

BYLAWS
of the
MEDICAL STAFF of NEWTON-WELLESLEY HOSPITAL

TABLE OF CONTENTS

PREAMBLE		11
ARTICLE 1	NAME	12
ARTICLE 2	DEFINITIONS	12
ARTICLE 3	STAFF MEMBERSHIP	14
3.1	HOSPITAL STAFFS	14
3.1.1	Appointment by the Board	
3.1.2	Three Staffs; Relationship	
3.1.3	Non-Discrimination	
3.2	MEDICAL STAFF	14
3.2.1	Nature of Medical Staff Membership	
3.2.2	Qualifications for Medical Staff Members	
3.2.3	Term of Appointment	
3.2.4	Contract Physicians	
3.2.5	Leave of Absence/Inactive Status	
3.2.6	Resignation	
3.3	PROFESSIONAL STAFF	17
3.3.1	Board Approval	
3.3.2	Conditions and Duration of Appointment; Evaluation; Scope	
3.3.3	Clinical Departments	
3.3.4	Due Process; Reporting	
3.4	POST-GRADUATE TRAINEE STAFF	18
3.4.1	Qualifications	
3.4.2	Appointment	
3.4.3	Duration of Membership, Privileges	
3.4.4	Supervision	
ARTICLE 4	MEDICAL STAFF CATEGORIES	19
4.1	MEDICAL STAFF CATEGORIES	19
4.2	PROVISIONAL STAFF	19
4.2.1	Initial Appointment	
4.2.2	Qualifications and Responsibilities	
4.2.3	Prerogatives	
4.2.4	Advancement : Timing	
4.2.5	Advancement : Criteria	
4.3	ACTIVE STAFF	21
4.3.1	Active Staff	
4.3.2	Qualifications and Responsibilities	
4.3.3	Prerogatives	
4.4	AFFILIATE STAFF	21

	4.4.1	Affiliate Staff	
	4.4.2	Qualifications and Responsibilities	
	4.4.3	Prerogatives	
4.5	HONORARY STAFF		22
	4.5.1	Qualifications	
	4.5.2	Prerogatives	
4.6	CHANGES IN STAFF CATEGORY		23
ARTICLE 5	APPOINTMENT AND REAPPOINTMENT		23
5.1	APPLICATION FOR APPOINTMENT AND PRIVILEGES		23
	5.1.1	The Application Form	
	5.1.2	Completed Application	
	5.1.3	Deadline	
	5.1.4	Breach	
5.2	APPOINTMENT PROCESS		23
	5.2.1	Notification of Incomplete Application	
	5.2.2	Recommendation by Chair/Chief	
	5.2.3	Credentials Committee Recommendation	
	5.2.4	ECMS Recommendation	
	5.2.5	Action by or on behalf of the Board	
5.3	APPLICATION FOR REAPPOINTMENT		25
	5.3.1	The Application Form	
	5.3.2	Completed Application; Breach	
5.4	REAPPOINTMENT PROCESS		25
	5.4.1	Mailing the Application Form; Deadlines; Effect	
	5.4.2	Reappointment Application Review Process	
5.5	GENERAL PROVISIONS		26
	5.5.1	No Guarantee	
	5.5.2	Appeal Rights	
	5.5.3	Basis of Actions on Applications	
	5.5.4	Confidentiality and Privilege	
	5.5.5	Deadline; Effect of Delay	
	5.5.6	Reapplication	
	5.5.7	Notification of Change	
ARTICLE 6	CLINICAL PRIVILEGES		27
6.1	EXERCISE OF CLINICAL PRIVILEGES		27
	6.1.1	Granted by the Board	
	6.1.2	Restrictions on Privileges	
	6.1.3	Evaluation of Requests to Exercise Privileges	
6.2	PROVISIONAL PRIVILEGES		28
	6.2.1	Defined	
	6.2.2	Proctoring	
	6.2.3	Advancement to Non-Provisional Privileges	
6.3	ADMITTING PRIVILEGES		28
	6.3.1	Physician Members	

<u>6.3.2</u>	Professional & Post-Graduate Trainee Staffs	
<u>6.4</u>	PRIVILEGES FOR MORE THAN ONE DEPARTMENT/SERV	28
<u>6.5</u>	EMERGENCY PRIVILEGES	29
<u>6.5.1</u>	Life-Threatening Emergency	
<u>6.5.2</u>	Disaster Status	
<u>6.6</u>	PRELIMINARY PRIVILEGES	29
<u>6.7</u>	TEMPORARY PRIVILEGES	30
<u>6.8</u>	REDETERMINATION OF PRIVILEGES	31
<u>6.8.1</u>	Basis	
<u>6.8.2</u>	Applications for Redetermination	
<u>6.8.3</u>	Mandatory Redetermination	
<u>6.8.4</u>	Elective Redetermination	
<u>6.8.5</u>	Reapplication	
<u>ARTICLE 7</u>	PRACTITIONERS HEALTH PROGRAM	31
<u>7.1</u>	DEFINITIONS	31
<u>7.1.1</u>	Impaired Practitioner	
<u>7.1.2</u>	Credible Information	
<u>7.1.3</u>	Program	
<u>7.2</u>	PROGRAM OBJECTIVES	32
<u>7.3</u>	INITIATION OF PROGRAM	32
<u>7.3.1</u>	Triggering Event	
<u>7.3.2</u>	Action of the HSC	
<u>7.3.3</u>	Participation Recommendation Accepted	
<u>7.3.4</u>	Participation Recommendation Rejected	
<u>7.4</u>	REMEDIAL PLANS AND MONITORING BY THE HSC	33
<u>7.4.1</u>	Development of Plan	
<u>7.4.2</u>	Monitoring	
<u>7.5</u>	NONCOMPLIANCE	33
<u>7.6</u>	TERMINATION OF LEAVE AND COMPLETION OF PROGRAM	33
<u>7.6.1</u>	Termination of Leave	
<u>7.6.2</u>	Completion of Program	
<u>7.7</u>	GENERAL PROVISIONS	33
<u>7.7.1</u>	Confidentiality	
<u>7.7.2</u>	Reports to Board of Registration	
<u>7.7.3</u>	Peer Review Files	
<u>7.7.4</u>	Hearing Rights	
<u>7.7.5</u>	Objectives of Article 7 Actions	
<u>ARTICLE 8</u>	PRELIMINARY INVESTIGATION AND CORRECTIVE ACTION	35
<u>8.1</u>	NATURE OF CORRECTIVE ACTION	35
<u>8.1.1</u>	Definition	
<u>8.1.2</u>	Grounds	

<u>8.2</u>	INITIATION	35
	<u>8.2.1</u> Written Request	
	<u>8.2.2</u> Authority to Make Request	
	<u>8.2.3</u> Action On Request	
<u>8.3</u>	PRELIMINARY INVESTIGATION	35
	<u>8.3.1</u> Procedure	
	<u>8.3.2</u> Report to ECMS	
<u>8.4</u>	ECMS ACTION	36
	<u>8.4.1</u> Substantial Evidence Does Not Warrant Any Action	
	<u>8.4.2</u> Substantial Evidence Warrants Only Actions That Do Not Substantially Restrict Privileges	
	<u>8.4.3</u> Substantial Evidence Warrants Restriction of Privileges	
<u>8.5</u>	BOARD ACTION	37
	<u>8.5.1</u> If the Board Agrees with ECMS Recommendation	
	<u>8.5.2</u> If the Board disagrees with Conclusion of ECMS Report	
<u>8.6</u>	SUMMARY ACTION	37
	<u>8.6.1</u> Criteria for Initiation; Authority; Definition	
	<u>8.6.2</u> Effectiveness; Notice; Transfer of Patients	
	<u>8.6.3</u> Review Procedure	
<u>8.7</u>	AUTOMATIC SUSPENSION	38
	<u>8.7.1</u> Licensure	
	<u>8.7.2</u> Controlled Substances	
	<u>8.7.3</u> Medical Records	
	<u>8.7.4</u> Failure to Pay Dues, Assessments	
	<u>8.7.5</u> Loss or Lapse of Professional Liability	
	<u>8.7.6</u> Ineligibility under Federal Health Programs	
<u>8.8</u>	GENERAL PROVISIONS	39
	<u>8.8.1</u> Confidentiality	
	<u>8.8.2</u> Reports to Board of Registration	
<u>ARTICLE 9</u>	FAIR HEARING PLAN	39
<u>9.1</u>	RIGHT TO HEARING AND APPEAL	39
	<u>9.1.1</u> Triggering Events	
	<u>9.1.2</u> Notice of Adverse Action and Right to Hearing	
	<u>9.1.3</u> Request for Hearing or Appeal	
	<u>9.1.4</u> Waiver by Failure to Request a Hearing	
	<u>9.1.5</u> Nature of Hearing	
<u>9.2</u>	SCHEDULING THE HEARING	41
	<u>9.2.1</u> Notice of Time and Place	
	<u>9.2.2</u> Expedited Hearing	
<u>9.3</u>	APPOINTMENT OF HEARING COMMITTEE	41
	<u>9.3.1</u> Composition of Hearing Committee	
	<u>9.3.2</u> Appointment of Hearing Committee	
	<u>9.3.3</u> Respondent's Right to Object	
<u>9.4</u>	PREHEARING PROCEEDINGS	42
	<u>9.4.1</u> Exhibits and Witnesses	
	<u>9.4.2</u> Depositions	

<u>10.8.3</u>	Secretary	
<u>10.8.4</u>	Treasurer	
<u>ARTICLE 11</u>	CLINICAL DEPARTMENTS AND SERVICES	50
<u>11.1</u>	ORGANIZATION	50
<u>11.2</u>	CURRENT DEPARTMENTS AND SERVICES	51
<u>11.3</u>	ASSIGNMENT TO DEPARTMENTS AND SERVICES	52
<u>11.4</u>	FUNCTIONS OF DEPARTMENTS AND SERVICES	52
<u>11.4.1</u>	Recommend Guidelines	
<u>11.4.2</u>	Adopt Policies and Procedures	
<u>11.4.3</u>	Conduct Patient Care Reviews	
<u>11.4.4</u>	Develop Objective Criteria	
<u>11.4.5</u>	Conduct and Make Recommendations	
<u>11.4.6</u>	Perform Other Duties	
<u>11.5</u>	DEPARTMENT CHAIRS	52
<u>11.5.1</u>	Duties	
<u>11.5.2</u>	Specific Duties	
<u>11.5.3</u>	Qualifications	
<u>11.5.4</u>	Selection	
<u>11.5.5</u>	Term, Reappointment, Compensation, Titles	
<u>11.5.6</u>	Evaluation	
<u>11.5.7</u>	Removal	
<u>11.6</u>	SERVICE CHIEFS	54
<u>11.6.1</u>	Duties	
<u>11.6.2</u>	Qualifications	
<u>11.6.3</u>	Selection	
<u>11.6.4</u>	Term, Reappointment, Compensation, Titles	
<u>11.6.5</u>	Evaluation	
<u>11.6.6</u>	Removal	
<u>11.7</u>	DEPARTMENT PEER REVIEW COMMITTEES	55
<u>11.8</u>	FORMATION, ELIMINATION OF DEPARTMENTS AND SERVICES	55
<u>11.8.1</u>	Clinical Departments, Services	
<u>11.8.2</u>	Formation of Subspecialty Services	
<u>11.8.3</u>	Professional Staff Services	
<u>ARTICLE 12</u>	COMMITTEES	56
<u>12.1</u>	GENERAL	56
<u>12.1.1</u>	Categories of Committees	
<u>12.1.2</u>	Appointment of Committee Chairs, Members; Election of Vice Chair	
<u>12.1.3</u>	Ex-officio Members	
<u>12.1.4</u>	Committee Action, Recommendations	
<u>12.1.5</u>	Creation of Specific or Ad Hoc Committees	
<u>12.1.6</u>	Creation of Subcommittees	
<u>12.1.7</u>	Policies and Procedures	
<u>12.1.8</u>	Meeting Frequency	
<u>12.1.9</u>	Record/Reports	
<u>12.2</u>	EXECUTIVE COMMITTEE	57
<u>12.2.1</u>	Composition	
<u>12.2.2</u>	Selection	

<u>12.2.3</u>	Removal of At-Large Members	
<u>12.2.4</u>	Duties	
<u>12.3</u>	STANDING COMMITTEES	59
<u>12.3.1</u>	Budget	
<u>12.3.2</u>	Bylaws	
<u>12.3.3</u>	Credentials	
<u>12.3.4</u>	Intensive Care Unit	
<u>12.3.5</u>	Education	
<u>12.3.6</u>	Ethics and Complex Care	
<u>12.3.7</u>	Health Status Committee	
<u>12.3.8</u>	Infection Control	
<u>12.3.9</u>	Medical Records	
<u>12.3.10</u>	Nominating	
<u>12.3.11</u>	Operating Room	
<u>12.3.12</u>	Patient Care Assessment	
<u>12.3.13</u>	Perinatal Care	
<u>12.3.14</u>	Pharmacy & Therapeutics	
<u>12.3.15</u>	Content Removed-QPIC eliminated (BOT 11/2006)	
<u>12.3.16</u>	Resuscitation	
<u>12.3.17</u>	Service Recognition	
<u>12.3.18</u>	Tissue and Transfusion	
<u>12.3.19</u>	Cancer Care	
<u>12.4</u>	JOINT COMMITTEES	67
<u>12.4.1</u>	Joint Conference	
<u>12.4.2</u>	Human Research and Investigation	
<u>12.4.3</u>	Medical Research	
<u>12.4.4</u>	Patient Safety Steering	
<u>ARTICLE 13</u>	STAFF, DEPARTMENT, SERVICE AND COMMITTEE MEETINGS	70
<u>13.1</u>	FREQUENCY OF REGULAR MEETINGS	70
<u>13.2</u>	ANNUAL MEETING	70
<u>13.3</u>	ATTENDANCE REQUIREMENT	70
<u>13.4</u>	QUORUM	71
<u>13.5</u>	MANNER OF ACTION	71
<u>13.6</u>	CONDUCT OF MEETINGS	71
<u>13.6.1</u>	Robert's Rules	
<u>13.6.2</u>	Confidentiality	
<u>13.7</u>	NOTICE OF MEETINGS	72
<u>13.7.1</u>	Regular Meetings	
<u>13.7.2</u>	Special Meetings	
<u>13.8</u>	POLICY ON CONFLICT OF INTEREST IN PEER REVIEW	72
<u>ARTICLE 14</u>	IMMUNITY AND INDEMNIFICATION	72
<u>14.1</u>	IMMUNITY FROM LIABILITY	72
<u>14.2</u>	INDEMNIFICATION	73
<u>14.2.1</u>	Covered Activities	
<u>14.2.2</u>	Excluded Activities	
<u>14.2.3</u>	Covered Payments	
<u>14.2.4</u>	Defense	

	14.2.5	Advance of Expenses	
	14.2.6	Duration	
ARTICLE 15		RULES AND REGULATIONS	75
	15.1	DEFINITION	75
	15.2	MANNER OF ADOPTION AND AMENDMENT	75
	15.3	POSTING OF STAFF RULES AND REGULATIONS	75
ARTICLE 16		POLICIES AND PROCEDURES	75
	16.1	DEFINITION	75
	16.2	DEPARTMENT & SERVICE POLICIES AND PROCEDURES	75
	16.2.1	Manner of Revision	
	16.2.2	Checklist	
	16.2.3	Board Approval; Prohibition	
	16.2.4	Consistency	
	16.2.5	Approval of Service Policies	
	16.2.6	Approval of Department Policies	
	16.2.7	Appeal	
	16.3	POSTING OF POLICIES AND PROCEDURES	76
ARTICLE 17		AMENDMENTS, ADOPTION, APPROVAL	77
	17.1	INITIATION	77
	17.2	BYLAWS COMMITTEE ACTION	77
	17.3	EXECUTIVE COMMITTEE ACTION	77
	17.4	LACK OF AGREEMENT	77
	17.5	ACTION BY THE ACTIVE STAFF	77
	17.5.1	Notice	
	17.5.2	Modification	
	17.5.3	Amendment	
	17.5.4	Mail Ballot	
	17.6	ADOPTION AND APPROVAL	78
ARTICLE 18		MEDICAL STAFF RULES AND REGULATIONS	78
	18.1	INTRODUCTION AND DEFINITIONS	78
	18.2	MEDICAL STAFF COVERAGE	79
	18.2.1	Coverage of Inpatients	
	18.2.2	Emergency Coverage	
	18.2.3	Referrals	
	18.3	ADMISSIONS	81
	18.3.1	General	
	18.3.2	Teaching Service	
	18.3.3	Intensive Care Unit	
	18.4	DISCHARGES	84
	18.4.1	General	
	18.4.2	Discharge Against Medical Advice	
	18.5	DEATH & AUTOPSIES	85
	18.5.1	Hospital Deaths	

<u>18.5.2</u>	Autopsies	
<u>18.5.3</u>	Death Certificates	
<u>18.5.4</u>	Anatomical Donations	
<u>18.6</u>	TRANSFERS	89
<u>18.6.1</u>	Institutional Transfers	
<u>18.6.2</u>	Transfers Within the Newton-Wellesley Hospital	
<u>18.7</u>	MEDICAL RECORDS	91
<u>18.7.1</u>	General	
<u>18.7.2</u>	Required Elements	
<u>18.7.3</u>	Confidentiality of Patient Records	
<u>18.8</u>	ORDERS	99
<u>18.8.1</u>	General	
<u>18.8.2</u>	Verbal Orders	
<u>18.8.3</u>	Standing or Standardized Orders	
<u>18.8.4</u>	PRN Orders	
<u>18.8.5</u>	Automatic Stop Orders	
<u>18.8.6</u>	Medication Orders	
<u>18.8.7</u>	Restraint Orders	
<u>18.8.8</u>	Do Not Resuscitate Orders	
<u>18.8.9</u>	Orders for Physical, Occupational & Speech Therapy	
<u>18.9</u>	CONSULTATIONS	103
<u>18.9.1</u>	General	
<u>18.9.2</u>	Mandatory Consultations	
<u>18.9.3</u>	Consultation Order	
<u>18.9.4</u>	Communications between Attending Medical Staff Member and Consultant	
<u>18.9.5</u>	Consultants Not on Staff	
<u>18.9.6</u>	Follow-up and Sign Off	
<u>18.10</u>	SURGICAL & INVASIVE PROCEDURES	106
<u>18.10.1</u>	Responsibilities Prior to Procedure; Informed Consent	
<u>18.10.2</u>	Surgical Tissue and Foreign Bodies	
<u>18.10.3</u>	Surgical Assistance	
<u>18.10.4</u>	Infection Control	
<u>18.10.5</u>	Anesthesia	
<u>18.10.6</u>	Non-Operating Room Surgical & Invasive Procedures	
<u>18.11</u>	INFECTION CONTROL	107
<u>18.11.1</u>	Handwashing	
<u>18.11.2</u>	Isolation and Precautions	
<u>18.11.3</u>	Diagnosing Infections	
<u>18.11.4</u>	Restricted Antibiotics	
<u>18.11.5</u>	Obligation to Report Communicable Diseases and Outbreaks	
<u>18.11.6</u>	Infection Control Policies	
<u>18.11.7</u>	Standard Precautions	
<u>18.11.8</u>	HIV-Infected Patient	
<u>18.11.9</u>	HIV-Infected Health Care Worker	
<u>18.11.10</u>	Authority to Act in Emergencies	
<u>18.12</u>	HOUSE OFFICERS	109
<u>18.12.1</u>	House Officer Supervision	

[18.12.2](#) Documentation

[18.13](#) RESEARCH

110

[18.13.1](#) Medical Staff Conducting Clinical Research

[18.13.2](#) Human Research Projects

BYLAWS OF THE MEDICAL STAFF
Of
NEWTON-WELLESLEY HOSPITAL

PREAMBLE

WHEREAS, Newton-Wellesley Hospital is a nonprofit corporation organized under the laws of the Commonwealth of Massachusetts; and

WHEREAS, the mission of the Newton-Wellesley Hospital is to provide exemplary patient care; and

WHEREAS, the Newton-Wellesley Hospital has delegated to its Medical Staff the responsibility for overseeing the quality of medical and health care rendered to patients in the Hospital; and

WHEREAS, the mission of the Medical Staff of Newton-Wellesley Hospital is to strive to deliver the highest quality medical care to the community served by the Hospital and to promote excellence in medical teaching; and

WHEREAS, the Medical Staff requires a framework in which to promote quality medical care for all Hospital patients, to review and evaluate medical care provided in the Hospital, and to discuss and resolve issues affecting it and patient care; and

WHEREAS, the cooperative efforts of the Medical Staff, the Newton-Wellesley Hospital Administration and the Board of Trustees are necessary to fulfill the Hospital's purposes;

THEREFORE, the Medical Staff is organized for the purpose of fulfilling these objectives and these Bylaws are adopted to provide the Medical Staff with a structure for the discharge of its responsibilities, for its organization and self-government, and for its relations with its members, applicants, the Hospital and the Board of Trustees.

ARTICLE I
NAME

The name of this organization shall be the Medical Staff of Newton-Wellesley Hospital. [↑Back to Top](#)

ARTICLE II
DEFINITIONS

"Board" means the Board of Trustees of the Hospital, or the Executive Committee of the Board of Trustees of the Hospital. (Amended July 16, 2001)

"Chair" means chair of a committee or department. If absence or conflicts prevent the chair from performing his/her duties, a committee's vice-chair or a department's associate chair shall assume the role of Chair. (Amended 10/04/00)

"Chief Executive Officer," "CEO" or "Hospital President" means the individual appointed by the Board to act on behalf of the Board in the overall management of the Hospital. In the performance of specific duties described in these Bylaws and the Rules and Regulations, it may also signify the Administrator on call, the relevant Hospital Vice President, or designee.

"Dean of the Medical School" means the Dean of a Medical School affiliated with the Hospital.

"Executive Committee" or "ECMS" means the Executive Committee of the Medical Staff, unless otherwise specified.

"Ex-officio member" means a committee member, pursuant to these Bylaws, who is a member by virtue of an appointed, elected or managerial position. Unless specifically provided by these Bylaws, ex officio members are not entitled to vote and are not counted in determining the existence of a quorum.

"Hospital" means Newton-Wellesley Hospital and all of its licensed satellites.

"House Staff" or "House Officer" means a post-graduate trainee or teaching fellow that is a member of either one of the Hospital's post-graduate training programs or a post-graduate training program of another hospital with an established rotation at the Hospital.

"Medical Director" means a physician Medical Staff member who has been engaged by the Hospital in accordance with these Bylaws to direct the performance of either a division of the Hospital (e.g., Critical Care Unit) or a Hospital program (e.g., Quality Assessment and Improvement Program).

"Medical Staff" means the organization to which the Board has delegated responsibility for overseeing, and reporting to the Board on, the quality of medical, professional services and patient care provided in the Newton-Wellesley Hospital, pursuant to these Bylaws.

"Medical Staff member" means a physician (M.D. or D.O.), dentist or podiatrist holding a current Massachusetts license to practice and who has been appointed to the Medical Staff pursuant to these Bylaws.

"Physician" means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.

"Practitioners" means licensed health care professionals including, but not limited to, physicians, dentists and podiatrists, and clinical psychologists.

"President" means President of the Medical Staff and shall signify Vice President or other Medical Staff officer in direct line of succession, in the event of absence or conflict.

"QA Committee of the Board" means a committee of the Board of Directors, consisting of five members of the Board, the CEO and five Medical Staff members selected by the ECMS, that assesses and makes recommendations to the full Board on matters concerning patient care and professional practices in the Hospital.

"Reappointment period" means the term of reappointment lasting a maximum of two years. "Reappointment year" means the final year in the reappointment period.

"Respondent" means a practitioner who is responding to an investigation or adverse action with respect to Staff membership or privileges.

"Special Notice" means written notification sent by certified mail, return receipt requested, or by personal delivery with signed acknowledgment of receipt.

"Staff Year" means the period from January 1 to December 31.

"Vice President for Quality Improvement" means the Hospital's administrative officer appointed to act as Patient Care Assessment Coordinator pursuant to 243 CMR 3.00. [↑Back to Top](#)

(Amended BOT 11/02/2011)

ARTICLE III
STAFF MEMBERSHIP

3.1 HOSPITAL STAFFS

3.1.1 *Appointment by the Board.* The Board has authority to make all appointments and reappointments to Hospital Staffs and shall exercise that authority with ECMS recommendations, in accordance with these Bylaws. No practitioner, including those in a medical administrative position by virtue of a Hospital contract, shall admit or provide medical or health-related services to patients in the Hospital, unless he or she is a member of the Hospital Staff and/or has been granted appropriate privileges consistent with these Bylaws. (Amended BOT 11/02/2011)

3.1.2 *Three Staffs; Relationship.* Hospital Staffs include the Medical Staff, Professional Staff and Post-Graduate Trainee Staff. The Medical Staff has overall responsibility, in accordance with these Bylaws, for the quality of patient care provided by Hospital Staffs in the Hospital.

3.1.3 *Non-Discrimination.* Neither Staff membership nor clinical privileges shall be denied or limited on the basis of sex, race, creed, color, national origin, sexual orientation, age, religion, presence or degree of disability, or other criterion lacking professional justification.

3.2 MEDICAL STAFF

3.2.1 *Nature of Medical Staff Membership.* Membership on the Medical Staff is a distinction that is extended only to professionally competent physicians, dentists and podiatrists who continuously meet the qualifications, standards and requirements established in these Bylaws in order to fulfill the Medical Staff mission stated in the Preamble and to account to the Board for the quality of medical care provided to Hospital patients. (Amended BOT 9/11/2013)

3.2.2 *Qualifications for Medical Staff Members*

3.2.2.1 *General Qualifications.* Only physicians dentists and podiatrists who can document their current licensure in the Commonwealth of Massachusetts; background, experience and training; demonstrated current competence; ability; personal character; judgment; adherence to the ethics of their profession; physical and mental health so as not to compromise the care of their patients; availability to provide continuous care to their patients in the Hospital in accordance with these Bylaws and the Medical Staff and Hospital Rules and policies; and ability to work cooperatively with others so as not to adversely affect patient care, with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them in the Hospital will be given high quality medical care; and satisfaction of the appropriate requirements stated in Section 3.2.2.2, shall be qualified for Medical Staff membership.

3.2.2.2 *Specific Qualifications.* To better accomplish the mission of Newton-Wellesley Hospital as stated in the Preamble to these Bylaws, as of March 27, 1995, initial applicants for appointment to the

Medical Staff membership must meet the following specific requirements:

a) Physicians. Prior to July 1, 2006, a physician applicant for Medical Staff membership must have completed a postgraduate training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), or document to the satisfaction of the Credentials Committee completion of an equivalent training program. Medical Staff members whose initial application to the staff occurred prior to July 1, 2006, shall not be subject to the reappointment requirements in paragraph 3.2.2.2.b below, except if the Departmental or Service requirements below (3.2.2.2.a.i) are applicable.

i. Applicants requesting privileges in Departments or Services whose Policies & Procedures establish a requirement for Board Certification or eligibility, must demonstrate such qualifications at the time of application and at each reappointment.

b) On or after July 1, 2006, a physician applicant for Medical Staff membership, must be certified or eligible for certification by a medical specialty board that is a member of the American Board of Medical Specialties (ABMS), the Royal College (Canada), or the American Osteopathic Association (AOA) and demonstrate such qualification at the time of application and at each reappointment in accordance with requirements of the Policies and Procedures of the department in which they seek appointment. Physician applicants not so certified or eligible may be admitted to the Medical Staff by virtue of equivalent qualifications upon recommendation of the Chair (and Service Chief, if applicable), the Credentials Committee and with approval of the Executive Committee by two-thirds vote.

i. Applicants requesting privileges in a Service whose Policies & Procedures establish a requirement for subspecialty certification or eligibility, must demonstrate such qualifications at the time of application and reappointment.

b) *Podiatrists*. A podiatrist applicant for Medical Staff membership must be certified or eligible to become certified by the American Board of Podiatric Surgery. Podiatrist applicants not so certified may be admitted to the Medical Staff by virtue of equivalent qualifications upon recommendation by the Chair, the Credentials Committee and with approval of the Executive Committee by two-thirds vote.

3.2.2.3 Professional Liability Insurance. Provide evidence for professional liability insurance coverage. The Medical Staff member is responsible for maintaining professional liability insurance coverage consistent with regulatory agencies, licensure and privileges requested and granted. (Amended 9/14/2005; BOT 11/02/2011)

3.2.2.4 Dues

a) *Obligation; Amount.* Each Provisional, Active, and Affiliate Staff category member shall, unless waived for due cause by the Medical Staff President, pay annual dues to the Medical Staff Fund in the amount determined by the Medical Staff at its annual meeting on ECMS recommendation, to be used at the direction of the Medical Staff. (Amended 8/11/2004; Amended BOT 11/02/2011)

b) *Failure to Pay.* Failure to pay dues by the subsequent annual meeting shall be grounds for suspension of the member's privileges until the charges are paid. Failure of a suspended member to pay dues within ninety (90) days of the suspension notice will result in automatic termination, in accordance with Section 8.7.

