



Bristol Health

<p>Title:</p> <p>Bylaws of the Medical Staff</p>	<p>Approved by:</p> <p>Medical Staff 6/19/19 Board of Directors 7/3/19</p> <p>Amended: 10/7/10, 10/6/11, 8/12, 10/12, 3/13, 10/3/13, 8/6/14, 11/6/14, 1/7/15, 11/4/15, 11/15/16, 7/3/19</p>
<p>Applies to:</p> <p>Medical and Adjunct Staffs</p>	<p>Responsible party:</p> <p>Medical Staff</p>

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BYLAWS OF THE MEDICAL STAFF OF BRISTOL HOSPITAL

PREAMBLE

Recognizing that the Medical Staff shares the responsibility for the quality of medical care in Bristol Hospital and must accept and discharge this responsibility subject to the ultimate authority of Bristol Hospital Board of Directors, and that the best interests of the patient are protected by the cooperative efforts of the Medical Staff, the Hospital Board and Administration, the physicians practicing in Bristol Hospital hereby organize themselves in conformity with the Bylaws.

The Medical Staff Bylaws aim to create and foster the following:

an excellent Medical Staff, to whom other members will feel comfortable referring their patients;

a physician-friendly "culture" in which issues are dealt with as collegially as possible; and trust among the Medical Staff, Board and management team, with open communication and meaningful physician input into major decisions that affect all.

DEFINITIONS

The term "Adjunct Staff" means all professional personnel other than a licensed physician, oral surgeon, dentist or podiatrist who contribute to the medical care and teaching programs of the Hospital.

The term "Board of Directors" or "Board" means the Board of Directors of Bristol Hospital.

The term "Chief Executive Officer" or "CEO" means the President and CEO of Bristol Hospital.

The abbreviation "ECMS" means the Executive Committee of the Medical Staff.

The term "Hospital" means Bristol Hospital.

The term "Medical Staff" means all physicians holding unlimited licenses and duly licensed oral surgeons, dentists and podiatrists who have privileges to attend patients in the Hospital.

The term "President" means the President of the Medical Staff. The President will act as the primary liaison between the Medical Staff and the Governing Body.

The term "patient contacts" means any physician encounter with a patient in the inpatient or outpatient Hospital setting that is documented in the patient's medical record.

The term "practitioner" any health care provider licensed to treat or provide care for patients.

The term “Chief Medical Officer” or “CMO” means the Chief Medical Officer that may be employed by Bristol Hospital to serve as the primary liaison between the Medical Staff and Bristol Hospital administration, the CEO or designee will serve as the liaison between the Bristol Hospital Administration.

ARTICLE 1.0

NAME

The name of this organization shall be "Medical Staff of Bristol Hospital".

ARTICLE 2.00

PURPOSES AND RESPONSIBILITIES

2.10 PURPOSES

The purposes of the Medical Staff shall include:

- To serve as the formal organizational structure through which practitioners shall obtain the benefits and fulfill the obligations of membership on the Medical Staff.
- To monitor the quality of medical care in the Hospital and take action and make recommendations to the Board of Directors in order to effectuate that goal.
- To strive for an acceptable level of professional performance of all practitioners through the appropriate delineation of clinical privileges and/or clinical functions and the ongoing review and evaluation of the performance of practitioners.
- To assure that all members of the Medical Staff are subject to review in accordance with the Hospital's Quality Management Program.
- To provide a means through which individual members of the Medical Staff may participate in the policy-making, planning, staffing and development processes of the Hospital.
- To provide a mechanism to create a uniform standard of quality patient care, treatment and services.
- To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Executive Committee of the Board of Directors, the Executive Committee of the Medical Staff, and the CEO.
- To initiate and maintain these Bylaws and for the effective functioning and self-governing of the Medical Staff.
- To provide for education and to maintain educational standards for all Medical Staff and personnel engaged in patient care in order to maintain and enhance professional knowledge and skill in their delivery of patient care.

2.20 RESPONSIBILITIES

Membership on the Medical Staff implies a responsibility and obligation consistent with full cooperative participation in all required and necessary activities for the assessment

and improvement of the effectiveness and efficiency of medical care provided in the Hospital, including, but not limited to:

The evaluation and proctoring of the performance of members of the Medical Staff through objective, clinically sound criteria;

Participation in the processes of peer review, quality assessment, studies of morbidity and mortality, credentialing and practitioner performance improvement through service on Medical Staff committees so as to assure that patient care in the Hospital is monitored continuously; and

Participation in educational programs for the benefit of members of the Medical Staff and employees of the Hospital so as to enhance the level of professional operations in the Hospital.

Each Member of the Medical staff shall:

Provide his or her patients with care and respond to all requests for consults at the generally recognized professional level of quality and efficiency;

Abide by these Medical Staff Bylaws and all other lawful standards, policies, rules and regulations of the Hospital;

Discharge such Medical Staff, department, committee and Hospital functions for which he or she is responsible by Medical Staff category assignment, appointment, election or otherwise;

Prepare and complete in a timely fashion the medical and other required records for all patients he or she admits or in any way provides care to in the Hospital; and

Abide by the ethical principles of his or her profession.

ARTICLE 3.00

CATEGORIES OF THE MEDICAL STAFF

3.10 THE MEDICAL STAFF

The Medical Staff shall be divided into Emeritus, Active, Limited, Ambulatory, Restricted, Consulting, Consulting Telemedicine, and Adjunct Staff.

3.20 THE EMERITUS MEDICAL STAFF

Qualifications:

The Emeritus Medical Staff consists of practitioners who are not active in the Hospital and who are honored by emeritus positions.

These may include:

- a. Practitioners who have retired from active Hospital service, or
- b. Practitioners of outstanding reputation not necessarily resident in the community.

Emeritus Medical Staff must be recommended by the ECMS and approved by the Board.

Prerogatives and Responsibilities:

Members of the Emeritus Staff:

- a. Are not eligible to vote or hold office, shall not admit, treat or consult on patients in the Hospital
- b. May serve but shall not vote on committees of the Medical Staff and shall have no assigned duties.
- c. May attend Medical Staff, department and section meetings and functions when invited to do so;
- d. Are not required to pay fees or dues.
- e. Emeritus status does not require renewal.
- f. Does not have a right to a hearing as specified in these Bylaws.

3.30 THE ACTIVE MEDICAL STAFF

ACTIVE STAFF

Qualifications:

The Active Medical Staff shall consist of those practitioners of recognized ability and experience who maintain an active practice within the community served by Bristol Hospital.

These practitioners must: be involved in at least 24 patient contacts at the Hospital during the two-year appointment term; or have expressed a willingness to contribute to Medical Staff functions and/or demonstrated a commitment to the Medical Staff and Hospital through service on Medical Staff or Hospital committees and/or active participation in performance improvement or professional practice evaluation functions.

Guidelines:

An Active Staff member shall demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his/her practice patterns will satisfy the activity requirements of this category:

- a. Any member who has fewer than 24 patient contacts per two-year appointment term or who is not sufficiently active in Medical Staff or Hospital functions shall not be eligible to request Active Staff status at the time of his/her reappointment.
- b. The member must select and be transferred to another Medical Staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options include Limited or Ambulatory).

Prerogatives and Responsibilities:

Active Staff members may:

- a. Admit patients without limitation, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Board, and exercise such clinical privileges as are granted to them.
- b. Vote in general and special meetings of the Medical Staff and applicable department, section/division, and committee meetings;
- c. Hold office, serve on Medical Staff committees, and serve as Department Chief, section chief, or committee chair.

Active Staff members shall assume all the responsibilities of the Active Staff, to include:

- a. Serve on committees, as requested;
- b. Provide on-call coverage for the Emergency Department in accordance with applicable Departmental rules and regulations and consistent with Hospital requirements to meet patient needs;
- c. Participate in the evaluation of new members of the Medical Staff;
- d. Participate in the professional practice evaluation and performance improvement processes, including participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties,
- e. Accept inpatient consultations, when requested; and
- f. Pay application fees, dues, and assessments.

3.40 THE LIMITED MEDICAL STAFF

Qualifications:

The Limited Medical Staff shall consist of those practitioners of recognized ability and experience who maintain a limited Hospital practice. These practitioners will:

- a. Maintain a current active medical staff appointment at another hospital accredited by the Joint Commission or other agency recognized by CMS and shall provide evidence of such appointment.
- b. Be involved in less than 24 patient contacts at the Hospital during the two-year appointment term, or provide clinical coverage/on call coverage.
- c. Agree to accept limited duties and responsibilities of patient care and Medical Staff functions.
- d. At reappointment time, provide quality data and other information as requested to contribute to an appropriate assessment of clinical competence for reappointment and clinical privileges.

Guidelines:

A Limited Staff member shall demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his/her practice patterns will satisfy the activity requirements of the category.

- a. Any member who has less than one patient contacts per two year appointment term or who does not provide defined clinical coverage/on call coverage shall not be eligible to request Limited status at this of his/her reappointment.
- b. A member who has zero patient contacts per two year appointment term must move to another staff category (Ambulatory). In the discretion of the Department Chair/Section Chief and President of the Medical Staff, when coverage is necessary, and with the approval of the Credentials Committee, a staff member with zero patient contacts may remain in the Limited category.

Prerogatives and Responsibilities:

Limited Staff members:

- a. May admit, attend and treat patients and exercise such clinical privileges as have been granted to them.
- b. Shall cooperate in performance improvement activities and professional practice evaluation processes.
- c. May attend meetings of the Medical Staff (without vote).
- d. May attend relevant department and section meetings (without vote).
- e. May be invited to serve on committees (without vote)
- f. May not hold office
- g. Shall pay applicable fees and dues.

3.50 THE CONSULTING MEDICAL STAFF

Qualifications:

The Consulting Staff shall consist of those practitioners of recognized ability and experience

who have an area of special expertise and are appointed for the specific purpose of providing consultation in the diagnosis and treatment of patients

and/or of the administration of clinical departments.

These practitioners must be a member in good standing on the active staff at another hospital.

Guidelines:

Appointment to the Consulting Staff is by invitation only and

practitioners must be invited to apply by the Medical Staff leadership and/or Hospital.

Prerogatives and Responsibilities:

Continuing Staff Members:

- a. Does not vote, hold staff office or serve on Medical Staff Committees ,
- b. Are encouraged to attend meetings of the Medical Staff without vote and may attend educational conferences.
- c. . Cannot admit patients or perform surgical or invasive procedures.
- d. May visit patients in the hospital, review their medical records and make recommendation to attending physician.
- e. Do not pay dues.
- f. Shall pay applicable fees.

3.60 THE CONSULTING TELEMEDICINE MEDICAL STAFF

Qualifications:

The Consulting Telemedicine Medical Staff shall consist of practitioners of recognized professional ability and experience who have a current active medical staff appointment at an accredited hospital and shall provide evidence of such appointment are limited to physicians licensed to practice medicine in the State of Connecticut who provide telemedicine services to Hospital patients from a distant site.

Prerogatives and Responsibilities

Consulting Telemedicine Medical Staff:

- a. DO not vote, hold staff office or serve on committees of the Medical Staff.
- b. Are encouraged to attend meetings of the Medical Staff (without vote) and may attend educational conferences.

- c. Cannot admit patients for treatment.
- d. Shall pay applicable fees.

3.70 THE AMBULATORY MEDICAL STAFF

Qualifications:

The Ambulatory Medical Staff shall consist of those practitioners of recognized ability and experience who maintain an active practice within the community served by Bristol Hospital. These practitioners are Primary Care Physicians, Psychiatrists, and/or other specialists who never admit or take care of inpatients. These practitioners:

- a. Wish to be associated with the Hospital
- b. Will assume all the responsibilities of memberships outlined below.

Guidelines:

- a. The Ambulatory Medical staff is a membership only category. These practitioners will not hold admitting or clinical privileges.
- b. The primary purpose of the Ambulatory staff category is to provide these practitioners access to Hospital services for their patients and to promote professional and educational opportunities.

Prerogatives and Responsibilities:

Ambulatory Staff:

- a. May visit their patients in the Hospital and review their medical records.
- b. May not make entries in the medical record or enter orders.
- c. Will actively participate in the Medical Staff and departmental functions (without vote)
- d. Agree to accept Medical Staff assignments
- e. Shall attend Departmental and Medical Staff meetings and educational conferences at the Hospital.
- f. May hold office and serve on committees, with vote, except as otherwise provided in these Bylaws.
- g. Shall pay applicable fees and dues.

3.80 ADJUNCT STAFF

Qualifications:

An Adjunct Staff member is an individual other than a licensed physician, dentist, oral surgeon or podiatrist who exercises independent judgment within the areas of his/her professional competence under the supervision of/collaboration with a practitioner who has been accorded privileges to provide such care in the Hospital, (i.e., nurse anesthetists, nurse practitioners, certified nurse midwives, physician assistants and registered nurse first assist).

Guidelines:

- a. Adjunct Staff members may function in the Hospital as permitted by their license and scope of practice or clinical privileges.
- b. Adjunct Staff shall maintain a collaborative agreement/delegation agreement as required by law and these Medical Staff Bylaws.
- c. Written guidelines for the performance of specified services by Adjunct Staff members will be developed by the ECMS with input, where applicable, from the physician director of the clinical service involved. For each category of the Adjunct Staff members, such guidelines must include, without limitation: specification of the classes of patients that may be seen (e.g. only those of the employer-physician, only those referred by or from a particular clinical service, or any referred by a physician or other authorized practitioner); a description of the services to be provided and procedures to be performed, including the equipment or special procedures or protocols that specific tasks may involve, and responsibility for charting services provided in the patient's medical record; definition of the degree of assistance that may be provided to a practitioner; and supervision required for each service.
- d. An application for specified clinical services to be provided by an Adjunct Staff member is submitted and processed in the same manner as provided for clinical privileges in the relevant section of the Medical Staff Bylaws.
- e. An Adjunct Staff member is individually assigned to the department appropriate to his/her professional training. The Adjunct Staff will be subject to the reappointment process, similar to that of the Active Medical Staff.

Prerogatives and Responsibilities:

Adjunct Staff:

- a. May serve and vote on committees of the Medical Staff.
- b. Shall not be eligible to hold office.
- c. Shall not admit patients to the Hospital without Active Medical Staff physician-specific authorization unless specifically delineated privileges have been granted by the Hospital and as permitted by state law.
- d. Holding a license, certificate or such other credential as may be required by applicable state law, are eligible to provide specified services in the Hospital.
- e. Provide specifically designated patient care services under the supervision or direction of a member of the Medical Staff and consistent with the limitations stated in these Bylaws;
- f. Enter orders only to the extent specified in the Medical Staff, or the position description, but not beyond the scope of the Adjunct Staff member's license, certificate or legal credential;

- g. Serve on Medical Staff, departmental and Hospital committees where his/her special training and knowledge are desirable,.
- h. Attend Medical Staff, Hospital and departmental education programs and clinical meetings related to his/her discipline (without vote).
- i. Shall meet the basic responsibilities required by the Bylaws, and retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision.
- j. Shall participate as appropriate in the Quality Management Program activities, in supervising new appointees in his/her discipline during the provisional period, and in discharging such other Medical Staff functions as may be required from time to time.
- k. Shall attend clinical meetings of the Medical Staff and department of which he/she is a member, when related to his/her discipline, and meetings of the committees of which he/she is a member.
- l. The various provisions of these Bylaws, and the Rules and Regulations shall apply to the Adjunct Staff member only where specifically stated. Provisions in these Bylaws relating to hearings, appeals, and appellate review shall apply to Adjunct Staff members.
- m. Must pay applicable fees and dues.

3.90 THE RESTRICTED MEDICAL STAFF

Qualifications:

The Restricted Medical Staff shall consist of those practitioners of recognized ability and experience who

- a. only provide clinical coverage and/or on-call coverage pursuant to a contract with the Hospital; or
- b. Only provide clinical coverage and/or on-call coverage for other members of the practitioner's medical practice group who are on the Active Staff of the Hospital.

