RHODE ISLAND HOSPITAL
PROVIDENCE, RHODE ISLAND

RHODE ISLAND HOSPITAL
MEDICAL STAFF BYLAWS

Adopted:	April 26, 2012
Approved:	June 7, 2012
Implemented:	July 1, 2012

TABLE OF CONTENTS

Section			Page
Preamble			11
Definitions			12
Article I		DESCRIPTION OF THE MEDICAL STAFF	14
Article II		CATEGORIES OF THE STAFF	15
Section 2.1		Overview of Staff Categories	15
	2.1.1	General Description	15
	2.1.2	Basic Obligations	15
	2.1.3	Requests for changes of categories	16
Section 2.2		Active Staff	16
	2.2.1	Defined	16
	2.2.2	Privileges	16
	2.2.3	Prerogatives	16
	2.2.4	Obligations	16
	2.2.5	Senior Active Status	17
Section 2.3		Courtesy Staff	17
	2.3.1	Defined	17
	2.3.2	Privileges	17
	2.3.3	Prerogatives	17
	2.3.4	Obligations	17
Section 2.4		Consulting Staff	18
	2.4.1	Defined	18
	2.4.2	Privileges	18
	2.4.3	Prerogatives	18
Section 2.5		Doctoral Staff	18
	2.5.1	Defined	18
	2.5.2	Privileges	18
	2.5.3	Prerogatives	18
Section 2.6		Associate Staff	19
	2.6.1	Defined	19
	2.6.2	Privileges	19
	2.6.3	Prerogatives	19
Section 2.7		Honorary Staff	19
	2.7.1	Defined	19
	2.7.2	Privileges	19
	2.7.3	Prerogatives	19

Section 2.8		Research Scientists	20
	2.8.1	Defined	20
	2.8.2	Privileges	20
	2.8.3	Prerogatives	20
Article III		MEDICAL STAFF APPOINTMENT	21
Section 3.1		Appointment Not Automatic	21
Section 3.2		Initial Appointment – Qualifications	21
	3.2.1	Education	21
	3.2.2	Licensure	21
	3.2.3	Board Certification and Qualification	22
	3.2.4	Clinical Competence	22
	3.2.5	Duty of Cooperation	22
	3.2.6	Insurance	22
	3.2.7	Required Disclosures	22
	3.2.8	Authorization to Obtain Information	23
	3.2.9	Consideration of Resources	23
	3.2.10	Policy of Non-Discrimination	23
	3.2.11	Discretion of Board	24
Section 3.3		Initial Appointment Procedures	24
	3.3.1	No Contractual Relationship	24
	3.3.2	Timing of Application Review	24
	3.3.3	Pre-Application	24
	3.3.4	Application	24
	3.3.5	Conditions of Appointment	25
	3.3.6	Notification of Inconsistencies or Omissions	26
	3.3.7	Department Review and Assessment	26
	3.3.8	Credentials Committee Review and Recommendation	27
	3.3.9	Medical Executive Committee Review and Recommendation	28
	3.3.10	Board Review and Final Action	28
	3.3.11	Right to a Hearing	28
	3.3.12	Appointment Limitation	29
	3.3.13	Scope of Privileges	29
	3.3.14	Continuity of Care	29
	3.3.15	Term of Initial Appointment	29
Section 3.4		Provisional Status	29
	3.4.1	Provisional Period	29
	3.4.2	Conditions of Provisional Review	29
	3.4.3	Extension of Provisional Period	29
	3.4.5	Board Certification Requirement	29
	3.4.6	Review and Conclusion	30
Section 3.5		Reappointment – Qualifications	30
	3.5.1	Licensure	30

	3.5.2	Board Certification and Qualification	30
	3.5.3	Insurance	30
	3.5.4	Required Disclosures	30
Section 3.6		Reappointment – Procedure	31
	3.6.1	Application	31
	3.6.2	Voluntary Non-renewal	32
	3.6.3	Department Review and Assessment	32
	3.6.4	Credentials Committee Review and Recommendation	33
	3.6.5	Medical Executive Committee Review and Recommendation	33
	3.6.6	Board Review and Final Action	34
	3.6.7	Right to a Hearing	34
	3.6.8	Appointment Limitation	34
	3.6.9	Scope of Privileges	34
	3.6.10	Continuity of Care	34
	3.6.11	Term of Reappointment	34
Section 3.7		Requests for Additional Privileges	35
	3.7.1	Requests for Additional Privileges	35
	3.7.2	Consideration of Requests for Additional Privileges	35
	3.7.3	Granting of Additional Privileges	35
Section 3.8		Board Qualifications and Certification	35
	3.8.1	Board Qualifications and Certification Requirement	35
	3.8.2	Waiver of Board Certification	36
	3.8.3	Board Recertification Requirement	36
Section 3.9		Reapplication Following Adverse Decision	36
Section 3.10		Leave of Absence	37
	3.10.1	Initiation of Leave of Absence	37
	3.10.2	Extension of Leave of Absence	37
	3.10.3	Routing Leave of Absence Request	37
	3.10.4	Member Status During Leave of Absence	37
	3.10.5	Termination of Leave of Absence	37
	3.10.6	Routing Termination Request	38
	3.10.7	Resuming Clinical Activity	38
Section 3.11		Temporary Privileges	38
	3.11.1	Circumstances for Temporary Privileges	38
	3.11.2	Temporary Privileges for Non Applicant	39
	3.11.3	Temporary Privileges for New Applicant	39
	3.11.4	Temporary Privilege Requirements	39

	3.11.5	Temporary Privilege Process	39
	3.11.6	Temporary Privilege Duration	40
	3.11.7	Temporary Privilege Termination	40
Section 3.12		Disaster Privileges	40
	3.12.1	Granting Disaster Privileges	40
	3.12.2	Exercising Disaster Privileges	41
	3.12.3	Verifying Credentials	41
	3.12.4	Disaster Privileges Termination	41
Section 3.13		Telemedicine Privileges	41
	3.13.1	Applicability	42
	3.13.2	Granting of Privileges	42
	3.13.3	Prerogatives	43
Article IV		OFFICERS AND MEETINGS OF THE RHODE ISLAND MEDICAL STAFF	44
Section 4.1		Structure	44
	4.1.1	Officers of the Medical Staff	44
	4.1.2	President of the Medical Staff	44
	4.1.3	President-Elect	45
	4.1.4	Secretary	45
	4.1.5	Treasurer	45
Section 4.2		Nominations	45
	4.2.1	Nominating Committee	45
	4.2.2	Nominating Process	45
Section 4.3		Removal of Officers	45
Section 4.4		Dues	46
Section 4.5		Meetings	46
	4.5.1	Regular Meetings	46
	4.5.2	Annual Meeting	46
	4.5.3	Special Meetings	46
	4.5.4	Quorum	46
Article V		MEDICAL STAFF ORGANIZATION	47
Section 5.1		Departments and Divisions	47
Section 5.2		Functions of Departments	47
	5.2.1	Clinical Functions	47
	5.2.2	Administrative Functions	47
	5.2.3	Quality Review/Risk Management/ Utilization Management	48
	5.2.4	Collegial and Educational Functions	48