3.2.3 Term of Appointment. Initial appointments shall be provisional for at least twelve months and shall be governed by the provisions of Section 4.2. Reappointments shall be for a term of not more than 24 months.

3.2.4 Contract Physicians

3.2.4.1 *Defined.* Contract Physicians include any member of the Medical Staff who provides professional medical services to Hospital patients pursuant to an exclusive contract with the Hospital or who contracts with the Hospital to provide full-time professional medical services to Hospital patients. "Full-time" means the member's medical or professional activity outside of the contractual obligations is insubstantial relative to those obligations as reasonably determined by the CEO. "Exclusive contract" means an agreement (1) in which the Hospital agrees not to contract with other(s) for the same professional medical services that are the subject of the contract for the term of the contract, or (2) which would preclude any otherwise qualified Medical Staff member or applicant from exercising the same clinical privileges as those covered by the contract.

3.2.4.2 *Applicable Procedures.* Initial appointment and biannual review for determination of Staff membership, category and privileges for Contract Physicians shall be by the same procedures as for other Staff members, as provided in Articles 4, 5, and 6, except that:

a) Requirements stated in Article 4 for the Active Staff category does not apply except as noted in Paragraph (b) below: (Amended BOT 11/02/2011)

b) Contract Physicians may be granted privileges other than those central to the performance of their contract duties by making application to and receiving approval from the appropriate department or service granting privileges, in accordance with Articles 5 and 6. A grant of privileges outside the scope of the contract duties shall subject the Contract Physician to Article 4 patient requirements as to those privileges. (Amended BOT 11/02/2011)

3.2.5 Leave of Absence/Inactive Status

3.2.5.1 Leave of Absence. The ECMS may recommend that the Board grant a Staff member a leave of absence for a period of at least three (3) months, but not to exceed two (2) years, including extensions. A member on leave of absence shall have none of the privileges or obligations of membership. (Amended BOT 12/13/06)

3.2.5.2 Request For Leave of Absence. Requests for leave of absence must be submitted in writing to Credentialing Services and include commencement and termination dates and coverage arrangement, as applicable. Credentialing Services shall refer all leave requests to the appropriate department chair for recommendation and to the ECMS for action at its next regular meeting.

3.2.5.3 Request For Reactivation. For privileges and membership to be reactivated after a leave, the member must submit a summary of all relevant activities during the leave and consent to the release of relevant information regarding the leave period. Such information shall be confidential and privileged, in accordance with the requirements of Articles 5, 6 and 7. At the request of the department chair, the member may be required to submit an Application for Reappointment as specified in Article 5. ECMS shall make a recommendation to the Board concerning reactivation. (Amended BOT 12/13/06)

3.2.5.4 Initial Application for Appointment and Privileges. A practitioner whose leave of absence extended beyond two years will relinquish Medical Staff membership. Reinstatement will require application for initial appointment to the Provisional Staff. An application for appointment shall be documented and processed in accordance with Article 5, and shall include documentation concerning professional and other activities while on leave of absence. (Amended 8/11/2004) (Amended BOT 12/13/06)

3.2.5.5 Reports to Boards of Registration. Leaves of absence, voluntary or involuntary, that state law defines as disciplinary actions, shall be reported to the relevant Board of Registration to the extent required by law.

3.2.6 Resignation. A member of the Medical Staff may at any time file his/her request for resignation in writing with the Secretary of the Medical Staff, who shall transmit this request to ECMS. ECMS shall recommend appropriate action to the Board, and the CEO will make any statutorily required reports. [↑Back to top](#)

3.3 PROFESSIONAL STAFF

3.3.1 Board Approval. The Professional Staff is composed of practitioners with limited scope of practice and includes appropriately licensed clinical psychologists, independent clinical social workers, radiology practitioner assistants, nurses practicing in an expanded role, physician assistants, pharmacists, and physicians without independent privileges. The Board may, on recommendation of the Medical Staff and amendment of these Bylaws, designate additional professional categories for appointment

to the Professional Staff and privileges. (Amended BOT 4/11/2005; 07/11/2007; 9/16/2015)

3.3.2 *Conditions and Duration of Appointment; Evaluation; Scope of Practice.* Appointment and privileges granted shall be (a) based on an objective evaluation of an applicant's credentials, (b) determined on an individual basis, and (c) commensurate with an applicant's education, training and experience. The Medical Staff shall be responsible for monitoring the evaluation of Professional Staff qualifications and the performance of the Professional Staff members and for making recommendations to the Board relating to Professional Staff services and procedures. Professional Staff shall practice in the Hospital within the scope of properly granted privileges and may not admit patients. After a provisional appointment of no less than twelve months, qualifying members of the Professional Staff shall be appointed for two-year terms. (BOT 11/2006)

3.3.3 *Clinical Departments.* Each Professional Staff member shall be assigned to a Medical Staff department/service and shall be granted practice privileges in one or more departments or services of the Medical Staff. Professional Staff may establish services in accordance with Section 10.7 and may participate in Medical Staff activities through membership on Medical Staff committees and attendance at Quarterly meetings.

3.3.4 *Due Process and Reporting.* Members of the Professional Staff are entitled and subject to the privileging, due process and reporting procedures described in these Bylaws as governing Medical Staff members and applicants, including reports to state boards of registration and the National Practitioner Data Bank, except as may be prohibited by law and except that privileges of Professional Staff that are subject to a Hospital employment arrangement or that may be exercised only under supervision of a physician with whom the Professional Staff member has an employment arrangement shall automatically terminate with the termination of employment, and neither termination shall trigger the appeal procedures referred to at the beginning of this paragraph. [↑Back to top](#)

3.4 POST-GRADUATE TRAINEE STAFF

3.4.1 *Qualifications.* Post-Graduate Trainee Staff membership shall be held by practitioners who are licensed to practice medicine in Massachusetts and who are:

3.4.1.1 members of any Newton-Wellesley post-graduate training program;

3.4.1.2 members of a post-graduate training program of another hospital with an established rotation at the Hospital; and

3.4.1.3 members of a Hospital preceptorship program and who are being tutored in the Hospital by a preceptor who is an Active or Affiliate Staff member, or a Provisional Staff member, if a department chair or service chief. (Amended BOT 11/02/2011)

3.4.2 *Appointment.* Post-Graduate Trainees who are not eligible for another Staff category and who are enrolled in the programs described in Section 3.4.1 shall be appointed to the Post-Graduate Trainee Staff and

shall not be members of the Medical Staff. They may participate in the activities of the Medical Staff through membership on Medical Staff committees and attendance at Quarterly meetings.

3.4.3 Duration of Membership, Privileges. Post-Graduate Trainee Staff membership and all privileges granted and exercised under the member's program shall terminate at the conclusion of the member's participation in the training program or preceptorship.

3.4.4 Supervision. All medical care provided by Post- Graduate Trainees must be under the supervision of an Active, Affiliate, or a Provisional Staff member holding clinical privileges applicable to the care being provided by the Post-Graduate Trainees. (Amended 8/7/2002; Amended BOT 11/02/2011) [↑Back to top](#)

ARTICLE IV
MEDICAL STAFF CATEGORIES

4.1 MEDICAL STAFF CATEGORIES
(Amended BOT 11/02/2011)

Prerequisite of Staff Membership

A prerequisite of membership at NWH, regardless of type, is the demonstration of current competency. Competency is the habitual and judicious use of communication, knowledge, technical skill, clinical reasoning, and professionalism in daily practice for the benefit of the individual and community being served. Additionally, there should be demonstration of collegial interpersonal relationships to assure coordinated care, commitment to practice-based improvement and respect for systems-based practice. Every clinician is personally responsible for maintenance of competency.

All appointments and reappointments to the medical staff are contingent on the faithful compliance with Medical Staff Bylaws, Rules and Regulations and Department/Service Policies and Procedures. It will be the obligation of the Medical Staff member to prove compliance when specifically requested to do so by the Department Chair or the Service Chief as designee of the Chair.

Each member of the Medical Staff shall be assigned membership in one department and shall comply with the policies and procedures of that department.

Each Medical Staff member shall be a member of one of the following Medical Staff Categories:

- | | | | |
|-------|-------------------|-------|-----------------|
| 4.1.1 | Provisional Staff | 4.1.3 | Affiliate Staff |
| 4.1.2 | Active Staff | 4.1.4 | Honorary Staff |

[↑Back to top](#)

4.2 PROVISIONAL STAFF

4.2.1 Initial Appointment. All initial Medical Staff appointments, except Honorary, are to the Provisional category.

4.2.2 *Qualifications and Responsibilities*

(Amended BOT 11/02/2011; 9/11/2013)

- o Fulfill requirements for direct patient care and consultation assignments of patients as specified by Medical Staff Bylaws, Rules and Regulations and department policies and procedures.

- o Participate in activities and functions of the Medical Staff, including but not limited to: quality/performance improvement and peer review, risk management, and medical records completion.

- o Demonstrate a commitment to an ongoing meaningful relationship with the Hospital community as defined by each Department in its Policies and Procedures.

4.2.3 *Prerogatives*

(Amended BOT 11/02/2011)

- o Read all Medical Staff communications.

- o May review the progress of their patients by communicating with the inpatient team and specialists, and via chart review.

- o Are ineligible to hold Staff office or vote but may be appointed to medical staff committees. They may vote on matters before committees on which they have been appointed to serve.

- o May or may not be granted clinical privileges by the Board. Clinical privileges required for providing services to NWH patients will be (1) according to the physician's approved Delineation of Privileges, and (2) evaluated on an ongoing basis and subject to revision.

- o Have appropriate access to hospital information systems.

4.2.4 *Advancement: Timing.* Initial appointees shall remain on the Provisional Staff a minimum of twelve (12) months (unless terminated sooner). At the end of twelve months, the chair of the appointee's department may recommend advancement to a more appropriate Staff category, termination from the Staff, or reappointment to the Provisional Staff category for a maximum of twelve (12) additional months. At the end of the second year of Provisional Staff appointment, the department chair must recommend either transfer to Active, Affiliate or Honorary Staff category or termination from the Staff. (Amended BOT 11/02/2011)

4.2.5 *Advancement: Criteria.* Advancement from Provisional to the Active or Affiliate Staff shall be based on the practitioner's demonstrated professional performance and judgment at least at the standards of the Medical Staff; behavior consistent with professional and ethical standards and fulfillment of Staff duties. (Amended BOT 11/02/2011; 01/11/2012)

4.2.5.1 If the practitioner fails within the provisional period to meet the departmental (or service) requirements for full membership in the department (or service), the practitioner's Staff appointment shall terminate, and the practitioner shall be entitled to request a hearing under Article 9 of these Bylaws.

[↑Back to top](#)

4.3 ACTIVE STAFF

4.3.1 The Active Staff shall consist of physicians, dentists and podiatrists who provide care or services for Newton-Wellesley Hospital patients and who demonstrate a commitment to the Medical Staff, the Hospital and the NWH patient community. (Amended BOT 11/02/2011)

4.3.2 *Qualifications and Responsibilities.* (Amended BOT 11/02/2011; 9/11/2013)

- o Fulfill requirements for direct patient care and consultation assignments of patients as specified by Medical Staff Bylaws, Rules and Regulations and department policies and procedures.
- o Contribute to the organizational and administrative affairs of the Medical Staff.
- o Actively participate in activities and functions of the Medical Staff, including but not limited to: quality/performance improvement and peer review, risk management, committee assignments, meeting attendance, and medical records completion.
- o Demonstrate an ongoing meaningful relationship with the Hospital community as defined by each Department in its Policies and Procedures.

4.3.3 *Prerogatives.*

- o Vote on all Medical Staff and Departmental business.
- o Hold Staff office or a physician leadership role in accordance with qualifying criteria as set forth in these Bylaws.
- o Read all Medical Staff communications.
- o May review the progress of their patients by communicating with the inpatient team and specialists, and via chart review.
- o May or may not be granted clinical privileges by the Board. Clinical privileges required for providing services to NWH patients will be (1) according to the physician's approved Delineation of Privileges, and (2) evaluated on an ongoing basis and subject to revision.
- o Have appropriate access to hospital information systems.

[↑Back to top](#)

4.4 AFFILIATE STAFF.

(Amended BOT 11/02/2011; 9/11/2013)

4.4.1 Affiliate staff shall consist of physicians, dentists and podiatrists who provide services to the NWH patient community on an infrequent basis or whose primary affiliation is not Newton-Wellesley Hospital.

4.4.2 *Qualifications and Responsibilities.*

- o Fulfill requirements for direct patient care and consultation assignments of patients as specified by Medical Staff Bylaws, Rules and Regulations and department policies and procedures.

- o Participate in activities and functions of the Medical Staff, including but not limited to: quality/performance improvement and peer review, risk management, and medical records completion.

- o Demonstrate an ongoing relationship with the Hospital community as defined by each Department in its Policies and Procedures

4.4.3 *Prerogatives.*

- o Read all Medical Staff communications.

- o May review the progress of their patients by communicating with the inpatient team and specialists, and via chart review.

- o Are ineligible to hold Staff office or vote, except they may vote on matters before committees on which they have been appointed to serve.

- o May or may not be granted clinical privileges by the Board. Clinical privileges required for providing services to NWH patients will be (1) according to the physician's approved Delineation of Privileges, and (2) evaluated on an ongoing basis and subject to revision.

- o Have appropriate access to hospital information systems.

[↑Back to top](#)

4.5 HONORARY STAFF

4.5.1 *Qualifications.* The Honorary Staff shall consist of physicians and other practitioners who are honored for their outstanding reputations, accomplishments, or services to the Hospital or medical community. Honorary Staff membership shall be for an unrestricted term without requirement for reappointment unless specified otherwise by the ECMS. (Amended BOT 12/13/06)

4.5.2 *Prerogatives.*
(Amended BOT 11/02/2011)

- o Read all Medical Staff communications.

- o Are ineligible to hold Staff office or vote, except they may vote on matters before committees on which they have been appointed to serve.

- o May not be granted any clinical privileges by the Board.

- o Are exempt from Medical Staff dues.

[↑Back to top](#)

4.6 CHANGES IN STAFF CATEGORY

Any Medical Staff member wishing to change Staff category must submit a request in writing to the chair of the department and chief of the service. The recommendation of the chair (chief) will be forwarded to ECMS, and its recommendations forwarded to the Hospital Board. The timing of requests need not be confined to reappointment. [↑Back to top](#)

ARTICLE V APPOINTMENT AND REAPPOINTMENT

5.1 APPLICATION FOR APPOINTMENT AND PRIVILEGES

5.1.1 *The Application Form.* The application form(s) and related credentialing policies for all applications for privileges and for appointment to the Medical Staff and the Professional Staff shall be approved by the Board with Credentials Committee and ECMS recommendation, in accordance with the procedures described in these Bylaws and applicable state and federal law. It shall inform the applicant of his/her obligation to produce sufficient information so that a proper evaluation of the applicant's competence, character, ethics and other qualifications can be made, and so that any doubts about such qualifications can be resolved. The application form shall assure the applicant that all information with respect to the applicant that is submitted, collected or prepared by any representative of the Hospital or Medical Staff shall be confidential and privileged in accordance with these Bylaws and to the fullest extent permitted by law. To the extent possible, the application shall conform to the format and content of the Integrated Massachusetts Application for Initial Credentialing/Appointment. (Amended BOT 7/7/2010)

5.1.2 *Completed Application.* In addition to the items prescribed by the medical staff and their preliminary verification by the Hospital including satisfactory reconciliation of inconsistencies and gaps, a completed application must include: all required signatures of the applicant, the application fee, and an interview with department chairs and service chiefs. (Amended 8/11/2004; Amended BOT 7/7/2010)

5.1.3 *Deadline.* If the application is not completed within six (6) months of the Hospital's receipt of the application, the application will be considered withdrawn, and the applicant shall have no hearing rights. The applicant may reapply. The Medical Staff and Board may extend the deadline for good cause.

5.1.4 *Breach.* Breach of agreements in the application required by these Bylaws is a breach of these Bylaws. [↑Back to top](#)

5.2 APPOINTMENT PROCESS

5.2.1 *Notification of Incomplete Application.* Within 14 days of receipt of the application, and again 14 days before the expiration of the six-month period, Credentialing Services will notify the applicant in writing whether the application is incomplete or inconsistent. The applicant is

responsible for expediting submission of the requested information. The Credentialing Services refers the completed application for review and recommendation to the chairs (chiefs) of all departments (services) in which the applicant is requesting privileges.

5.2.2 Recommendation by Chair(s). The chair (chief) of the department (service) in which the applicant seeks membership shall review the application, interview the applicant and make recommendations to deny or grant appointment, to grant the privileges requested or with modification, or to deny privileges, as to Staff category, department and service (if applicable). All other chairs (chiefs) shall make recommendations with respect to the privileges sought. Each chair (chief) shall state the reasons for each recommendation. The chair's (chief's) recommendations will be referred to the Credentials Committee, together with the completed application.

5.2.3 Credentials Committee Recommendation. At its next regularly scheduled meeting, the Credentials Committee will consider the application and the chair's (chief's) recommendation, and formulate a recommendation based on the documentation provided and covering the matters listed in Section 5.2.2, which it will submit to ECMS, together with the application and earlier recommendation.

5.2.4 ECMS Recommendation. ECMS will consider the application and the previous recommendations at its next regularly scheduled meeting. It may request additional information, return the matter to the Credentials Committee for further investigation, and/or elect to interview the applicant. It will prepare a report of its findings, conclusions and recommendations, made in the reasonable belief the actions and recommendations further quality health care and based on the documentation provided and covering the matters listed in Section 5.2.2, which it will refer to the QA Committee of the Board, together with the application and earlier recommendations.

5.2.5 Action by or on behalf of the Board

a. The QA Committee of the Board will consider the application and recommendations and make determinations regarding appointment, privileges, and staff category and department or service assignment of most applicants. All determinations by the QA Committee of the Board shall be effective upon the decision of that committee. However, the Board shall subsequently ratify all such determinations by the QA Committee.

b. The Board will consider the application and recommendations and make determinations concerning the following applicants: applicants concerning whom the final recommendation of the ECMS is adverse to the applicant or with limitation; applicants with respect to whom there is a current challenge or a previously successful challenge to licensure or registration; applicants who have an involuntary termination of medical staff membership at another organization; applicants who have received involuntary limitation, reduction, denial, or loss of clinical privileges; or applicants with respect to whom there has been final judgment adverse to the applicant in a professional liability action.

c. If necessary to meet exceptional time constraints, the Board will also consider and act upon applications covered by paragraph 5.2.5a.

d. Before the Board takes any final action contrary to an ECMS recommendation, it will refer the matter for review and recommendation by the Joint Conference Committee. (Section 5.2.5 amended July 16, 2001) [↑Back to top](#)

5.3 APPLICATION FOR REAPPOINTMENT

5.3.1 *The Application Form.* The application form(s) and related credentialing policies for reappointment and renewal of privileges shall be approved by the Board with Credentials Committee and ECMS recommendation, consistent with the procedures described in these Bylaws and applicable state and federal law. To the extent possible, the form shall conform to the format and content of the Massachusetts Integrated Application for Re-Credentialing/Re-Appointment. The form shall state the applicant's responsibility to provide, consistent with state and federal law, information necessary to assess the applicant's qualifications for reappointment and authority to make inquiries and receive information from external parties capable of reporting on the individual's experience and qualifications. (Amended BOT 7/7/2010)

5.3.2 *Completed Application; Breach.* An application is not deemed complete until the Medical Staff Services has received information prescribed by the medical staff, including preliminary verification and satisfactory reconciliation of inconsistencies and gaps. Breach of an agreement in the application required by these Bylaws shall be deemed a breach of these Bylaws. (Amended BOT 7/7/2010)

[↑Back to top](#)

5.4 REAPPOINTMENT PROCESS

5.4.1 *Mailing the Application Form; Deadlines, Effect.* The reappointment application forms will be mailed six (6) months prior to member's appointment expiration date. The completed application form and supporting documents must be received in the Medical Staff Services office four (4) months prior to the expiration date of appointment. If the applicant has not responded to the Special (third and final) notice for timely return of the application materials, the applicant will be deemed to have resigned from the Medical Staff as of the reappointment expiration date with no appeal rights. (Amended BOT 03/26/08)

5.4.2 *Reappointment Application Review Process.* The reappointment application review process shall be as described in Sections 5.2.2 through 5.2.5, with the following exceptions:

5.4.2.1 *Performance Record.* Recommendations shall take into consideration information from Medical Staff Services (Credentialing) about (a) the applicant derived from quality assessment, utilization practices relating to quality patient care, risk management, and medical records activities conducted in accordance with these Bylaws and (b) the applicant's participation in Medical Staff duties required by these Bylaws. In the event the

Medical Staff member has had insufficient activity at the Hospital to assess the criteria enumerated under 5.4.2.1 (a), the Medical Staff member may be required to make available quality assessment information from other hospitals, managed care organizations or office assessments before the application is considered complete and eligible for further consideration. (Amended 1/09/2002)

[↑Back to top](#)

5.5 GENERAL PROVISIONS

5.5.1 *No Guarantee.* Even though the Staff and the Board assess the qualifications of each applicant for appointment and reappointment in light of numerous standards and criteria in order to promote quality patient care, nothing contained in these Bylaws shall be interpreted as a representation or guarantee by the Staff or the Board as to the skills, qualifications or competence of any individual appointee.

5.5.2 *Appeal Rights.* ECMS recommendation or Board action (a) to deny or revoke appointment, (b) not to appoint or reappoint, (c) to reduce privileges may be appealed in accordance with Article 9 of these Bylaws.

5.5.3 *Basis of Actions on Applications.* The recommendations and actions on each application shall be based on the reasonable belief that they further quality health care and shall be subject to further review procedures afforded under these Bylaws.

5.5.4 *Confidentiality and Privilege.* All information with respect to the applicant that is submitted, collected or prepared by any representative of the Hospital or Medical Staff for the purpose of achieving and improving quality of patient care shall be confidential and privileged to the fullest extent permitted by law, and shall not be disseminated or used in any way except as provided in these Bylaws or as required by law.

5.5.5 *Deadline; Effect of Delay.* Once an initial application is deemed complete, it shall be the responsibility of the CEO to take all reasonable steps to see that final action is taken on the application within 120 days. If reappointment is delayed for any reason other than untimely submission of a completed application, membership and privileges of the preceding year, subject to the provisions of Article 9, shall be continued until the Board takes action on them. (Amended 1/9/2002)

5.5.6 *Reapplication.* An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for two (2) years following the date of the final adverse decision. Any such reapplication shall be treated as an initial application, subject to the requirements of Section 5.1 and 5.2, and in addition the applicant shall submit such further documentation as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

5.5.7 *Notification of Change.* A Medical Staff member or applicant to the Medical Staff is required to notify the Medical Staff Office and the Department Chair promptly if a material change occurs to information provided in the Application for Appointment (5.1) or Reappointment (5.3) as soon as the member or applicant becomes aware of such a change in status. Furthermore, the member or applicant is required to immediately

notify the Medical Staff Office and Department Chair of any interval changes relevant to:

- a) Final judgments and settlements in professional liability actions.
- b) Lapse or expiration of:
 - i. Massachusetts Medical License
 - ii. Federal or state controlled substances registration
 - iii. Professional liability insurance
 - iv. Board Certification
- c) Disciplinary or corrective action resulting in denial, revocation, limitation, or suspension of:
 - i. Hospital or institutional membership or privileges
 - ii. Out of state medical license
 - iii. Board certification
 - iv. Eligibility for participation in Medicare, Medicaid or other health plan.
- d) Any adverse action reported to the Board of Registration in Medicine or to the National Practitioner Data Bank (NPDB).
- e) Any sanctions by the Food and Drug Administration (FDA) or the Office of Human Research Protections (OHRP) pertaining to the conduct of research.
- f) Physical or mental health that may impact the ability to perform privileges granted and/or the ability to provide safe patient care.
- g) Contact information (address/home/office/cellular telephone numbers and electronic email address).
- h) Arrest, indictment or conviction in a criminal proceeding.
(Amended BOT 11/2006; 05/05/2010; 11/02/2011)

[↑Back to top](#)

ARTICLE VI CLINICAL PRIVILEGES

6.1 EXERCISE OF CLINICAL PRIVILEGES

6.1.1 *Granted by the Board.* Except as otherwise provided in these Bylaws, a practitioner providing clinical services at this Hospital may exercise only those clinical privileges specifically granted by the Board based on the recommendation of the Medical Staff in accordance with procedures outlined in these Bylaws.

6.1.2 *Restrictions on Privileges.* The exercise of any privilege is subject to the requirements of these Bylaws, the Medical Staff Rules and Regulations, the policies and procedures of the granting department and the Hospital bylaws. The grant of a specific clinical privilege carries with it the privilege to use, on a nondiscriminatory basis, available Hospital personnel, instruments and facilities necessary to the exercise of the clinical privilege, unless otherwise provided by specific contract terms.

6.1.3 *Evaluation of Requests to Exercise Privileges.* Every application for appointment and reappointment shall request the specific privileges desired by the applicant. Requests are subject to clarification upon interview. The evaluation of requests for privileges shall be based on the applicant's education, training, experience, demonstrated current

competence and judgment, references and other relevant information, including documented results of patient care and other quality review and assessment activities deemed appropriate by the Medical Staff, and clinical performance information obtained from other institutions where the practitioner exercises or has exercised privileges. Other compelling quality, safety and peer review evidence of current competency may supercede specific volume-based privileging criteria. Every grant of privileges is specifically subject to the requirements of Section 3.2.1, regardless of whether the practitioner is or seeks to be a Medical Staff member. (Amended 1/12/2005) [↑Back to top](#)

6.2 PROVISIONAL PRIVILEGES

6.2.1 *Defined.* All initially granted privileges shall be provisional upon the practitioner's demonstrated competence in exercising the privileges; and character, ethical, moral, physical and emotional qualifications for Medical Staff membership, whether or not the practitioner is a member of the Medical Staff, during the provisional period. For Medical Staff members, the duration of the provisional period shall be as described in Article 4. For Professional Staff, the provisional period shall last no less than one year, unless terminated sooner pursuant to these Bylaws.

6.2.2 *Proctoring/Monitoring.* The chair of the department or chief of the service to which the practitioner with provisional privileges is assigned shall have the practitioner's performance observed as prescribed in the Hospital's and department's or service's policies and procedures, in order to determine eligibility for unobserved and non-provisional privileges. (BOT 11/2006)

6.2.3 *Advancement to Non-Provisional Privileges*

6.2.3.1 In order to be considered for advancement from provisional to non-provisional privileges, the practitioner must have met the requirements outlined in the department's (service) policies and procedures, by the end of the provisional period. (Amended BOT 1/11/12)

6.2.3.2 If the practitioner fails within the provisional period to meet departmental (service) requirements for specific clinical privileges, those specific clinical privileges shall automatically terminate, and the practitioner shall be entitled to request a hearing under Article 9 of these Bylaws.

[↑Back to top](#)

6.3 ADMITTING PRIVILEGES

6.3.1 *Physician Members.* Qualified physicians, oral-maxillofacial surgeons, podiatrists and dentist members of the medical staff may admit patients to the hospital according to privileges recommended by a department or service and approved by the Board of Trustees (amended BOT 07/01/09).

6.3.2 *Professional Staff and Post-Graduate Trainee Staff.* Members of the Professional and Post-Graduate Trainee Staffs shall not be granted admitting privileges. [↑Back to top](#)

6.4 PRIVILEGES FROM MORE THAN ONE DEPARTMENT/SERVICE

Qualified Medical Staff members who are members of one department but who satisfy the criteria for a delineated privilege established in another department's policies and procedures might apply to be granted such a privilege by the other department. The performance of all privileges shall be overseen and evaluated by the department granting the privilege. [↑Back to top](#)

6.5 EMERGENCY PRIVILEGES

(Amended 6/18/2003)

6.5.1 *Life-Threatening Emergency.* In a life-threatening emergency, any qualified physician, regardless of privileges or Staff status shall be permitted and assisted to do everything possible, within the scope of his or her license, to save the life of a patient, using every facility of the Hospital necessary or desirable. When the emergency situation no longer exists, the patient shall be assigned to a member of the Staff with appropriate privileges.

6.5.2 *Disaster Status.* When the Hospital's Emergency Preparedness Plan has been activated and an urgent need for clinical staff is present, the President of the Hospital or the Medical Staff President, or their designees, may grant emergency privileges to any licensed and qualified clinician to assist in the care of patients during the Disaster. Emergency privileges may be granted upon verification of the individual's identity (government-issued photo I.D.) and at least one of the following:

- (1) a current picture hospital ID card that clearly identifies professional designation;
- (2) examination of a valid professional license;
- (3) primary source verification of the license;
- (4) by attestation to the individual's identity and professional status by a current member of Newton-Wellesley Hospital's Active Medical Staff
- (5) upon presentation of valid U.S. Disaster Medical Assistance Team credentials (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organization or group
- (6) Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).