Guidelines:

These practitioners must be a member in good standing on the Active Staff at another hospital.

A Restricted Staff member shall demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his/her practice patterns will satisfy the requirements of the category.

- a. Clinical coverage to meet patient care needs as defined above.

- b. On-call coverage to meet patient care needs as defined above.
- c. The Medical Staff may require a change in category (Limited) if the practice patterns extend beyond clinical coverage/on call coverage.

Prerogatives and Responsibilities:

Restricted Staff members:

- a. May admit patients without limitation except as otherwise provided in the Bylaws or Bylaws- related documents or as limited by the Board.
- b. May exercise such clinical privileges as are granted to them .
- c. May participate in continuing medical education activities of the Hospital and the Medical Staff.
- d. Shall cooperate in performance improvement activities and professional practice evaluation processes.
- e. May attend meetings of the Medical Staff and departmental education programs and clinical meetings related to his/her discipline (without vote).
- f. May not serve on Medical Staff committees.
- g. May not vote or hold office.
- h. Shall pay applicable fees.
- i. Shall not pay dues.

ARTICLE 4.00

OFFICERS

4.10 OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be the President, Vice President, Staff Representative and Secretary/Treasurer.

4.20 QUALIFICATIONS OF OFFICERS

Only those members of the Active Medical Staff who satisfy the following qualifications and maintain such qualifications during their term of office shall be eligible to serve as an officer of the Medical Staff. All Medical Staff Officers shall:

- be appointed to the Active Medical Staff of the Hospital and shall remain in good standing during their term of office;

- have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;

- be certified by an appropriate specialty board or, if appointed prior to 9/9/97, have affirmatively established, through the privilege delineation process, that he/she possesses comparable competence;

- have demonstrated interest in maintaining quality medical care at the Hospital;

- have constructively participated in Medical Staff affairs, including quality improvement and peer review activities;

- be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected;

- be knowledgeable concerning the duties of the office; and

- possess and demonstrate an ability for harmonious interpersonal relationships.

4.30 NOMINATION OF OFFICERS OF THE MEDICAL STAFF

A nominating committee shall consist of three (3) individuals appointed by the ECMS. This committee shall offer one or more nominees for each Medical Staff office position. Nominations must be announced, and the names of the nominees shall be distributed to all members of the Active Medical Staff and Ambulatory Medical Staff at least 30 days prior to the annual meeting of the Medical Staff.

Nominations may also be made by petition signed by at least 20% of the appointees of the Active Medical Staff and Ambulatory Medical Staff. Such petition must be submitted to the President at least 14 days prior to the annual Medical Staff meeting.

4.40 ELECTION OF OFFICERS

Election of officers will take place at the annual meeting of the Medical Staff. Only members of the Active Medical Staff and Ambulatory Medical Staff categories shall be eligible to vote. All officers will be approved by the Board of Directors. If the Board does not approve an officer, the matter will be referred back to the Nominating Committee for a new nominee.

4.50 TERM OF OFFICE

All officers shall serve a term of two years or until a successor is elected in each office. No officer may serve more than two successive two-year terms in the same office. Officers shall take office on the first day of the calendar year following their election

4.60 VACANCIES IN OFFICE

President. If there is a vacancy in the office of the President, the Vice President shall serve the remainder of the term.

Other Officers. If there is a vacancy in the office of Vice President, Staff Representative, or Secretary/Treasurer, it shall be filled as described below.

Inability to Complete Term. In the event that the Vice President, Staff Representative or Secretary/Treasurer, is unable to complete the term of appointment, the President shall recommend to the ECMS an individual to complete the unexpired term. Immediately after the ECMS meeting in which the recommendation is made, the President shall communicate this recommendation to the members of the Medical Staff. This recommendation is subject to ratification by a majority vote of the members of the ECMS at its next regularly scheduled meeting following the meeting in which the recommendation was made, and shall be approved by the Board of Directors.

Notification of Vacancies. The Medical Staff will be apprised of all vacancies in office.

4.70 REMOVAL OF OFFICER

I'm gonna

Basis for Removal. In its sole discretion, the ECMS, by a two-thirds vote, may remove any Medical Staff officer for conduct detrimental to the interests of the Hospital or its Medical Staff, or if the officer is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of the office, or if the officer fails to fulfill the duties and responsibilities of the position to which he/she is elected or appointed, provided that notice of the ECMS meeting at which such action shall be decided is given in writing to such officer at least ten days prior to the date of the meeting. The officer shall be afforded the opportunity to speak prior to the taking of any vote on such removal. The removal shall be effective when approved by the Board.

4.80 DUTIES OF OFFICERS

President. The President shall fulfill those duties listed below:

Acts in coordination and cooperation with the Chief Executive Officer in matters of mutual concern involving the Medical Staff, Hospital, nursing and other patient care services.

Attends meeting of the Board of Directors with a vote and is accountable to the Board, through the Executive Committee of the Medical Staff, for monitoring the quality and efficiency of clinical services and the effectiveness of quality improvement functions delegated to the Medical Staff.

Acts in cooperation with the department and committee chairpersons to review, update and ensure the effective function of methods of credentials review and for delineation of privileges and continuing medical education.

Communicates and represents the opinions, policies, concerns, needs and grievances of the Medical Staff to the Board of Directors, CEO of the Hospital, and applicable department and section chairpersons.

Responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where a practitioner performance improvement plan has been recommended against a Medical Staff member.

Informs the CEO of all infractions of Medical Staff Bylaws, and practitioner performance improvement plans recommended.

Calls, presides at, and is responsible for the agenda of all general meetings of the Medical Staff.

Serves as Chairperson of the Executive Committee of the Medical Staff, and as an ex-officio member on all other Medical Staff committees with a vote.

Appoints the Medical Staff representatives to all standing, special and multidisciplinary Medical Staff committees, except as otherwise expressly provided by these Bylaws and/or by the Hospital bylaws, policies and procedures.

Appoints members to chair Medical Staff committees, unless otherwise designated in the Medical Staff Committee structure.

Evaluates in an ongoing fashion the functioning of individual Medical Staff committees as well as the committee structure.

Acts on behalf of the ECMS between meetings of the ECMS.

Consults with the Vice President on matters of special concern to Medical Staff members and maintains medical liaison with the Vice President to assist in settling grievances and problems of the Medical Staff.

Acts as spokesperson for the Medical Staff in its external professional and public relations.

Has the authority, in the event a Medical Staff member is unable to provide necessary treatment to his Hospital patient(s), or in the event the attending Medical Staff member fails for any reason to provide or arrange for necessary treatment with respect to a Hospital patient, to arrange (either directly or through a designee) for alternate medical coverage for such patient(s). In making such arrangements, due regard shall be given to the wishes of such patients.

Vice President. In the absence of the President, the Vice President shall assume all the duties and have the authority of the President. He/she shall perform such further duties to assist the President as the President may from time to time request. The Vice President will serve as the chairperson of the Credentials Committee and will be a member of such other Medical Staff committees as appointed to by the President. The Vice President shall be a voting member of the ECMS. The Vice President will serve on the Board of Directors with a vote.

Staff Representative. The Staff Representative shall function as a voting member of the ECMS, and will serve as a member of such committees as the President appoints him/her to, and shall act as the primary voice of issues of the Medical Staff to the ECMS and the Board of Directors with a vote. At the discretion of the President, the Staff Representative may serve as the chairperson of the Hospital's Physician Relations Committee and the Bylaws Committee.

Secretary/Treasurer. The Secretary/Treasurer shall function as a voting member of the ECMS and will be accountable for all Medical Staff funds, the administration of all Medical Staff expenditures, the collection of dues, and for making periodic reports of the status of the same to the Medical Staff. The Secretary/Treasurer will oversee the Continuing Medical Education Program for the Medical Staff. The Secretary/Treasurer shall be responsible for assuring that accurate and complete minutes of ECMS and quarterly Medical Staff Meetings are compiled and maintained.

4.90 PROCEDURE FOR ELECTION OF OFFICERS OF THE MEDICAL STAFF.

Eligible Votes. Those eligible to vote include all Active and Ambulatory Medical Staff members.

Form of Voting. The voting will be by ballot.

Absentee Ballots. Absentee balloting will be allowed if the Medical Staff member cannot attend the Medical Staff meeting because of physical illness, vacation or because of emergency patient care. Absentee ballots must be requested on an individual basis.

Medical Staff Meeting. At the meeting, prior to voting, the names of the candidates on the ballot and a description of how to mark the ballot will be reviewed.

Single Candidate. If there is a single candidate for any office, the Staff Representative shall cast one vote for that candidate, affirming his/her election by acclamation.

Multiple Candidates.

If there is more than one candidate for any office, ballots will be distributed to all members of the Active and Ambulatory Medical Staff eligible to vote who are present at the Medical Staff Meeting.

At the conclusion of voting, all ballots will be collected and counted, including absentee ballots.

The candidate receiving a majority of the ballots cast in his/her favor for the office is elected to that office.

If no candidate for an office receives a majority of the ballots cast in his/her favor for that office, a ballot containing only the top two candidates who received the highest number of ballots cast in their favor for the office shall be distributed to all members of the Active and Ambulatory Medical Staff eligible to vote who are present at the Medical Staff meeting. At the conclusion of voting, all ballots will be collected and counted. The candidate receiving a majority of the ballots cast in his/her favor is elected to the office.

Voting Report. Prior to the conclusion of the Medical Staff meeting a voting report will be submitted consisting of a table listing all candidates with the number of ballots that were cast in favor of each candidate.

The Active and Ambulatory Medical Staff members who are present at the time the voting occurs will decide all questions arising which are incidental to the voting or the counting of the ballots.

After completion of the election, the Secretary/Treasurer will be responsible for preserving the ballots until the next quarterly Medical Staff Meeting. At that next meeting, if there are no objections, he/she will dispose of the ballots.

ARTICLE 5.00

DEPARTMENTS AND SECTIONS AND SUBSECTIONS

5.10 DEPARTMENTS AND SECTIONS

The Medical Staff shall be organized into separate departments and sections. Each department is accountable to the ECMS and ultimately to the Board of Directors. The departments and sections of the Medical Staff shall be as follows:

Department of Medicine

- Section of Inpatient Medicine
- Section of Pulmonology and Critical Care
- Section of Gastroenterology
- Section of Cardiology
- Section of Hematology/Oncology

Department of Pediatrics

Department of Psychiatry

Department of Surgery

- Section of General Surgery
- Section of Orthopedic Surgery

Department of Anesthesia

Department of Obstetrics and Gynecology

Department of Pathology and Clinical Services

Department of Emergency Medicine

Department of Diagnostic Imaging

- Section of Radiology (including Teleradiology)
- Section of Radiation Oncology

Departments may be comprised of sections. A section may be formed as described in Section

5.20 QUALIFICATIONS, SELECTION, AND TENURE OF DEPARTMENT CHAIRPERSONS AND SECTION CHIEFS

Chairpersons. Each department shall have a chairperson and each section shall have a Chief. He/she shall be responsible for the supervision of the clinical work within the department or section.

Appointment of Chairpersons. The Active and Ambulatory Medical Staff members of each clinical department and section shall elect, in a meeting prior to the annual Medical Staff meeting, an eligible member of their respective department or section to serve as the chairperson or chief of that department or section. The names of the individuals elected as chairpersons or chiefs will be transmitted to the ECMS. The ECMS shall then express in writing their approval or disapproval of these individuals and submit their names to the Board of Directors of the Hospital for approval. In the event of a tie vote in the department or section, the names of all individuals receiving the same number of votes shall be submitted to the ECMS and Board of Directors of the Hospital for approval.

Qualifications of Department Chairpersons and Section Chiefs. Only those members of Active and Ambulatory Medical Staff of the appropriate department/section who satisfy the following qualifications and maintain such qualifications during their term of office shall be eligible to serve as a Department Chairperson or Section Chief of the Medical Staff. All shall:

be appointed to the Active or Ambulatory Medical Staff of the Hospital in their respective department or section and shall remain in good standing during their term of office;

have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;

be certified by an appropriate specialty board or, if appointed prior to 9/9/97, have affirmatively established, through the privilege delineation process, that he/she possesses comparable competence;

have demonstrated interest in maintaining quality medical care at the Hospital;

have constructively participated in Medical Staff affairs, including quality improvement and peer review activities;

be willing to discharge faithfully the duties and responsibilities of the position to which the individual is elected;

be knowledgeable concerning the duties of the office; and

possess and demonstrate an ability for harmonious interpersonal relationships.

Term. Each Department Chairperson or Section Chief shall serve for a two year term subject to approval of the Board of Directors.

Removal of Department Chairperson or Section Chief. Removal of a Chairperson or Chief during his/her term of office may be initiated by a 40% vote of all Active and Ambulatory Medical Staff members of the department or section but no such removal shall be effective unless and until it has been ratified by the ECMS and by the Board of Directors; or the ECMS, by a two-thirds vote, may remove any Department Chairperson or Section Chief for conduct detrimental to the interests of the Hospital or its Medical Staff, or if he/she is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of the office, or if the he/she fails to fulfill the duties and

responsibilities of the position to which he/she is elected or appointed, provided that notice of the ECMS meeting at which such action shall be decided is given in writing to such officer at least ten days prior to the date of the meeting. The individual shall be afforded the opportunity to speak prior to the taking of any vote on such removal. The removal shall be effective when approved by the Board.

Contracted Chairpersons or Chiefs. The Board of Directors may choose to contract with a full-time Department Chairperson/Section Chief. That contracted practitioner physician must meet the requirements as outlined above. This process must be undertaken with the full involvement and knowledge of the members of the department/section. If the contracted practitioner is not already a member of the Medical Staff, prior to assuming his/her duties he/she must apply for and be granted Active Medical Staff status.

5.30 VACANCY IN OFFICE

Temporary Absence. In the event of the Chairperson's or Chief's temporary absence, the Chairperson or Chief may appoint a member of the Medical Staff in his/her department or section to act on his/her behalf.

Inability to Complete Term. In the event that the Chairperson or Chief is unable to complete the term of appointment the members of that department/section shall meet to recommend to the President an individual to complete the unexpired term. The President shall forward that recommendation to the ECMS. The ECMS and Board must approve the recommended replacement.

5.40 FUNCTIONS OF CLINICAL DEPARTMENT CHAIRPERSONS AND SECTION CHIEFS

Each Chairperson or Chief shall be accountable to the Board of Directors through the ECMS, the President, and the CEO for all professional, clinical and Medical Staff activities within their department or section. Each Chairperson or Chief shall be responsible for: (1-26)

All clinically related activities of the department or section.

All administratively related activities of the department or section.

Recommending to the ECMS and Board the criteria for the granting and maintenance of clinical privileges that are relevant to the care provided in the department or section.

Developing and updating objective criteria that reflect current knowledge and clinical experiences concerning the performance of certain procedures and practice patterns.

Continuing monitoring and surveillance of the professional performance of all individuals in the department or section who have delineated clinical privileges.

Recommending Medical Staff assignment and clinical privileges for each member of the department or section.

Monitoring and evaluating all major clinical activities of the department or section. Monitoring and evaluation shall include, where appropriate, the following: (i) the routine collection of information about important aspects of patient care; and (ii) the ongoing surveillance of the clinical performance of the members of the department or section, which information may be collected through activities of the department, both physician and non-physician, through the overall quality improvement program or through other Medical Staff monitoring functions.

Preparing a quality of care audit when monitoring and evaluation of clinical activities indicate that a problem may exist and that more details are required. Each department or section shall have a mechanism to conduct an audit.

Documenting and reporting the departments or section's findings and conclusions from monitoring and evaluation on a monthly basis.

Identifying opportunities to improve the efficiency and quality of patient care.

Assessing and recommending to the ECMS and Board off-site sources for needed patient care services not provided by the department or the section.