	5.2.5	Department Meetings	48
Section 5.3		Department Chief	48
	5.3.1	Appointment	49
	5.3.2	Responsibilities to the Department	49
	5.3.3	Reporting Responsibility	49
	5.3.4	Respective Roles and Responsibilities	49
Section 5.4		Function of Divisions	50
Section 5.5		Division Director	50
	5.5.1	Option for Assistants	50
	5.5.2	Roles and Responsibilities	50
Section 5.6		Organization of Departments	50
Article VI		COMMITTEES OF THE RHODE ISLAND HOSPTIAL MEDICAL STAFF	52
Section 6.1		General	52
	6.1.1	Types of Committees: Appointments	52
	6.1.2	Membership	52
	6.1.3	Term of Membership	52
	6.1.4	Chair of the Committee	52
	6.1.5	Committee Reports and Minutes	52
Section 6.2		Committee Meetings	52
	6.2.1	Regular Meetings	52
	6.2.2	Special Meetings	52
	6.2.3	Notice of Meetings	52
	6.2.4	Quorum	52
Section 6.3		Medical Executive Committee	53
	6.3.1	Composition	53
	6.3.2	Chair of the Medical Executive Committee	53
	6.3.3	Term	53
	6.3.4	Vacancies	53
	6.3.5	Replacement	54
	6.3.6	Duties of the Medical Executive Committee	54
Section 6.4		Credentials Committee	55
	6.4.1	Composition	55
	6.4.2	Duties of the Credentials Committee	55
Section 6.5		Other Committees	55
Article VII		CONDUCT OF THE MEDICAL STAFF: INVESTIGATION AND INTERVENTION	56

Section 7.1		Expectations of Conduct	56
Section 7.2		Collegial Intervention	56
Section 7.3		Purpose	56
Section 7.4		Definitions	56
	7.4.1	Disciplinary Action	56
	7.4.2	Investigation	57
Section 7.5		Initial Inquiry	57
	7.5.1	Process	57
	7.5.2	Determination and Interventions	57
Section 7.6		Investigation	59
	7.6.1	Initial Determination	59
	7.6.2	Process	60
	7.6.3	Non-Compliance with the Investigation	60
	7.6.4	Extension of Investigation	60
	7.6.5	Review of Investigation Results	61
Section 7.7		Medical Executive Committee Interventions	61
	7.7.1	Medical Executive Committee Options	61
	7.7.2	MEC Actions: Non-Adverse Interventions	62
	7.7.3	MEC Actions: Adverse Interventions	62
Section 7.8		Board Action	63
Section 7.9		Appellate Review Request	63
Section 7.10		Final Action of the Board	63
Section 7.11		Automatic Suspension	63
	7.11.1	Medical Staff Response	63
	7.11.2	Governmental /Other External Agency Action	64
	7.11.3	Change in Circumstances	65
	7.11.4	Continuation of Suspension	65
	7.11.5	Mandatory Reporting Requirements	65
	7.11.6	Felony Conviction	66
	7.11.7	Medical Staff / Hospital Administrative Policy	66
Article VIII		DUE PROCESS HEARINGS AND APPEALS	67
Section 8.1		Right to Hearing	67
	8.1.1	Actions Prompting a Right to a Hearing	67
	8.1.2	Appeal Process Limitations	67
Section 8.2		Exclusions to Right to Hearing or Appellate Review	67
	8.2.1	Contract/Employment Related Circumstances	67
	8.2.2	Staff Appointment/Clinical Privileges	

		Related Circumstances	68
Section 8.3		Request for a Hearing	68
	8.3.1	Process	68
	8.3.2	Waiver of Right to a Hearing	68
Section 8.4		Hearing Participants	69
	8.4.1	Hearing Committee	69
	8.4.2	Arbitration Alternative	69
	8.4.3	Hearing Committee Chair	69
	8.4.4	Parties	70
	8.4.5	Counsel	70
Section 8.5		Pre-Hearing Matters	70
	8.5.1	Notice	70
	8.5.2	Pre-Hearing Conference	70
	8.5.3	Exchange of Documentation and Witness Lists	71
	8.5.4	Conduct Regarding Identified Witnesses	72
Section 8.6		Conduct of Hearing	72
	8.6.1	Timing	72
	8.6.2	Attendance	72
	8.6.3	Rights of Parties	72
	8.6.4	Rights of Counsel	73
	8.6.5	Rights of Hearing Committee	73
	8.6.6	Burden of Proof	73
	8.6.7	Admissibility of Evidence	74
	8.6.8	Recording of Hearing	74
	8.6.9	Recess and Adjournment	74
Section 8.7		Final Decision Following a Hearing	74
	8.7.1	Recommendation of the Hearing Committee	74
	8.7.2	Review by Medical Executive Committee	75
	8.7.3	Board Action	75
Section 8.8		Appellate Review	75
	8.8.1	Appeal to the Board	75
	8.8.2	Admission of Evidence	75
	8.8.3	Powers of the Board	76
	8.8.4	Final Action	76
Section 8.9		Status of Clinical Privileges During Hearing and Appellate Review	76
Section 8.10		No Effect on Board's Authority	76
Article IX		ALLIED HEALTH PROFESSIONALS	77
Section 9.1		Overview of Allied Health Professionals	77
	9.1.1	General Description	77

	9.1.2	Eligible Practitioners	77
	9.1.3	Prerogatives	77
	9.1.4	Department Assignment	77
	9.1.5	Applicability of the Bylaws	77
Section 9.2		Privileges	77
	9.2.1	Application Process	77
	9.2.2	Scope of Practice	77
Article X		AMENDMENTS	79
Section 10.1		Core Bylaws Provisions	79
Section 10.2		System-Wide Bylaws Review Committee (SBRC)	79
	10.2.1	Membership	79
	10.2.2	Quorum and Vote	79
Section 10.3		Amendment Process	79
	10.3.1	Amendment Process at Affiliate Level	79
	10.3.2	SBRC Review and Deliberation Process	80
	10.3.3	Amendment Proposal Generated by the SBRC	80
	10.3.4	MEC Consideration of an SBRC Approved Amendment	81
	10.3.5	Medical Staff Review and Deliberation	81
	10.3.6	Approval by all Affiliates	81
	10.3.7	Amendment Consideration by the Board	82
Section 10.4		Non-Core Bylaws Provisions	82
	10.4.1	Amendment Process	82
	10.4.2	Medical Staff Review and Deliberation	83
	10.4.3	Amendment Consideration by the Board	83
	10.4.4	Non-Recommendation for Approval by The Medical Staff	83
Section 10.5		Rules and Regulations and Other Bylaws-Related Manuals	84
	10.5.1	Proposals to Amend	84
	10.5.2	Approval of Proposed Amendment	84
	10.5.3	Medical Staff Review	84
Section 10.6		Technical and Editorial Amendments	84
	10.6.1	Modifications and Clarifications by SBRC	84
	10.6.2	Modifications and Clarifications by the MEC	84
	10.6.3	Clerical Modifications	85
Section 10.5		Modifications Required by Statutes and Standards	85
Article XI		AUTHORIZATION, CONFIDENTIALITY, AND IMMUNITY FROM LIABILITY	86