An assigned member of the medical staff will provide oversight of the care, treatment and services provided by the volunteer practitioner. Oversight will be provided through direct observation, clinical record review and/or mentoring.

The Emergency Privileges shall be reviewed within 72 hours and a decision will be made based on the information obtained on the professional practice of the volunteer on whether the disaster privileges are continued. All emergency privileges expire at the conclusion of the Disaster status and patients will be transferred to a member of the Medical Staff with appropriate privileges. (Adopted 6/18/2003; amended 2/9/2005) (Amended BOT 12/13/06) [↑Back to top](#)

6.6 PRELIMINARY PRIVILEGES

6.6.1 *Request for Preliminary Privileges.* An applicant for medical staff appointment whose completed application has not yet received final approval may request preliminary privileges. Such a request, made in

writing, shall be considered when compelling institutional or patient needs so require. The request must state the basis for the applicant's belief that preliminary privileges are needed. (Amended 4/11/2005)

6.6.2 *Reviews and Approval of Preliminary Privileges.* Such privileges may be granted for a period of time not to exceed that that is allowed by the Massachusetts Board of Registration in Medicine. The complete application and request for preliminary privileges must be reviewed and approved by:

- a) The Chair of the department in which the applicant seeks privileges, who must assess and endorse the institutional or patient care needs justifying preliminary privileges;
- b) The Chief of the service, if any, in which the applicant seeks privileges,
- c) The Chair of the Credentials Committee, on behalf of the Credentials Committee;
- d) The President of the Medical Staff, on behalf of the Executive Committee of the Medical Staff;
- e) The CEO, on behalf of the Board of Trustees.

Preliminary privileges must be exercised under the supervision of the department chair and service chief (or designee).

6.6.3 *Ineligibility for Preliminary Privileges.* The Credentials Committee shall maintain criteria excluding applicants from consideration for preliminary Privileges, such as prior disciplinary actions or loss of privileges.

6.6.4 *Denials, Termination or Lapse of Preliminary Privileges.* The CEO shall, upon request of any of those named in 2.a-e, terminate any or all of a practitioner's preliminary privileges, effective immediately or at such time judged by the CEO to be in the best interests of the institution and the practitioner's hospitalized patients. If necessary, the department Chair shall assume responsibility for arranging continuity of care for hospitalized patients. Denial, termination or lapse of preliminary privileges does not give rise to appeal rights under Article 9 of these Bylaws.

6.6.5 *Withdrawal or Denial of Application.* In the event the application for medical staff appointment or reappointment is withdrawn or denied, the preliminary privileges shall immediately lapse. (Adopted 1/9/2002)

[↑Back to top](#)

6.7 TEMPORARY PRIVILEGES

Temporary privileges may be granted for the care of specific patient(s) to a practitioner who is not an applicant for Medical Staff membership for a period of time not to exceed that that is allowed by the Board of Registration in Medicine. Such a request shall be made on the prescribed forms and state the basis for the belief that temporary privileges are needed. Review and approval, ineligibility for, and denial, termination, or lapse of temporary privileges is

in accordance with Section 6.6, Preliminary Privileges, paragraph 2,3 and 4, above. (Amended 1/9/2002) [↑Back to top](#)

6.8 REDETERMINATION OF PRIVILEGES

6.8.1 Basis. Redetermination and the increase or curtailment of privileges of a practitioner shall be as in 6.1.3.

6.8.2 Applications for Redetermination. Application for additional, or changes in, privileges must be submitted in writing on forms furnished by the Hospital. The applicant must state clearly the type of changes and privileges desired and document the applicant's relevant training and/or experience with certificates of achievement, letters from supervisors or other appropriate means. Applications are processed in the same manner as applications for initial appointment and privileges, as provided in Article 5.

6.8.3 Mandatory Redetermination. The exercise of all Medical Staff and Professional Staff members' non-provisional privileges is redetermined every two years. The redetermination procedure is described in Article 5.

6.8.4 Elective Redetermination. Any practitioner seeking change in clinical privileges may make a request in writing at any time to the department chair and the service chief or their designees, delineating the specific changes requested and stating reasons in support of such changes. Following review by the department chairs and service chiefs or their designees, the request will be forwarded to the Credentials Committee, which will make its recommendation to ECMS, which will in turn make its recommendation to the Board. Denial of a properly documented request shall give rise to an Article 9 hearing right.

6.8.5 Reapplication. A practitioner who has received a final adverse decision regarding the exercise of a clinical privilege shall be ineligible to reapply for such privilege for a period of one (1) year following the date upon which the adverse decision became final. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional documentation as may be required to demonstrate that the basis for the earlier adverse action no longer exists. [↑Back to top](#)

ARTICLE VII
PRACTITIONERS HEALTH PROGRAM
(Rewrite of Article VII; Approved. BOT 5/7/2001)

7.1 DEFINITIONS

7.1.1 "Impaired practitioner" means a practitioner with Hospital practice privileges whose practice has been deemed by the Health Status Committee ("HSC") on the basis of credible information or an admission, to be affected by physical, mental or emotional impairment, and/or drugs, and/or alcohol.

7.1.2 "Credible information" of impairment means information presented by an eyewitness's belief that the practitioner may be impaired.

7.1.3 "Program" means the Practitioners Health Program established under this Article. [↑Back to top](#)

7.2 PROGRAM OBJECTIVES

The objectives of the Program are (a) to safeguard patients, (b) to assist impaired practitioners in recovering from illness with the least interference with their ability to practice their profession consistent with patient safety, and (c) to satisfy the requirements of state and federal law. Evaluations conducted and actions taken as part of the Program are remedial and are neither part of the corrective action process nor disciplinary in nature. [↑Back to top](#)

7.3 INITIATION OF PROGRAM

7.3.1 *Triggering Event.* Credible information or admission of impairment should be brought to the Medical Staff President who will convene the Health Status Committee.

7.3.2 *Action of the HSC.* The HSC will meet promptly to review the information and interview the practitioner in question to determine whether there is a reasonable basis to conclude that the practitioner is impaired. The HSC shall have the authority to require an independent physical and/or psychiatric evaluation by an evaluator acceptable to both parties, provided the advisability of such evaluation is determined unanimously by the HSC and in consultation with Hospital Legal Counsel. The evaluator's findings shall be reported to the HSC.

7.3.2.1 If the HSC finds no reasonable basis to conclude that the practitioner is impaired, the HSC shall report its findings back to the Medical Staff President, who shall then have the option of initiating corrective action under Section 8.2. No further action or reporting will be undertaken by the HSC and confidentiality will be strictly observed by the HSC.

7.3.2.2 If the HSC finds a reasonable basis to conclude that the practitioner is impaired, it shall recommend the practitioner participate in the Program and may recommend, as part of a remedial plan, that the practitioner take a leave of absence for the purpose of evaluation, treatment and counseling. The Patient Care Assessment Coordinator shall make any statutorily required reports.

7.3.3 *Participation Recommendation Accepted.* If the practitioner agrees to participate in the Program, the HSC will develop and recommend a remedial plan in consultation with the practitioner under Section 7.4. The remedial plan may include a recommendation that the practitioner take leave as provided in Section 7.4.1.1. The findings, recommendations and actions of the HSC concerning participating practitioners will be kept strictly confidential and shall not be used in a corrective action so long as the practitioner remains compliant with his or her remedial plan.

7.3.4 *Participation Recommendation Rejected.* If the practitioner refuses to participate in the Program, the HSC shall either initiate a request for corrective action under Section 8.2 or recommend Summary Suspension to the Presidents of the Medical Staff and the Hospital. Failure of a practitioner to respond within a reasonable time to a recommendation by the HSC for participation in the Program or for leave shall be construed as refusal to participate in the Program. [↑Back to top](#)

7.4 REMEDIAL PLANS AND MONITORING BY THE HSC

7.4.1 *Development of Plan.* Upon acceptance of the recommendation by the practitioner to participate in the Program, the HSC shall develop a remedial plan in consultation with the practitioner, and may revise the plan from time to time after consultation with the practitioner. The Medical Staff President must approve a remedial plan and any modification to a remedial plan.

7.4.1.1 *Leave.* If the HSC recommends leave for evaluation, treatment or counseling as part of the remedial plan for the practitioner, the leave shall commence when recommended by the HSC and shall last a minimum of thirty days. The procedures for leave described in Section 3.2.5 do not apply to leave under this Article.

7.4.1.2 *Other Elements of Remedial Plan.* In addition to leave, a remedial plan may include, but is not limited to, counseling and treatment, urine screening or other surveillance for drug or alcohol use, voluntary curtailment or other change in clinical privileges, and the use of monitors, proctors, chaperones, or supervised practice.

7.4.2 *Monitoring.* The HSC shall monitor the compliance of a practitioner with the terms of the practitioner's remedial plan. The HSC may require as part of its monitoring that the practitioner agree to communication between the HSC and the practitioner's physician, therapist, department chair or chief of service, or others as determined by the HSC.

[↑Back to top](#)

7.5 NONCOMPLIANCE

The HSC may initiate a request for corrective action under Section 8.2 or recommend Summary Suspension to the Presidents of the Medical Staff and the Hospital when a practitioner fails or refuses to comply with the recommendation or leave or any provision of a remedial plan adopted by the HSC. [↑Back to top](#)

7.6 TERMINATION OF LEAVE AND COMPLETION OF PROGRAM

7.6.1 *Termination of Leave.* The HSC will terminate leave and reactivate privileges and membership once the practitioner has demonstrated successful completion of any terms and conditions of the leave and current capacity to meet the qualifications, standards and requirements established in these Bylaws. The HSC may require, in connection with the termination of leave and the reactivation of privileges and membership, that the practitioner agree to other elements of a continuing plan of remediation, including revised or restricted clinical privileges.

7.6.2 *Completion of Program.* The HSC will terminate the practitioner's participation in the program and remove any restrictions or limitations imposed on the practitioners privileges or membership once the practitioner has demonstrated successful completion of the terms and conditions of his or her remedial plan and current capacity to meet the qualifications, standards and requirements established in these Bylaws.

[↑Back to top](#)

7.7 GENERAL PROVISIONS

7.7.1 Confidentiality

7.7.1.1 Generally. Each report, piece of information, allegation made and evidence given, and each recommendation made under this Article shall be deemed privileged and confidential to the fullest extent permitted by law, and shall not be disseminated or used in any way except as provided herein or as required by law.

7.7.1.2 Information Concerning Practitioners In Compliance with the Program. In addition to the general confidentiality principles stated in Section 7.7.1.1, information and reports provided to or created by the HSC shall not be placed in the practitioner's permanent credentials file and shall not be used in any subsequent corrective action against a practitioner who has been compliant with his or her remedial plan.

7.7.1.3 Information Concerning Practitioners Not In Compliance with the Plan. When the HSC has reason to believe that a practitioner has not been compliant with his or her remedial plan, the HSC may disclose the terms and conditions of the practitioner's remedial program and the basis for its belief that the practitioner has been noncompliant in connection with a corrective action or summary suspension initiated under Article 8.

7.7.1.4 Use of Credible Information of Impairment. The general confidentiality principles stated in Section 7.6.1.1 do not preclude that use of credible information of impairment when a practitioner refuses a leave recommended by the HSC or to participate in the Practitioners Health Program on the terms and conditions recommended by the HSC. In such cases, credible information of impairment conveyed to the President of the Medical Staff or the HSC may be considered and used as a basis for corrective action or summary suspension under Article 8.

7.7.2 Reports to Board of Registration. Hospital legal counsel shall advise the HSC of requirements to report to state and federal agencies pursuant to state and federal law. The Patient Care Assessment Coordinator shall make all such reports, and the subjects of the reports shall be given notice of their contents.

7.7.3 Peer Review Files. No adverse information about a Staff member may be inserted into the member's peer review file without a member having been provided a reasonable opportunity to respond to the information.

7.7.4 Hearing Rights. The Practitioners Health Program is remedial and not disciplinary in nature, and there are no hearing or appeal rights under Article 9 from any recommendation made or any action taken by the HSC for a practitioner who elects to participate in the Practitioners Health Program under this Article.

7.7.5 Objectives of Article 7 Actions. Each action and recommendation pursuant to this Article 7 shall be taken in the reasonable belief that it is in furtherance of quality health care after making a reasonable effort to obtain the facts and is warranted by such facts after providing the practitioner with opportunity to respond. (Rewrite of Article VII, Amended 5/7/2001) [↑Back to top](#)

ARTICLE VIII
PRELIMINARY INVESTIGATION AND CORRECTIVE ACTION
(Rewrite of Article VIII, Amended 5/7/2001)

8.1 NATURE OF CORRECTIVE ACTION

8.1.1 Definition. "Corrective action" includes any action by the Staff, Hospital or Board, except those provided in Articles 5 and 7, to restrict, suspend, revoke or otherwise reduce Staff membership or the exercise of non-temporary privileges.

8.1.2 Grounds. Grounds include incompetence; unethical or unprofessional conduct; conduct below the standards of the Staff as stated in these Bylaws and the Rules and Regulations; persistent, severe disruption of Hospital operations that threatens the health or safety of others; noncompliance with the terms of a remedial plan in the Practitioners Health Program; violation of these Bylaws or the Rules and Regulations; falsification of a patient's record; or false or misleading information in an application. [↑Back to top](#)

8.2 INITIATION

8.2.1 Written Request. Corrective action is initiated by a written request for preliminary investigation (or request for corrective action) that describes specifically the conduct that constitutes the grounds for the request.

8.2.2 Authority to Make Request. The request may be made by (a) any officer of the Medical Staff, (b) the chair or chief of any department or service in which the practitioner in question holds membership or exercises privileges, (c) the chair of the Health Status Committee, acting pursuant to 7.5, (d) the CEO, or (e) the QA Committee of the Board. (Amended 1/3/2000)

8.2.3 Action On Request. The request must be submitted to the President, who shall promptly: (Amended 1/3/2000)

8.2.3.1 Notify the practitioner in question in writing of the request and the grounds; and

8.2.3.2 Forward a copy of the request to the chair of the department in which the practitioner in question performs the greatest part of his/her patient services. If the practitioner in question is a department chair, the copy of the request will be referred to a person designated by the Medical Staff President, and "department chair" in 8.3 below shall refer to that person. [↑Back to top](#)

8.3 PRELIMINARY INVESTIGATION

8.3.1 Procedure. The department chair shall promptly upon receipt of the request, and with the assistance, when appropriate, of the relevant service chief, conduct an investigation of the matters giving rise to the request. Before making the report (8.3.2), the department chair shall give the practitioner in question an opportunity for an informal meeting, to provide information, explain or refute the department chair's findings.

This informal meeting is preliminary in nature; it shall not constitute a "hearing," as that term is used in Article 9, and none of the procedural rules with respect to hearings and appeals shall apply.

8.3.2 Report to ECMS. The department chair shall submit a concise written report of his/her findings and recommendations to ECMS within fourteen (14) days of receipt of the request (five (5) days if the practitioner is under summary suspension). Recommendations may include those listed in Section 8.4.2 and/or continued investigation coupled with any advisable administrative measures to protect patients, including supervision or concurrent review. [↑Back to top](#)

8.4 ECMS ACTION

Within fourteen (14) days of its receipt of the report (five (5) days if the practitioner is under summary suspension), ECMS shall determine whether substantial evidence exists to support a reasonable conclusion that the practitioner's conduct warrants corrective action. ECMS shall provide the practitioner with an opportunity to appear informally in person to provide information; this appearance is preliminary in nature, does not constitute a "hearing," as that term is used in Article 9, and none of the procedural rules with respect to hearings and appeals shall apply. If ECMS determines that the:

8.4.1 Substantial Evidence Does Not Warrant Any Action: it will report its conclusion, together with the department chair's report and any supporting documentation, to the Board for further action under Section 8.5.

8.4.2 Substantial Evidence Warrants Only Actions That Do Not Substantially Restrict Privileges: it shall take appropriate action, which may include, without limitation:

- a) Placing a letter of warning or written reprimand in the practitioner's file,
- b) Requiring reasonable, short-term 100% retrospective chart review, observation or supervision of certain or all privileges (neither supervision nor observation require prior consultation with or approval by the observer/supervisor),
- c) Imposing terms of probation, continuing education or retraining;
- d) Requiring psychiatric or physical evaluation or counseling, provided the advisability of evaluation is determined in consultation with Hospital Legal Counsel.

8.4.3 Substantial Evidence Warrants Restriction of Privileges, including, without limitation:

- a) Required consultation prior to patient treatment;
- b) Restriction, suspension or reduction of privileges;
- c) Modification of Staff category; and
- d) Revocation of Staff membership.

Upon a determination made under either 8.4.2 or 8.4.3, ECMS shall promptly issue its written findings to the Staff member and report its recommendation to the Board, together with department chair's report; and the Senior Vice President for Medical Affairs shall make any statutorily required report upon notification of the practitioner of the substance of the report and of the practitioner's Article 9 hearing rights, if any. If

it deems necessary, ECMS may also recommend administrative protective measures pending final resolution of the matter. Such measures may include required consultation, observation, supervision (physical presence of another member during specified procedures), and 100% chart review. ECMS shall take action and make recommendations in the reasonable belief that the action or recommendation furthers quality patient care and is warranted by the facts obtained after reasonable effort to determine the facts, consistent with these Bylaws. [↑Back to top](#)

8.5 BOARD ACTION

Within thirty (30) days of receiving notice of ECMS action, the Board shall review the entire record.

8.5.1 If the Board agrees with the ECMS recommendation made under 8.4.1, it will adopt the recommendation and the matter shall be closed.

8.5.2 If the Board disagrees with the conclusion of the ECMS report made under 8.4.1 and concludes that substantial evidence exists that the practitioner engaged in conduct warranting corrective action and that such conduct is sufficiently serious to require action under either 8.4.2 or 8.4.3, it shall refer the matter back to ECMS for reconsideration.

[↑Back to top](#)

8.6 SUMMARY ACTION

(Amended 4/3/2002)

8.6.1 *Criteria for Initiation; Authority; Definition.* Whenever a practitioner's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient or other person, the practitioner's department chair and service chief and the Presidents of the Hospital and Medical Staff, acting together, or the ECMS, by a two-thirds vote of the quorum, are authorized to suspend, restrict or otherwise reduce summarily all or any portion of his or her clinical privileges.

8.6.2 *Effectiveness; Notice; Transfer of Patients.* Summary Suspension initiated in accordance with 8.6.1 shall be in writing and shall become effective immediately. The Vice President for Quality Improvement shall give prompt written notice of the Summary Suspension to the practitioner (together with notification of the practitioner's rights under this Article 9), ECMS and the Board. If required by the scope of the Summary Suspension, the practitioner's patients shall be promptly assigned to another member by the department chair, considering when feasible, the wishes of the patient in the choice of a substitute member.

8.6.3 *Review Procedure.* ECMS shall promptly meet to conduct its preliminary investigation under 8.4, providing the practitioner with an opportunity to appear in person to show reason why the Summary Suspension and other corrective action are unwarranted. This meeting is informal and preliminary in nature; it shall not constitute a "hearing," as that term is used in Article 9, and none of the procedural rules with respect to hearings and appeals shall apply. ECMS may modify, continue, or terminate the Summary Suspension or restriction, but in any event, it shall furnish the practitioner with notice of its decision within two working days of the meeting. [↑Back to top](#)

8.7 AUTOMATIC SUSPENSION

Clinical privileges and/or Staff membership shall be automatically suspended for the reasons provided below, with written notification to the practitioner, the Medical Staff President and the practitioner's department chair, all of who shall cooperate with the CEO in enforcing the automatic suspension. Any hearing, if properly requested in accordance with Article 9, shall be limited to determining whether the grounds for the automatic suspension have occurred.

8.7.1 Licensure

8.7.1.1 Revocation and Suspension. Whenever a member's Massachusetts license or certification to practice is revoked or suspended, Staff membership and clinical privileges shall be automatically revoked as of the effective date of such action.

8.7.1.2 Restriction. Whenever a member's license or certificate to practice in Massachusetts is limited or restricted, any clinical privileges within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

8.7.1.3 Probation. Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

8.7.1.4 Lapse. A member's appointment and privileges shall be automatically suspended upon expiration of a member's license or certificate to practice in Massachusetts until the member has provided documentation of renewal. (Adopted 7/97)

8.7.2 Controlled Substances. Whenever a member's federal or state controlled substances certification is revoked, restricted or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term. Whenever a member's federal or state controlled substances certification is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

8.7.3 Medical Records. A limited suspension of admitting and/or consulting privileges and of the right to schedule surgery (effective until medical records are complete) shall be imposed automatically after warning for delinquency for failure to comply with properly established policies and Rules regarding satisfactory and timely completion of records. The number of medical records suspensions shall be recorded and kept in the practitioner's file for consideration at reappointment time. Continuous suspension for incomplete medical records for longer than sixty (60) days shall result in termination of Staff membership and privileges with the right to a hearing under Article 9.

8.7.4 Failure to Pay Dues, Assessments. Failure to pay Staff membership dues by the annual meeting after the time the dues are payable shall

result in automatic suspension of clinical privileges until the charges are paid. Failure of a suspended member to pay dues within ninety (90) days of the suspension notice will result in automatic termination of privileges and membership.

8.7.5 *Loss or Lapse of Professional Liability.* A member's appointment and privileges shall be automatically suspended upon expiration or other loss of the member's professional liability coverage until the member has provided documentation of continuing coverage. (Adopted 7/97)

8.7.6 *Ineligibility under Federal Health Care Programs.* A member designated an Ineligible Person under Federal health care programs shall automatically have their privileges restricted to conform to the final judgment of the Court imposing the sanction. (Adopted 4/3/2002; amended 4/11/2005) [↑Back to top](#)

8.8 GENERAL PROVISIONS

8.8.1 *Confidentiality.* Each report, piece of information, complaint or accusation made and evidence given, and each recommendation made under this Article shall be deemed privileges and confidential to the fullest extent permitted by law, and shall not be disseminated or used in any way except as provided herein or as required by law.

8.8.2 *Reports to Boards of Registration*
(Rewrite of Article VIII, Amended 5/7/2001)
[↑Back to top](#)

ARTICLE IX FAIR HEARING PLAN (Rewrite of Article IX, Amended 5/7/2001)

9.1 RIGHT TO HEARING AND APPEAL

9.1.1 *Triggering Events.* An appointee or an applicant shall have a right to a hearing and/or appeal when properly requested in accordance with these Bylaws upon any adverse recommendation by the ECMS or any adverse action by the Board (collectively: "Adverse Action"), except as expressly provided in these Bylaws, that would deny, revoke, suspend, reduce or otherwise restrict the membership and/or non-temporary privileges of an appointee (unless such restriction constitutes non-reviewable corrective action under Art. 8), including any of the following:

- 9.1.1.1** Denial of initial Staff appointment
- 9.1.1.2** Denial of reappointment
- 9.1.1.3** Suspension of Staff appointment
- 9.1.1.4** Revocation of Staff appointment
- 9.1.1.5** Denial of requested advancement from provisional to non-provisional category
- 9.1.1.6** Reduction in Staff category
- 9.1.1.7** Limitation of the right to admit patients
- 9.1.1.8** Denial of requested department or service affiliation
- 9.1.1.9** Denial of requested clinical privileges
- 9.1.1.10** Reduction in clinical privileges
- 9.1.1.11** Suspension of clinical privileges

9.1.1.12 Revocation of clinical privileges

9.1.1.13 involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional status)

9.1.1.14 Any action reportable to the Board of Registration in Medicine, or the National Practitioner Data Bank (new BOT 9/19/07)

9.1.2 *Notice of Adverse Action and of Right to Hearing.* The CEO shall give the Respondent Special Notice of any Adverse Action giving rise to a right to the Hearing described in this Article. In this hearing the Respondent and either the Board or ECMS oppose one another on the validity of the Adverse Action. This notice shall state:

9.1.2.1 the proposed action to be taken against the Respondent;

9.1.2.2 the reasons for the proposed action;

9.1.2.3 that the Respondent has thirty (30) days to request a hearing on the proposed action;

9.1.2.4 a summary of the rights in the hearing;

9.1.2.5 that failure to submit a proper request for a hearing within the specified time period shall constitute a waiver of rights to any hearing or appellate review of the matter that is subject to the notice and the consequences of a final Adverse Action, consistent with Section 8.1.4; and

9.1.2.6 that the CEO will notify the Respondent of the date, time and place of the hearing and the witnesses expected to testify in support of the Adverse Action upon receipt of the Respondent's request and appointment of the Hearing Committee.

9.1.3 *Request for Hearing or Appeal.* The right to any hearing or appeal is expressly conditioned upon the Respondent's proper and timely request for the hearing. To be effective, the request must be in writing, delivered by Special Notice to the CEO within thirty (30) days of the Respondent's receipt of the notice of the Adverse Action.

9.1.4 *Waiver by Failure to Request a Hearing.* Failure to make a timely and proper request shall constitute consent by the Respondent to final action by the Board without a hearing or appeal. The waiver shall apply only to the matters that were the basis of the Adverse Action triggering the notice. The CEO shall transmit notice of the Respondent's waiver to the Board, and as soon as reasonably practicable, shall send the Respondent notice of the Board's final action. The CEO shall make all statutorily required reports regarding the final action.

9.1.4.1 Massachusetts law requires that certain adverse privilege actions be reported to state boards of registration, which may in turn report this information to other health care facilities. The same reporting and disclosure obligations pertain to a Medical Staff member's resignation of privileges or Staff membership, once an investigation has commenced or in lieu of an investigation.

9.1.4.2 Federal law requires hospitals to report to the National Practitioner Data Bank certain adverse privilege actions, and a resignation of privileges or Staff membership once an investigation has started. Thereafter, all qualifying health care institutions in the U.S. may obtain such information.

9.1.5 Nature of Hearing. The hearing shall be a hearing de novo by which the Hearing Committee (1) reviews all of the information available to the ECMS and such other evidence as may be presented in accordance with this Article, (2) reaches an independent determination and (3) makes recommendations in accordance with Sections 8.4.1, 8.4.2 and 8.4.3.

[↑Back to top](#)

9.2 SCHEDULING THE HEARING

9.2.1 Notice of Time and Place for Hearing. Upon receiving a timely and proper hearing request, the CEO shall deliver the request to the Medical Staff President, who shall schedule the hearing. At least thirty (30) days before the hearing, the CEO will send the Respondent Special Notice (1) of the date, time and place of the hearing, and (2) of the witnesses expected to testify at the hearing on behalf of the body whose action triggered the hearing. The hearing date shall be set for not less than thirty (30) days nor more than ninety (90) days after the CEO receives the Respondent's written request for a hearing, unless the Respondent is under suspension and requests an expedited hearing under section 9.2.2. Except in cases involving expedited hearings for a Respondent under suspension, the time for scheduling a hearing may be extended through agreement between the Respondent and the Medical Staff President or by the Medical Staff President upon determination that the practical considerations require additional time. The list of witnesses may be supplemented upon reasonable notice to the Respondent. [↑Back to top](#)

9.2.2 Expedited Hearing. A Respondent who is under suspension may request an expedited hearing. An expedited hearing must be held as soon as the arrangements may reasonably be made, but not later than ten (10) days after the CEO's receipt of the written request for the expedited review. The Medical Staff President shall meet with the Respondent at the earliest opportunity to adjust all other deadlines leading to a final action. Any Respondent, with the consent of the President, can waive the time requirements in order to expedite the hearing process. [↑Back to top](#)

9.3 APPOINTMENT OF HEARING COMMITTEE

9.3.1 Composition of Hearing Committee. The Hearing Committee shall be composed of at least three persons, none of who may be in direct economic competition or have a formal business association with the Respondent, or have other significant bias as to the outcome of the Hearing. No Committee member may have had prior active participation in the consideration of the Adverse Action. Members of the Hearing Committee shall be physicians duly licensed by one of the fifty states and may, but need not be members of the Newton-Wellesley Hospital Medical Staff. The Committee members should include one individual with a license or certificate comparable to that of the Respondent. The person appointing the Hearing Committee shall designate one of its members to be chair.

9.3.2 Appointment of Hearing Committee. The person appointing the Hearing Committee may not be in direct economic competition or have a formal business association with the Respondent. If not so disqualified, the Medical Staff President shall appoint the Hearing Committee. If the President is disqualified from selecting Committee members by reason of conflict of interest or bias, the person to appoint the Committee members and chair shall be one of the following, in the following order: Vice President, remaining elected members of ECMS by seniority. Before the

Committee appointments are finalized, the CEO shall approve the proposed Committee members on advice of Hospital Legal Counsel who shall review the proposed appointments for conflicts or bias. The CEO shall notify the appointing ECMS member before the Hearing of any reason why any proposed Hearing Committee member should not serve.