Integrating the department or section into the primary functions of the Medical Staff organization and Hospital.

Coordinating and integrating interdepartmental and intradepartmental services.

Developing, implementing, updating and enforcing Medical Staff Bylaws and of department or section policies and procedures that guide and support the provision of service in the department or section.

Recommending to the ECMS and Board a sufficient number of qualified and competent practitioners to provide care or service in the department or section.

Determining the qualifications and competencies of department or service personnel who are not licensed independent practitioners and who provide patient care services.

Continually assessing and improving the quality of care and services provided in the department or section.

Maintaining quality control and performance improvement programs in the department or section.

Orienting and continuing education of all persons in the department or section.

Recommending space and other resources needed by the department or section.

Reporting on the functions of the department or section to the ECMS on a monthly basis.

Serving as a member of the ECMS, if provided for in Section 6.2a, providing guidance on the overall medical policies of the Hospital and making specific

recommendation regarding the department or section in order to assure quality medical care.

Establishing an emergency department call roster of members of the department or section.

Acting as attending physician or securing a qualified attending member of the Medical Staff for hospitalized patients who are without an attending physician, or when the attending practitioner has been suspended from the Medical Staff.

Providing leadership in activities related to patient safety and the education of patients and families.

Providing oversight in the process of analyzing and improving patient satisfaction.

5.50 FUNCTIONS OF CLINICAL DEPARTMENTS AND SECTIONS

Privilege Criteria. Each clinical department and section shall establish its own criteria consistent with the policies of the Medical Staff and of the Board of Directors for the granting of clinical privileges and for the holding of office in the department or section. Department or section criteria shall be consistent with the Bylaws and Rules and Regulations of the Medical Staff or relevant policies of the Medical Staff. In the event of any inconsistency, the provisions of the Bylaws or the Rules and Regulations of the Medical Staff or relevant policies of the Medical Staff shall be deemed to supersede the inconsistent provisions of department or section criteria.

Department and section criteria rules and regulations shall become effective only after they have been reviewed by the ECMS and approved by the Board of Directors.

Monitoring Care in the Department/Section. The clinical departments and sections will provide effective mechanisms to monitor and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges in the department or section consistent with the Hospital Quality Management Program. Such mechanisms shall include a systematic, coordinated and continuous program for measuring, assessing and improving the quality of care and service through the use of approved indicators.

Reports to ECMS. A report shall be submitted to the ECMS detailing department or section analysis of patient care rendered by members of the department or section.

5.60 ASSIGNMENT TO DEPARTMENTS AND SECTIONS

The ECMS shall, after review of the recommendations of the clinical departments and sections recommend initial assignments for all Medical Staff members with clinical privileges. The Board of Directors shall have final approval of the Medical Staff member's assignment to a specific department and/or section.

5.70 DEPARTMENT CHAIRPERSONS AS MEMBERS OF ECMS

Each department chairperson shall be a member of the ECMS with a vote, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding his/her own department in order to assure quality patient care.

5.80 ESTABLISHMENT OF NEW SECTIONS

Establishment. The ECMS shall, from time to time, based on recommendations of departments, establish sections into which the Medical Staff shall be subdivided. No section shall consist of less than three (3) members, and any section whose membership decreases below three (3) shall be dissolved, and its members assigned to the applicable department or another section.

Composition. Sections shall be composed of Medical Staff members who share a commonality of interest based on the practice of a recognized specialty or subspecialty. All members of the Active Medical Staff, and other Medical Staff members granted privileges pursuant to these Bylaws, shall be assigned by the ECMS to a section as recommended by the Medical Staff member's department, upon appointment to the Medical Staff, and thereafter may be reassigned consistent with any organizational changes in the Medical Staff or any change in the Medical Staff member's specialty or area of practice. Medical Staff members may request assignment to a section, or to more than one section, subject to the approval of the Medical Staff member's department, the ECMS and the Board. Medical Staff member's assigned to more than one section shall vote in only one section, that being the one to which the Medical Staff member is assigned by the ECMS as the Medical Staff member's primary section.

5.90 CHIEF MEDICAL OFFICER

The Hospital may employ a CMO. The CMO shall be a physician who is on the Active Medical Staff. The CMO shall serve as the primary liaison between the Medical Staff and Hospital administration. It will be in the discretion of Hospital administration and the Board of Directors to determine the duties and responsibilities of the CMO. The Hospital shall not bestow upon the CMO any authority or responsibility which is properly vested in the Medical Staff, the ECMS, another Medical Staff committee, a department or section, an officer of a Medical Staff committee, department or section, or a member of the Medical Staff, pursuant to these Bylaws, the Medical Staff Rules and Regulations, a Medical Staff manual, Medical Staff Policies, or applicable law. However, the Hospital may charge the CMO with assisting those individuals and bodies in exercising their authority and responsibilities when the Hospital requests him/her to do so.

ARTICLE 6.00

COMMITTEES

6.1 COMMITTEES GENERALLY

Designation And Substitution. There shall be an Executive Committee of the Medical Staff (ECMS), and such other standing and special committees of the Medical Staff responsible to the Executive Committee of the Medical Staff as may from time to time be necessary and desirable to perform the Medical Staff functions listed in these Bylaws. The committees shall report findings and recommendations to the ECMS and clinical departments, as appropriate.

Those functions requiring participation of, rather than direct oversight by, the Medical Staff may be discharged by Medical Staff representation on such Hospital committees as are established to perform such functions.

Whenever these Bylaws require that a function be performed by, or that a report or recommendation be submitted to the ECMS or a department, but a standing or special committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

The ECMS may, at any time it deems it necessary and desirable for the proper discharge of the functions required of the Medical Staff by these Bylaws and the bylaws and policies of the Hospital, by resolution and upon approval of the Board of Directors establish, eliminate or merge standing or special committees, change the function of a Medical Staff committee, or assign the function to the Medical Staff as whole.

Appointment of Chairperson. All committee chairpersons, unless otherwise provided for in these Bylaws, will be appointed biennially by the majority vote of the Executive Committee of the Medical Staff.

Appointment/Removal of Members.

Appointment. Except as otherwise provided for in these Bylaws, members of each standing and special committee shall be appointed by the President and the Executive Committee of the Medical Staff, biennially at the beginning of the Medical Staff year. There shall be no limit on the number of terms a committee member may serve.

Removal of Members. Except as otherwise provided for in these Bylaws, all appointed members may be removed and vacancies filled or additional members appointed at the discretion of the President and the Executive Committee of the Medical Staff by majority vote. Permissible bases for removal may include, but are not limited to; poor attendance; failure to perform the duties of the position held in a

timely and appropriate manner; and failure to continuously satisfy the qualifications for the position.

Qualification for Committee Membership. Active and Ambulatory Medical Staff members are eligible for membership on Medical Staff committees and are required, when requested, to participate in committee work.

Committee membership may include, where appropriate, Adjunct Staff as well as representation from administration, nursing, medical records and such other Hospital departments as are appropriate to the function(s). The committee chair, at the committees' initial meeting of the Medical Staff year, shall determine the voting status of non-Medical Staff members of the Committee.

Ex-Officio Members. The President shall be an ex-officio member of all Medical Staff committees with a vote. The CEO and his/her respective designee shall be members ex officio, without vote, on all Medical Staff committees. An ex-officio member of the committee ceases to be such if he/she ceases to hold the designated position which is the basis for ex-officio membership.

Notice Of Committee Meetings. Written notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the committee not less than seven (7) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

Quorum. A quorum at the Credentials Committee and Peer Review Committee shall consist of fifty percent (50%) of the voting members of the committee. A quorum for all other Medical Staff committees shall consist of the voting members of the committee who are present, but not less than two (2) members.

Minutes. Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. Copies thereof shall be submitted to the ECMS. Each committee shall maintain a permanent record of each meeting.

Standing Committees. Standing Committees of the Medical Staff shall include: The Executive Committee of the Medical Staff, the Bylaws Committee, the Credentials Committee, the Medical Staff Peer Review Committee, and the Nominating Committee.

Special Committees. The President may appoint special committees subject to approval by the ECMS, as may be required to carry out the duties of the Medical Staff, to meet regulatory requirements or assist in properly carrying out the duties of the Hospital. Special Committees of the Medical Staff shall include: The Cancer Committee, the Critical Care Committee, the Infection Prevention Committee, the Perioperative Oversight Committee and the Pharmacy and Therapeutics Committee.

Such committees shall confine their work to the purpose for which they were appointed and shall report in writing and/or in person to the ECMS as requested. Minutes of the meetings of the special committees shall be kept and the date of the meeting, duration, members participating, discussions, decisions, and recommendations shall be recorded and the report filed with the ECMS.

Medical Review Committees; Committees Conducting Studies of Morbidity and Mortality.

It is intended and understood that, when engaged in any peer review activity, each committee or subcommittee created or referred to in or authorized by these Bylaws or the Bylaws of the Hospital, is a "Medical Review Committee" as such term is defined in Chapter 368a of the Connecticut General Statutes as amended from time to time. Such medical review committees, all of which have been deemed to be established by the Bylaws, include but are not limited to:

- all committees and subcommittees identified in or created pursuant to or under authority of these Bylaws, including all those committees created or approved by the Executive Committee of the Medical Staff, and all Departments and Services and Sections of the Medical Staff and their committees and subcommittees.
- meetings of the Medical Staff at which peer review actions are taken.
- the Board of Directors and its committees and subcommittees when engaged in peer review or studies of morbidity and mortality, and
- any individual gathering information or providing services for or acting on behalf of any such entity, including but not limited to Department Chairs, Service or Section Chiefs, committee and subcommittee chairs, the President and other officers of the Medical Staff, and experts or other consultants retained to perform peer review.

The Joint Commission, while performing accreditation services for the Hospital involving peer review, shall be acting as part of a medical review committee engaged in peer review, as an agent of the Hospital and the committee. In its capacity as agent, the Joint Commission shall be bound to protect the confidentiality of information of the medical review committee engaged in peer review, pursuant to state law and the contract between the Joint Commission and the Hospital.

It is further intended that all persons and entities referred to in this provision, when conducting studies of morbidity and mortality, are intended to function in accordance with and be subject to the protections as set forth in the Connecticut General Statutes.

List of Committees. The Medical Staff Office at all times shall maintain a list of committees; such list shall be deemed to be incorporated into these Bylaws by this reference and each committee that is listed, whenever engaged in peer review activities, shall be deemed to be a "medical review committee" that is established by written bylaws.

6.2 EXECUTIVE COMMITTEE OF THE MEDICAL STAFF

Composition. All Active and Ambulatory Medical Staff members of any discipline or specialty are eligible for membership on the ECMS. The voting members of the Executive Committee of the Medical Staff shall consist of: (i) the President; (ii) Vice President; (iii) Staff Representative; (iv) Secretary/Treasurer; (v) each Department Chairperson; (vi) one representative from the Section of Pulmonary and Critical Care; (vii) one representative from the Section of Inpatient Medicine elected by the members of the Section of Inpatient Medicine; (viii) one representative from the Section of General Surgery elected by the members of the Section of General Surgery.

The CEO (or designee), the Chief Nursing Officer, the Board Representative, Representative from the Nursing Staff and Chairman of the Medical Staff Peer Review Committee shall be ex-officio members without vote. The Chairperson of the ECMS will be the President.

Duties. The duties of the Executive Committee of the Medical Staff shall be to:

receive and act upon reports and recommendations of the Medical Staff committees, departments and others concerning patient care quality and appropriateness reviews, evaluation and monitoring functions and the discharge of their delegated administrative responsibilities and recommend to the Board of Directors specific programs and systems to implement these functions;

coordinate the activities of and policies adopted by the Board of Directors;

fulfill the Medical Staff's accountability to the Board for the medical care rendered to patients in the Hospital by making recommendations directly to the Board concerning, but not limited to, the following: the structure of the Medical Staff; the mechanisms used to review credentials and delineate individual clinical privileges; recommendations of individuals for Medical Staff membership; appointment, reappointments, Medical Staff category, department assignments delineated clinical privileges and corrective action; the organization of the quality assessment activities of the Medical Staff as well as the mechanisms used to conduct, evaluate and revise such activities; the mechanisms by which membership on the Medical Staff may be terminated; and the mechanisms for fair hearing procedures and an appellate review process.

account to the Board of Directors and to the Medical Staff for the overall quality and efficiency of patient care at the Hospital;

take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of Medical Staff appointees including initiating investigations, and initiating and pursuing practitioner performance improvement plans and summary or precautionary suspension, when warranted;

make recommendations to the CEO, and/or Board as appropriate on medico-administrative Hospital and management matters;

keep the Medical Staff up-to-date concerning the licensure and accreditation status of the Hospital;

consistent with the mission and philosophy of the Hospital, the Executive Committee of the Medical Staff will participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

formulate and implement Medical Staff rules, policies and procedures;

Be regularly involved in Medical Staff management, including the enforcement of the Bylaws, Rules and Regulations, and oversight of committee and department affairs.

Coordinate the activities and general policies of the various departments and sections as required.

Provide liaison between the Medical Staff, CEO and the Board.

Report to the Medical Staff at each Medical Staff meeting.

Act for the organized Medical Staff between meetings of the Medical Staff.

Communicate findings, conclusions, recommendations and actions to improve performance to appropriate numbers of the Medical Staff and the Board.

Meetings. The Executive Committee of the Medical Staff shall meet at least ten (10) times per year and maintain a permanent record of its proceedings and actions.

6.3 BYLAWS COMMITTEE

Composition. The Bylaws Committee shall consist of at least three (3) Active Medical Staff members, and may include one or more member(s) of the Hospital administrative staff, and representatives of the Board of Directors. Legal counsel to the Hospital may sit with this committee to render legal advice. The Staff Representative shall chair the Bylaws Committee.

Duties. The duties of the Bylaws Committee shall be to:

Be responsible for receiving all Medical Staff Bylaws amendments proposed by any Active Medical Staff member, department, or committee.

Consider amendments to the Medical Staff Bylaws, Rules and Regulations, which are referred to the committee or proposed by members of the committee or any member of the Active Medical Staff.

Review newly proposed department, committee, and Hospital policies for composition and compliance with the Bylaws, and at the request of the President or Executive Committee of the Medical Staff.

Meetings. The Bylaws Committee shall meet as needed.

6.4 CANCER COMMITTEE

Composition: The Cancer Committee shall be a special committee of the Medical Staff as required in the guidelines of the American College of Surgeons. The Chairperson and physician members shall be appointed on an annual basis by the President of the Medical Staff and shall include the following:

One board certified physician representative from surgery, medical oncology, radiation oncology, diagnostic imaging, and pathology.

Representatives from administration, nursing, social services, cancer registry and Quality Improvement.

Other physicians and allied health representatives based on the cancer experience of the hospital and/or needs of the committee.

All members appointed to the committee will be documented in the minutes. Any changes in the committee will also be documented in the minutes.

Duties and Responsibilities

The duties of the Cancer Committee shall include:

Develops and evaluates the annual goals and objectives for the clinical, educational and programmatic activities related to cancer.

Promotes a coordinated, multidisciplinary approach to patient management.

Ensures that educational and consultative cancer conferences cover all major cancer sites and related issues.

Ensures that an active supportive care system is in place for patients, families and staff.

Monitors quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes.

Promotes clinical research.

Supervises the cancer registry and ensures accurate and timely abstracting, staging and follow-up reporting.

Performs quality control of registry data.

Encourages data usage and regular reporting.

Ensures the content of the annual report meets all of the requirements.

Ensures the annual report is published by November 1st of the following year.

Upholds medical ethical standards.

Meetings.

The committee shall meet as often as needed, but at least quarterly. The minutes and an annual report will be submitted to the ECMS outlining the activities of the Committee. Minutes shall be maintained in the Cancer Center and the Medical Staff Services Department

6.5 CREDENTIALS COMMITTEE

Composition. The Credentials Committee shall consist of six (6) members of the Active Medical Staff including the Vice President, who will act as the role of Chairperson. The CEO's

designee and Chief Nursing Officer (or designees) will also serve on the Credentials Committee. All members of the Credentials Committee shall have a vote except the Chief Nursing Officer and CEO's designee.