Section 11.1		Authorizations and Confidentiality	86
	11.1.1	Express Consent	86
	11.1.2	Confidential Information	86
Section 11.2		Immunity from Liability	86
Section 11.3		Activities and Information Covered	87
Section 11.4		Cumulative Effect	88

PREAMBLE

Whereas, Rhode Island Hospital, Providence, Rhode Island (the "Hospital"), is a non-profit corporation organized under the laws of the State of Rhode Island; and

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

Whereas, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility subject to the ultimate authority of the Board of Trustees, and that the cooperative efforts of the Medical Staff, the President/Chief Executive Officer and the Board of Trustees are necessary to fulfill the Hospital's obligations to its patients;

Therefore, the physicians, podiatrists, dentists, and other doctoral level professionals practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

DEFINITIONS

1. "Allied Health Professional" ("AHP") means those individuals licensed by or registered with the State of Rhode Island to exercise independent judgment within their area of professional competence and allowed by these Bylaws to participate in Hospital patients' direct care under appropriate Medical Staff Member supervision. The Medical Executive Committee and the Board of Trustees shall determine the types of health care providers included in this staffing category.

2. "Board" means the Board of Trustees of the Hospital, which has legal responsibility for the governance of the Hospital and any *ad hoc* and standing committees appointed by it.

3. "Board Certified" shall mean holding current certification by a specialty or subspecialty Board of the American Board of Medical Specialties.

4. "Board Qualified" shall mean qualified by training and experience to become Board Certified by a specialty or subspecialty board of the American Board of Medical Specialties within the time period established by the provisions of Section 3.8 of these Bylaws.

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

6. "Dentist" means an individual licensed to practice dentistry pursuant to the laws of the State of Rhode Island.

7. "Hospital" means Rhode Island Hospital located in Providence, Rhode Island.

8. "Hospital Administration" means, collectively, all managers, directors, administrative directors, vice presidents, senior vice presidents, the chief operating officer and the president and chief executive officer.

9. "Licensed Independent Practitioner" ("LIP") means an individual permitted by the laws of the State of Rhode Island to provide care, treatment, and services without direction or supervision but whose scope of practice may be limited by the Hospital's policies and Rules and Regulations.

10. "Lifespan Affiliate" shall be those licensed hospitals under common control and ownership of the Lifespan Corporation and includes, but is not 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.

11. "Medical Executive Committee" means the Executive Committee of the Medical Staff.

12. "Medical Staff" means all Members of the Active, Courtesy, Consulting, Doctoral, Associate, and Honorary Staffs, and Research Scientists.

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

14. “Office of Medical Staff Services” shall mean that office which supports the Medical Staff, is responsible for Medical Staff appointments, and oversees all Medical Staff functions.

15. “Physician” means an individual licensed to practice allopathic or osteopathic medicine pursuant to the laws of the State of Rhode Island.

16. “Podiatrist” means an individual licensed to practice podiatric medicine pursuant to the laws of the State of Rhode Island.

17. “President and Chief Executive Officer” or (the “Hospital President”) means the individual appointed by the Board of Trustees to act in its behalf in the overall management of the Hospital and may also be referred to as “the President of the Hospital”.

18. “Senior Vice President of Medical Affairs” (“SVPMA”) or “Vice President of Medical Affairs” (“VPMA”) or “Chief Medical Officer” (“CMO”) means a practitioner appointed by the Board on the recommendation of the Hospital President to serve as a liaison between the Medical Staff and the Hospital Administration. The SVPMA/VPMA/CMO may be appointed by the Hospital President to act on his/her behalf.

19. “Special Notice” means written notice delivered by certified or registered mail, return receipt requested, to the last address as it appears in the office records of the Office of Medical Staff Services of the Hospital.

20. “Staff Member” means a Member of the Medical Staff of the Hospital.

ARTICLE I

DESCRIPTION OF THE MEDICAL STAFF

Purposes

The purposes of the Medical Staff are:

1. to strive to assure that all patients admitted to or treated at the Hospital receive the best possible medical care consistent with the resources available;

2. to be accountable to the Board of Trustees for the quality and appropriateness of the professional performance of all individuals exercising clinical privileges in the Hospital;

3. to assist the Board of Trustees to provide and to maintain an appropriate educational setting that will elevate scientific standards and lead to advancement in professional knowledge and skills of practitioners and enrolled students, and that will support high quality research programs;

4. to recommend, and to regularly, and as necessary, review and propose revisions to the Bylaws and Rules and Regulations consistent with all applicable laws, regulations and standards;

5. to provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by representatives of the Medical Staff with the Senior Vice President of Medical Affairs and the representatives of the Board of Trustees;

6. to cooperate with those educational programs that will further the mission of the Hospital and the Medical Staff;

7. to participate in long range planning for the Hospital in order to assist Hospital Administration and the Board of Trustees in effectively meeting their continuing responsibility for the appropriate development of programs and facilities; and,

8. to initiate and maintain rules and regulations for self-government 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.

ARTICLE II

CATEGORIES OF THE STAFF

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 Office of Medical Staff Services 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 Office of Medical Staff Services for processing. The request will be forwarded to the applicable Department Chief, the Credentials Committee, and the Medical Executive Committee for review and recommendation, and to the Board 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 **Obligations** – 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 **Senior Active Status** – 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 Chief. 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 Courtesy Staff

2.3.1 **Defined** – The Courtesy Staff shall consist of physicians, dentists, and podiatrists who wish to exercise clinical activity but are anticipated to have fewer than fifteen (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, Section 3.8.

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 outlined in the Hospital's Rules and Regulations, 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 Chief, 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 III

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 Medical 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; 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.

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.

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.

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. a specialty board;

b. state or federal jurisdiction;

c. Medicare, Medicaid or state or federal Drug Enforcement Agency;

d. healthcare entity;

e. educational 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 Office of Medical Staff Services. 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 Chief. 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 Office of Medical Staff Services 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 Office of Medical Staff Services 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 SVPMA/CMO, may be deemed a voluntary withdrawal of the application.

