5) days indicating the intervention being recommended to the Board. The notice shall include the following information:

(a) That a professional review of a complaint or external action was completed;

(b) The statement of charges, the final recommendation of the Medical Executive Committee, and the grounds for the recommended action; and

(c) The procedural rights delineated in Article VIII.

Procedures to be followed when the Medical Executive Committee recommends an adverse action and the Medical Staff Member requests a Hearing are delineated in Article VIII.

7.8 <u>Board Action</u>

7.8.1 Following receipt of a written Medical Staff Member appeal of a non-adverse intervention by the Medical Executive Committee or an adverse action recommendation from the Medical Executive Committee when the involved Medical Staff Member has waived procedural rights, the Board shall take action on that recommendation at the Board's next regularly scheduled, or specially convened, meeting.

(a) The Board shall direct that written notice of the action be provided to the Medical Staff Member in a timely manner with a copy to the President of the Medical Staff.

(b) The President of the Medical Staff shall report the Board's action to the Medical Executive Committee at the Medical Executive Committee's next regularly scheduled meeting.

7.8.2 If the Board action is more adverse than the Medical Executive Committee recommended action, the Medical Staff Member shall be entitled to appeal the decision to the Board. The written appeal to the Board must be made within ten (10) days of the date that the Medical Staff Member receives notification of the action taken by the Board. If the Medical Staff Member does not submit a written appeal within ten (10) days of receiving the notice, then the Medical Staff Member shall be deemed to have waived his/her right to appeal and the action taken by the Board shall become final.

7.9 **Appellate Review Request** – The Medical Staff Member shall provide a written, substantive description of the evidence he/she wishes to have considered by the Board and may request to appear before the Board in advance of its review. The Board, in its discretion, may or may not grant the Medical Staff Member's request to appear before the Board or may require the Medical Staff Member to appear before the Board.

7.10 **Final Action of the Board** – Upon completion of its review, the Board shall take final action, which shall become effective immediately.

7.10.1 The Board shall immediately communicate the final action to the Medical Staff Member and provide written notification of the final action by Special Notice within five (5) days of initiation of the final action and copy the President of the Medical Staff.

7.10.2 The notification shall state the reasons for the action taken.

7.10.3 The President of the Medical Staff shall report the Board's final action to the Medical Executive Committee at the Medical Executive Committee's next regularly scheduled meeting.

7.11 **Automatic Suspension**

7.11.1 **Medical Staff Response** – Certain circumstances, as delineated in this section, may result in an automatic suspension of a Medical Staff Member's staff appointment and/or clinical privileges.

(a) When an automatic suspension is imposed, the Medical Staff Member does not have the right to a hearing or appeal.

(b) Immediately upon the imposition of an automatic suspension, the appropriate Department Chair or, if unavailable, the President of the Medical Staff, shall assign to another individual with appropriate clinical privileges the responsibility for care of the suspended individual's hospital associated patients that may be affected by the action and any other clinical service that the affected individual provides at the Hospital. The assignment shall be effective until such time as the patients are discharged, their care is completed, or the suspension is rescinded. The wishes of the patient shall be considered in the selection of the assigned Medical Staff Member coverage.

7.11.2 **Governmental or Other External Agency Action**

(a) Any action by any governmental authority or other entity affecting and/or restricting a Medical Staff Member's ability to practice, including but not limited to,

(i) Revocation, suspension or involuntary relinquishing of, individual lapse of, or expiration of that Member's

(1) Professional license;

(2) Professional liability insurance;

(3) Medicare or Medicaid certification;

(ii) Revocation, suspension, or involuntary relinquishment of DEA authorization; or

(iii) Suspension, revocation, or restriction of medical staff membership and/or clinical privileges at any other hospital or health care institution for other than minor administrative reasons;

shall result in the imposition of an automatic suspension of the Medical Staff Member's appointment and clinical privileges.

(b) The automatic suspension is effective immediately upon the Hospital's receipt of notification of the sanction.

(c) The Hospital President, or designee, shall immediately communicate the action to the Medical Staff Member and provide written notification by Special Notice, with copy to the President of the Medical Staff, within five (5) days of imposition of the suspension, stating the reasons therefore.

(d) Depending on the circumstance, the Medical Executive Committee may consider whether additional investigation of the circumstances surrounding the events leading to the automatic suspension is warranted. The investigative process shall follow Sections 7.6 through 7.8.

7.11.3 **Change in Circumstances** – When the Medical Staff Member can show that the reasons for the automatic suspension either no longer exist or are no longer applicable, the Member may request in writing that the Medical Executive Committee, or delegated authority under its purview, review the automatic suspension at its next regularly scheduled, or specially convened, meeting.

(a) The Medical Staff Member must provide the Medical Executive Committee with appropriate documentation to confirm the changed circumstances in advance of the meeting.

(b) The Medical Executive Committee, after review of such documentation, and, if applicable, a report from the delegated authority under its purview, may conclude or continue the suspension.

(c) The President of the Medical Staff shall notify the Medical Staff Member of the Medical Executive Committee's decision and the reasons therefore by Special Notice within five (5) days.

7.11.4 **<u>Continuation of Suspension</u> –** If the suspension is continued, the Medical Staff Member's appointment and/or privileges shall remain suspended until a final action is rendered.

(a) If the suspension is concluded, the Medical Executive Committee shall reinstate the Medical Staff Member's appointment and/or privileges, either in full or with conditions.

(b) If the Medical Staff Member's appointment ends while the sanction and suspension are in place, the Medical Staff Member shall be required to reapply for appointment once the sanction has been lifted.