Duties. The duties of the Credentials Committee shall be to:

In accordance with the credentials policies, review and investigate the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations to the ECMS;

Review, as may be requested, all information available regarding the current clinical competence and activities of persons currently appointed to the Medical Staff and, as a result of such review, make a written report of its findings and recommendations;

Review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital;

Review proposed revisions for clinical privileging by members of the Medical Staff in the department/sections; and

Ensure that criteria used for measuring qualifications of prospective and current Medical Staff members are fair, objective, impartial and designed to promote quality care in the Hospital.

Meetings. The Credentials Committee shall meet at least ten (10) times per year.

6.6 CRITICAL CARE COMMITTEE

Composition. The Critical Care Committee shall consist of at least five (5) members of the Active Medical Staff including members of the Department of Medicine, the Department of Surgery, a representative from the Section of Anesthesia, a representative from the ICU nursing staff, representatives from Hospital administration and from other departments as needed. The Chairperson of the Critical Care Committee shall be the Critical Care unit director. The unit director is an individual, whose credentials document knowledge of, and special interest or experience in, critical care.

Duties. The duties of the Critical Care Committee shall be to:

Guide and monitor the activities of the critical care patient.

Assure that the highest quality care is provided the critically ill patient by:

- (i) Setting standards for patient care;
- (ii) Reviewing/revising policies and procedures annually;
- (iii) Evaluating current technology in use;
- (iv) Assessing and recommending advances in technology as appropriate;
- (v) Monitoring and evaluating the care provided; and

- (vi) Monitoring the appropriateness of invasive therapeutic procedures performed in the critical care unit.

Meetings. The Critical Care Committee shall meet ten (10) times per year and reports to the ECMS.

6.7 INFECTION PREVENTION COMMITTEE

Composition. The Infection Prevention Committee shall consist of at least two (2) members of the Active Medical Staff and representatives of Hospital administration, the Laboratory and representatives from other departments as needed. The Chairperson of the Infection Prevention Committee shall be an individual whose credentials document knowledge of, and special interest or experience in, infection prevention.

Duties. The duties of the Infection Prevention Committee shall be to:

Assure that the greater Hospital environment minimizes the exposure of both patients and Hospital personnel to infectious complications.

Develop policies and procedures relative to infection prevention.

Assure accurate reporting of infectious occurrences.

Investigate and control nosocomial infections and monitor the Hospital's infection prevention program.

Develop and implement preventive and corrective programs designed to minimize infection hazards

Meetings. The Infection Prevention Committee shall meet monthly and reports to the ECMS.

6.8 MEDICAL STAFF PEER REVIEW COMMITTEE

Composition. The Medical Staff Peer Review Committee shall consist of five members of the Medical Staff, one of whom shall be the Chairperson. The, CEO designee, CNO, a representative from Nursing Peer Review and a representative from Quality Improvement will be additional ex-officio members without a vote. The Chairperson will be appointed by the President.

Duties. The duties of the Medical Staff Peer Review Committee shall be to:

Continuously monitor and improve the performance of all Medical Staff members who provide patient care services. The Medical Staff Peer Review Committee shall serve as an interdisciplinary forum for the peer review of individual events related to patient care.

Report to the ECMS key indicators of quality and review these indicators to improve quality and reduce risk.

Establish benchmarks, whenever possible, and recommend the establishment of quality teams, if appropriate, to review process or system concerns and make recommendations for improvement.

Medical Staff department/sections will collaborate with the Medical Staff Peer Review Committee to establish its own set of quality indicators for review. The Medical Staff Peer Review Committee will incorporate these indicators into the physician reappointment profile. Such quality indicators will include: drug use evaluation; operative and invasive procedures; blood usage review; medical record review and general clinical review.

Meetings. The Medical Staff Peer Review Committee shall meet ten (10) times per year.

6.9 NOMINATING COMMITTEE

Composition. The Nominating Committee shall consist of at least three (3) members of the Active Medical Staff appointed by the ECMS.

Duties. The duties of the Nominating Committee shall be to:

Nominate persons for the Medical Staff offices of President, Vice President, Staff Representative and Secretary/Treasurer.

Distribute the names of the nominees to all members of the Active and Ambulatory Medical Staff at least 30 days prior to the Annual Meeting of the Medical Staff.

Meetings. The Nominating Committee shall meet as needed.

6.10 PERIOPERATIVE OVERSIGHT COMMITTEE

Composition. The Perioperative Oversight Committee consists of Chairpersons from the Departments of Surgery, Obstetrics and Gynecology, and Anesthesia; Two additional medical staff members; Director of Perioperative Services; Operations Managers of the Operating Room, Central Sterile Services, PACU/ASU/ENDO; Chief Nursing Officer; and Chief Medical Officer. All of them with votes. Director of Clinical Informatics and Director of Quality Improvement will be additional members without a vote. Other guests may be invited without a vote for discussion as necessary.

The Chairperson of the Perioperative Oversight Committee is the Chairperson of Surgery. In the absence of the Chairperson of Surgery, the Chairperson of the Department of Anesthesia or Chairperson of Obstetrics and Gynecology shall chair the meetings.

Duties. The duties of the Perioperative Oversight Committee shall be to:

Assure that the highest quality care is provided to the surgical patient by:

- (i) setting standards for patient care;
- (ii) reviewing/revising policies and procedures regularly;
- (iii) evaluating current medical technology in use;
- (iv) assessing and recommending new technology specific to the care of surgical patients;
- (v) monitoring and evaluating the care provided;
- (vi) monitoring the appropriateness of invasive therapeutic procedures performed;

- (vii) appropriate use of IT.
- (viii) Monitoring the efficient use of Peri-Operative Services.

Ensure an optimally safe, efficient, and friendly work environment for all disciplines by:

- (i) monitoring delays within the perioperative continuum;
- (ii) monitoring adherence to the policies and procedures of the Perioperative Center and the relevant Departments and Sections;
- (iii) monitoring behaviors of team members;
- (iv) reviewing and acting on personnel issues that may impact perioperative services.

Meetings. The Perioperative Oversight Committee shall meet at least once every two months. Minutes will be forwarded to the ECMS and maintained by the Medical Staff Services Department.

6.11. PHARMACY AND THERAPEUTICS COMMITTEE

Composition. The Pharmacy and Therapeutics Committee shall consist of representatives from the Medical Staff, Pharmacy Services and other departments as needed. The Chairperson of the Pharmacy and Therapeutics Committee is appointed by the President in consultation with the ECMS.

Duties. The duties of the Pharmacy and Therapeutics Committee shall be to:

Assist in the evaluation and formulation of professional practices and policies regarding the appraisal, selection, procurement, storage, distribution and administration of medications.

Review adverse drug events.

Perform ongoing review of the Hospital's formulary.

Recommend policies, procedures and practices to reduce errors in the medication process.

Meetings. The Pharmacy and Therapeutics Committee shall meet at least six (6) times per year and shall report to the ECMS.

ARTICLE 7.00

MEDICAL STAFF MEETINGS

7.10 MEDICAL STAFF MEETINGS

Call of Meetings and Notice. A meeting of the Medical Staff shall be held a minimum of once each calendar year. Written notice of the meeting and all action to be taken shall be sent to all Medical Staff members and conspicuously posted. The agenda of the meeting may include reports on review and evaluation of the work done in the departments, election of officers and the conduct of other Medical Staff business.

Purpose and Minutes. The primary objective of the meeting shall be to report on the activities of the Medical Staff and to conduct other business as may be on the agenda. Written minutes of all meetings shall be prepared and recorded.

Annual Meeting. There shall be an annual meeting of the Medical Staff. The meeting time will be determined by the Executive Committee of the Medical Staff. The election of officers and other business as may be appropriate will be conducted at the annual meeting. Notice of this meeting shall be given to the Medical Staff members at least thirty (30) days prior to the meeting.

7.20 SPECIAL MEETINGS

When Called. The President may call a special meeting of the Medical Staff at any time. The President shall call a special meeting within 30 days after receipt of a written request therefore signed by not less than twenty (20) percent of the Active Medical Staff, or upon a resolution by the Executive Committee of the Medical Staff. Such request or resolution shall state the purpose of the meeting. The President shall designate the time and place of any special meeting.

Notice of Special Meetings. Written or printed notice stating the time, place and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff at least (7) seven days before the date of such meeting. The attendance of the Medical Staff members at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice of such meeting.

7.30 DEPARTMENTAL MEETINGS

Departmental meetings shall be held at least four (4) times per year to review and evaluate current clinical activities of their respective members and other matters pertaining to the Hospital.

Minutes of the departmental meetings shall be kept. Minutes shall be filed with the Medical Staff Office within one (1) week following the departmental meeting for distribution to ECMS.

7.40 ATTENDANCE REQUIREMENTS

Medical Staff Meetings. Each member of the Medical Staff shall be encouraged to attend all Medical Staff meetings.

Medical Staff Committees. Each member appointed to serve on a Medical Staff committee shall be encouraged to attend all regular meetings of the committee. Failure to meet this requirement, unless excused upon a showing of good cause, may be a basis for removal from the position.

Participation by Conference Telephone. With the exception of meetings of the General Medical Staff, Executive Committee of the Medical Staff, Credentials Committee and Peer Review Committee, a member of the committee may participate in a meeting of the committee by means of a conference telephone or similar communications equipment enabling all members participating in the meeting to hear one another, and such participation in a meeting shall constitute presence in person at such meeting.

7.50 QUORUM

General Medical Staff Meetings. A quorum at a meeting of the general Medical Staff shall consist of at least 10% of the Active and Ambulatory Staff Members eligible to vote.

Executive Committee of the Medical Staff Meeting. A quorum at a meeting of the ECMS shall consist of fifty percent (50%) of the voting members of the committee.

Departmental Meetings. A quorum at a meeting of a department shall consist of at least 10% of the voting members of the department, but not less than two members.

Medical Staff Committee Meetings. A quorum at the Credentials Committee and Peer Review Committee shall consist of fifty percent (50%) of the voting members of the committee. A quorum for all other Medical Staff committee shall consist of the voting members of the committee who are present, but not less than two members.

7.60 MEDICAL STAFF MEETINGS, VOTING

If there is no specific voting requirement defined and a quorum is present at a meeting, a majority vote of those present will carry a motion.

ARTICLE 8.00

MEDICAL STAFF MEMBERSHIP

8.10 QUALIFICATIONS FOR MEMBERSHIP

- 8.1a Only physicians with Doctor of Medicine (MD) or Doctor of Osteopathy (DO) degrees, oral surgeons (DMDs), dentists (DDSs) or podiatrists (DPMs) holding a license to practice in the State of Connecticut, who can document their background, experience, training, judgment, individual character and demonstrated competence, physical and mental capabilities, adherence to the ethics of their profession and ability to work with others with sufficient adequacy to assure the Medical Staff and Board of Directors (hereafter referred to as "Board") that any patient treated by them will be given a high quality of medical or dental care, shall be qualified for membership on the Medical Staff. No physician, oral surgeon, dentist or podiatrist shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges merely by virtue of licensure to practice in this or in any other state, or of membership in any professional organization, or of privileges at another hospital.
- 8.1b In documentation of experience and training, completion of an Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), American Podiatric Medical Association (APMA) or American Dental Association (ADA) approved residency is required.
- 8.1c ABMS, AOA or ADA Board certification (or comparable board certification as determined by the ECMS) must be obtained by all members of the Medical Staff within the period of eligibility as defined by the respective board, and such board certification must be maintained continuously thereafter. Those members of the Medical Staff appointed prior to 9/9/97 shall not be subject to this requirement. Members of the Medical Staff whose board certification is time limited must become recertified within two years after the date of expiration.
- 8.1d Exceptions to the board certification requirement in Section 8.1c above may be made only by the Board after an ECMS recommendation.
- 8.1e Proof of professional liability insurance written by a carrier licensed or authorized to do business in Connecticut in the amount specified by the Board from time to time is required of all members of the Medical Staff. In the event of a lapse of a policy or a change in carrier, the Practitioner must obtain tail insurance, or the new policy must be fully retroactive in terms of coverage, so that the Practitioner remains fully insured at all times.
- 8.1f Practitioners appointed by the Medical Staff must promptly notify the President in the event of any occurrence or change in qualifications that would be material to his/her membership on the Medical Staff.

8.20 NONDISCRIMINATION

The Hospital Medical Staff will not unlawfully discriminate against any person in granting appointment/clinical privileges.

8.30 STAFF DUES

- 8.3a Annual Medical Staff dues shall be governed by the most recent action which has been recommended by the Executive Committee of the Medical Staff and adopted at a regular or special Medical Staff meeting. The Medical Staff Office shall notify each relevant Medical Staff member in writing of any contemplated change in Medical Staff dues at least 21 days before the meeting at which voting on such proposed changes is to take place.
- 8.3b Emeritus Medical Staff members will not be required to pay dues.
- 8.3c Dues shall be due and payable upon request. Failure to pay dues shall be construed as a voluntary resignation from the Medical Staff.

8.40 ETHICAL REQUIREMENTS

A person who accepts membership on the Medical Staff agrees to act in an ethical, professional, and courteous manner in accordance with the mission and philosophy of the Hospital.

8.50 RESPONSIBILITIES OF MEMBERSHIP

- 8.5a Each Medical Staff member directs the care of his/her patients. He/She is not responsible for the actions of other physicians, dentists, oral surgeons, podiatrists, allied health professionals, or Hospital employees, unless such person(s) are under his/her supervision.
- 8.5b Each Medical Staff member must abide by the Bylaws, and other policies and procedures of the Hospital.
- 8.5c All members of the Medical Staff are obligated to treat all patients appropriately referred to them by Bristol Hospital Clinic or the Emergency Room in a timely fashion. On a case-by-case basis, extenuating circumstances will be decided by the Department Chairman or the President.
- 8.5d Each Medical Staff member must abide by Bristol Hospital Medical Staff Membership Code of Conduct, the Professionalism Policy and the Hospital's Sexual Harassment Policy.
- 8.5e Health Information Management: Admission and Progress Notes

The patient receives a medical history and physical (H & P) examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services, by a physician or other qualified practitioner, in accordance with state law and hospital policy.

For a medical H & P that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services, by a physician or other qualified practitioner.

For outpatient surgery, the H & P shall be performed within thirty (30) days prior to the procedure, with an appropriate assessment including physical examination.

The H & P shall include sufficient pertinent and relevant information necessary for the care of the patient given his/her diagnosis and/or procedure. Specific elements should include chief complaint, details of the present illness, personal and family history, review of systems, physical examination, conclusions or impressions and a course of action planned for the patient.

8.60 BILL OF RIGHTS FOR MEDICAL STAFF MEMBERS

- 8.6a Each member on the Medical Staff has the right to an audience with the Executive Committee of the Medical Staff (ECMS). In the event a member of the Medical Staff is unable to resolve a difficult issue working with his/her respective Department Chair, that member of the Medical Staff may, upon presentation of a written notice, meet with the ECMS to discuss this issue.
- 8.6b Any member of the Medical Staff has the right to initiate a recall election of a Medical Staff Officer and/or Department Chair. A petition for such recall must be presented, signed by at least 20% of the members of the Active Medical Staff or department members. Upon presentation of such valid petition, the ECMS will schedule a special general Medical Staff meeting/department meeting for purposes of discussing the issue and (if appropriate) entertain a nonconfidence vote.
- 8.6c Any member of the Medical Staff may call a general Medical Staff meeting. Upon presentation of a petition signed by 20% of the members of the Active Medical Staff, the President will schedule a Medical Staff meeting for the specific purpose addressed by the petitioners. The meeting will be convened within one month of request. No business other than that in the petition may be transacted.
- 8.6d Any member of the Medical Staff may propose to adopt a rule, regulation, or policy, or an amendment by communicating them to the President of the Medical Staff for consideration at the Executive Committee of the Medical Staff.
- 8.6e Any member of the Medical Staff may raise a challenge to any rule or policy established by the Executive Committee of the Medical Staff. In the event a rule, regulation or policy is felt to be inappropriate, any member of the Medical Staff may submit a petition signed by 20% of the members of the Active Medical Staff. When such petition has been received by the ECMS, the ECMS will either provide the petitioners with information clarifying the intent of such rule, regulation or policy, or, if there is no resolution, a meeting will be scheduled with the petitioners to discuss the issue.
- 8.6f If there is no resolution of the conflicting rule or policy by the ECMS and the Medical Staff after the meeting/s, any member of the Medical Staff may submit a petition signed by 20% of the members of the Active Medical Staff to the President of the Hospital or the Chairperson of Board of Directors for further action. The Medical Staff member or members may request an audience with the Board of Directors and/or may be requested to present themselves at the meeting of the Board of Directors.