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

a. Division Director Review – The applicable Division Director, or designee, shall have twenty (20) days from receipt to complete his/her review and submit a written assessment to the Office of Medical Staff Services for forwarding to the applicable Department Chief. The Division Director, 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 Division Director, or designee, requires the applicant to provide additional information or execute a release/authorization allowing the Hospital to obtain additional information, the Office of Medical Staff Services 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 SVPMA/CMO, may be deemed a voluntary withdrawal of the application.

ii. Failure to Respond – If the Division Director'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 Division Director and shall be referred to the Department Chief.

b. Department Chief Review – Upon completion of the divisional/section review and recommendation, or in the event that one is not required, the application shall be forwarded to the chief/chair of the department in which privileges are being sought. In the event of an applicant who has been selected to be a department chief/chair, the application shall be forwarded to the President of the Medical

Staff (or his/her designee) and the SVPMA/CMO. The Department Chief, or designee, (or the President of the Medical Staff, or designee, and the SVPMA/CMO) shall have twenty (20) days from receipt to complete his/her review and written assessment of the application. The Department Chief, or designee, (or the President of the Medical Staff, or designee, and the SVPMA/CMO) 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 Chief, or designee, (or the President of the Medical Staff, or designee, and the SVPMA/CMO) requires the applicant to provide additional information or execute a release/authorization allowing the Hospital to obtain additional information, the Office of Medical Staff Services 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 SVPMA/CMO, may be deemed a voluntary withdrawal of the application.

ii. Favorable Assessment – A favorable assessment for applicant appointment by the Department Chief, or designee, (or the President of the Medical Staff, or designee, and the SVPMA/CMO) 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 Chief, or designee, (or the President of the Medical Staff, or designee, and the SVPMA/CMO) 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 Chief, or designee, (or the President of the Medical Staff, or designee, and the SVPMA/CMO) -- and the Division Director where applicable -- shall be forwarded to the Credentials Committee for review and recommendation at its next regularly scheduled meeting.

3.3.8 **Credentials Committee Review and Recommendation**

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 Chief, 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 Office of Medical Staff Services 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 **Medical Executive Committee Review and Recommendation** – 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 **Board Review and Final Action** – 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 enumerated in Section 3.3.11.

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

3.3.11 **Right to a Hearing** – 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 **Appointment Limitation** – 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 Period** – 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 Chief. 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 Chief 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 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. a specialty board;

b. state or federal jurisdiction;

c. Medicare, Medicaid or state or federal Drug Enforcement Agency;

d. healthcare entity;

e. educational 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 Office of Medical Staff Services 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 Chief.

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 Office of Medical Staff Services shall forward the application for reappointment for divisional/section assessment, when applicable.

a. Division Director Review – The applicable Division Director, or designee, shall have fifteen (15) days from receipt to complete his/her review and submit a written assessment to the Office of Medical Staff Services for forwarding to the applicable Department Chief. The Division Director, 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 Division Director, or designee, requires the applicant to provide additional information or execute a release/authorization allowing the Hospital to obtain additional information, the Office of Medical Staff Services 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 SVPMA/CMO, may be deemed a voluntary withdrawal of the application.

ii. Failure to Respond – If the Division Director'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 Division Director and shall be referred to the Department Chief.

b. Department Chief Review – Upon completion of the divisional/section, or designee, review and assessment, or in the event that one is not required, the application shall be forwarded to the applicable Department Chief. With respect to reappointment of department chiefs/chairs, the application shall be forwarded to the President of the Medical Staff (or his/her designee) and the SVPMA/CMO. The Department Chief, or designee, (or the President of the Medical Staff, or designee, and the SVPMA/CMO) shall have twenty (20) days from receipt to complete his/her review and written assessment of the application. The Department Chief, or designee, (or the President of the Medical Staff, or designee, and the SVPMA/CMO) 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 Chief, or designee, (or the President of the Medical Staff, or designee, and the SVPMA/CMO) requires the applicant to provide additional information or execute a release/authorization allowing the Hospital to obtain additional information, the Office of Medical Staff Services 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 SVPMA/CMO, 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 Chief, or designee, (or the President of the Medical Staff, or designee, and the SVPMA/CMO) 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 Chief, or designee, (or the President of the Medical Staff, or designee, and the SVPMA/CMO) --and the Division Director where applicable -- shall be forwarded to the Credentials Committee for review and recommendation at its next regularly scheduled meeting.

3.6.4 **Credentials Committee Review and Recommendation** – 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 Chief's/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 **Medical Executive Committee Review and Recommendation** – 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 **Board Review and Final Action** – 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 (2) 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 Chief. The request shall be handled in accordance with the appointment procedures set forth in Sections 3.3.4 through 3.4.

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 **Granting of Additional Privileges** – 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 Board Qualification and Certification

3.8.1 **Board Qualification and Certification Requirement** – 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 Chief for the opportunity to register and take the next board examination. The Department Chief 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 Chief 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 3.8.2, then the Medical Staff Member shall be ineligible for clinical privileges.

i. The Member may submit a written request to change his/her 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 Medical Staff Member is not granted a waiver and does not desire to be a Member of the Associate Staff, his/her Medical 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 effectuate the request for conversion to Staff Associate or the cessation of Medical 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 Chief, 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 Chief 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 Chief. 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 Chief 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 Chief 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 **Member Status During Leave of Absence**

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 Medical 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 **Termination of Leave of Absence**

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 Medical 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 Chief to the Credentials Committee. The Department Chief 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 **Routing Termination Request**

a. Department Chief Recommendation – The Department Chief 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 is required prior to the Member being permitted to exercise Medical Staff membership and clinical privileges.

c. Denial of Request – Action by the Board 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 and

there is a demonstrated, important patient care need that has been validated by the SVPMA/CMO.

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 Chief. 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, may be granted temporary privileges if a demonstrated and important patient care need, that has been validated by the SVPMA/CMO, 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 Medical 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 Medical Staff Members;

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. a 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 Chief and forwarded to the SVPMA/CMO for validation of the demonstrated patient care need. The request will then be forwarded to the Credential Committee Chair, the President of the Medical Staff (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.