7.11.5 **<u>Mandatory Reporting Requirements</u>** – A Medical Staff Member, or an applicant to the Medical Staff, must immediately notify the respective Department Chair and Vice President of Medical Affairs and Chief Medical Officer or Medical Staff Services Office of the following:

(a) Revocation or suspension of any professional licenses in any state;

(b) Revocation, suspension, or exclusion from Medicare or Medicaid participation;

(c) Revocation or suspension of Drug Enforcement Agency ("DEA") authorization;

(d) Lapse or any loss of required Board Certification;

(e) The imposition of a probation or limitation on his/her practice of medicine by any federal or state agency;

(f) Involuntary loss of, or restriction on, staff membership and/or privileges at any other hospital or health care institution for other than minor administrative reasons;

(g) Issuance of a specification of charges of unprofessional conduct by any Board of Medical Licensure and Discipline or the filing of charges by the United States Department of Health and Human Services or Department of Justice;

(h) Termination, suspension or revocation of professional liability insurance, and/or knowledge of his/her professional liability insurer's insolvency, bankruptcy, or liquidation; and

(i) Judgment in a professional liability action against the Medical Staff Member or applicant.

Failure of the Medical Staff Member to notify the aforementioned individuals of any of the above may result in the immediate revocation of the Medical Staff Member's appointment and privileges or other such action as may be determined by the Medical Executive Committee.

7.11.6 **<u>Felony Conviction</u> –** An automatic suspension shall be imposed if a Medical Staff Member is convicted of a felony in any federal or state court in the United States. The automatic suspension is effective immediately upon imposition and the Medical Staff Member's staff appointment and clinical privileges are terminated.

7.11.7 **Medical Staff or Hospital Administrative Policy** –Additional circumstances that result in an automatic suspension of a Medical Staff Member's appointment or clinical privileges may be stipulated in the Rules and Regulations, or other medical staff or Hospital policies.

(a) Such suspension shall remain in effect until the situation is remedied.

(b) If the situation is not remedied within three (3) months, the Medical Staff Member may be subject to additional disciplinary action, up to and including the initiation of disciplinary proceedings.

ARTICLE EIGHT: DUE PROCESS: HEARINGS AND APPEALS

8.1 Right to Hearing

8.1.1 **Actions Prompting a Right to a Hearing** – A Medical Staff Member or applicant to the Medical Staff who receives notice of an adverse decision by the Board under Article III or of an adverse recommended action by the Medical Executive Committee under Article VII that will result in any of the following actions shall be entitled to a hearing regarding the matter:

(a) Denial of initial appointment to the medical staff;

(b) Denial of reappointment to the medical staff;

(c) Denial of requested clinical privileges (except for failure to meet specific departmental privileging criteria);

(d) Suspension of medical staff membership (except for automatic and precautionary suspensions);

(e) Revocation of medical staff membership (except when related to automatic suspension outcomes such as a felony conviction);

(f) Suspension of clinical privileges (except for temporary and disaster privileges);

(g) Involuntary revocation, reduction or limitation of clinical privileges (except for temporary and disaster privileges);

(h) An individually imposed consultation requirement to obtain permission to render treatment, with or without a direct supervision component; and

(i) Special limitation on the right to admit patients.

8.1.2 **Appeal Process Limitations** – The Medical Staff Member or applicant shall pursue the procedural rights afforded in this Article before resorting to any legal action. Each Medical Staff Member or applicant shall be entitled to only one hearing at the Hearing Committee level and one appeal at the Board level for each adverse decision by the Board or adverse recommended action by the Medical Executive Committee. All actions taken under this Article are intended to be protected by applicable federal and state law.

8.2 Exclusions to Right to Hearing or Appellate Review

8.2.1 **Contract/Employment Related Circumstances** – A Medical Staff Member or applicant to the Medical Staff shall not be entitled to a hearing or appellate review under the following contract/employment related circumstances:

(a) Termination of the Medical Staff Member's individual contract with, or employment by, an entity that has an exclusive contract for that specialty's clinical services at the Hospital;

(b) Termination of the Medical Staff Member's individual contract with, or employment by, the Hospital when the specialty services are exclusively rendered under an employed relationship;

(c) Termination of the Staff Member's employer, corporation, or partnership's exclusive contract with the Hospital; or

(d) Removal of a Medical Staff Member from a medico-administrative office within the Hospital, unless a contract or employment agreement provides otherwise.

8.2.2 **Staff Appointment/Clinical Privileges Related Circumstances** – A Medical Staff Member or applicant to the Medical Staff shall not be entitled to a hearing or appellate review under the following Medical Staff appointment/clinical privileges related circumstances:

(a) Imposition of a monitoring or consultation requirement as a condition attached to the exercise of clinical privileges during a provisional period;

(b) An individually imposed requirement of concurrent consultation, up to and including, direct supervision as part of a performance improvement plan;

(c) Denial of appointment or reappointment, or suspension or revocation of membership, because of a material misstatement or omission on an application or on a request for modification of status or privileges; or

(d) Any other administrative action or recommended action not listed in Section 8.1.1.

8.3 Request for a Hearing

8.3.1 **Process** – If a Medical Staff Member or applicant chooses to request a hearing following any adverse action by the Board or adverse recommended action by the Medical Executive Committee identified in Section 8.1.1,

(a) he/she must notify the President of the Medical Staff in writing, within thirty (30) days of receiving notice of the adverse action or recommended action;.

(b) The President of the Medical Staff, or designee, shall review the request, determine if the action or recommended action meets criteria to entitle the Medical Staff Member to a hearing, and

(c) notify the Medical Staff Member of the determination within five (5) days by Special Notice.

8.3.2 **Waiver of Right to a Hearing –** Failure of the Medical Staff Member to request a hearing within this time-frame shall constitute a waiver of the right to a hearing or appeal, and the action shall become final. The process undertaken when the Medical Staff Member waives hearing rights is delineated in Article VII, Section 7.8.