9.3.3 Respondent's Right to Object. The CEO shall inform the Respondent of the names of the Committee members, and the Respondent may, within 10 days of the notification, object to the appointment of any member(s). The objection must be in writing and must include the basis for the objection. If the person who appointed the Committee members determines that the objection is reasonable, he or she may name new member(s) and notify the Respondent thereof. The Respondent may object to any new members as before. [↑Back to top](#)

9.4 PREHEARING PROCEEDINGS

9.4.1 Exhibits and Witnesses. Not later than thirty (30) days before the scheduled hearing commencement date, the ECMS shall file with the CEO a copy of any documentary evidence intended to be offered at the hearing, except for impeachment evidence. The CEO shall promptly deliver the evidence to each member of the Hearing Committee and the Respondent. Not later than twenty (20) days before the scheduled hearing commencement date the Respondent shall file with the CEO (a) a list of witnesses intended to be called to testify and (b) a copy of any documentary evidence intended to be offered at the hearing, except for impeachment evidence. The CEO shall promptly deliver the evidence to the each member of the Hearing Committee.

9.4.2 Depositions. If a witness is unable to appear in person, then either party, upon not less than five (5) days' notice, may take testimony of the witness by deposition, in accordance with the Federal Rules of Civil Procedure. The written transcript of the deposition will have the same force and effect as if the witness testified personally at the hearing. Notice of a deposition shall be provided to all parties, the Medical Staff President and the CEO. No deposition may be taken later than three days before the hearing is scheduled to begin.

9.4.3 Preliminary Statements in Support. A party who wishes to may submit a written statement to the other party and the Hearing Committee by supplying seven copies of the statement to the CEO to distribute at least five (5) days before the scheduled hearing commencement date. Nothing in this paragraph precludes either the ECMS or the Board from submitting procedural information to the Hearing Committee. [↑Back to top](#)

9.5 CONDUCT OF HEARING

9.5.1 Personal Presence. The Respondent is required to be personally present throughout the hearing. The presence of the Respondent's counsel or other representative does not constitute the personal presence of the Respondent. A Respondent who fails without good cause to be present throughout the hearing shall be deemed to have waived his or her rights in the same manner and with the same consequence as provided in Section 9.1.4. The Hearing Committee shall determine what constitutes "good cause."

9.5.2 Presiding Officer. The Hearing Committee chair shall be the presiding officer. The presiding officer shall maintain decorum and assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence. The chair shall be entitled to vote.

9.5.3 Representation. The Respondent and the ECMS or Board (whichever originated the Adverse Action) may be represented at the hearing by legal counsel or other person of the party's choice. Each party shall notify the CEO of the identity of the party's representative at least three (3) days before the scheduled hearing commencement date, and the CEO shall promptly convey such information to the other party.

9.5.4 Rights of the Parties. During the hearing, each party shall have the following rights, subject to the rulings of the Hearing Committee chair on the admissibility of evidence and provided that the rights are exercised in a way that permits the hearing to proceed effectively and expeditiously to:

- 9.5.4.1** call, examine and cross-examine witnesses;
- 9.5.4.2** present relevant evidence;
- 9.5.4.3** rebut any evidence,
- 9.5.4.4** submit a concluding statement in support of the party's position at the close of the hearing,
- 9.5.4.5** have a record made of the proceedings, copies of which may be obtained by the Respondent upon payment of any reasonable charges associated with the preparation thereof; and
- 9.5.4.6** receive, upon the completion of the hearing, the written recommendation of the Hearing Committee and the reconsidered Action of the ECMS or Board, both of which must include a statement of the basis of the decision.

9.5.5 Burden of Proof. The Respondent has the ultimate burden of proving his/her qualifications for (a) appointment to the Staff and (b) requested clinical privileges, based on the Respondent's presented evidence that the Adverse Action lacks substantial factual basis or is otherwise arbitrary, unreasonable or capricious.

9.5.6 Order of Presentation. The Board or ECMS (whoever originated the Adverse Action) shall make the first presentation showing the reasons for its action. At the conclusion of the opening presentation, the Respondent shall have the opportunity to make a responding presentation.

9.5.7 Procedure and Evidence. The hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. At the discretion of the Hearing Committee chair, any relevant matter may be considered. In addition, the Respondent may be examined by the ECMS or Board representative and the Hearing Committee regardless of whether the Respondent testifies on his/her own behalf. Any written preliminary or concluding statements submitted in accordance with this Article shall become part of the hearing record. The Hearing Committee may ask questions of witnesses, call additional witnesses, or request documentary evidence if deemed appropriate. The chair may order that oral evidence be taken only on oath.

9.5.8 Quorum. At least a majority of the members of the

Hearing Committee shall be present when the hearing takes place. No member may vote by proxy, and no member may vote who was not present at the hearing.

9.5.9 *Postponement, Timeliness, Recesses and Adjournment.* Requests for postponement or continuance of a hearing may be granted by the chair of the Hearing Committee only upon a timely showing of good cause. The Hearing Committee may recess and reconvene for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation, but the hearing shall be completed within thirty (30) days of its commencement. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. Any written concluding statements of the parties must be submitted within five (5) days of the hearing's completion.

9.5.10 *Deliberations.* After adjourning and receiving any written concluding statements, the Hearing Committee shall meet to deliberate on all matters before it, and no one other than the Hearing Committee members shall be present at, or participate in, the deliberations. The Hearing Committee's recommendation shall be based on oral, documentary and other information made part of the Hearing Record. The Committee shall adopt findings of fact and make its recommendations. In reaching its conclusions of fact and making its recommendations, the Hearing Committee must act:

9.5.10.1 in the reasonable belief that the recommendation is in furtherance of quality health care; and

9.5.10.2 in the reasonable belief that the action is warranted by the facts, known after reasonable effort to obtain such facts.

[↑Back to top](#)

9.6 HEARING COMMITTEE REPORT AND FURTHER ACTION

Within 10 days after adjournment of the hearing, the Hearing Committee shall submit to the CEO a written report of its findings and recommendations, including a statement of the basis for the recommendations. The CEO shall forward the Hearing Committee report to the ECMS or the Board, depending on whose Adverse Action triggered the hearing. The CEO shall send the Respondent by Special Notice a copy of the Hearing Committee's report, and, if the recommendation is adverse to the Respondent, the CEO shall also notify the Respondent of the Respondent's appeal rights and any consequences of waiving those rights. The CEO shall notify the appropriate licensing authority and make such other notifications as may be required by law regarding the recommendations/actions and the Respondent's pending appeal rights.

[↑Back to top](#)

9.7 APPELLATE REVIEW

9.7.1 *Request for Appellate Review.* The Respondent and the ECMS have a right to appellate review; each shall have 10 days after receiving notice under Section 9.6 to file a written request for appellate review with the CEO. The request shall identify the grounds for appeal and include a clear and concise statement of the facts in support of the appeal. (Throughout the remainder of Sections 9.7 and 9.8, "Respondent" may refer to either party, depending on who the appellant is.) If the Respondent desires to present an oral statement in favor of his or her position, the request must include a request to present an oral statement before the

appellate review body. The request must be delivered to the CEO and may include a request for a copy of the record, upon payment of any reasonable charges associated with its preparation. The grounds for appeal shall be:

9.7.1.1 the hearing was in substantial non-compliance with the procedures required by these Bylaws or applicable law and created demonstrable prejudice;

9.7.1.2 the hearing record lacks substantial evidence to support the Hearing Committee's recommendation.

9.7.2 *Failure to Request Appellate Review*

9.7.2.1 *Waiver.* A party who fails to request appellate review within the time and in the manner specified in Section 9.7.1 shall have waived any right to review. The waiver has the same force and effect as provided in Section 9.1.4.

9.7.2.2 *Final Action.* If no party requests appellate review, the Board shall make a final decision on the matter, unless its Adverse Action triggered the Hearing, in which case the Appellate Review Committee, described in Section 9.7.4, shall take such action. If the Board or Appellate Review Body's action affirms the Hearing Committee's, the matter will be closed. If the Board or Appellate Review Body's action modifies or reverses the Hearing Committee's, it will be forwarded to the Joint Conference Committee for further action pursuant to Section 9.8.8.

9.7.3 *Notice of Time and Place for Appellate Review.* The CEO shall promptly deliver a request for appellate review to the Board Chair. Within thirty (30) days after the receipt of the request, the Board's Appellate Review Committee shall have been appointed, if necessary, and within ten (10) days of its appointment, the chair of the Appellate Review Committee shall schedule a time, place and date for the appellate review hearing.

The CEO shall notify the parties of the time, place and date of the appellate review hearing, the Respondent practitioner by Special Notice. The date of the appellate review shall not be fewer than twenty (20) days not more than sixty (60) days from the date of the appointment of the Appellate Review Committee, except that when the Respondent practitioner is under suspension, then in effect, the review shall be scheduled as soon as practicable, but in no event later than fifteen (15) days from the date of receipt of the request for appellate review.

9.7.4 *Appellate Review Body; Presiding Officer*

9.7.4.1 If ECMS Adverse Action triggered the Article 8 Hearing; the Appellate Review Body shall be the Board (as defined in these Bylaws), and its presiding officer the Board Chair.

9.7.4.2 If the Board's Adverse Action triggered the Article 9 Hearing, the Board Chair shall appoint the members of an Appellate Review Body ("ARB"), which shall be composed of five (5) members who have not previously been involved in the matter and who may include physicians, whether or not members of the Medical Staff. The ARB

shall elect its presiding officer who shall determine the order of procedure, and make all required rulings and maintain decorum.

[↑Back to top](#)

9.8 APPELLATE REVIEW PROCEDURE

9.8.1 Nature of Proceedings. The Appellate Review provided by this Article shall be to determine whether:

9.8.1.1 the hearing was in substantial non-compliance with the procedures required by these Bylaws or applicable law and created demonstrable prejudice; and/or

9.8.1.2 the hearing record lacks substantial evidence to support the Hearing Committee's recommendation. (See 9.8.5)

The ARB shall consider the record, including all oral and documentary evidence made a part of the Hearing Committee's record and the Hearing Committee report.

9.8.2 Written Statements. The Respondent may submit a written statement in support of his/her position, which may cover any matters raised at the hearing. The statement shall be submitted through the CEO to the ARB at least ten (10) days before the scheduled appellate review date, unless such time limit is waived by the ARB. The ECMS or Board, depending on whose Adverse Action gave rise to the hearing, shall submit a written statement in response to the Respondent's statement at least three (3) days before the scheduled appellate review date.

9.8.3 Oral Statements. If an oral statement has been requested pursuant to Section 9.7.1, the ARB shall allow the Respondent to make relevant oral statements in favor of his/her position. The Respondent shall have the right to legal and/or other counsel of his/her choice. Any party or representative appearing shall be required to answer questions asked by any member of the ARB.

9.8.4 Quorum. There shall be at least a majority of the members of the ARB present at the review. No member may vote by proxy, and no member may vote who was not present at the review.

9.8.5 Consideration of New or Additional Matters. New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall not be introduced at the appellate review; provided that the ARB may remand to the Hearing Committee for the taking of further evidence and a revised recommendation, significant evidence that it determines could not previously have been made available to the Hearing Committee in the exercise of reasonable diligence. The ARB chair shall inform the CEO, Hearing Committee chair and parties of the remand in writing. The Hearing Committee chair shall reconvene the Hearing Committee within ten (10) working days of receipt of notice of remand. Only new evidence and objections to and comments on it may be presented.

9.8.6 Recesses and Adjournment. The ARB may recess and reconvene the review proceedings without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the

appellate review shall be closed. The ARB shall thereupon, at the time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared adjourned.

9.8.7 Powers. The ARB shall have such powers as are reasonably necessary to the appropriate discharge of its responsibilities.

9.8.8 Recommendations and Final Action. Within ten (10) days of adjournment, the ARB shall communicate its recommendation to the CEO. The ARB may recommend that the decision of the Hearing Committee be affirmed, modified or reversed. An ARB decision to affirm the Hearing Committee recommendation shall be final. An ARB recommendation to modify or reverse the Hearing Committee recommendation shall be forwarded together with all pertinent documentation to the Joint Conference Committee, which shall, within fourteen (14) days, review the matters on the record and forward its recommendation, together with all pertinent documentation to the Board. The Board's action shall follow the recommendation of the Joint Conference Committee except in the most extraordinary circumstances. In making its recommendations, the ARB, the Joint Conference Committee and the Board shall act in the reasonable belief that its recommendation and/or action is in furtherance of quality health care and is warranted by the facts known after reasonable effort to obtain the facts.

9.8.9 Reporting of Adverse Action. If the final action of the Board following the procedures set forth in this Article 9 results in reduction, limitation, suspension or termination of the Respondent's clinical privileges or appointment, the CE shall make such reports as are required by law and these Bylaws. If the final action taken by the Board removes the basis of a previously reported Adverse Action, the Board shall so report its action to the relevant authorities.

[↑Back to top](#)

9.9 GENERAL PROVISIONS

9.9.1 Right to One Hearing Review Only. Notwithstanding any other provision of these Bylaws, no Respondent shall be entitled as a right to more than one hearing and one appellate review on any matter that shall have been the subject of an Adverse Action.

9.9.2 Release. By requesting a hearing or appellate review under this Article, a Respondent agrees to be bound by the provisions of these Bylaws relating to confidentiality, releases and immunity from liability.

9.9.3 Time Periods

9.9.3.1 For Hearing Process and Appellate Review. The procedures outlined in Sections 9.2.1 through 9.6.1 shall be completed within 135 days of the CEO's receipt of a timely request for hearing, unless time periods have extended with the agreement of the Respondent or, in cases where the Respondent is not under suspension, have been extended by the chair of a Hearing Committee for good cause shown or by the Medical Staff President under Section 9.2.1. When time periods for those procedures have been extended, the outermost limit of 135 days shall be extended by a like amount. The appellate review shall be concluded with final action within 140 days of the CEO's receipt of a timely request for appellate review.

The CEO shall keep all involved with the appellate review informed of pending deadlines.

9.9.3.2 Exceptions. Notwithstanding the foregoing, the time periods within which to hold hearings or render decisions are subject to practical considerations. Whenever a person, Board or committee has the right, or is required, to do some act or requests some action within a prescribed period after the service of a notice or other paper upon him, and the last day for doing the act falls on a Saturday, Sunday or legal holiday, then the period for performing the act shall be extended to the end of the next day which is not a Saturday, Sunday, or legal holiday. (Rewrite of Article IX, Amended 5/7/2001) [↑Back to top](#)

ARTICLE X OFFICERS

10.1 POSITIONS; NOMINATION

The Medical Staff shall have four officers: President, Vice President, Secretary and Treasurer. Nominations shall be made as described in Section 12.3.10 (Nominating Committee). (Amended 1/3/2000) [↑Back to top](#)

10.2 QUALIFICATIONS

Officers must be members of the Active Medical Staff at the time of their nomination and election, and must remain Active members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved. [↑Back to top](#)

10.3 ELECTION

Voting shall be by the members of the Active Staff at the Annual Meeting for (a) Vice President, (b) Secretary and (c) Treasurer, each member casting a single vote per office. (At the end of his/her term, the Vice President shall automatically assume the office of President.) A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for an office receives a majority on the first vote, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. (Amended 7/97; 1/3/2000) [↑Back to top](#)

10.4 TERM

Each Officer shall be elected to serve a two-year term, commencing at the close of the Annual Meeting of the Medical Staff. (BOT 7/12/17) [↑Back to top](#)

10.5 REMOVAL FROM OFFICE

Any Officer may be removed from office for any reason, including failure to perform duties required by the Bylaws, by a two-thirds (2/3) majority vote of the total Active Staff membership. This action can be taken at any regular meeting of the Medical Staff or at a special meeting of the Staff called for that purpose, or by mail or electronic ballot. (Amended BOT 12/13/06)
[↑Back to top](#)

10.6 MANNER OF VOTING

Voting shall be by a show of hands unless (a) there are two or more nominees for a single office, (b) voting member requests a written ballot and the request is supported by a majority vote or (c) the vote is to remove an officer from office in which case voting shall be by written ballot. (Adopted 7/97) [↑Back to top](#)

10.7 VACANCIES

10.7.1 Causes. Vacancies in office occur upon the death, disability, resignation or removal of the officer, or such officer's loss of membership on the Active Medical Staff.

10.7.2 Filling Vacancies Other Than President's. Vacancies, other than that of the President, shall be filled by appointment by the ECMS until the next regular election. If the office of Vice President becomes vacant, the next regular election shall also include the office of President. (Amended 1/3/2000)

10.7.3 Filling Vacancy Left by President. If the office of the President becomes vacant, the Vice President shall serve out that remaining term and the Nominating Committee shall promptly convene to propose nominees for the office of Vice President. The nominees shall be reported to the ECMS and the Medical Staff. A special election to fill the position shall occur at the next regular Staff meeting. (Amended 1/3/2000)

10.7.4 Filling Simultaneous Vacancies Left by President and Vice President. If both the offices of President and Vice President become vacant, the immediate Past President shall temporarily assume the office of President and the Nominating Committee shall promptly convene to propose nominees for both offices and shall call a special election to fill the positions. (Amended 1/3/2000) [↑Back to top](#)

10.8 DUTIES OF OFFICERS

10.8.1 President. The President shall serve as the chief officer of the Medical Staff and shall:

10.8.1.1 take reasonable steps to promote compliance with these Bylaws and the Medical Staff Rules and Regulations and their procedural safeguards,

10.8.1.2 call, preside at and are responsible for the agenda of all regular and special meetings of the Medical Staff,

10.8.1.3 serve as Chair of the ECMS and an ex officio member of all other committees, (Amended 1/3/2000)

10.8.1.4 act in coordination with the CEO, Administration and Board in all matters of mutual concern within the Hospital,

10.8.1.5 appoint standing and ad hoc committee chairs and members, except as otherwise provided in these Bylaws,

10.8.1.6 represent the views and policies of the Medical Staff to the Board and the CEO,

10.8.1.7 receive and communicate the policies of the Board to the Staff and report to the Board on matter pertaining to the quality of professional performance in the Hospital,

10.8.1.8 communicate regularly with Members of the Medical Staff to inform them about matters relevant to their practice and the hospital, utilizing appropriate methods of communication including meetings, mail, electronic messaging, intranet, bulletin boards and others. (Adopted 1/9/2002)

10.8.1.9 serve on liaison committees with the Board and Administration, and as may be required, with outside licensing or accreditation agencies,

10.8.1.10 serve as spokesperson for the Medical Staff in external professional and public relations,

10.8.1.11 perform such other functions as may be required by these Bylaws, the Medical Staff or the ECMS.

10.8.2 *Vice-President.* The Vice President shall assume all duties and authority of the President in the President's absence; be a member of the ECMS; and perform duties assigned by the President or ECMS, consistent with these Bylaws. (Amended 1/3/2000)

10.8.3 *Secretary.* The Secretary shall keep accurate and complete minutes of Quarterly and Special Meetings of the Medical Staff, call Special Meetings as directed by the President, attend to all correspondence and perform such other duties as ordinarily pertain to this office.

10.8.4 *Treasurer.* The Treasurer shall have custody of all funds of the Medical Staff; present a properly audited accounting to the Medical Staff at its Annual Meeting; and report from time to time as the ECMS may require. [↑Back to top](#)

ARTICLE XI CLINICAL DEPARTMENTS AND SERVICES

11.1 ORGANIZATION

The Medical Staff shall be divided into clinical departments. A department may be further divided into services, which shall be directly responsible to the department within which they function. Each department shall have a chair and an associate chair and each service shall have a chief with the authority and duties specified in this Article. On the basis of specific needs, the Executive Committee may determine that departments and services may require additional leadership (associate chair(s) or assistant chair(s) or assistant chief(s) who shall be appointed as stipulated in this Article. Each department shall organize a peer review committee to fulfill the responsibilities described in this Article. (Amended 11/98; 10/4/2000; 8/11/2004)

11.1.1 A clinical subspecialty service may be established under two or more departments when patient care and/or medical education will benefit from close interdepartmental collaboration. (Adopted 8/11/2004)

[↑Back to top](#)

11.2 CURRENT DEPARTMENTS AND SERVICES

1. Anesthesiology
2. Emergency medicine
 - Pediatric Emergency Medicine
3. Family medicine
 - Geriatrics and Extended Care*
4. Medicine
 - Adult Inpatient Medicine
 - Cardiology
 - Dermatology
 - Endocrinology & Diabetes
 - Gastroenterology
 - General Internal Medicine
 - Geriatrics and Extended Care*
 - Oncology/Hematology
 - Infectious Diseases
 - Nephrology
 - Neurology
 - Physical Medicine
 - Pulmonary Disease
 - Radiation Oncology
 - Rheumatology
5. Obstetrics and Gynecology
6. Orthopaedics
 - Arthroplasty and Joint Reconstruction
 - Foot and Ankle Surgery
 - General Orthopaedic Surgery
 - Hand Surgery
 - Spine Surgery
 - Sports Medicine
7. Pathology
8. Pediatrics
 - Pediatric Gastroenterology
 - Neonatology
9. Psychiatry
 - Child and Adolescent Psychiatry
10. Radiology
11. Surgery
 - General Surgery
 - Neurosurgery
 - Ophthalmology
 - Otolaryngology
 - Oral and Maxillofacial Surgery, Dentistry
 - Pediatric Surgery
 - Plastic, Reconstructive Surgery
 - Thoracic Surgery
 - Urology
 - Vascular Surgery

* = Interdepartmental Family Medicine/Medicine Service

(Amended 7/17/2000; 10/04/2000; 1/09/2002; 4/3/2002; 8/11/2004; 07/01/09; 05/05/2010; 01/05/11; BOT 11/02/11; BOT 11/13/2013; BOT 3/12/14)

[↑Back to top](#)

11.3 ASSIGNMENT TO DEPARTMENTS AND SERVICES

Each member of the Medical Staff and Professional Staff shall be assigned membership in one department and shall comply with the policies and procedures of that department. Membership may be granted in one or more services of the member's department. [↑Back to top](#)

11.4 FUNCTIONS OF DEPARTMENTS AND SERVICES.

Each department and service shall:

11.4.1 recommend guidelines for granting clinical privileges within the department or service and for evaluating applicants for appointment and reappointment.

11.4.2 adopt policies and procedures to govern the activities of the department (service) and its members.

11.4.3 conduct patient care reviews to evaluate and improve the quality and appropriateness of the care and treatment provided within the department or service.

11.4.4 develop objective criteria for use in evaluating the department's patient care.

11.4.5 conduct and make recommendations regarding continuing education programs.

11.4.6 perform other duties consistent with these Bylaws.

[↑Back to top](#)

11.5 DEPARTMENT CHAIRS

11.5.1 Duties. Each department chair shall:

11.5.1.1 have administrative responsibility for assessing and improving the performance of professional activities within the department, its clinical services, divisions and laboratories,

11.5.1.2 annually appoint associate chairs, subject to approval by the ECMS and the Board, (Amended 11/18/98)

11.5.1.3 annually appoint assistant chairs, as deemed necessary, subject to approval of the ECMS and Board, (Added 10/04/00)

11.5.1.4 annually appoint assistant chiefs, as deemed necessary, in collaboration with the service chief and subject to approval by the ECMS and the Board, (Added 10/04/00)

11.5.1.5 represent the department and its service(s) on the ECMS,

11.5.1.6 recommend clinical privileges for members of the department and others who apply for such privileges within the department on the basis of duly approved criteria,

11.5.1.7 provide necessary orientation to new members of the department, (Adopted 8/11/2004)

11.5.1.8 are responsible for the professional activities and performance of (a) post-graduate trainees and (b) undergraduate medical students in the department,

11.5.1.9 take steps to involve department members in monitoring and evaluation activities as well as in the analysis of the findings and development of recommendations for action,

11.5.1.10 take steps to assure that all members of the department abide by their professional ethical standards,

11.5.1.11 assure departmental implementation of ECMS actions pertaining to the department,

11.5.1.12 communicate regularly with Members of Department to inform them about matters relevant to their practice at the hospital, utilizing appropriate methods of communication including meetings, mail, electronic messaging, intranet, bulletin boards and other. (Adopted 1/9/2002)

11.5.1.13 report annually in writing to the ECMS on the functions of the department, making recommendations about space and other resources;

11.5.1.14 perform other duties assigned by the CEO that are consistent with these Bylaws.

11.5.2 *Specific Duties.* The chairs of the Medicine and Surgery Departments shall be jointly responsible for the functioning and performance of the Critical Care Unit. The chairs of the Surgery and Anesthesia Departments shall jointly supervise clinical aspects of the Operating Suite.

11.5.3 *Qualifications.* Except as described below, department chairs shall be Active Staff members; be certified by the American Board or Royal (Canada) Board in a specialty or subspecialty listed in the American Board of Medical Specialties' Directory of medical specialties that pertains to the department or service for which the chair has responsibility; be clinically competent; demonstrate teaching and research skills; possess administrative ability to ensure effective leadership of the department; and demonstrate an ability to work with the members of the department and to stimulate collaborative efforts to improve the department's performance. Department chairs shall be appointed initially to the Provisional Staff category and advance to Active Staff category, in accordance with Article 4.

11.5.4 *Selection.* At least six (6) months (if possible) before the chair of a department is anticipated to become vacant, the President shall appoint an ad hoc search committee to nominate a new department chair. The committee shall be composed seven (7) members, each having one vote and including members of the department in which the vacancy occurs (other than the chair of that department), representation from one or more other departments, and may include individuals from the Hospital affiliates, where appropriate. The CEO shall serve on the committee. ECMS may direct

the search committee to conduct a preliminary study of the department's needs and to report the results to ECMS before proceeding with the search. The Board shall refer the search committee's recommendation for chair to ECMS for approval before final action. (Amended 1/3/2000; 7/17/2000; 11/07/2001)

11.5.5 *Term, Reappointment, Compensation, Titles.* Appointments shall be for one (1) year, renewable annually, by the Board on recommendation of the ECMS. Determination of stipend and other support shall be the responsibility of the Board; academic titles of department chairs shall be determined by the Dean of the Medical School on recommendation of the Board.

11.5.6 *Evaluation*

11.5.6.1 *Frequency.* At least every five (5) years the Hospital President and the Medical Staff President shall evaluate, with the help of an ad hoc Evaluation Committee, the performance of each department chair. (Amended 1/3/2000)

11.5.6.2 *Ad Hoc Evaluation Committee.* The committee shall be composed of seven (7) persons: (a) the Hospital President or designee, a Trustee, and one other department chair, all appointed by the Hospital President; and (b) one department member from a list of three or more selected by the department, one other department member and two other Medical Staff members, all appointed by the Medical Staff President. The evaluation committee shall make its report to the Medical Staff President, Hospital President (and/or designee), and Board Chair. The evaluation committee shall inform the ECMS of the report's conclusions and recommendations and respond to any concerns of the ECMS. The Medical Staff President (or designee) will also inform the Joint-Trustee Staff Committee of the Board of the conclusions and recommendations for their review/approval. (Amended 11/7/2001) (Amended 10/5/2016)

11.5.7 *Removal.* Failure to satisfactorily perform duties required by these Bylaws or actions in violation of these Bylaws shall be grounds for removal, which shall be by action of the Board on recommendation of the ECMS. [↑Back to top](#)

11.6 SERVICE CHIEFS

11.6.1 *Duties.* Service chiefs shall have the same responsibilities for their service as department chairs have for their departments, except they shall also be responsible to their department chair(s). (Amended 8/11/2004)

11.6.1.1 In the case of interdepartmental services, the service chief shall be responsible to the department chairs under which the service is established. Conflicts among department chairs regarding interdepartmental services shall be resolved by referral to the Executive Committee of the Medical Staff. (Adopted 8/11/2004)

11.6.2 *Qualifications.* Shall be as described in 11.5.3.

11.6.3 *Selection.* The process described in Section 11.5.4 shall apply to the selection of service chiefs, except that the President shall appoint the ad hoc search committee in consultation with the department chair;

committee membership shall include the department chair and members of the service (other than the existing service chief); and the preliminary report, if ordered, will be made to the department chair and ECMS. (Amended 1/3/2000)

11.6.4 *Term, Reappointment, Compensation, Titles.* Term, reappointment, compensation and titles for service chiefs shall be as described in 11.5.5, except that titles shall be jointly determined by the Dean of the Medical School (designee) and the department chair on recommendation of the Board.