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. Notification to Committees – 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 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 thirty (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. Information and Identification Requirement – Disaster Privileges may be granted by the Incident Commander based upon recommendation of the designated Medical Director and upon presentation of 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 Office of Medical Staff Services 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 Office of Medical Staff Services 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 Medical 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 IV

OFFICERS AND MEETINGS OF THE RHODE ISLAND HOSPITAL MEDICAL STAFF

4.1 Structure

4.1.1 **Officers of the Medical Staff** – The officers of the Medical Staff shall be the President, the President-Elect, the Secretary, the Treasurer, and the immediate Past President.

a. Officers must be Members of the Active Staff at the time of nomination and election and must remain Members of the Active Staff in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. During the course of any disciplinary action involving an officer, that individual officer will temporarily step down from his/her office until the issue is resolved.

b. The President, the President-Elect, the Secretary, and the Treasurer shall be elected at the Annual Meeting of the Medical Staff and shall hold office until the Annual Meeting two (2) years after their election or until their successors are elected.

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

d. Vacancies in any of the offices of the Medical Staff may be filled at any Regular meeting or at a Special meeting of the Medical Staff.

4.1.2 **President of the Medical Staff** – The President shall act as the chief administrative and principal elected officer of the Medical Staff. He/she shall call and preside at all meetings of the Medical Staff and of the Medical Executive Committee and shall have such powers and duties as are provided in these Bylaws.

a. Duties – The President shall aid in coordinating the activities and concerns of the Hospital Administration and of the nursing and other patient care services with those of the Medical Staff develop and implement, in cooperation with the Department and Committee Chairmen, methods for credentials review and for delineation of privileges, continuing education programs, utilization review, concurrent monitoring of practice, and quality assessment; communicate and represent the opinions, policies, concerns, needs and grievances of the Medical Staff to the Hospital President and to the Board; be responsible for enforcement of these Bylaws and of the Medical Staff rules and regulations; arrange annually for a review of the Medical Staff financial records; call, preside at and be responsible for the agenda of all general meetings; and serve as the Medical Staff spokesman in its external professional and public relations.

b. Succession – If the President is permanently unable to perform his/her duties for any reason, including, but not limited to, the President's incapacity, resignation or removal, then the President-Elect, the immediate Past President, the Secretary, or

the Treasurer, in that order, shall assume all the duties and responsibilities of the Presidency.

4.1.3 **President-Elect** – The President-Elect shall perform all duties as may be assigned to him/her by the President or as assigned in these Bylaws and related manuals. The President-Elect shall assume all duties and authority of the President in his/her temporary absence and as referenced in Section 4.1.2, in the event the President is unable to complete his/her term of office. In such instances, the President-Elect shall assume all duties and authority of the President for the remainder of the President's term.

4.1.4 **Secretary** – The Secretary of the Medical Staff shall keep accurate and complete minutes of all meetings of the Medical Staff and the Medical Executive Committee; call meetings at the direction of the President; give proper notice of all meetings; attend to all correspondence, and, perform such other duties as ordinarily pertains to the Secretary's office.

4.1.5 **Treasurer** – The Treasurer shall properly and appropriately deposit any of the funds of the Medical Staff as the Medical Executive Committee shall designate, and shall disburse such funds under the direction of the Medical Executive Committee. All checks shall be signed by the Treasurer, and shall direct that any bank or trust company in which the funds of the Medical Staff are deposited shall pay checks signed by the Treasurer, including those drawn to his/her own individual order. These financial transactions shall be subject to annual review and audit. The Treasurer shall, on an annual basis, provide a report of the status of Medical Staff finances to the Medical Executive Committee and shall also provide a report to the Medical Staff at its Annual Meeting.

4.2 **Nominations** – The nominations for candidates for the officers of President, President-Elect, Secretary, and Treasurer shall be selected by a five (5) member panel known as the Nominating Committee.

4.2.1 **Nominating Committee** – The Nominating Committee shall be comprised of the President, President-Elect and the immediate past President, as well as two (2) members of the Medical Staff at-large selected by the President.

4.2.2 **Nominating Process** – The Nominating Committee shall convene two (2) months prior to the Annual Meeting and nominate one or more qualified candidates for each of the offices of President, President-Elect, Secretary, and Treasurer. The Nominating Committee shall also nominate two (2) candidates for each of the vacant at-large positions on the Medical Executive Committee. The list of nominations shall be sent to each Member of the Medical Staff at least thirty (30) calendar days in advance of the Annual Meeting. Write-In candidates shall be considered for election if submitted to the Nominating Committee in writing by at least thirty (30) voting Members of the Medical Staff. Once confirmed by the Nominating Committee, the names of any additional Write-In candidates shall be sent to each voting Member of the Medical Staff at least five (5) calendar days in advance of the Annual Meeting.

4.3 **Removal of Officers** – Any officer of the Medical Staff or member of the Medical Executive Committee may be removed for the inability or unwillingness to attend to official duties and responsibilities, or unprofessional conduct or misconduct amounting to a serious breach of ethics or duty of office. Removal shall be by affirmative vote of two-thirds (2/3) of the voting Medical

Staff Members present at a Special Meeting of the Medical Staff called for that purpose and subsequently ratified by the Medical Executive Committee. Voting shall be conducted by secret ballot.

4.4 **Dues** – Each Member required to pay dues pursuant to Article II of these Bylaws shall pay to the Treasurer such fees each year as may be assessed or determined by the Medical Executive Committee. The Medical Executive Committee shall determine the manner of expenditure of such funds received; however, such expenditures must be appropriate to the purposes of the Medical Staff and shall not jeopardize the nonprofit tax-exempt status of the Hospital.

4.5 **Meetings**

4.5.1 **Regular Meetings** – Regular business meetings of the Medical Staff shall be held at least four (4) times per calendar year, one of which shall be the Annual Meeting, at such a date and time determined by the President of the Medical Staff, or as otherwise selected by the Medical Executive Committee. Written or electronic notice of such meetings shall be sent to each Member of the Medical Staff at least ten (10) days prior to such meeting.
At each meeting, the activities of the Medical Executive Committee shall be reported to the Medical Staff.

4.5.2 **Annual Meeting** – One Regular Meeting per calendar year shall be deemed the Annual Meeting. Written or electronic notice of the Annual Meeting shall be sent to each Member of the Medical Staff at least twenty (20) days prior to such meeting.

At the Annual Meeting:

a. outgoing officers and committees shall make final reports as may be appropriate;

b. the Nominating Committee shall present its nominees; and

c. elections for the incoming officers of the Medical Staff and vacant at-large seats of the Medical Executive Committee shall be conducted.

4.5.3 **Special Meetings** – Special Meetings of the Medical Staff may be called at any time by: the President of the Medical Staff, the Board, the Hospital President, the Medical Executive Committee, or at the written request of ten (10%) percent of the voting Members of the Medical Staff. Written or electronic notice of any Special Meeting shall be sent to each voting Member of the Medical Staff within at least fifteen (15) days prior to such meeting. The written notice shall set forth the purpose and topics for discussion at the Special Meeting. No business shall be transacted except that stated in the notice calling the meeting.

4.5.4 **Quorum** – Those voting Members of the Medical Staff present at any Regular or Special meeting shall constitute a quorum.