8.4 Hearing Participants

8.4.1 **Hearing Committee** – If a request for a hearing is granted, it shall be held before a Hearing Committee appointed by the President of the Medical Staff, comprised of not less than three (3) and not more than seven (7) members of the Active Staff, except in the event the affected Medical Staff Member is a member of the Doctoral Staff, in which case the committee shall include member(s) of the Doctoral Staff, and except as noted below.

(a) The President of the Medical Staff shall ensure that no Medical Staff Member who had any involvement in the matter at issue, who may be in direct economic competition with the affected Medical Staff Member, or who may have a conflict of interest in the matter, shall be a member of the Hearing Committee, unless such participation is absolutely essential for the Hearing Committee to make a proper decision.

(b) Medical Staff Members who were designated to conduct the Medical Executive Committee directed investigation discussed in Article VII shall not serve on the Hearing Committee.

(c) The President of the Medical Staff may be one of the Hearing Committee members.

(d) To the extent possible, the Hearing Committee should be comprised of practitioners from diverse practice groups.

(e) Circumstances may warrant appointment of Committee members with pertinent clinical expertise from outside of the medical staff or Hospital to ensure an unbiased due process.

(f) Appointment of members outside of the medical staff or Hospital will be a joint decision made by the President of the Medical Staff and the Hospital President.

(g) In the event that the President of the Medical Staff must recuse him/herself due to a conflict of interest, another Medical Staff Officer shall be designated to fulfill that role.

8.4.2 **Arbitration Alternative –** In the event that the President of the Medical Staff determines that it is not possible to convene a Hearing Committee whose members satisfy the above criteria, the hearing shall be conducted by an appointed arbitrator or hearing officer who is mutually acceptable to the Medical Staff Member, the President of the Medical Staff, and the Hospital President.

8.4.3 **Hearing Committee Chair** – The President of the Medical Staff shall designate one member of the Hearing Committee to serve as Chair. The Hearing Committee Chair shall

(a) maintain decorum and assure that all participants have a reasonable opportunity to present relevant evidence;

(b) determine the order of procedure during the hearing and make all rulings on matters of procedure and the admissibility of evidence, including prohibiting conduct or the presentation of evidence that is cumulative, irrelevant, abusive, or causes undue delay;

(c) not act as a prosecuting officer or as an advocate to any party;

(d) have the opportunity to consult with the Hearing Committee's legal counsel when the Chair believes it is appropriate; and

(e) be entitled to vote.

8.4.4 **Parties** – The parties to a hearing shall be the Medical Staff Member or applicant requesting the hearing (collectively referred to herein as the "Medical Staff Member"), and the body that took the adverse action or determined the adverse recommended action against the Medical Staff Member (collectively referred to herein after as the "Hospital").

8.4.5 **Counsel –** The Medical Staff Member, at his/her own expense, may be represented by counsel at the hearing. The Hospital and the Hearing Committee may each be represented by separate counsel with whom they may confer at the hearing. The Medical Staff Member and the Hospital shall advise the Hearing Committee whether they will be represented by counsel, and the name of counsel, at least ten (10) days prior to the pre-hearing conference.

8.5 Pre-Hearing Matters

8.5.1 Notice

(a) Within fifteen (15) days of the Medical Staff Member having been notified that a hearing was granted,

(i) the Hearing Committee shall convene in order to review the complaint;

(ii) identify a proposed start date for the hearing; and

(iii) issue notice to the Medical Staff Member and other interested parties of the proposed start date.

(b) The proposed start date of the hearing shall not be less than twenty (20) days, nor more than forty (40) days, after the date the Hearing Committee issues its notice.

(c) The Hearing Committee Chair may delay the start date for good cause.

8.5.2 Pre-Hearing Conference

(a) The Committee Chair shall require a representative (who may be legal counsel) for both the Medical Staff Member and the Hospital to participate in a pre-hearing conference.

(b) Counsel for the Hearing Committee shall be present at the pre-hearing conference.

(c) At the pre-hearing conference, the Chair shall review the statement of charges and address all procedural questions, including any objections to exhibits or witnesses and the time to be allotted to each witness's testimony and cross-examination.

(d) The parties shall agree upon the scope of issues to be addressed at the hearing, so as to provide for orderly and efficient proceedings.

8.5.3 **Exchange of Documentation and Witness Lists –** At least ten (10) days prior to the start of the hearing, the Hospital and the Medical Staff Member shall exchange documentation and witness lists.

(a) The parties shall do so by providing two (2) copies of the documents set forth below to the Hearing Committee Chair.

(i) The Hospital shall provide:

(1) The documentation that it will present at the hearing;

(2) A list of witnesses who will appear on its behalf; and

(3) All documents relating to the complaint and the investigation thereof.

(ii) The Medical Staff Member shall provide:

(1) The documentation that he/she will present at the hearing; and

(2) A list of witnesses who will appear on his/her behalf.

(iii) Neither party shall be entitled to introduce the individual peer review records of any other physician.

(b) The Hearing Committee Chair shall retain one copy of each set of documents for the Hearing Committee's review and reference and forward one copy of each set of documents to the other party.

(c) Neither party shall have a right to the other party's documents and/or witness list unless it has timely forwarded its own documentation and list to the Hearing Committee Chair.

(d) If the documents and/or witness lists are not timely delivered to the Hearing Committee Chair, then the documents cannot be used, nor the listed witnesses called.

(e) The exchange of this documentation is not intended to waive any privilege under the state peer review protection statute.

8.5.4 **Conduct Regarding Identified Witnesses –** Once a party has identified a witness, the other party or their counsel shall not be entitled to speak to that witness about this matter outside of questioning before the Hearing Committee. In the event that both parties identify the same witness, neither party nor their counsel shall be entitled to speak to that witness about this matter outside of any questioning before the Hearing Committee.