11.6.5 *Evaluation.* Evaluation of service chiefs shall be as described in 11.5.6, except that the ad hoc Evaluation Committee shall be appointed by the President of the Medical Staff and shall be composed of the department chair, two other department members and an at-large Medical Staff member. (Amended 1/3/2000; 11/02/2011)

11.6.6 *Removal.* Removal of a service chief shall be as described in 11.5.7. [↑Back to top](#)

11.7 DEPARTMENT PEER REVIEW COMMITTEES

Each department shall establish a committee pursuant to its policies and procedures to set standards of care, evaluate and improve professional performance. (Adopted 11/98) [↑Back to top](#)

11.8 FORMATION, ELIMINATION OF DEPARTMENTS AND SERVICES

11.8.1 *Clinical Departments and Services.* Departments and services are established or eliminated by the Board on ECMS recommendation after ECMS review of the effects on quality of care in the Hospital and/or community of the proposed formation or elimination. (The review may be conducted by an ECMS ad hoc.)

11.8.1.1 The ECMS shall make a finding of appropriateness of formation or elimination on the basis of available relevant information and following notice to the Medical Staff and opportunity for written comment.

11.8.1.2 Medical Staff member(s) whose privileges or practice may be adversely affected by the department/service elimination may request an interview before the full ECMS, provided that all such requests are consolidated. Once an affected Medical Staff member requests an interview, the ECMS recommendation on eliminating the department/service will be deferred until after the interview.

11.8.1.3 The Board shall report in writing to the ECMS the bases for an administrative decision to form or eliminate that is contrary to the ECMS finding.

11.8.2 *Formation of Clinical Subspecialty Services.* A clinical subspecialty service may be formed as follows. Five or more Active Staff members of a department may submit to the department chair written proposed policies and procedures for the proposed service, which shall set forth the organizational structure, functions, duties, and clinical privileges (with criteria), consistent with the policies and procedures of the department, the Bylaws and Rules of the Medical Staff and Hospital

Bylaws. Upon approval of the policies and procedures in accordance with Article 16 and consequent Bylaws amendment, the new service shall be established.

11.8.3 Professional Staff Services. Whenever five (5) or more Professional Staff members are assigned to a Medical Staff department or service, they may form a Professional Staff service. They shall submit a proposal in the form of draft policies and procedures for the proposed service, which shall set forth the organizational structure, functions, duties, and clinical privileges (with criteria), all of which shall be consistent with the policies and procedures of the service and department, the Bylaws and Rules of the Medical Staff and Hospital Bylaws and policies and procedures. Formation of the Professional Staff service requires approval of its proposed policies and procedures as described in Article 16 and of the enabling Medical Staff Bylaws amendment as described in Article 17. [↑Back to top](#)

ARTICLE XII COMMITTEES

12.1 GENERAL

Unless these Bylaws otherwise state:

12.1.1 Categories of Committees. Committees of the Medical Staff shall consist of (a) the ECMS, (b) standing committees, (c) department and service committees and (d) special or ad hoc committees; committees in categories (b) - (d) are responsible to ECMS. Joint committees report directly to the ECMS and either the Board or the CEO. (Amended 11/18/99)

12.1.2 Appointment of Committee Chairs and Members; Election of Vice Chair. The Medical Staff President shall appoint each committee chair and all Medical Staff committee members. The term shall be for one year. The committee members shall elect a vice chair at the first meeting of the Staff Year. The CEO shall appoint committee representation from Administration, Nursing and/or other Hospital personnel.

12.1.3 Ex-officio Members. Ex-officio committee members may participate in discussions but do not have a vote and are not counted in determining a quorum. The Medical Staff President and the CEO are ex-officio members of each standing committee. Practitioners who are not Medical Staff members may be appointed as ex-officio members of committees other than those that review the quality of care rendered by physicians.

12.1.4 Committee Action/Recommendations. Committee actions and recommendations shall be by majority vote.

12.1.5 Creation of Special or Ad Hoc Committees. The Medical Staff President may appoint, independently or by ECMS vote, ad hoc committees as deemed necessary.

12.1.6 Subcommittees. Committees may form subcommittees as deemed necessary to carry out their functions. Subcommittees are subject to these Bylaws in the same manner as committees.

12.1.7 Policies and Procedures. Standing committees, department and service committees and ad hoc committees shall adopt policies and procedures as described in Article 16.

12.1.8 Meeting Frequency. Each committee shall meet at least quarterly.

12.1.9 Record/Reports. Each committee shall keep an accurate written record of attendance, proceedings, actions taken, results of actions taken, recommendations made and shall report regularly thereon to ECMS and to the Medical Staff at the Quarterly Staff meetings, including an annual report at the Annual Meeting of the Medical Staff. [↑Back to top](#)

12.2 EXECUTIVE COMMITTEE

12.2.1 Composition. The ECMS shall consist of twenty-four (24) Persons: the President (who shall serve as chair) and the Vice President of the Medical Staff; the chairs of the Departments of Anesthesiology, Emergency Medicine, Family Medicine, Medicine, Obstetrics and Gynecology, Orthopaedics, Pathology, Pediatrics, Psychiatry, Radiology and Surgery; and eleven (11) other members of the Active Staff chosen at large from the Staff. Ex officio members without a vote shall include the President of Newton-Wellesley Hospital, Chief Medical and Innovation Officer, Chief Quality and Experience Officer and immediate Past President of the Medical Staff.
(Amended 11/98; 1/3/2000; 10/4/2000; 12/13/06; 01/05/11; 7/12/17; 10/10/2018)

12.2.2 Selection of At-Large Members. The at-large members shall be nominated and elected by the Medical Staff at its Annual Meeting pursuant to Article 12.3.10.2. At-large members shall serve staggered three (3) year terms, so that at least two (2) new members are elected each year. At least two (2) of the at-large members who are not Officers shall be in the practice of internal medicine, pediatrics or family practice. If at any time ECMS membership falls below twenty-two (22), additional members shall be elected by the Medical Staff at its next regular meeting to fill the vacancies. In the interim, vacancies may be filled by appointment by the Medical Staff President. (Amended 1/3/2000; 10/4/2000; 12/13/06)

12.2.3 Removal of At-Large Members. Any At-Large member of ECMS may be removed from office for any reason, including failure to perform duties required by the Bylaws, by a two-thirds (2/3) majority vote of the total Active Staff membership. This action can be taken at any regular meeting of the Medical Staff, at a special meeting of the Staff called for that purpose or by mail or electronic ballot. (Adopted BOT 12/13/06)

12.2.4 Duties. The ECMS is the Medical Staff's governing body, whose duties include, without limitation, the following:

- a) To receive and act upon reports and recommendations of the Active Staff and of Medical Staff departments, services and committees, and otherwise to represent the interests and act on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws;
- b) To report to the Medical Staff on actions taken by the ECMS since the previous Staff meeting.

- c) To take all reasonable steps to fulfill the Staff's accountability to the Board for the care rendered to Hospital patients by evaluating the quality and appropriateness of medical services provided and making regular reports to the Board on its recommendations;
- d) To review the qualifications, credentials, performance, professional competence, and character of all who exercise or seek to exercise clinical privileges, and to make recommendations to the Board regarding (re) appointments, assignments to departments and clinical privileges.
- e) To review the Hospital's Performance Improvement/Patient Care Assessment/Medical Safety Plan annually, making recommendations to the CEO and/or Board.
- f) To recommend actions to the CEO and Board on matters of a medical-administrative nature;
- g) To assist the Hospital in complying with State and Federal Law and accreditation standards, (Amended 11/18/99)
- h) To make timely recommendations to the Hospital solely regarding quality of care issues raised by proposed Hospital arrangements involving or requiring professional medical services to Hospital patients (documents for review contain no financial or provider-identifying information);
- i) To take all reasonable steps to promote professionally ethical conduct and competent clinical performance of every practitioner exercising privileges in the Hospital, including the initiation of and/or participation in corrective or review measures when warranted, as provided in these Bylaws,
- j) To assist the Board and the CEO to determine the appropriateness, from a quality of care standpoint, of closing a department or service or otherwise entering into an exclusive physician services agreement, or modifying such an agreement, if the modification may affect quality of care;
- k) To meet at least monthly and maintain a permanent record of its proceedings and actions, providing copies of its general session meeting minutes to all Staff members and to the Board;
- l) To review and approve Hospital policies that directly affects the operation of the Medical Staff and performance of its members, (Amended 2/9/2005)
- m) To review and recommend for adoption or amendment Medical Staff Rules and Regulations and the policies and procedures of Medical Staff departments, services and committees,
- n) To create such additional Medical Staff committees and ECMS subcommittees as may be appropriate or necessary to carry out the duties and responsibilities of the Medical Staff and ECMS,

o) To exercise, as it deems necessary, the authority to review all actions of the Medical Staff President, including committee appointments,

p) To assist the Hospital in developing and maintaining procedures for protecting and caring for patients and others in the event of internal or external disaster;

q) On advice of Hospital legal counsel, to make reports required by state and federal law; and

r) To perform such other duties as are provided in the Bylaws.

[↑Back to top](#)

12.3 STANDING COMMITTEES

12.3.1 *Budget Committee*

12.3.2.1 *Composition.* The Committee shall consist of the Medical Staff President, Vice President and the Treasurer who shall be chair. (Amended 1/3/2000)

12.3.2.2 *Duties.* The Committee shall recommend for ECMS approval, an appropriate budget for the subsequent Staff Year, to be presented for Medical Staff approval at the Annual Meeting. The Treasurer may disburse up to \$1000, and ECMS up to \$3000 per annum in unbudgeted funds, with approval of the Executive Committee. (Amended 1/3/2000)

12.3.2 *Bylaws Committee*

12.3.2.1 *Composition.* This Committee shall consist of at least three (3) Active Staff members.

12.3.2.2 *Duties.* The Committee shall be responsible for a continuing review of Bylaws and Rules and Regulations of the Staff, making recommendations relating to their revision as provided in Articles 15 and 17. It shall review, prior to their adoption or revision, department, service and standing committee policies and procedures for consistency with the Staff Bylaws, Rules and Regulations.

12.3.3 *Credentials Committee*

12.3.3.1 *Composition.* The Credentials Committee shall consist of at least six (6) Active Staff members; ex-officio members shall include Hospital legal counsel and Staff support from Administration. Medical Staff members shall be appointed for staggered three-year terms, two appointments a year. (Amended 9/14/2005)

12.3.3.2 *Duties.* The Committee shall thoroughly and objectively review and evaluate the credentials of all applicants for (re) appointment, (re) classification of Staff category, privileges and changes in privileges against the membership and privileging criteria stated in these Bylaws and the pertinent departmental policies and procedures and shall refer its recommendations with supporting documentation to ECMS. It shall review proposed changes

and additions to privileging criteria. It shall refer its recommendations with supporting documentation to ECMS.

12.3.4 Intensive Care Unit Committee

12.3.4.1 Composition. The Intensive Care Unit ("ICU") Committee shall consist of Chairs of the Departments of Anesthesiology, Medicine, and Surgery, Director(s) of the ICU, Chief of Cardiology, ICU Nurse Manager, and the Associate Chief Nurse responsible for Critical Care. (Amended BOT 7/17/2000; 9/16/2015)

12.3.4.2 Duties. The Committee will meet quarterly and report at least annually to the Executive Committee of the Medical Staff. The Committee shall: (Amended BOT 9/16/2015)

- a) Assure that the physician and nurse staffing model of coverage for ICU patients provides high quality and safe patient care.
- b) Develop strategies for maximizing access of patients to the ICU and properly balancing optimal access and optimal care.
- c) Assure appropriate supervision and education of the ICU house staff, students, and nursing staff.
- d) Develop and maintain rules and policies governing practices in the ICU, including:
 - 1) Define criteria for admission to and discharge from the ICU;
 - 2) Define privileging criteria for practitioners treating ICU patients;
 - 3) Define medical and nursing coverage criteria for patients in the ICU;
 - 4) Oversee the development of clinical practice guidelines and order sets for care of patients in the ICU (Adopted 11/18/99)
- e) Develop a systematic process for assessing and improving the quality and appropriateness of patient care in the ICU;
- f) Develop a systematic process for assessing and resolving identified problems in the ICU; (Amended 11/18/99)
- g) Make recommendations through the Executive Committee of the Medical Staff to the Hospital Administration regarding personnel and equipment needs and physical design plans.

12.3.5 Education Committee

12.3.5.1 Composition. The Committee shall consist of at least the chairs (or other representative) of the departments that provide undergraduate and postgraduate educational programs. In addition, there shall be at least three (3) members of the Medical Staff and the Director of Medical Education or Continuing Medical Education if those positions are filled, and a member of the Board. The Senior Resident shall serve as an ex-officio member.

12.3.5.2 Duties. The Committee shall be responsible for continuing education programs for the Medical Staff; and make recommendations regarding courses of instruction for Medical Students, House Officers and Fellows.

12.3.6 Ethics and Complex Care Committee (BOT 10/15/08)

12.3.6.1 Composition. The Ethics and Complex Care Committee shall be composed of two groups: (Amended BOT 9/16/2015)

- a) A core group composed of at least five (5) Active Staff members selected on the basis of interest and diversity of experience; and representation from nursing, social services, spiritual services, and risk management.
- b) An ad hoc consulting group composed of a representative from the Emergency Department, Surgery, Oncology, Administration and other subspecialty areas as needed. An ethicist and/or an advisor from the community may be requested to participate as a consultant.

The Committee shall be co-chaired by an Active Staff member appointed by the Medical Staff President and a member chosen by the Committee.

12.3.6.2 Duties. The Committee shall meet as needed, but no less often than every six months, and then will report to the Executive Committee of the Medical Staff. The duties of the Committee include: (Amended BOT 9/16/2015)

- a) Develop policies and procedures pertaining to ethical issues in patient care;
- b) Provide Ethics consults;
- c) Serve in an advisory role for services such as Pain and Palliative Care for unusually complicated cases;
- d) Advise, as needed, concerning the longitudinal management of highly complex patients;
- e) Collaborate with Schwartz Rounds and Pain and Palliative Care educational efforts.

12.3.7 Health Status Committee

12.3.7.1 Composition. The President shall appoint Committee members and select the chair. The Health Status Committee shall have between two (2) and three (3) standing or voting members, including the chair or other member of the Psychiatry Department; the practitioner's department chair shall be a non-voting member. Other advisors may be included, as needed at the discretion of the Committee chair, such as a Medical Staff member with expertise in addiction medicine, the Nursing Administrator and an occupational health specialist.

12.3.7.2 Duties. The Committee shall report to the President and meet as necessary to:

a) Implement the Practitioners Health Program described in Section 7.3; and

b) Develop individualized intervention and monitoring programs for practitioners with physical, mental, behavioral, drug and/or alcohol impairment and who wish or require assistance maintaining a hospital practice that protects patient welfare. (Adopted 5/7/2001)

12.3.8 Infection Control Committee.

12.3.8.1 Composition. The Infection Control Committee is a multidisciplinary committee whose membership includes at least six (6) Active Staff members in addition to the Chief of the Infectious Disease Service; ex-officio members shall include representation from Nursing and Maternity and Pediatric Nursing, and, as may be required by anticipated agenda items, from Housekeeping, Central Supply, Laundry, the Kitchen, Engineering, Maintenance, Pharmacy and the Operating Suite.

12.3.8.2 Duties. The Committee oversees the effectiveness of the Hospital's Infection Control Program in reducing infection; assesses and makes recommendations intended to improve the type and scope of surveillance activities; reviews selected microbiology reports; approves prevalence and incidence studies; and develops infection control policies and procedures to implement strategies to reduce infection; analyzes and disseminates infection control data to Medical Staff and Hospital departments and services. (Amended 11/18/99)

12.3.9 Medical Records Committee

12.3.9.1 Composition. The Medical Records Committee shall consist of at least five (5) members of the Medical Staff; ex-officio members shall include the Director of the Medical Records Department, the Director of the Quality Management Department and one representative each from Administration and Nursing.

12.3.9.2 Duties. Oversees evaluation of medical records for timeliness and quality of documentation (clinical pertinence). Approves chart structure and forms. Oversees Medical Records Service, including effectiveness of written policies and procedures for medical record storage and preservation of confidentiality. Regularly reviews rules and policies pertaining to medical records, making recommendation to ECMS to improve the content and methodology of medical record documentation. (Amended 11/18/99)

12.3.10 Nominating Committee

12.3.10.1 Composition. The Nominating Committee shall consist of the President, Vice President and Immediate Past President, and four (4) members of the Active Staff, nominated from the floor and seconded at the September Staff Meeting and elected by written

ballot at the December Meeting. A minimum of four nominees is required, and each Active Staff member shall cast a single vote for each seat. (Amended 1/3/2000)

12.3.10.2 Duties. The Committee shall:

a) Elect its chair at its first meeting, which the Immediate Past President shall convene no later than March 15. (Adopted 1/3/2000)

b) Meet at least twice before making final recommendations of candidates for election. (Amended 1/3/2000)

c) Recommend a slate of nominees for Vice President, Secretary, Treasurer, at-large members of the ECMS and the AMA-OMSS representative; the slate, consisting of one nominee for each position, will be presented to the Medical Staff two weeks before the Quarterly Meeting preceding the Annual Meeting. The Committee shall not nominate one of its own members for the position of President of the Medical Staff. (Amended 1/3/2000)

d) Send, together with the President, a notice to the Staff two weeks before the Quarterly Meeting preceding the Annual Meeting, of the upcoming election and advising the Staff that nominations from the floor will be accepted if seconded. (Amended 1/3/2000)

12.3.11 Operating Room Committee

12.3.11.1 Composition. The Operating Room ("OR") Committee shall be composed of three (3) chairs (Surgery, Anesthesia, and Obstetrics/Gynecology), three (3) associate chairs (Surgery, Anesthesia, and Obstetrics/Gynecology), the Chief of Orthopedic Surgery, and four (4) representatives of Administration: the Administrative Director of Perioperative Services, the Nurse Manager of the OR, Nurse Manager of the PACU, and the (Nursing Director of Perioperative Services. The chairs of Surgery and Anesthesia shall co-chair the Committee. (amended BOT 07/01/09)

12.3.11.2 Duties. The Committee shall meet no less than monthly to review and develop policies and procedures that cover practices in the OR; make recommendations regarding purchase of capital equipment for the OR; and engage in an ongoing forward planning process for the operating room. The committee shall regularly provide a forum for discussion with medical staff members utilizing the Operating Room. (amended BOT 07/01/09)

12.3.12 Patient Care Assessment Committee

12.3.12.1 Composition. The composition of the Committee shall be in accordance with the Hospital's annual Performance Improvement Plan as reviewed and approved by the Executive Committee of the Medical Staff. (Amended 11/98; 1/3/2000; 1/09/2002; 8/07/2002)

12.3.12.2 Duties. The Committee shall:

(a) Review potentially reportable sentinel and reviewable occurrences, and make recommendations regarding their reportability based on established criteria,

(b) Annually review and revise, as it deems necessary and subject to the approval of the Board, the Hospital's Qualified Patient Care Assessment Program so that it complies with the requirements of Massachusetts Law,

(c) Take steps to assure that all Medical Staff and Hospital departments adopt policies and procedures for their compliance with the Program,

(d) Work to design measures to prevent adverse patient outcomes and improve the quality of patient care rendered by providers of health care services. (Amended 11/98)

12.3.13 *Perinatal Care Committee*

12.3.13.1 *Composition.* The Perinatal Care Committee shall consist of at least five (5) Active Staff members, including the chairs (or their representatives) of Pediatrics, Obstetrics, Pathology, and Anesthesiology. In addition there shall be not more than five (5) ex-officio members from Nursing, Administration and/or other Hospital personnel.

12.3.13.2 *Duties.* The Committee shall:

(a) Oversee the management of newborns in the Nursery and the Special Care Nursery and the management of newborn and maternal patients in the Labor, Delivery, Recovery and Postpartum Rooms, evaluating the care and making recommendations for improvement,

(b) Coordinate maternal-newborn care through long-range program planning, policies and procedures, and community input on the Hospital's maternal-newborn service.

12.3.14 *Pharmacy and Therapeutics Committee*

12.3.14.1 *Composition.* The Pharmacy and Therapeutics Committee shall consist of at least five (5) Active Staff members. Ex-officio members shall include the Director of the Pharmacy, the Supervisor of Parenteral Therapy, and one representative each from Nursing and Administration.

12.3.14.2 *Duties.* The Committee reports to ECMS on drug usage and the operation of the pharmacy. The Committee shall: (Amended BOT 9/16/2015)

a) Assess the appropriateness, safety, and effectiveness of drug ordering, administration and usage;

b) Develop systematic and continuous processes to use to assess and improve drug usage, including drug use evaluation measures;

- c) Develop and make recommendation for approval of policies and procedures to improve the process of selection, handling, distribution, storage, and use and administration of drugs and diagnostic material to minimize drug errors;
- d) Oversee the formulary at NWH to assure safe and appropriate administration of formulary medications in conjunction with the Partners P and T Committee, which is responsible for developing and maintaining the formulary at the health care system level;
- e) Define and review adverse drug reactions;
- f) Evaluate and approve investigational or experimental drug protocols as necessary to the Human Research and Investigation Committee;
- g) Monitor, analyze and make recommendations for reducing medication errors via the work of its subcommittee on Medication Errors;
- h) Develop a pain and palliative care pharmaceutical management function to improve effective and safe care of opioids, opiates and other pain management medications;
- i) Participate in assuring effective and safe use of pharmaceuticals within order sets, guidelines, and policies in conjunction with PCAC & ECMS as appropriate;
- j) Develop and monitor policies on medication usage including use of non-formulary pharmaceuticals as well as patient-requested ingestion of biologically active substances, such as dietary supplements, brought from home while in the hospital.

12.3.15 Content removed QPIC eliminated (BOT 11/2006)

12.3.15.1 Content removed QPIC eliminated (BOT 11/2006)

12.3.15.2 Content removed QPIC eliminated (BOT 11/2006)

12.3.16 Resuscitation Committee. (Adopted 1/3/2000)

12.3.16.1 Composition. The Resuscitation Committee is a multidisciplinary committee composed of at least seven (7) Active Staff members representing Anesthesia, Cardiology, Critical Care, Emergency Medicine, Internal Medicine, and Pediatrics; and representatives of Administration from all affected departments including Nursing, Pharmacy, Respiratory Services, Clinical Care Nursing and Education Resources. The chair shall have a background in Intensive Medicine and/or Cardiology and shall confer with the Medical Staff President in the appointment of the physician members of the committee.

12.3.16.2 Duties. The committee is responsible for improving the Hospital's emergency resuscitation response, performance and outcomes by assessing performance of each code, providing education,

making recommendations to improve response to codes and performance of codes and by monitoring the effectiveness of its interventions. The committee reports to ECMS. (BOT 11/2006)

12.3.17 *Service Recognition Committee*

12.3.17.1 *Composition.* The Service Recognition Committee shall consist of at least three (3) Active Staff members.

12.3.17.2 *Duties.* The Committee shall make recommendations to ECMS on matters pertaining to the commemoration of deceased Staff members and with appropriate recognition of the achievements of retiring and other Staff members.

12.3.18 *Tissue and Transfusion Committee*

12.3.18.1 *Composition.* The Tissue and Transfusion Committee shall consist of six (6) members of the Medical Staff representing the Departments of Anesthesia, Medicine, Obstetrics and Gynecology, Pathology, and Surgery and the Hematology/Oncology Service. Ex-officio members shall include one representative each from Nursing and Administration.

12.3.18.2 *Duties.* The Committee shall:

- a) Meet quarterly; (Amended 10/10/2012)
- b) Study and report to ECMS on the correspondence between pre-operative, post-operative and pathological diagnoses, and the justification for surgical procedures undertaken in the Hospital;
- c) Study and report to ECMS on use of blood and blood components, including transfusion reactions, means of procurement and administration;
- d) Assist appropriate Medical Staff departments and services in performing surgical case review and conducting monthly audits.

12.3.19 *Cancer Care Committee.* (BOT 12/10/2014)

12.3.19.1 *Meeting Requirement.* The Cancer Committee shall meet at least quarterly. (Added 1/12/2005)

12.3.19.2 *Composition.* The Cancer Care Committee shall be multidisciplinary and consist of at least one physician member from each of the required specialties: Diagnostic Radiology, Pathology, General Surgery, Medical Oncology and Radiation Oncology. Other physicians may be asked to attend meetings as deemed appropriate by the committee.

The committee shall consist of at least one non-physician member from each of the following services: Cancer Program Administration, Oncology Nursing, Social Services, Cancer Registry (CTR), Quality and Patient Safety, Clinical Research, Genetics Counseling Services and Pharmacy.

Additional required physician or professional staff member for a Comprehensive Community Cancer Program (CCCP) includes at least one palliative care team member.

The Cancer Care Committee Chair is a physician who may also fulfill the role of one of the required physician specialties. The Cancer Liaison Physician must be a member of the Cancer Care Committee and fulfill the role of one of the required physician specialties. The Cancer Liaison Physician is responsible for evaluating, interpreting and reporting on the program's performance using data from the National Cancer Data Base. (Amended 1/12/2005; 8/10/2005)

12.3.19.3 Responsibilities. The Cancer Care Committee provides the leadership for the cancer program at Newton-Wellesley Hospital and is responsible for all cancer program activities at the institution.

The Cancer Care Committee at Newton-Wellesley Hospital will follow the requirements outlined in the most current American College of Surgeons Commission on Cancer (CoC) Program Standards. [↑Back to top](#)

12.4 JOINT COMMITTEES

12.4.1 Joint Conference Committee. The Joint Conference Committee is not a standing committee but rather a mechanism for resolving differences between the Medical Staff and the Board, when existing procedures have proved inadequate. It shall not have a continuing membership, but instead be constituted when either the Board or ECMS refers a matter to it. At that time, the Board, on recommendation of its chair, and the ECMS, on recommendation of the Medical Staff President, shall each appoint three people to serve on the Committee until the matter has been resolved. The appointment process and the members appointed shall meet the standards established in Section 10.3 of these Bylaws for the avoidance of conflicts of interest.

12.4.2 Human Research and Investigation Committee
(Adopted 11/18/1999; 01/09/2019)

12.4.2.1 The Newton-Wellesley Hospital (NWH) Human Research and Investigation Committee has been consolidated into a centralized IRB conducted by the Partners Human Research Committees (PHRC).

12.4.2.2 Proposals and current programs for non-oncology related human research being conducted at NWH will be processed, reviewed, approved and monitored by the PHRC.

12.4.2.3 Proposals and current programs for human research being conducted at NWH for oncology patients will be processed, reviewed, approved and monitored by the Dana-Farber Cancer Institute's Investigational Review Board.

12.4.3 Healthcare Research Committee (Adopted 11/7/2001) (Amended 01/06/2010; 01/09/2019)

12.4.3.1 Composition. The Healthcare Research Committee shall be a Joint Committee of the Medical Staff and the Hospital chaired by the

Medical Director of Research who is appointed by the President of the Medical Staff.

The Committee shall also include the following members or their designees - Chief Medical and Innovation Officer (CMIO), three (3) at-large members appointed by the President of the Medical Staff, additional representation from appropriate clinical disciplines as needed.

The Director of the Office of Research and clerical personnel Approved by the CMIO shall staff the committee.

12.4.3.2 Duties. The Healthcare Research Committee shall:

- a) Develop and maintain guidelines and policies relating to research;
- b) Assure a knowledgeable physician group to work with the Office of Research,
- c) Plan and promote research, education, and/or technology advancement at Newton-Wellesley Hospital;
- d) Oversee and distribute any funds and private endowments donated or gathered for the purpose of conducting clinical research at Newton-Wellesley Hospital;
- e) Consider proposals on a competitive basis and using majority rules criterion, make recommendations to the Senior CMIO who will evaluate in concert with the Vice President for Development. In turn, the CMIO will ask for final approval by the President of the Hospital or a committee of the Board of Trustees of Newton-Wellesley Hospital,
- f) Promote and support Clinical Research Day including participation in abstract review and grading,
- g) Report at least on an annual basis to the Executive Committee of the Medical Staff (ECMS). If deemed appropriate by ECMS, report at least annually to the Board of Trustees.

12.4.4 Patient Safety Steering Committee (PSSC)

12.4.4.1 Composition. The composition of the Committee shall be in accordance with the Hospital's annual Performance Improvement Plan as reviewed and approved by the Executive Committee of the Medical Staff. (BOT 11/2006)

12.4.4.2 Duties.

- a. To create a Joint Committee of the Medical Staff and Hospital that will increase the detection and analysis of adverse events, medical errors, and near misses.
- b. To direct the Medical Safety Plan as defined in the annually updated PI/PCA Plan of Newton-Wellesley Hospital.