ARTICLE V

MEDICAL STAFF ORGANIZATION

5.1 **Departments and Divisions** – The Medical Staff shall be organized into Departments and Divisions. Departments shall be created by the Board upon the recommendation of the Medical Executive Committee. Divisions shall be created by the Board after consulting with the Department Chief and the Medical Executive Committee, as to what, if any, specialty Divisions will exist as distinct organizational components within each Department.

5.1.1 The duties, responsibilities, and privileges of Members of the Medical Staff not otherwise stated in these Bylaws or the Rules and Regulations shall be formulated for each Department by its respective Chief and for each Division by its respective Director with the approval of the Department Chief.

5.1.2 The number of Departments and Divisions, as well as their titles, may be modified on the recommendation of the Medical Executive Committee and upon approval of the Board.

5.2 **Functions of Departments** – The Departments fulfill certain clinical, administrative, quality review/risk management / utilization management, and collegial and education functions as set forth in Sections 5.2.1 through 5.2.4 below.

5.2.1 **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. participate in peer review activities as appropriate to ensure patient safety and quality of care; and

d. develop consistency in the patient care standards, policies, procedures and practices within the department and across its constituent sections.

5.2.2 **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 Department Chief, formulated policies and plans to its members for implementation;

c. coordinate, through its Department Chief, the professional services of its members with those of other Departments and Divisions and with the Hospital support services;

d. make recommendations, through its Department Chief, to the Medical Executive Committee, SVPMA/CMO, the Hospital President, and other components, as appropriate, concerning the short- and long-term allocation and acquisition of resources to allow provision of services by the Hospital and the Department; and

e. review and monitor the Department's rules, regulations, and other policies and make revisions as necessary to comply with Hospital rules and Bylaws.

5.2.3 **Quality Review/Risk Management/Utilization Management**

Each Department shall:

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

b. determine the type of data to be collected for on-going professional practice evaluation with approval by the organized Medical Staff; carry out delegated peer review and quality improvement functions in a manner consistent, timely, fair and ongoing; and conduct or participate in mortality and morbidity reviews; and

c. report all findings of studies and other activities performed to the appropriate Staff-wide committee(s).

5.2.4 **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 Divisions.

5.2.5 **Department Meetings**

Each Department shall meet at least quarterly to review and evaluate any clinical, administrative, collegial and utilization management issues that exist within the Department. A record shall be maintained describing the general topics discussed at the meeting.

5.3 **Department Chief –** Each Department of the Medical Staff shall have as its leader a Department

Chief who shall be a Member of the Medical Staff.

5.3.1 **Appointment** – The Chief shall be appointed by the Hospital President upon approval of the Board. Should a vacancy exist in the office of Chief of a Department, a search committee shall be established, appointed by the Hospital President and, in the case of a Chief who is also the Chair of a Brown Department, the appointment shall be by Hospital President and the Dean of Medicine at Brown University. The nominee's appointment shall become effective when approved by the Board.

5.3.2 **Responsibilities to the Department** – The Chief of each Department shall be responsible and accountable for all administrative, clinical, educational, and research activities within his/her Department, as delineated in the Chief job description in effect from time to time.

5.3.3 **Reporting Responsibility** – The Chief is accountable to the Hospital President for resolution of all issues which may arise between an individual Staff Member and the Chief.

5.3.4 **Respective Roles and Responsibilities**

Each Chief Shall:

a. give guidance on the overall medical policies of the Hospital and make specific recommendations and suggestions regarding the provisions of quality patient care;

b. maintain ongoing Professional Practice Evaluations of all practitioners with clinical privileges in the Department;

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

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

e. be responsible for the development, with assistance from the various sections, specialists and sub specialists, of 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;

f. be responsible for recommendations concerning appointment, changes in status, reappointment, and the delineation of clinical privileges for all practitioners in the Department to the Medical Executive Committee;

g. be responsible for the teaching, clinical training, and research program in the Department;

h. be responsible for ensuring the review of the performance and evaluation of medical students, physicians in residency or fellowship training programs and

non-physician trainees directly related to the proper functions of the Department, consistent with LCME, ACGME and GMEC training program requirements, through the Department's clerkship, residency and fellowship program directors;

i. be responsible for ensuring provision of quality clinical, educational and research training programs for medical students, residents and fellows, through the Department's clerkship, residency and fellowship program directors;

j. be responsible for ensuring that physician-specific quality assurance and credentialing activities are conducted and that data is recorded and evaluated within their Department; and

k. be responsible for ensuring that the quality and appropriateness of patient care provided within the Department are monitored and evaluated.

5.4 **Functions of Divisions** – A Division shall be a defined subsection of a Department that shall perform the same type of clinical, administrative, quality risk management/utilization management, and collegial/education functions delineated for Departments in Section 5.2 as specifically assigned by the Department Chief and Medical Executive Committee.

5.5 **Division Director** – A Division Director shall be an Active Staff Member appointed by the Department Chief with the input of the Hospital President or the Executive Director and the approval of the Board.

5.5.1 **Option for Assistants** – In order to ensure the proper operation of Divisions, the Director of a Division, with the approval of the Chief of the appropriate Department, may designate an Associate Director and/or Assistant Director.

5.5.2 **Roles and Responsibilities**

Each Division Director shall:

a. have the responsibility and authority to carry out those duties and functions delegated to him/her by the Board, the Medical Executive Committee, and the Department Chief, as delineated in these Bylaws and related manuals, in other policies and rules of the Hospital or Staff, and, where applicable, by contract or job description;

b. serve at the pleasure of the Department Chief and the Hospital President and the Executive Director; and

c. be responsible to the Department Chief for the professional and administrative functions of the Division.

5.6 **Organization of Departments**

The Departments shall be entitled as follows:

- Department of Anesthesiology

- Department of Dermatology
- Department of Diagnostic Imaging
- Department of Emergency Medicine
- Department of Family and Community Medicine
- Department of Gynecology & Obstetrics
- Department of Medicine
- Department of Neurology
- Department of Neurosurgery
- Department of Ophthalmology
- Department of Orthopaedics (Podiatry/ Rehabilitation Medicine)
- Department of Otolaryngology
- Department of Pathology & Laboratory Medicine
- Department of Pediatrics
- Department of Plastic Surgery
- Department of Psychiatry & Behavioral Medicine
- Department of Radiation Oncology
- Department of Surgery

ARTICLE VI

COMMITTEES OF THE RHODE ISLAND HOSPITAL MEDICAL STAFF

6.1 General

6.1.1 **Types of Committees; Appointments** – There shall be both standing committees and special committees of the Medical Staff. Committee appointments shall be made by the Medical Executive Committee of the Medical Staff unless otherwise set forth in these Bylaws.