8.6 Conduct of Hearing

8.6.1 Timing

(a) The Hearing Committee shall determine the date, time, and place of each additional hearing session required after the set start date, and shall provide reasonable notice to all interested parties.

(b) The hearing shall conclude within sixty (60) days of commencement, unless extended by mutual agreement of the Hospital, the Medical Staff Member, and the Hearing Committee Chair.

8.6.2 Attendance

(a) Parties – Attendance at hearing sessions shall be limited to

(i) the Hearing Committee,

(ii) the involved Medical Staff Member,

(iii) counsel for the interested parties, and

(iv) the transcriber/recorder.

(b) Witnesses – Witnesses for the Hospital and the Medical Staff Member will only be present at the hearing when testifying.

(c) Excused Absence – Every member of the Hearing Committee must be present throughout the hearing and deliberations unless excused for good cause by the Hearing Committee Chair. If a member is excused from any portion of the proceedings, then that member shall not be permitted to participate in the deliberations unless and until the member reads the entire transcript of the portion of the hearing for which he/she was excused.

(d) Unexcused Absence – Provided proper notice has been given, the Medical Staff Member's failure to attend any hearing session discussed in this Article, disciplinary, appellate, or otherwise, shall constitute a waiver of the Medical Staff Member's right to a hearing and/or to continue an ongoing hearing, unless the Hearing Committee shall conclude that such absence was beyond the Medical Staff Member's reasonable control.

8.6.3 Rights of Parties

(a) The Medical Staff Member and the Hospital, in accordance with the hearing procedures adopted by the Hearing Committee, shall be entitled to

(i) present witnesses,

(ii) cross-examine witnesses,

(iii) impeach witnesses,

(iv) introduce exhibits, and

(v) rebut any evidence.

(b) Prior to, or during the hearing, the parties shall be entitled to submit memoranda concerning any issue of law or fact, and those memoranda shall become part of the hearing record.

(c) Written memoranda, if any, must be presented to the Hearing Committee Chair and a copy must be provided to the other party.

(d) The Medical Staff Member and the Hospital shall also be entitled to make an oral closing argument at the completion of the hearing and to present a written statement to the Hearing Committee within five (5) days of the completion of the hearing. If a party chooses to present a written statement, the party must advise the Hearing Committee upon completion of the hearing process that such a statement will be submitted.

8.6.4 **Rights of Counsel** – All counsel representing parties at the hearing shall act in accordance with procedures outlined in this Article and as may be determined by the Hearing Committee Chair. Counsel shall be entitled to participate in the elements delineated in Section 8.6.3 and to object to the admission of evidence or matters of procedure. The Hearing Committee Chair shall rule on all such objections.

8.6.5 **Rights of Hearing Committee** – The Hearing Committee shall have the right to request the testimony of a witness who has not been identified and to request any documents not identified, should the Committee believe that it would benefit from such witnesses or documents. The Committee shall also have the right to review the Medical Staff Member's appointment history and to question any witnesses called.

8.6.6 **Burden of Proof**

(a) Hearing Issue Relating to Appointment or Privileges – If the hearing pertains to an initial application for appointment or privileges, the applicant shall have the burden of proof to demonstrate by clear and convincing evidence, that the adverse action or recommended action lacks substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.

(b) Hearing Issue Related to Other Matters – In all other circumstances, the Hospital shall present the evidence in support of the adverse action or recommended action. Thereafter, the Medical Staff Member shall have the burden of proof to demonstrate by the preponderance of the evidence, that the adverse action or recommended action lacks substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.

8.6.7 **Admissibility of Evidence** – The admissibility of evidence is at the discretion of the Hearing Committee Chair regardless of the existence of any common law or statute which might make such evidence inadmissible in civil or criminal actions.

8.6.8 **Recording of Hearing** – A record of each hearing session shall be kept by a certified stenographer or court reporter retained by Hospital Administration.

(a) Those giving testimony shall be sworn under oath by the certified stenographer or court reporter.

(b) The Medical Staff Member may obtain a transcript of the proceedings at his/her own expense.

8.6.9 **Recess and Adjournment**

(a) The Hearing Committee may recess and reconvene the hearing, without notice, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

(b) Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned.

(c) The Hearing Committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

8.7 Final Decision Following a Hearing

8.7.1 Recommendation of the Hearing Committee – Within thirty (30) days after completion of the hearing (or after the filing of written statements), the Hearing Committee shall render its recommendation as to whether to affirm, reverse, or modify the original adverse action or recommended action.

(a) The recommendation shall be made in a written report which shall include the procedural history with statement of charges, the scope of the evidence, a summary of the Hearing Committee's findings, and the basis for the recommendation.

(b) The recommendation shall be the result of a majority vote by the Hearing Committee members, for which no members may vote by proxy.

(c) All members of the Hearing Committee shall sign the written report.

(d) If a majority decision is not possible, that outcome should be reported and a new hearing must be convened with a newly appointed Hearing Committee.

(e) The Hearing Committee shall forward its written report to the Medical Executive Committee.

8.7.2 Review by Medical Executive Committee – The Medical Executive Committee shall review the Hearing Committee’s written report at its next regularly scheduled, or specially convened, meeting. The Medical Executive Committee shall forward the Hearing Committee’s recommendation and written report to the Board for action.

8.7.3 Board Action

(a) Following receipt of the Hearing Committee’s recommendation and written report, the Board shall deliberate the matter at its next regularly scheduled, or specially convened, meeting and take action.

(b) Within five (5) days of that meeting, the Board shall direct that written notice of the action be provided to the Medical Staff Member by Special Notice with a copy to the President of the Medical Staff.

(c) The notification shall state the reasons for the action taken and shall advise the Medical Staff Member of his/her right to appeal the action directly to the Board.