- 8.6g Any section/subspecialty group may request a department meeting when a majority of the members/sub-specialists believe that the department has not acted in an appropriate manner.
- 8.6h This Bill of Rights does not pertain to issues involving disciplinary action, denial of requests for appointment or clinical privileges, or any other regulatory requirement. The sections of the Bylaws dealing with Practitioner Performance Improvement Plans, and Hearing and Appeals Procedures govern the rights of the Medical Staff member in these matters.
- 8.6i A practitioner has a right to a hearing/appeal if the ECMS makes one of the recommendations set forth in Section 12.1a of the Bylaws related to the practitioner's clinical privileges.

ARTICLE 9.00

APPOINTMENT AND REAPPOINTMENT

9.10 GENERAL CONDITIONS AND DURATION OF APPOINTMENT

- 9.1a Every application for Medical Staff appointment or reappointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligations to provide continuous care and supervision of his patients, to abide by the Medical Staff Bylaws and Rules and Regulations.
- 9.1b Initial appointments and reappointments to the Medical Staff shall be made by the Board. The Board shall act on appointments and reappointments only after there has been a recommendation from the ECMS in accordance with the provisions of these Bylaws.
- 9.1c Appointments to the Medical Staff will be for no more than twenty-four calendar months. Annually, the Board of Directors on the recommendation of the ECMS will reappoint members of the Medical Staff whose terms are expiring that year.
- 9.1d Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board.
- 9.1e These Bylaws and the Rules and Regulations do not apply to the terms of contractual arrangements between the Hospital and a physician(s). The terms of the contract (including any waiver of procedural rights) control over any conflicting provision in the Bylaws or Rules and Regulations provided, however, that each physician must meet and maintain all of the requirements for Medical Staff membership.

9.20 INITIAL APPOINTMENT

- 9.2a Basic Criteria. The applicant must meet the following basic criteria for granting an application:

Have completed (or be in the last 6 months of) a residency program of at least 3 years duration that is approved by the ACGME, or the AOA or the APMA;

Have been engaged in active clinical practice during the last twelve months (residency or private practice) provided, however that exceptions to this requirement may be granted by the ECMS for reasonable cause and with an appropriate proctoring plan approved by the Department Chairperson;

Applicants whose practice includes inpatient hospital care must have actively practiced in an accredited hospital at least two of the past five years. Three months of recent experience in a full-time clinical residency will be considered equivalent;

Applicant is responsible for providing satisfactory peer and/or faculty recommendation including written information regarding the applicant's current: medical/clinical knowledge; technical and clinical skills; clinical judgment; interpersonal skills; communication skills; and professionalism;

Be currently licensed to practice without stipulation in the State of Connecticut;

Maintain professional liability insurance in the amount specified by the Board of Directors; and

Provide evidence of ABMS or AOA Board certification or eligibility to take the Board examination, except for dentists. Certification must be achieved within the period of eligibility as defined by the respective medical specialty board unless an exception is granted by the ECMS and Board of Directors.

Only an Adjunct Staff member holding a license, certificate or such other credentials as may be required by applicable state law, is eligible to provide specified services in the Hospital. An Adjunct Staff member is individually assigned to the department appropriate to his/her professional training. The Adjunct Staff will be subject to the reappointment process, similar to that of the Active Medical Staff.

9.2b Submission of Application. Application for Medical Staff appointment is to be signed and submitted by the applicant on the prescribed form. The application must be typed or clearly legible. Prior to the application being submitted, the applicant will be provided with a copy of the Medical Staff Bylaws and accompanying Rules and Regulations.

9.2c Effect of Application. The applicant must sign the application and in so doing the applicant thereby:

1. Signifies his/her willingness to appear for interviews in regard to his/her application;

Authorizes Hospital representatives to consult with others who have been associated with the applicant and/or who have information bearing on the applicant's competence and qualifications;

Consents to Hospital representatives' inspection of all records and documents that may be material to an evaluation of the applicant's: professional qualifications and competence to carry out the clinical privileges (s)he requests; physical and mental health status; and professional and ethical qualifications;

Releases from any liability and agrees not to make any claims or bring any suits or actions against all Hospital representatives for their acts performed in connection with evaluation of his/her application and credentials;

Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives concerning his/her competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff appointment and clinical privileges;

Authorizes and consents to Hospital representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the Hospital may have concerning the applicant, and releases Hospital representatives from liability for so doing;

Signifies that he/she has read the current Medical Staff Bylaws, and agrees to abide by their provisions; and

Agrees to notify immediately the President of the Medical Staff or Chief Medical Officer, or their designees, of any changes in the information including, but not limited to, any pending investigations or completed action involving denial, challenges to, revocation, suspension, reduction, limitation, or probation of any of the following:

- (i) License or certification to practice any profession in any state or country.
- (ii) DEA or other controlled substances registration.
- (iii) Membership or fellowship in local, state or national professional society.
- (iv) Appointment or employment status, prerogatives or membership or clinical privileges at any other hospital, clinic, health-care institution or organization.
- (v) Professional liability insurance. This would include any changes in professional liability insurance coverage, any filing of a professional liability lawsuit, settlement or final judgment,
- (vi) Any change in the credentialing or privileging status at any other Hospital
- (vii) Any change in eligibility for participation in the Medicare or Medicaid program.

For purposes of this Article 9.00, the term "Hospital representatives" includes the Board of Directors, its directors and committees, the CEO of the Hospital or his/her designee, , registered nurses and other employees of the Hospital; the Medical Staff organization and all Medical Staff members; clinical units and committees which have responsibility for collecting and evaluating the applicant's credentials or acting upon his/her application; and any authorized representative of any of the foregoing.

9.2d Content of Application. Every applicant must furnish complete information in the application concerning at least the following:

- 2. Undergraduate, medical school, and postgraduate training, including the name of each institution, degrees granted, program completed, dates attended, and for all postgraduate training, names of practitioners responsible for monitoring the applicant's performance.
- 3. Detailed information concerning the applicant's professional qualifications, competency and experience, including a current curriculum vitae.
- 4. All past and current valid medical, dental, podiatric and other professional licensure or certifications, and DEA and any other controlled substances registration, with the date and number of each. A copy of the current Connecticut license and DEA controlled substances certificate must accompany the application. A Connecticut license and DEA controlled substances certificate

must be kept current during the full term of initial appointment and/or reappointment.

5. Specialty or subspecialty board certification, recertification, or eligibility status to sit for its examination as defined by the applicable board.
6. Any current physical and/or mental health problem or disability (including alcohol or drug dependencies) that affects, or within the period of appointment may reasonably be expected to progress to a point that affects the applicant's skills or judgment reasonably required for professional and Medical Staff duties.
7. Professional liability insurance coverage and information on malpractice claims history and experience (suits and settlements made, concluded and pending), including the names of present and past insurance carriers.
8. Any pending investigations or completed action involving denial, challenges to, revocation, suspension, reduction, limitation, or probation of any of the following:
 - (i) License or certification to practice any profession in any state or country.
 - (ii) DEA or other controlled substances registration.
 - (iii) Membership or fellowship in local, state or national professional society.
 - (iv) Appointment or employment status, prerogatives or membership or clinical privileges at any other hospital, clinic, health-care institution or organization.
 - (v) Professional liability insurance.
 - (vi) Eligibility to participate in the Medicare or Medicaid program.
9. Any instances of non-renewal, voluntary or involuntary relinquishment (by resignation or expiration), limitation, or withdrawal or failure to proceed with an application for any of the items listed in 9.2d7 above in order to foreclose or terminate actual or possible investigation or disciplinary or adverse action.
10. Location of offices, names and addresses of other practitioners with whom the applicant is or was associated and inclusive date of such association, names and locations of all other hospitals, clinics or health care institutions or organizations where the applicant had or has any association, employment, privileges or practice with the inclusive date of each affiliation, status held, and general scope of clinical privileges.
11. Any current criminal charges (other than minor motor vehicle violations) which are pending against the applicant and any past charges including their resolution, and any current and past charges involving a drug or alcohol-related offense.
12. References. The application must include the names of at least two (2) references in the applicant's same profession who are not newly associated or about to become partners with applicant in professional practice or personally related to him, who have personal knowledge of the applicant's current clinical ability, ethical character and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from Medical Staff or Hospital representatives. The applicant must provide the name of

Department Chair/Chief/clinical supervisor who can provide specific written comments regarding the applicant's current clinical ability, ethical character, and ability to work cooperatively with others.

13. Evidence of the applicant's agreement to abide by the Medical Staff Bylaws.
14. Information from all prior and current insurance carriers concerning claims, suits and settlements (if any) during the past five years.
15. Medical Staff category, clinical department, clinical privileges requested and intended use of Hospital facilities.

In the event that an appointment has been granted prior to the discovery of such falsification, omission, concealment, misrepresentation, or misstatement, such discovery shall be deemed to constitute automatic relinquishment of all clinical privileges and Medical Staff appointment, and the affected individual is not entitled to any hearing or appeal rights that are otherwise contained in the Medical Staff Bylaws and policies.

9.2e Procedure for Processing Applications for Medical Staff Appointment.

16. A processing fee will be assessed to each Medical Staff applicant as established by the ECMS from time to time.
17. If all information required in the application as described in Section 9.2d above is not submitted within forty-five days of receipt of the application by the Medical Staff Office it will be considered withdrawn and no further processing will take place. (One reminder notice will be sent to the applicant after receipt of the application.)
18. An application shall be complete when all the questions on the application form have been answered, all supporting documentation has been supplied and all information has been verified from primary sources. An application may become incomplete if the need arises for new, additional or clarifying information at any time. The applicant is responsible for providing a complete application, including adequate response from references. An incomplete application shall not be processed. Applicants have the burden of providing evidence that all the statements made and information given on the application are accurate. The applicant agrees that any material misstatement or omission from the application is grounds to stop processing the application with no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee will review the individual's response and provide a recommendation to the ECMS. The ECMS will recommend to the board whether the application should be processed further.
19. Upon receipt of a completed application as defined above, the applicant will be sent a letter of acknowledgement by the Medical Staff Office.
20. Verification. Upon receipt of a completed application, the Medical Staff Office in a timely manner, will verify its contents and collect additional information as follows:

- (i) Information from all prior and current insurance carriers concerning claims, suits and settlements (if any) during the past five years;
- (ii) Secure administrative and clinical references questionnaires from all significant past practice settings for the previous ten years;
- (iii) A verified report documenting the applicant's clinical work during the past six to twelve months;
- (iv) Verification of licensure status in all current and past states of licensure;
- (v) Information from the Federation of State Medical Boards;
- (vi) Information from the National Practitioners Data Bank;
- (vii) Verification that the applicant is the individual named in the credentialing documents by viewing a valid ID issued by a state or federal agency (driver's license or passport);
- (viii) Verification, in writing, from the primary source (or credentials verification organization) of the following:
 - (a) applicant's current licensure at time of initial application, reappointment, revision of privileges and expiration of license;
 - (b) applicant's relevant training; and
 - (c) applicant's current competence.

21. Department Action.

- (i) When all items have been obtained, the file will then be presented to the appropriate Department Chairperson or Section Chief.
- (ii) The applicable Department Chairperson(s) will, review the entire file and document findings on a report to the Credentials Committee.
- (iii) Deferral: Department Chairpersons may not defer consideration of an application. Upon receipt of an application and completion of the verification process, a report must be forwarded to the next scheduled Credentials Committee meeting. In the event a Chairperson is unable to formulate a report for any reason, the Chairperson must so inform the Credentials Committee.
- (iv) Favorable Findings: Departmental Chairpersons must document their findings pertaining to adequacy of education, training and experience for all privileges requested. Reference to any criteria for privileges must be documented. Specific reference to the credentials file should be made in support of all findings.
- (v) Unfavorable Findings: Department Chairpersons must document the rationale for all unfavorable findings. Reference to any criteria for clinical privileges that is not met should be documented.

22. Credentials Committee Action.

- (i) The applicant's file will be reviewed by the Credentials Committee at its next regularly scheduled meeting following receipt of the report of the Department Chairperson.
- (ii) The Credentials Committee will review and investigate the credentials of the applicant, conduct a thorough review of the applicant, interview the applicant as may be necessary, and make a written report of its findings and recommendations to the ECMS.
- (iii) The Chairperson of the Credentials Committee or their designee will present a summary of the applicant's file and Credentials Committee recommendations to the ECMS at its next scheduled meeting.
- (iv) Deferral: Action by the Credentials Committee to defer the application for further consideration must be followed within thirty (30) days by subsequent recommendations for approval or denial of, or any special limitations to, Medical Staff appointment, category of Medical Staff and prerogatives, department affiliation and scope of privileges. The Chairperson of the Credentials Committee shall promptly send the applicant written notice of an action to defer.

23. ECMS Action.

- (i) The applicant's file will be reviewed by ECMS at its next regularly scheduled meeting following receipt of the report of the Credentials Committee.
- (ii) Deferral: Action by the ECMS to defer the application for further consideration must be followed within thirty days by subsequent recommendations for approval or denial of, or any special limitations to, Medical Staff appointment, category of Medical Staff and prerogatives, department affiliation, and scope of clinical privileges. The President shall promptly send the applicant written notice of an action to defer.
- (iii) Favorable Recommendations: When the ECMS's recommendation is favorable to the applicant in all respects, the President shall promptly forward it, together with all supporting documentation, to the Board of Directors.
- (iv) Adverse Recommendations: When the ECMS's recommendation is adverse to the applicant, a special notice will be sent to the applicant stating the reason(s) for the adverse recommendation and that the applicant is entitled to the procedural rights as provided in Article 12.00 herein. An "adverse recommendation" by the ECMS is defined as a recommendation to deny appointment, or to deny or restrict requested clinical privileges.

24. Board of Directors Action.

- (i) The new appointee will be notified in writing by the President of the Medical Staff of the actions of the Board of Directors. The signature of the

President of the Medical Staff and Chairperson of the Board of Directors will indicate approval by the Board appointing the applicant with specified privileges to the indicated category of the Medical Staff. Any pertinent information regarding appointment to the Medical Staff will be forwarded or made available to the appointee at this time.

- (ii) The Board of Directors may adopt or reject, in whole or in part, a favorable recommendation of the ECMS or refer the recommendation back to the ECMS for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. Favorable action by the Board of Directors is effective as its final decision. If, after complying with the requirements, the Board's action is adverse to the applicant, a special notice will be sent to the applicant stating the reason(s) for the adverse action and that the applicant is entitled to the procedural rights.
- (iii) In the case of an adverse ECMS recommendation, the Board of Directors shall take final action in the as provided in Article 12.00.
- (iv) Adverse Board Action Defined: "Adverse action" by the Board of Directors means action to deny appointment or to deny or restrict requested clinical privileges.

25. Basis for Recommendations and Action.

The report of each individual or group, including the Board of Directors, required to act on an application must state reasons for each recommendation or action taken, with specific reference to the completed application and all other documentation considered.