6.1.2 **Membership** – Members of the Active, Senior Active, Courtesy, Consulting, Doctoral, Associate, Honorary and Research Scientists are eligible to serve as members of a committee. A Hospital administrator and the President of the Medical Staff shall be a non-voting ex-officio member of each committee. Members who serve on a committee shall be expected to actively and constructively participate in committee activities.

6.1.3 **Term of Membership –** The term of a Medical Staff Member's appointment to a committee shall be at the discretion of the Medical Executive Committee. Overall committee membership shall be reviewed bi-annually by the President of the Medical Staff to ensure that the committee is still able to accomplish its mandate. The President of the Medical Staff shall make any recommendations for changes in committee membership to the Medical Executive Committee.

6.1.4 **Chair of the Committee –** Except as otherwise directed in these Bylaws, Rules and Regulations and other related manuals, the Chairman, the Vice Chairman and members of each Medical Executive subcommittee shall be appointed by the President of the Medical Staff with the approval of the Medical Executive Committee.

6.1.5 **Committee Reports and Minutes** – Copies of signed minutes of all committee meetings will be forwarded to the Medical Executive Committee for review and action, as appropriate. The minutes shall contain the signatures of the Chairman (or designee) and the recording Secretary.

6.2 Committee Meetings

6.2.1 **Regular Meetings** – Committees may, by resolution, provide the time for holding Regular Meetings without notice other than such resolution.

6.2.2 **Special Meetings** – A Special Meeting of any Committee may be called by, or at the request of, the Chair of the Committee thereof, the President of the Medical Staff, or by one-third of the committee's members (but not to be less than two (2) members).

6.2.3 **Notice of Meetings** – Written or oral notice stating the place, day and hour of any Special Meeting or any Regular Meeting not held pursuant to resolution shall be given to each member of the committee not less than five (5) days prior to the time of such meeting, except in emergency situations.

6.2.4 **Quorum** – Except for meetings of the Medical Executive Committee, a majority of those present at a committee meeting shall constitute a quorum. All members of a committee

shall be entitled to vote, except ex-officio members.

6.3 Medical Executive Committee

6.3.1 **Composition –** There shall be nineteen (19) voting members of the Medical Executive Committee, as follows:

a. The Chief or a designated Chief or Site Director of the following Departments:

i. Anesthesiology

ii. Diagnostic Imaging

iii. Emergency Medicine

iv. Medicine

v. Orthopedics

vi. Pathology

vii. Pediatrics

viii. Psychiatry

ix. Surgery

b. The Medical Staff Officers (President, President-Elect, Secretary, Treasurer and Immediate Past President);

c. Five (5) Members-at-Large who shall be elected pursuant to the nominating process set forth in Section 4.2.2 for two-year terms.

d. Non-voting ex-officio members of the Medical Executive Committee shall be the Hospital President, the Executive Director/Chief Operating Officer, the Chief Nursing Officer, and the SVPMA/CMO.

6.3.2 **Chair of the Medical Executive Committee** – The President of the Medical Staff shall be the Chair of the Medical Executive Committee.

6.3.3 **Term** – An elected member shall serve a single two (2) year term on the Medical Executive Committee as a Member-at-Large. An elected member may not serve consecutive two (2) year terms as a Member-at-Large. An elected member shall be eligible for re-election after vacating the position for a single two (2) year election cycle. This term limit shall not apply if a member is elected or appointed as an officer of the Medical Staff immediately following their at-large term.

6.3.4 **Vacancies**

a. Vacancy Because of Ascension – When any ex-officio Department Chief

becomes an officer of the Medical Staff, additional Members At-Large shall be elected to maintain full complement of nineteen (19) members in accordance with the provisions governing the composition of the Medical Executive Committee.

b. Vacancy by Inability to Serve – In the event that the Immediate Past President is unable to serve as a Medical Executive Committee member, a previous Past President that has most recently held such office shall serve in his or her place, in order to maintain the full complement of nineteen (19) members in accordance with the provisions governing the composition of the Medical Executive Committee and to ensure continued preservation of the institutional memory.

c. Vacancy of Ex-Officio Seat – If a vacancy shall occur in the position of an ex-officio Department Chief, the Acting Chief, or his or her designee, shall serve on the Medical Executive Committee until a successor has been appointed by the Hospital.

6.3.5 **Replacement** – In the event that a term of membership on the Medical Executive Committee is interrupted, an alternate appointment to fill the duration of the unexpired term shall be made on the recommendation of the President of Medical Staff and approval of the Medical Executive Committee.

6.3.6 **Duties of the Medical Executive Committee** – The Medical Executive Committee shall report directly to the Board. Its duties shall be as follows:

a. meet at least monthly;

b. have the authority to initiate, modify, amend, or repeal any of the Rules and Regulations for the Rhode Island Hospital Medical Staff;

c. have review and oversight of administrative policies relating to Medical Staff function and the management of patient care;

d. coordinate and be responsible for all committees of the Medical Staff;

e. appoint and define the duties and responsibilities of such committees as may from time to time be needed;

f. consult the Medical Staff on appropriate matters, and shall review its activities with the Medical Staff at Medical Staff meetings;

g. consider any complaint, criticism, or suggestion of a Medical Staff Member relating to Hospital Administration or the Board pursuant to the Conflict Resolution Policy;

h. review all accreditation and regulatory standards, recommendations, and reports from accreditation organizations and regulatory agencies, and recommend any corrective action to the Board;

i. coordinate with the Hospital's quality and safety committees to ensure patient

safety and quality care;

j. review the clinical services to be provided by contracted service corporations;

k. be empowered to act for the Medical Staff in the interval between Medical Staff meetings; and,

l. may, from time to time, delegate to its Chair or any subcommittee of its members any of the powers vested in the Medical Executive Committee by these Bylaws.

6.4 **Credentials Committee**

6.4.1 **Composition** – The membership of the Credentials Committee shall consist of representatives of each Department as well as one representative from the Allied Health staffing category, and a member of the Board. The Secretary of the Medical Staff shall be an ex-officio member. At least five (5) additional members shall be appointed at the discretion of the Medical Executive Committee.

6.4.2 **Duties of the Credentials Committees** – The Credentials Committee shall report to the Medical Executive Committee. Its duties shall be as follows:

a. review and make recommendations to the Medical Executive Committee, on all proposed appointments ad reappointments to the Medical Staff and on all actions involving changed in the status of Medical Staff appointments (including, but not limited to, changes in admitting and clinical/operative privileges; transfer or change of staff; and/or non-reappointment);

b. request and review all relevant information which it deems necessary to conduct its duties effectively;

c. consult with quality and safety data concerning proposed reappointments prior to rendering its recommendations to the Medical Executive Committee;

d. have responsibility for reviewing and making recommendations to the Medical Executive Committee on changes privileging forms and criteria; and

e. meet at least quarterly and as more frequently as needed.