(d) The President of the Medical Staff shall report the Board's action to the Medical Executive Committee at the Medical Executive Committee's next regularly scheduled meeting.

8.8 Appellate Review

8.8.1 Appeal to the Board – The Medical Staff Member shall have the right to appeal the Board's action by submitting a written appeal to the Board.

(a) Such appeal must be made within ten (10) days of the date that the Medical Staff Member receives notification of the action taken by the Board.

(b) If the Medical Staff Member does not submit a written appeal within ten (10) days of receiving the notice, then the Medical Staff Member shall be deemed to have waived his/her right to appeal and the action taken by the Board shall become final.

8.8.2 Admission of Evidence – The Medical Staff Member shall provide a written, substantive description of the evidence he/she wishes to have considered by the Board and may request to appear before the Board in advance of its review.

(a) New or additional matters or evidence not raised or presented to the Hearing Committee may be introduced during appellate review only at the discretion of the Board, and only if the parties demonstrate to the satisfaction of the Board that the information could not have been discovered in time for the initial hearing or was not deemed to be admissible by the Hearing Committee.

(b) Any such new or additional matters or evidence shall be subject to the same rights of cross-examination, impeachment, and rebuttal as provided for during the initial hearing.

(c) The Board, in its discretion, may or may not grant the Medical Staff Member's request to appear before the Board or may require the Medical Staff Member to appear before the Board.

8.8.3 Powers of the Board – The Board shall have all of the powers granted to the Hearing Committee, and any additional powers that are reasonably necessary for the discharge of its responsibilities.

8.8.4 Final Action –Upon completion of its review, the Board shall take final action, which shall become effective immediately.

(a) The Board shall immediately communicate the final action to the Medical Staff Member and provide written notification of the final action by Special Notice within five (5) days of initiation of the final action and copy the President of the Medical Staff. The notification shall state the reasons for the action taken.

(b) The President of the Medical Staff shall report the Board's final action to the Medical Executive Committee at the Medical Executive Committee's next regularly scheduled meeting.

8.9 Status of Clinical Privileges During Hearing and Appellate Review

8.9.1 The privileges of the involved Medical Staff Member will remain in effect during any hearing and/or appeal unless the Medical Staff Member is subject to a suspension. A

Medical Staff Member whose privileges remain in effect during any hearing and/or appeal process is eligible for reappointment when due.

8.9.2 A Medical Staff Member subject to a suspension during any hearing and/or appeal process is not eligible to apply for reappointment while under suspension. The Medical Staff Member's eligibility to reapply for staff appointment shall be addressed after final action is taken by the Board.

8.10 No Effect on Board's Authority

This Article shall not be interpreted in any way to affect the Board's authority to impose disciplinary action on any Medical Staff Member, but even in such circumstances, the Medical Staff Member's due process hearing rights, as discussed herein, shall be applicable.

ARTICLE NINE: ALLIED HEALTH PROFESSIONALS

9.1 Overview of Allied Health Professionals

9.1.1 General Description – Allied Health Professionals shall include designated independent and non-independent health care professionals who are qualified by formal training, licensure, and current competence in a health care discipline which the Board of Trustees has approved for practice within the Hospital's scope of services. Individuals in this category are not considered to be members of the Medical Staff and not eligible for Medical Staff membership.

9.1.2 Eligible Practitioners – The specific disciplines approved by the Board of Trustees for inclusion in this category are delineated in the Credentialing Procedures Manual. The Chairs of the various Departments shall recommend eligible health care professionals to the Board of Trustees for consideration and approval consistent with the Hospital's scope of services.

9.1.3 Prerogatives – Allied Health Professionals:

(a) Are not eligible to vote at Medical Staff meetings or hold office on the Medical Staff;

(b) Are eligible to serve on Medical Staff committees and vote on matters before such committees;

(c) Are not required to pay Medical Staff dues; and

(d) May be eligible to attend annual, regular, and special meetings of the Medical Staff and their assigned Department as determined by the individual(s) convening the meeting.

9.1.4 Department Assignment – Such individuals shall be assigned to one of the Departments of the Medical Staff even though they are not considered members of the Medical Staff.

9.1.5 Applicability of the Bylaws – The provisions of these Bylaws and related manuals shall apply to the Allied Health Professionals including the basic obligations and the provisions relating to hearings, appeals and appellate review.

9.2 **Privileges** – The scope of practice or clinical privileges of Allied Health Professionals shall be determined by the appropriate Chair of the Department and forwarded through the Credentials Committee and Medical Executive Committee for final approval by the Board of Trustees.

9.2.1 **Application Process** – Applications for Hospital affiliation by Allied Health Professionals will be considered in accordance with the Medical Staff credentialing process outlined in Article III with education, training, and certification requirements modified as pertinent to the applicant's profession.

9.2.2 **Scope of Practice** – The extent of an individual Allied Health Professional's scope of practice or clinical privileges shall be set forth in the terms of his/her appointment or reappointment.

(a) Certain Allied Health Professionals are authorized to conduct medical screening examinations as defined under federal law, delineated in the Rules and Regulations, and defined in the individual's clinical privileges or scope of practice.

(b) Notwithstanding the apparent scope of practice permitted to any group of Allied Health Professionals under Rhode Island law or licensure, the scope of practice authorized by the Hospital may be limited as deemed necessary by the Board of Trustees.

(c) Detailed requirements related to Allied Health Professionals' practice are delineated in the Credentialing Procedures Manual.

ARTICLE TEN: AMENDMENTS

10.1 **Core Bylaws Provisions** – The following Articles shall be considered the "Core Provisions" of these Bylaws: Article II (Medical Staff Categories); Article III (Medical Staff Appointment); Article VII (Conduct of the Medical Staff; Investigation and Intervention); Article VIII (Due Process: Hearings and Appeals); Article IX (Allied Health Professionals); and Article X (Amendments). The Core Provisions are intended to be adopted by all affiliates and shall be amended in the following manner:

10.2 **System-wide Bylaws Review Committee (SBRC)** – The System-wide Bylaws Review Committee is a standing committee that meets on an ad hoc basis to consider proposed core Bylaws Amendments.