11. Notice of Final Decision.

- (i) Notice of the Board's final decision shall be given through the President of the Medical Staff and the Chairperson of the Board of Directors. The applicant shall receive written notice of appointment and special notice of any adverse final decision.
- (ii) A decision and notice of appointment includes: the Medical Staff category to which the applicant is appointed; the Department to which the applicant is assigned; the clinical privileges the applicant may exercise; and any special conditions attached to the appointment.

9.30 FOCUSED PROFESSIONAL PRACTICE EVALUATION

All initial appointments and clinical privileges as well as any new clinical privileges granted to an existing Medical Staff member are subject to a Focused Professional Practice Evaluation (FPPE) as outlined in the FPPE policy.

9.40 REAPPOINTMENT

9.4a Reappointment Term. All current Medical Staff appointments in good standing are for a period not to exceed two years from the date of appointment. All reappointments are based on Ongoing Professional Practice Evaluation (OPPE).

9.4b Procedure.

26. Reappointment forms should be returned to the Medical Staff Services Department within 30 days of initial mailing.
27. Applicant will be notified if reappointment form has not been received by the first deadline date that is 30 days from initial mailing.
28. If reappointment form is not returned within 60 days of initial mailing, applicant will be charged a late fee as established by the ECMS from time to time.
29. If reappointment form is not returned within 90 days of initial mailing, applicant will be considered voluntarily resigned from the Medical Staff. If the applicant requests reappointment at that time, he/she must apply for initial appointment and will be required to pay the initial appointment application fee in addition to the late fee previously assessed.

9.4c Information Collection and Verification.

30. The Medical Staff member must furnish a completed Reappointment Application including:
 - (i) Complete information to update his/her file on items listed, in his/her original application, including but not limited to previously successful or current pending challenges to any licensure or registration; or voluntary relinquishment of such licensure or registration; voluntary or involuntary termination of medical staff membership; or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and involvement in any professional liability action with pending lawsuits, the final judgments or settlements; any change in eligibility to participate in Medicare or Medicaid program.
 - (ii) Board certification or status of eligibility.
 - (iii) Participation in FPPE and OPPE.
 - (iv) Specific request for the clinical privileges sought on reappointment, with any basis for changes; and
 - (v) Requests for changes in Medical Staff category or department assignments.
 - (vi) The Medical Staff Member in the Limited Staff category must provide the name of Department Chair/Chief/clinical supervisor who can provide

specific written comments regarding the applicant's current clinical ability, ethical character, and ability to work cooperatively with others.

In the event that a reappointment has been granted prior to the discovery of such falsification, omission, concealment, misrepresentation, or misstatement, such discovery shall be deemed to constitute automatic relinquishment of all clinical privileges and Medical Staff appointment, and the affected individual is not entitled to any hearing or appeal rights that are otherwise contained in the Medical Staff Bylaws and policies.

From Internal and/or External Sources: The Medical Staff Office collects for each Medical Staff member's credentials file relevant information regarding the individual's professional and collegial activities, performance and conduct in this Hospital and/or other hospitals to include:

- (i) Patterns of care and utilization as demonstrated in the findings of quality assurance, risk management and medical management activities.
- (ii) Peer review committee reports, Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE).
- (iii) Sanctions, imposed or pending, and other problems.
- (iv) Health Status
- (v) Participation in Medical Staff affairs.
- (vi) Timely and accurate completion and preparation of medical records.
- (vii) Cooperativeness in working with other practitioners and Hospital personnel.
- (viii) General attitude toward patients and the Hospital.
- (ix) Compliance with all applicable Bylaws, policies, and procedures of the Hospital and Medical Staff
- (x) Any other pertinent information that may be relevant to the Medical Staff member's status and privileges at this Hospital including the Medical Staff member's activities at other hospitals and his/her medical practice outside the Hospital.

All returned documents shall be reviewed and verified as described in the Initial Appointment section.

9.4d Procedure for Processing Applications for Medical Staff Reappointment.

- 31. The Medical Staff Office or appropriate Medical Staff administrative representative shall review all pertinent Medical Staff committee minutes and

studies and prepare a summary of findings for each Medical Staff member due for reappointment.

32. The completed file, including all documentation mentioned above, shall be sent to the chairperson of the relevant clinical department for his/her review.
33. Department Action. Each chairperson of a department in which the Medical Staff member requests or has exercised privileges reviews the Medical Staff member's file as described above and forwards to the Credentials Committee written verification of the Medical Staff member's performance, including a statement as to whether or not the department chairperson knows of, or has observed or been informed of any conduct which indicates significant present or potential physical or behavioral problems affecting the Medical Staff member's ability to perform professional, and Medical Staff duties appropriately. The department chairperson shall make recommendations for reappointment or non-reappointment, Medical Staff category, department assignment and clinical privileges.
34. Credentials Committee Action. The Credentials Committee reviews the Medical Staff member's file, the department recommendation and all relevant information available to it and forwards to the ECMS a written recommendation for reappointment or non-reappointment, Medical Staff category, department assignment and clinical privileges.
35. Executive Committee Action. The ECMS reviews the Medical Staff member's file, the department and Credentials Committee recommendations and all relevant information available to it and forwards to the Board of Directors a written recommendation for reappointment, or non-reappointment, Medical Staff category, department assignment and clinical privileges.
36. Final Processing And Board Action: Final processing of requests for reappointment follows the procedure set forth for initial appointment in Section 5.20. For the purposes of reappointment, an "adverse recommendation" by the Board of Directors as used in these provisions means a recommendation or action to deny reappointment, to deny a requested change in, or to change without the Medical Staff member's consent, his/her Medical Staff category or department assignment; or to deny or restrict requested clinical privileges.
37. Request For Modification Of Appointment Status Or Privileges: A Medical Staff member, either in connection with reappointment or at any other time, may request modification of his/her Medical Staff category, department assignment, or clinical privileges by submitting a written request to the ECMS. A modified application is processed in the same manner as a reappointment. All requests for increased privileges must be accompanied by information demonstrating current clinical competence in the specific privilege requested.

9.50 LEAVE OF ABSENCE

- 9.5a Request A Medical Staff member may request a voluntary leave of absence from the Medical Staff by submitting written notice to the Department Chairperson and President of the Medical Staff. The information will be informational to the Credentials Committee

and Executive Committee. The request should, when possible, state the beginning and ending dates and the good cause reasons for the leave.

- 9.5b A leave of absence may not exceed twelve (12) months. During this leave of absence the Medical Staff member shall be relieved of any and all Medical Staff duties except the duty to timely submit a written request for reinstatement and to apply for reappointment, if the Practitioner's reappointment cycle occurs during his or her leave of absence. During a leave of absence, the individual will not exercise any clinical privileges. A leave of absence prevents any Medical Staff dues from accruing. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.
- 9.5c Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.
- 9.5d Termination of Leave. Prior to the termination of leave, the Medical Staff member must request reinstatement of his/her privileges by submitting a written notice to the Department Chairperson and the President of the Medical Staff. If the leave of absence was due to health reasons affecting the Practitioner's ability to exercise privileges, a (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's treating physician/approved facility indicating that the individual is capable of resuming a hospital practice and safely exercising the clinical privileges requested.
- 9.5e The President of the Medical Staff in consultation with the Department Chairperson shall review the request and make a recommendation to the ECMS for a final decision regarding reinstatement. A leave of absence lasting longer than twelve (12) months, a failure to request return from the leave of absence within such 12 month period, or a failure to apply for reappointment within the leave of absence shall be considered a voluntary resignation of Medical Staff membership and privileges without right of hearing or appellate review. A request for membership subsequently received from a Medical Staff member after the 12 month leave of absence period shall be submitted and processed in the manner specified for applications for initial appointments.
- 9.5f If an individual is subject to conditional appointment or reappointment or is participating in a Performance Improvement Plan/FPPE at the time the LOA is requested, Medical Staff leaders, Administration, and legal counsel will consider whether the LOA would constitute a surrender of privileges reportable to the National Practitioner Data Bank. If a determination is made that the LOA, failure to request reinstatement in a timely manner, failure to reapply or any other action or inaction on the part of a practitioner would constitute a reportable surrender of privileges, the practitioner will be advised of that determination and may be allowed an opportunity to withdraw the request for LOA or resignation, request reinstatement, or reapply and satisfy the conditions of the Performance Improvement Plan/FPPE, if the practitioner is cooperating in good faith, and improvement is reasonably likely.

ARTICLE 10.00

CLINICAL PRIVILEGES

10.10 CLINICAL PRIVILEGES

10.1a Every practitioner practicing at this Hospital by virtue of Medical Staff membership or otherwise shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him by the Board of Directors, except as provided in Sections 10.20, 10.30, and 10.40 below .

10.1b Every initial application for Medical Staff appointment and application for reappointment must contain a request for specific clinical privileges desired by the applicant. Specific requests must also be submitted for temporary privileges and for modification of privileges in the interim between reappointments. In the event a request for privileges is submitted for which no criteria have been created, the request will be tabled for a reasonable period of time during which the Board of Directors will, after consultation with the ECMS, formulate the necessary criteria. Once objective criteria have been established the original request will be processed as described herein.

10.1c Privilege Review Criteria.

The evaluation of all requests for privileges (initial appointment, reappointment and increase or modification of privileges) shall be based upon criteria recommended by the Medical Staff and approved by the Board that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of the following are included in the criteria:

Current licensure and/or certification, as appropriate, verified with the primary source.

The applicant's education.

The applicant's specific relevant training, verified with the primary source.

Experience and demonstrated competence.

Clinical judgment.

Evidence of physical ability to perform the requested privilege.

Data from professional practice review by an organization that currently privileges the applicant (if available).

Peer and/or faculty recommendation including written information regarding the applicant's current: medical/clinical knowledge; technical and clinical skills; clinical judgment; interpersonal skills; communication skills; and professionalism.

When renewing privileges, review of the applicant's performance within the Hospital including direct observation of clinical care provided; review of the records of

patients treated in the Hospital and review of the records of the Medical Staff quality assurance program activities which document the evaluation of the Medical Staff member's participation in the delivery of care.

Morbidity and mortality data when available.

Data specific to the applicant as compared to aggregate data, when available.

Other relevant information including an appraisal by the clinical department in which such privileges are sought.

Participation in continuing medical education.

The applicant must submit a statement that no health problems exist that could affect his or her ability to perform the privileges requested.

The Hospital queries the National Practitioner Data Bank.

Before recommending privileges the Medical Staff shall also evaluate the following:

38. Challenges to any licensure or registration.
39. Voluntary and involuntary relinquishment of any license or registration.
40. Voluntary and involuntary termination of medical staff membership at any hospital.
41. Voluntary and involuntary limitation, reduction, or loss of clinical privileges at any hospital.
42. Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant.
43. Documentation as to the applicant's health status.

The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges requested.

10.1d Each credentialed Medical Staff member shall have the right to voluntarily request reduction in their clinical privileges. Such requests shall be made to the Department Chairperson for review by the ECMS.

10.1e Oral Surgeons. Privileges granted to oral surgeons shall be based on evidence of their training, experience, demonstrated competence, judgment, references and other relevant information, including an appraisal by the clinical department in which such privileges are sought. The scope and extent of surgical procedures that each oral surgeon may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by oral surgeons shall be under the overall supervision of the Chairperson of Surgery. All oral surgery patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of

any medical problem that may be present at the time of admission or that may arise during hospitalization.

10.1f Podiatrists. Podiatrists are directly responsible to the Chairperson of Surgery. Privileges granted to podiatrists shall be based on evidence of their training, experience, demonstrated competence, judgment, references and other relevant information, including an appraisal by the clinical department in which such privileges are sought. The scope and extent of surgical procedures that each podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Podiatrists will be assigned to the Department of Surgery and shall be subject to the Rules, Regulations and policies of such department. Podiatric procedures performed by podiatrists shall be under the overall supervision of the Chairperson of Surgery. All podiatry patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

10.1g Dentists. Dentists are directly responsible to the Chairperson of Surgery. Privileges granted to dentists shall be based on evidence of their training, experience, demonstrated competence, judgment, references and other relevant information, including an appraisal by the clinical department in which such privileges are sought. The scope and extent of procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other privileges. Dentists will be assigned to the Department of Surgery and shall be subject to the Rules, Regulations and policies of such department. Procedures performed by dentists shall be under the overall supervision of the Chairperson of Surgery. All patients undergoing dental procedures shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

10.20 TEMPORARY PRIVILEGES

10.2a Grant of Temporary Privileges.

44. New Applicants.

The Chief Executive Officer and the President may, upon the basis of information obtained from the completed application, which may reasonably be relied upon as to the competence and ethical standing of this applicant, and with the written concurrence of the Departmental Chairperson concerned, grant temporary admitting and delineated clinical privileges to the applicant. The ECMS and the Board of Director's ratification of temporary privileges for this practitioner shall be required within ninety (90) days of granting such privileges. Temporary privileges will be for a ninety (90) day period.

Specific Patient Privileges.

The CEO and President may, with the written concurrence of the departmental chairperson concerned, grant temporary delineated privileges to a practitioner for the care of a specific patient. Temporary privileges may be granted on a case by

case basis. Such temporary privileges shall be for the period in which the specific patient is in the Hospital, but will not exceed ninety (90) days.

10.2b Criteria for Temporary Privileges.

Temporary privileges for new applicants may be granted upon verification of the following:

45. Current licensure.
46. Relevant training or experience.
47. Current competence.
48. Ability to perform the privileges requested.
49. A query and evaluation of the NPDB information.
50. A completed application.
51. No current or previously successful challenge to licensure or registration.
52. Not subject to involuntary termination of medical staff membership at another organization.
53. Not subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another organization.

Temporary privileges to meet an important care need may be granted upon verification of current licensure and current competence.

An applicant will generally be ineligible for temporary privileges if:

54. There is a current challenge or a previously successful challenge to licensure or registration.
55. The applicant has received an involuntary termination of medical staff membership at another organization.
56. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.
57. The Hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions against the applicant.

10.2c Special Requirements for Temporary Privileges. Special requirements of supervision and reporting may be imposed on any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer and President upon notice of any failure by the applicant to comply with such special conditions or if the ECMS or Board does not ratify the applicant's temporary privileges or limits the temporary privileges. Termination of temporary privileges shall not be subject to the provisions of Hearing and Appeals Procedures section of these Bylaws.

10.30 EMERGENCY PRIVILEGES

- 10.3a In the case of a patient emergency, any practitioner, to the degree permitted by his/her license and regardless of service or Medical Staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary including calling for any consultation necessary.

When a patient emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or the practitioner does not desire to request these privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purposes of this section, an "emergency" is defined as a condition which can result in serious permanent injury to the patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

10.40 DISASTER PRIVILEGES

Practitioners who do not possess Medical Staff privileges at the Hospital may practice at the Hospital during a "disaster" (defined as an officially declared emergency, whether it is local, state or national resulting in the activation of the Hospital's Emergency Management Plan and the inability of the Hospital to meet immediate patient needs). All practitioners volunteering to provide services during a disaster are to report to the Medical Staff Office and must present any of the following information in order to be granted temporary disaster privileges and a proper form of identification to provide such privileges within the Hospital:

58. Valid professional license to practice medicine/healthcare in Connecticut (depending upon the extremity of the disaster, out of state licensure may be accepted if so declared by the State of Connecticut) and a valid photo ID issued by a state, federal or regulatory agency.
59. Current picture hospital photo ID card.
60. Presentation by current Hospital or Medical Staff member(s) with personal knowledge regarding practitioner's identity and ability.
61. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).
62. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity.

Primary source verification of licensure will occur as soon as the immediate situation is under control and is completed within 72 hours from the time the practitioner presents to the Hospital.