6.5 **Other Committees –** The composition, functions, reporting and meeting requirements of special and standing committees that are or may be required under any section of these Bylaws, shall be set forth in the Rules and Regulations and Bylaws related manuals of Rhode Island Hospital.

ARTICLE VII

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 Medical 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 Medical 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 Rules and Regulations, 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 shall be referred to the relevant Department Chief, the President of the Medical Staff, and the SVPMA/CMO, 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 7.5.2 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 SVPMA/CMO, the President of the Medical Staff, and the respective Department Chief 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 the imposition of an 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 shall 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 Chief 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 Chief 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 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 sixty (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 ten (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; and/or

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 7.7.1, 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 **Medical Executive Committee Actions: Adverse Interventions** – Recommendations for options (i), (j), and (k) in Section 7.7.1 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 **Board Action**

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 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 Chief 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, or expiration, of that Member's

1. professional license,

2. professional liability insurance coverage, or his/her

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 **Continuation of Suspension** – 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 **Mandatory Reporting Requirements –** A Medical Staff Member or an applicant to the Medical Staff must immediately notify the respective Department Chief and SVPMA/CMO or Office of Medical Staff Services 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, Medical 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 **Felony Conviction** – 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 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 VIII

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 VII, Section 7.8, or of an adverse recommended action by the Medical Executive Committee under Article VII, Section 7.7, 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; and,

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 Relating 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 a 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 Medical 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 IX

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 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 for inclusion in this category are delineated in the Credentials Manual or other related manuals. The Chiefs of the various Departments shall recommend eligible health care professionals to the Board 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 Department Chief and forwarded through the Credentials Committee and Medical Executive Committee for final approval by the Board.

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 or other related manuals, 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.

c. Detailed requirements related to Allied Health Professionals' practice are delineated in the Credentials Manual or other related manuals.

ARTICLE X

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 Medical Staff; Investigation and Intervention); Article VIII (Due Process Hearings and Appeals); Article IX (Allied Health Professionals); and Article X (Amendments).

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** – 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 sixty (60) days of the 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 SBRC** – 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 **MEC Consideration of an SBRC 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 sixty (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 Office of Medical Staff Services 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, 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 by the President of the Medical Staff, 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 President of the Medical Staff 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 manner outlined below.

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 **Medical Staff Review and Deliberation**

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 Office of Medical Staff Services 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 **Amendment Consideration by the Board**

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 President of the Medical Staff 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 President of the Medical Staff shall report on the final outcome of the proposed amendment to the Medical Executive Committee and the Medical Staff.

10.4.4 **Non-Recommendation for Approval by the Medical Staff** – 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 President of the Medical Staff shall report 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 SBRC** – 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 **Modifications and Clarifications by the Medical Executive Committee** – 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 **Clerical Modifications** – 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 **Modifications Required by Statutes and Standards** – 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 XI

AUTHORIZATIONS, CONFIDENTIALITY, AND IMMUNITY FROM LIABILITY

11.1 Authorizations and Confidentiality

11.1.1 **Express Consent** – By applying for appointment, or exercising admitting and/or clinical privileges or providing specified patient care services within the Hospital, a practitioner:

a. authorizes the Hospital and the Medical Staff representatives to solicit, provide and act upon information on the practitioner's professional ability and qualifications;

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

c. acknowledges that the provisions of this Section are express conditions to his/her application for, or acceptance of, Medical Staff membership or of his/her exercise of admitting and/or clinical privileges or provision of patient services at the Hospital.

11.1.2 **Confidentiality of Information** – Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility, organization or medical staff for the purpose of, among other reasons, achieving and maintaining quality patient care, reducing morbidity and mortality or contributing to clinical teaching and research, to the fullest extent permitted by law, shall be confidential and shall not be disseminated to anyone other than a representative nor used in any way except as provided herein, unless otherwise required by law.

a. Such confidentiality also shall extend to information of like kind that may be provided by third parties.

b. This information shall not become part of any particular patient's file nor of general Hospital records.

11.2 Immunity from Liability

11.2.1 Neither the Hospital nor any representative shall be liable in any judicial proceeding for damages or for other relief for any action taken or for any statement or recommendation made within the scope of his/her duties as a representative, if:

a. such representative acts in good faith and without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts; and,

b. in the reasonable belief that the action, statement or recommendation is warranted by such facts.

11.2.2 Regardless of the provisions of any law, the practitioner agrees that truth shall be an absolute defense in all circumstances.

11.2.3 Neither the Hospital, any representative nor any third party shall be liable in any judicial proceeding for damages or for other relief for providing information, including otherwise privileged or confidential information, to:

a. a representative of:

i. the Hospital;

ii. the Medical Staff;

iii. any other hospital;

iv. governmental entity;

v. organization of health professionals; or,

vi. other health related organization;

b. concerning a practitioner or affiliate who:

i. is or has been an applicant to or Member of the Medical Staff;

ii. did or does exercise admitting and/or clinical privileges; or,

iii. provides specified services at the Hospital;

c. provided that such representative or third party acts in good faith and without malice.

d. In dealing with governmental entities empowered by law with access to any such afore-described information, no representative can be held liable for damages or for any other relief even should the aforesaid entity not act in good faith or with malice.

11.3 Activities and Information Covered

11.3.1 The confidentiality and immunity provided by this Section shall apply to all acts, communications, reports, recommendations or disclosures made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

a. applications for appointment, admitting and/or clinical privileges or specified services;

b. periodic reappraisals for reappointment, admitting and/or clinical privileges or specified services or change/increase in appointment and/or privileges;

c. corrective action;

d. hearings and appellate review;

e. patient care audits;

f. utilization reviews;

g. quality assurance;

h. other hospital, department, service or committee activities related to monitoring and/or to maintaining quality patient care and appropriate professional conduct;

i. third party, governmental or otherwise, payor information;

j. professional impairment;

k. professional insurance (medical malpractice**)** carriers; and/or,

l. incident reports.

11.3.2 The acts, communications, reports, recommendations, disclosures and other information referred to in this Section may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or any other matter that might directly or indirectly affect patient care.

11.4 **Cumulative Effect –** Provisions in these Bylaws and in application and reapplication forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Rhode Island Hospital Medical Staff on April 26, 2012

_____
Edward J. Marcaccio, Jr., M.D.
President
Rhode Island Hospital Medical Staff

Approved by the Rhode Island Hospital Board of Trustees on June 7, 2012

_____
Jane Williams, Ph.D., R.N.
Secretary
Rhode Island Hospital Board of Trustees

_____
Timothy J. Babineau, M.D.
President and Chief Executive Officer
Rhode Island Hospital