- c. To implement systems improvements to prevent future errors using rapid-cycle improvement methodology; and to disseminate information on patient safety to the hospital community.
- d. To monitor and evaluate the organization's response to all sentinel, adverse and potential adverse events including medication practices.
- e. To oversee all root cause and failure mode effect and criticality analyses and to determine strategies for system changes to prevent future occurrences.
- f. To oversee and monitor all quality indicators and safety issues identified by QI Committee Chairs, the Patient Care Assessment Committee and Leadership Safety Walk rounds and to promote dissemination of lessons-learned. (BOT 11/2006)
- g. To evaluate effectiveness of safety interventions.
- h. To establish timetables and track actions in response to JCAHO sentinel event alerts and alerts from other quality organizations such as the National Quality forum, Leapfrog and the Institute for Safe Medication Practices.
- i. To identify Patient Safety Initiatives to be implemented by interdisciplinary teams.
- j. To oversee the safe implementation of the Utilization Management Plan.
- k. To report to the Joint Trustee Staff Committee as required for safety enhancement and professional performance coordination. At a functional level, PCAC and PSSC will collaborate as appropriate. The PSSC shall have its key activities also be made known to the Executive Committee of the Medical Staff and the Patient Services Executive Committee, no less often than quarterly. The committee is administratively accountable to the Senior Vice-President for Medical Affairs. (Adopted 6/13/2005) (BOT 11/2006)

[↑Back to top](#)

ARTICLE XIII
STAFF, DEPARTMENT, SERVICE AND COMMITTEE MEETINGS

13.1 FREQUENCY OF REGULAR MEETINGS

Regular Active Staff, department, service and committee meetings shall be held at least quarterly, unless otherwise provided in these Bylaws. [↑Back to top](#)

13.2 ANNUAL MEETING

The fourth quarterly meeting of the Active Staff shall be the Annual Meeting. [↑Back to top](#)

13.3 ATTENDANCE REQUIREMENT

Active Staff members are encouraged to attend all meetings of the Active Staff; of their department and service; and of any committee of which they are members. Attendance at these meetings will be considered at time of Medical Staff reappointment in determining appropriate staff category. (Amended 1/09/2002)

[↑Back to top](#)

13.4 QUORUM

The presence of 15% or more of the Active Staff members of a department, service or committee shall constitute a quorum at their respective meetings. At general Active Staff meetings, twenty-five (25) shall constitute a quorum. (Amended 1/3/2000)

[↑Back to top](#)

13.5 MANNER OF ACTION

The action of a majority of the persons entitled to vote who are present at a meeting at which a quorum is present shall be the action of the Staff, a department, service or committee. Business may be conducted at a duly called meeting of a Medical Staff committee, department or service in the absence of a quorum, provided the actions are communicated to all the members of the committee, department or service. Action may be taken without a meeting by written consent (setting forth the action so taken) of 50% or more of the persons entitled to vote on such action. (Amended 1/3/2000)

[↑Back to top](#)

13.6 CONDUCT OF MEETINGS

13.6.1 Roberts Rules. All meetings shall be conducted according to Robert's Rules of Order, Revised, unless specifically modified by these Bylaws. The presiding officer may appoint another member to act as parliamentarian.

13.6.2 Confidentiality. All agenda items shall be designated as either general or executive session matters.

13.6.2.1 Purpose of General Session. General session is for the discussion of administrative matters pertaining to Medical Staff, Hospital and patient care that are general in nature.

13.6.2.2 Purpose of Executive Session. Executive session is for the discussion of particular professional practices in order to promote candor in monitoring and evaluation of the quality of patient care, to reduce morbidity and mortality, and to improve patient care. To preserve statutory protections, everyone in attendance in executive sessions is obligated to preserve the confidentiality of the proceedings, records and materials of executive sessions. No one may voluntarily disclose privileged information except pursuant to these Bylaws for the purposes for which the information was provided and as may be required by law.

13.6.2.3 Convening/Closing Executive Session. The chair should announce that executive session is convened; and, if general session has been in session, that it is formally closed. Once all confidential matters have been treated, the chair should close executive session (and reconvene general session, if necessary, inviting all those previously excused to return).

13.6.2.4 Attendance in Executive Session. Meeting attendance should be limited to the committee's members; medical, administrative and nursing staff and others may be permitted to attend to the extent necessary to assist in the professional practices review. Persons who were present or involved in the situation under review and the Medical Staff member/applicant under review may be invited to provide information to the committee and shall be interviewed separately as follows: They should enter the meeting only after other persons providing information have left, and they should leave once they have provided the information and answered any questions. Any person who has been directly or personally involved in the situation under review should not hear the deliberations or discussions.

13.6.2.5 Minutes. General and executive session minutes are made and kept separate. In addition, executive session minutes for the review of a physician's conduct or practice must be recorded separately and kept confidential in accordance with law.

[↑Back to top](#)

13.7 NOTICE OF MEETINGS

13.7.1 Regular Meetings. Notice of all quarterly meetings of the Active Staff shall be given by the Secretary in writing and mailed to each Active Staff member not less than seven (7) full days before the time of the meeting, except in an extraordinary and unavoidable emergency.

13.7.2 Special Meetings. Special meetings may be called at any time by the President of the Medical Staff and shall be called whenever requested in writing by five (5) members of the Active Staff. Notice shall be as described in 13.8.2. [↑Back to top](#)

13.8 POLICY ON CONFLICT OF INTEREST IN PEER REVIEW

The objectives of the Medical Staff's policy on conflict of interest in peer review are to encourage responsible peer review and to preserve the integrity of the peer review process by promoting impartiality of Medical Staff decision-makers and fairness for Medical Staff members under review. Medical Staff peer review activities are intended to improve the quality of patient care in the Hospital. Privileging decisions should always be based upon the training, experience and demonstrated competence of candidates; and be made in the reasonable belief that they are appropriate, warranted by the facts and designed to further quality health care. Personal friendships, antagonisms, jurisdictional disputes or fear of competition should be disregarded in making these decisions. Physicians involved in granting, denying or terminating privileges have an ethical responsibility to be guided primarily by concern for the welfare and best interests of patients in discharging this responsibility.

[↑Back to top](#)

ARTICLE XIV IMMUNITY FROM LIABILITY AND INDEMNIFICATION

14.1 IMMUNITY FROM LIABILITY

As a condition to application, appointment and the exercise of privileges at this Hospital, each applicant for Staff appointment and each Staff appointee expressly agree as follows:

14.1.1 that any act, communication, report, recommendation or disclosure with respect to the applicant or appointee, performed or made pursuant to these Bylaws at the request of an authorized representative of this or any other health care facility pursuant to a current consent of the applicant or appointee, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged (i.e., protected from disclosure for purposes other than maintaining and improving quality patient care and immune from liability) to the fullest extent permitted by law;

14.1.2 that such privilege shall extend to members of the Staff, the Board, the Administration and to third parties who supply information in accordance with these Bylaws to any of the foregoing authorized to receive, release or act upon the information. For the purpose of this Article "third parties" means both individuals and organizations from which an authorized representative of the Board or the Staff has requested information,

14.1.3 that the privilege shall extend to acts, communications, reports, recommendations and disclosures relating to the applicant's or appointee's professional qualifications, clinical competency, character, character, mental or emotional stability, physical condition, ethics or any other matter that might directly or indirectly affect quality patient care;

14.1.4 that there shall be, to the fullest extent permitted by law, immunity from civil liability arising from any act, communication, report, recommendation or disclosure made in accordance with these Bylaws in connection with this or any other health care facility's activities related, but not limited to:

- 14.1.4.1** application for appointment, reappointment or privileges,
- 14.1.4.2** corrective action including summary suspension,
- 14.1.4.3** hearings and appellate reviews,
- 14.1.4.4** patient care evaluations,
- 14.1.4.5** utilization reviews, and
- 14.1.4.6** other Hospital, department, service and committee activities related to quality patient care and interpersonal conduct; and

14.1.5 that applicability of the various consents, authorizations, releases, rights, privileges and immunities provided for in these Bylaws for the protection of the Medical Staff, its appointees, the Hospital and third parties in connection with applications for initial appointments shall extend to the activities and procedures described in these Bylaws.

[↑Back to top](#)

14.2 INDEMNIFICATION

14.2.1 *Covered Activities.* The Board indemnifies each Medical Staff member from all civil liability arising out of peer review and other activities delegated to the Medical Staff by the Board and undertaken in compliance with these Bylaws, such as activities related to appointments,

reappointments, privileging, and corrective action under these Bylaws, quality assessment and improvement, and utilization management.

14.2.2 Excluded Activities. The indemnification provided by this Article 14 is not available for liability arising out of a Medical Staff member's willful or malicious misconduct; willful and intentional infliction of harm; gross negligence; bad faith activities; actions inconsistent with these Bylaws without Board approval; or patient care activities, unless such patient care was an integral part of the member's fulfillment of an assigned Covered Activity of Section 14.2.1.

14.2.3 Covered Payments. The Hospital will pay on behalf of any Medical Staff member:

14.2.3.1 all sums that the member shall become legally obligated to pay as damages because of any claim or claims made against the member while carrying out any of the Covered Activities of Section 14.2.1.

14.2.3.2 all costs required to defend any claim arising from a Covered Activity including, without limitation, all attorneys fees and expenses in accordance with Section 14.2.4 below, all costs taxed against a member, all interest on any judgment, premium on appeal bonds, and reasonable expenses incurred by the member.

14.2.4 Defense

14.2.4.1 The Hospital shall defend each claim or suit arising out of the Covered Activities of Section 14.2.1, even though wholly without merit and even though malice, fraud, criminality, or bad faith is alleged, brought against any Medical Staff member to enforce any liability imposed by law and seeking payment of damages or other legal remedy or equity. This duty to defend shall not pertain to suits arising out of patient care, unless such patient care is alleged to have arisen because of a member's participation in any of the activities described above.

14.2.4.2 Whenever in the opinion of Hospital legal counsel any claim presents a potential conflict of interest between the Medical Staff member and the Hospital, the Hospital shall promptly provide the Medical Staff member with separate counsel of the Medical Staff member's reasonable choice, at no expense to the Medical Staff member.

14.2.5 Advance of Expenses. The Hospital will pay expenses incurred in defending any action, suit, claim or proceeding described in above Section 14.2.1 in advance of its final disposition, if (a) the Staff member delivers to the Hospital an executed, written undertaking to repay the advance if it is ultimately determined that the member is not entitled to indemnification under above Section 14.2.2 and (b), if the amount is to be paid in settlement, the Board determines that the amount is reasonable. The written undertaking shall be an unlimited general obligation but need not be secured and shall be accepted without regard to the member's ability to make repayment.

14.2.6 Duration. The indemnification and defense provided by this Article 13 shall survive the termination of Staff membership and clinical

privileges for all Covered Activities of Section 14.2.1 when such activities were undertaken at the time the affected Staff member was a member of this Staff. [↑Back to Top](#)

ARTICLE XV
RULES AND REGULATIONS

15.1 DEFINITION

The Staff shall adopt Rules and Regulations it deems necessary for the proper conduct of its work. Whereas these Bylaws pertain generally to the Medical Staff organization's relation to its members, the Administration and the Board, the function of Rules and Regulations is primarily to compile individual Medical Staff members' and practitioners' obligations to the Hospital and patients. The Rules and Regulations shall conform with and be a part of these Bylaws as delineated in Article XVIII.

[↑Back to top](#)

15.2 MANNER OF ADOPTION AND AMENDMENT

15.2.1 The Rules and Regulations shall be amended or repealed in the same manner as these Bylaws, in accordance with Article 17, provided, however, that amendments of the Rules and Regulations shall be provisionally effective on approval of the ECMS and that the vote of the Active Staff, and approval of Board shall ratify the amendments. (Amended 7/97)

15.2.2 Any member, department, service or committee of the Staff may make recommendations for Staff Rules and Regulation changes.

15.2.3 The Bylaws Committee shall periodically review and recommend revisions to the Rules and Regulations so that they comply with current Medical Staff practice. [↑Back to top](#)

15.3 POSTING OF STAFF BYLAWS, RULES AND REGULATIONS

Current Staff Bylaws and Rules and Regulations shall be available electronically via the NWH Hospital system or upon request from Medical Staff Services.

[↑Back to top](#)

ARTICLE XVI
POLICIES AND PROCEDURES

16.1 DEFINITION

Policies and procedures are required guidelines for individual clinical departments and services and each standing committee described in Article 11 to implement the principles of these Bylaws and the Staff Rules and Regulations.

[↑Back to top](#)

16.2 DEPARTMENT & SERVICE POLICIES AND PROCEDURES

16.2.1 Manner of Revision. No less often than every three years, each department and service shall review and revise, if necessary, its policies and procedures pertaining to its functions and responsibilities. Any member of a department or service may propose changes in policies and procedures at any regular meeting or special meeting (called for the purpose) of the department or service. (Amended BOT 05/04/2011)

16.2.2 Checklist. Each clinical department and service shall include in its policies and procedures a checklist of delineated privileges in the department or service to be granted as provided in Article 6. The checklist includes criteria (including any supervision requirements) for granting privileges.

The listing department or service only may recommend privileges after supervision requirements and other stated criteria have been met.

16.2.3 Board Approval; Prohibition. Policies and procedures governing the qualifications, privileges, and restrictions of individual Medical and Professional Staff members, shall be formulated and adopted by the departments and services subject to Board approval.

16.2.3.1 No privileges may be granted or exercised until policies and procedures and checklists, as provided in this Section has been approved by the department or service concerned, and ECMS and is in effect.

16.2.4 Consistency. Department and service policies and procedures must be consistent with the Medical Staff Bylaws.

16.2.5 Routing of Proposed Revisions to Service Policies and Procedures. When approved by a service, service policies and procedures shall be submitted for approval to the department of which it is a part. If so approved, the department shall forward the checklist to the Credentials Committee and the rest of the policies and procedures to the Bylaws Committee for their review and recommendations before final action by ECMS. Except as provided in Section 16.2.3, upon approval by ECMS the policies and procedures shall become effective.

16.2.6 Routing of Proposed Revisions to Department Policies and Procedures. When approved by the department, the department shall forward its checklist to the Credentials Committee and the rest of its policies and procedures to the Bylaws Committee for their review and recommendations before submission to ECMS for action. Except as provided in Section 16.2.3, upon approval by ECMS, the policies and procedures shall become effective.

16.2.7 Appeal. If ECMS fails to approve a proposed change in the policies and procedures of a department or service, the department/service may appeal to the Medical Staff at its next regular meeting. An adverse decision of the Medical Staff may be appealed to the Board, whose decision shall be final. [↑Back to top](#)

16.3 POSTING OF POLICIES AND PROCEDURES

Current policies and procedures of each department and service shall be available electronically via the NWH Hospital system. [↑Back to top](#)

ARTICLE XVII
AMENDMENTS, ADOPTION AND APPROVAL

17.1 INITIATION

These Bylaws may be amended only pursuant to this Article. One or more members of the Active Medical Staff may propose an amendment to these Bylaws by submitting the proposed amendment in writing to the Bylaws Committee.

[↑Back to top](#)

17.2 BYLAWS COMMITTEE ACTION

The Bylaws Committee shall:

17.2.1 provide an opportunity for the sponsor(s) to attend the next regular meeting of the Committee to discuss the proposal, its rationale, and the Committee's suggestions to improve clarity and consistency with the rest of the Bylaws,

17.2.2 refer the (revised) proposed amendment to ECMS with the Bylaws Committee's recommendation. [↑Back to top](#)

17.3 EXECUTIVE COMMITTEE ACTION

The Bylaws Committee chair shall present the proposed amendment at the next regular meeting of the ECMS at which both a quorum of ECMS and the sponsor(s) are present. ECMS shall accept or reject the proposed amendment by a two-thirds vote of the quorum and may modify the proposed amendment on agreement of the sponsor(s) and a majority vote of the ECMS quorum. If amendment(s) pertains to content within Article XVIII [Medical Staff Rules and Regulations], the ECMS by simple majority vote may make the amendment(s) provisionally effective until final action by the Active Staff and subsequently by the Board of Trustees (see section 15.2.1). [↑Back to top](#)

17.4 LACK OF AGREEMENT

If ECMS and the sponsor(s) cannot agree on a proposed amendment, the proposed amendment shall, at the discretion of the sponsor(s):

17.4.1 either be submitted to the Staff in the form proposed by the sponsor, together with the recommendations of the Bylaws and Executive Committees,

17.4.2 or be referred back to the sponsor's group (department, committee, service, etc.) for reconsideration, after which it may be resubmitted to ECMS at its next regular meeting. [↑Back to top](#)

17.5 ACTION BY THE ACTIVE STAFF

17.5.1 Notice. The proposed amendment, together with the recommendations of the Bylaws and Executive Committees, shall be:

17.5.1.1 presented to the Active Staff at a regular or special meeting of the Active Staff prior to the regular or special meeting

of the Active Staff at which the vote on the amendment is to be held, and

17.5.1.2 sent to each member of the Active Staff at least one week before the meeting at which the Active Staff is to vote on the amendment.

17.5.2 Modification. At the regular or special meeting at which the Active Staff is to vote on the amendment, the proposed amendment, together with the recommendations of the sponsor, Bylaws and Executive Committees, shall be discussed. The amendment may be modified by a majority vote of an Active Staff quorum.

17.5.3 Amendment. A two-thirds vote of an Active Staff quorum present in person is required to amend the Bylaws.

17.5.4 Amendment in Absence of a Quorum. If a quorum is not present an electronic mail ballot shall be used, and amendment shall require the vote of at least two-thirds (2/3) of the Active Staff membership voting, providing that the number of Members casting ballots constitutes a quorum as defined in Section 13.4. Medical Staff Services will mail an official ballot for voting on a proposed Bylaws amendment to each Active Staff member within seven (7) days of the Quarterly or Special Meeting in which a quorum was not present. The ballot will be accompanied by a synopsis of the rationale for the amendment and the discussion at the preceding Staff Meeting at which the item was first presented. The completed ballots must be received in Medical Staff Services by 5:00 p.m. on a date which shall be the fourteenth day after the mailing of the ballots. The ballots shall be counted before midnight of the due date by a group of authorized tellers in the presence of at least one ECMS member (amended BOT 01/07/09).

[↑Back to top](#)

17.6 ADOPTION AND APPROVAL

Amendments made pursuant to this Article shall become effective upon approval of the Board, last updated 01/09/2019. [↑Back to top](#)

ARTICLE XVIII

MEDICAL STAFF RULES AND REGULATIONS

(incorporated into the Bylaws of the Medical Staff of Newton-Wellesley Hospital
On 10/15/14)

18.1. INTRODUCTION AND DEFINITIONS

It is a privilege to be a member of the Newton-Wellesley Hospital Staff as defined in section 3.1.2. These Rules and Regulations are established to assist and guide the conduct of medical care and inter-professional relationships at our institution. These Rules and Regulations should be read, understood and adhered to. This represents part of a Staff Member's obligation to support our stated mission to deliver the highest quality medical care and to promote excellence in medical teaching.

"Attending Medical Staff Member" means the Newton-Wellesley Hospital Medical Staff Member who is primarily responsible for the care of a Newton-Wellesley Hospital patient with whom the Member has a current physician-patient relationship; and includes the Member's cover. Within the Critical Care Unit the "Attending Intensivist" (see 18.3.3.2) is the "Attending Medical Staff Member." Every Hospital patient must have an Attending Medical Staff Member.

"Orders" means medication, treatment, diagnostic testing, general patient care, admission and discharge orders issued by a Medical Staff, Professional Staff or Post-Graduate Trainee Staff member consistent with their privileges. In accordance with section 18.8 of these Rules and Regulations, an order may be issued in writing or electronically, or when permitted, necessary and authenticated, verbally or by telephone. (ECMS 02/17/09; BOT 07/01/09)

"Patient," in the context of medical decision-making and release of medical records, means "patient or person legally authorized to act on behalf of the patient." [↑Back to Top](#)

18.2. MEDICAL STAFF COVERAGE

18.2.1 Coverage of Patients. All hospitalized patients, all patients who have undergone an outpatient procedure in the hospital, and all Medical Staff Members' patients with medical tests being performed in the hospital or for the hospital must have readily available a staff member with privileges appropriate to their condition. Attending Medical Staff Members must arrange coverage for their patients during any absences.

18.2.1.1 Covering Medical Staff Members must have appropriate Newton-Wellesley Hospital privileges.

18.2.1.2 The Attending Medical Staff Member must inform his/her Office and/or answering service of any absence and the identity of, and instructions for contacting, the covering Medical Staff Member.

18.2.1.3 Medical Staff members must provide a reliable mechanism by which they (or a designee with appropriate privileges) may be directly contacted without delay to provide, arrange for, and/or coordinate care for inpatients and for patients who have undergone an outpatient procedure. (Approved as amended ECMS 1/18/2005; Ratified Med. Staff 3/8/05; Approved BOT 4/11/2005.)

18.2.1.4 Medical Staff Members must provide a reliable mechanism by which they (or a designee with appropriate privileges) may be directly contacted without delay to receive notice of inpatient and outpatient critical results from laboratory, EKG, and/or imaging studies. (Approved as amended ECMS 1/18/2005; Ratified Med. Staff 3/8/05; Approved BOT 4/11/2005.)

18.2.1.4.1 The Attending Medical Staff member must set up his/her telephone answering system for inpatients, outpatients, and office patients such that other Medical Staff members and Hospital personnel with critical test results may receive paging instructions or may communicate with a person from the attending Medical Staff Member's office or with a person from the Attending Medical Staff Member's answering service as a first step without delay in reaching the

Attending Medical Staff member or his/her covering Medical Staff member. (Approved as amended ECMS 1/18/2005; Ratified Med. Staff 3/8/2005; Approved BOT 4/11/2005)

18.2.1.4.2 The Attending Medical Staff member must set up his/her call system for inpatients, outpatients, and office patients such that other Medical Staff members and Hospital personnel may communicate critical test results directly to the Attending Medical Staff Member or his/her covering Medical Staff member followed by immediate read back by the Attending Medical Staff Member or his/her covering Medical Staff member. (Approved as amended ECMS 1/18/2005; Ratified Med. Staff 3/8/05; Approved BOT 4/11/2005)

18.2.1.4.3 The Medical Staff member must update the online Partner's phone directory and notify the Newton-Wellesley Hospital Medical Staff Services Department with any change in the Medical Staff member's office phone number immediately after the phone number change takes effect. [↑Back to Top](#)

18.2.2 *Emergency coverage.*

18.2.2.1 *On-Call Roster.* Medical Staff Members are assigned to the on-call roster according to Hospital needs, as determined by the department chair or service chief, which will notify the Members and the Emergency Department (ED) of the assignments. Medical Staff Members with restricted privileges or on probationary status are not eligible to be on the on-call roster unless the respective service chief and/or department chair makes an exception. (Approved as Amended ECMS 11/21/2000; Ratified Med. Staff 3/12/2001; Approved BOT 5/7/2001)

18.2.2.2 *Absence.* Whenever an On-Call Medical Staff Member is unable to fulfill on-call duties, he/she must arrange cover by an appropriately privileged Medical Staff Member and so inform the Medical Staff Member In Charge of the ED.

18.2.2.3 *On-Call Duties.* The On-Call Medical Staff Member (cover) must: (ECMS 08/01/06) (ECMS 10/17/06)

a) Accept, as Attending Medical Staff Member, patients requiring admission who have no private physician. After discussion between the ED physician and On-Call Medical Staff Member and acceptance of the admission by the On-Call Medical Staff Member, the ED physician transfers responsibility for the patient to the On-Call Medical Staff Member.

b) Consult on patients with emergency medical conditions in the ED and in emergent circumstances in the Hospital.

1) The On-Call Medical Staff Member must respond by acknowledging within 30 minutes a request for consultation made by an ED physician, House Officer, Administrator-on-call or department chair.

2) If the On-Call Medical Staff Member (cover) is unavailable, (1) the department chair (service chief)

will arrange for substitute coverage and (2) the chair (chief) will take disciplinary action, as appropriate.

c) Provide in-office follow-up care to patients treated and released from the ED, provided the Medical Staff Member in Charge of the ED contacted the On-Call Medical Staff Member at the time of treatment. [↑Back to Top](#)

18.2.3 Referrals

18.2.3.1 The Medical Staff Member must provide care for Patients referred by members of the Newton-Wellesley Hospital Active Medical Staff within a clinically appropriate timeframe. Any conflicts will be resolved by the Chief and/or Chair. (Med Staff 06/27/2012; BOT 07/11/2012)

18.3. ADMISSIONS

18.3.1 *General*

18.3.1.1 *Admitting Privileges Required.* Only Medical Staff Members with admitting and appropriate privileges may admit patients.

18.3.1.2 *Provisional Diagnosis Required.* The admitting Medical Staff Member must communicate a provisional diagnosis before a patient may be admitted.

18.3.1.3 *Admission Note Required Within 24 Hours.* The admitting Medical Staff Member must see the patient and write an admission note within 24 hours of admission.

18.3.1.4 *Admission Orders Required.* The admitting Medical Staff Member is responsible for written admission orders guiding patient care as expeditiously as possible but no later than 12 hours after admission. These should direct issues regarding diagnoses, allergies, diet, activity, ancillary health care needs, diagnostic evaluations, and medications. (Approved as Amended ECMS 1/18/2005; Ratified Med. Staff 6/13/2005)

a) *Patient Risk.* If the admitting Medical Staff Member suspects that the patient may present a danger to others or self, the admission orders should notify appropriate caregivers.

b) *Suicidal Risk.* The admitting Medical Staff Member must order an immediate psychiatric consultation, if he/she believes the patient is at suicidal risk.

18.3.1.5 *Direct Admissions.*

a) The admitting medical Staff Member must provide a handwritten or typed Holding Note to accompany a patient for direct admission to the hospital without Emergency Department evaluation. The Holding Note must state:

Clinical reason for the admission;
Relevant medical history;

Key physical examination findings;
Current medications;
Drug allergies;
Brief description of the diagnoses and treatment plan

(The Holding Note is not a substitute for the complete history and physical required under 18.7.2.2).

b) Orders for treatment and care required immediately must be provided and a Do Not Resuscitate order, as appropriate and verifiable as per the Medical Staff Rules and Regulations. (Approved as Addition ECMS 3/7/00; Ratified Med. Staff 6/6/00; Approved BOT 7/17/00)

c) Admissions for observation or recovery following an ambulatory interventional procedure must adhere to the standards in 18.3.1.5. At the time of such admission, the Orders must document the attending-of record for the admission. Whenever possible, arrangements for post-procedural care should be made prior to the interventional procedure. When care is transferred from the Medical Staff member performing the ambulatory procedure to the patient's Primary Care Physician or Hospitalist, direct communication between the involved physicians is required. (Approved as Addition ECMS 10/7/2003; Approved as amended ECMS 2/10/04; Ratified Med. Staff 3/9/2004; Approved BOT 8/11/2004) [↑Back to Top](#)

18.3.2 Teaching Service.

18.3.2.1 Admissions. Admission to the Teaching Service is determined jointly by the Attending Medical Staff Member and the House Officer, and depends on patient need and the House Officers' patient load. (Each department must maintain policies regarding House Officers' workloads.) In the event of irresolvable disagreements, the department chair or service chief shall be the ultimate arbitrator. House Officers must write admission notes and orders within twelve (12) hours of patients' admission to the Teaching Service.

18.3.2.2 Responsibilities. Attending Medical Staff Members whose patients are admitted to the Teaching Service must be actively involved in the patient's care and the House Officer's supervision. The Attending Medical Staff Member is ultimately responsible for the patient's care. Attending Staff members and House officers must maintain communication regarding patient care. House officers and Attending Medical Staff members shall promptly communicate any changes in patient status expected to affect outcome. Transfer, major changes in therapeutics and discharge require approval of the Attending Medical Staff Member. The department chair/service chief shall resolve disputes. (Amended 12/15/97; Reviewed/Amended by ECMS 11/6/2001; Amended 8/7/02) [↑Back to Top](#)

18.3.3 Intensive Care Unit (ICU)

18.3.3.1 Definitions.

Attending Intensivist: the intensivist (or equivalent designee) identified by the roster as being primarily responsible for the care of the patients on a particular service (cardiology, medicine or surgery) in the ICU.

Attending Physician: the physician who currently cares for a patient, primary care, surgeon or intensivist who is not on-service during the patient's stay in the ICU.

Concurrent Care: a system by which the care of the patient is directed by the cardiologist, medical intensivist or surgical intensivist with collaboration of the patient's attending medical staff member.

Critical Care Locum Tenens, a physician with specialized training and clinical privileges assigned to care for ICU patients from 1900 to 0700 weekdays, and twenty four (24) hours a day weekends and holidays.

In-hospital Intensivist: attending intensivist appropriate to the ICU Service or intensive care locum tenens.

Service: an organized attending system, (Cardiology, Medical or Surgical) within the ICU.

On-service: the time frame in which the attending intensivist is identified on the roster to provide ICU service coverage.

18.3.3.2 Admissions. Admission to the ICU is determined by patient need, unit bed availability, and recovery potential, based on the criteria stated in the "Intensive Care Unit Admission Criteria Policy." Each patient within the ICU shall be assigned to the service most appropriate to the needs of the patient. Assignment of service shall be determined by the primary presenting problem or suspected problem. Patients who present with multiple problems shall be assigned to the service most appropriate to the most critical presenting problem or suspected problem.