10.2.1 **Membership** – The membership shall be comprised of two (2) Medical Staff Members from Bradley Hospital and three (3) Medical Staff Members from each of the other affiliate hospitals.

(a) Appointment to the System-wide Bylaws Review Committee shall be for a two (2) year term by a nomination and approval process conducted by the hospital's Medical Executive Committee.

(b) Each affiliate's System-wide Bylaws Review Committee representation shall include the current President of the Medical Staff (or other Medical Executive Committee designee), the Bylaws Committee Chair (or other Committee representative), and the remaining seats(s) will be open to an additional Active Staff or Doctoral Staff Member.

(c) The Chief Medical Officers at each affiliate will be non-voting members providing direct support to the Committee.

10.2.2 **Quorum and Vote** – The System-wide Bylaws Review Committee quorum shall consist of at least one voting member representative from each affiliate. Action on a proposed Amendment, whether approval or denial, shall be by simple majority vote.

10.3 **Amendment Process** – The Core Provisions are intended to be adopted by all affiliates and shall be amended in the manner outlined below.

10.3.1 **Amendment Proposal at Affiliate Level** – A Medical Staff Member or group of Medical Staff Members may present a request for an amendment to the Medical Executive Committee for consideration at a regularly scheduled, or specially convened, meeting.

(a) The Medical Executive Committee shall consider the request and if met with approval, shall direct the request to the Bylaws Committee.

(b) The Bylaws Committee shall develop the proposed amendment language in conjunction with the submitting Medical Staff Member(s) and submit a draft provision to the Medical Executive Committee for approval.

(c) If approved, the Medical Executive Committee shall then submit the proposed drafted Amendment in writing to the System-wide Bylaws Review Committee for consideration and review.

(d) If the Medical Executive Committee denies the requested change and the Medical Staff disagrees with the action, the Medical Staff may request that the Medical Executive Committee reconsider its action or the Medical Staff may exercise its option to appeal directly to the Board.

10.3.2 **SBRC Review and Deliberation Process** – The System-wide Bylaws Review Committee shall distribute the proposed drafted Amendment to its members and schedule a meeting to determine if the proposal warrants consideration by the Medical Staffs at all affiliate hospitals.

(a) In its deliberation, the System-wide Bylaws Review Committee may:

(i) accept the language as drafted and approve for presentation back to the originating Medical Executive Committee and to the other affiliate Medical Executive Committees;

(ii) modify the language and approve it for presentation back to the originating Medical Executive Committee and to the other affiliate Medical Executive Committees; or,

(iii) reject the proposed Amendment on the basis of its findings following deliberation.

(b) The System-wide Bylaws Review Committee review process shall be completed within 60 days of draft proposal receipt.

(c) Proposed Amendments receiving System-wide Bylaws Review Committee approval shall be sent to the affiliate Medical Executive Committees with a summary report prepared by the System-wide Bylaws Review Committee introducing the proposed

Amendment, identifying the issues raised by existing core Bylaws language and the manner in which these issues are addressed by the proposed Amendment.

(d) If the proposed drafted Amendment is rejected, the System-wide Bylaws Review Committee shall prepare a summary report outlining the basis for denial and forward to the originating Medical Executive Committee with the proposed drafted Amendment language. The originating Medical Executive Committee shall have the opportunity to direct its Bylaws Committee to revise the proposed language and resubmit it for an additional round of consideration by the System-wide Bylaws Review Committee.

10.3.3 **Amendment Proposal Generated by the System-wide Bylaws Review Committee –** The members of the System-wide Bylaws Review Committee may generate proposed Amendments for System-wide Bylaws Review Committee consideration. The System-wide Bylaws Review Committee reviews the proposed Amendment, and if approved by simple majority vote, forwards it to the affiliate Medical Executive Committees with a summary report for consideration as outlined previously.

10.3.4 **Medical Executive Committee Consideration of a System-wide Bylaws Review Committee Approved Amendment –** Following deliberation and approval by the System-wide Bylaws Review Committee, the proposed Amendment shall be presented at each affiliate Medical Executive Committee.

(a) The Medical Executive Committee shall have the opportunity for discussion and determination of approval or denial.

(b) Medical Executive Committee approval or denial shall be accomplished by simple majority vote of those members present at the meeting, assuming a quorum is present.

(c) If any of the affiliate Medical Executive Committees votes to reject the proposed Amendment, the System-wide Bylaws Review Committee has the opportunity to revise the proposed Amendment for reconsideration.

(d) If each affiliate Medical Executive Committee approves the proposed Amendment for consideration by the medical staff, each affiliate has 60 days to present the proposed Amendment to its Medical Staff.

10.3.5 **Medical Staff Review and Deliberation**

(a) When recommended for approval by all affiliate Medical Executive Committees, the Medical Executive Committee shall then submit the proposed Amendment and summary in writing to the Medical Staff for consideration at the next regularly scheduled, or specially convened, Medical Staff meeting.

(i) The meeting notice will include notice that the proposed Amendment will be addressed at the meeting.

(ii) The proposed Amendment and summary report shall be made available to each voting member of the Medical Staff by hard copy, electronic conveyance, or notification of electronic posting on a designated website in advance of the Medical Staff meeting.

(iii) Medical Staff members who are not able to attend the Medical Staff meeting may be afforded an opportunity to submit hard copy or electronic votes regarding the proposed Amendment.

(b) The meeting notice will indicate that votes cast in this manner must be received by the Medical Staff Services Office at least twenty-four (24) hours prior to the meeting. Votes received after that time shall not be considered.