Privileges will be granted by the CEO or the President or their designee(s). The Hospitals' Incident Commander will accomplish the coordination and deployment of temporary disaster staff. The practitioner receiving disaster privileges shall perform

services under the supervision of the chairperson of the department to which he/she is assigned.

Within 72 hours after activation of the Hospital's emergency management plan, the Hospital will assess the need for continuation of the disaster privileges granted.

Without limiting any other provision hereof, when the declared emergency has been terminated, all privileges granted will terminate automatically.

10.50 PROFESSIONAL PRACTICE EVALUATION/MONITORING

10.5a Ongoing Professional Practice Evaluation. The Medical Staff shall identify professional practice trends that impact on quality of care and patient safety. The criteria used in this evaluation shall be determined by the relevant department or section as outlined in the OPPE policy.

Relevant information obtained from the ongoing professional practice evaluation is used to determine whether to continue, limit or revoke existing privileges.

10.5b Practice Concerns. Clinical or professional practice concerns regarding a member of the Medical Staff shall be investigated and addressed by the applicable Department Chairperson, Section Chief, Medical Staff leadership or Medical Peer Review Committee as outlined in the Practitioner Performance Improvement Plan section of these Bylaws and, if appropriate, referred to the ECMS for corrective action.

10.60 CHIEF MEDICAL OFFICER

The Chief Medical Officer may be employed by the Hospital and his/her duties would include the exercise of clinical privileges. The CMO must be a member of the Active Medical Staff and shall only be granted clinical privileges in accordance with these Bylaws. The Medical Staff appointment and clinical privileges of the CMO shall also be subject to the other pertinent provisions of these Bylaws except that: (i) the CMO need not satisfy the patient contact requirements and (ii) the CMO's contract may provide for the waiver of the procedural rights set forth in Article 12.00.

ARTICLE 11.00

PRACTITIONER PERFORMANCE IMPROVEMENT PLAN

11.10. PROCEDURE

11.1a Collegial Intervention. The use of progressive steps by Medical Staff Leaders (Department Chairpersons, Officers, appropriate Committee Chairs or their designees) and Hospital management, beginning with collegial and educational efforts, is encouraged, to address questions relating to a Medical Staff member's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the Medical Staff member to resolve questions that have been raised. Collegial intervention efforts are part of confidential routine peer review, professional review activity and ongoing and focused professional practice evaluation. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leader(s) and Hospital management.

The relevant Medical Staff Leader(s), , shall determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy, physician health policy, professional practice evaluation policy), or to direct it to the ECMS. Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of Medical Staff members and pursuing counseling, education, and related steps, such as the following:

advising Medical Staff members of all applicable policies, such as policies regarding appropriate behavior, communication issues, emergency call obligations, and the timely and adequate completion of medical records; and

sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist Medical Staff members to conform their practices to appropriate norms.

The relevant Medical Staff Leader(s) will document collegial intervention efforts and/or institute an FPPE plan if appropriate as outlined in the FPPE policy and such documentation will be kept in the Medical Staff member's confidential file. The Medical Staff member shall have an opportunity to review any formal documentation that is prepared by the Medical Staff Leader(s) and respond in writing. The response shall be maintained in the Medical Staff member's file along with the original documentation.

11.1b Initiation of Investigations. Whenever a serious question has been raised, or where collegial efforts or the routine peer review process have not resolved an issue, regarding:

63. the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;

64. the safety or proper care being provided to patients;

65. the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, rules and regulations, and policies of the Hospital or the Medical Staff; and/or
66. conduct by any member of the Medical Staff that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others,

The matter may be referred to the President of the Medical Staff, another Officer, the Chairperson of a Department, the chair of a standing committee, , or the Chief Executive Officer or designee. The person to whom the matter is referred shall conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, may forward it in writing to the ECMS. When a question involving clinical competence or professional conduct is referred to, or raised by the ECMS, the ECMS shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (e.g., code of conduct policy, practitioner health policy, professional practice evaluation policy), or to proceed in another manner. The ECMS may determine to refer matters involving disruptive behavior or sexual harassment to the Board for further action. In making this determination, the ECMS or designee(s) may discuss the matter with the Medical Staff member. An investigation shall begin only after a formal determination by the ECMS to do so. The ECMS shall inform the Medical Staff member that an investigation has begun. Notification may be delayed if, in the ECMS's judgment, informing the Medical Staff member immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff. The President of the Medical Staff shall keep the Chief Executive Officer fully informed of all action taken in connection with an investigation.

- 11.1c Investigative Procedure. Once a determination has been made to begin an investigation, the ECMS shall either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an investigative committee to conduct the investigation. To preserve impartiality, the investigative committee will not include any individual who is in direct economic competition with the Medical Staff member being investigated; is professionally associated with, a relative of, or involved in a referral relationship with, the Medical Staff member being investigated; or who has actively participated in the matter at any previous level. Any investigative committee may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the Medical Staff member under review, the investigative committee shall include a peer of the Medical Staff member (e.g., physician, dentist, oral surgeon, or podiatrist).

Within 30 days after the ECMS initiates an investigation, or as soon as reasonably possible thereafter, the investigative committee shall make a report of its investigation to the ECMS. Prior to the making of such report, the member of the Medical Staff with respect to whom an investigation has been initiated shall have an opportunity for an interview with the investigative committee. At such interview, the Medical Staff member shall be informed of the general nature of matters being investigated, and shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such interview shall be made and included with the investigative committee's report to the ECMS.

- 11.1d ECMS Review. The ECMS shall take action upon the investigative committee report: (i) within thirty (30) days following the receipt of the investigative committee report (if the report would not result in the reduction or suspension of clinical privileges); or (ii) if the report could result in the reduction or suspension of clinical privileges as soon as reasonably possible following receipt of the report from the investigative committee. If the ECMS is considering a reduction or suspension of clinical privileges, or a suspension or expulsion from the Medical Staff, the affected practitioner shall be permitted to make an appearance before the ECMS prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the ECMS.
- 11.1.e ECMS Action. The action of the ECMS may be: 1) to reject or modify the request for action; 2) to issue a warning letter, a letter of admonition, or a letter of reprimand; 3) to impose terms of probation or a requirement for consultation or additional medical education; 4) to recommend reduction, suspension or revocation of clinical privileges; 5) to recommend that an already imposed precautionary or summary suspension of clinical privileges be terminated, modified or sustained; or 6) to recommend that the practitioner's Medical Staff membership be suspended or revoked. The ECMS shall explain in writing the reasons for its action. Any action of the ECMS shall be in the form of a recommendation to the Board of Directors.
- 11.1f Board Action. The Board of Directors shall review and act upon the recommendation of the ECMS.
- 11.1g Medical Staff Member's Right of Appeal. Any recommendation by the ECMS for reduction, suspension, restriction or revocation of clinical privileges, or for suspension or revocation of Medical Staff appointment shall entitle the affected Medical Staff member to the procedural rights provided in Article 12.00 of these Bylaws.
- 11.1h Notification of CEO. The Chairperson of the ECMS shall promptly notify the Chief Executive Officer in writing of all questions involving clinical competence or professional conduct referred to or raised by the ECMS and shall continue to keep the Chief Executive Officer fully informed of all action taken in connection therewith.
- 11.20 SUMMARY SUSPENSION
- 11.2a Initiation of Summary Suspension. The Chairperson of the ECMS, the chairperson of a clinical department, the Chief Executive Officer, and the Executive Committee of either the Medical Staff or the Board of Directors - shall each have the authority, whenever action must be taken immediately in the best interest of patient care in the Hospital, to summarily suspend all or any portion of the clinical privileges of a member of the Medical Staff, and such summary suspension shall become effective immediately upon imposition. Summary suspension only may be imposed under extraordinary circumstances to prevent imminent danger to the health or safety of any patient, staff member or other person in the Hospital.
- 11.2b Hearing. A summary suspension or restriction of clinical privileges may be instituted for a period of not longer than 30 days.

A member of the Medical Staff whose clinical privileges have been summarily suspended shall be entitled to request that the ECMS hold a hearing on the matter within such reasonable time period thereafter as the ECMS may be convened in accordance with Article 12.00 of these Bylaws.

- 11.2c ECMS Action. After a hearing held in accordance with the provisions of Article 12.00, the ECMS may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such hearing, the ECMS does not recommend immediate termination of the summary suspension, the affected practitioner shall in accordance with Article 12.00, be entitled to request an appellate review by the Board of Directors, but the terms of the summary suspension as sustained or as modified by the ECMS shall remain in effect pending a final decision thereon by the Board of Directors.

11.30 PRECAUTIONARY SUSPENSION

- 11.3a Initiation of Precautionary Suspension. The Chairperson of the ECMS, the chairperson of a clinical department, the Chief Executive Officer, and the Executive Committee of either the Medical Staff or the Board of Directors may impose a precautionary suspension, in the event that a situation arises where it is not entirely clear that summary suspension is required, but the situation is serious enough to warrant an immediate investigation to determine the need for a summary suspension.

- 11.3b Investigation. An immediate investigation shall be conducted upon the imposition of a precautionary suspension. If it is determined that the matter does not require suspension of clinical privileges, it shall either be deemed resolved or shall be referred for a practitioner performance improvement plan. Precautionary suspension shall not be instituted for longer than fourteen (14) days. If it is determined that there should in fact be a summary suspension, a summary suspension shall be imposed, provided, however, that the days during which there was a precautionary suspension shall be counted toward the thirty (30) day maximum time frame for a summary suspension.

11.40 VOLUNTARY AGREEMENT TO EXTEND TIME LIMITS FOR INVESTIGATION WITH RESPECT TO A SUMMARY OR PRECAUTIONARY SUSPENSION

- 11.4a Voluntary Agreement. If a Member of the Medical Staff has been placed on summary or precautionary suspension, such Member, in the Member's sole discretion, may request that the applicable fourteen (14) or thirty (30) day time frame be waived so that a complete internal investigation may be completed by the Medical Staff, or so that an outside impartial consultant may be engaged to review the situation and report back to the ECMS.

- 11.4b Health Care Quality Improvement Act. If a request is made to waive the time frame, such request shall be deemed to constitute an agreement by the Member of the Medical Staff that the procedure is in full compliance with the provisions of the Health Care Quality Improvement Act, and that no claim shall be made to the contrary.

- 11.4c Internal Investigation. If the internal investigation is to continue without the assistance of any outside consultant, it may continue but not for more than 60 days from the date of the initial suspension, at which time a report shall be made to the ECMS.

- 11.4d Selection of Outside Impartial Consultant. The outside impartial consultant shall be chosen by the ECMS, but the Member shall be provided an opportunity to raise reasonable objections to the selection on the grounds that the consultant is not impartial; any objections shall be in writing and shall provide details of why the proposed impartial consultant is in fact not impartial. Upon review of the objections, the ECMS then shall either propose another outside impartial consultant, or shall explain in writing to the Member of the Medical Staff why the objections are without any merit.
- 11.4e. Duties of the Outside Impartial Consultant. The ECMS's written charge to the outside impartial consultant shall be provided to the Medical Staff Member. The outside impartial consultant shall be asked to complete the consultation in as timely a manner as is practicable. Whenever practical, the outside consultant shall meet with the ECMS and with the Member; if meetings are not possible, the written comments of the ECMS and the Member shall be solicited whenever appropriate. The report of the outside impartial consultant shall be provided both to the ECMS and to the Member of the Medical Staff.
- 11.4f. Report of Outside Impartial Consultant. Upon receipt of the report of the outside impartial consultant, unless the ECMS proposes restoring the Member to full clinical privileges, the ECMS shall provide the Member of the Medical Staff with an opportunity to meet with it before it makes any adverse recommendation with respect to the Member's clinical privileges or Hospital appointment.
- 11.4g Final ECMS Action. After receipt of the consultant's report and providing the Member with an opportunity to meet with it, the ECMS, may recommend modification, continuance or termination of the terms of the suspension. The Member of the Medical Staff then shall have such rights to a hearing and appeal as provided in Article 12.00 Hearing and Appeals Procedures, but the terms of the suspension as sustained or as modified by the ECMS shall remain in effect pending a final decision thereon by the Board of Directors.
- 11.4h Alternative Coverage for Patients. Immediately upon the imposition of a summary or precautionary suspension, the responsible Departmental Chairperson or President shall be responsible for providing for alternative medical coverage for the patients of the suspended Medical Staff member still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative Medical Staff member.

11.50 AUTOMATIC RELINQUISHMENT OF MEMBERSHIP/PRIVILEGES

11.5a Delinquent Medical Records.

The failure of a Medical Staff member to comply with the medical records requirements of the State of Connecticut, regulatory agencies or the Hospital, as set forth in more detail in the Rules and Regulations shall result in an automatic temporary suspension of the Medical Staff member's ability to admit patients to the inpatient units or emergency department, or schedule new operative procedures.

- 11.5b State or Federal Actions. Action by a State Board of Examiners suspending or revoking a Medical Staff member's license, or action by federal or state authorities suspending or revoking a Medical Staff member's registration to prescribe controlled substances, or a

voluntary relinquishment of a license by a Medical Staff member, or the voluntary relinquishment of a registration to prescribe controlled substances by a Medical Staff member under circumstances where it has been challenged by state or federal agents or agencies, automatically shall suspend all of the Medical Staff member's Hospital privileges.

The automatic suspension described above may be stayed by the Board of Directors if:

67. The practitioner is in a bona fide rehabilitation program accepted by his/her County or State Professional Association, and/or
68. The license suspension by the State of Connecticut has been stayed (whether or not a consent agreement has been signed).

If a Medical Staff member voluntarily relinquishes his/her license to prescribe controlled substances, whether or not under challenge, but his/her license to practice medicine in the State of Connecticut is not under suspension, or if he/she has entered into a consent agreement so that his/her state license suspension has been stayed, the automatic suspension of Hospital privileges may be stayed by the Board of Directors, but he/she may not enter orders for controlled substances within the Hospital.

- 11.5c Loss of Professional Liability Insurance. The failure of a Medical Staff member to maintain adequate professional liability insurance as required by the Board of Directors shall result in an automatic suspension of all of the Medical Staff member's clinical privileges.
- 11.5d No Hearing Rights. In the event of automatic suspension of privileges, the provisions of Article 12.00 Hearing and Appeals Procedures, shall not apply.
- 11.5e Alternate Coverage for Patients. In the event that the privileges of a Medical Staff member are automatically suspended, the President or Department Chair, or his/her delegate, shall be responsible for providing for alternate medical coverage for patients of the suspended Medical Staff member who remain in the Hospital at the time of such suspension. The wishes of patients shall be considered in the selection of such alternative Medical Staff member.
- 11.5f Notification of CEO/Enforcement. It shall be the duty of the President to notify promptly, the CEO of all automatic suspensions and to cooperate with the Chief Executive Officer in enforcing all automatic suspensions.

ARTICLE 12.00

HEARING AND APPEALS PROCEDURES

12.10 INITIATION OF HEARING

12.1a Grounds for Hearing.

A Medical Staff member is entitled to request a hearing whenever the ECMS makes one of the following recommendations:

- (i) Denial of initial appointment, reappointment or requested clinical privileges;
- (ii) Revocation of appointment or clinical privileges;
- (iii) Suspension of clinical privileges for more than 30 days (other than precautionary suspension);
- (iv) Restriction of clinical privileges, meaning a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance; or
- (v) Denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct and if a report to the National Practitioner Data Bank is required.

No other recommendation or action will entitle the individual to a hearing.

If the Board determines to take any of these actions without an adverse recommendation by the ECMS, a Medical Staff member is entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the ECMS. When a hearing is triggered by an adverse proposed action of the Board, any reference in this Article to the "ECMS" will be interpreted as a reference to the "Board."