Admission of a patient to the ICU is conditioned on the approval (based on the Intensive Care Unit Admission Criteria Policy) of the in-hospital intensivist responsible for the ICU Service (i.e., cardiology, medicine or surgery) to which the patient will be admitted. The House Officer shall contact the appropriate in-hospital intensivist and shall obtain approval prior to a patient's admission to the ICU. Approval, the name of intensivist giving approval, and time of approval obtained shall be documented on the "Patient Admission to the ICU: Approval and Notification" form. Disputes between House Officers shall be adjudicated by the in-hospital intensivist. In cases of dispute between the in-hospital intensivist and the House Officer or attending physician, the Director of the ICU or his/her designee shall adjudicate. If the Director of the ICU is the in-hospital intensivist, the Chair of Medicine or his/her designee shall adjudicate.

When the in-hospital intensivist is not the attending intensivist, the attending intensivist shall be notified by the House Officer of the patient's admission upon the patient's admission to the ICU.

Notification shall be documented by the House Officer on the "Patient Admission to the ICU: Approval and Notification" form.

Exceptions:

Patients determined by the evaluating House Officer to be in extremis shall not require approval prior to the patient's admission to the ICU. However, the in-hospital intensivist shall be notified immediately of the patient and the patient's condition.

When the in-hospital intensivist is not the attending intensivist, the House Officer or his/her designee shall notify the attending intensivist of the patient's admission within 30 minutes of the patient's admission to the ICU. The notification and time of notification shall be documented on the "Patient Admission to the ICU: Approval and Notification" form by the House Officer or his/her designee.

18.3.3.3 ICU Responsibilities. The intensivist appropriate to the patient's critical care service shall direct the daily care of the patient throughout the patient's stay in the ICU. Each attending intensivist shall assess each patient assigned to his/her service at least daily and record his/her findings in a progress note. Consultations shall be obtained in accordance with the "Intensive Care Consultation: Indications and Procedures for Obtaining" policy.

18.3.3.4 SCN Responsibilities. The neonatologist on service or his/her designee shall direct the daily care of the patient throughout the patient's stay in the SCN. The neonatologist or his/her designee shall assess each patient at least daily and record his/her findings in a progress note. [↑Back to Top](#)

18.4. DISCHARGES

18.4.1 General.

18.4.1.1 Discharge Order. The Attending Medical Staff Member, authorized member of the Professional Staff or House Officer must issue a discharge order before the patient will be discharged. If written by the House Officer, verbal approval of the Attending Medical Staff Member is required. (Approved as Amended ECMS 1/18/2005; Ratified Med. Staff 6/13/2005)

18.4.1.2 Timing. Attending Medical Staff Members should discharge their patients as soon as medically appropriate.

18.4.1.3 Discharge Summary. The Attending Medical Staff Member is responsible for the completion of a discharge summary on all patients within 24 hours of discharge except as provided below. It is recommended that the discharge summary be done on the same calendar day as the patient discharge. The discharge summary must conform to the requirements in 18.7.2.9. (Amended ECMS 02/21/2012)

Exceptions:

- a) Normal newborns
- b) Uncomplicated vaginal deliveries

c) Observation status

18.4.1.4 Discharge Note. When a discharge summary is not required, a discharge progress note is required on the chart at the time of discharge and must conform to the requirements in 18.7.2.10. (Amended ECMS 02/21/2012)

[↑Back to Top](#)

18.4.2 Discharge Against Medical Advice. If a patient wishes to leave the Hospital against medical advice, the Attending Medical Staff Member will be notified so that the Member may document the circumstances surrounding the event. The Member should attempt to have the patient sign documentation of discharge against medical advice, including a statement that the risks have been explained. [↑Back to Top](#)

18.5. DEATH, AUTOPSIES, ANATOMICAL DONATIONS

18.5.1 Hospital Deaths. (Amended ECMS 02/04/2014)

18.5.1.1 Responsibility. Whenever possible, the Attending Medical Staff member should pronounce the deceased dead within 2 hours and notify the patient's designated emergency contact of the patient's death. If the patient is a declared organ donor or a potential organ donor, death should be pronounced within no more than one hour. If the Attending Medical Staff member is unable to pronounce death, and/or notify the emergency contact in a timely fashion, his/her designee may do so and advise the Attending Medical Staff member as soon as possible. The patient's Primary Care physician should be notified of the death no later than the next business day. Declaration of brain death may only be made by a neurologist or neurosurgeon in accordance with the hospital policy on Brain Death.

[↑Back to Top](#)

18.5.2 Autopsies. (Amended ECMS 12/03/2013)

18.5.2.1 Policy. The Medical Staff has adopted a policy to attempt to secure autopsies in all deaths occurring in the Hospital that meet the following criteria:

- a) All obstetric, perinatal and pediatric deaths.
- b) All deaths in which the cause of death is not known with reasonable certainty on clinical grounds.
- c) All deaths that are unexpected or unexplained.
- d) All deaths in patients enrolled in clinical trials.
- e) All deaths in which it is believed that the autopsy may disclose an illness that may have a bearing on the health of family members, the health of hospital personnel, the health of the general public, or the health of recipients of transplant organs.
- f) All deaths in which an autopsy may help allay concerns or provide reassurance to the family regarding the death.

18.5.2.2 *Deaths that require a report to the Office of the Chief Medical Examiner (OCME).* In accordance with Massachusetts General Law, c.38, s.3, deaths that occur in certain defined circumstances must be reported to the OCME by the attending physician in conjunction with administration. Reports to the OCME must include deaths:

- a) Where criminal violence may have taken place,
- b) By accident or unintentional injury;
- c) By suicide;
- d) Under suspicious or unusual circumstances;
- e) Following an unlawful abortion,
- f) Related to occupational illness or injury,
- g) In custody, in any jail or correctional facility;
- h) In a mental health or mental retardation institution;
- i) Where suspicion or abuse of a child, family or household member, elder person or disabled person exists,
- j) Due to poison or acute or chronic use of drugs or alcohol;
- k) Associated with diagnostic or therapeutic procedures,
- l) Suddenly when the decedent was in apparent good health;
- m) Within 24 hours of admission to a hospital or nursing home;
- n) In any public or private conveyance;
- o) Fetal death, reportable under C 111, 202, where the period of gestation has been 20 weeks or more, or where fetal weight is 350 grams or more;
- p) All children under the age of 18 years;
- q) In an emergency treatment facility, medical walk-in center, day-care center or under foster care;
- r) Any person found dead.
- s) Occurring in circumstances as defined by regulations.

All deaths listed above must be referred to the OCME regardless of the time interval between the incident and death, and regardless of whether such incident appears to have been the immediate cause of death, or a contributory factor thereto.

In certain circumstances the OCME may decline jurisdiction of a death, or the OCME may accept jurisdiction but decide not to perform an autopsy. In these circumstances, the attending physician or

family may request that an autopsy be performed under the auspices of NWH. In these circumstances, and pending approval by the Pathology Department (section 18.5.2.3), the standard consent process must be followed (section 18.5.2.4).

18.5.2.3 Role of the Pathology Department. The final decision to perform a postmortem rests with the responsible NWH Attending Pathologist, in consultation with the MGH Department of Pathology, where all NWH autopsies are performed. This decision is based on the medical-legal circumstances of the case, the safety to personnel and the policies and procedures of the NWH and MGH Pathology Departments. The NWH Pathology Department will notify interested members of the Medical Staff, e.g., Attending physician, when an autopsy is being performed, assure that provisional and final reports are issued, and present the relevant findings at departmental and institutional educational and quality assurance meetings, when requested.

18.5.2.4 Consent to Autopsy.

a) *Responsibility.* In cases of in-Hospital death, Attending Medical Staff Members are responsible for discussing and requesting postmortem examination from the person competent to consent to the autopsy. On the Teaching Service, after receiving notification of a patient's death, the Attending Medical Staff Member may designate the responsibility to a House Officer.

b) *Who may consent?* The Hospital will assist in identifying and contacting the person legally competent to consent to autopsy.

c) *Documentation.* Documented witnessed consent on the Hospital's autopsy permit is required before a postmortem examination may be performed. The consent may be obtained by telephone if witnessed by a third party and documented in the medical record. (Approved as Amended ECMS 1/18/2005; Ratified Med. Staff 6/13/2005)

d) When Autopsy is by Medical Examiner. Consent of next of kin is not required when the Medical Examiner has accepted a case for autopsy, but in those cases, the Attending Medical Staff Member should explain to the next of kin that autopsy is required by law. [↑Back to Top](#)

18.5.3 Death Certificates.

18.5.3.1 Responsibility. The Attending Medical Staff Member must complete the death certificate for a patient that dies at the Hospital.

18.5.3.2 Exceptions.

a) If the Attending Medical Staff Member is not available, the House Officer or the Emergency Department Medical Staff Member who pronounced the patient dead must complete the death certificate.

b) In those cases accepted by the Medical Examiner for autopsy, the Medical Examiner will complete the death certificate.

18.5.3.3 Contents: Cause of Death. The Massachusetts death certificate tells the physician completing the form to provide the "immediate cause (final disease or condition resulting in death)." For the "immediate cause," the death certificate instructs:

a) "Do not use only the mode of dying such as cardiac or respiratory arrest, shock or heart failure" and

b) "Enter underlying cause (disease or injury that initiated events resulting in death) last."

The prohibition against disclosing HIV status does not prohibit identifying AIDS as cause of death on the death certificate.

[↑Back to Top](#)

18.5.4 Anatomical Donations.

18.5.4.1 Obligation to Seek Donation; Exceptions. Whenever a death occurs at the Hospital, the decedent's next of kin will be informed about the opportunity to make an organ or tissue donation, unless:

a) It would cause undue emotional stress to the next of kin, or

b) A member of the health care team has received actual notice of a contrary intention; or

c) The Attending Medical Staff Member does not believe that the patient's organ or tissue is likely to be suitable for transplantation under "New England Organ Bank Criteria" (the Hospital will confirm suitability with the NEOB); or

d) The case must be reported to the Medical Examiner, and the Medical Examiner has neither waived the case nor authorized the harvesting.

18.5.4.2 Responsibility for Obtaining, Documenting Consent. If none of the 18.5.4.1 exceptions apply, the New England Organ Bank in coordination with the Attending Medical Staff Member will initiate discussion of the donation option with the next-of-kin and obtain informed consent. A physician, RN, or social worker may document the consent, which may be given by phone, provided one witness in addition to the person obtaining consent hears it contemporaneously. (Approved as Amended ECMS 1/18/2005; Ratified Med. Staff 6/13/2005)

18.5.4.3 Next of Kin Lineage for Organ Donation. It is Hospital policy to seek post-mortem consent, even if the decedent has expressed intent to make an organ or tissue donation. The Hospital will assist the Attending Medical Staff Member in identifying and contacting the person(s) authorized to consent.

18.5.4.4 Prohibition. The Medical Staff Member who determines the time of death shall not participate in the procedure for removing or transplanting an organ or other body part. [↑Back to Top](#)

18.6. TRANSFERS

18.6.1 Institutional Transfers.

18.6.1.1 Introduction. The Hospital is required to comply with all of the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) and its corresponding CMS guidelines. EMTALA applies to all patients, who present to hospitals with an emergency department, who request medical care or treatment. Under EMTALA, the hospital must provide for an appropriate medical screening examination (within the capabilities of its' emergency department and the hospital's ancillary services) to determine whether an emergency medical condition exists. Qualified medical personnel must conduct the medical screening examination; such personnel include attending physicians, residents, physician assistants (PA), certified nurse midwives (CNM) and nurse practitioners. In addition, specially trained nurses can perform a medical screening exam on pregnant patients, in collaboration with the obstetrician or certified nurse midwife. EMTALA further requires that certain criteria relevant to patient transfer be met, as delineated below and as contained in Hospital policy. (Approved as Amended ECMS 8/6/2002; As Amended ECMS 1/18/2005; Ratified Med. Staff 6/13/2005)

18.6.1.2 General Rule. Patients may be transferred to another institution for reasons of medical need or patient preference. The transferring physician or CNM must complete the Authorization for [Institutional] Transfer Form prior to transfer to another institution from anywhere in the Hospital, including the ED. Medical information (i.e. admission H&P, progress notes, pertinent laboratory values, radiology reports) must be transferred with the patient, along with any other medical information that the transferring physician, in collaboration with the receiving institution, deems necessary to the patient's care. The patient's informed consent regarding risks and benefits of the transfer must be documented. If the patient is medically unable to request or consent to transfer and no responsible representative is available, the physician shall use/his/her best judgment and act in the patient's best interest. Transfers will be undertaken only if the receiving facility has available space and qualified personnel for the treatment of the patient, and has agreed to accept transfer of the patient and to provide appropriate medical treatment. (Amended ECMS 4/2/2002)

18.6.1.3 Definition. "Stabilized," means:

- a) No material deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital; or
- b) A woman having contractions has delivered child and placenta.

18.6.1.4 Transfer of Unstabilized Patient. Discharge or transfer of an unstabilized patient is prohibited, unless the requirements stated in 18.6.1.1 are met and:

a) The physician (1) certifies his/her reasonable belief that the medical benefits reasonably expected from the transfer outweigh the increased risks to the patient and (2) documents a summary of the risks and benefits upon which the certification is based; or

b) The patient (representative) requests the transfer in writing after being informed by the Hospital of the Hospital's obligations to treat and of the risks of transfer in an unstabilized condition. (Amended ECMS 4/2/2002)

18.6.1.5 Disputes. Disputes about a patient's stability or the benefits and risks of transfer that arise between the ED physician and an on-call (attending) physician who has come to the ED and personally examined the patient shall be resolved by the on-call physician's department chair in consultation with the ED chair, and as approved by the Conduct of Care Policy. (Amended ECMS 4/2/2002)

[↑Back to Top](#)

18.6.2 Transfers within the Newton-Wellesley Hospital

18.6.2.1 Transfers Between Medical Staff Members. Primary responsibility for a patient is transferred when (1) the Attending Medical Staff Member, who is transferring the patient to another attending physician, notifies the accepting physician by phone, communicates the relevant clinical information to the accepting physician, and documents the conversation in the medical record. AND (2) the accepting Medical Staff Member writes a progress note acknowledging acceptance of the patient and enters the change of attending order in the computer. (ECMS 02/05/08)

18.6.2.2 Transfer Between Units. Patient transfer from one unit to another requires the review and modification of orders by either the accepting Medical Staff Member or the House Officer on the accepting unit. If a delay of 2 hours or more is anticipated, the Attending Medical Staff Member who initiated the transfer of the patient may enter transitional orders. The transferring physician remains responsible for the patient until the change in attending order is entered. This must occur within 12 hours. (ECMS 02/05/08)

Exceptions:

a) Surgeons' orders entered immediately post-surgery in the OR or PACU. (ECMS 02/05/08)

b) Orders for a patient who transfers because of room availability or other administrative reason and not because of the difference between the levels of medical care on the two units. (Amended 12/15/97)

18.6.2.3 ICU Transfers. Transfers of patients from an inpatient unit to the Intensive Care Unit require documentation of approval by the in-hospital intensivist (based On Intensive Care Unit Admission Criteria Policy). The in-hospital intensivist adjudicates disputes

between the floor House Officer and the ICU House Officer. The ICU Director or his/her designee resolves disputes between the in-hospital intensivist and the ICU or House Officer. If the in-hospital intensivist is the ICU Director, the Chair of Medicine or his/her designee shall adjudicate.

If a House Officer determines that an emergency transfer is indicated and orders the transfer, he/she must notify the in-hospital intensivist immediately of the patient and the patient's condition; he/she or designee must notify the Attending Medical Staff Member within 30 (thirty) minutes of the patient's admission to the ICU. [↑Back to Top](#)

18.7. MEDICAL RECORDS

18.7.1 General

18.7.1.1 Purpose. The medical record must contain sufficient information to identify the patient, justify the admission and continued hospitalization, support the diagnosis, document the course of treatment, describe the patient's progress and response to medications and services, and facilitate continuity of care. It serves as an instrument for communicating among physicians and other health professionals contributing to the patient's care and as a basis for planning and evaluating that care. (Amended 12/15/97)

18.7.1.2 Abbreviations. Each abbreviation and symbol used in a medical record may have only one meaning, as determined by the Medical Records Committee based on department requests. The medical record may not contain entries using Prohibited Dangerous Abbreviations, as identified and published by the Pharmacy & Therapeutics Committee. (Amended as approved by the ECMS 2/10/04; Ratified Medical Staff 6/2/2004; Approved BOT 8/11/2004)

18.7.1.3 Correcting the Medical Record. Once an entry has been made in the medical record, it is a part of the medical record, whether or not the medical record is complete. Entry in the medical record may not be altered in any way. Corrections must be made either by addenda and/or by drawing a single line through the error and initialing and dating the addendum and the line striking the entry.

a) Proofing Transcribed Dictation. Transcriptions of dictated entries may be corrected for grammatical, syntactical and other non-substantive matters. If the Medical Records Director finds substantive differences, both versions will become part of the record.

18.7.1.4 Completion of Medical Record. Medical records must be completed within 30 days of patient discharge. (Approved as Addition ECMS 2/2/99; Ratified Med. Staff 9/14/99; Approved BOT 11/18/99)

[↑Back to Top](#)

18.7.2 Required Elements.

18.7.2.1 Identifying data. The record must identify:

a) The patient (name, address, date of birth, medical record number, name of legally authorized representative); and

b) The Attending Medical Staff Member primarily responsible for the patient's care. Transfers of primary responsibility are not effective until documented on the order sheet or other appropriate place in the record by the transferring physician and accepted by the physician assuming the primary care of the patient.

18.7.2.2 History & Physical (H&P). (BOT 06/14/06)

a) Requirement. A History & Physical must be completed in the medical record of any patient admitted to the hospital or undergoing a procedure for which moderate sedation, deep sedation, or general anesthesia is planned and for any other procedures delineated in the Policies & Procedures of the applicable department or service.

b) Source. The History & Physical must be completed by one or more members of the Medical Staff, House Staff, or Professional Staff authorized (see 18.7.2.2.e) to perform a History & Physical. (Amended ECMS 12/3/2013). The attending physician or covering physician of record is responsible for the content and completeness of the History & Physical. (Amended ECMS 7/1/2014; BOT 12/10/2014)

i. A History & Physical prepared by a physician not a member of the NWH Staff, may be made part of the patient's record to satisfy the requirements of this section following its review and endorsement by the NWH treating physician.

c) Timeliness. The History & Physical must be recorded no more than 30 days prior to the admission or procedure. The History & Physical must be filed in the chart (written or dictated and transcribed) and updated or made current within 12 hours of the patient's admission and before the patient undergoes any invasive procedures except in the Normal Newborn Nursery (24 hours), or in documented emergencies.

This update must include any changes in patient condition (including medication therapy) that affect the plan of care and may be performed by a member of the Medical Staff, House Staff, or Professional Staff authorized to perform a History & Physical. (ECMS 08/05/08; BOT 01/07/09)

d) Contents. The History & Physical must include the elements enumerated below documented by one of more of the individuals qualified per 18.7.2.2.b (Amended ECMS 12/3/2013)

a. for inpatients:

i. documentation of comprehensive history and current physical assessment, including review

- of past medical history, systems review and pertinent immunization status;
- ii. details of current illness, including, when appropriate, assessment of emotional, behavioral and social status;
- iii. family and social history;
- iv. review of a medication reconciliation report including current medications, dosages, routes and frequency; known allergies, including medication reactions;
- v. admitting (or pre-op) diagnosis;
- vi. reasons for admission;
- vii. pertinent recent laboratory data, and relevant diagnostic study results;
- viii. initial treatment goals and plan;

b. for ambulatory surgery patients: (Amended ECMS 12/3/2013)

- i. documentation of pertinent physical examination and medical history;
- ii. mental status;
- iii. existing co-morbid conditions;
- iv. review of medication reconciliation report including current medications, dosages, routes and frequency; known allergies, including medication reactions;
- v. history of present illness and surgical disease;
- vi. description of the operative site and/or surgical lesion;
- vii. results of pertinent diagnostic studies;
- viii. plan of treatment.

e) Specific History & Physicals (Amended BOT 07/11/07)

1. H&P for Obstetrical Patients.

Every obstetrical patient must have a prenatal H&P. A copy of a prenatal H&P from the physician's and/or certified nurse midwife's office is acceptable if updated and authenticated at the time of admission. H&P's for patients having an elective C-Section must be completed before the procedure and admission.

2. H&P's may be performed by qualified Physician Assistants and Nurse Practitioners if the Practitioner has clinical privileges to do so under the supervision of a qualified physician. Admission H&P's performed by these individuals must be co-signed by the supervising physician within 24 hours of the patient's admission to the hospital.

18.7.2.3 Ambulatory Clinic Notes. (ECMS 01/03/06)

Ambulatory Clinic Notes must be completed on the day of the clinic visit by the authorized member of the medical or professional hospital staff. The initial visit note should record the present illness or complaint, relevant history and review of systems pertinent to the patient condition or reason for visit. The physical examination should include those elements relevant to the patient's condition and presenting complaint.

The initial visit note should include a diagnostic impression and plan of care.

A problem list must be maintained in the Ambulatory Clinic record including the following elements:

- Current medications
- Drug allergies and adverse reactions
- Medical and surgical conditions

The problem list must be reviewed and updated, as necessary, at the time of each Ambulatory Clinic visit by a member of the medical, professional or hospital staff authorized to do so.

Follow-up/return visit notes must be entered on the day of the patient's visit and include documentation of the patient's condition, pertinent examination, and any changes in the diagnostic impression or plan of care.

18.7.2.4 Procedural Assessment. (ECMS 12/20/05)

Patients undergoing outpatient treatments and procedures other than those specified under 18.7.2.2 with a significant potential for bleeding, mechanical or infectious complications, except as delineated in the Policies & Procedures of the applicable department or service, shall have a Procedural Assessment recorded in the medical record which includes, at a minimum:

- Diagnosis and indication for planned treatment or procedure
- A problem list including the following elements:
 - a. current medications
 - b. drug allergies
 - c. medical and surgical conditions
- Mental status and capacity to consent to planned treatment or procedure

For patients undergoing a planned series of treatments, the Procedural Assessment must be reviewed and updated, as necessary, at the time of each visit by a member of the medical, professional or hospital staff authorized to do so. Interval changes since the prior visit or treatment must be documented.

18.7.2.5 Properly Executed Informed Consents For Procedures and Treatments. The general consent that patients sign on admission allows physicians to order routine diagnostic tests for a patient. Additional, specific informed consent is necessary prior to any non-routine diagnostic or treatment procedure. "Informed" consent requires that the patient understand all material consequences of

either positive or negative results or outcomes as well as alternative treatments and the prognosis with and without treatment.

18.7.2.6 Progress Notes. Progress notes must be written daily by the Attending Medical Staff Member documenting pertinent information that should include review of drug and IV therapy and response to treatment to maintain good continuity of care. Notes must be legible, dated, timed and signed with appropriate professional designation. House Officer daily notes do not substitute for Attending Medical Staff member notes. Exception: Pediatrics Department Policies govern progress notes for "Normal Newborns-Uncomplicated" that continuously meets Pediatrics Department Criteria. (Amended 12/15/97)

18.7.2.7 Operative Reports. (Amended 12/15/97; ECMS 4/19/16; BOT 10/5/16)

a) Operative Note and Report. Immediately after surgery or other invasive diagnostic or therapeutic procedure, the Medical Staff Member who performed the procedure (or authorized designee present during the procedure; designee notes must be co-signed by the Medical Staff Member who performed the procedure) must write a Brief Operative Note indicating the procedure's completion and including the items below carrying an asterisk (*). If the Medical Staff Member who performed the diagnostic or therapeutic procedure (or authorized designee present during the procedure; designee reports must be signed by the Medical Staff Member who performed the procedure) completes a detailed full Operative Report that is available immediately after surgery, a Brief Operative Note is not required. Full Operative Reports must be completed and available within 24 hours of the surgery or procedure and must include: (ECMS 02/17/2009; BOT 07/01/09; ECMS 4/19/16; BOT 10/5/16)

- The patient's name and medical record number*;
 - The name of the primary surgeon and any assistants*;
 - The date and name of the specific procedures performed*;
 - The indications for procedure (pre-operative diagnosis);
 - A description of the technical procedures used;
 - A description of the surgical findings*, and the tissues removed or altered;
 - Estimated blood loss*;
 - Complications*, if any;
 - Type of anesthesia administered;
 - Prosthetic devices or implants used*; if any, and
 - The post-operative diagnosis*. (Amended 12/15/1997.)
- (Approved as Amended ECMS 6/7/2005; 09/19/06)

b) Anesthesia Report. Within 24 hours of the procedure, the anesthesiologist must have the original, signed anesthesia report filed in the medical record. The Report must document:

i. Pre-anesthesia Evaluation performed within 30 days prior to surgery and including notation of anesthesia risk; (anesthesia, allergy and drug history; potential anesthesia problems; and patient's condition before induction of anesthesia); Approved as amended ECMS 3/19/2002; Ratified Med. Staff 9/19/2002; Approval BOT 10/2/2002)

ii. Intra-operative Activities, including record of all anesthesia, including name, dosage, route, time and duration of all anesthetic agents, other drugs, intravenous fluids and blood or blood components; oxygen flow rate; continuous recordings of patient blood pressure, heart and respiration rate; complications or problems, including time, description of symptoms, vital signs, treatments and response to treatment, and

iii. Post-anesthesia Assessment, including at least one description of presence/absence of anesthesia-related complications; cardiopulmonary status, level of consciousness, follow-up care and/or observations. (Amended 12/15/97)

c) Surgical Specimen Report. Except as noted on the Surgical Exceptions List maintained in the OR, all tissue removed anywhere in the Hospital is sent to the Pathology Department for examination. The pathologist's report is part of the medical record.

d) Results of diagnostic and therapeutic procedures.

e) Consultation Reports. (See section 18.9)

18.7.2.8 Orders. (See section 18.8) Orders must be written, legible, dated, timed and signed with appropriate professional designation.

18.7.2.9 Discharge Summary. The Attending Medical Staff Member is responsible for the completion of a discharge summary on all patients (except as provided for in 18.4.1.3) within 24 hours of discharge. The Attending Medical Staff Member may delegate the completion of the discharge summary provided s/he electronically signs the discharge summary. The summary must include:

- a) Admitting diagnosis,
- b) Principal discharge diagnosis,
- c) Secondary diagnoses,
- d) Procedures performed,
- e) Inpatient Attending and 24/7 contact information,
- f) Discharge medications and reconciliation (noting any changes and rationale for these changes),
- g) Anticoagulation details, if applicable (anticoagulants specifically, not antiplatelets)
- h) Allergies,
- i) Hospital course,
- j) Discharge exam,

- k) Code status and/or advance directives,
 - l) Primary Care Provider and method of communication regarding hospitalization
 - m) Follow-up plans post discharge,
 - n) Pending tests/studies that require follow-up, and contact information for obtaining results.
- (Amended 12/15/97; 02/21/2012)

18.7.2.10 Discharge Progress Notes. When a Discharge Summary is not required, the Attending Medical Staff Member must write a final discharge note before discharge. The Discharge Instruction Sheet is considered part of the discharge note. The note includes:

- a) Primary diagnosis
 - b) Secondary diagnoses,
 - c) Procedures performed,
 - d) Discharge medication reconciliation
 - e) Diet
 - f) Allergies, except for newborns
 - g) Condition on discharge,
 - h) Follow-up plans,
 - i) Additional elements as specified by departmental policy,
 - j) Pending tests/studies that require follow-up, and contact information for obtaining results.
- (Amended 02/21/2012)

18.7.2.11 Signatures. Every entry must be signed and dated. Signatures must be legible and include notation of credentials. Medical Staff Members must authenticate some entries and co-sign others.

- a) *Authentication.* "Authentication" verifies authorship and the substance of the entry. Transcribed dictations and written entries must be authenticated. Medical Staff Members must "authenticate" others' entries, only if made at the Member's specific direction, e.g., verbal orders.
- b) *Co-Signing.*
 - i. Entries by medical students must be co-signed by a House Officer or Medical Staff member. House Officer entries must be co-signed in accordance with 18.12.2.1. (Approved ECMS 3/29/2005; Ratified by Med. Staff 9/12/2005; Approved BOT 9/14/2005)
 - ii. Entries by other practitioners must be co-signed as may be required by protocols approved by the Medical Staff and the Board of Trustees.

18.7.2.12 Incomplete Medical Records. Failure to meet deadlines, if not cured within 48 hours of notification by the Director of Medical Records (designee) will result in medical records suspension, in accordance with Bylaws Art.8.