(c) Approval of the proposed Amendment requires two-thirds (2/3) of all votes cast.

10.3.6 **Approval by all Affiliates** – Prior to presenting the proposed Amendment to the Board of Trustees, the Medical Executive Committee must confirm that the medical staffs of all affiliates recommend approval of the proposed Amendment. If a proposed Amendment does not obtain the requisite approval at any of the affiliates, it shall not be submitted to any of the respective Boards for their adoption.

10.3.7 **Amendment Consideration by the Board**

(a) Once the proposed Amendment is recommended for approval at all affiliates, the proposed Amendment language, System-wide Bylaws Review Committee summary report, and voting report shall be presented to the Board of Trustees by the Medical Staff President, or his/her designee, at the Board's next scheduled, or specially convened, meeting. The Board shall take up the recommendation pursuant to its rules and procedures.

(b) If the Board approves the proposed Amendment, ultimate enactment requires approval by all Lifespan affiliate Boards. When approval by all affiliate Boards is confirmed, the Medical Staff President shall report on passage and adoption of the Amendment to the Medical Executive Committee and the Medical Staff.

(c) If the Board rejects the proposed Amendment, the Board will state its reason(s) and will work to reconcile their concern(s) with the Medical Staff.

(i) The differences may be resolved through the conflict management process.

(ii) If the ultimate resolution of the disagreement results in rejection of the proposed Amendment, the proposed Amendment will not be enacted at any affiliate.

10. 4 **Non-Core Bylaws Provisions** – All Bylaws Articles not identified in Section 10.1 shall be considered the "Non-Core Provisions" of these Bylaws. The Non-Core Provisions shall be amended in the following manner:

10.4.1 **Amendment Process** – A Staff Member, or group of Staff Members, may present a request for an amendment to the Medical Executive Committee for consideration at any regularly scheduled, or specially convened, meeting.

(a) The Medical Executive Committee shall consider the request and if met with approval, shall direct the request to the Medical Staff Bylaws Committee.

(b) The Bylaws Committee shall develop the proposed Amendment language in conjunction with the submitting Medical Staff Member(s) and submit a draft provision with a summary report introducing the proposed Amendment, identifying the issues

raised by existing Bylaws language, and the manner in which these issues are addressed by the proposed Amendment.

(c) The proposed Amendment and supporting documentation is then submitted to the Medical Executive Committee for consideration.

(d) If the Medical Executive Committee denies the requested change and the Medical Staff disagrees with the action, the Medical Staff may request that the Medical Executive Committee reconsider its action or the Medical Staff may exercise its option to appeal directly to the Board.

10.4.2 <u>Medical Staff Review and Deliberation</u>

(a) If the Medical Executive Committee recommends the requested change for approval, the Medical Executive Committee shall then submit the proposed Amendment and summary in writing to the Medical Staff for consideration at the next regularly scheduled, or specially convened, Medical Staff meeting.

(i) The meeting notice will include notice that the proposed Amendment will be addressed at the meeting.

(ii) The proposed Amendment and summary report shall be made available to each voting member of the Medical Staff by hard copy, electronic conveyance, or notification of electronic posting on a designated website in advance of the Medical Staff meeting.

(iii) Medical Staff members who are not able to attend the Medical Staff meeting may be afforded an opportunity to submit hard copy or electronic votes regarding the proposed Amendment.

(b) The meeting notice will indicate that votes cast in this manner must be received by the Medical Staff Services Office at least twenty-four (24) hours prior to the meeting. Votes received after that time shall not be considered. Approval of the proposed Amendment requires two-thirds (2/3) of all votes cast.

10.4.3 <u>Amendment Consideration by the Board</u>

(a) If recommended for approval by the Medical Staff, the proposed Amendment language, summary report, and voting report shall be presented to the Board by the Medical Staff President, or his/her designee, at the Board's next scheduled, or specially convened, meeting. The Board shall take up the recommendation pursuant to its rules and procedures.

(b) If the Board rejects the proposed Amendment, the Board will state its reason(s) and will work to reconcile their concern(s) with the medical staff. The differences may be resolved through the conflict management process.

(c) The Medical Staff President shall report on the final outcome of the proposed Amendment to the Medical Executive Committee and the Medical Staff.

10.4.4 <u>Non-Recommendation for Approval by the Medical Staff</u> – If a proposed Amendment is not recommended for approval by the Medical Staff, the interested parties may submit a revised proposal for Amendment based on Medical Staff feedback during the voting

process. Any revised proposal must be submitted to the Bylaws Committee for reconsideration. Denial of the revised proposed Amendment by the Medical Executive Committee defers resubmission/reconsideration on the same matter no sooner than one (1) calendar year following the failed vote.

10.5 Rules and Regulations and Other Bylaws-Related Manuals

10.5.1 **Proposals to Amend** – Proposals to amend the Rules and Regulations and other Bylaws-related manuals are submitted in the same manner as the non-core Bylaws provisions.

(a) Recommendation for approval or denial of proposed Amendments occurs at the Medical Executive Committee by a simple majority vote.

(b) Proposed Amendment denial can occur at the Medical Executive Committee.

(c) Amendments recommended for approval are considered by the Board pursuant to its rules and regulations.

10.5.2 **Approval of Proposed Amendment**

(a) Approval of a proposed Amendment requires a positive recommendation from the Medical Executive Committee that is considered and approved by the Board.

(b) If the Medical Executive Committee approves a proposed Amendment but the Board rejects it, the Board will state its reason(s), and the concern(s) may be resolved through modification and resubmission or through the conflict management process.

10.5.3 **Medical Staff Review**

(a) The Medical Staff President reports Medical Executive Committee denials and final Board decisions to the Medical Staff.