12.1b Actions Not Grounds for Hearing. None of the following actions constitute grounds for a hearing. These actions take effect without hearing or appeal. The Medical Staff member is entitled to submit a written statement regarding these actions for inclusion in his or her file:

- 69. A letter of guidance, counsel, warning, or reprimand;
- 70. Conditions, monitoring, or proctoring;
- 71. A lapse, withdrawal of or decision not to grant or not to renew temporary privileges;
- 72. Automatic relinquishment of appointment or privileges;
- 73. A requirement for additional training or continuing education;
- 74. Precautionary suspension;

- 75. Denial of a request for leave of absence or for an extension of a leave;
- 76. Removal from the on-call roster or any reading or rotational panel;
- 77. The voluntary acceptance of a performance improvement plan;
- 78. Determination that an application is incomplete;
- 79. Determination that an application will not be processed due to a misstatement or omission; or
- 80. Determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

12.1c Notice of Recommendation. The President of the Medical Staff will promptly give special notice of a recommendation which entitles a Medical Staff member to request a hearing. This notice will contain:

- 81. A statement of the recommendation and the general reasons for it;
- 82. A statement that the Medical Staff member has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
- 83. A copy of this Article 12.00 of the Bylaws.

12.20 REQUEST FOR HEARING

A Medical Staff member has 30 days following receipt of the notice to request a hearing, in writing, to the President of the Medical Staff, including the name, address, and telephone number of the Medical Staff member's counsel, if any. Failure to request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

12.30 NOTICE OF HEARING AND STATEMENT OF REASONS

12.3a Notice of Hearing.

- 84. The President of the Medical Staff, after consulting with the CEO will schedule the hearing and provide to the Medical Staff member requesting the hearing, by special notice, the following:
 - (i) The time, place, and date of the hearing;
 - (ii) proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;
 - (iii) The names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and
 - (iv) A statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any

time, even during the hearing, so long as the additional material is relevant to the recommendation or the Medical Staff member's qualifications and the Medical Staff member has had a sufficient opportunity, up to 30 days, to review and respond with additional information.

12.3b Date of Hearing. The hearing will begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

12.3c Witness List. At least 10 days before the pre-hearing conference, the Medical Staff member requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf. The witness list will include a brief summary of the anticipated testimony. The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

12.40 HEARING PANEL, PRESIDING OFFICER, AND HEARING OFFICER

12.4a Hearing Panel. The President of the Medical Staff, after consulting with the Chief Executive Officer, will appoint a Hearing Panel in accordance with the following guidelines:

85. The Hearing Panel will consist of at least three members, one of whom will be designated as chair.
86. The Hearing Panel may include any combination of:
 - (i) Any member of the Medical Staff or Adjunct Staff, or
 - (ii) Physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or Adjunct Staff or laypersons not affiliated with the Hospital).
87. Knowledge of the underlying peer review matter, in and of itself, will not preclude an individual from serving on the Hearing Panel.
88. Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Hearing Panel.
89. The Hearing Panel will not include any individual who:
 - (i) Is in direct economic competition with the Medical Staff member requesting the hearing;
 - (ii) Is professionally associated with, a relative of, or involved in a referral relationship with, the Medical Staff member requesting the hearing;
 - (iii) Has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

- (iv) Actively participated in the matter at any previous level.

12.4b Presiding Officer.

- 90. The President of the Medical Staff, after consultation with the Chief Executive Officer, will appoint an attorney to serve as Presiding Officer. The Presiding Officer will not act as an advocate for either side at the hearing.
- 91. The Presiding Officer will:
 - (i) Schedule and conduct a pre-hearing conference;
 - (ii) Allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
 - (iii) Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
 - (iv) Maintain decorum throughout the hearing;
 - (v) Determine the order of procedure;
 - (vi) Rule on matters of procedure and the admissibility of evidence; and
 - (vii) Conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Hearing Panel wishes to be present.
- 92. The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.
- 93. The Presiding Officer may participate in the private deliberations of the Hearing Panel, may be a legal advisor to it, and may draft the report of the Hearing Panel's decision based upon the findings and discussions of the Hearing Panel, but will not vote on its recommendations.

12.4c Hearing Officer.

- 94. As an alternative to a Hearing Panel, in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, or failure to comply with rules, regulations or policies and not issues of clinical competence, knowledge, or technical skill, the President of the Medical Staff, after consulting with and obtaining the agreement of the Chief Executive Officer, may appoint a Hearing Officer. The Hearing Officer, who should preferably be an attorney, will perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the Medical Staff member requesting the hearing.
- 95. If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" will be deemed to refer to the Hearing Officer.

12.4d Compensation. Members of the Hearing Panel, the Presiding Officer, or the Hearing Officer may be compensated for their service by the Hospital. The Medical Staff member requesting the hearing may participate in that compensation. Compensation will not constitute grounds for challenging the impartiality of the Hearing Panel members.

12.4e Objections. Any objection to any member of the Hearing Panel, to the Hearing Officer, or to the Presiding Officer will be made in writing, within ten days of receipt of notice of the Hearing Panel members, to the President of the Medical Staff. The objection must include reasons to support it. A copy of the objection will be provided to the President of the Medical Staff. The President of the Medical Staff will be given a reasonable opportunity to comment. The President of the Medical Staff will rule on the objection and give notice to the parties. The President of the Medical Staff may request that the Presiding Officer make a recommendation as to the validity of the objection.

12.4f Counsel. The Presiding Officer, Hearing Officer, and counsel for either party may be attorneys at law licensed to practice, in good standing, in any state.

12.50 PRE-HEARING PROCEDURES

12.5a General Procedures. The pre-hearing and hearing processes will be conducted in an informal manner. Formal rules of evidence or procedure will not apply.

12.5b Time Frames. The following time frames, unless modified by mutual written agreement of the parties, will govern the timing of pre-hearing procedures:

96. The pre-hearing conference will be scheduled at least 14 days prior to the hearing;

97. The parties will exchange witness lists and proposed exhibits at least 10 days prior to the pre-hearing conference; and

98. Any objections to witnesses and/or proposed exhibits must be provided at least five days prior to the pre-hearing conference.

12.5c Provision of Relevant Information.

99. Prior to receiving any confidential documents, the Medical Staff member requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The Medical Staff member must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

100. Upon receipt of the above agreement and representation, the Medical Staff member requesting the hearing will be provided with the following:

(i) Copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the Medical Staff member's expense;

(ii) Reports of experts relied upon by the ECMS;

- (iii) Copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
- (iv) Copies of any other documents relied upon by the ECMS.

The provision of this information is not intended to waive any privilege.

- 101. The Medical Staff member will have no right to discovery beyond the above information. No information will be provided regarding other practitioners on the Medical Staff or Adjunct Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.
- 102. Ten days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits.
- 103. Neither the Medical Staff member, nor any other person acting on behalf of the Medical Staff member, may contact Hospital employees, other Medical Staff members or Adjunct Staff members whose names appear on the ECMS's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the Medical Staff member who requested the hearing once it has contacted such employees, other Medical Staff members or Adjunct Staff members and confirmed their willingness to meet. Any employee or Medical Staff or Adjunct Staff member may agree or decline to be interviewed by or on behalf of the Medical Staff member who requested a hearing.

12.5d Pre-Hearing Conference.

- 104. The Presiding Officer will require the Medical Staff member and the ECMS (or a representative of each, who may be counsel) to participate in a pre-hearing conference.
- 105. All objections to exhibits or witnesses will be submitted, in writing, five days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- 106. At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses.
- 107. Evidence unrelated to the reasons for the recommendation or to the Medical Staff member's qualifications for appointment or the relevant clinical privileges will be excluded.
- 108. The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination.

12.5e Stipulations. The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

12.5f Provision of Information to the Hearing Panel.

The following documents will be provided to the Hearing Panel in advance of the hearing:

- 109. A pre-hearing statement that either party may choose to submit;
- 110. Exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and
- 111. Stipulations agreed to by the parties.

12.60 THE HEARING

12.6a Time Allotted for Hearing. It is expected that the hearing will last no more than 15 hours, with each side being afforded no more than approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

12.6b Record of Hearing. An accurate record of the hearing must be kept. The mechanisms shall be established by the Presiding Officer and may be accomplished by use of a court reporter, electronic recording unit or detailed transcription. The affected Medical Staff member shall be entitled upon payment of reasonable charges associated with preparing the record, if any, to obtain a copy of the record of the proceedings. Oral testimony will be taken on oath or affirmation administered by any authorized person.

12.6c Rights of Both Sides and the Hearing Panel at the Hearing.

112. At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer:

- (i) To call and examine witnesses, to the extent they are available and willing to testify;
- (ii) To introduce exhibits;
- (iii) To cross-examine any witness;
- (iv) To have representation by counsel, who may call, examine, and cross examine witnesses and present the case;
- (v) To submit a written statement at the close of the hearing; and
- (vi) To submit proposed findings, conclusions and recommendations to the Hearing Panel.

113. If the Medical Staff member who requested the hearing does not testify, he or she may be called and questioned.

114. The Hearing Panel may question witnesses, request the presence of additional witnesses, or request documentary evidence.
- 12.6d Order of Presentation. The ECMS will first present evidence in support of its recommendation. Thereafter, the burden will shift to the Medical Staff member who requested the hearing to present evidence.
- 12.6e Admissibility of Evidence. The hearing will not be conducted according to rules of evidence. Evidence will not be excluded merely because it is hearsay. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. The guiding principle will be that the record contains information sufficient to allow the Board to decide whether the Medical Staff member is qualified for appointment and clinical privileges.
- 12.6f Persons to Be Present. The hearing will be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the President of the Medical Staff.
- 12.6g Presence of Hearing Panel Members. A majority of the Hearing Panel will be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, that Hearing Panel member must certify that he or she read the entire transcript or reviewed the electronic recording of the portion of the hearing or from which he or she was absent.
- 12.6h Failure to Appear. If the Medical Staff member for whom the hearing has been scheduled fails without good cause, to appear and proceed at the hearing he/she shall be deemed to have waived his/her right to a hearing and the matter will be forwarded to the Board for final action.
- 12.6i Postponements and Extensions. Postponements and extensions of time may be requested by anyone, but will be permitted only by the Presiding Officer or the President of the Medical Staff on a showing of good cause.
- 12.70 HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS
- 12.7a Basis of Hearing Panel Recommendation. Consistent with the burden on the Medical Staff member to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel will recommend in favor of the ECMS unless it finds that the Medical Staff member who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.
- 12.7b Deliberations and Recommendation of the Hearing Panel. Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel will conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel will render a recommendation, accompanied by a report, which will contain a statement of the basis for its recommendation.

12.7c Disposition of Hearing Panel Report. The Hearing Panel will deliver its report to the President of the Medical Staff. The President of the Medical Staff will send a copy of the report to the Medical Staff member who requested the hearing. The President of the Medical Staff will also provide a copy of the report to the Chief Executive Officer and to the Board for their final decision in accordance with Section 12.90.

12.80 APPEAL PROCEDURE

12.8a Time for Appeal.

115. Within ten (10) days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the President of the Medical Staff in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

116. If an appeal is not requested within ten (10) days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

12.8b Grounds for Appeal. The grounds for appeal will be limited to the following:

117. There was substantial failure by the Hearing Panel to comply with the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; or

118. The recommendations of the Hearing Panel were made arbitrarily or capriciously or were not supported by credible evidence.

12.8c Time, Place and Notice. Whenever an appeal is requested, the chair of the Board will schedule and arrange for an appeal. The Medical Staff member will be given notice of the time, place, and date of the appeal. The appeal will be held within 30 days of request if the affected Medical Staff member is suspended and 60 days for all other matters, taking into account the schedules of all the individuals involved.

12.8d Nature of Appellate Review.

119. The Board may serve as the Review Panel or the chair of the Board may appoint a Review Panel, composed of members of the Board or others, including but not limited to reputable persons outside the Hospital.

120. The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the ECMS and Hearing Panel and any other information that it deems relevant, and recommend final action to the Board.

121. Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have ten days to respond. In its sole discretion, the

Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

122. When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

12.90 BOARD ACTION

12.9a Final Decision of the Board.

123. The Board will take final action within 30 days after it (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report when no appeal has been requested.
124. The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the ECMS, Hearing Panel, and Review Panel (if applicable).
125. Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may adopt, modify, or reverse any recommendation that it receives or refer the matter for further review.
126. The Board will render its final decision in writing, including the basis for its decision, and will send notice to the individual. A copy will also be provided to the President of the Medical Staff.
127. Except where the matter is referred by the Board for further review, the final decision of the Board will be effective immediately and will not be subject to further review.

12.9b Right to One Hearing and One Appeal Only. No Medical Staff member will be entitled to more than one hearing and one appeal on any matter.

ARTICLE 13.00

IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application for, reapplication for, or exercise of Medical Staff or Adjunct Staff membership or clinical privileges at this Hospital.

128. That any act, communication, report, recommendation, or disclosure, with respect to any such practitioner, performed at the request of an authorized representative of this or any other health care facility, for the purpose of credentialing or achieving and maintaining quality patient care in this or any other health care facility shall be privileged to the fullest extent permitted by law.
129. That such privilege shall extend to members of the Hospital's Medical Staff, the Board of Directors, the Chief Executive Officer, and their authorized designees and representatives, Hospital employees and committees of the Medical Staff or Hospital or Board of Directors and third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article 13.00, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Board of Directors or of the Medical Staff.
130. That there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation or disclosure, even where the information involved would otherwise be deemed privileged.
131. That such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with (1) applications for appointment or clinical privileges, (2) periodic reappraisals for reappointment or clinical privileges, (3) corrective action, including summary or precautionary suspension, (4) hearings and appellate reviews, (5) medical care evaluations, (6) utilization reviews, and (7) other Hospital, departmental, service or committee activities related to credentialing, quality patient care, professional conduct and peer review.
132. That the acts, communications, reports, recommendations and disclosures referred to in this Article 13.00 may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics or any other matter that might directly or indirectly have an effect on patient care.
133. The practitioner agrees that the hearing and appeal process is the sole and exclusive remedy for professional review actions.
134. An practitioner who has sued the Hospital and Medical Staff members, and does not prevail, must reimburse the defendants for all legal fees incurred.

ARTICLE 14.00

SUCCESSOR INTEREST

In the event that the Hospital is contemplating merging with, or being consolidated into any other corporation(s), or in the event that it contemplates selling or transferring substantially all or a significant amount of its assets to another corporation or entity, then (1) the Medical Staff leadership will be notified of any such situation; (2) there will be full consultation with the Medical Staff before any contemplated transaction is finalized.

ARTICLE 15.00

REVIEW, REVISION, ADOPTION AND AMENDMENT

15.10 MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the responsibility to formulate, review annually, adopt and recommend to the Board, Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the review, adoption and amendment of the related, policies and protocols developed to implement various sections of these Bylaws.

15.20 METHODS OF ADOPTION AND AMENDMENT

- 15.2a Medical Staff Bylaws. These Bylaws may be amended after notice given at any regular meeting of the Medical Staff and may be voted on at any subsequent regular meeting of the Medical Staff. A two-thirds vote of those present at a meeting is required for passage of the amendment. Amendments so made shall be effective when approved by the Board of Directors.
- 15.2b Board Approval. The Board of Directors has ultimate legal authority for the approval and adoption of the Medical Staff Bylaws, Rules & Regulations, Policies and Procedures. Notwithstanding the foregoing, neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws or rules and regulations or policies.
- 15.2c Provisional Amendments. The Executive Committee of the Medical Staff may provisionally adopt and the Board of Directors may provisionally approve an urgent amendment to the Medical Staff Bylaws without prior notification of the Medical Staff. This would only occur when an urgent amendment is necessary to comply with law or regulation. In such cases, ECMS will immediately notify the Medical Staff. The Medical Staff will then have the opportunity to review and comment on the provisional amendment and vote to adopt the amendment at the next General Meeting of the Medical Staff. If approved by the organized Medical Staff, the provisional amendment will stand as it has already been approved by the ECMS and the Board. If there is conflict over the amendment, the process for resolving conflict between the Medical Staff and ECMS will be implemented. If necessary, a revised amendment will then be submitted to the Board for action.