- a) *Suspension.* Medical records suspension prohibits admitting and/or consulting privileges and the right to schedule procedures until such reports are complete. A suspended

physician may not admit a patient under another physician's name and then assume the patient's care.

b) *Exceptions.* Medical records suspension does not affect a Medical Staff Member's: (amended ECMS 10/06/09; Ratified BOT 05/05/2010)

1) Routine care for his/her own patients already in the Hospital at the time of suspension. (Routine care does not include consultations, invasive procedures or assistance at surgery.)

2) Prompt urgent care for his/her own patients requiring Hospital services. Approval for admissions, consultations or urgent procedures will be given by the Department Chair or Division Chief during normal business hours. At night and on weekends or holidays, approval must be obtained from the on-site nursing supervisor, who will communicate the "waiver" to the Department Chair or Division Chief either by electronic mail in real time or via direct conversation during normal business hours.

3) ED Call duties. When an ED patient requires consultation, emergency admission or a procedure, the suspended on-call physician may attend to the patient's urgent needs after approval as in the preceding paragraph.

c) *Termination of Medical Staff Membership.* If a Medical Staff Member remains on medical records suspension continuously for 60 days, the Medical Records Director will direct the Member, by certified letter, to complete all delinquent records within five working days. If the records remain incomplete, the Member's Staff membership will be terminated consistent with Medical Staff Bylaws.

[↑Back to Top](#)

18.7.3 Confidentiality of Patient Records.

18.7.3.1 General. Because patients' medical records are confidential, information in them is generally available only (1) to people appropriately providing direct patient care or evaluating patient care pursuant to approved policies; (2) on written release by the patient; or (3) as may be required by law. The Hospital maintains a record of all disclosures to third parties.

a) **Authorized Internal Uses.** Internal access to medical record information without the written consent of the patient is permitted only on a need-to-know basis to those directly involved in the care of the patient, or trained and authorized to perform or oversee Hospital-approved programs, such as quality improvement, peer review, utilization management, and bona fide study and research.

b) **Authorized External Disclosure.** Except as may be required or authorized by law, the Hospital does not disclose medical

record information to third parties without the patient's written authorization. Such authorizations are time-limited and specific to the subject matter to be disclosed and to the person to receive the information. Any other disclosure, including, but not limited to unauthorized discussion or revelation of information related to a patient represents a failure to meet professional and ethical standards and constitutes a breach of confidentiality and a violation of these Rules and Regulations. A breach of confidentiality need not take the form of a deliberate attempt to divulge confidential information. It includes the casual, unnecessary or unauthorized discussion, exchange or communication of confidential information in any form. (Approved as amended ECMS 3/19/2002; Ratified Med. Staff 9/19/2002; Approved BOT 10/2/2002)

18.7.3.2 Exceptionally Sensitive Information. Because certain information in the medical record (e.g., drug and alcohol treatment, psychiatric, communicable diseases and HIV-related information) requires additional protection (the violation of which may result in criminal and civil penalties and civil liability), Hospital procedures prevent such information from being released on a general consent. Medical Staff Members should guard against their own unauthorized disclosure of such information. (See 18.11.8)

18.7.3.3 Removal of Medical Records. Medical records may not be removed from the Hospital premises except on court order or as otherwise required by law. Unauthorized removal is grounds for suspension of privileges.

18.7.3.4 Patient Access to Medical Records. Generally patients have the right to inspect their own records and to obtain copies for a reasonable fee. Patient access to mental health records may be limited if medically contraindicated, in accordance with rules of the Department of Mental Health. [↑Back to Top](#)

18.8. ORDERS

18.8.1 General. Attending Medical Staff Members must ensure that appropriate orders are written on their patients. Orders:

18.8.1.1 must be personally written (or entered into computer), legible, dated, timed and signed with appropriate professional designation, (Approved as Amended ECMS 2/2/99; Ratified Med. Staff 9/14/1999; Approved BOT 11/18/1999)

18.8.1.2 may be written only within the scope of the practitioner's license and delineated privileges,

18.8.1.3 of medical students must be countersigned before they are effective,

18.8.1.4 should be written on the medical ordering sheet and are part of the permanent medical record.

18.8.1.5 must be written consistent with "Intensive Care Consultation: Indications and Procedure for Obtaining" policy, for ICU patients.

[↑Back to Top](#)

18.8.2 Verbal Orders. Verbal orders should be used infrequently and only under exceptional circumstances and only in a fashion incorporating the precautions outlined in the Clinical Policy on Medication Orders.

(Approved as Amended ECMS 2/2/99; Ratified Med. Staff 9/14/99; Approved BOT 11/18/99.) Approved as Amended ECMS 2/10/04; Ratified Med. Staff 6/2/2004; Approved BOT 8/11/2004)

18.8.2.1 Direct and Telephoned Verbal Orders.

a) Direct verbal orders may be given in emergent situations such as when a patient code prevents the ordering Medical Staff Member from writing the order. (Approved as Addition ECMS 2/2/99; Ratified Med. Staff 9/14/1999; Approved BOT 11/18/1999)

b) Telephoned verbal orders may be used when the ordering Medical Staff Member is physically unavailable to write on the order sheet or in the computer and believes a telephone order best facilitates the care of the patient. (Approved as addition by ECMS 2/2/99; Approval Med. Staff 9/14/99; Ratified BOT 11/18/99)

18.8.2.2 Acceptance of Verbal Orders. If circumstances prevent the ordering Medical Staff Member from writing an order, the Member may verbally communicate the order as follows:

a) Registered nurses may accept all orders.

b) Respiratory therapists may accept orders pertaining to respiratory therapy.

c) Physical, occupation and speech therapists may accept orders pertaining to their specific treatments.

d) Pharmacists clarifying medication orders may accept verbal changes to the original order.

e) Dietitians may accept diet and enteral orders.

f) Licensed or certified radiology staff may accept orders pertaining to their area of practice. (Approved as Amended ECMS 05/15/07)

g) Medical Technologists, Technicians, Medical Laboratory Assistants, Laboratory Customer Service Representatives and Outpatient Registration Staff may all accept verbal orders for laboratory studies. (Approved ECMS 08/21/07; BOT 12/12/07)

18.8.2.3 Documentation of Verbal Orders. The person accepting a verbal order must document the time, date and name of the ordering Medical Staff Member, and sign the entry with professional

designation. (Approved as Amended ECMS 2/2/1999; Ratified Med. Staff 9/14/1999; Approved BOT 11/18/1999)

18.8.2.4 Authentication of Verbal Orders. To provide prompt review of quality and accuracy, the ordering physician, or in his/her absence, the attending medical staff member or his/her designee, should review verbal and telephone order entries in the medical record in a timely fashion. Such orders should be signed, dated or corrected when necessary. All verbal orders should be reviewed, signed, dated or corrected within 48 hours. (Approved as Amended ECMS 2/2/99; Ratified Med. Staff 9/14/1999; Approved BOT 11/18/1999) Approved as Amended ECMS 2/19/2002; Ratified Med. Staff (Approved as Amended ECMS 05/15/07)

[↑Back to Top](#)

18.8.3 Standing or Standardized Orders

8.3.1 Use. To ensure uniformity of care for patients in particular situations, physician orders may be grouped and standardized. These Standardized Orders may be specific to procedures, diagnostic workups or therapies and are implemented unless expressly overridden by the physician.

8.3.2 Adoption; Review. Individual departments may adopt, for inclusion in their policies and procedures, standardized orders that pertain only to that department's practice. The Executive Committee must approve standardized orders that pertain to more than one department. All standardized orders should be reviewed for pertinence every two years. [↑Back to Top](#)

18.8.4 PRN Orders. A PRN order must include the reason for the order. (Approved as Addition ECMS 2/2/99; Ratified Med. Staff 9/14/1999; Approved BOT 11/18/1999) [↑Back to Top](#)

18.8.5 Automatic Stop Orders. All daily self-renewing orders are automatically discontinued after two (2) days, unless the ordering Medical Staff Member has renewed the order. This does not apply to medication orders described in 18.8.6. (Approved as Addition ECMS 2/2/99; Ratified Med. Staff 9/14/1999; Approved BOT 11/18/1999) [↑Back to Top](#)

18.8.6 Medication Orders. Medications should be designated by generic or common names when possible. Quantities should be designated according to the metric system. Route of administration, frequency, and if appropriate, duration of therapy, should be included with all medication orders. (Approved as Amended ECMS 1/18/2005; Ratified Med. Staff 6/13/2005)

18.8.6.1 Hospital Drug Formulary. All medication orders are filled according to a Hospital Drug Formulary which is established and which can be revised by ECMS on the recommendation of the Pharmacy and Therapeutics (P&T) Committee. All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopeia, the National Formulary American Hospital Formulary Service or the AMA Drug Evaluations.

18.8.6.2 Use of Nonformulary Drugs. Any use of a nonformulary drug must first be approved by the Chair of the P&T Committee, or, if unavailable, by the Chair (designee) of the ordering Medical Staff Member's department.

18.8.6.3 Investigational Drugs. No investigational drug, as defined by the hospital policy, "Investigational Drugs", may be used within the Hospital without prior approval in accordance with this section. To use an investigational drug, the ordering physician must obtain the approval of the Partners Human Research Committee, or the Dana-Farber Cancer Institute's Investigational Review Board, which includes pharmacy review, and the written informed consent of the patient or his/her legal representative in accordance with the conditions of the Partners Human Research Committees or the Dana-Farber Cancer Institute's Investigational Review Board as required.

In a documented emergency, an investigational drug may be used in accordance with the hospital policy, "Research: Emergency Use of an Investigational Drug or Biological Product, or Unapproved Medical Device". Also, use of an investigational drug requires the approval of the Chair of the Pharmacy and Therapeutics Committee at Newton-Wellesley Hospital or his/her designee after consultation of an appropriate specialist familiar with that specific drug. The episode should be reviewed at the next Pharmacy and Therapeutics Committee meeting and, at their discretion, the committee evaluation can be forwarded to the PHRC for review. (Approved 01/09/2019)

[↑Back to Top](#)

18.8.7 Restraint Orders.

18.8.7.1 Definition. A restraint is any method of physically restricting a person's freedom of movement or normal access to the body in order to prevent them from interfering with medical therapy, when interference poses greater risk than the use of restraint, or there is an imminent risk of the patient injuring themselves or others. Examples of restraints include posey vests, hand mitts, wrist and ankle restraints (soft or leather), geri chairs with tabletops and beds with all four side rails raised. Not included in the definition are devices used for forensic restraint, medical immobilization, or adaptive or protective supports used to allow normal bodily functioning. Examples include, but are not limited to: IV immobilization boards, safety straps on procedure/OR tables, side rails on stretchers during transportation and protective helmets. (Approved as Amended ECMS 8/10/2004. Ratified by Med. Staff 12/13/2004. Approved BOT 1/12/2005) [↑Back to Top](#)

18.8.7.2 When a restraint is to be used, state and federal law protect patients. Any use of restraints must be compliant with NWH policies on "Restraint for Medical Purposes" or "Restraint Use for Psychiatric Purposes" and requires a physician, NP or PA order. The NP, PA or physician order must specify the (1) type of restraint, (2) reason for the restraint, and (3) maximum duration of the order. (Approved as Amended ECMS 8/10/2004. Ratified by Med. Staff 12/13/2004. Approved BOT 1/12/2005)

18.8.8 Do Not Resuscitate Orders. DNR orders apply only to CPR. It is Hospital policy to presume in favor of CPR. (See "DNR Policy")

18.8.8.1 Informed Consent. The Attending Medical Staff Member or covering Medical Staff Member, should determine whether certain patients do not want CPR by discussing the risks and benefits of resuscitation with them at the time of admission; and write orders accordingly. House Officers and Professional Staff members with privileges to write orders, with the permission and concurrence of the Attending Medical Staff Member, or covering Medical Staff Member, may make this determination and write the corresponding order and progress note entry, documenting the concurrence of the Attending Medical Staff Member. The discussion leading to the DNR order must be documented in the progress notes within 24 hours of writing the DNR order. (Approved as Amended ECMS 05/15/07)

18.8.8.2 Daily Re-evaluation. The Attending Medical Staff Member must re-evaluate the DNR order daily.

18.8.8.3 Duration of Order. The DNR order remains in effect for the duration of the hospital admission unless:

- a) The patient has requested its cancellation;
- b) The physician discontinues the order after review by documenting the cancellation in the record.

18.8.8.4 Effect on DNR Order of Any Procedure Involving Anesthesia or Sedation and Analgesia.

- a) Discussion with Patient. Before the procedure, the physician performing the procedure and the anesthesiologist (if involved) will discuss with the patient the implications of continuing the order during the procedure and immediately post-op.
- b) Physician Right not to Treat. The physician performing the procedure and/or anesthesiologist may decline to participate in the case, if the patient refuses to lift the order.

18.8.8.5 Effect of Discharge. The DNR order automatically expires upon discharge unless the patient requests its continuation. If the order is to be continued at another facility, the physician will notify the receiving facility. [↑Back to Top](#)

18.8.9 Orders for Physical, Occupational & Speech Therapy.

18.8.9.1 Content, effect. Referrals to physical, occupational or speech therapists should state the problem for which therapy is requested. Therapists are authorized to order patient evaluations and appropriate treatment plans (which include the amount, type, frequency and duration of therapy services) in accordance with Hospital policies and state law. Therapists provide to referring Medical Staff members' summaries of the assessment, treatment goals and plan; progress reports; and notice of termination of services. (Approved. as Addition ECMS 5/11/99; Ratified Med. Staff 12/13/99; Approved BOT 1/3/2000) [↑Back to Top](#)

18.9. CONSULTATIONS

18.9.1 General. Consultation with other qualified Medical Staff Members is highly recommended when, in the opinion of the Attending Medical Staff Member, the diagnosis and/or definitive patient care plan is not apparent, or additional expertise would benefit the patient's care. The consultant should complete a consultation report for the Medical Record. Consultants for emergent inpatient consultations may be obtained from the ED On-Call roster. [↑Back to Top](#)

18.9.2 Mandatory Consultations. A consultation with an appropriate specialist is required for:

18.9.2.1 all patients whose suicide attempt resulted in the admission;

18.9.2.2 all hospitalized patients known to be pregnant, if the Attending Medical Staff Member does not have obstetrical privileges;

18.9.2.3 all patients determined by the Attending Medical Staff Member's department chair to require a consultation;

18.9.2.4 ICU patients, consistent with "Intensive Care Consultation: Indications and Procedure for Obtaining."

18.9.2.5 pediatric patients, consistent with "Pediatric Consult Policy." [↑Back to Top](#)

18.9.3 Consultation Order.

18.9.3.1 Authority to Order Consultation. (Amended 09/11/2013)

a) *Rule.* The patient's Attending Medical Staff Member must order the consultation.

b) *Exceptions.*

(i) House Officers or other physician-supervised designee (hereinafter referred to as "physician-supervised designee") may order "routine" consultations upon approval of the Attending Medical Staff Member.

(ii) In emergencies and for urgent consultations, the physician-supervised designee may initiate the consultation if the Attending Medical Staff Member is unable to be reached immediately.

(iii) ICU patients, consistent with "Intensive Care Consultation: Indications and Procedure for Obtaining." Amended 8/26/97.

18.9.3.2 Contents of Inpatient Consultation Request. Except in emergencies (see order) shall be documented in writing in the medical record or in CPOE. Email is not an acceptable means for communicating the request for a consult. The consultant must acknowledge the request as per section 18.9.4. The order shall state (Amended 9/11/2013):

- a) The reason(s) for the consultation;
 - b) The urgency of the consultation and when it must be performed;
 - c) Whether the consultant may write orders; and
 - d) If by a physician-supervised designee, that the approval of the attending has been obtained consistent with 18.9.3.1 b)i).
- (Amended 8/26/1997; 9/11/2013) [↑Back to Top](#)

18.9.4 *Communications between Attending Medical Staff Member and Consultant (Amended 09/11/2013)*

18.9.4.1 For urgent or emergency consultations, the Attending Medical Staff Member or physician-supervised designee must make direct verbal contact with the consultant to provide appropriate information regarding the patient, the reason(s) for consultation, and whether the consultant may write orders. As appropriate, the consultant may require speaking with the Attending Medical Staff member.

18.9.4.2 The consultant should directly contact the Attending Medical Staff Member and/or the physician-supervised designee to briefly discuss the patient's status, care plan, and recommendations.

18.9.4.3 The consultant may write orders only with express permission of the Attending Medical Staff Member or the physician-supervised designee consistent with 18.9.3.1 b) (ii). In emergent situations (sense of urgency), the consultant may write orders in real time and must notify the Attending Medical Staff member as soon as possible. (Amended 8/26/1997; 09/11/2013)

18.9.4.4 On-call consultants and their office practices shall maintain accurate contact information as required by Medical Staff Rules and Regulations section 18.2. Acknowledgement by the consultant is expected within 30 minutes if no direct conversation has occurred between the requestor and consultant. In the event of a delay, when an emergent consultation is needed, the primary team should contact either another available consultant, Service Chief or Department Chair.

18.9.4.5 If the on-call consultant is unavailable, (1) the Service Chief or Department Chair will be notified and will assist in arranging for substitute coverage and (2) the Chief/Chair will take disciplinary action, as appropriate.

18.9.4.6 Every effort should be made to perform the consultation within 24 hours of the request. Urgent consultation requests should be seen as soon as possible. While a consultant can provide input into the urgency and most appropriate timing of a consultation during direct verbal contact (per 18.9.4.1), it is the Attending Medical Staff member who ultimately determines the necessary timing of the consultation (per 18.9.3.2b). Disputes regarding the urgency or timing of a consultation can be resolved through escalation as per the Conduct of Care/Conflict Resolution policy.

18.9.4.7 Differing opinions or disagreements may arise between the Attending Medical Staff member and consultant, as well as between

various consultants regarding a patient's management. In such instances, all involved parties are expected to reach a consensus. If this cannot be accomplished in a timely manner, the Conduct of Care/Conflict Resolution policy should be invoked.

[↑Back to Top](#)

18.9.5 Consultants Not on Staff. A Medical Staff Member may obtain consultation from a recognized specialist not on the NWH Medical Staff, provided (a) it is first approved by the chair of the department related to the consultant's field of expertise and (b) the consultant is granted appropriate temporary privileges. The necessary temporary privileges forms are available through Medical Staff Services. [↑Back to Top](#)

18.9.6 Follow-up and Sign Off. (Amended 09/11/2013)

18.9.6.1 On subsequent hospital days, consultants are expected to follow up regularly regarding the clinical question(s) initially presented to them. When appropriate, consultants are responsible for ensuring their colleagues are available should questions arise. An exception occurs if the process of signing off has taken place immediately after the initial consultation (see 18.9.6.2). Clear and consistent two-way communication between the primary team and the consultant is expected throughout the duration of the consultant's involvement. This communication may occur verbally and through written communication in the medical record. Verbal communication is strongly encouraged when recommendations require expeditious acknowledgement and/or implementation.

18.9.6.2 Consultants may sign off when they are reasonably certain their services are no longer needed by the primary team. In all such instances, the intent to sign off should be written in the medical record and agreed upon by the primary team.

[↑Back to Top](#)

18.10. SURGICAL & INVASIVE PROCEDURES

18.10.1 Responsibilities Prior to Procedure; Informed Consent. The following actions must be taken prior to performing any invasive procedure at the Hospital:

18.10.1.1 Prior Written Informed Consent.

a) *Documentation: Timing.* Prior to the procedure, the Medical Staff Member performing the surgical or invasive procedure is responsible for the documentation in the medical record of the discussion with the patient (1) of the nature of the condition for which the procedure is to be performed and the alternatives, including not undergoing the procedure; and (2) of the nature and probability of specifically enumerated risks and benefits reasonably foreseeable from the procedure. An anesthesiologist must document the discussion leading to informed consent to anesthesia. Members must document informed consent on a Hospital consent form of alternative form approved by the Hospital appropriate to the circumstance.

b) *Exceptions.* Prior written informed consent is not required (1) in an emergency that precludes prior written informed

consent, provided the Member documents the basis for his/her belief regarding the emergency; and (2) for venipuncture, intravenous therapy, and insertion of nasogastric tubes and foley catheters.

18.10.1.2 History & Physical ("H&P").

a) *Timing.* Appropriate history & physical examinations must be documented in the medical record prior to surgery or invasive procedures otherwise the procedure is canceled.

b) *Exception.* Emergencies that preclude prior completion of H&P must be documented in the chart; the H&P must be placed in the medical record as soon as possible thereafter.

18.10.1.3 Pre-Op Tissue Specimens. The Medical Staff Member performing the procedure must have the NWH Department of Pathology review tissue or cytologic specimens when significant surgical and invasive procedures are based on pathologic specimens obtained and read at other institutions. A written copy of the outside and NWH Pathology Report(s) must be part of the medical record prior to the procedure.

[↑Back to Top](#)

18.10.2 Surgical Tissue and Foreign Bodies. Tissues and foreign bodies removed at operations must be sent to the Laboratories of Pathology for examination unless they are (a) on the Surgical Exceptions List mutually developed by the Surgery and Pathology chairs and maintained in the OR, and (b) described in the operative note. [↑Back to Top](#)

18.10.3 Surgical Assistance. Medical Staff Members performing invasive or operative procedures in the OR or Delivery Room must arrange surgical assistance when required in accordance with the list maintained in the OR Policy Manual. [↑Back to Top](#)

18.10.4 Infection Control. Standard precautions must be adhered to at all time, consistent with section 18.11.) [↑Back to Top](#)

18.10.5 Anesthesia. Procedures for the delivery of anesthesia are maintained by the Department of Anesthesia.

18.10.5.1 Sedation and Analgesia. Non-anesthesiologists may use sedation only pursuant to the NWH policy for "Guideline for Sedation and Analgesia by Non-Anesthesiologists." [↑Back to Top](#)

18.10.6 Non-Operating Room Surgical & Invasive Procedures. Medical Staff Members who perform invasive procedures outside the OR and Delivery Room, e.g., in the Intensive Care Unit and Gastroenterology Suite, etc., must comply with the procedure-specific policies of those Hospital areas. Unless expressly overridden by such policies, the Rules of this section apply to all areas of the Hospital. [↑Back to Top](#)

18.11. INFECTION CONTROL

18.11.1 Handwashing. All Medical Staff Members must wash their hands before and after they examine patients or perform procedures. [↑Back to Top](#)

18.11.2 Isolation and Precautions. Nursing personnel will advise the admitting Medical Staff Member of the need for isolation or other precautions based on the CDC's Isolation Precautions Standards, and will implement appropriate measures. [↑Back to Top](#)

18.11.3 Diagnosing Infections. Medical Staff Members who suspect their patients might have communicable infections are expected to order appropriate cultures, serologic tests, and other studies sufficient to diagnose or rule out infections and guide appropriate antibiotic treatment. [↑Back to Top](#)

18.11.4 Restricted Antibiotics. To ensure that antibiotics are used to the best advantage for individual patients and with the smallest impact upon the Hospital environment, the use of certain antibiotics is restricted. Medical Staff Members must contact a Member of the Infectious Diseases Service for prior approval to use a restricted antibiotic for a particular purpose. Approval should be noted on the order sheet when the drug is ordered. [↑Back to Top](#)

18.11.5 *Obligation to Report Communicable Diseases and Outbreaks*

18.11.5.1 Reportable Communicable Diseases. The Massachusetts Department of Public Health requires that certain communicable diseases be reported. The Infection Control Department will report communicable diseases occurring in Hospital patients and will assist Medical Staff Members in reporting patients seen in the Member's office, if requested to do so.

18.11.5.2 Reporting Outbreaks. Members of the Medical and Professional Staffs who have knowledge of the occurrence of any suspected or confirmed cluster or outbreak of any illness, must report said outbreak promptly by telephone, by facsimile, or by other electronic means to appropriate local Board of Health.
(Approved as Amended ECMS 08/02/2011)

[↑Back to Top](#)

18.11.6 Infection Control Policies. Medical Staff Members must adhere to the infection control policies in the Infection Control Manual that pertain to Medical Staff. [↑Back to Top](#)

18.11.7 Standard Precautions. It is Hospital policy to consider the blood of every patient as potentially infected with bloodborne and other pathogenic organisms. Medical Staff Members must utilize personal protective equipment as described below.

18.11.7.1 Gloves. Medical Staff Members must wear gloves when:

Drawing blood;
Performing obstetrical perineal care,
Handling bloody materials during and after:
Surgery

Trauma repair
Obstetric procedures
Radiology procedures
Pathological examinations and autopsies;
Handling newborn infants prior to the initial bath,
Having contact with blood or body fluids or materials
contaminated thereby;
Cleaning incontinent patients.

18.11.7.2 Face Shields. Medical Staff Members must wear face shields or masks and eye coverings in all situations in which blood contamination of the mouth, face or eyes might be anticipated.

18.11.7.3 Gowns. Medical Staff Members must wear impervious gowns or aprons in all situations in which contamination of the clothing by blood or body fluids might be anticipated. [\(Back to Top\)](#)

18.11.8 HIV-Infected Patient.

11.8.1 Testing. State law prohibits testing anyone for HIV infection without prior written informed consent.

11.8.2 Warning a Third Party at Risk of Exposure to HIV. State law prohibits releasing test results to third parties without prior written informed consent. (See 18.7.3.2) The Hospital will make required reports. (See 18.11.5) [↑Back to Top](#)

18.11.9 HIV-Infected Health Care Worker. Medical Staff Members who are infected with HIV or any other bloodborne pathogen must be familiar with and adhere to Hospital Policy (Policy for the Physician or Other Health Care Worker Infected with HIV or Hepatitis B). [↑Back to Top](#)

18.11.10 Authority to Act in Emergencies. In accordance with the standards of the JCAHO, the Infection Control Committee, through its Chair or Medical Staff Members, has authority to institute reasonable, appropriate measures or studies reasonably likely to reduce danger to any Hospital patient or personnel. [↑Back to Top](#)

18.12. HOUSE OFFICERS

18.12.1 House Officer Supervision. House Officers take an active part in the care of Newton-Wellesley Hospital patients assigned to the teaching service(s). Attending Medical Staff Members whose patients are admitted to the Teaching Service must be actively involved in the patient's care and the House Officer's supervision. The Attending Medical Staff Member is ultimately responsible for the patient's care. Attending Staff Members and House Officers must maintain communication regarding patient care. Transfer, major changes in therapeutics, consultation, and discharge require approval of the Attending Medical Staff Member. The department chair/service chief shall resolve disputes.

18.12.1.1 Operating Room. Attending surgeons are required to be present during all critical parts of the procedure.

18.12.1.2 Intensive Care Unit. Attending Intensivists direct the care of patients in the ICU. The attending intensivists round with the House Staff daily on all patients in the ICU. The in-hospital

intensivist is involved with the House Officer in the care of an ICU patient when a patient's condition deteriorates, when a patient does not respond to therapy as expected, and/or upon request of a patient and/or patient's family to speak with an intensivist.

18.12.1.3 Inpatient Units. Attending medical staff members are actively involved with the care of patients on the teaching service. The Attending Member approves major changes in therapeutics, transfer and discharge. House Officer entries into the medical records are reviewed daily by the Attending medical staff member. The attending enters his/her own daily progress note into the record after review of the House Officer's entry. [↑Back to Top](#)

18.12.2 Documentation. Supervision of the House Staff is documented in the medical record.

18.12.2.1 Co-signature. An attending medical staff member is required to review and co-sign the following entries made by a House Officer on the member's "team."

a) Brief Operative Note

b) Consultation Note (Approved ECMS 2/10/04; Ratified Med. Staff 6/2/04; Approved BOT 8/11/2004)

18.12.2.2 Signature. An attending Medical Staff member must review and sign the following dictated report(s) that he/she delegated to the House Officer to dictate for him/her.

a) Operative Report

b) Consultation Report

c) Discharge Summary.

18.12.2.3 Review and verification of verbal/telephone orders. The ordering resident should review and verify verbal and telephone orders as provided for in section 18.8. In the absence of the resident, the residency site director, teaching medical staff member, respective department chair/service chief may review and verify verbal/telephone orders issued by house officers by signing and dating such orders. (Approved ECMS 2/19/2002; Ratified Med. Staff 6/10/2002; Approved BOT 8/7/2002) [↑Back to Top](#)

18.13. RESEARCH

18.13.1 Medical Staff members conducting clinical research, whether in the Hospital or in their offices, must be familiar with current federal, state and other requirements covering protection of human research subjects.

[↑Back to Top](#)

18.13.2 Human research projects conducted at the Hospital require review and approval of the Partners Human Research Committee (PHRC) or the Dana Farber Cancer Institute's Investigational Review board as required.

[↑Back to Top](#)

(Approved to Adopt ECMS 1/18/2005; Ratified Med. Staff 6/13/2005; BOT
01/09/2019)

KEY SEARCH WORDS: bylaws, medical staff bylaws, medical staff, rules and
regulations, rules and regs