(b) If the Medical Staff disagrees with the Medical Executive Committee action, the Medical Staff may request that the Medical Executive Committee reconsider its action or the Medical Staff may exercise its option to appeal directly to the Board.

(c) If the Medical Staff disagrees with the final Board action, the disagreement may be resolved through the conflict management process.

10.6 Technical and Editorial Amendments

10.6.1 **Modifications and Clarifications by the System-wide Bylaws Review Committee** – The System-wide Bylaws Review Committee shall have the power to adopt such amendments to the core Bylaws that, in its judgment, are technical modifications or clarifications, reorganization of the Bylaws, or amendments made necessary because of errors of grammar, punctuation, or expression.

(a) The affiliate Medical Executive Committees will be notified of the amendments, which shall be effective immediately and shall be permanent.

(b) Such amendments shall be communicated in writing to the Medical Staff and the Board of each affiliate.

10.6.2 **<u>Modifications and Clarifications by the Medical Executive Committee</u>** – The Medical Executive Committee shall have the power to adopt such amendments to the non-core Bylaws and other related manuals that, in its judgment, are technical modifications or clarifications, reorganization of the Bylaws, or amendments made necessary because of errors of grammar, punctuation, or expression.

(a) Such amendments shall be effective immediately and shall be permanent.

(b) The action to amend may be acted upon in the same manner as any other business before the Medical Executive Committee.

(c) After approval, such amendments shall be communicated in writing to the Medical Staff and the Board.

10.6.3 **<u>Clerical Modifications</u>** – Purely clerical modifications such as correction of spelling errors, font consistency items, or renumbering related to formally approved changes to the core or non-core Bylaws and other related manuals can be conducted by administrative support staff outside of the formal approval process as long as the changes do not materially affect the letter or intent of the involved statement.

10.7 **<u>Modifications Required by Statutes and Standards</u>** – Accreditation standards and state and federal statutes and regulations will be reviewed when they are promulgated for changes that require modification of the Bylaws. Core Bylaws modifications initiated by accreditation or regulatory changes may be generated by the System-wide Bylaws Review Committee. Non-core Bylaws and other related manual modifications initiated by accreditation or regulatory changes will be generated by the Medical Executive Committee or Bylaws Committee.

ARTICLE ELEVEN: COLLEGIAL INTERVENTION

11.1 Collegial Intervention

The Bylaws and related manuals encourage the use of progressive steps by Medical Staff leaders and Hospital Administration, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve issues that have been raised.

(a) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

(b) All collegial intervention efforts by Medical Staff leaders and Hospital administration are part of the Hospital's performance improvement and professional and peer review activities.

(c) The relevant Medical Staff leader(s) shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation of collegial efforts is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.

(d) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

(e) The President of the Medical Staff in conjunction with the Hospital President shall determine whether to direct that a matter be handled in accordance with the Policy on Physician Health or the Policy on Disruptive Physicians or referred directly to the Medical Executive Committee for further determination.

ARTICLE TWELVE: GENERAL AND SPECIAL PROVISIONS

12.1 Special Definitions

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

(a) Information means record 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 knowing falsehood or of information with a reckless disregard for whether or not it is true or false.

(c) Representative means the Board of Trustees of the Hospital and any Trustee or committee thereof; the President or designees; registered nurses and other employees of the Hospital; the Medical Staff 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.

(d) Third Parties means both individuals and organizations providing information to any representative.

12.2 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 and efficiency 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 to other health care facilities or organizations 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 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 Medical Staff membership and/or clinical privileges or specified services.

12.3 Immunity from Liability

12.3-1 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 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 the matter as to which he/she acts, and acts in the reasonable belief that the action is warranted by such facts. Every representative shall act with great care and caution and any actions shall be the result of mature judgment and high ethical standards.

12.3-2 <u>For Providing Information</u>

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, 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 matter as to which he/she 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.

12.4 <u>Activities and Information Covered</u>

12.4-1 <u>Activities</u>

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 facility's or organization's activities concerning, but not limited to:

(a) Applications for appointment, 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 review;

(h) Profiles and profile analysis;

(i) Risk management and liability prevention activities;

(j) Other Hospital, committee, department, section, or Medical Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

12.4 -2 <u>Information</u>

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.

12.5 Releases

Each practitioner shall, upon request of the Hospital, complete general and specific releases in accordance with the tenor and import of this Article in favor of the representatives and/or third parties specified in Section 12.1, subject to such requirements, including those of good faith, absence of malice, and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under relevant Rhode Island law.

12.6 Cumulative Effect

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability are in addition to other protections provided by relevant Rhode Island 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.

12.7 Conflicts of Interest

When performing a function outlined in the Bylaws and related manuals or other applicable policy, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest or bias in any matter involving another individual, the individual with a conflict shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may be asked, and may answer, any questions concerning the matter before leaving.

The existence of a potential conflict of interest or bias on the part of any member may be called to the attention of the President of the Medical Staff or applicable Department Chair or Section Chief by any other member with knowledge of it.

The fact that a Department Chair, Section Chief or Medical Staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No Medical Staff Member has a right to compel a determination that a conflict exists.

The fact that a committee member or Medical Staff leader chooses to refrain from participation shall not be interpreted as a finding of actual conflict.

12.8 Construction of Terms and Headings

Words used in these Bylaws and related manuals will be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these Bylaws and related manuals are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws and related manuals.

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Staff on November 26, 2012

/s/ Randall Rosenthal, MD
Randall Rosenthal, MD
President of the Medical Staff
Newport Hospital

Approved by the Board of Trustees on December 10, 2012

/s/ Suzette Schochet
Suzette Schochet
Secretary, Board of Trustees
Newport Hospital

/s/ August B. Cordeiro, FACHE
August B. Cordeiro
President
Newport Hospital